

Interview: The chronic conditions approach by the Unified Health System

Eugênio Vilaça Mendes ¹

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Abstract *The interview explains the analysis of Eugenio Vilaça Mendes regarding the importance of chronic conditions in the morbidity and mortality profile and its impact on the Unified Health System (SUS) in Brazil. It points out which measures should be prioritized, in the interviewee's view, for the improvement of the SUS in order to qualify the care offered to the patients of these conditions, and finally brings a set of considerations formulated by him regarding the organization of access to Primary Care the health.*

Key words *Health Unic System, Health care, Chronic conditions, Public health*

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I would like you to comment on the participation of the so-called “chronic conditions” in the morbimortality profile of the Brazilian population nowadays.

We must understand the recent concept of health conditions.

Classical typology classifies diseases into communicable diseases and noncommunicable chronic diseases, having the etiopathogenesis as a criterion. This typology works well, especially in the field of epidemiological studies; however, it is not enough to support the organization of health care systems.

For this reason, the recent proposal of health conditions emerged being understood as the circumstances in people’s health that are presented in a more or less persistent way and demand responsive or proactive, episodic or continuous and fragmented or integrated social solutions from the health care systems, health professionals and users. Therefore, the criterion of this new typology is not etiopathogenesis, but the ways health care systems are organized to socially respond to these conditions. Health conditions are divided into acute and chronic conditions.

The acute conditions are those short-term health conditions that manifest themselves in a hardly predictable way. They can be controlled in a reactive and episodic but integrated way, demanding a convenient time of response from the health care system. Short-term communicable diseases have acute conditions, such as influenza, infectious and inflammatory diseases – within these, we could mention appendectomies and tonsillitis, traumas and general and nonspecific conditions that manifest themselves in acute manner such as fever, generalized pain and chest pain.

Chronic conditions are those health conditions of longer, shorter or permanent term that require continuous proactive and integrated responses and actions from the health care system, health professionals and users for its effective, efficient and quality control. Chronic conditions, therefore, are not the same as noncommunicable chronic diseases. All chronic diseases are chronic conditions; however, there are other chronic conditions such as: individual biopsychological risk factors; long-term communicable diseases, such as HIV/AIDS, hanseniasis and certain viral hepatitis; maternal and perinatal conditions; health maintenance per life cycles as childcare, adolescent and geriatric care; illnesses, long-term mental disorders and continuous physical and

structural disabilities such as amputations and persistent motor disabilities.

Disease burden studies demonstrate that Brazil lives a triple burden of diseases situation, in which there are contemporarily manifested an unfinished agenda of infections, malnutrition and reproductive health problems, the external causes and chronic diseases that already reach 77% of the total burden. If other chronic conditions are considered, we can estimate that around 85% of the burden of diseases in our country is from chronic conditions.

In your opinion, what is the impact of this predominance of chronic conditions on existing health systems in Brazil?

The impact is huge. The “epidemic” of chronic conditions is a recent fact and is due to the health transition that has occurred in Brazil since the second half of the last century. The first element of the health transition is the transition of health conditions determined by contextual factors of health care systems. The second element is the transition of the health care system determined by internal factors to this system.

The transition of health conditions is expressed in four complementary dimensions: the demographic transition, which leads to rapid population aging; the nutritional transition, which increases the number of overweight or obese people; the technological transition, which is manifested in the paradox of incorporation of new effective technologies that, due to their large volume, surpass the ability of systems in rationally applying them; and the epidemiological transition, which leads to the triple burden of diseases. All these transitions consolidate a situation of relative growing predominance of chronic conditions.

Health transition, due to its speed and depth, could not be accompanied by a consequent transition of health care systems because of the inherent difficulties in processes of changes of these systems.

As a result, the 21st century health situation, relatively predominated with chronic conditions, is being socially answered through a health care model developed in the first half of the 20th century, when acute conditions predominated. This occurred because of a temporal mismatch between contingent factors that evolve rapidly (demographic, nutritional, technological and epidemiological transitions) and internal factors (organizational culture, resources, incentive sys-

tems, leadership styles, health care models and organizational arrangements) that evolve very slowly.

This is the central crisis settled in all health care systems in the world. Brazil was no different.

Acute conditions can be faced by reactive and episodic social responses; on the other hand, chronic conditions necessarily require proactive, continuous and network-integrated responses. The transposition of the health care model to acute conditions — which was relatively successful when confronting these conditions —, to the management of chronic conditions is a huge failure in both SUS and supplementary private health insurance.

