Executive Summary

Strategy for Addressing Chronicity in the National Health System

Strategy approved by the Interterritorial Council of the National Health System (NHS) on 27 June 2012

SANIDAD 2012
MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

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Introduction

The current organization of health services, which focuses on the resolution of acute pathologies, stimulates episodic care of health problems with a curative approach, while giving little value to preventive aspects of care, the perspective of care, or the responsibility of persons to care for themselves

The lack of coordination between levels of care (primary care/specialized care) and between health and social systems is one of the main determinants of inefficiency in providing, developing and managing health-care resources.

The organization of health care is particularly inappropriate for patients with multiple diseases, co-morbidity or with a particularly complex situation.

Addressing chronicity requires fostering interdisciplinary teamwork formed by professionals from different health and social service agencies involved in caring for these patients who guarantee the continuity of care with maximum participation of patients and their environments.

The improvement of the organization within the NHS to meet the challenge of chronicity does not necessarily imply an increase in resources, but requires adaptation and optimization of the use of the facilities already available. It is therefore necessary to increase the accountability of managers, professionals and the population at large.

Analysis of the Situation

In Spain, according to the European Health Survey (ESS) of 2009, 45.6% of the population over 16 years of age has at least one chronic condition, and 22% of the population has two or more processes, and these percentages increase with age.

It is estimated that chronic diseases are responsible for 80% of primary care consultations.

A particularly important aspect is the fact that the most important chronic diseases are related to common health determinants, upon which one can act through measures of health promotion and prevention activities.

In the **international framework**, the World Health Organization (WHO) urges health systems worldwide to design appropriate strategies and establish effective measures to face the challenge of chronicity, refocusing its systems of care.

In the **European Union**, in December 2010 the Council of the European Union (EPSCO Council) invited Member States to "develop patient-centered policies for health promotion, primary and secondary prevention, and treatment and care of chronic diseases, in cooperation with policy makers and especially with patient organizations."

In Spain, the Ministry of Health, Social Services and Equality have developed strategies for care of some of the illnesses with the highest burden of disease: cancer, ischemic heart disease, stroke, diabetes mellitus, mental health, palliative care, chronic obstructive pulmonary disease, and rare diseases.

In their strategic plans, all **Autonomous Regions** refer to the addressing of chronicity, have implemented projects and programs for the care of persons with chronic diseases, or are developing strategies of coordinated care to patients with chronic diseases.

The recommendations in this Strategy will complement and enhance the initiatives that are already being developed by the Autonomous Regions, and will form a cohesive framework to guide common goals across the NHS, the changes to be implemented by the Regional Governments to address the prevention of chronic diseases, and ensure that persons with chronic health problems have the same attention all over Spain.

Mission, Vision, Objectives and Guiding Principles of the Strategy

Mission

To establish a set of **goals and recommendations** for the NHS which **would guide the organization of services** towards improving the health of the population and its determinants, preventing health conditions***** and chronic limitations of activity****** and their comprehensive care.

Vision

Adapting the National Health System to respond to the changes in health and social care needs that cause population aging, and the increase in the chronicity of health conditions and activity limitations, **ensuring quality, safety, continuity of care, equity and social participation.**

General Objectives

To decrease the prevalence of health conditions and chronic limitations of activity, **reducing premature mortality** of people who already have any of these conditions, **preventing deterioration of functional capacity** and complications associated with each process, and **improve the quality of life** of people and of their caregivers.

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*According to the International Statistical Classification of Diseases and Related Health Problems (ICD), *health condition* is a generic term that includes disease (acute or chronic), disorder, trauma and injury.

******Activity limitations* are difficulties an individual may have to carry out activities. An "activity limitation" ranges from a mild to severe deviation in terms of quantity or quality in performing the activity, compared with the manner, extension or intensity that is expected of an individual without this condition of health. *Health conditions and chronic activity limitations* are those of long expected duration and generally slow progression that are often associated with different degrees of disability or dependence, either temporarily or permanently, and affect the quality of life of affected persons and caregivers.

Guiding Principles

- **People** are the center of the NHS**,** in its individual and social sphere.
- To consider the **life cycle perspective** and the social determinants of health;
- To consider **all health conditions** and chronic limitations of activity;
- **Primary health care** is the core of patient care for those with chronic health conditions and activity limitations.
- **Continuity of care**, avoiding fragmentation, duplication and improving communication and coordination.
- Professionals in the NHS have to **share responsibility in health care** and in the appropriate use of health and social service resources **with all citizens**.

