Innovative Care for Chronic Conditions

Building Blocks for Action

GLOBAL REPORT

Noncommunicable Diseases and Mental Health
World Health Organization
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Innovations in Care: Meeting the Challenge of Chronic Conditions

Innovation is Imperative

The magnitude of change needed in current health care systems to address chronic conditions might seem overwhelming. Health care leaders in every country need a strategy to help their systems evolve to meet the increasing challenges. In some countries, timing, knowledge, and resources might align to support a complete overhaul of an existing health system to more effectively address chronic problems. However, in most countries, a gradual approach to change will be a better tactic, and small steps in the right direction can greatly influence the health and clinical care of a population.

Initiating a major change in thinking among all stakeholders in the health care system is an especially challenging task. Nevertheless, the magnitude of the undertaking is not a justification to continue to ignore the chronic conditions problem or pass it on to future policy and health care leaders. Today’s decision-makers have the responsibility for initiating the process of health care system change and improvement.

This section presents a new framework for health care systems to improve care for chronic conditions. The framework is comprised of fundamental components within the patient (micro-), organization/community (meso-), and policy (macro-) levels. These components are described as “building blocks” that can be used to create or redesign a health care system that can more effectively manage long-term health problems. Decision-makers can use the building blocks to develop new systems, initiate changes in existing systems, or make strategic plans for future systems. A number of
countries have already implemented innovative programmes for chronic conditions using building blocks from the framework. These are presented as examples of real world successes.

System-wide improvement or integrated health care can be a long time in development and implementation. Fortunately, smaller, more individual changes can happen more quickly and have dramatic impact on the quality of clinical care.

Institute for Health Care Improvement, Eye on Improvement, 2001; VIII(1).

What is Innovative Care for Chronic Conditions?

Innovation in health care for chronic conditions is the introduction of new ideas, methods, or programmes to change the way chronic conditions are prevented and managed. Innovation means integration of fundamental components from each of the micro-, meso-, and macro-levels of the health care system, but first, a re-conceptualization of chronic conditions is needed to create a necessary foundation from which to build.

A New Way of Thinking about Chronic Conditions

From a health care perspective, it is no longer advantageous to view chronic conditions as discrete health problems, nor according to the traditional categories of noncommunicable and communicable diseases. Innovative care is not based on the etiology of a particular problem, but is based on the demands that the health problem places on the health care system. In the case of chronic conditions, the demands are similar regardless of the cause of the condition. Moreover, effective management strategies are remarkably comparable for many chronic problems, and chronic conditions management, inclusive of all chronic health problems, is developing an identity of its own in health care.

In new conceptualizations of chronic conditions, the quality of life of the patient and family is thought an important outcome, and the role of the patient in producing this outcome is emphasized. The patient is not an inactive participant in care; rather, he/she is considered a “health producer.”


A New Way of Organizing Health Care Systems

Innovative care means re-orienting health care systems such that outcomes valued by the system are the ones that actually are produced. The outcomes desired for chronic health problems differ from those considered necessary for acute problems. The needs of patients with chronic conditions differ as well. Patients with chronic problems need broader support; they
need more than solely biomedical interventions. Patients need planned care; they need care that anticipates their needs. Patients need integrated care that cuts across time, settings, and providers and patients need self-care skills for managing problems at home. Patients and their families need support within their communities and support from broader policies to effectively manage or prevent chronic conditions. Optimal care for chronic conditions requires a different type of health care system.

One strategy for re-orienting services is to recognize previous successes in a health care organization or system. When effective clinical and operational solutions such as successful HIV/AIDS or depression programmes can be identified in existing systems, they can be leveraged into better care for other chronic problems.

**Connecting the Patient, Community, and Health Care Organization**

Innovative care elevates the roles of patients and their families and recognizes that they can most effectively manage chronic conditions with the support of their health care teams and their communities. All three entities need to be linked and each is integrally important to the other. Patients, communities, and health care organizations each have important roles to play in improving outcomes for chronic problems.

Innovation in care for chronic conditions is the integration of “building blocks” from the micro-, meso-, and macro-levels of the health care system.

**Building a Health Care System for Chronic Conditions: The Innovative Care for Chronic Conditions Framework**

The framework described in this section is an expansion of an earlier model, the Chronic Care Model, which was developed to present a structure for organizing health care for chronic conditions.


The new, expanded framework, called the Innovative Care for Chronic Conditions (ICCC) Framework, recognizes a broader policy environment that envelops patients and their families, health care organizations, and communities. The policy environment is responsible for legislation, leadership, policy integration, partnerships, financing, and allocation of human resources that allow communities and health care organizations to help patients and families with chronic conditions.
Guiding Principles of the Framework

The ICCC Framework is based upon a set of guiding principles. Each of the principles is fundamental to the micro-, meso-, and macro-levels of the health care system.

Evidence-based decision making

Evidence should be the basis for all decisions in policy-making, service planning, and clinical management of chronic conditions. Evidence includes the available information about the magnitude of chronic conditions, effective and efficient interventions to reduce the associated burden, current and anticipated resource needs, and the appropriate mix of skilled health care personnel. Evidence-based information includes what is known about clinical processes of care and patient outcomes.

