Quality of chronic care: the possible contribution of purchasing arrangements in LMICS

Round 1 Report

Participation rate
94.23 %

Completion rate
37.55 %

Statistics

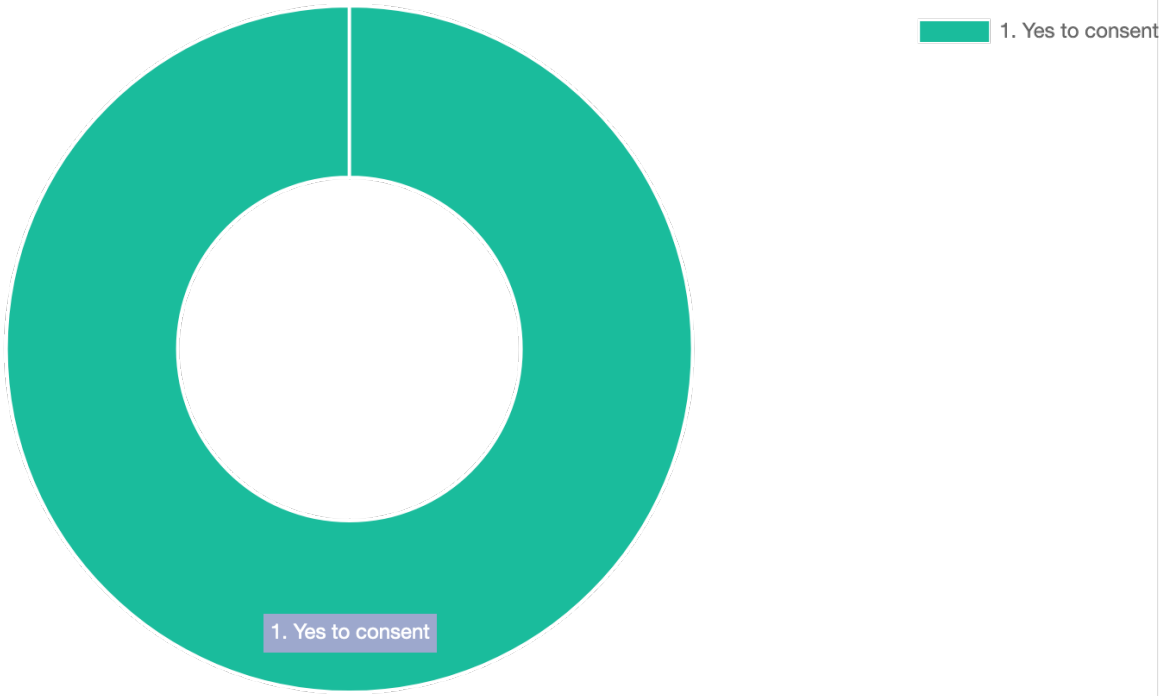
Answers	3753
Questions	204
Respondents	52
Active respondents	49
Answers - Words count	24525 words
Q. EN - Words count	12257 words
Q. EN - Reading time	61 min

1.1.1 — Informed consent (Page 1)

EN

I consent to participate in this survey and the following has been explained to me: The survey may not be of direct benefit to me. My participation is completely voluntary. I have the right to withdraw from the survey at any time without any implications to me.

1.1.1 — Informed consent



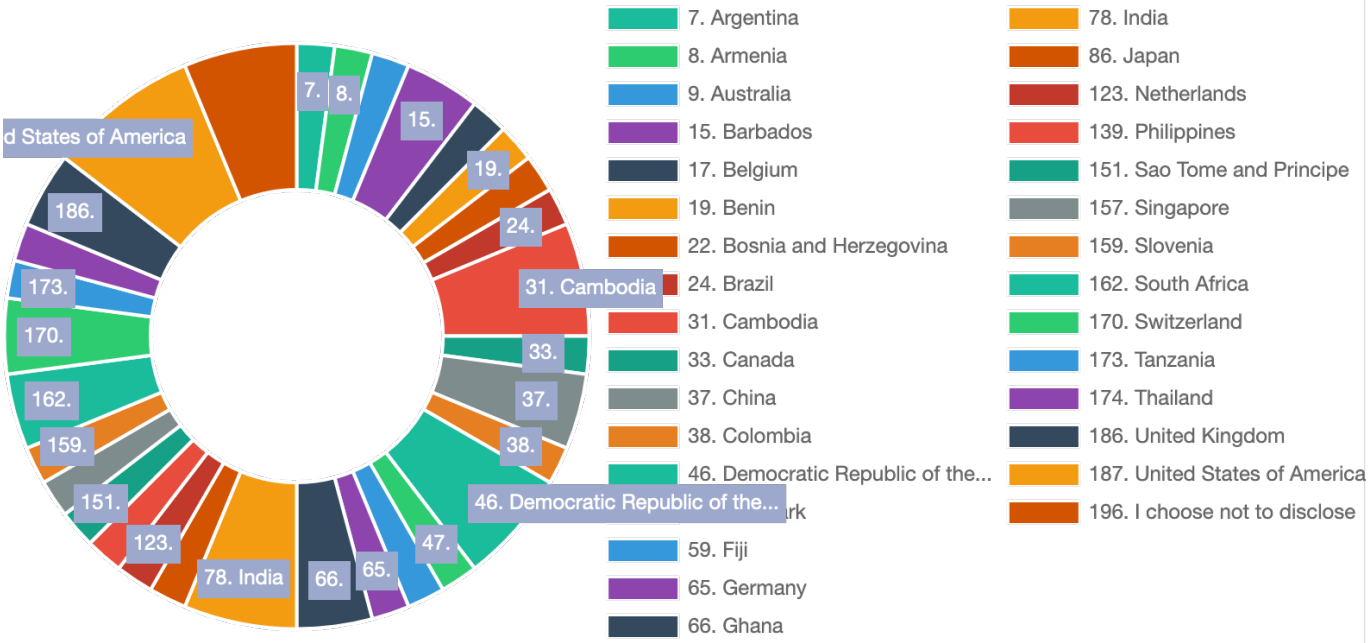
Choices	#
1. Yes to consent	49 (100 %)
Total	**49**

1.2.1 — Country/ies of residence (Page 2)

EN

Please state your country of residence or I choose not to disclose

1.2.1 — Country/ies of residence



Choices	#
7. Argentina	1 (2.08 %)
8. Armenia	1 (2.08 %)
9. Australia	1 (2.08 %)
15. Barbados	2 (4.17 %)
17. Belgium	1 (2.08 %)
19. Benin	1 (2.08 %)
22. Bosnia and Herzegovina	1 (2.08 %)
24. Brazil	1 (2.08 %)
31. Cambodia	3 (6.25 %)
33. Canada	1 (2.08 %)
37. China	2 (4.17 %)
38. Colombia	1 (2.08 %)
Total	**48**

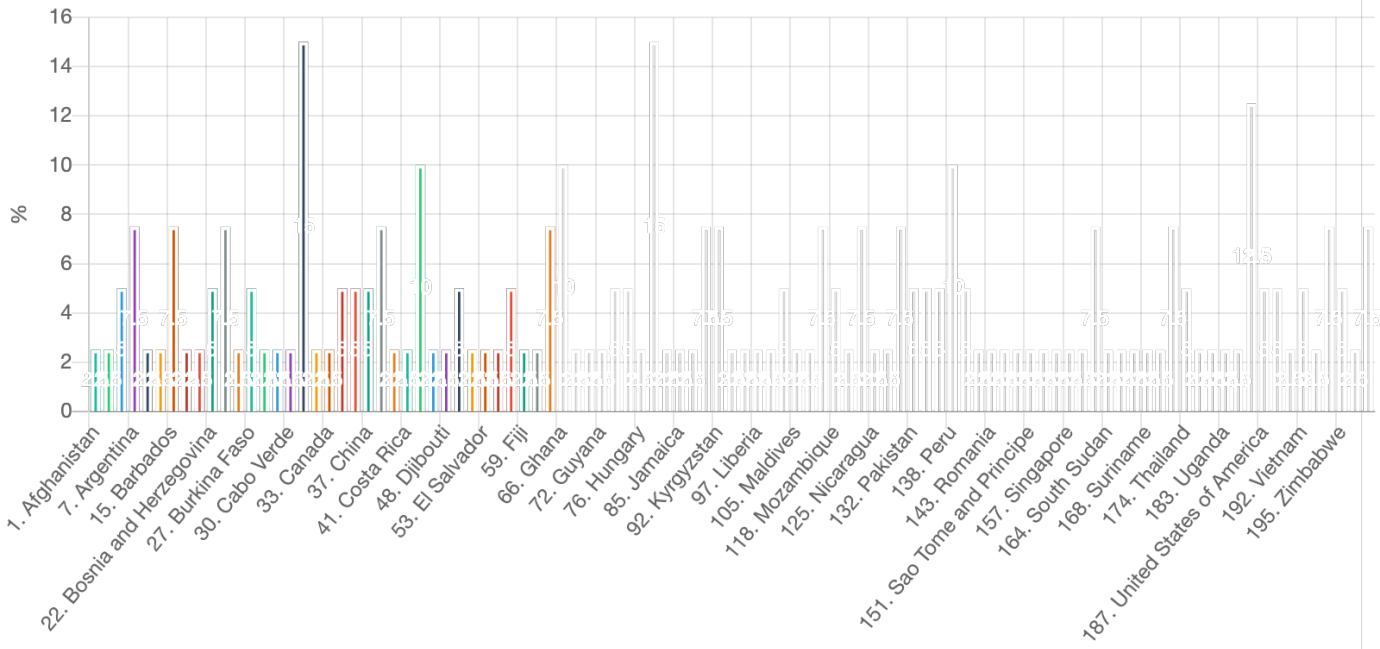
Choices	#
46. Democratic Republic of the Con	3 (6.25 %)
47. Denmark	1 (2.08 %)
59. Fiji	1 (2.08 %)
65. Germany	1 (2.08 %)
66. Ghana	2 (4.17 %)
78. India	3 (6.25 %)
86. Japan	1 (2.08 %)
123. Netherlands	1 (2.08 %)
139. Philippines	1 (2.08 %)
151. Sao Tome and Principe	1 (2.08 %)
157. Singapore	1 (2.08 %)
159. Slovenia	1 (2.08 %)
162. South Africa	2 (4.17 %)
170. Switzerland	2 (4.17 %)
173. Tanzania	1 (2.08 %)
174. Thailand	1 (2.08 %)
186. United Kingdom	2 (4.17 %)
187. United States of America	4 (8.33 %)
196. I choose not to disclose	3 (6.25 %)
Total	**48**

1.2.2 — Country/ies of expertise (Page 2)

EN

For which country, can we consider that you have professional expertise? (check all that apply) Write down as many countries as you consider that you have the professional expertise, or check if it is not applicable or if you choose not to disclose.

1.2.2 — Country/ies of expertise



Choices	#
1. Afghanistan	1 (2.5 %)
2. Albania	1 (2.5 %)
5. Angola	2 (5 %)
7. Argentina	3 (7.5 %)
8. Armenia	1 (2.5 %)
Participants	**40**
Total	**171**

Choices	#
9. Australia	1 (2.5 %)
15. Barbados	3 (7.5 %)
19. Benin	1 (2.5 %)
21. Bolivia	1 (2.5 %)
22. Bosnia and Herzegovina	2 (5 %)
24. Brazil	3 (7.5 %)
25. Brunei	1 (2.5 %)
27. Burkina Faso	2 (5 %)
28. Burundi	1 (2.5 %)
29. Côte d'Ivoire	1 (2.5 %)
30. Cabo Verde	1 (2.5 %)
31. Cambodia	6 (15 %)
32. Cameroon	1 (2.5 %)
33. Canada	1 (2.5 %)
35. Chad	2 (5 %)
36. Chile	2 (5 %)
37. China	2 (5 %)
38. Colombia	3 (7.5 %)
40. Congo (Congo-Brazzaville)	1 (2.5 %)
41. Costa Rica	1 (2.5 %)
Participants	**40**
Total	**171**

Choices	#
46. Democratic Republic of the Con	4 (10 %)
47. Denmark	1 (2.5 %)
48. Djibouti	1 (2.5 %)
50. Dominican Republic	2 (5 %)
51. Ecuador	1 (2.5 %)
53. El Salvador	1 (2.5 %)
56. Estonia	1 (2.5 %)
58. Ethiopia	2 (5 %)
59. Fiji	1 (2.5 %)
61. France	1 (2.5 %)
65. Germany	3 (7.5 %)
66. Ghana	4 (10 %)
69. Guatemala	1 (2.5 %)
71. Guinea-Bissau	1 (2.5 %)
72. Guyana	1 (2.5 %)
73. Haiti	2 (5 %)
75. Honduras	2 (5 %)
76. Hungary	1 (2.5 %)
78. India	6 (15 %)
79. Indonesia	1 (2.5 %)
Participants	**40**
Total	**171**

Choices	#
85. Jamaica	1 (2.5 %)
86. Japan	1 (2.5 %)
89. Kenya	3 (7.5 %)
92. Kyrgyzstan	3 (7.5 %)
95. Lebanon	1 (2.5 %)
96. Lesotho	1 (2.5 %)
97. Liberia	1 (2.5 %)
102. Madagascar	1 (2.5 %)
104. Malaysia	2 (5 %)
105. Maldives	1 (2.5 %)
106. Mali	1 (2.5 %)
111. Mexico	3 (7.5 %)
118. Mozambique	2 (5 %)
122. Nepal	1 (2.5 %)
123. Netherlands	3 (7.5 %)
125. Nicaragua	1 (2.5 %)
126. Niger	1 (2.5 %)
127. Nigeria	3 (7.5 %)
132. Pakistan	2 (5 %)
135. Panama	2 (5 %)
Participants	**40**
Total	**171**

