Innovative care for chronic conditions: building blocks for action: global report

5. Consumer participation 6. Intersectoral cooperation 7. Evidence-based medicine


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This report was produced under the direction of JoAnne Epping-Jordan, Health Care for Chronic Conditions. It is the first key component of a three-pronged WHO strategy to improve the prevention and management of chronic conditions in health care systems. This strategy is overseen by Rafael Bengoa, Director, Management of Noncommunicable Diseases, and Derek Yach, Executive Director, Noncommunicable Diseases and Mental Health.

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- Improving Adherence (managed by Eduardo Sabaté)
- Primary Health Care for Chronic Conditions (managed by Rania Kawar)

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Taking Action to Improve Care for Chronic Conditions

No health system is exempt from addressing the growing epidemic of chronic conditions, and this mandate holds despite health care resource limitations. Every system has limited resources, and even those with seemingly high resources are faced with the dilemma of allocating assets and planning for the future health care of their populations. Moreover, despite a country’s economic prosperity, some groups and regions within every country have inadequate access to care.

Decision-makers in policy and services face similar and uncertain futures regarding care for chronic health problems. The overall challenges they face, from supporting a change in thinking towards chronic care to ensuring consistent financing are similar; however, the solutions to health care problems may differ based on resource realities in each country. Nevertheless, success in re-orienting health care systems will depend on the leadership and informed guidance of decision-makers and the degree to which current leaders continue to invest solely in the acute care model.

The eight essential elements, below, describe suggestions for action based upon resource availability. However, a single country may have geographic areas or settings that span the resource spectrum from low to high. In these situations, the individual decision-maker must prioritize the actions that are most appropriate for his or her unique circumstances. Settings with high levels of resources should ensure that low- and mid-resource suggestions are implemented in addition to the high-resource suggestions for action.

Regardless of resource level, every health care system has the potential to make significant improvements in caring for chronic conditions. Resources are necessary, but
not sufficient for success. Leadership combined with a willingness to embrace change and innovation will have far more impact than simply adding capital to already ineffectual health care systems. To improve the care for chronic conditions, decision-makers need:

✦ knowledge about gravity of the chronic conditions problem
✦ leadership to do something about it
✦ a clear assessment of their current health care situation
✦ a plan for action

Where to Begin

Eight Essential Elements for Improving Health Care for Chronic Conditions

1. Support a Paradigm Shift

What Decision-Makers Need to Know

Health care is organized around an acute, episodic model of care that no longer meets the needs of many patients, especially those with chronic conditions. Decreases in communicable diseases and the rapid ageing of the population have produced this mismatch between health problems and health care, and chronic conditions are on the rise. Patients, health care workers, and most importantly, decision-makers must recognize that effective chronic condition care requires a different kind of health care system. The most prevalent health problems such as diabetes, asthma, heart disease, and depression require extended and regular health care contact. Appropriate management often involves medications and always requires that patients make lifestyle adjustments to manage their persistent health problems. Health care systems that are based upon an acute care model cannot meet these demands.

Where are You Now?

✦ Can your health system provide medications in addition to supporting patients’ efforts to manage their chronic problems?
✦ What will happen if you allow health care to continue to operate solely from an acute care paradigm?
✦ How will shifting the paradigm from acute to chronic care improve the health of your population?

What You Can Do

Consider using these building blocks from the ICCC Framework:

Policy: Provide leadership and advocacy
Policy: Integrate policies
Organization: Ensure quality through leadership and incentives
Organization: Organize and equip health care team
Community: Raise awareness and reduce stigma
4. Taking Action to Improve Care for Chronic Conditions

- **Low level of resources**
  In these settings, health care resources (financial and human) are scarce. Comprehensive care for chronic conditions is completely absent or very limited. Coordination and continuity of health services are lacking. Services (where available) are fragmented and designed in response to acute problems. Computers are rarely available. Though most commonly encountered in low income countries, this resource scenario is not limited to them; many high-income countries also have populations (e.g. rural populations and indigenous groups) with this health care profile.

- **Medium level of resources**
  In these settings, more resources are available for health care, although they are limited. In certain settings, like urban hospitals or pilot programmes of community care, care for chronic conditions is less fragmented, but these centres are few and inadequate for providing care for chronic conditions to the total population. Primary care providers are largely unaware and untrained in continuity of care for chronic conditions. Computers may be available, but typically are located in urban settings. Admission and discharge data from clinics and hospitals may be the only data available in information systems.