If reliable data are scarce, it is necessary to build capacity and infrastructure for the collection and analysis of relevant information about chronic conditions. When evidence, rather than intuition or impulse guides decisions, care for chronic conditions is optimized.

Population focus

Health care systems for chronic conditions are most effective when they prioritize the health of a defined population rather than the single unit of a patient seeking care. Population management is a long-term, proactive strategy in which resources are organized to improve quality of care and health outcomes in populations with well known and well understood medical service needs. This approach reduces the need for high cost, high intensity resources.

Prevention focus

Because most chronic conditions are preventable, every health care interaction should include prevention support. When patients are systematically provided with information and skills to reduce health risks, they are more likely to reduce substance use, to stop using tobacco products, to practice safe sex, to eat healthy foods, and to engage in physical activity. These risk reducing behaviours can dramatically reduce the long-term burden and health care demands of chronic conditions. To promote prevention in health care, the commitment and action of the health care organization, community, and government are vital for success.

Quality focus

Quality control ensures that resources are used properly, that providers are accountable for providing effective and efficient care, and that patient outcomes are the best possible given any limitations. Quality is not only a health care delivery issue. A quality focus that begins at the policy level ensures better quality at the organization/community and patient levels of the system.

Integration

Integration is the core of the ICCC Framework and health care for chronic problems requires integration from multiple perspectives. Each level of the health care system, micro-, meso-, and macro-, must work together and share in the unmistakable goal of better care for chronic conditions. Boundaries among the levels of the system must blur to allow true integration of health care organizations and communities, policies, and patients.
Integration, coordination, and continuity should occur across time and health care settings, including primary health care, specialty care (if available), and inpatient care. Care should be integrated across all categories of chronic conditions, moving beyond traditional disease boundaries.

**Flexibility/adaptability**

Health care systems need to be prepared to adapt to changing situations, new information, and unforeseen events. Changes in disease rates and burden, as well as unpredicted disease crises can be assimilated into systems that are designed to adapt to change. The occurrence of political party transitions or unexpected economic downturns need to be planned for and accommodated in health care systems.

Routine surveillance, monitoring, and evaluation are key for systems to be able to adapt to changing contexts. When these processes are embedded within a health care system, it has the potential to become a constantly evolving, adapting “learning system” that foresees and responds flexibly to changing health care demands.

A flexible framework that tolerates transitions, yet remains robust in the face of changing demands is ideal. The building block concept of the ICCC Framework allows systems to adapt by emphasizing or developing different areas (building blocks) given situational pressures.

### Innovative Care for Chronic Conditions Framework

![Innovative Care for Chronic Conditions Framework](image-url)
Building Blocks of the ICIC Framework

Micro-Level: Building Blocks at the Patient Interaction Level

Patients and their families are the most undervalued assets in the health care system. Their potential to affect outcomes is undeniable and their capabilities should be leveraged fully in any model designed to improve care for chronic conditions. The ICIC Framework elevates the role of patients and families and partners them with their communities and health care organizations.

The triad at the centre of the ICIC Framework consists of the patient and family, community partners, and the health care team. This partnership triad is unique to the care of chronic conditions. Whereas successful outcomes for acute health problems can occur with a single health care provider, positive outcomes for chronic conditions are achieved only when patients and families, community partners, and health care teams are informed, motivated, prepared, and working together.

Note in the framework that the triad is influenced and supported by the larger health care organization and by the broader community, which in turn influence, and are influenced by, the broader policy environment. In essence, the meso- and macro-levels of the system enable the triad of the patient/family, community partners, and health care team to function at its best.

When the components of each level of the health care system are integrated and working optimally, the patient and family become active participants in care, supported by their community and their health care team. A well functioning triad occurs as the result of good communication between the health care organization and the community about patient-specific issues and about health care, in general. The triad is functioning optimally when patients and their families deny gaps, inconsistencies, and redundancies in their health care. They report feeling empowered, capable, and supported to self-manage their chronic problems.

Prepared, informed, and motivated patients and families

Patients and families make up one section of the triad. They need three fundamental things to manage and prevent chronic conditions.

✔ They need to be informed about their chronic conditions, including the expected course, expected complications, and effective strategies to prevent complications and manage symptoms.

✔ They need motivation to change and maintain daily health behaviours, adhere to long-term therapies, and self-manage their conditions.

✔ They need to be prepared with behavioural skills to manage their conditions at home. This includes having the necessary medications and medical equipment, self-monitoring tools, and self-management skills.

Prepared, informed, and motivated health care teams

In the ICIC Framework, the health care “team” is part of the partnership triad. The team includes multiple categories of care providers, from each level of care (including specialists), and within all clinical settings. Team members accept roles and responsibilities for tasks according to their professional strengths and capacities. The traditional hierarchy flattens and moves
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away from physician dominated models because each team member is valued for his or her unique skills in the management of chronic conditions. Teams form according to human resource and geographic realities of the health care organization. However, innovations in the team concept may be necessary. For example, virtual teams, linked through information technology, would be practical in many regions.