Choices	#
137. Paraguay	2 (5 %)
138. Peru	4 (10 %)
139. Philippines	2 (5 %)
141. Portugal	1 (2.5 %)
143. Romania	1 (2.5 %)
145. Rwanda	1 (2.5 %)
147. Saint Lucia	1 (2.5 %)
151. Sao Tome and Principe	1 (2.5 %)
153. Senegal	1 (2.5 %)
154. Serbia	1 (2.5 %)
157. Singapore	1 (2.5 %)
159. Slovenia	1 (2.5 %)
162. South Africa	3 (7.5 %)
164. South Sudan	1 (2.5 %)
166. Sri Lanka	1 (2.5 %)
167. Sudan	1 (2.5 %)
168. Suriname	1 (2.5 %)
170. Switzerland	1 (2.5 %)
173. Tanzania	3 (7.5 %)
174. Thailand	2 (5 %)
Participants	**40**
Total	**171**

Choices	#
176. Togo	1 (2.5 %)
178. Trinidad and Tobago	1 (2.5 %)
183. Uganda	1 (2.5 %)
184. Ukraine	1 (2.5 %)
186. United Kingdom	5 (12.5 %)
187. United States of America	2 (5 %)
188. Uruguay	2 (5 %)
191. Venezuela	1 (2.5 %)
192. Vietnam	2 (5 %)
193. Yemen	1 (2.5 %)
194. Zambia	3 (7.5 %)
195. Zimbabwe	2 (5 %)
196. Not applicable	1 (2.5 %)
197. I choose not to disclose	3 (7.5 %)
Participants	**40**
Total	**171**

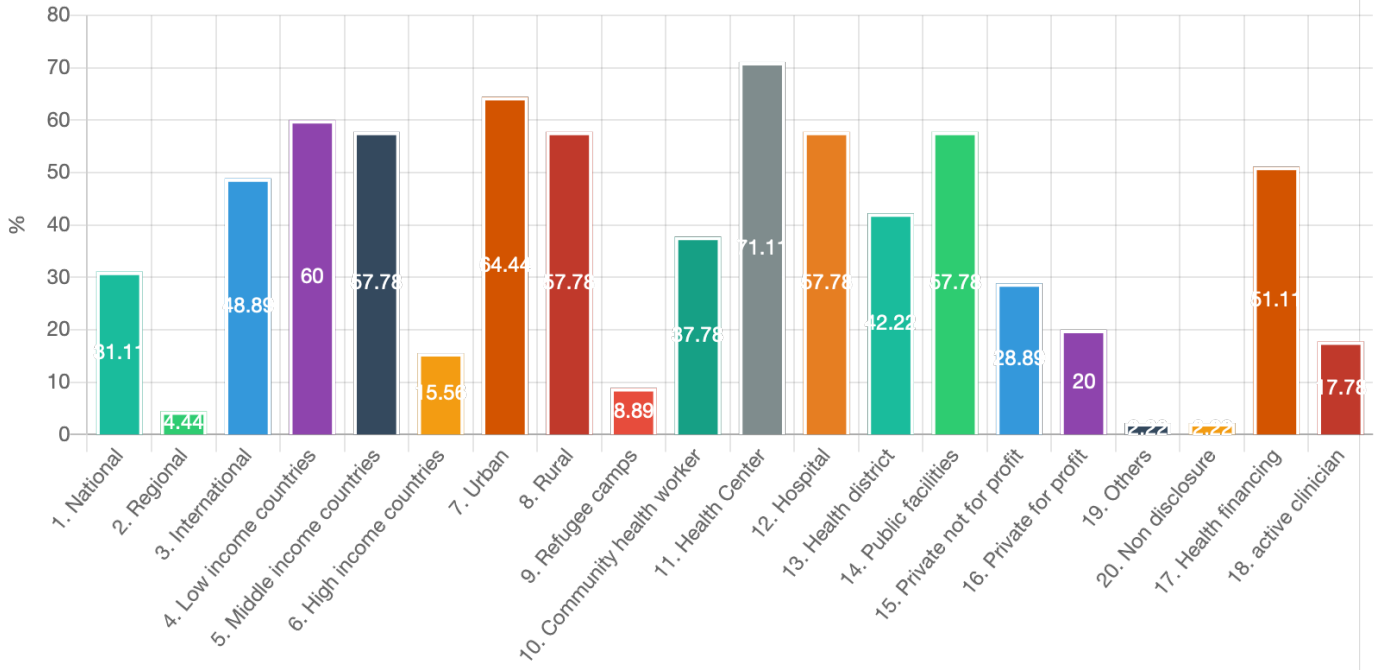
☐ 1.2.3 — Settings of professional expertise

(Page 2)

EN

For which settings, can we consider that you have professional expertise in? (check all that apply)

1.2.3 — Settings of professional expertise



Choices	#
1. National	14 (31.11 %)
2. Regional	2 (4.44 %)
3. International	22 (48.89 %)
4. Low income countries	27 (60 %)
5. Middle income countries	26 (57.78 %)
6. High income countries	7 (15.56 %)
7. Urban	29 (64.44 %)
8. Rural	26 (57.78 %)
9. Refugee camps	4 (8.89 %)
10. Community health worker	17 (37.78 %)
Participants	**45**
Total	**332**

Choices	#
11. Health Center	32 (71.11 %)
12. Hospital	26 (57.78 %)
13. Health district	19 (42.22 %)
14. Public facilities	26 (57.78 %)
15. Private not for profit	13 (28.89 %)
16. Private for profit	9 (20 %)
19. Others	1 (2.22 %)
20. Non disclosure	1 (2.22 %)
17. Health financing	23 (51.11 %)
18. active clinician	8 (17.78 %)
Participants	**45**
Total	**332**

1.2.4 — Other specity (Page 2)

EN
If you checked "other" in the previous question, please specify here:

1.2.4 — Other specity

Engaging people living with noncommunicable diseases/civil society interested in supporting increased access to NCDs in LMIC

a77d36f9 answered 1 week ago

Migrant groups, illiterate populations, health reforms, human rights.

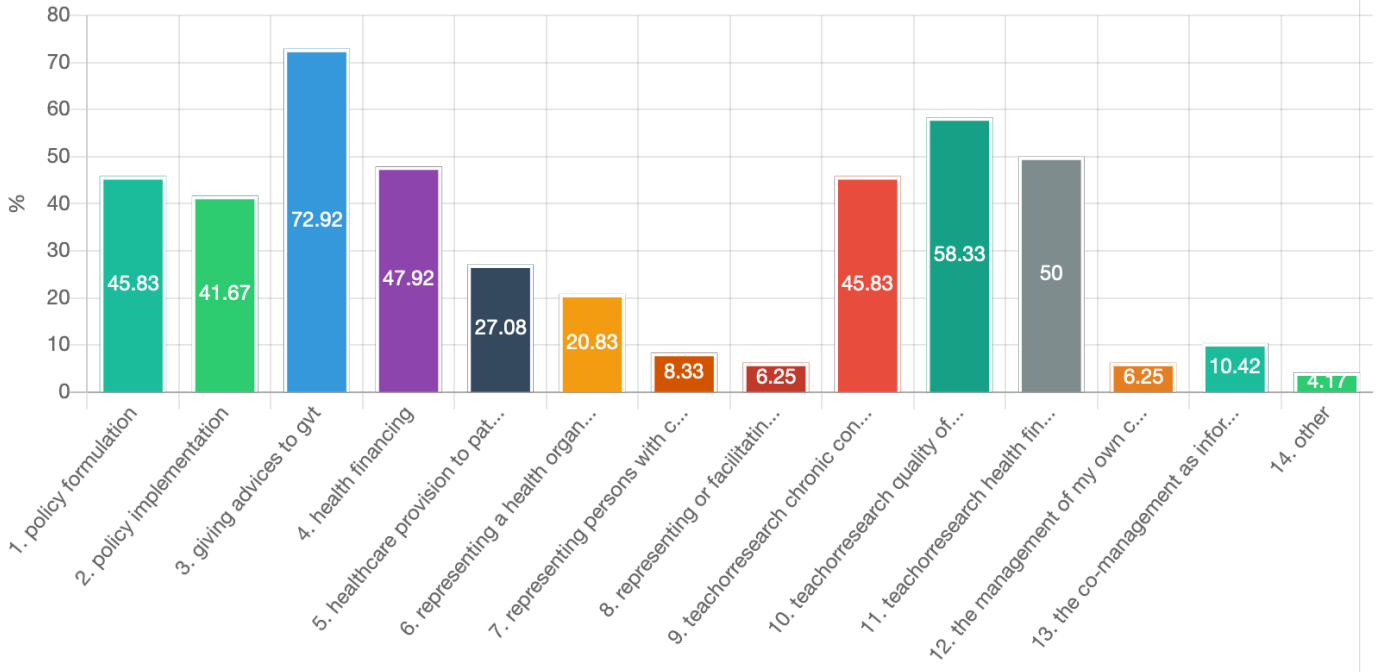
93089cc1 answered 1 day ago

1.2.5 — Regular involvement (Page 2)

EN

You are an expert in this field because of your regular involvement in (check all that apply):

1.2.5 — Regular involvement



Choices	#
1. policy formulation	22 (45.83 %)
2. policy implementation	20 (41.67 %)
3. giving advices to gvt	35 (72.92 %)
4. health financing	23 (47.92 %)
Participants	**48**
Total	**214**

Choices	#
5. healthcare provision to patien	13 (27.08 %)
6. representing a health organisa	10 (20.83 %)
7. representing persons with chro	4 (8.33 %)
8. representing or facilitating	3 (6.25 %)
9. teachorresearch chronic cond	22 (45.83 %)
10. teachorresearch quality of car	28 (58.33 %)
11. teachorresearch health financi	24 (50 %)
12. the management of my own chron	3 (6.25 %)
13. the co-management as informal	5 (10.42 %)
14. other	2 (4.17 %)
Participants	**48**
Total	**214**

1.2.6 — Other specify (Page 2)

EN
If you checked "other" in the previous question, please specify here:

1.2.6 — Other specify

revolving drug fund for chronic conditions

e39890ca answered 2 weeks ago

Local roll-out (London, United Kingdom) of nationally mandated health programmes in Polypharmacy, ADHD and Atrial Fibrillation to improve care delivery and increase uptake of evidence-driven technologies in the care of chronic, non-communicable diseases.

18480606 answered 2 weeks ago

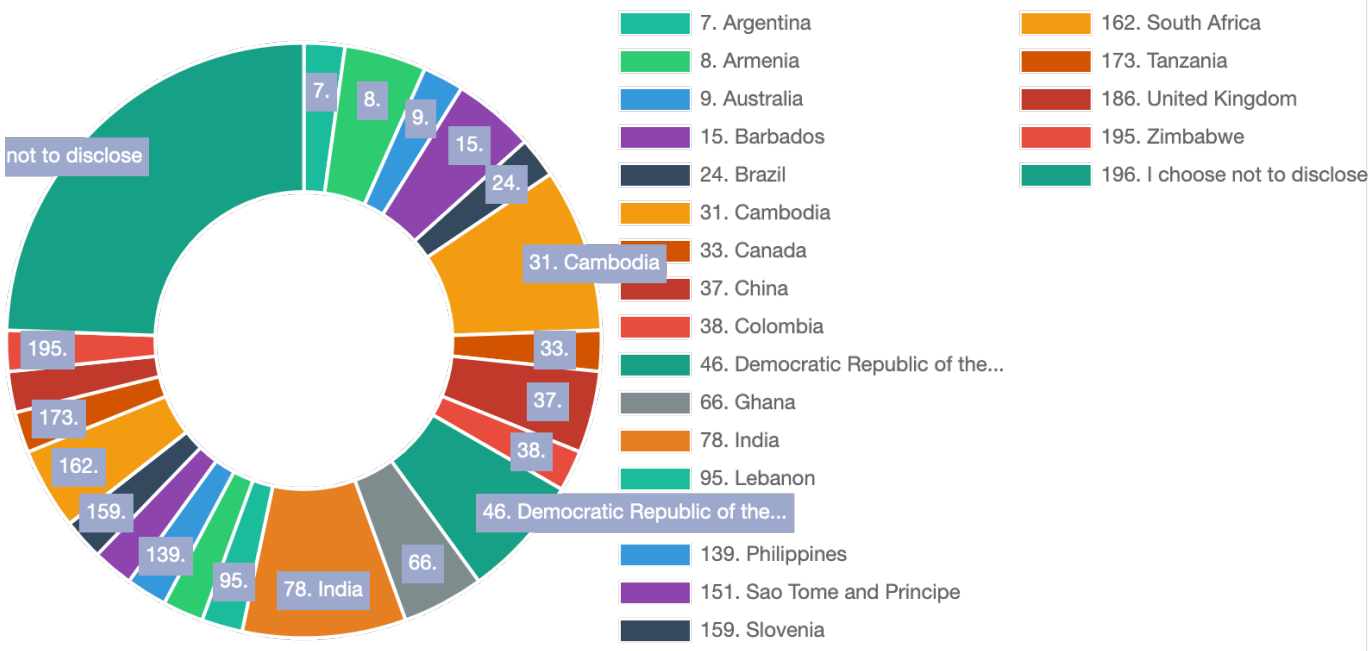
1.3.1 — Quality of chronic care in general in the country (Page 3)

EN

Please indicate below the country/ies you are using as a reference. If you do not wish to disclose the country/ies, please indicate in the next question instead whether this is a low-income (LIC), middle-income (MIC), or high-income (HIC) country.

