

## Integrating a new public health order

The Mental Health Series in *The Lancet* made a compelling case for launching a new movement for mental health.<sup>1</sup> The Series' call to integrate mental health into public health must, however, be viewed in the context of its current Series, which aims to place chronic diseases higher on the global public-health agenda. Both Series underscore the need to reorient public-health priorities worldwide—and rightly so given that 63% of the global burden of disease can be attributed collectively to mental health and chronic diseases.<sup>2</sup>

Both Series hold individual merit in terms of their potential to advocate for change in global health priorities and policies, set global norms and standards, and provide globally acceptable knowledge for action in their respective domains. However, they also raise a number of questions: is there a need to converge both the calls to action into a common message for unified action to reorient public-health priorities? Can prevention and health promotion for chronic diseases and mental health be combined in the same programme with similar activities but hold different meanings for two groups of target population? And is it plausible to advocate for integration across this new public-health agenda?

Clearly evidence from process and outcome evaluations is needed to answer these questions because countries have limited experience with such integration despite the existence of plans which show that some public-health actions can be combined.<sup>3</sup> Such actions include population-level surveillance, reorganisation of facility-based instruments geared to gathering data on communicable diseases, and structuring of synchronous messaging for behaviour change communication.

Additionally, it seems logical to address both dimensions of public health at the same time while recasting

health services in terms of building capacity of health professionals, upgrading basic infrastructure, and updating national essential drug lists. However, for cross-country comparisons, integration has proven difficult.<sup>4</sup>

Integration across public-health domains might also be needed in view of the evidence of inadvertent weaknesses that vertical infectious disease programmes have created in health systems and from which agencies such as WHO are now moving away. A coordinated agenda is also preferred over the silo approach in view of other contemporaneous public-health needs such as injury prevention and control of emerging and re-emerging infections, which also need to be mainstreamed into public-health planning.

Compelling as it seems, the process needs to be guided by evidence—not just on disease domain and action-level integration but also evidence that makes a case for health-systems strengthening.

I declare that I have no conflict of interest.

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- 1 Horton R. Launching a new movement for mental health. *Lancet* 2007; **370**: 1.
- 2 The Lancet. Preventing chronic disease: a forthcoming initiative. *Lancet* 2007; **370**: 630.
- 3 Nishtar S, Bile KM, Ahmed A, et al. Process, rationale, and interventions of Pakistan's National Action Plan on Chronic Diseases. *Prev Chronic Dis* 2006; **3**: A14.
- 4 WHO. STEPwise approach to surveillance. <http://www.who.int/chp/steps/en/> (accessed Dec 31, 2003).

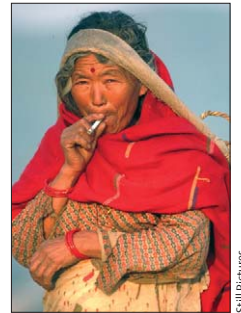
## Global interest in addressing non-communicable disease

The burden of chronic disease is increasing, and now accounts for 70% of the global burden of disease and 60% of mortality. Yet this increase has not been accompanied by a proportionate rise in resources, neither human nor

financial. Ovations, a subsidiary of the UnitedHealth Group, recently pledged US\$15 million in cash and kind over 5 years to fund the creation of centres of excellence to increase individual, institutional, and community capacity to counter the pandemic of chronic non-communicable disease in developing countries. The global response to a request for proposals was surprisingly large and shows that there is appreciable—yet largely untapped—global interest for non-communicable disease prevention and control and that many partners from around the globe are gearing up to tackle the pandemic.

More than 70 countries across six continents responded to Ovations with 136 proposals, representing over 400 partnerships bridging academic institutions, non-governmental organisations, hospitals, public-private organisations, and government. Proposals included studies that focused on surveillance, community-based interventions, medical research, training of health professionals and community health workers, public education, and capacity-building. About 30% of the proposals highlighted training of health professionals and paraprofessionals, 30% proposed medical research, and more than 40% proposed community interventions. Interestingly, several proposals focused on forging strategic links with the private sector to harness market expertise.