Prepared, informed, and motivated community partners

Community partners are the third part of the micro-level triad. When community partners are armed with information and skills about the management of chronic conditions, a previ-
ously untapped collection of individuals become prepared to take on functions traditionally assigned to health care workers in a public health system. Large populations of persons willing to assist can transform into abundant and prepared resources for the delivery of essential services related to chronic conditions. Community partners can provide services that span all chronic problems, from diabetes and high blood pressure, to community based care of mental disorders. These community resources can reduce unnecessary demands for follow-up services and tertiary care typically provided in formal health care organizations.

**Meso-Level: Building Blocks for the Health Care Organization**

Health care organizations can create an environment in which efforts to improve health care for chronic conditions take hold and flourish. A recent Cochrane Collaboration review found several organizational factors, including health care workers’ skills, personnel mix, visit schedules, information systems, and patient self-management made a difference in outcomes.

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**Scotland**

**Integrating Primary and Community Health Services**

**The building blocks:**

- Strengthen partnerships (policy environment)
- Develop and allocate human resources (policy environment)
- Organize and equip health care teams (health care organization)
- Support self management and prevention (health care organization)
- Encourage better outcomes through leadership and support (community)
- Mobilize and coordinate resources (community)

In Scotland, Local Health Care Cooperatives (LHCCs) are part of the internal structure of Primary Care Trusts (PCTs). They are local integrating organizations, bringing together primary and community health services with a range of specialist services. Participation in LHCCs by general practitioners is voluntary, but after only 2 years, the vast majority of medical practices in Scotland are involved. Most LHCCs have a multi-disciplinary management board typically drawn from medicine, nursing, pharmacists, the professions allied to medicine, and the public. LHCCs serve populations from under 10,000 to over 172,000. Although formal evaluation of LHCCs is pending, there is a growing view that they play an important part in the evolution of a care hierarchy that supports local community health and well-being through the integration of care.

**A New Hierarchy of Care Promoted by Scotland’s Local Health Care Cooperatives**

**Community Health and Well Being**

A non-medical emphasis on the control of local health hazards, and the promotion of positive health through public health programmes linked to community plans.
for chronic conditions. The review also noted that more comprehensive intervention is more likely to be successful; those that target only provider behaviour do not change patient outcomes unless accompanied by interventions directed at patients. In addition, the review reports health care organizations that delegate roles to non-physicians, assure close surveillance of patients, and plan follow-up care improve outcomes for chronic health problems, as well.


3. Innovations in Care: Meeting the Challenge of Chronic Conditions

Promote continuity and coordination

Patients with chronic conditions need services that are coordinated across levels of care – primary, secondary, and tertiary care – and across providers. Health care workers who care for the same patients need to communicate with each other. There is strength in the collective knowledge, information, and skills of multiple health care workers that far surpass that

Self Care

Enabling people to look after themselves with the assistance of carefully designed information and educational materials, including advice offered through services delivered on line or through digital TV

NHS 24

A nurse-led triage system to direct patients unable to care for themselves to the most appropriate member of the extended primary care team or in emergency to the ambulance service or hospital

Extended Primary Care

Stronger teams of primary care professionals including doctors, nurses, midwives, pharmacists, social workers etc. able to meet the vast majority of patients care needs

Intermediate Care

Focused on community hospitals, nursing, residential care and the patient’s own home; utilizing the skills of ‘intermediate care physicians’, nurses, therapists and social workers IC offers locally provided ‘step-up, step-down’ services including investigation, rehabilitation, and respite, principally but not exclusively for the elderly

Secondary Care

Linked through managed clinical networks, and supporting the work of the levels below

Tertiary Care

Linked through managed clinical networks, as centres of highly specialized advice and care

of a single provider. Where possible, an identified “care coordinator” can serve as the overseer and director of a patient’s care ensuring that efforts of all involved health care workers are integrated and coordinated.

Continuity of care for chronic conditions also is critical. Care must be planned and thoughtfal over the course of the condition. Follow-up visits should be scheduled and organizations must be proactive in caring for patients with chronic problems. Allowing symptoms or the onset of preventable complications to prompt patients to seek care is costly, inefficient, and ineffective. By contrast, planned care permits the early detection of complications and the swift identification of decline in patients’ health status.

**Encourage quality care through leadership and incentives**

Senior and other influential leaders need to lend clear support and sponsorship for improving the care of chronic conditions in their health care organizations. Incentives for administrators, health care workers, and patients can be re-aligned; rewards for effective clinical processes that affect management and prevention of chronic problems can be established. Ongoing quality monitoring and quality improvement projects should become routine activities among all health care workers. The quest for quality must emerge as part of the organizational culture. Health care leaders play a pivotal role in creating an environment that values quality.

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**Sub-Saharan Africa**

**The Essential NCD Health Intervention Project**

**The building blocks:**

- Organize and equip health care team (health care organization)
- Use information systems (health care organization)

There is evidence that the prevalence of certain noncommunicable diseases, such as diabetes and hypertension, is increasing rapidly in parts of Sub-Saharan Africa. To address this emergent need, a pilot project is being undertaken in Tanzania and Cameroon. The aim of the project is to provide evidence-based treatment packages for hypertension, heart disease, and diabetes in primary health care. Project developments include:

- clinical guidelines;
- patient education materials to support the use of the guidelines;
- methods and materials for training and supporting staff in the use of the guidelines;
- patient record forms, and a system for appointments and follow-up.