- **High level of resources**
  This resource scenario is largely in economically developed settings that have adequate resources for health care. Specialized settings may have innovative programmes for chronic conditions. However, despite the relative availability of resources, the majority of health care settings still use an acute, episodic care model. Computers and information systems are common, although the indicators they monitor are used primarily for financial purposes.

**Action Examples**
- Share this document with other decision-makers to initiate a discussion about making changes in your health care system.
- Assemble information on the problem of chronic conditions in your setting.
- Sensitize policy-makers and health authorities to the growing burden of chronic conditions, and the existence of effective strategies for managing them.
- Use the media as a forum for educating and promoting new attitudes in the general public, via publicity, advertising, and regular programming.
- Use readily available powerful and credible voices to spread the message about chronic conditions.
- Encourage the spread of new ideas through local demonstration projects of innovative care models and strategies.
- Use mass marketing strategies to persuade the population to think differently about chronic conditions.
2. Manage The Political Environment

What Decision-Makers Need to Know

Policy-making and service planning inevitably occur in a political context. Political decision-makers, health care leaders, patients, families, and community members, as well as the organizations that represent them, need to be considered. Each group will have its own values, interests, and scope of influence. For transformation towards care for chronic conditions to be successful, it is crucial to initiate bi-directional information sharing and to build consensus and political commitment among these stakeholders at each stage.

Where Are You Now?

+ Do you have mechanisms for consulting with those who can influence the political process of health care change?
+ Do you educate stakeholders concerning the benefits of chronic conditions management?
+ To what extent do you incorporate multiple stakeholder perspectives into your health care planning?

What You Can Do

Consider using these building blocks from the ICCC Framework:

- **Policy**: Provide leadership and advocacy
- **Health Care Organization**: Ensure quality through leadership and incentives
- **Community**: Encourage better outcomes through leadership and support
- **Community**: Raise awareness and reduce stigma

Action Examples

- Educate and inform patients, families, and other influential people on the growing burden of chronic conditions, and the existence of effective strategies for managing them in the country’s context.
- Build dialogue with key leaders in the government, health care organization, and community to better understand their values and interests.
- Use health care opinion leaders and community leaders to advocate for change in local contexts.
- Identify the organizations and associations that represent diverse interests in the health care debate.
- Include stakeholders in policy formulation and service planning.
- Develop political leadership and commitment to reorient health care towards chronic conditions.
- Assemble systematic reviews on the costs and effects of chronic conditions management.
- Conduct local research to demonstrate the cost-effectiveness of innovative care models and strategies.
3. Build Integrated Health Care

What Decision-Makers Need to Know

Health care systems must guard against the fragmentation of services. Care for chronic conditions needs integration to ensure shared information across settings and providers, and across time (from the initial patient contact, forward). Integration also includes coordinating financing across different arms of health care (e.g., inpatient, outpatient, and pharmacy services), including prevention efforts, and incorporating community resources that can leverage overall health care services. The outcome of integrated services is improved health, less waste, less inefficiency and a less frustrating experience for patients.

Where are You Now?

✦ To what extent are segments of your health care system integrated?
✦ If you allow fragmentation of services, what is the cost? What is the benefit?
✦ What strategies have you used in the past to integrate successfully fragments of your system into a whole?

What You Can Do

Consider these building blocks from the ICCC Framework:

Policy: Integrate policies
Policy: Strengthen partnerships
Health Care Organization: Use information systems
Community: Mobilize and coordinate resources

Action Examples

✦ Ensure that policies, plans, and financing structures are up to date and reflect consistent messages about chronic conditions.
✦ Develop basic patient registries – as simple as paper and pencil notebooks – and basic information systems.
✦ Upgrade information systems to increase coordination across public and private health care settings, providers, and time.
✦ Develop information sharing strategies across health care organizations and communities.
✦ Link health care settings via a common information system.
4. Align Sectoral Policies For Health

What Decision-Makers Need to Know
In government, diverse authorities create policies and strategies that affect health. The policies of all sectors need to be analysed and aligned to maximize health outcomes. Health care can be and should be aligned with labour practices (e.g., assuring safe work contexts), agricultural regulations (e.g., overseeing pesticide use), education (e.g., teaching health promotion in schools), and broader legislative frameworks.

Where are You Now?
✦ To what extent do you work to link together government sectors, private sectors, non-government health sectors, and non-health related, nongovernmental organizations?
✦ What are the advantages and disadvantages of developing relationships with other sectors?

