

Volume 14, 8 December 2014

Publisher: Igitur publishing

URL: <http://www.ijic.org>

Cite this as: Int J Integr Care 2014; WCIC Conf Suppl; [URN:NBN:NL:UI:10-1-116681](https://nbn-resolving.org/urn:nbn:nl:ui:10-1-116681)

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Conference Abstract

An Integrated Chronic Disease Management Model- A diagonal approach to health system strengthening

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Abstract

South Africa is facing a complex burden of disease arising from a combination of rapidly growing chronic infectious illness (driven by HIV/AIDS) and non-communicable diseases (NCDs). The extent of this burden has few global parallels and demands an extraordinary response (1). A recent publication of a multi-centre prospective cross-sectional survey of consultations in primary care in four provinces of South Africa: Western Cape, Limpopo, Northern Cape and North West indicated that Hypertension, HIV/AIDS, Type 2 Diabetes and Tuberculosis (TB) were the most common conditions in terms of chronic care visits (2)

The unprecedented roll out of antiretroviral treatment (ART) has transformed HIV / AIDS into a chronic disease, as people with HIV are living longer and ageing, and are developing non-HIV-related chronic conditions similar to the rest of the population. Some NCDs are related to HIV infection itself and to the side effects of some of the medicines used to treat HIV infection (3). Providing affordable and effective care to the often large and increasing numbers of people is already an immense challenge but as the burden of chronic diseases both (communicable and NCDs) increases, this will become an even bigger problem requiring a different and innovative approach.

Whilst chronic disease management of NCDs and mental health within primary care is and has been provided in primary care for many years, in many instances the health system has put greater emphasis on the relief of acute symptoms to the detriment of prevention and optimal care of chronic conditions. Moreover chronic disease services are primarily run as disease specific entities and hence programmes treat specific diseases rather than the whole person. Where an individual has more than one condition they often need to attend on different days of the week and be seen by a different practitioner with consequences not only for patient care but costs to patient in terms of time and transport.

The successful management of chronic diseases requires coordination of services for individuals over an extended time period and across disciplines and is dependent on a strong health system and innovative, robustly supported service delivery models that promote patient empowerment (4). Leveraging on the innovations of the HIV program and utilising South Africa's recently adopted policy for re-engineering primary health care an integrated chronic disease management (ICDM)

model, based on the WHO health system building blocks was proposed as a vehicle to improve the management of chronic conditions.

The aim of the ICDM is to achieve optimal clinical outcomes for patients with chronic communicable and non-communicable diseases in order to respond to the growing burden in an efficient and cost effective manner (5). The ICDM is designed using a Public Health approach to empower the individual to take responsibility for their own health whilst simultaneously intervening at a community/population and health service level. The model was developed through a combination of initial theoretical and academic considerations over a two year period.

The ICDM consists of four inter-related phases that are dependent on overarching strong stewardship and ownership at all levels of the health system I

The four inter-related phases include:

- Facility re-organisation to improve service efficiency.
- Clinical supportive management to improve quality of clinical care.
- “Assisted “self-support and management of patients through the ward based outreach teams (WBOT) to empower individuals to take responsibility for managing their own conditions and increasing awareness of chronic diseases at the population level
- Strengthening of support systems and structures outside the facility to ensure a fully functional and responsive health system.

Achieving an integrated chronic care disease management model requires a new way of thinking and acting. It is imperative that this model is piloted at a limited number of sites to assess the feasibility and sustainability whilst simultaneously evaluating the outcomes of chronic patients managed within the model. The lessons gained from the pilot sites can be used to further develop the model and scale up the implementation to saturate all districts in the country.

Keywords

Integrated care; health system strengthening; non communicable diseases; HIV&AIDS; facility re-organisation; clinical supportive management; assisted self supportive management

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