Organize and equip health care teams

Health care teams need to be equipped to manage chronic conditions. They need necessary supplies, medical equipment, laboratory access, and essential medications to provide care that is informed by scientific evidence. Teams require support to make optimal decisions, including written guidelines of care, and diagnostic and treatment algorithms.

Health care teams need special skills and knowledge that extend traditional biomedical training. Effective communication abilities are important to promote information exchange, open questioning, and shared decision-making with patients. In addition, health care workers need expertise in behavioural interventions to help patients initiate new self-management techniques, adhere to complex regimens, and make lifestyle changes. Even more importantly, workers need the skills to support patients in their efforts to maintain change over the long-term course of the condition.

Physicians and other health care workers need skills that enable them to work cooperatively. The traditional independent practice model is not optimal when health problems are chronic. In contrast, teams made up of multiple health care workers must learn to work collaboratively and share patient responsibilities.

Support self-management and prevention

Effective self-management helps patients and families adhere to regimens in ways that minimize complications, symptoms, and disability associated with chronic problems. Patients and their caregivers need to be informed about self-management strategies and be motivated to implement them on a daily basis over the course of time. Self-management training (for example, to improve adherence to medications, consistent exercise, proper nutrition, regu-
lar sleep, and tobacco cessation) can reduce the frequency of follow-up visits and will prove cost-effective with time.

Health care workers are crucial in educating patients and families about self-management. They are instrumental in helping patients initiate new behaviours. However, more importantly, health care workers must support patients’ self-management efforts over time. Attention to self-management and prevention of chronic conditions should occur at every patient encounter.

USA

Integrated Care for Chronic Conditions

The building blocks:

- Promote continuity and coordination (health care organization)
- Organize and equip health care teams (health care organization)
- Use information systems (health care organization)
- Support self-management and prevention (health care organization)

Kaiser Permanente, a large managed care organization in California, recently re-oriented its primary care clinics to better meet the needs of patients, emphasizing the needs of those with chronic conditions. Multidisciplinary teams were created that include physicians, nurses, health educators, psychologists, and physical therapists. These primary care teams link with pharmacy, the telephone advice and appointment centre, chronic conditions management programmes, and specialty clinics creating a totally integrated system of care from outpatient clinics to inpatient hospital care.

Patients are enrolled in the chronic conditions management programs via outreach strategies that identify those with chronic conditions who have not sought primary care, and through physician identification during primary care office visits. Patients receive services from multiple disciplines, based on the intensity of their needs. There is an emphasis on prevention, patient education, and self-management. Non-physician team members facilitate group appointments. Biological indices have improved across conditions such as heart disease, asthma, and diabetes. Screening and prevention services have increased and hospital admission rates have declined.

A recent comparison of Kaiser's integrated care system with the UK's National Health System found that although costs per capita in each system were similar, Kaiser's performance was considerably better in terms of access, treatment, and waiting times. Explanations for Kaiser's better performance included real integration across all components of health care, treating patients at the most cost-effective level of care, market competition, and advanced information systems.

Use information systems

Timely information about individual patients, and populations of patients is a critical feature of effective care for chronic conditions. Information systems gather and organize data about epidemiology, treatment, and health care outcomes. The goal is to use information systems to improve planning and the general standard of care.

China

Volunteer Lay Leaders Increase Self-management and Reduce Health Care Utilization

The building blocks:

- Support self-management and prevention (health care organization)
- Encourage better outcomes through leadership and support (community)
- Provide complementary services (community)

Chronic conditions – mainly heart disease, stroke, cancer and lung diseases – are becoming the leading causes of disability and premature death in China, and its major health care expense. In one of the most severely affected areas of the country, Shanghai, researchers have demonstrated that a chronic disease self management programme is successful in increasing self-management behaviours, maintaining and improving health status, and decreasing health service utilization.

This programme, modelled upon an approach developed and proven in the United States, is based on the following assumptions:

+ People with chronic conditions have similar concerns and problems;
+ People with chronic conditions can learn to take responsibility for the day-to-day management of their disease(s), and physical and emotional problems caused by their disease(s);
+ Lay people with chronic conditions, when given a detailed leaders manual, can lead a self-management programme as effectively, if not more effectively, than health professionals.

The programme is conducted in groups by trained volunteer lay leaders working in pairs. A total of seven sessions are scheduled on consecutive seven weeks, and are 2 to 2.5 hours per session in length. Topics include exercise, use of cognitive symptom management techniques, nutrition, fatigue and sleep management, use of community resources, use of medications, managing fear, anger, and depression, communication with health professionals, problem-solving, and decision-making.

The encouraging results demonstrate that this USA-developed approach is culturally acceptable to Chinese and feasible in China when delivered according to a locally based model and integrated into the routine of community government organizations and the community health services.

An information system that lists patients with chronic conditions (referred to as a “patient registry”) can serve a reminder function for prevention and follow-up services. Health care teams can use this list to identify patients’ needs, to follow-up and plan care, to monitor responses to treatment, and to assess health outcomes. Information systems can be as simple and low cost as a paper-based registry of patients. Alternatively, information systems can be highly automated using the latest electronic technology. The essential point is to integrate a systematic strategy for collecting useful patient information that will result in effective management.