What You Can Do
Consider these building blocks from the ICCC Framework:
- Policy: Integrate policies
- Policy: Strengthen partnerships

Action Examples
- Develop links to private sector health workers, including traditional healers.
- Develop links to non-health government sectors that have the potential to influence population health.
- Support regulation and legislation that curbs the marketing of public health risks (e.g., tobacco and alcohol).
- Implement population-based prevention activities in collaboration with other government sectors.
- Implement a multisectoral private/public governing body, which advocates for the promotion, prevention, and comprehensive management of chronic conditions.
5. Use Health Care Personnel More Effectively

What Decision-Makers Need to Know

Health care providers, public health personnel and those who support health care organizations need new, team care models and evidence-based skills for managing chronic conditions. Advanced communication abilities, behaviour change techniques, patient education, and counselling skills are necessary in helping patients with chronic problems. Clearly, health care workers do not have to possess physician degrees to provide such services. Health care personnel with less formal education and trained volunteers have critical roles to play.

Where are You Now?

✦ What is the status of your training models and what approaches to the allocation of tasks among health care personnel are you promoting?
✦ What are potential benefits of using a mix of health care personnel in your organizations and communities?

What You Can Do

Consider these building blocks from the ICCC Framework:

- **Policy:** Integrate policies
- **Policy:** Strengthen partnerships
- **Health Care Organization:** Organize and equip health care team
- **Health Care Organization:** Support self-management and prevention

Action Examples

- Promote basic skills training for health care workers, who help patients with chronic conditions.
- Where there are multipurpose health workers, study possibilities of reinforcing their decision-making via linkages with specialists.
- Educate health care workers via workshops and printed materials.
- Mandate continuing education on management of chronic conditions across a range of health care workers.
- Influence medical schools and other training programmes to promote chronic conditions management.
- Implement joint committees between the Ministry of Health and Ministry of Education to promote a common understanding of medical education needs.
- Develop a range of health care personnel (e.g., self-management counsellors and quality improvement specialists) to meet changing health care needs.
- Reallocate training resources in favour of a range of health care personnel.
6. Centre Care On The Patient And Family

What Decision-Makers Need to Know
Because the management of chronic conditions requires lifestyle and daily behaviour change, emphasis must be upon the patient’s central role and responsibility in health care. Focusing on the patient in this way constitutes an important shift in current clinical practice. At present, systems relegate the patient to the role of passive recipient of care, missing the opportunity to leverage what he or she can do to promote personal health. Health care for chronic conditions must be re-oriented around the patient and family.

Where are You Now?
✦ To what extent does your health care system emphasize the role of the patient and family in caring for chronic conditions?
✦ How would your health care system be improved if a significant portion of care were transferred to the patient? Would money be saved? Would your system be more efficient?
✦ What will happen if you continue to ignore patients’ roles and responsibilities?

What You Can Do
Consider these building blocks from the ICCC Framework:
- **Health Care Organization**: Organize and equip health care team
- **Health Care Organization**: Support self-management and prevention

Action Examples
- ☐ Provide basic information about chronic conditions management to patients and families.
- ☐ Include self-management support instruction during health care interactions.
- ☐ Develop educational and skill-building workshops for patients and families on the management of chronic conditions.
- ☐ Use written educational materials to supplement self-management messages.
- ☐ Provide patients and families access to information and self-management support outside the health care setting, via telephone or Internet.
7. Support Patients In Their Communities

What Decision-Makers Need to Know

Health care for patients with chronic conditions does not end or begin at the doorway of the clinic. It has to extend beyond clinic walls and permeate patients' living and working environments. To successfully manage chronic conditions, patients and families need services and support from other institutions in the communities. Moreover, communities can fill a crucial gap in health services that are not provided by organized health care.

Where are You Now?

- To what extent does your health care system rely on different community-based services to support care for chronic conditions?
- Does your health care system have methods for exchanging information and interacting with community-based services?
- Do your health care workers routinely refer patients with chronic conditions to community-based services?
- Are your community resources adequately supported to help address needs that are not met by health care organizations?