1. Country /ies(or classification) of reference:

1.3.1 — Quality of chronic care in general in the country



Choices	#
7. Argentina	1 (2.22 %)
Total	**45**

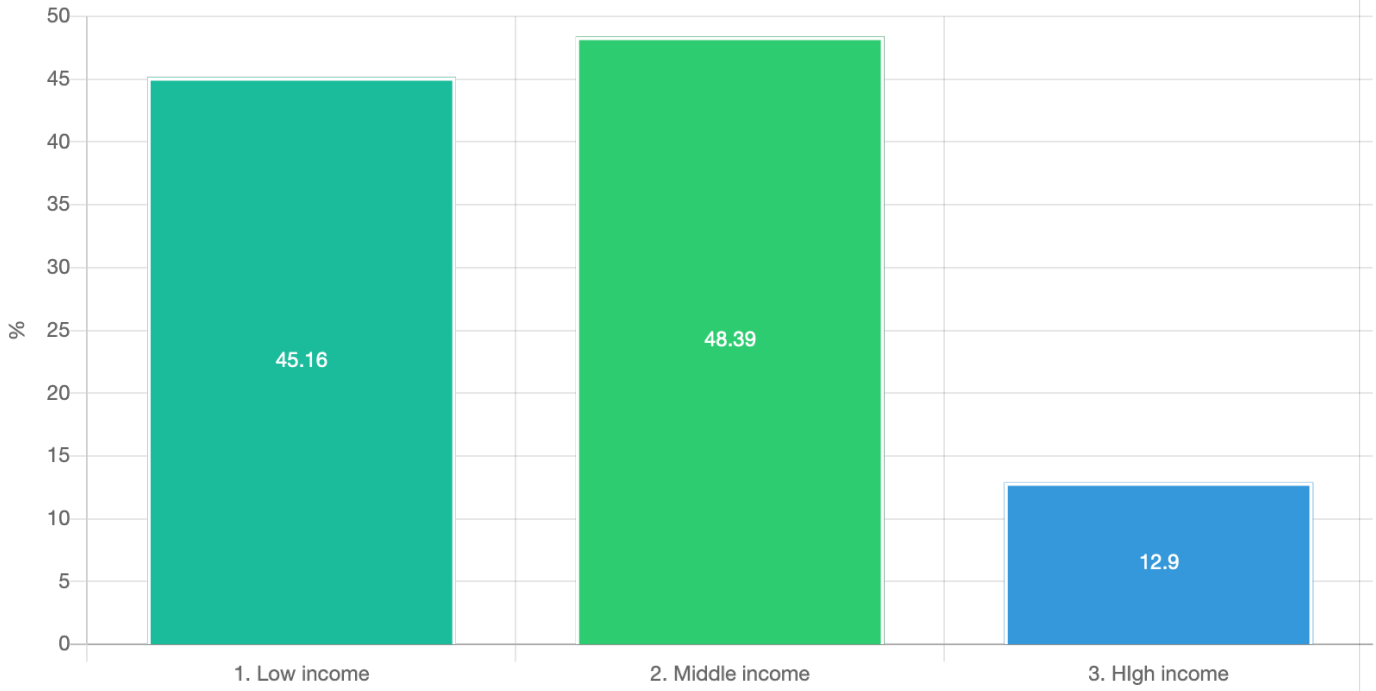
Choices	#
8. Armenia	2 (4.44 %)
9. Australia	1 (2.22 %)
15. Barbados	2 (4.44 %)
24. Brazil	1 (2.22 %)
31. Cambodia	4 (8.89 %)
33. Canada	1 (2.22 %)
37. China	2 (4.44 %)
38. Colombia	1 (2.22 %)
46. Democratic Republic of the Con	3 (6.67 %)
66. Ghana	2 (4.44 %)
78. India	4 (8.89 %)
95. Lebanon	1 (2.22 %)
138. Peru	1 (2.22 %)
139. Philippines	1 (2.22 %)
151. Sao Tome and Principe	1 (2.22 %)
159. Slovenia	1 (2.22 %)
162. South Africa	2 (4.44 %)
173. Tanzania	1 (2.22 %)
186. United Kingdom	1 (2.22 %)
195. Zimbabwe	1 (2.22 %)
Total	**45**

Choices	#
196. I choose not to disclose	11 (24.44 %)
Total	**45**

☐ 1.3.2 — Quality of chronic care in the country, LIC, MIC, (Page 3)

EN
If you have not reported any specific country, please indicate instead whether your reference is a low-income (LIC), middle income (MIC) or high income (HIC) country.

1.3.2 — Quality of chronic care in the country, LIC, MIC,



Choices	#
Participants	**31**
Total	**33**

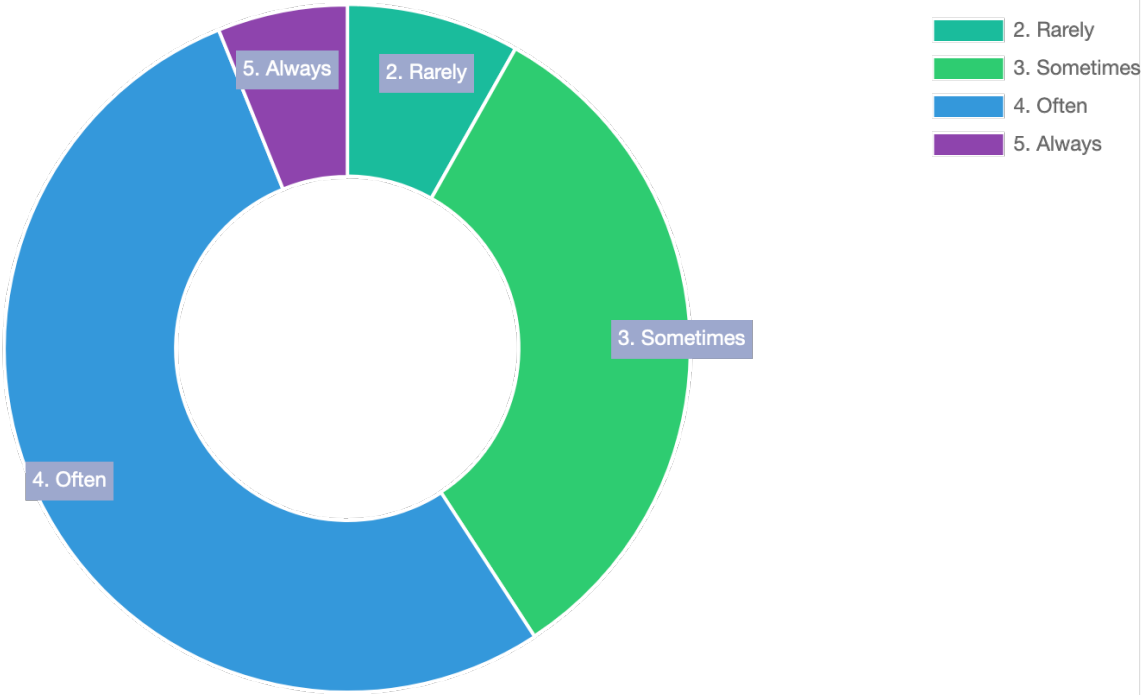
Choices	#
1. Low income	14 (45.16 %)
2. Middle income	15 (48.39 %)
3. HIgh income	4 (12.9 %)
Participants	**31**
Total	**33**

1.3.3 — Quality of chronic care in general per country, ac (Page 3)

EN
QUESTION: Among the determinants (the ones that matter the most) of quality of chronic care, rank on a scale of 1 (never) to 6 (not sure), to what degree are these possible shortcomings happening? Rating scale 1 – never, 2 – rarely, 3 – sometimes, 4 – often, 5 – always, 6 - not sure

( ) Accessibility: there is a general lack of service provision for people with a chronic conditions, especially for non-communicable diseases

1.3.3 — Quality of chronic care in general per country, ac



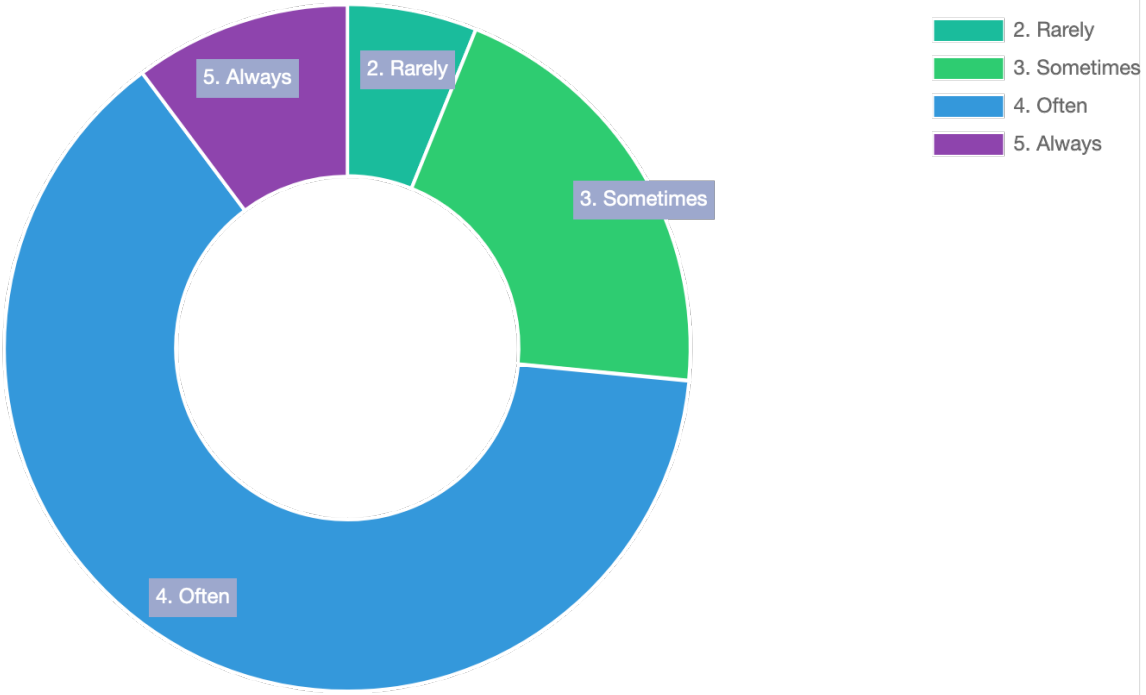
Choices	#
2. Rarely	4 (8.16 %)
3. Sometimes	16 (32.65 %)
4. Often	26 (53.06 %)
5. Always	3 (6.12 %)
Total	**49**

○ 1.3.4 — Quality of chronic care in general, effectiveness (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), to what degree are these possible shortcomings, in terms of quality chronic care, happening?

Effectiveness: for several reasons, there is a general problem of dissatisfactory outcomes leading to avoidable morbidity and premature mortality

1.3.4 — Quality of chronic care in general, effectiveness



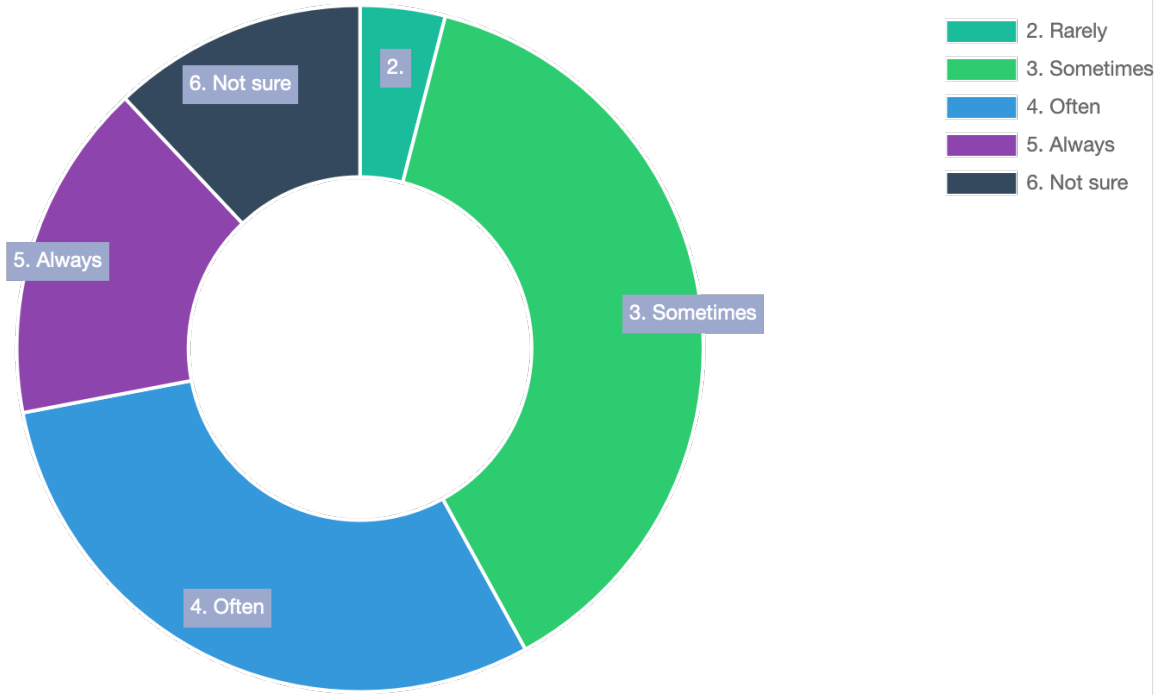
Choices	#
2. Rarely	3 (6.12 %)
3. Sometimes	10 (20.41 %)
4. Often	31 (63.27 %)
5. Always	5 (10.2 %)
Total	**49**

1.3.5 — Quality of chronic care in general, efficiency (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), to what degree are these possible shortcomings, in terms of quality chronic care, happening?