Actually, this is a universal failure. A survey conducted in the United Kingdom reported the rule of halves when managing chronic conditions: for every 100 persons with chronic diseases only half of them have a diagnosis; of the diagnosed people, only half are stabilized (for example, people with diabetes with controlled blood sugar); and of the diagnosed people, only half are enrolled into effective programs of health promotion or disease prevention. As for SUS, in some regions where I work, this rule is not of halves, but of thirds.

Personally, do you think SUS is prepared to face the health needs arising from this transition?

SUS – but also the supplementary private health insurance – is not prepared to face chronic conditions. The reason is still unknown and, therefore, health care models that are effective in assisting these conditions are not practiced on scale.

The models of chronic condition health care engender proactive, continuous and integrated social responses in three dimensions: health care systems, health professionals and users. These models are based on a support tripod: stratification of users' risks, stabilization of chronic conditions and supported self-care. You don't work with people with arterial hypertension, but with people of low, medium, high and very high risk regarding this disease; the aim is to stabilize the chronic conditions to contain its evolutionary risk. These conditions are not stabilized without a proactive component from people who are no longer patients and have become agents of the social production of their health with the support of a health team and its social protection network.

The model of seminal care was originally developed in the United States of America and

it was named Chronic Care Model. It was widely disseminated and has been applied in almost all developed countries and in some developing ones. This model proposes concomitant changes in six elements of health care systems: health care organization, clinical information system, delivery system design; self-management support and relations with the community. Acting as an expanded model, it was used in countries that have universal health care such as Canada and the United Kingdom. There are hundreds of scientific articles that evaluate this model and show that, when applied, it contributes to the improvement of health outcomes, cost reduction and increase in the users' satisfaction.

Another important model for the proper management of chronic conditions is the risk pyramid model that creates operational bases for stratification of the risks of people with chronic conditions. This model has also been widely evaluated in different countries and presents very positive results.

Based on these two models and adding the Social Model of Health of Dahlgren and Whitehead, I elaborated a health care model to chronic conditions for SUS. This model was built by assuming that a universal health care system should incorporate different patterns of social determination of health, operating at five levels: the first level of health promotion with intersectoral activities on intermediate determinants; the second level of prevention of chronic health conditions acting on the proximal determinants related to behaviors and lifestyles; the third and fourth levels acting on the chronic conditions stratified by risks and managed by technologies that handle health conditions; and a fifth level operating on people with high complexity chronic conditions through clinical management technology. This model has been used in SUS with some positive results, especially in a network operation model of primary health care and specialized outpatient care.

Which measures are, in your view, necessary and should be prioritized for the improvement of SUS, aiming at the qualification of the care offered to patients with chronic conditions? Could you comment about your view regarding the PHC participation in this process and the necessary measures aiming at its qualification?

The critical issue of SUS resides in the inconsistency between a health situation that combines accelerated demographic and nutritional tran-

sitions and triple burden of disease, with high prevalence of chronic conditions and a fragmented health system that operates in an episodic and reactive form and that is primarily directed to the health care of acute conditions and aggravations of chronic conditions. Fragmented systems present several characteristics: they are hierarchically organized by isolated components; they are oriented to the health care of acute events; the subject is the patient who receives prescriptions from health professionals; their answers are reactive and episodic; and they emphasize the curative and rehabilitational acts and the medical professional care. This fragmented system has been failing when confronting chronic conditions. A study conducted in clinical centers of diabetes management in Brazil reported that only 10% of people with type 1 diabetes and 27% of people with type 2 diabetes were stabilized.

The response to this critical issue of SUS is on the health care networks structure. These networks have the following characteristics: they are organized by a care continuum and in a polyarchic manner; they are oriented to the health care of acute events and chronic conditions; they are intended to an affiliated population; the subjects are agents of their own health in collaboration with the health professionals; their answers are proactive and continuous; they evenly offer actions that are promotional, preventive, curative, rehabilitative and palliative; and they emphasize multi-professional and interdisciplinary health care. I did an extensive bibliographic review, with hundreds of published studies in many countries, which reported strong evidence that health care networks improve sanitary outcomes in chronic conditions, reduce references to specialists and hospitals, increase the efficiency of health care systems, produce more cost/effective services and increase the users' satisfaction.

Health care networks consist of three essential elements: population, operational structure and health care models for acute events and for chronic conditions.

The population of a health care network is not the one from IBGE (Brazilian Institute of Geography and Statistics), but the population socially organized in families and registered and related to a primary health care team. This population should be stratified by social and sanitary risks.

