

Long-Term Health Condition Having no Cure

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Abstract

Chronic diseases have traditionally included cardiovascular disease, diabetes and asthma or chronic obstructive pulmonary disease. As survival rates and durations have improved, this type of disease now also included many varieties of cancer, HIV/AIDS, mental disorders and disabilities such as sight impairment and arthritis.

Keywords: Financial Incentives; Cardiovascular; Productivity; Health; WHO; Improvements

Introduction

Many chronic diseases and conditions are linked to an ageing society, but also to lifestyle choices such as smoking, sexual behaviour, diet and exercise, as well as to genetic predispositions. In particular, our analysis suggests that new pharmaceuticals and medical devices can help to improve treatment for the chronically ill, but will bring new difficulties in terms of marketing authorization and reimbursement. Moreover, we argue that properly applied financial incentives can be powerful tools to bring about effective and rapid change. However, policy-makers need to pay attention to operational aspects, such as the size of variable compensation or funding, as well as issues relating to goal-setting. In terms of chronic care, benefits tend to become apparent only after several years, which means that policy-makers must realize that often the quality of care will only be improved if providers are confident that they will be able to benefit from their investments [1]. Hence, they need to look carefully at which strategy to follow with regard to continuity of care [2]. In addition, policy-makers should recognize that reforms intended to improve coordination must be well prepared and supported by strong political will. They should map out clearly the responsibilities of all the individuals and groups involved. The balance between local autonomy and central authority must be carefully defined. Policy-makers will also need to provide enough funding to enable reform, while at the same time setting up compensation schemes that will encourage professional groups to cooperate. Finally, health workers need adequate training and mutual learning and communication [3]. Furthermore, to release the full potential of information and communication technology, agreement must be reached on international technical standards. Solutions must be found for translating the vast amounts of data into meaningful information that health professionals can use. Finally, evaluation should be an integral part of programmes to improve the management of chronic disease. The process should not block effective patient-oriented innovations, which is a dilemma for which new approaches need to be developed and agreed [4]. Because policy-makers need better evidence in order to make informed decisions, existing data should immediately be made available for research. Chronic disease is responsible for most of the disease and deaths in Europe.

Discussion

One measure of the overall burden of disease, developed by WHO, is the disability-adjusted life year. It is designed to quantify the impact on a population of premature death and disability by combining them into a single measure. The DALY relies on the assumption that the most appropriate measure of the effects of chronic illness is time either spent disabled by disease or lost due to premature death. One DALY equals

one year of healthy life lost. Most studies focus on chronic conditions and on risk factors between countries, while only a few have looked at the distribution within countries [5]. However, increasing data from high-income countries almost unanimously show that the poor within these countries carry a higher chronic disease burden than the rich. The contribution of chronic diseases to the overall mortality and burden of disease varies within Europe, as the leading chronic conditions illustrate. However, with some diseases we do not know how much of this variation is caused by disease, and how much by differences in coding by health professionals in the various countries. However, the mortality and disease burden attributed to stroke in Europe varies considerably. The Russian Federation, Kyrgyzstan and Kazakhstan have up to normal times higher levels than Switzerland, Israel and France. Mortality and disease burden from diabetes mellitus also vary considerably. These figures however, are likely to be an underestimate because diabetes is not always recorded as the underlying cause of death, particularly for older people. In addition, for some countries with apparently low death rates the burden of disease has been estimated to be above average. Predictions for specific chronic conditions vary. For example, WHO has projected fewer deaths and DALYs from stroke for both sexes and across all ages in Europe. Microeconomics examines the consequences of chronic disease on individuals and households. The key routes through which ill health in general, and chronic diseases in particular, may impact on the economy, are through its effects on consumption and savings, labour productivity and supply as well as education. The evidence from European countries is growing but still limited [6]. So far it has identified various effects of chronic conditions, explored here. Treating chronic diseases may be particularly costly in countries where a high share of total health spending is paid out of pocket. Spending on addictive products such as tobacco and alcohol may cause poor health, and the household's ability to keep consumption levels constant in the face of health shocks can be very costly. In contrast, Carandang, Seshadri and Beiser, while agreeing that both incidence and mortality are declining, argue for a higher prevalence, and therefore burden of disease, due to improvements in stroke treatment and an ageing population prone to strokes. There is considerable evidence on the

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epidemiology of chronic disease, but little on its economic implications. This chapter reviews recent microeconomic and macroeconomic evidence. The economic implications of specific strategies should not be the main or only guide when making health care decisions, but one purpose of any intervention must be to improve health cost-effectively. Clearly, policy-makers often target economic variables such as cost savings, greater labour productivity or economic growth, but these should not be the main criteria for evaluating specific strategies in chronic disease management. In order to understand the implications of chronic conditions and diseases, the economic implications should be examined. Education and human capital formation are accepted as a powerful determinant of future earnings and future health. A full assessment of the costs of chronic disease should include the impact on education; current evidence shows that it affects educational performance. The death of a parent can reduce school enrolment. Several studies have reported an association between maternal smoking and impaired cognitive and behavioural development, which in turn affects the academic performance of children [7]. Alcohol abuse is related to poor performance. This applies to young people in developed countries, where excessive drinking among younger age groups is relatively widespread. Overweight or obese children are more likely to suffer from low self-esteem as a result of stigmatization and this leads to absence from school. The effects of chronic conditions and diseases on labour market outcomes and education are especially pronounced in low- and middle-income countries. In Europe, health insurance mitigates some of these effects. Nevertheless, the consequences remain negative in terms of the impact on labour supply, productivity, education and the accumulation of human capital. Overall, the evidence shows that chronic conditions and diseases have a negative effect on the labour market and on the formation of human capital. However, the causal linkages are far from clear and these gaps need to be filled by further research. The macroeconomic perspective looks at the overall effect in terms of GDP or the GDP growth rate. Health as measured by life expectancy or adult mortality is a robust predictor of economic growth [8]. Chronic disease constitutes a major part of the global health burden. Mortality, DALYs and reduced life expectancy from chronic disease can be expected to depress economic growth. However, research on this has been limited, partly as a result of data and methodological challenges. There is evidence that health is a significant determinant of economic growth for high-income countries [9]. A study estimated that a advantage in life expectancy explains a higher annual GDP growth rate in subsequent years. Although this study does not focus on chronic disease, these results suggest a significant relationship between health and growth. More recently, found that cost-of-illness studies showed that the cost of chronic diseases and their risk factors had a sizeable impact on a country GDP, They looked at the worldwide impact of cardiovascular mortality on economic growth among the working-age population. In high-income countries, they found that an increase in the mortality rate decreased the growth rate of per capita income. This may appear a small figure in terms of growth, but it becomes quite

substantial when calculated over the long term [10]. Similar policies have been developed for alcohol abuse. Raising prices with higher taxes does reduce consumption. Bans on advertising are thought to reduce social acceptance of excess drinking. Sales of alcohol may be restricted to licensed retail outlets or during limited hours, and minimum age restrictions applied. Strict driving laws discourage excessive drinking and prevent traffic accidents. The dominant approach in obesity control is primary prevention. The European Commission has developed an action plan for European dietary guidelines based on existing evidence on health promotion programmes.

Conclusion

The plan describes population goals in terms of nutrients and lifestyle for the prevention of chronic diseases in Europe. Although there are effective interventions to reduce obesity, in many countries the response to the challenge is inadequate.

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Conflict of Interest

None

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