Efficiency: there is a lack of priority setting; some highly cost-effective interventions are under-delivered while some interventions with low cost-effectiveness are delivered

1.3.5 — Quality of chronic care in general, efficiency



Choices	#
2. Rarely	2 (4 %)
3. Sometimes	19 (38 %)
4. Often	15 (30 %)
5. Always	8 (16 %)
Total	**50**

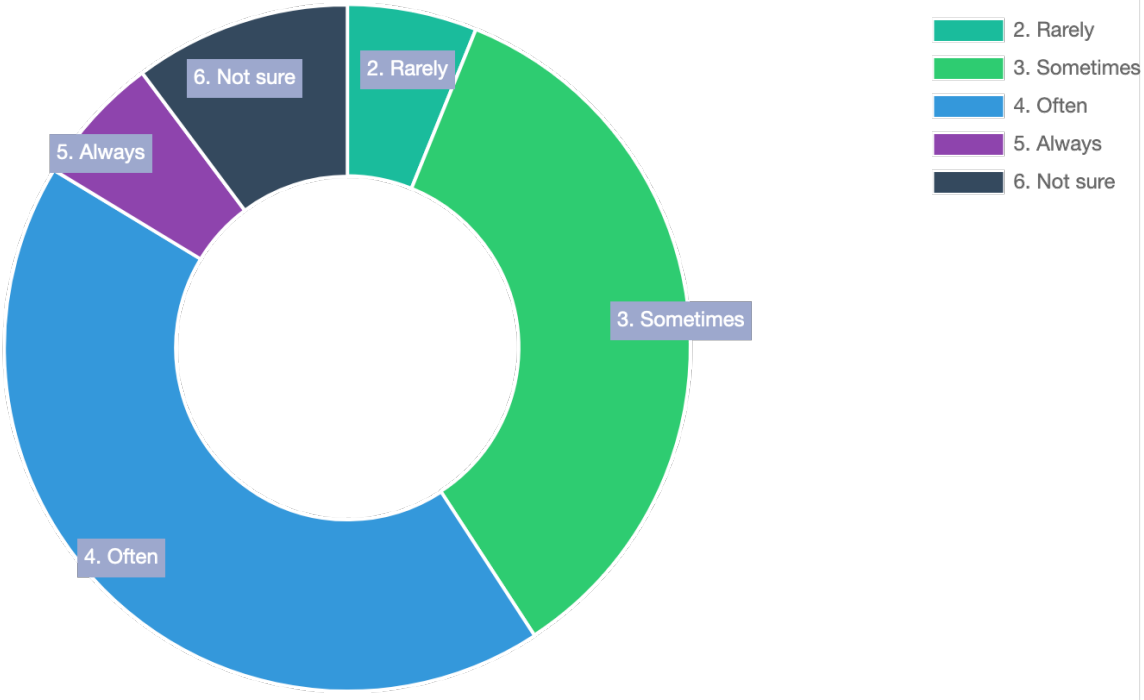
Choices	#
6. Not sure	6 (12 %)
Total	**50**

1.3.6 — Quality of chronic care in general, safety (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), to what degree are these possible shortcomings, in terms of quality chronic care, happening?

Safety: there is a lack of attention to patient and staff safety; for instance, there is little guidance on the interaction between drugs prescribed to patients with multimorbidity

1.3.6 — Quality of chronic care in general, safety



Choices	#
2. Rarely	3 (6.12 %)
Total	**49**

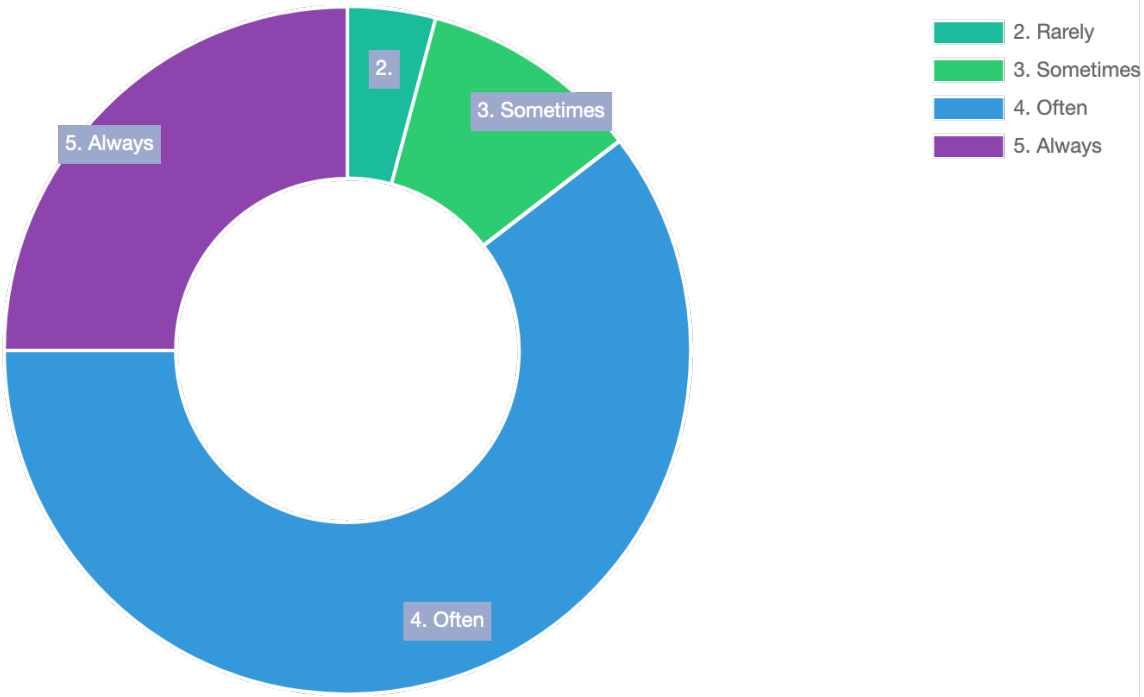
Choices	#
3. Sometimes	17 (34.69 %)
4. Often	21 (42.86 %)
5. Always	3 (6.12 %)
6. Not sure	5 (10.2 %)
Total	**49**

1.3.7 — Quality of chronic care in general, continuity (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), to what degree are these possible shortcomings, in terms of quality chronic care, happening?

Continuity of care: continuity of care is very fragile, for several reasons including poor coordination across providers and/or poor patient files maintenance and/or lack of system approach

1.3.7 — Quality of chronic care in general, continuity



Choices	#
2. Rarely	2 (4.17 %)
3. Sometimes	5 (10.42 %)
4. Often	29 (60.42 %)
5. Always	12 (25 %)
Total	**48**

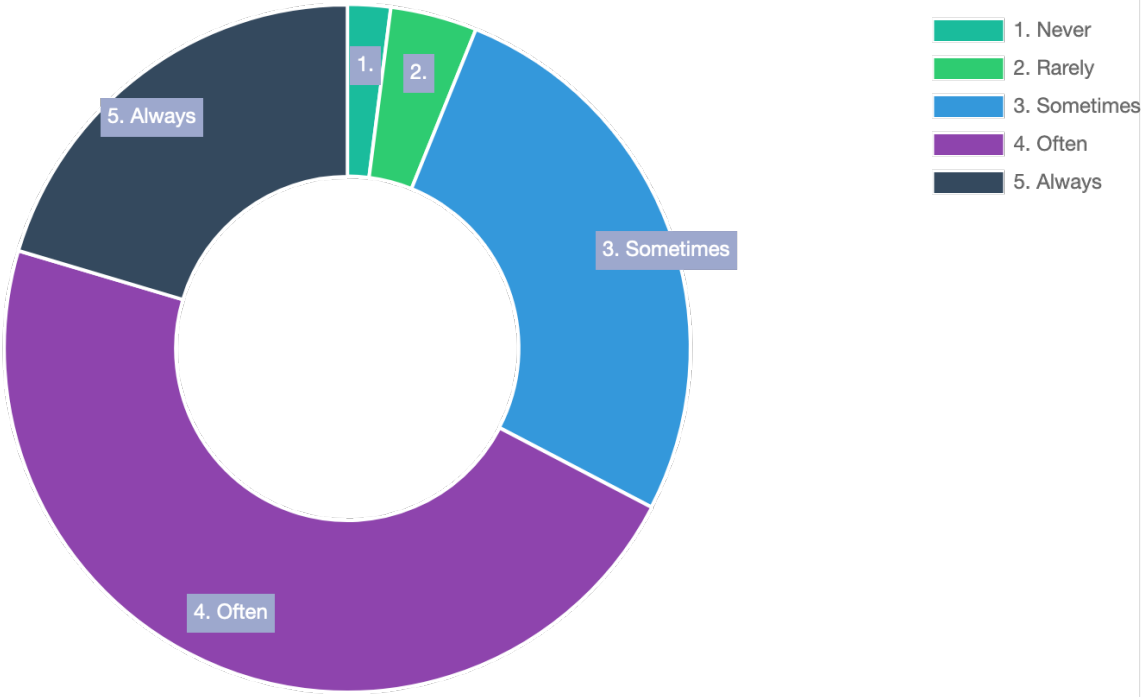
○ 1.3.8 — Quality of chronic care in general, person-centere (Page 3)

EN

On a scale of 1 (never) to 6 (not sure), to what degree are these possible shortcomings, in terms of quality chronic care, happening?

Person-centeredness: health providers pay little attention to person-centeredness; persons with chronic conditions are left to find solutions by themselves, with too limited personalized support from the organized health system

1.3.8 — Quality of chronic care in general, person-centere



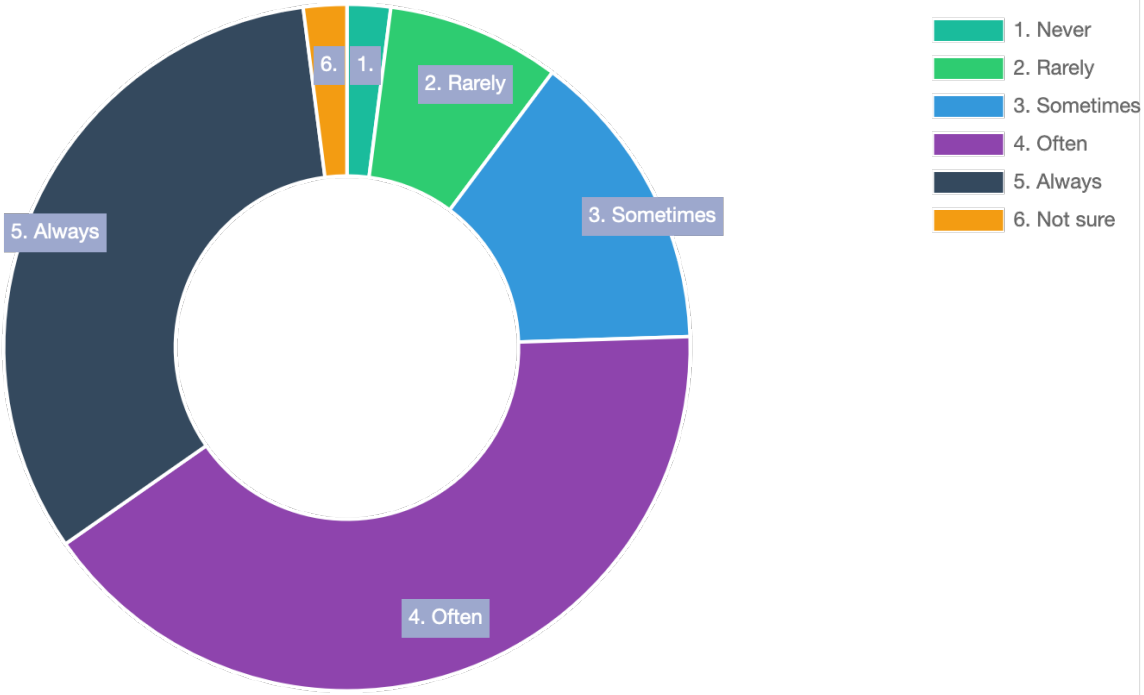
Choices	#
1. Never	1 (2.04 %)
2. Rarely	2 (4.08 %)
3. Sometimes	13 (26.53 %)
4. Often	23 (46.94 %)
5. Always	10 (20.41 %)
Total	**49**

1.3.9 — Quality of chronic care in general, equity (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), to what degree are these possible shortcomings, in terms of quality chronic care, happening?