The operational structure of networks consists of primary health care, secondary and tertiary outpatient and hospital care points, support systems (pharmaceutical care system, diagnostic

and therapeutic support systems and information systems on health), logistic systems (regulated access system, electronic record in health and health transportation system) and governance system.

Primary health care consists of three essential functions in the health care networks: establishment and maintenance of population base, case management and coordination. In addition, it must be structured according to the attributes of first contact, longitude, completeness, coordination, focus on family, community orientation and cultural competence.

Research conducted in the SUS showed that well-qualified primary health care solves from 90% to 95% of the problems that come to this stage of health care. Furthermore, primary health care has the role of ordering the flows of people, products and data through the networks, defining who should go to specialized health care and to hospital health care, except acute events.

Based on my experience, I can say that the most complex aspect regarding the organization of health care networks is to qualify them so they can fulfill their duties and operate according to their attributes.

From research about the demand on primary health care, I identified ten demand profiles and aggregated them into six supply profiles: health care to the demand of acute events; health care to the demand for non-acute chronic conditions and hyper-using users; health care to the demand for preventive health care; health care to administrative demands; health care to the demand for home care; and health care to the demand for self-management support.

In order to structure these six offer profiles, I developed a methodology that uses the construction metaphor of the "house" of primary health care. This methodology is applied according to the improvement models, focusing on the management of processes and through active educational activities, exercised by a tutorial system.

This social construction proposal of primary health care has been applied in different regions of our country, generally with satisfactory results.

You recently published a document for CON-ASS regarding the "access to PHC". I would like you to comment your view and the main points discussed regarding the organization of access to PHC in that publication.

Evidence show that one of the best programs of SUS is the Family Health Strategy (ESF). This

strategy had a remarkable expansion, which contributed to the improvement on the equity of access to primary health care. However, there are points to be improved in this theme. The long waiting lines and time in primary health care are issues that need to be resolved on a large scale.

This led me to prepare a document on how to organize the access in primary health care for the National Council of State Health Secretaries (CONASS).

International experience indicates that the main barriers to eliminate waiting times are psychological: fear of change and the lack of confidence that existing resources can be sufficient for reducing these times. The lines not always derive from the imbalances between supply and demand, even though they may exist in certain circumstances. There is a culture of line impregnated in health professionals and population that is not easy to be reversed.

Experiments performed in different countries reported that it is possible to overcome the culture of lines and organize the prompt access to primary health care. They all proceeded from the fact that primary care demand is entirely predictable and, therefore, it can be perfectly managed.

The main focus that has been used is the advanced access. Its logic is “do all of today’s work today,” using knowledge from the theory of lines and the Lean manufacturing system, it has open agenda every day and overcomes the current paradigm: “If you’re really sick, you will be treated in the same day, if you’re not, you can wait.” It is not a model of organization of primary health care, but only a model of access. This approach, which started to be used in SUS, increases the supply of treatments, but is limited: it increases the amount of treatments, but not always the number of people treated; it is not always able to attend all the demand on the same day; it is neutral or has little impact on absenteeism, longitude of health care and satisfaction of users; their effects on clinical outcomes are not shown; the strict focus on reducing waiting time can affect the patient-centered care and increase iniquity in access; and the evaluations available are generally based on anecdotal evidence, which summons the need for new research to its evaluation.

Based on these evaluations I proposed an organizational system of access to primary health care that uses advanced access principles and some of its elements, combining it with three other approaches: smoothing of care flows, technological alternatives to in-person treatments and the model of delegation using interdisciplinary multi-professional teams.

The focus on the smoothing of care flows identifies and quantifies the various types of variability in the flow of users (demand) and the available resources for different user groups (offer), aiming at reducing waiting times. The focus of technological alternatives to in-person treatment seeks to introduce remote health care devices such as treatments by phone, e-mail, videoconference and in chats. And the delegation focus seeks to increase the number of primary health care team professionals, working in an interdisciplinary manner, and offering new forms of clinical encounters beyond individual care such as continuous care, shared care to groups, pair groups, operating groups and others.

This methodology of organization of access to primary health care by combining the four complementary approaches has been applied in SUS, in several municipalities, and it has allowed, without increasing existing resources, to eliminate the lines and build a schedule of treatments with an appointment for users by blocks of hours.

The authors thank Espaço da Escrita – Coordenadoria Geral da Universidade – UNICAMP – for the language services provided.