**Meso-Level: Building Blocks for the Community**

Community resources are vital to health care systems and to the management of chronic problems. Consider that persons with chronic conditions spend the vast majority of their time

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**USA**

**Community-Based Outreach Programme Helps Urban Poor Adhere to HIV/AIDS Treatment**

The building blocks:

- Ensure quality through leadership and incentives (health care organization)
- Support self-management and prevention (health care organization)
- Use information systems (health care organization)
- Mobilize and coordinate resources (community)
- Provide complementary services (community)

The competing life priorities of people living in poverty make it difficult to adhere to complex medication regimens. The San Francisco Department of Health developed a community-based, locally-funded, drop-in medication adherence programme (ActionPoint) to help the city's HIV-positive urban poor adhere to antiretroviral medications and benefit from advances in HIV treatment.

A variety of adherence support services is available. A small cash incentive is dispensed weekly to clients who use services at least once a week. In addition, after one month of enrolment, clients are offered a pager that buzzes at specific times of the day to remind them to take their medications. Other adherence support options include a buddy system among ActionPoint clients, and medical and psychological support groups to help instil a sense of community among clients and staff.

The cost of the project per client, per year is roughly equivalent to the yearly retail cost of a single protease inhibitor. Five months after the programme opened, the results were promising: many clients improved their living conditions, and 76% of the clients on antiretroviral therapy showed improved viral suppression.

outside the walls of a health care clinic, living within their communities. Informed and prepared community resources can fill an important gap in services that are not provided by the health care organization. When community services complement organized health care, outcomes associated with chronic conditions have the potential to improve significantly.

**Raise awareness and reduce stigma**
Communities play a crucial role in improving the lives of those living with chronic conditions. Leaders of local and international organizations, NGOs, and support and women’s groups are perfectly positioned to raise awareness about chronic conditions and their associated risk factors. For example, community leaders can be “credible voices” for sensitizing the public to the rising burden of chronic conditions and for reducing the stigma associated with them. Leaders in the community also can lobby their political counterparts to enhance support for chronic conditions care.

**Encourage better outcomes through leadership and support**
Community leaders should be identified and supported in the quest to improve care for chronic conditions. Recognized structures, such as community development/health boards or village development groups can advocate for better health care for chronic problems. The leaders of these boards and groups are in the position to explore the best strategies to support fellow community members who are living with long-term problems.

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**Lebanon**

**Effective and Affordable Treatment for Children**

**The building blocks:**
- Provide complementary services (community)
- Raise awareness and reduce stigma (community)

In Lebanon, public health service gaps are filled by nongovernmental organizations, such as the Chronic Care Center (CCC), which specializes in the management of childhood chronic conditions. One priority area for CCC is thalassemia, a chronic, genetic disease of the blood that is especially prevalent in Lebanon and other Eastern Mediterranean countries.

CCC provides effective and affordable treatment for thalassemia at little cost to patients and families. The Ministry of Health and the European Commission has supported these health care activities since 1994.

With the support of the Ministry of Social Affairs, CCC is also coordinating a national programme to raise awareness and change negative attitudes about this chronic condition. Based on a five year action plan, this programme is targeting different groups: the medical community, universities, secondary schools, youth groups and primary health care workers.

*Source: http://www.chroniccare.org.lb*
When communities do not have established structures, other community leaders become involved in the decision-making that can influence care for chronic conditions. Religious leaders, mayors, or chiefs of villages may be the ones to provide direction on health care issues. Thus, it is important for all leaders in the community, such as those from religious groups, schools, and employer organizations, to be knowledgeable about the burden of chronic conditions and strategies for prevention. All leaders are influential in aligning their policies and practices with the main objectives of optimal chronic conditions care.

**Mobilize and coordinate resources**

Locally generated funds can greatly affect health-related activities at the community level. Health promotion and prevention campaigns, assessment of risk factors, training of community health workers, or supplying health centres with basic equipment and supplies are important activities that can occur through the mobilization of local groups. Community leaders from local and international organizations, NGOs, community support groups, and women’s groups can be invaluable resources. They can be encouraged to raise funds and to identify financing schemes that will generate resources to support screening, prevention, and improved management of chronic conditions.

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**Peru**

**Community Participation to Improve Primary Health Care**

**The building blocks:**

- Encourage better outcomes through leadership and support (community)
- Mobilize and coordinate resources (community)

In Peru, the CLAS (Comités Locales de Administración de Salud) are private, non-profit community-administered institutions created by community members around a health centre or post. Their objective is to improve the quality of primary health care services through community participation in the planning and management of public health care. The CLAS collaborate with health workers to develop a local health plan, determine a budget, and monitor expenditures and health services provision to the community. This arrangement has a number of benefits:

- Community-based planning of health activities
- Increased health care accountability, and incentives to raise productivity
- Flexibility in budget management
- Flexibility in hiring of staff
- Improved quality of care

_Cotlear D. Peru: Reforming Health Care for the Poor. 2000; The World Bank, Latin America and the Caribbean Regional Office, Human Development Department, LCSHD Paper Series No. 57._
Provide complementary services

Local and international NGOs play an important role in providing complementary preventive and management services for a given community, along with the participation of the community members. Every community has an informal network of providers, such as community health workers and volunteers, who are invaluable in the management and prevention of chronic health problems. In many developing countries, health care organization and NGOs use this network of community health workers to build stronger connections with the community, and therefore they are trained to provide basic services for patients with chronic conditions, including education about risks and self-management. In other situations, these informal providers operate independently and they could be more effective if they had stronger connections with a health care organization. In this case, they can be trained to provide basic services and encouraged to educate the community-at-large about the prevention of chronic problems.

