



PART 3

Read the text below and answer questions 27–40.

THE RISE OF NON-COMMUNICABLE DISEASES: A GLOBAL SHIFT

A The world's disease profile has been reshaped by a sweeping epidemiological transition. In many regions, the dominant threats to life are no longer acute infections but chronic, non-communicable diseases (NCDs), most notably cardiovascular disease, cancers, chronic respiratory disorders and diabetes. These conditions are not transmitted from person to person in the way that influenza or tuberculosis is. Instead, they develop over time through interacting genetic predispositions, physiological pathways, environmental exposures and behavioural patterns. As NCDs have risen, they have forced a rethinking of what health systems are for: services built around short episodes of infectious illness must increasingly deliver prevention, early detection and long-term management as core functions rather than optional add-ons. This shift is particularly consequential because NCDs now dominate mortality at the global level and, in many countries, account for the majority of health-system demand.

B The most influential drivers of the NCD surge are modifiable risk factors that spread with modernisation and globalisation. Tobacco use, diets high in salt, sugar and saturated fats, physical inactivity and harmful alcohol consumption remain central. Urbanisation often intensifies these risks by reshaping daily life: jobs become less physically demanding, transport becomes motorised, and affordable processed foods become widely available. Yet behaviour does not occur in a vacuum. Social conditions such as poverty, education, job insecurity and chronic stress can strongly shape exposure to risk and the capacity to avoid it. For this reason, NCDs can no longer be seen as “diseases of affluence”. They increasingly burden low- and middle-income countries, where resources for prevention and chronic care are often weakest, and where illness can strike in working-age populations, deepening economic vulnerability.

C The economic footprint of NCDs is vast, combining direct medical spending with indirect costs from disability and lost productivity. For families, long-term illness can translate into catastrophic health expenditure—spending so large it forces painful trade-offs between treatment and basic needs such as food or schooling. At the system level, the demands of chronic disease management require a departure from episodic models of care. Effective control depends on continuous monitoring, stable supplies of essential medicines (such as insulin or antihypertensives), and well-developed primary care capable of follow-up rather than crisis-only intervention. This, in turn, depends on health information systems that can track patients across time and facilities. In many regions, those forms of



infrastructure remain underbuilt, meaning preventable complications accumulate and hospital costs rise.

D Because NCDs are shaped by long-term exposure to risk, prevention tends to be more cost-effective than late-stage treatment. Population-level policies—those that alter environments rather than targeting only individual willpower—often have the broadest reach. Tobacco taxation, plain packaging, and restrictions on marketing can reduce smoking rates at scale. Regulation can also reshape food environments through limits on trans fats and incentives or rules that reduce salt and added sugars in processed products. Urban planning can matter as much as clinics: safe pavements, reliable public transport, and green spaces can increase routine physical activity. Individual-level measures, such as screening for hypertension and diabetes, remain important, but they work best when affordable and integrated into accessible primary care. Public campaigns can raise awareness, yet they are usually insufficient without policies that make healthier choices easier to sustain.

E The policy challenge is therefore not confined to health ministries. A multisectoral response is required because the determinants of NCD risk are embedded in finance, trade, agriculture, education, labour policy and urban design. This is why many experts call for a whole-of-government approach, in which multiple departments align incentives to reduce risk rather than inadvertently amplifying it. A central obstacle is the commercial determinants of health: corporate practices that promote unhealthy products through pricing strategies, branding, lobbying and extensive distribution networks. Regulation can provoke sustained resistance from powerful commercial actors, particularly when reforms threaten profits or market share. Nevertheless, international commitments reflect the scale of the threat. The Sustainable Development Goals include a target to reduce premature NCD mortality by one-third by 2030, a goal that implies long-term political commitment and consistent coordination across sectors.

F NCD risk also accumulates across the life course, which complicates both prevention and politics. Early-life nutrition, exposure to air pollution, and repeated experiences of stress can shape susceptibility to cardiovascular disease and diabetes decades later. In practical terms, this means some of the highest-yield policies are those aimed at children, even though their benefits are delayed. Healthier school meals, restrictions on marketing sugary foods to young audiences, and safe routes that enable walking or cycling can reduce long-term risk trajectories. The difficulty is that political systems often favour short-term results, while life-course prevention is inherently longitudinal. Yet without these upstream investments, later healthcare costs rise and inequalities become harder to reverse.



G Inequality becomes even more visible once disease develops. The ability to obtain diagnosis, start treatment promptly, and remain on continuous medication differs sharply by geography and income. Interruptions in care—caused by medicine stock-outs, clinic fees, long travel distances or unstable employment—can lead to preventable complications such as stroke, kidney failure or diabetic blindness. Where primary care is weak, people may delay seeking help until symptoms become severe, making treatment more complex and costly and placing avoidable strain on hospitals. NCDs therefore function not only as medical conditions but also as stress tests of social systems: they expose how gaps in access convert manageable illness into disability.

H Tracking progress depends on measurement, yet many countries lack robust systems to monitor risk and control at the population level. Reliable surveillance is needed to see whether blood pressure is being controlled, whether diabetes management is improving, and whether tobacco consumption is truly declining. Without consistent indicators, governments may underestimate the scale of the NCD burden, allocate resources poorly, or miss failures among vulnerable groups underrepresented in surveys. Data also matters for accountability: population-level interventions may take years to show effects, so credible indicators help sustain policy attention and reveal whether reforms are reaching those most at risk. In this sense, measurement is not a technical afterthought but a prerequisite for effective governance in an era where chronic disease dominates.

Questions 27–31

Choose the correct heading for each paragraph.

List of Headings

- i** Why childhood and early-life conditions can shape disease decades later
- ii** Prevention through policy: changing environments as well as individual behaviour
- iii** The case for coordinated action beyond the health sector
- iv** The role of measurement and national data in guiding effective action
- v** How modifiable lifestyles and wider social conditions drive risk
- vi** Why unequal access increases complications once disease begins
- vii** The financial burden of chronic illness and the need for continuous care systems
- viii** Why long-term illnesses now dominate the global health picture

27 Paragraph A



28 Paragraph B

29 Paragraph C

30 Paragraph D

31 Paragraph E

Questions 32–35

Choose **YES** if the statement agrees with the claims of the writer, choose **NO** if the statement contradicts the claims of the writer, or choose **NOT GIVEN** if it is impossible to say what the writer thinks about this.

32 The writer suggests that health systems designed mainly for infectious diseases face a different kind of challenge from NCDs.

33 The writer claims that deaths from NCDs are rising fastest among older adults.

34 The writer argues that population-level policies can reduce risk even when individual motivation is limited.

35 The writer believes that regulating unhealthy products is easy because commercial actors rarely resist.

Questions 36–40

Complete the summary below. Choose **ONE WORD AND/OR A NUMBER** from the text for each answer.

Preventing and Managing NCDs

NCD prevention and management requires more than treatment. Chronic illness can result in **36** health expenditure for families. Effective prevention often relies on **37** interventions that reshape environments. Because many risk factors lie outside medicine, a **38** approach is needed. Without consistent **39**, governments may struggle to track progress and allocate resources effectively. Despite these difficulties, the long-term goal includes cutting premature NCD mortality by one-third by **40**

Answer Key

27. viii

28. v

29. vii



30. ii

31. iii

32. YES

33. NOT GIVEN

34. YES

35. NO

36. catastrophic

37. population-level

38. whole-of-government

39. indicators

40. 2030