The figure shows the global distribution of applicant partners by region, and the corresponding share of non-communicable disease deaths by region. About 61% of partners are from the three regions with the highest non-communicable disease mortality (Europe and central Asia, east Asia and Pacific, and Latin America and Caribbean). However, a substantial proportion (nearly a third) also comes from the two regions with the lowest non-communicable disease mortality (south Asia and sub-Saharan Africa), possibly indicating a desire to stop the



Still Pictures

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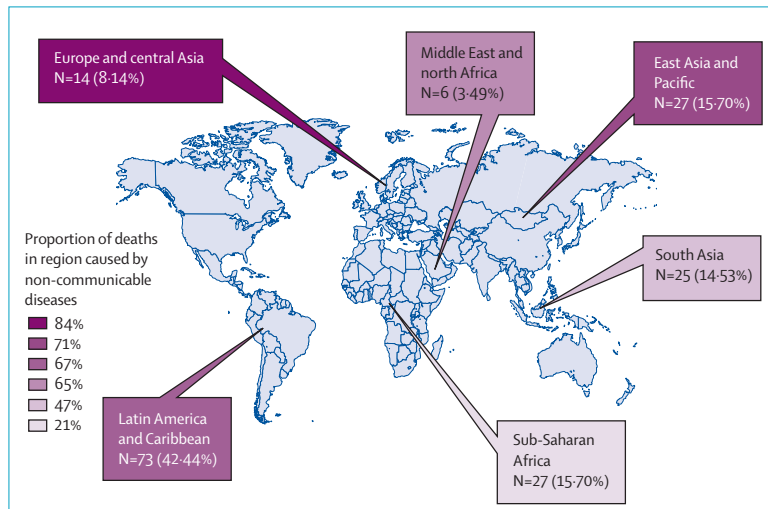


Figure: Number of proposals and proportion of non-communicable disease deaths<sup>1</sup> by World Bank region

non-communicable disease pandemic before it escalates to levels seen in other parts of the world. As might be expected, the largest responses came from India (14 proposals), China (10 proposals) and Brazil (13 proposals)—three emerging-market countries with a disproportionately large burden of chronic diseases that threatens to hinder economic growth in the coming decades.

The time is surely ripe for major funders to respond to the pandemic of non-communicable diseases in developing countries, and there are promising signs. For example, the Oxford Health Alliance, one of the leading non-governmental organisations tackling chronic disease globally, has received a \$5.3 million grant from Pepsico Foundation to fund a pilot study that includes innovative comprehensive community interventions to combat chronic disease in India, China, Mexico, and the UK. It is crucial that more donors join them and respond to the grand challenges in chronic non-communicable disease published in *Nature* last month.<sup>2</sup>

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## Should we undertake an MRI breast screening trial?

Christiane Kuhl and colleagues (Aug 11, p 485)<sup>1</sup> report that MRI has significantly higher sensitivity than mammography in detecting ductal carcinoma in situ (DCIS), especially high-grade DCIS. On the basis of these findings, Carla Boetes and Ritse Mann conclude their accompanying Comment<sup>2</sup> by saying that a multicentre breast screening trial with MRI for the general population is now essential. We must pause for a moment to ponder over the expected outcomes and consequences of such a trial before committing to this kind of large-scale effort.

The reduction in mortality in screening trials is proportional to the reduction achieved in tumour size at diagnosis.<sup>3</sup> However, such a reduction in

mortality comes with a price. In a high-quality systematic review,<sup>4</sup> Gøtzsche and colleagues concluded: “for every 2000 women invited for screening throughout 10 years, one will have her life prolonged. In addition, 10 healthy women, who would not have been diagnosed if there had not been screening, will be diagnosed as breast cancer patients and will be treated unnecessarily”. The higher sensitivity of MRI in detecting DCIS also means a higher propensity for overdiagnosis. Additionally, the per-unit cost of MRI is at least seven times higher than that of mammography,<sup>5</sup> which means very high costs for running a screening programme using MRI.

An MRI breast-screening trial might well improve on the current absolute reduction in mortality of 0.05%.<sup>4</sup> However, it will certainly cause more overdiagnoses, which by themselves increase health-care costs, and will cost much more to run in itself. Implementing the findings of such a trial will be very difficult. Should we pursue clinical research that will probably not find an application in the near future? The answer to this question should dictate whether we should undertake an MRI breast-screening trial or not.

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