Redundancies in services between the health care organization and local organizations should be minimized. The goal for organizations and communities is to have complementary functions. Ideally, community organizations will fill the gaps in services for patients with chronic problems that are not provided in health care organizations.

Brazil

Preventive Health Services in Low Resource Communities

The building blocks:
- Mobilize and coordinate resources (community)
- Provide complementary services (community)

Ceará, a poor state in Brazil presents a model of care that may be achievable for other countries in which resources, income, and education levels are limited. In 1987, auxiliary health workers, supervised by trained nurses (1 nurse to 30 health workers) and living in local communities, initiated once-monthly home visits to families to provide several essential health services. The programme was successful in improving child health status and vaccinations, prenatal care, and cancer screening in women. It was low cost, too. Salaries for the health workers were minimum wage, few medications were used and no physicians were included. Overall, the programme used a very small portion of the state’s health care budget.

In 1994, the health worker programme integrated into the Family Health Programme that includes physicians and nurses on the team with the health workers. For the first time in Brazil, large scale integrated, preventive health services are in place.

Macro-Level: Building Blocks for a Positive Policy Environment

Policies are powerful means for organizing the values, principles, and general strategies of governments or administrative divisions to reduce the burden of chronic conditions. With properly formulated policies and plans, decision-makers and planners can significantly impact the health of the population. To optimize health care for chronic conditions, a positive policy framework is essential. Critical components at the policy level are described below.

Provide leadership and advocacy

Decision-makers can influence senior political leaders to advance care for chronic conditions. Political leaders need to be identified and then encouraged to create a positive policy environment for patients, their communities and health care organizations managing chronic problems. Other crucial groups should be sensitized and informed about the rising burden of chronic conditions, and the existence of effective strategies and models for managing them.

Decision-makers can also increase awareness among policy-makers, health care leaders, health care workers, the general community, patients, and families. These groups can be influenced using a range of proven strategies to increase advocacy. For example, credible spokespersons can be recruited to share the message about chronic conditions. Effective media campaigns will go far in creating leadership and support.

Zambia

Home-Based Care for HIV/AIDS and TB

The building blocks:

- Encourage better outcomes through leadership and support (community)
- Mobilize and coordinate resources (community)
- Provide complementary services (community)

Only a small proportion of people living with HIV/AIDS in Africa have access to home care services. In Zambia, two community-based programmes, coordinated by the Family Health Trust and the Ndola Catholic Diocese, provided home based care for people with HIV/AIDS and people with TB.

In both programmes, the community is leveraged as a health care partner. Teams of mobile community nurses provide direct patient care and support community health workers. Nurses and community volunteers perform a wide range of tasks, including direct patient care, self-management support, and support to family caregivers.

The integration of HIV/AIDS and TB home based care appears to be a success factor for the programmes. High TB cure rates are possible through community-based DOTS, and the detection of HIV is facilitated in TB patients, and vice versa.

Integrate policies

Integrated policies for chronic conditions minimize redundancies and fragmentation in the health care system. Policies are most effective when they cut across boundaries of specific diseases, and when they emphasize the management of a defined population over the management of one patient at a time. They also are most effective when they encompass prevention, promotion, and control strategies, and when they make explicit links to other governmental programmes and community-based organizations.

Policy-making and health care planning are ongoing processes. To support effective care strategies, policies and plans must be updated continually, based on ever-changing needs, priorities, and efficacious intervention strategies.

Finland

Reducing Stigma and Improving Care in Chronic Mental Disorders

The building blocks:

- Organize and equip health care team (health care organization)
- Raise awareness and reduce stigma (community)
- Provide complementary services (community)

Beginning in the early 1990s, rates of depression were on the increase as were suicides in Finland. An innovative project to curtail these growing concerns included plans to increase public awareness of the problem of depression, in addition to developing intersectoral relationships to help those suffering from its effects. Training courses were developed and implemented for health and social welfare professionals. Public campaigns were launched and community self-help groups were implemented for persons who had depressive symptoms. An internal evaluation found that public awareness of depression greatly increased over this decade; the topic is a regular theme in the mass media. In addition, health professionals reportedly address depression much more than they did before the project began.

The schizophrenia programme had goals of reducing long-term in-patient hospital stays for newly diagnosed and chronic patients by 50% over a 10-year period. This goal was met and surpassed. Psychiatric hospital stays declined by 60% for newly diagnosed patients and by 68% for patients with chronic schizophrenia. The programme included families of patients and incorporated new mental health treatment approaches. Multidisciplinary crisis teams worked in the communities to keep patients safe and free from hospitalization. The programme was a nation-wide success in facilitating rapid de-institutionalization.