Equity: there is a general pattern of inequity in the use of services, with huge inequality across groups

1.3.9 — Quality of chronic care in general, equity



Choices	#
1. Never	1 (2.04 %)
2. Rarely	4 (8.16 %)
3. Sometimes	7 (14.29 %)
4. Often	20 (40.82 %)
Total	**49**

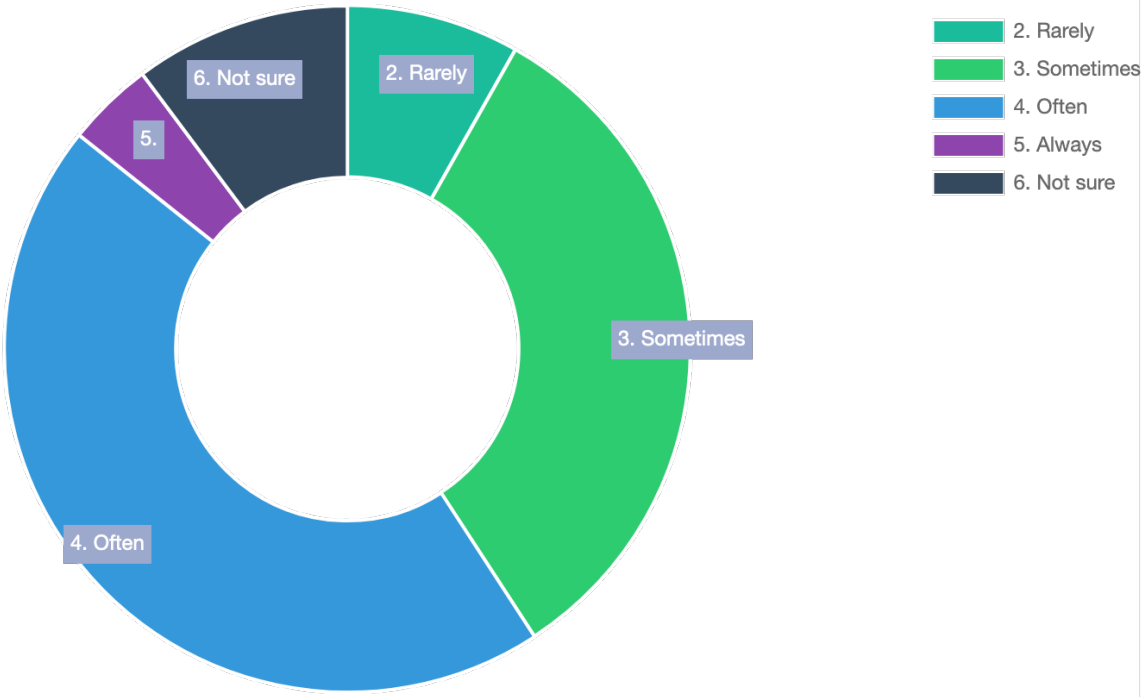
Choices	#
5. Always	16 (32.65 %)
6. Not sure	1 (2.04 %)
Total	**49**

1.3.10 — Quality of chronic care per country, leadership (Page 3)

EN
On a scale of 1 (never) to 5 (always), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country? Rating scale 1 – never, 2 – rarely, 3 – sometimes, 4 – often, 5 – always, 6 - not sure

General lack of leadership of the health authorities

1.3.10 — Quality of chronic care per country, leadership



Choices	#

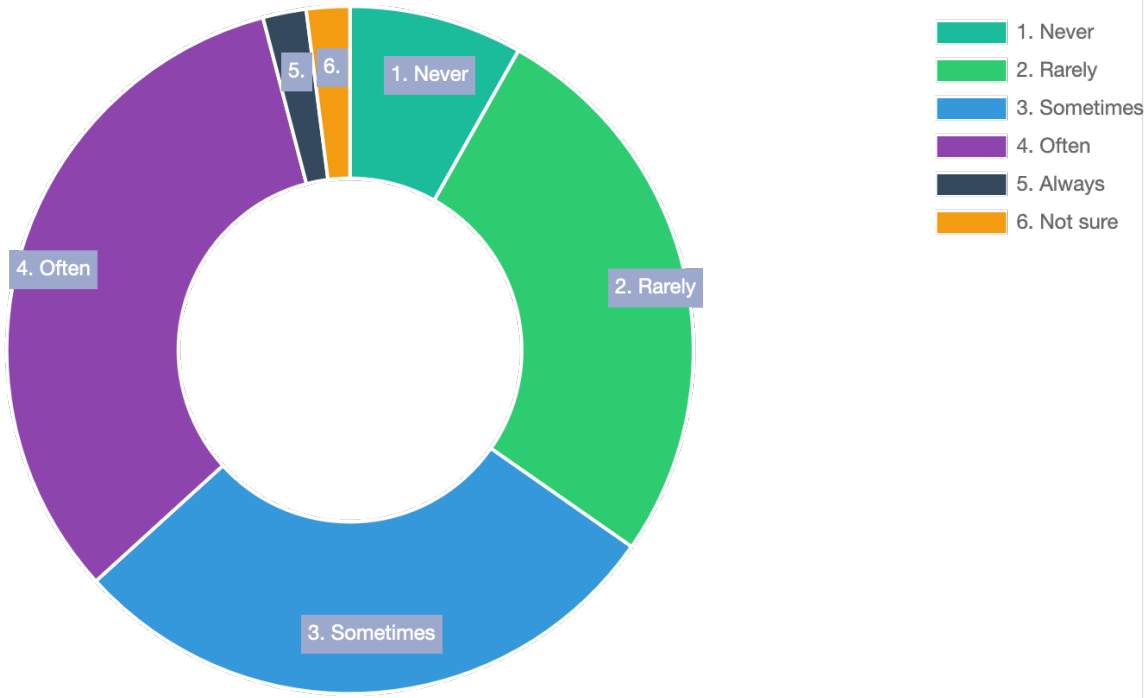
Choices	#
2. Rarely	4 (8.16 %)
3. Sometimes	16 (32.65 %)
4. Often	22 (44.9 %)
5. Always	2 (4.08 %)
6. Not sure	5 (10.2 %)
Total	**49**

1.3.11 — Quality of chronic care in general, national capac (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

No national capacity to set priorities independently from donors and global health initiatives

1.3.11 — Quality of chronic care in general, national capac



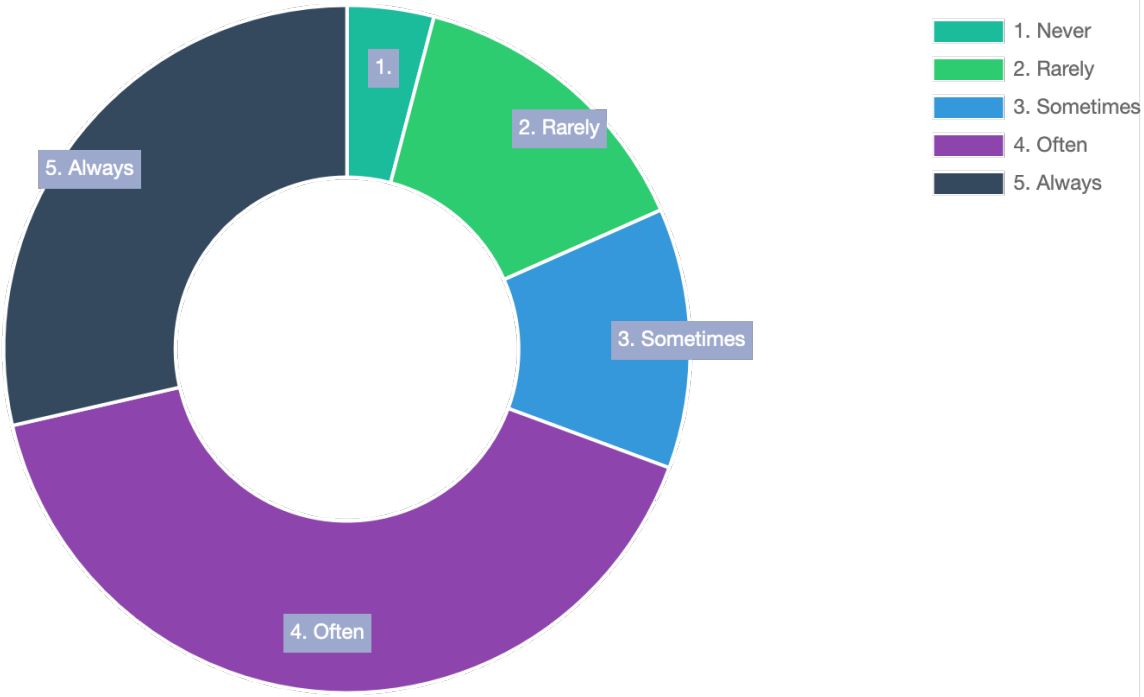
Choices	#
1. Never	4 (8.16 %)
2. Rarely	13 (26.53 %)
3. Sometimes	14 (28.57 %)
4. Often	16 (32.65 %)
5. Always	1 (2.04 %)
6. Not sure	1 (2.04 %)
Total	**49**

○ 1.3.12 — Quality of chronic care in general, underfinancing (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

General pattern of under-financing ((by pooled resources) because NCD are not seen as a priority

1.3.12 — Quality of chronic care in general, underfinancing



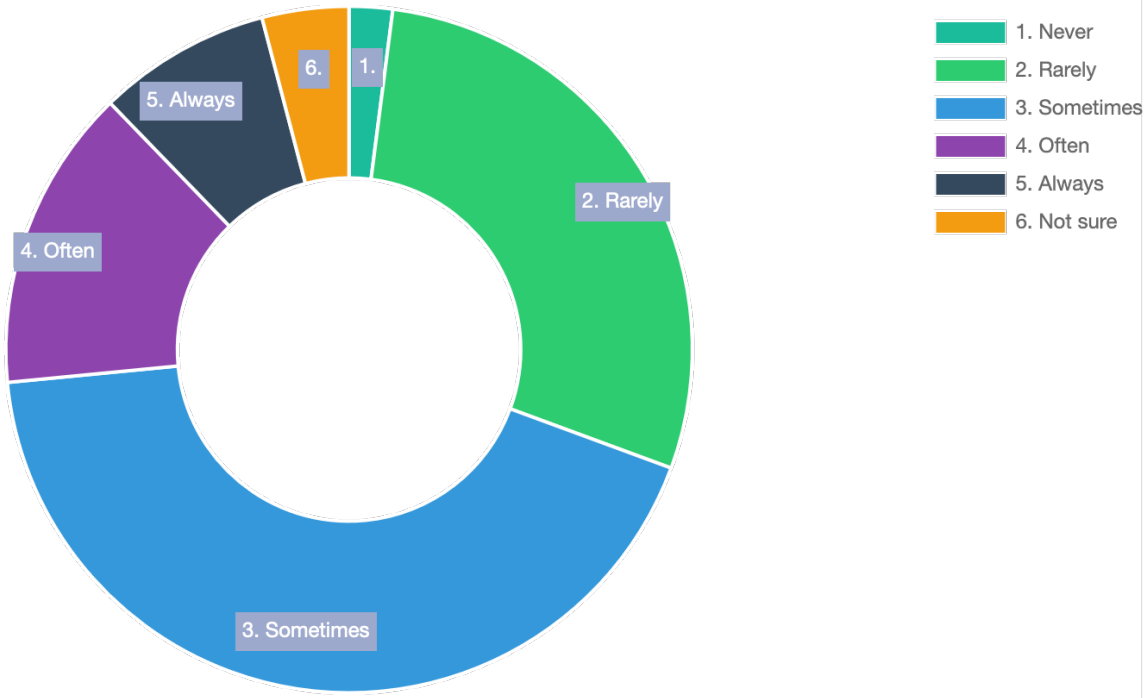
Choices	#
1. Never	2 (4.08 %)
2. Rarely	7 (14.29 %)
3. Sometimes	6 (12.24 %)
4. Often	20 (40.82 %)
5. Always	14 (28.57 %)
Total	**49**

1.3.13 — Quality of chronic care in general, up to date gui (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

Lack of up-to-date guidelines and medical protocols

1.3.13 — Quality of chronic care in general, up to date gui



Choices	#
1. Never	1 (2.04 %)
2. Rarely	14 (28.57 %)
3. Sometimes	21 (42.86 %)
4. Often	7 (14.29 %)
Total	**49**

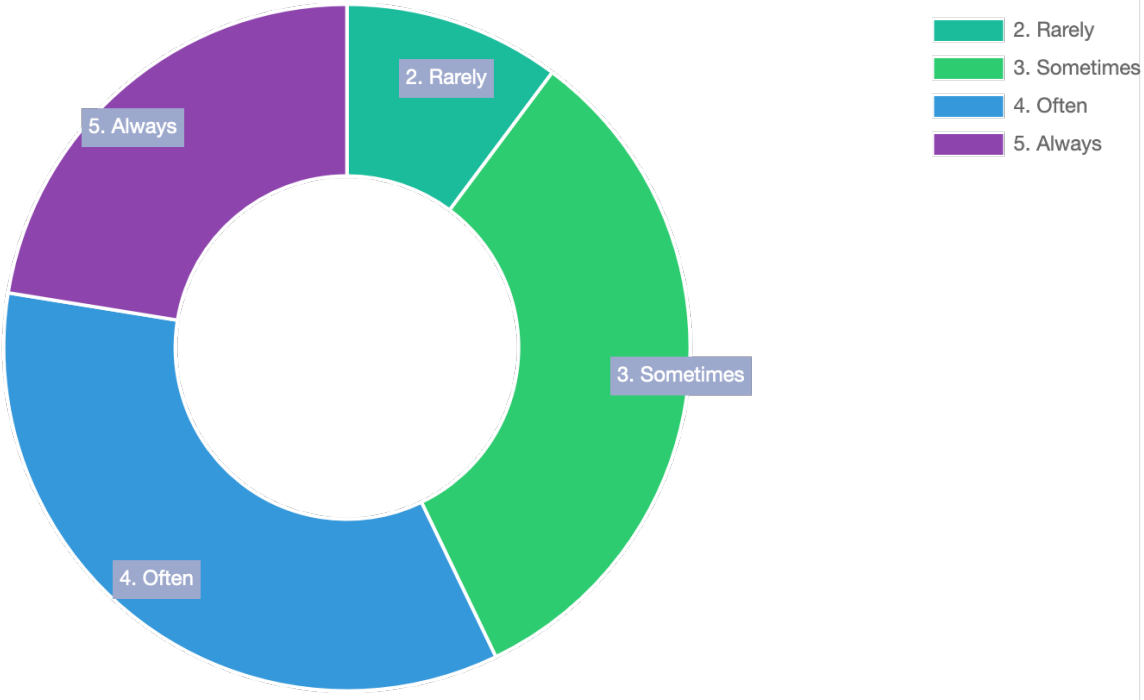
Choices	#
5. Always	4 (8.16 %)
6. Not sure	2 (4.08 %)
Total	**49**