What You Can Do

Consider these building blocks from the ICCC Framework:

- Community: Encourage better outcomes through leadership and support
- Community: Raise awareness and reduce stigma
- Community: Mobilize and coordinate resources
- Community: Provide complementary services

Action Examples

- Support and involve community groups and NGOs in providing care for chronic conditions.
- Establish a structure whereby health care organizations can exchange information concerning policies and strategies with community-based services.
- Support the roles of community organizations in policy-making and service planning.
- Develop patient information sharing strategies across health care organizations and communities.
- Ensure employers are informed about chronic conditions management. Take steps to support prevention and self-management efforts in the workplace.
8. Emphasize Prevention

What Decision-Makers Need to Know
Most chronic conditions are preventable. Additionally, many of the complications of chronic conditions can be prevented. Strategies for reducing onset and complications include early detection, increasing physical activity, reducing tobacco use, and limiting prolonged, unhealthy nutrition. Prevention should be a component of every health care interaction.

Where are You Now?
✦ To what extent does your health care system emphasize prevention of onset or complications of chronic conditions?
✦ If prevention strategies were discussed at every health care contact, what impact would you anticipate on the health of your citizens?
✦ What predictions would you make about the prevalence of chronic conditions if prevention were ignored in your health care system?

What You Can Do
Consider these building blocks from the ICCC Framework:
- **Policy**: Integrate policies
- **Policy**: Strengthen partnerships
- **Policy**: Support legislative frameworks
- **Health Care Organization**: Organize and equip health care team
- **Health Care Organization**: Support self-management and prevention
- **Health Care Organization**: Use information systems
- **Community**: Provide complementary services

Action Examples
- Ensure that prevention of chronic conditions is addressed in primary health care visits.
- Provide health workers with information and basic skills to help patients minimize risks associated with chronic conditions.
- Support regulation and legislation that curbs the marketing of public health risks (e.g., tobacco and alcohol).
- Support population-based prevention activities.
- Monitor risk factors and identify persons at risk for developing chronic conditions.
- Assist providers through education and tools to “put prevention first”.
- Ensure every patient encounter addresses prevention.
- Align provider incentives so that prevention efforts are rewarded.
How to Finance: Ensuring Adequate and Sustainable Financial Support for Innovative Care

Financing is one important means to implement the eight essential elements described above. In general, appropriate financing for health care for chronic conditions should be guided by principles that are consistent with those for a mainstream health care system (see WHO’s World Health Report 2000 for a complete review of financing health systems):

- People should be protected from catastrophic financial risk due to illness
- The healthy should subsidize the sick
- The rich should subsidize the poor, at least to an extent

Notwithstanding these general principles, chronic conditions pose unique characteristics that bear upon financing, and these special features should be considered.

A Range of Services is Needed to Manage Chronic Conditions

The continuum of care for chronic conditions includes prevention, long-term maintenance treatment, management of acute symptom exacerbation, rehabilitation, and palliative or hospice care. For some patients, ongoing social services in the community are also required. These different forms of services are typically delivered across a range of settings, and often by several distinct health care teams. As a result, services are often needlessly duplicated with significant waste of scarce economic resources.

Despite the range of required services, it is important to remember that more expensive interventions are not necessarily better. In most health care systems, opportunities exist to improve the use of resources through careful examination of the services required. The current practice of managing chronic conditions may appear to be expensive, especially for developing countries, but it should not obscure the fact that low-cost interventions are available – and in many cases, the first-line treatment – for a number of conditions.

Many of the noncommunicable diseases, including cardiovascular disease, diabetes, mental illnesses, and cancers, can be addressed by relatively low-cost interventions, especially using preventive actions related to diet, smoking, and lifestyle.

Macroeconomics and Health: Investing in Health for Economic Development
The Needs of Patients with Chronic Conditions are Long-Term and Predictable

Patients with chronic conditions are likely to use health care services on a regular and expected basis, as compared to the unpredictable needs of patients with acute problems. As a result, voluntary, private insurance schemes may try to avoid insuring these “high risk” patients, or charge higher insurance premiums. If insurance premiums rise too high, patients may elect to forego this type of financial protection, thus placing themselves and their families at risk for financial catastrophe or higher risk of loss of quality of life due to untreated chronic conditions.

Resource Allocation for Chronic Conditions Challenges the Historical Status Quo

Chronic conditions share fundamental features, and place similar demands on health care systems. Yet all too frequently, financing for disease-specific vertical programmes is at the expense of comprehensive, coordinated care, both by taking up resources (financial, human and time) and by directing attention away from the day-to-day problems of caring for common problems presented by chronic conditions. More importantly, many high-cost acute care medical interventions can be delayed or prevented by better management of chronic conditions. In fact, if the innovative care framework for chronic conditions is implemented, demand for acute care services may actually decline.