Lehtinen V, & Taipale V. Integrating mental health services – the Finnish experiment. International Journal of Integrated Care 2001; 1(3).
**Promote consistent financing**

Health financing is an important mechanism by which policies and plans translate into reality. Financing decisions based on principles of equity and effectiveness will ensure adequate health care access and coverage for all segments of the population. All financing components (funding, resource allocation, contracting, and reimbursement) should be used as means for encouraging the implementation of innovative care strategies.

In all cases, but particularly for chronic conditions, financing is most effective when it is consistent across all divisions of the health care system. It must be integrated across traditionally disparate disease categories such as HIV/AIDS and diabetes, as well as levels of care and care settings such as primary health care and hospital-based care. Finally, financing must be structured so that resources can be maintained over time. (For more information about financing health care, please see pages 77–85 of this report.)

**Develop and allocate human resources**

Education authorities have the ability to enhance care for chronic conditions through augmenting health care workers’ training. For example, medical and nursing school curricula can be upgraded to better address the needs of patients with chronic conditions. Thus, decision-makers in Ministries of Education play an important role in improving care for chronic conditions and decision-makers in Ministries of Health should not overlook this important connection.

In addition to upgraded curricula, mandated continuing education for health professionals in the specific area of chronic conditions can greatly advance health care for this problem. Incentives and quotas are useful to attract and create an optimal mix of health care professionals needed to meet the demands of chronic health problems.

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**Botswana**

**Government Leadership in Addressing Chronic Conditions**

**The building blocks:**
- Provide leadership and advocacy (policy environment)
- Enhance and allocate human resources (policy environment)

Botswana is experiencing a population increase, reduced fertility rate, and an increase in chronic conditions such as cancer, diabetes, and hypertension. An increase in deaths from stroke as a complication of hypertension has been observed. More people with chronic conditions are seeking treatment, countrywide. To address the problem, the government of Botswana has adopted a multifaceted approach. In 2002, the Ministry of Health established a team responsible for noncommunicable disease surveillance, prevention, and control. In addition, the escalating burden on HIV/AIDS has resulted in a shift in training for health care workers once trained only in acute care.

*Source: Botswana Ministry of Health, Community Services Division, Epidemiology and Disease Control Unit, 2002.*
The concept of allocation and development of human resources extends beyond direct service providers. Policy and service planners, researchers, information technology designers, and support personnel are needed to improve care for chronic problems. New categories of health care workers such as self-management counsellors should be explored as they can assist in meeting the growing needs in chronic conditions care.

**India**

**Integrated NCD Management and Prevention**

The building blocks:

- Integrate policies (policy environment)
- Provide leadership and advocacy (policy environment)
- Enhance and allocate human resources (policy environment)

Cardiovascular and cerebrovascular diseases, diabetes, and cancer are emerging as major public health problems in India. Apart from a rising proportion of older adults, population exposure to risks associated with certain chronic conditions is increasing. Obesity in increasing, physical activity is declining, and tobacco use is a substantial problem in the country.

Although it is commonly believed that noncommunicable diseases are more prevalent in higher income groups, data from India’s 1995–1996 national survey showed that tobacco intake and alcohol misuse are higher in the poorest 20% of the income quintile. As a result, the government of India is anticipating that the prevalence of tobacco-related conditions will increase in lower socioeconomic groups in the coming years.

The government has adopted an integrated noncommunicable disease management programme. The main components of this programme are:

- Health education for primary and secondary prevention of NCDs through mobilizing community action, including mass media
- Development of treatment protocols for education and training of physicians in the diagnosis and management of NCDs
- Strengthening/creation of facilities for the diagnosis and treatment of CVD and stroke, and the establishment of referral linkages
- Promotion of the production of affordable drugs to combat diabetes, hypertension, and myocardial infarction
- Development and support of institutions for the rehabilitation of people with disabilities
- Research support for:
  - epidemiological studies on CVD, stroke, diabetes
  - multisectoral population-based interventions to reduce risk factors
  - the role of nutrition and lifestyle-related factors
  - the development of cost effective interventions at each level of care

*Source: Planning Commission, India, 2002.*
Support legislative frameworks
Legislation and regulations can reduce the burden of chronic conditions. For example, legislation that mandates seatbelt use, speed limits, and allows prosecution of impaired drivers is critical for the prevention of disabling injuries that often become chronic problems. In addition, controls on health threatening products reduce the burden associated with chronic conditions. Age eligibility laws and local statutes that restrict tobacco and alcohol sales to youth are effective, as are laws that limit or ban tobacco advertising. Regulations for informative food labelling should be considered as well.

Legislation also can protect the rights of people with chronic conditions. Human rights can be promoted in health care via access to care and voluntary treatment. Regulatory frameworks can be developed and enforced that protect health care institutions and workers. Anti-discrimination laws for housing and employing persons with chronic conditions also can be adopted.

Strengthen partnerships
Within the policy environment, strong partnerships among government sectors have the potential to influence health and chronic conditions. Agriculture, labour, education, and transportation sectors are important ones to consider because they have tremendous possibilities for influencing health and preventing chronic problems, but do not always do so in a positive manner. As examples, agricultural policies based solely on commercial objectives do not necessarily parallel national health and nutrition needs; transportation policies could do more to promote physical activity and better safety.

