Cardiovascular Risk Reduction: Where Are We Now?

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It is proved beyond doubt; with available statistics that cardiovascular disease burden is the most important public health priority in regions of epidemiologic transition.[1] National governments have already started initiatives for addressing this priority. The national program for NCD control is an example. Though the guidelines are mostly about easily implementable and relatively noncontroversial interventions and, the program is already on the anvil, the impact of the program is yet to be felt. Even in Kerala state which has adopted the program for the whole state with considerable support by private and NGO sector, the major emphasis is on secondary prevention than on primary. Mortality reduction is certainly a priority but it should not be neglecting the efforts on morbidity reduction.

A drop of preventive care is considered to be far better than an ounce of curative care. Still prevention many a times become lip service only. Though Governments are committed towards this mission, curative services dominate and people also demand drugs because of the deep rooted concept of a 'pill for an ill'.

The problems identified for successful accomplishment of total preventive care orientation are;

- Poor budget allotment for exclusive preventive services.
- Lack of domain delegation and evidence establishment of preventive services.
- Lack of sufficient clarity and emphasis in preventive prescriptions which needs deep rooted behavioural modification. Considerable uncertainty still remains about primary prevention of cardiovascular diseases.
- Lack of support from non-health sectors. The education department, Public works department Labour departments, social justice department etc also are stakeholders of the mission of cardiovascular disease control. Convergence of activities of these departments is essential to show results in primary prevention.
- Lack of orientation of the medical education curriculum towards preventive health care: From theoretical rhetoric to action points: Integrating new frontiers in to the RNMCH platform for addressing the youth for healthy lifestyle changes is needed.
- Let us look in to the major criticisms of the existing governmental program.

First and foremost is about the burden assessment. It needs a lot to be done about improving the quality of data collected. Available statistics is only about the hospital level information. Further steps for improving quality of documentation like maintaining effective community level registries, computerisation of existing hospital information and sharing the secondary data with researchers and policy people. Though the Govt. of India started an NCD Surveillance program this was stopped short.

There are many issues to be addressed about the conduct of screening camps for detection of hypertension and diabetes. What is the mechanism for follow up? Is there a total evaluation of the newly detected cases at least? Are the prescriptions provided along with enough interventions for primary prevention also? This is relevant because bitter tablet of prevention should be coated with sugar of treatment so that this becomes acceptable to people.

Access to drugs is important but drug delivery should not be undertaken as an isolated event. As there is high demand for this activity, this should be used as a galvanizing agent for behaviour modification and further secondary prevention activities. Though protocols and guidelines are plenty the adherence is less and it needs considerable popularization among the medical caregivers.[2]

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Among the artillery for primary prevention, tobacco smoking activity is perhaps the single intervention which got fast momentum and has a visible impact. Legislation and implementation of law can make still more wonders. There is no justification for tolerances to sale of lose cigarettes by law in our country and there are many other equally important and doable efforts.

In short, cardiovascular disease control program is very much the need of the hour. The program should be implemented with more directionality towards primary prevention, the implementation should be done without neglecting primary care infrastructure, regular care giver education including physician updating and demystifying the technology for primary prevention are the steps needed for this mission of achieving cardiovascular morbidity reduction.

END NOTE

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