To implement innovative care for chronic conditions, it is necessary to re-evaluate traditional health care resource allocation lines. Integrated financing reforms imply that traditionally separated budget lines – for example, for HIV/AIDS and diabetes – be integrated to promote effective and efficient health care.

Problems perpetuated by the status quo of resource allocation

<table>
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<tr>
<th>The problems</th>
<th>The facts</th>
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<tr>
<td>Allocation of resources to non cost-effective interventions</td>
<td>Many chronic conditions interventions are effective and affordable, but they are not being used.</td>
</tr>
<tr>
<td>Allocation of resources to health systems that perpetuate fragmented, episodic care</td>
<td>Health care that is designed around episodic care is unable to respond effectively to the needs of patients with chronic conditions.</td>
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<tr>
<td>Allocation of resources to several diseases with a fragmented approach</td>
<td>Chronic conditions are no longer considered in isolation. Awareness is increasing that similar strategies can be equally effective in treating many different conditions.</td>
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<tr>
<td>Disproportionate expenditure to select subgroups</td>
<td>In many countries, health expenditures are concentrated on affluent or urban areas, or on tertiary hospitals.</td>
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<tr>
<td>Lack of sustainability of donor-funded infrastructures and dependency on external resources</td>
<td>Several countries depend on donors for a large share of total expenditure on health. In some cases, donors may inadvertently support a fragmented approach to chronic conditions through the support of certain conditions and the exclusion of others, and due to the time-limited nature of some donor subsidies.</td>
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Economic arguments, such as those provided in this report, can convince decision-makers of the need to generate new resources, or shift existing resources, to care for chronic conditions. Decision-makers may also want to know the short-term costs involved in making this change. Using a realistic prevalence rate and the recommended number of patient contacts in a year, the time cost for health care personnel can be obtained. The medication cost for a number of chronic conditions can also be estimated. Indirect costs, such as investments in information systems, training, and community outreach are other important components that can be considered.

Although some may see this as a daunting task, in reality, the rational use of health resources for chronic conditions may not be that expensive. Indeed, the experiences of several developing countries demonstrate that it is possible to improve the health status of the population at a very low cost.

**Rwanda**

In Rwanda, pilot prepayment schemes, coupled with external aid, are allowing health centres to cover services for HIV/AIDS patients. The annual premium of FRw 2,500 (US$ 7.80) entitles a family of up to seven members to membership for one year. Members benefit from all services and essential drugs provided at the health centre, ambulance transport to the district hospital, and a limited benefit package at the district hospital. This pilot programme shows that community prepayment based on solidarity values, complemented with external aid, can ensure access to care for individuals with complex and costly chronic conditions. Prepayment schemes in the three pilot sites have resulted in:

- Increased use of health services, including prevention
- Improved financial accessibility to health services
- Improved quality of care

Source: [www.unaids.org](http://www.unaids.org)

**Strategies for Generating Resources for Chronic Conditions**

The scarcity of resources for health care is a problem in most settings. Nevertheless, the Commission on Macroeconomics and Health (*Macroeconomics and Health: Investing in Health for Economic Development; Report of the Commission of Macroeconomics and Health, 2001*) concluded that it is feasible, on average, for even low- and middle-income countries to increase their budget expenditures for health. The Commission estimated that these countries could increase their expenditures by one percent of their GNPs by 2007, and by two percent of their GNPs by 2015. While these amounts may not be sufficient to address the full spectrum of health care needs, they would represent important and meaningful steps in the right direction.

There are several financing mechanisms that can be considered in generating resources for chronic conditions’ care.
Universal prepayment schemes

Universal prepayment schemes such as general taxation and social insurance are the most progressive, stable, and sustainable source of health care finance. In high and middle-income countries, where the formal sector has a significant size, contributions to social security are also a sustainable source of funding.

Costa Rica

The government of Costa Rica has been successful in achieving universal health care coverage through prepayment mechanisms and health sector reforms, which began in 1994. These reforms have extended coverage to the previously uninsured (mostly poor) 10 percent of the population. Virtual contracts (Management Commitments) have been implemented to improve efficiency and quality, which have allowed the government to achieve universal coverage with only a three percent additional budget outlay. The health sector reform has established a new model of care with an integrated approach, which anticipates demand and encourages community-based efforts. This model is based on a primary health care strategy to ensure timely, comprehensive, and continuous care to the entire population and includes a targeted package of services aimed at prevention, detection, and treatment. By mutual agreement, the financing-purchasing entity and the service provider specify their expected results and the resource allocation mechanisms.