It is imperative to work with different sectors to identify which policies simultaneously maximize population health status while addressing economic needs. Non-government health sectors, such as private health care providers and charities can be influential as well.

Peru

Improving Care for TB through Policy Support

The building blocks:
- Provide leadership and advocacy (policy environment)
- Promote consistent financing (policy environment)
- Encourage quality through leadership and incentives (health care organization)
- Organize and equip health care team (health care organization)

In Peru, TB is a national priority. The Peru TB programme increased the proportion of infectious cases treated under DOTS from 70 percent in 1990 to 100 percent by 1998, with a cure rate over 90 percent. In the programme, medications are free of charge, and food is an incentive for low-income patients to adhere to treatment. Rapid success of this programme was possible because the country had trained nurses in place, to which political commitment, sufficient resources for drugs, and a dynamic leadership were added.

Source: Scaling up the response to infectious diseases: A way out of poverty. World Health Organization, 2002
Connections with district, municipal, or local governments and community entities such as religious groups, schools, and employers should also be examined and strengthened where necessary. Professional, patient, and family NGOs should be considered important partners in improving care for chronic conditions.

**Islamic Republic of Iran**

**Addressing Chronic Conditions in Primary Health Care**

**The building blocks:**
- Strengthen partnerships (policy environment)
- Provide leadership and advocacy (policy environment)
- Develop and allocate human resources (policy environment)
- Promote coordination and continuity (health care organization)
- Organize and equip health care teams (health care organization)

The health policy of the Islamic Republic of Iran has been based on primary health care since 1979 with particular emphasis on the expansion of health networks and programmes in rural areas. In towns and smaller villages, the Health Centre performs its functions with the help of a large number of Health Houses that are the first points of contact for persons in the community. Each Health House serves a population of about 1500, and behvarz (i.e., health workers) have the responsibility for providing care. Rural Health Centres consist of general practitioners, midwives, and dentists. These Health Centres supervise, support, and accept referrals from the Health Houses. Urban health centres mainly perform their functions with the help of Health Posts.

District hospitals in towns offer services to cases referred from rural as well as urban Health Centres. District hospitals are responsible for specialized, hospital, and outpatient curative services.

Many regions recently have integrated clear standards and guidelines on diabetes and hypertension. Primary activities in the Health Houses and the Health Posts are finding cases in the community that have not been receiving care and providing follow-up care especially in cases of tuberculosis, malaria, and mental disorders. Recently, hypertension and diabetes were also included in some communities.

The Ministry of Health and Medical Education shares the responsibility for provision of health services and medical training throughout the country. In addition, active involvement of the community is encouraged for the planning and implementation of health services.

Over the past 15 years, life expectancy in the Islamic Republic of Iran has increased by 13 years for males and 15 years for females. Similarly, maternal and infant mortality rates have decreased to less than 1⁄4 of what rates were 15 years ago. Primary health care coverage is available for more than 90% of the population and this is significantly higher that the negligible coverage rates in the early 1980s. These achievements in health care occurred in the presence of an ongoing demographic and epidemiological transition in the country.

*Source: Ministry of Health and Medical Education, Islamic Republic of Iran, 2001.*
The Philippines

National Health Sector Reform

The building blocks:
- Integrate policies (policy environment)
- Provide leadership and advocacy (policy environment)

Increasing life expectancy, urbanization, and lifestyle changes have brought about a considerable change in the health status of the Philippines. Globalization and social change has influenced the spread of non-communicable or lifestyle/degenerative diseases by increasing exposure to risk. As the country's per capita income increases, the social and economic conditions necessary for the widespread adoption of risky behaviour gradually emerge. This in turn has brought a considerable challenge to the country's health policy and health system to address growing lifestyle/degenerative diseases amidst the unfinished agenda of communicable diseases.

The Health Sector Reform Agenda of the Philippine Department of Health is improving health services to ensure a more efficient delivery of Public Health Programmes. A targeted group is the under-served population. Health sector reforms are occurring across the entire health system.

Concerning chronic conditions, reform activities have focused upon:
+ guidelines and clinical pathways
+ surveillance systems
+ registry systems
+ community-based approaches
+ research
+ health financing

These activities are tailored to the unique needs of different chronic conditions, including cardiovascular disease, cancer, diabetes, asthma, and musculoskeletal disorders.

Summary

Decision-makers and other leaders in health care are in positions to initiate changes in health systems to address care for chronic conditions. To be most effective, leaders need to consider influencing the micro-, meso-, and macro-levels of the system. Change can be started with small steps, using various building blocks described in this section. A complete system overhaul is not necessary, although the more building blocks that can be integrated into a health care system, across the micro-, meso-, and macro-levels, the greater the expected benefits.

When building blocks are organized into conceptual frameworks, planning and change processes may become clearer to leaders. Comprehensive models for health care systems are optimal because they broaden the way people think about problems, and because when implemented, they produce better outcomes. In the case of chronic conditions, new, expanded models that include policy-level building blocks promise a brighter future for health care leaders and patients alike.