Development of the Strategic Lines

1. Health Promotion

A large proportion of chronic health conditions and their risk factors are preventable. In this regard, the promotion of healthy lifestyles is an essential course of action to improve the health of the population that involves actions to modify the personal, social, environmental, and economic conditions in which we live

OBJECTIVE **1**

To encourage an intersectoral approach in health promotion through the principle **"Health in All Policies".**

OBJECTIVE **2**

To facilitate **social participation** in the prioritization, development, monitoring and evaluation of health policies related to addressing chronicity

OBJECTIVE **3**

To promote and strengthen the **training of persons** and the community to promote independent, self-care and healthy lifestyles

2. Prevention of Health Conditions and Chronic Limitations of Activity

To effectively address the wide range of health determinants associated with chronicity, it is necessary to go beyond the health sector and adopt a multisectoral approach in prevention that integrates health in other areas such as education, social services, the workplace, the environment, research and others.

OBJECTIVE **4**

To reduce the prevalence of risk factors that determine the occurrence or progression of health conditions and chronic limitations of activity.

OBJECTIVE **5**

To reduce injuries and accidents as causes of health conditions and chronic limitations of activity.

OBJECTIVE **6**

To detect, **diagnose, and begin early treatment** of health conditions and chronic limitations of activity.

OBJECTIVE **7**

To prevent, in patients with chronic health conditions, **functional loss, complications** associated with their disease, and the emergence of new diseases.

3. Continuity of Care

It is necessary to develop instruments and channels of co-ordination between different levels of health care and social services in order to progressively achieve comprehensive care for health problems.

Home care should be strengthened to ensure continuity in the caregiving process

OBJECTIVE **8**

To ensure care for people in the most **appropriate** system and **level** and by professionals that can best respond to their needs.

OBJECTIVE **9**

To ensuring continuity of care in healthcare, avoiding duplication of interventions and **facilitating the transition between levels of care.**

OBJECTIVE **10**

To ensure continued care of people requiring health and social care, promoting **integration of care at the structural and organizational level**

4. Reorientation of Health Care

Comprehensive care requires, first, stratifying the population according to the situation of each person and his or her needs. It is necessary to promote the systematic implementation of individualized care plans that result of the comprehensive assessment of medical needs, and functional and social care.

OBJECTIVE **11**

To identify in each patient his or her level of need and facilitate the provision of specific interventions tailored to every need.

OBJECTIVE **12**

To ensure **effective, safe, efficient, sustainable and proportionate health interventions**, based on the best available scientific evidence.

OBJECTIVE **13**

To **optimize pharmacological therapy** in patients with chronic treatments, with special attention to polimedicated patients.

5. Health Equity and Equal Treatment

Equity in health implies that resources are allocated according to the needs of people.

OBJECTIVE **14**

To reduce inequalities in health from a social determinant approach to chronic health problems, with special emphasis on gender inequalities.

OBJECTIVE **15**

To improve access (availability, accessibility and acceptability) to **health and social systems** and optimize care processes in order to achieve equitable outcomes in different social groups.

OBJECTIVE **16**

To remove any **discrimination or unequal treatment** of persons on the grounds of having any disease or health condition, developmental disorder, disability or dependency.

6. Research and Innovation

Integrating research with clinical practice promotes a higher quality of health services. Health systems must interact closely with health research systems to generate and use knowledge relevant for their own improvement.

Health innovation includes not only technological innovation but also organizational innovation and innovation in services, and should be understood as a process of continuous improvement of the capacity to respond to the needs of the population and professionals. The role of Information and Communication Technologies (ICT) as drivers of competitiveness and development of public health and social services is stressed.

OBJECTIVE **17**

To promote integrated health research that allows a deeper understanding of the mechanisms that influence the genesis of health conditions and chronic limitations of activity, with the aim of establishing the most effective intervention strategies to address them

OBJECTIVE **18**

To promote technological innovation, its evaluation and practical, rational, and **evidence-based** use to support processes for addressing chronicity from the needs of citizens, professionals, and healthcare organizations.

OBJECTIVE **19**

To foster **innovation in services and organizational models** to facilitate changes in the delivery model for health and social services related to chronicity.

OBJECTIVE **20**

To promote **innovation** in the process of **assessment, planning, and service delivery** in order to ensure equity, efficiency and sustainability of care for patients with chronic health conditions.

Plan for the Implementation of the Strategy

As part of the Strategy for Addressing Chronicity in the NHS, the Ministry of Health, Social Services and Equality (MSSSI) coordinates the implementation of various projects and areas of work to carry out the implementation, monitoring and evaluation of the Strategy.

- A **Project of Stratification of the Population in the NHS**, with the aim of establishing a tool that permits identification of subgroups with different levels of care needs.

- A **System Indicator Project,** which allows tracking the implementation of the Strategy. In addition, developing, with state vision, a common minimum set of indicators that will enable following up on the care for patients with chronic diseases.

- To promote the **Network of Health Schools for Citizens** in order to promote, share and develop training tools to improve self-management of health and disease of citizens.

- A **Project for the Improvement of chronic pain in the NHS** for its impact on the quality of life of people and the subsequent impact on health outcomes.

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