Source: www.paho.org

Community financing

In poor countries where additional sources of funding are urgently needed, community financing schemes are a viable option for providing financial protection and access to basic health care for the poor. These schemes provide more equitable access than user fees, are better suited for the needs of patients with chronic conditions, and are relatively sustainable.

The effectiveness and sustainability of community financing schemes can be enhanced through:
- Well-targeted subsidies to pay for premiums of poor populations
- Pooled re-insurance schemes to enlarge the effective size of small risk pools
- Investment in effective prevention and disease management strategies
- Capacity building for managers of local community financing schemes
- Strengthening of links with formal financing and provider networks

Excise taxes

Excise taxes for harmful products (e.g., tobacco and alcohol) are an effective mechanism to discourage consumption, and have the added benefit of generating new funding for chronic conditions.

In many countries, opportunities to increase cigarette prices via excise taxes, increase government revenue, and improve health have been overlooked. There is a wide discrepancy in the minutes of labour required to purchase a pack of local brand cigarettes: from 7 minutes in Taiwan, China to 92 minutes in Kenya. Around the world, cigarettes have failed to keep up with increases in the general price level of goods and services, rendering them relatively more affordable in the year 2000 than they were in 1991.


USA and China

The State of Oregon in the USA has achieved impressive declines in per capita consumption following the implementation of a 1996 voter-supported initiative to raise tobacco taxes and to authorize funding of a statewide tobacco prevention and education programme. Between 1996 and 1998, per capita cigarette consumption declined 11.3% (or 10 packs per capita) in Oregon. Similarly, the States of California and Massachusetts have shown that implementing comprehensive statewide tobacco control programmes can result in substantial reductions in tobacco use. Between 1992, the year prior to a voter-approved petition to raise tobacco taxes and to fund a statewide mass-media antismoking campaign, and 1996, per capita consumption declined 20 percent in Massachusetts. California’s per capita consumption declined by 16 percent for the same period. Continued on next page…

Guinea-Bissau

In Guinea Bissau, the Abota prepayment system provides access to primary care at the village level and to a package of essential drugs, as well as free services at higher levels of referral. Health care is provided voluntarily by trained members of the village. Each village’s committee (lowest level of decentralization in the country) administers the Abota system. The strengths of the strategy include:

+ Affordability. This scheme is affordable because the contribution is set at the village level and considering seasonal incomes.
+ Community support.
+ Revitalization of village health posts.

Since the programme’s inception, access to basic health care has been improved considerably, and near universal membership has been documented in participating villages.


Continued on next page…
Excise taxes are not only for developed countries. To the contrary, the World Bank estimates that a price rise of 10 percent on a pack of cigarettes will reduce demand for cigarettes by about four percent in high-income countries. In low- and middle-income countries, where lower incomes tend to make people more responsive to price changes, the demand is expected to decrease by about eight percent. Moreover, children and adolescents are more responsive to price rises than older adults, so excise taxes would have a significant impact on onset of tobacco use among youth in developing countries.

In China, conservative estimates suggest that a ten percent increase in the cigarette tax would decrease consumption by five percent and increase revenue by five percent. This tax increase would be sufficient to finance a package of essential health services for one-third of China’s poorest 100 million citizens.


Private resources

Increasingly, private sector resources are being considered as viable funding sources for public sector health care. These resources may be generated from individuals, as in the case of India below. Businesses that are in the position to donate needed medical equipment or essential drugs, or that may determine that investing in population health will not only be a social good, but will also be good for business, are an additional resource.

India

In India, some states have initiated innovative financing schemes to mobilize private resources for the public health care sector. For example, Kerala has established an innovative measure of raising resources for cancer control initiated through unique community involvement. It was announced to the public that 25 percent of their contributions to a development bond would be used for cancer screening and control. This resulted in an unexpected positive response, which translated into 700 percent more funding than was anticipated. The amount earmarked for cancer screening and control was equivalent to nearly 10 years of the sanctioned budget.

Donor funding

Even with increased domestic funding, many low-income countries will continue to rely upon external donors for a portion of their health budgets. In these cases, it is crucial for country decision-makers to advocate for innovative care strategies that address chronic conditions.