1.3.14 — Quality of chronic care in general, quality assura (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

Inadequate quality assurance mechanism

1.3.14 — Quality of chronic care in general, quality assura



Choices	#
Total	**49**

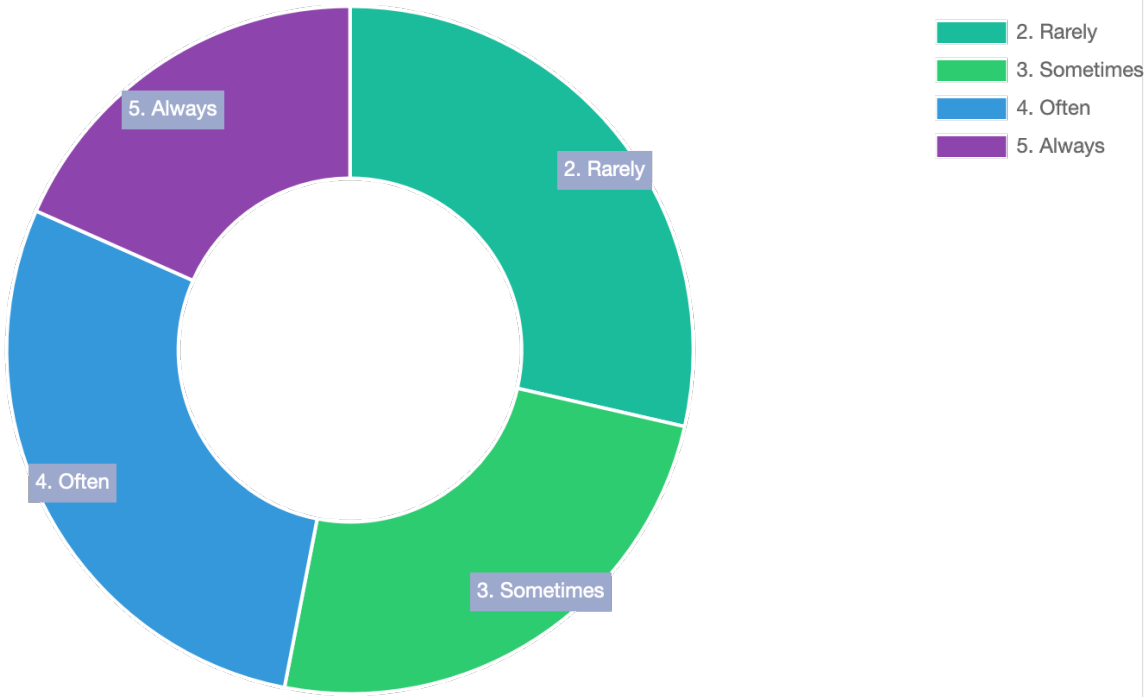
Choices	#
2. Rarely	5 (10.2 %)
3. Sometimes	16 (32.65 %)
4. Often	17 (34.69 %)
5. Always	11 (22.45 %)
Total	**49**

○ 1.3.15 — Quality of chronic care in general, availability o (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

Major problems with the availability of medicines and medical products

1.3.15 — Quality of chronic care in general, availability o



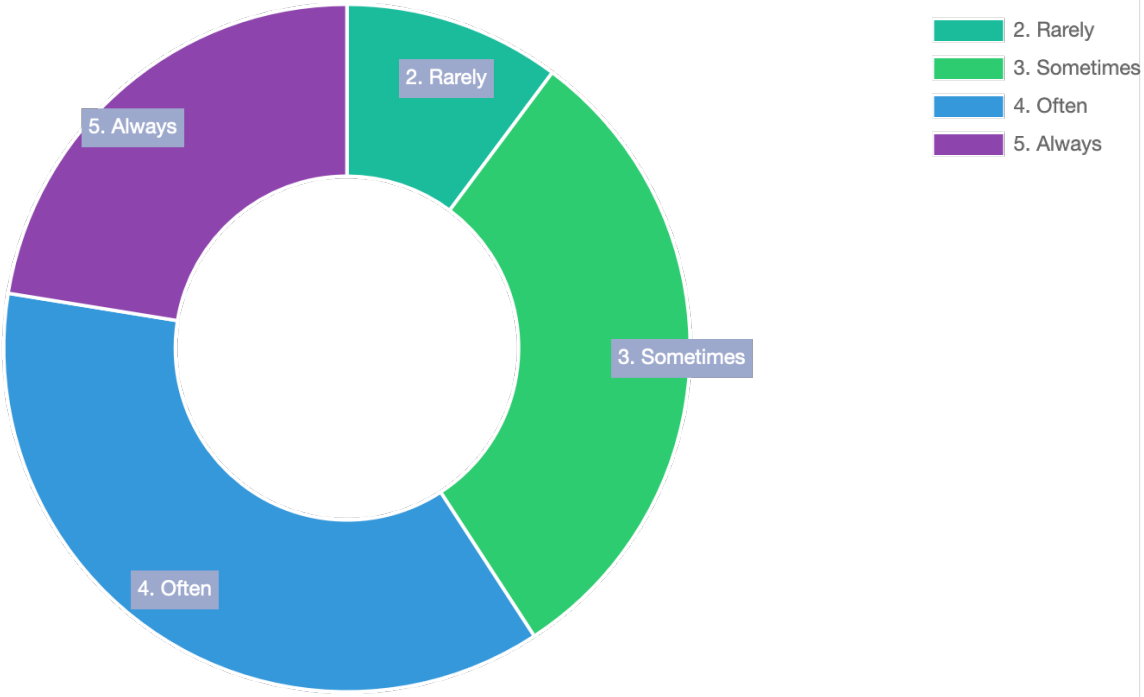
Choices	#
2. Rarely	14 (28.57 %)
3. Sometimes	12 (24.49 %)
4. Often	14 (28.57 %)
5. Always	9 (18.37 %)
Total	**49**

○ 1.3.16 — Quality of chronic care in general, availability o (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

Major gaps in the availability of health workers (numbers)

1.3.16 — Quality of chronic care in general, availability o



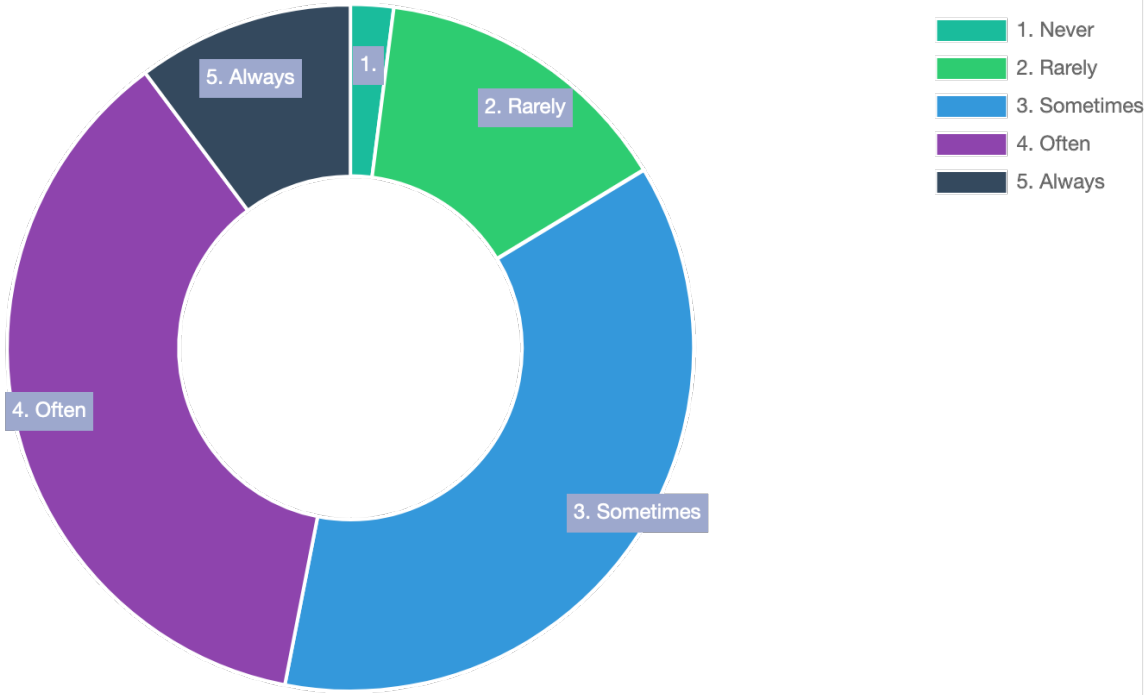
Choices	#
2. Rarely	5 (10.2 %)
3. Sometimes	15 (30.61 %)
4. Often	18 (36.73 %)
5. Always	11 (22.45 %)
Total	**49**

1.3.17 — Quality of chronic care in general, gaps of knowle (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country? Rating scale 1 – never, 2 – rarely, 3 – sometimes, 4 – often, 5 – always, 6 - not sure

Major gaps of knowledge and skills at the level of health staff, including medical doctors, on the prevention and management of chronic conditions

1.3.17 — Quality of chronic care in general, gaps of knowle



Choices	#
1. Never	1 (2.04 %)
2. Rarely	7 (14.29 %)
3. Sometimes	18 (36.73 %)
Total	**49**

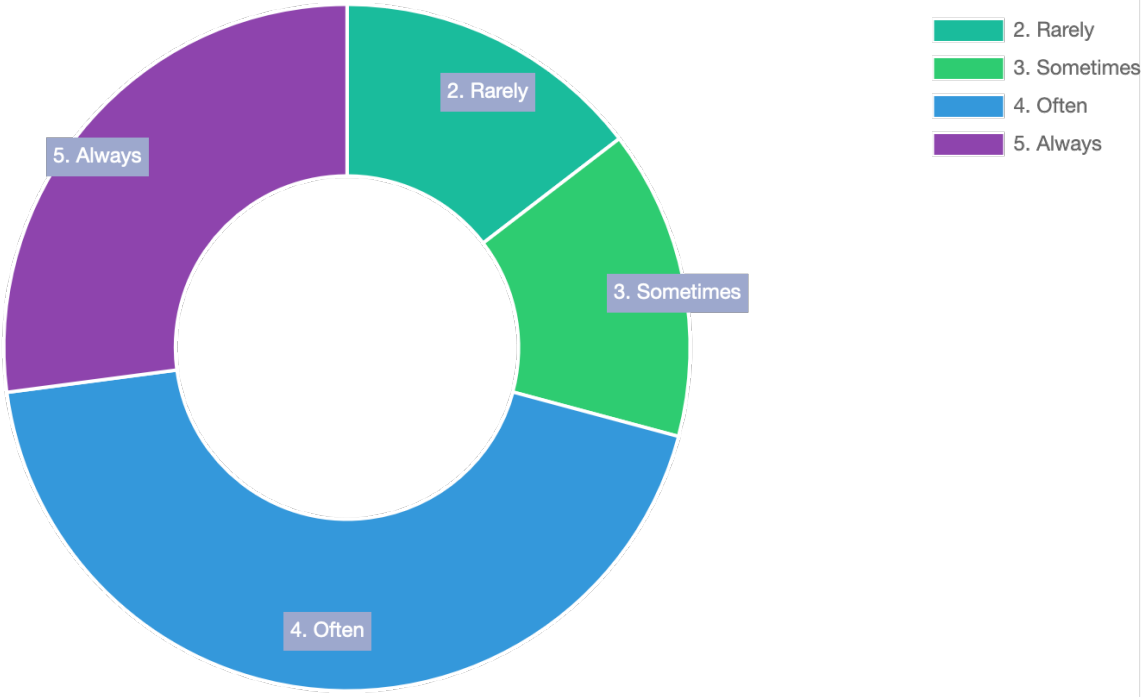
Choices	#
4. Often	18 (36.73 %)
5. Always	5 (10.2 %)
Total	**49**

1.3.18 — Quality of chronic care in general, information ma (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

