Among the regulators, Mullard does not mention the Haute Autorité de Santé (the French health-care watchdog) and its "transparency" committee. This committee assesses drugs for reimbursement and pricing. A draft report[4] it produced in 2006 on the reassessment of benfluorex included a prominent note that benfluorex was (a) a hidden anorexigen misused for slimming; (b) a derivate of the fenfluramine family, withdrawn for pulmonary hypertension and valvular disease; and (c) withdrawn in Spain for these same adverse effects. The final version of the report contained no such note.[5]

Lastly the role of the experts and of many medical colleges was not mentioned by Mullard. This might need a separate piece.

I was sacked by the Department of Health from my position as a senior tenured consultant in public health at Amiens University Hospital.

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Non-communicable diseases in southeast Asia

In describing features of a comprehensive response to the rise of chronic non-communicable diseases (NCDs) in southeast Asia, Antonio Dans and colleagues (Feb 19, p 680)[1] highlight the need to strengthen primary health care as the way to ensure care for millions affected with chronic conditions. This point echoes that of recent reviews on NCDs.[2,3] But beyond establishment of a comprehensive service at primary level, putting people living with chronic conditions at the centre of managing themselves must be considered.

Traditional service delivery platforms that put health teams at the heart of disease management might not be feasible given the nature of chronic conditions and current resources. Even with stronger prevention programmes, we can expect an ever-growing number of people to be affected with chronic disease in the next decades. Just between Indonesia and the Philippines, the most populous countries in the region, there will already be an estimated 29·2 million people with diabetes by 2030.[4]

Organisation of lifelong care for chronic conditions must move towards greater self-management, whereby patients gain a mastery of their disease. The role of expert patients, and peer and community support groups, must be harnessed further. In Cambodia, a community-based diabetes support group[5] provides not only information but also facilitates greater access to laboratory tests and essential medicines among its members. We must also seize the opportunities provided by the spread of mobile phones and smart devices to support patients in managing their own conditions and to reshape how they interact with health-care providers.

We need to radically rethink our concept of health care to address the rise of non-communicable disease. This shift implies very simple diagnostic and treatment protocols, fewer barriers to essential medicines, greater access to simple monitoring devices, and a move towards true empowerment of patients.

I declare that I have no conflicts of interest.

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According to Antonio Dans,[1] lack of workforce and infrastructure is one of the limitations to management of non-communicable diseases (NCDs) in southeast Asia. We agree that the health-care delivery system was designed mainly to manage acute infectious diseases in resource-limited southeast Asian countries. However, many of these countries have also established a system to manage HIV as a chronic disease, and such systems can be applied for the management of NCDs too.

In Burma, Cambodia, Thailand, and Vietnam, 312 566 HIV patients were on antiretroviral therapy (ART) in 2009: 68% of those in need.[2] To promote a long-term continuum of care, these countries established pioneer chronic disease management systems. Services were integrated within public health-care facilities and linked to the communities. A key feature was the involvement of affected communities as co-service providers,[2,3] whereby patients had a central role in promoting self-care, treatment adherence, and peer support. Further, a longitudinal patient follow-up system has been developed with registers and individual patients' cards and files,[2]