Uganda

In Uganda, the government identified mental health as one of its priority areas. Treatment of mental disorders was included in the Uganda Minimum Health Care Package (UMHCP) both within the Health Policy and the Health Sector Strategic Plan. The presence of people within the government, who were committed to a mental health agenda, was important to achieve this goal. The donor community was convinced and mental health remains in the UMHCP and continues to receive donor funding.

Report of the Mental Health Policy Project: Working Group Meeting on Financing and Mental Health. WHO/MSD/MPS/01.2

Making the Most of Existing Resources

Decision-makers can enhance outcomes for chronic conditions by applying existing resources to more equitable and efficient care. By managing chronic conditions more comprehensively, acute symptom exacerbations can be minimized, thus resulting in greater health care efficiency for the system.

Many high-cost, acute care interventions can be delayed or prevented by better management of chronic conditions.

Adopt the Innovative Care for Chronic Conditions Framework

Implementing at least some of the building blocks for action, as described in Section 3, is a good way to start. Better coordination of health care workers, well-aligned policies, linkages to the community, investments in prevention, and provision of evidence-based treatment at the most cost-effective level of care are some effective methods for achieving substantial improvements in caring for chronic conditions.

Assemble local evidence

In many settings, it is vitally important to develop context-specific evidence for implementing innovative care strategies. Information is needed at the macro level to evaluate overall
funding strategies; at the meso level to assess organizations’ financial solvency and performance; and at the micro level, to assess costs and effects of interventions.

**Align incentives**

Health care workers’ routine practices for making appointments, diagnosing chronic conditions, recommending and administering treatments, offering prevention and self-management advice, and referring patients greatly affect health care utilization, efficiency, and quality. Therefore, incentives for workers should be established such that health care workers maximize quality of care while minimizing costs. In particular, incentives should function to promote preventive services and self-management.

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**Peru and USA**

Because chronic conditions frequently demand adherence to long-term therapies, specialized patient incentives to promote adherence can be considered. In Peru, for example, food is given as an incentive for low-income patients to adhere to TB treatment. In San Francisco, USA, a small cash incentive is dispensed to patients with HIV/AIDS who use adherence support services at least once a week.

*Scaling up the response to infectious diseases: A way out of poverty. World Health Organization, 2002*

**Action Examples for Financing Innovative Care**

<table>
<thead>
<tr>
<th>Legislation and policy</th>
<th>In countries where public spending on health is very low, commit additional domestic financial resources.</th>
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<tbody>
<tr>
<td></td>
<td>✦ Raise taxes on harmful products (tobacco, alcohol) to reduce the prevalence of unhealthy habits and therefore the spread of chronic conditions.</td>
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<tr>
<td>Insurance</td>
<td>✦ Use prepayment systems that protect users from financial catastrophe and spread risk across the population. Where prepayment is not immediately feasible, one alternative is community-based health insurance.</td>
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<td></td>
<td>✦ View user fees as a funding strategy that is unlikely to be equitable or sustainable for the needs of people with chronic conditions.</td>
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<td>✦ Adopt a comprehensive benefit package that includes, but is not limited to, preventive care services, self-management support, acute and chronic care services, rehabilitative care, emergency care services, and community-based care.</td>
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<td>Efficiency</td>
<td>✦ Use financial incentives to encourage quality and efficiency.</td>
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<td>✦ Align financing mechanisms so that delivery of services occurs in the most appropriate and cost-effective setting.</td>
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<td>Systemic quality</td>
<td>✦ Include incentives to promote continuity and coordination of care by primary care workers.</td>
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<td>✦ Incorporate appropriate mechanisms for monitoring and reporting quality-of-care measurements, including assessments of structure, process and outcome, access, and patient satisfaction.</td>
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<td>Payment systems incentives</td>
<td>✦ Give incentives to maximize the quality of care while minimizing costs: promote preventive services and self-management.</td>
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<td>Private sector</td>
<td>✦ Collaborate with the private sector to optimize the use of available resources.</td>
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<td>✦ Consider using pluralistic purchasing agreements with private and public providers based on a common set of financial rules.</td>
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<td>✦ Embrace fair competition based on access, service, and quality could improve health services for people with chronic conditions.</td>
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<td>✦ Implement accreditation and continuous monitoring of health care performance.</td>
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<td>Delivery</td>
<td>✦ Consider implementing networks of organizations, which provide a coordinated continuum of services to a defined population, and which are held clinically and fiscally accountable for population outcomes.</td>
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<td>Health reforms</td>
<td>✦ Use reform initiatives as an opportunity to improve financing for chronic conditions, such as:</td>
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<td>• Resource allocation and reimbursement schemes;</td>
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<td>• Development and operation of primary health care;</td>
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<td></td>
<td>• Organization of district, integrated health care systems and networks;</td>
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<td></td>
<td>• Collaboration of private providers in delivering health care, particularly for the poorer populations.</td>
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</tbody>
</table>
When to Initiate Change: Proven Methods for the Rapid Spread of Innovative Care