Inadequate information management system to inform decisions

1.3.18 — Quality of chronic care in general, information ma



Choices	#
Total	**48**

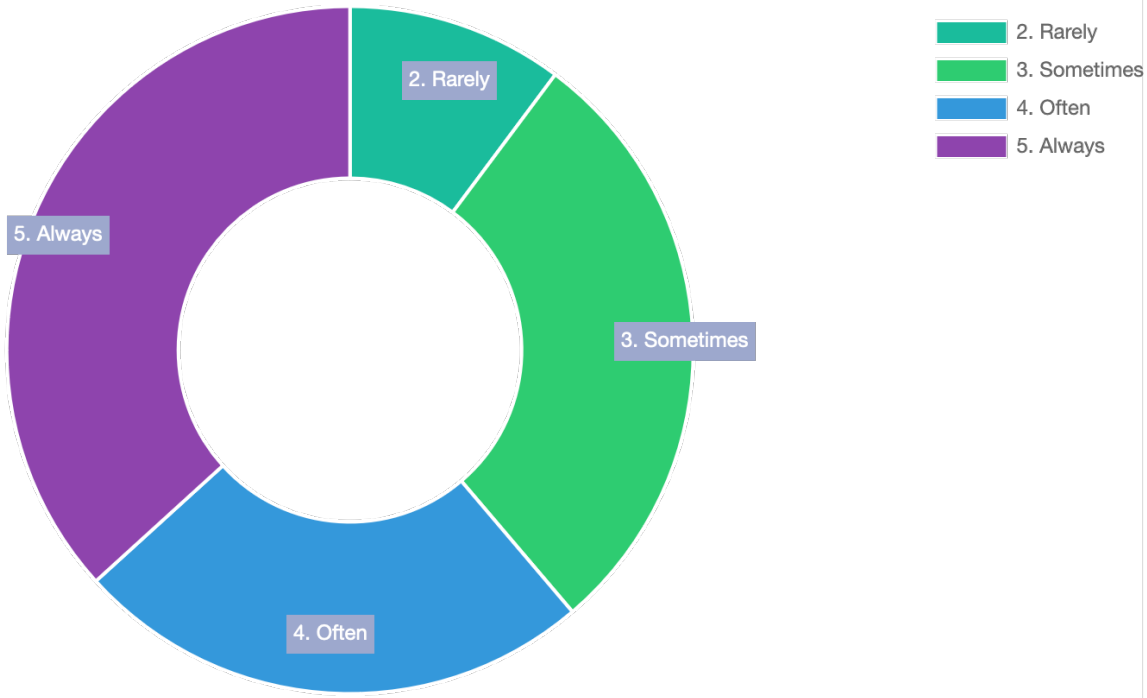
Choices	#
2. Rarely	7 (14.58 %)
3. Sometimes	7 (14.58 %)
4. Often	21 (43.75 %)
5. Always	13 (27.08 %)
Total	**48**

1.3.19 — Quality of chronic care in general, insufficient d (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

Insufficient digitalization of the information management system

1.3.19 — Quality of chronic care in general, insufficient d



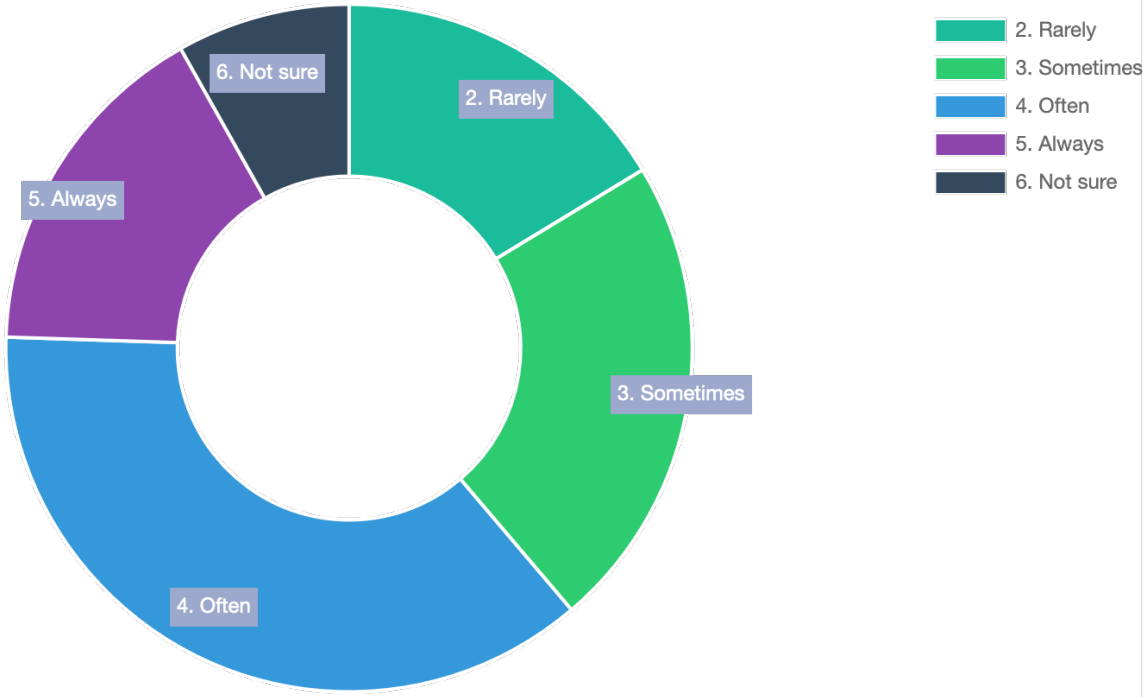
Choices	#
2. Rarely	5 (10.2 %)
3. Sometimes	14 (28.57 %)
4. Often	12 (24.49 %)
5. Always	18 (36.73 %)
Total	**49**

○ 1.3.20 — Quality of chronic care in general, limited accoun (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

Limited accountability of health providers to regulators or funders (e.g., no transparency, difficult to sanction)

1.3.20 — Quality of chronic care in general, limited accoun



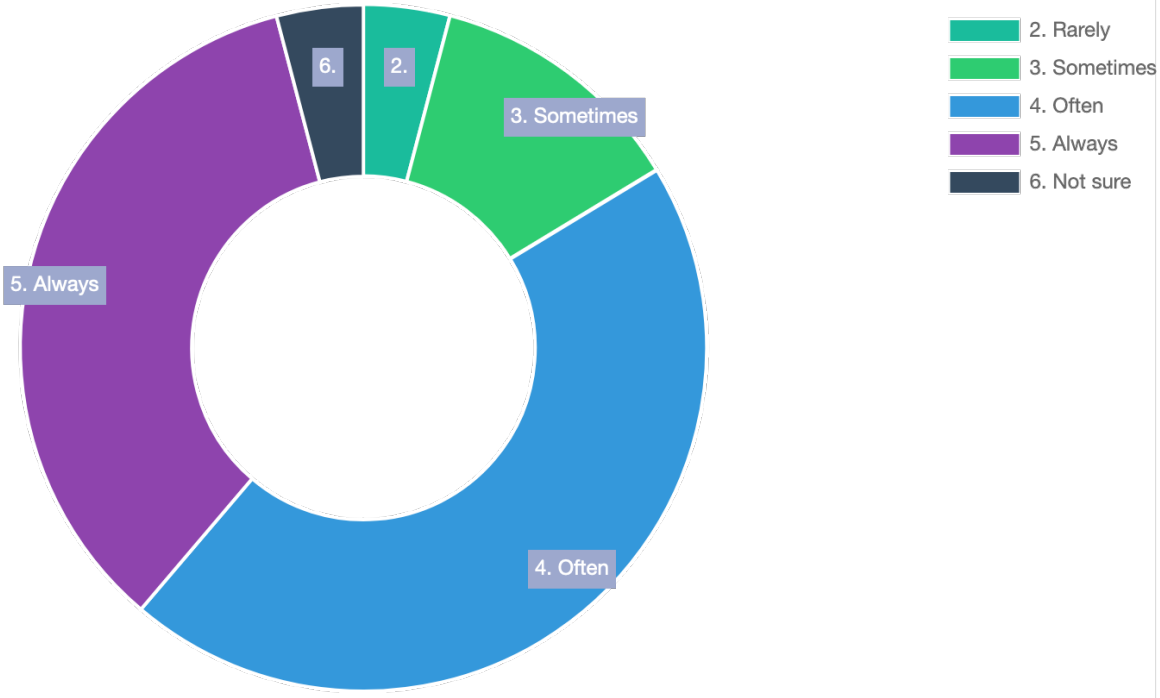
Choices	#
2. Rarely	8 (16.33 %)
3. Sometimes	11 (22.45 %)
4. Often	18 (36.73 %)
5. Always	8 (16.33 %)
6. Not sure	4 (8.16 %)
Total	**49**

1.3.21 — Quality of chronic care in general, coordination a (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

A major problem of coordination across providers

1.3.21 — Quality of chronic care in general, coordination a



Choices	#
2. Rarely	2 (4.08 %)
3. Sometimes	6 (12.24 %)
4. Often	22 (44.9 %)
5. Always	17 (34.69 %)
Total	**49**

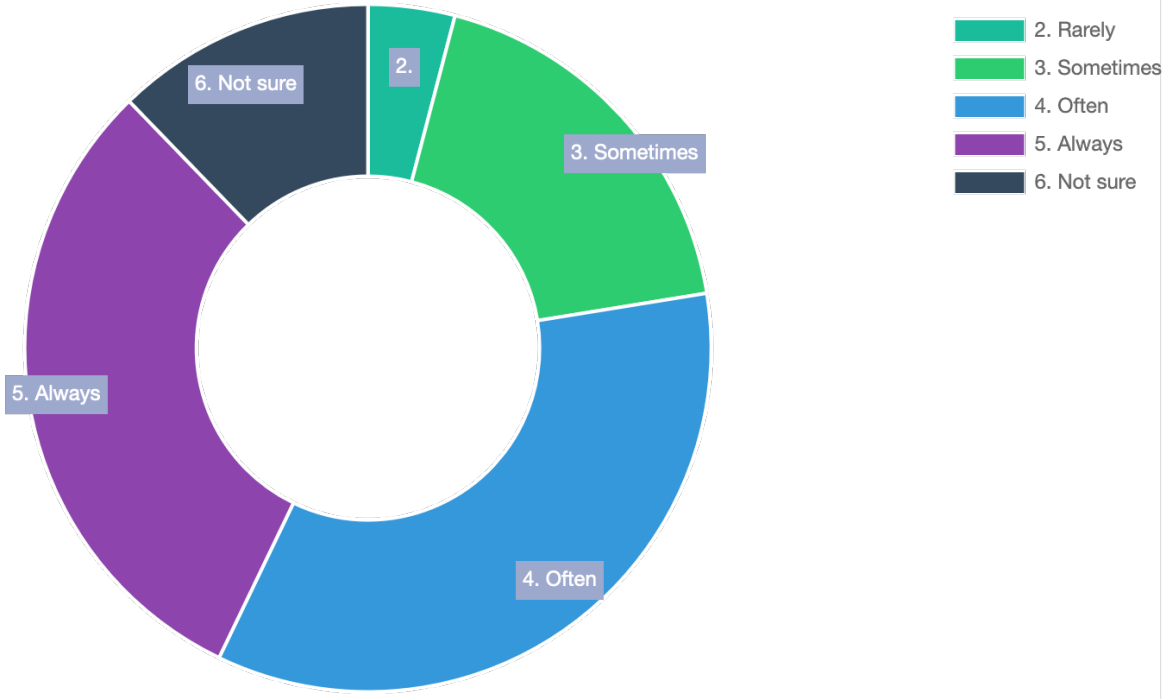
Choices	#
6. Not sure	2 (4.08 %)
Total	**49**

1.3.22 — Quality of chronic care in general, systemic learn (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

No commitment to systemic learning at different levels of relevance

1.3.22 — Quality of chronic care in general, systemic learn



Choices	#
2. Rarely	2 (4.08 %)
Total	**49**

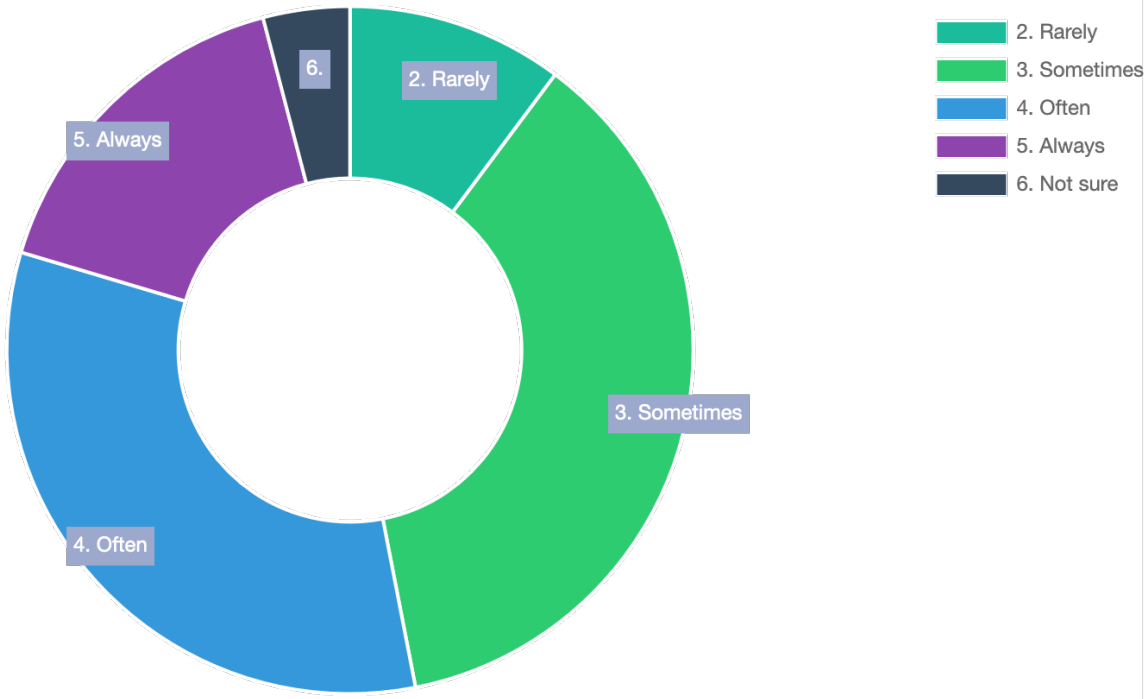
Choices	#
3. Sometimes	9 (18.37 %)
4. Often	17 (34.69 %)
5. Always	15 (30.61 %)
6. Not sure	6 (12.24 %)
Total	**49**