Health system changes that have the potential to significantly influence the development and management of chronic conditions can begin immediately. A strategy for implementing rapid change is available.

The Breakthrough Series

The Breakthrough Series (BTS) is a proven strategy for rapidly changing the way that health care organizations provide services and interventions. The BTS strategy is a general template for making changes, but it specifically outlines the critical steps for implementing innovative health care programmes.

The Institute for Healthcare Improvement (IHI) developed the concept of the BTS in 1995. The purpose was to bring together groups of health care organizations that share a commitment to making system changes within their organizations. These groups, called “collaboratives,” consist of 20 to 40 different health care organizations that work together to improve a specific clinical or operational area for a particular health problem. The time frame is 6 to 13 months and participants follow a cycle of “plan, do, study, act” to yield improved outcomes. Under the guidance of an IHI panel of national experts, the collaborative teams study, test, and implement the latest scientific knowledge available to accelerate improvements in their health care organizations.

To date, the BTS collaborative model has been applied to a variety of chronic conditions. Diabetes, back pain, congestive heart failure, depression, and asthma have been the focus of several BTS endeavours with demonstrated improvements across numerous operational and clinical outcomes.

One example of a BTS implementation comes from Clinica Campesina, a clinic in the USA that serves a population of 15,000 patients. Forty percent of the clinic’s patients are Hispanic, 50% are uninsured, and 100% are medically underserved. Diabetes management was identified as an area ripe for improvement. The BTS method was used to promote rapid change in the management of this chronic condition. A reduction in the average patients’ HbA1c level from 10.5 to 8.5 was observed by the end of the study period. This outcome is significant because a decrease of even one percentage point in HbA1c means a 15% to 18% reduction in mortality, heart attack, and stroke, and a 35% reduction in cardiovascular complications. Of note, these clinical improvements occurred in Clinica Campesina without the input of any additional resources.
Summary

Given the currently available information about the prevention and management of chronic conditions and their complications, the failure to use this knowledge to change health care systems is unjustified and reckless with the future of our populations. Countries and their decision-makers can continue the misguided course of episodic and unplanned care, or these leaders can direct the re-orientation of their health care systems to improve overall population health. Greater social and economic prosperity will follow as a result.

This section provided specific strategies for creating innovations in the care of chronic conditions. Eight essential elements for improving care were described. The micro-, meso-, and macro-level “building blocks” from the ICCC framework that can be used to support these elements were identified. Examples of specific actions to be taken by countries or regions with different levels of resource availability were outlined. Decision-makers have a clarified role with a strategy for where to begin making changes to improve care for chronic problems.

Decision-makers also have guidelines on how to finance care for chronic conditions. Strategies to ensure that financial support is adequate and sustainable were presented, including ways to generate new financial resources and to optimize existing financial supports. When to change is now, and the BTS method for implementing rapid improvements in health care organizations was described.

The evolution of health care systems can advance rapidly with the leadership of informed decision-makers. The goal is to embrace a new overarching framework that allows innovation in the care of chronic conditions. This framework supports a shift in thinking about care for persistent health problems and will dramatically advance efforts to solve the problem of managing diverse patient demands given limited resources. Through innovation, health care systems can maximize their returns from scarce and seemingly non-existent resources by shifting their focus from an acute to a chronic care model.

While the solution to improving caring for chronic conditions is complex, it can be simplified by using the building blocks in the different levels of the health care system and ensuring financing for these changes. Decision-makers should implement changes where feasible among the micro-, meso-, and macro-levels of the system; begin by using some of the building blocks. These changes will support the addition of more building blocks over time and ultimately will complete the ICCC framework for improving outcomes for chronic conditions. Those who embrace innovation experience the benefits today, and ensure success for the future health and economic prosperity of their countries.