1.3.23 — Quality of chronic care in general, inappropriate (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

Inappropriate health-seeking behaviours by persons with chronic conditions because of low health literacy

1.3.23 — Quality of chronic care in general, inappropriate



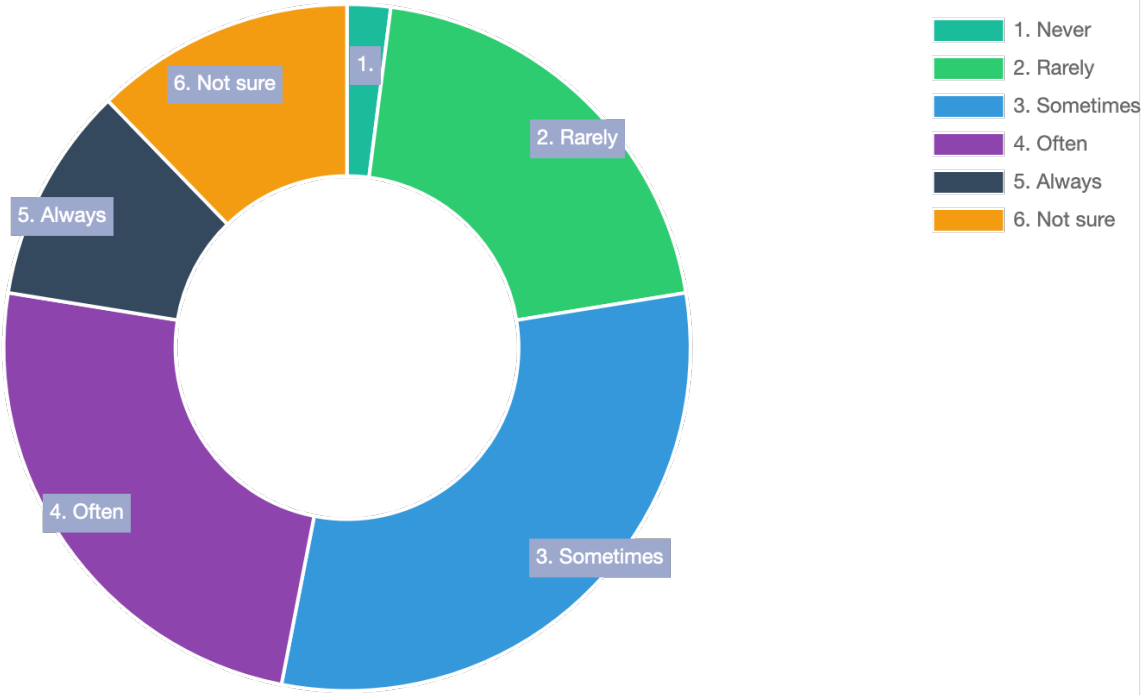
Choices	#
2. Rarely	5 (10.2 %)
3. Sometimes	18 (36.73 %)
4. Often	16 (32.65 %)
5. Always	8 (16.33 %)
6. Not sure	2 (4.08 %)
Total	**49**

○ 1.3.24 — Quality of chronic care in general, health seeking (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

Inappropriate health-seeking behaviours by persons with chronic conditions because of for-profit strategies adopted by some providers

1.3.24 — Quality of chronic care in general, health seeking



Choices	#
1. Never	1 (2.04 %)
2. Rarely	10 (20.41 %)
3. Sometimes	15 (30.61 %)
4. Often	12 (24.49 %)
5. Always	5 (10.2 %)
Total	**49**

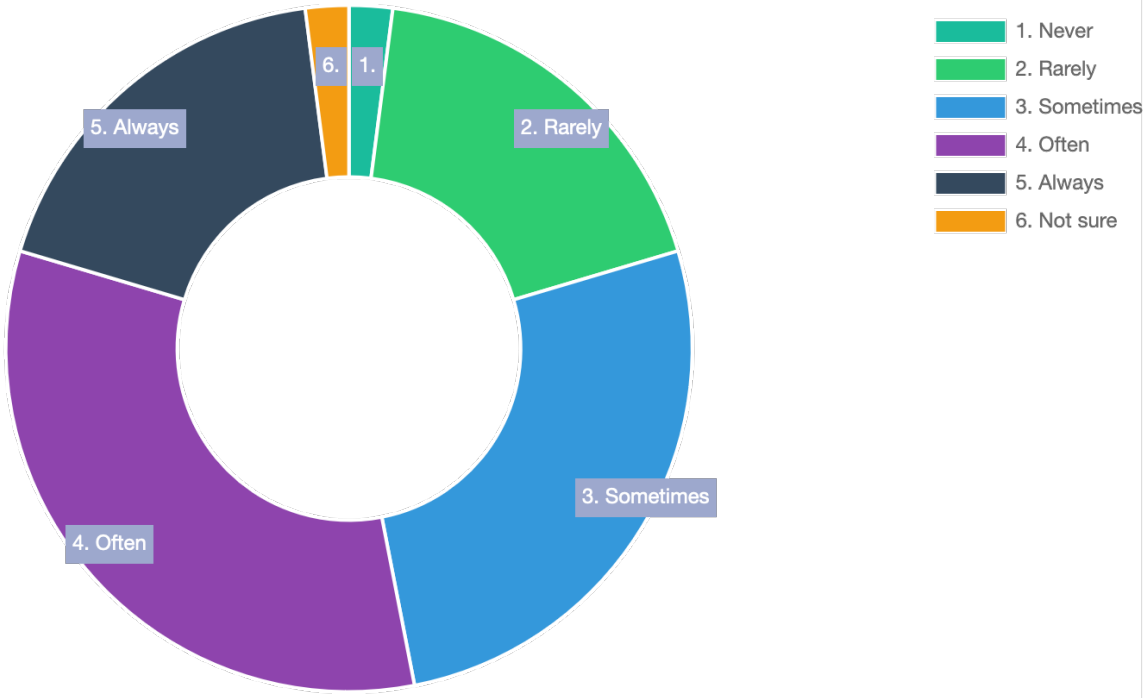
Choices	#
6. Not sure	6 (12.24 %)
Total	**49**

1.3.25 — Quality of chronic care in general, institutional (Page 3)

EN
On a scale of 1 (never) to 6 (not sure), what are the main bottlenecks creating this dissatisfactory quality of chronic care in this country?

Absence of institutional mechanisms to ensure solidarity (pooled funding and removal of barriers faced by the most disadvantaged)

1.3.25 — Quality of chronic care in general, institutional



Choices	#
Total	**49**

Choices	#
1. Never	1 (2.04 %)
2. Rarely	9 (18.37 %)
3. Sometimes	13 (26.53 %)
4. Often	16 (32.65 %)
5. Always	9 (18.37 %)
6. Not sure	1 (2.04 %)
Total	**49**

1.3.26 — Quality of chronic care in general, others (Page 3)

EN
What are other main bottlenecks creating this dissatisfactory quality of chronic care in this country which have not been mentioned in the above previous choices

( ) Others, specify: _____

1.3.26 — Quality of chronic care in general, others

- Uneven territorial distribution of health personnel and urban/rural health services - Insufficient participation of citizens in decision-making in the health sector - The Voice of the People - Lack of planning of health personnel according to the health needs of the population - Inadequate coordination of the health and social sectors - Insufficient strategic planning in the health sector - Lack of monitoring and evaluation of performance in the health sector

`9f0db521` answered 2 weeks ago

predominance of fee for service medicine = low incentive for co-ordination across providers and levels of care. Co-payments for medicines and some medical services. Different levels of care provdied and funded by different levels of govt (e.g. hospitals - states; primary care - federal) means essentially two different health systems with a lack of mechanism for co-ordination e.g. post discharge care and rehabilitation).

760ac409 answered 2 weeks ago

1. Context: The context in terms of socio-economic and commercial determinants of health cannot be undermined as a significant contributor to bottlenecks even when systems are in place to strengthen care for persons at risk or diagnosed with NCDs 2. BOD Trends and Equity : Equitable access to Chronic Care for NCDs is impacted by an increasing prevalence of co and multi-morbidities. It is critical to ensure that existing funding mechanisms are not allowed to benefit access to care by patients only if they also present with "communicable diseases".

17b7b82a answered 2 weeks ago

Benefits package funded by state excludes several services for prevalent NCDs; payment mechanisms do not reward quality for NCDs and incentivize over-referrals from primary to specialist care among covered groups;

61e45e05 answered 2 weeks ago

Poor oversight and regulation of care provision (for both acute and chronic illnesses) by various cadres, including medical doctors, and by health facilities (public and private alike) broadly. Weak to non-existent continuous learning and professional development of various cadres, including but not limited to the absence of robust and effective relicensing (i.e. renewal and maintenance of professional licenses) systems. Absence of structural/system level arrangements (e.g. things like prescription audits, guidelines and protocols, or disbursements linked to the following of guidelines and protocols), that promote the provision of appropriate, good quality care for chronic illnesses by various cadres, including medical doctors, and also by health facilities (public and private alike) broadly.

560d961f answered 2 weeks ago

Limited or no populations need assessment and monitoring to prevent the design and delivery of care adapted to the needs of the population. Poor urban planning prevents the implementation of quality preventive and promotional care happening outside of health facilities.

9a5c49a2 answered 2 weeks ago

Financial schemes and insurance programs rarely reach those who need the most because of poor implementation at the grassroot level

e15461db answered 2 weeks ago

Chronic care has been neglected as a topic for decades until it become the main cause of mortality, morbidity and

poverty but then it had become much more difficult to make changes. It was not included into the design of public primary health care in Cambodia, but it was also not a priority in other LMIC. In Cambodia, it was left unregulated and unsupported, and therefore it was captured almost completely by local market forces and for doctors as opportunities to supplement their meagre government salaries (dual practice). 30 years on, that path dependency makes it difficult to change. Private Interests in chronic care became vested at all levels, and this was driven by influential donors. This has determined the perceptions of what the public health care system is supposed to do until today. Health care was not organized as chronic versus actute, but as noncommunicable versus communicable, with all donor support going to communicable and viritually none to NCD. Chronic patients have no voice. Health care organization is dominated by these hybrid dual interests of private and public, where some public actors can behave as private actors and some private actors serve public interests.

`e39890ca` answered 2 weeks ago

The above-mentioned is a comprehensive list.

`48319912` answered 2 weeks ago

Cultural values which understate the importance of risk factors in disease causation eg. smoking, poor diet, importance of exercise etc.

`69938cd2` answered 2 weeks ago

Centralized funding, lack of autonomy for the frontline facilities and providers.

`b0e7e1ac` answered 1 week ago

Policy coherence

`32f8706f` answered 1 week ago

The above answers, they pertain to combined public and private systems.

`4be93ebb` answered 1 week ago

District Health authorities (like health delegates for example) with insuficient knowledge on chronic diseases management; Lack of a implemented family doctor system - identifying a link between the patient and the health service; Absent surveillance health indicators for chronic diseases in the health systems; Lack of support for home care treatment for chronic diseases.

`fd6fba5e` answered 1 week ago

Au niveau de ressources : absence de chaine de froid pour assurer le transport et le stockage dans les conditions optimales des intrants diabète (insuline, certains réactifs de HA1C, ...) Manque des équipements de diagnostic du diabète dans certains milieux reculés.

6a16d290 answered 1 week ago

- Alternative sources of medicine e.g. herbal treatment centers are more available. The proliferation of these treatment centers and patients' preference for them - Lack of coordination between different healthcare providers - Difficulties with access to care especially in rural areas

da55c53c answered 1 week ago

Under-supply of qualified healthcare workers Underfunding of the healthcare system Insufficient linkage of available patient data and electronic patient records to enable integrated care of chronic conditions Siloed delivery of care across primary, secondary & tertiary care Insufficient engagement and co-development of care interventions, and care treatment plans with patiets

18480606 answered 1 week ago

1) Limited research evidence on quality of chronic care to inform evidence-based decisions to providers, managers and policy makers. 2) Limited community awareness about management of chronic conditions, existing different myths and misconceptions, which hinders timely and appropriate seeking and provision of health care.

d123bd0f answered 1 week ago

Lack of engagement of people living with lived experience within creation of health policy. Lack of global indicators related to quality chronic care deliver at the global level.

a77d36f9 answered 1 week ago

Fragmentation and disintegrated care provision in the Colombian health system, coupled with healthcare facilities' passive and disease-focused approach.

c8b8aeb4 answered 1 week ago

In this country's case, there has been an ongoing political-economic crisis since 2019, which has considerably worsened pre-existing bottlenecks regarding the quality of care of chronic conditions. The two major problems are inadequate leadership and lack of financing, both of which are consequences of poor governance and non-

accountability at the political level.

81dd720d answered 1 week ago

Lack/absence of ommunity-based/family support and self-care

1b72b6c0 answered 1 week ago

poor care coodianation and integration between levels of care high levels of social determinants of health - patients living with poor housing and nutrition conditions workforce with temporary contracts, with overload of work - specially in public ambulatories, public hospitals and PHC units. electronic health systems does not work equaly in all regions of the country. some units do not have access to the internet - specially in PHC

7dba40b8 answered 1 week ago

Reactive healthcare delivery with very little thinking on chronic care (repeated visits, integrated care, who's responsible for who, etc.)

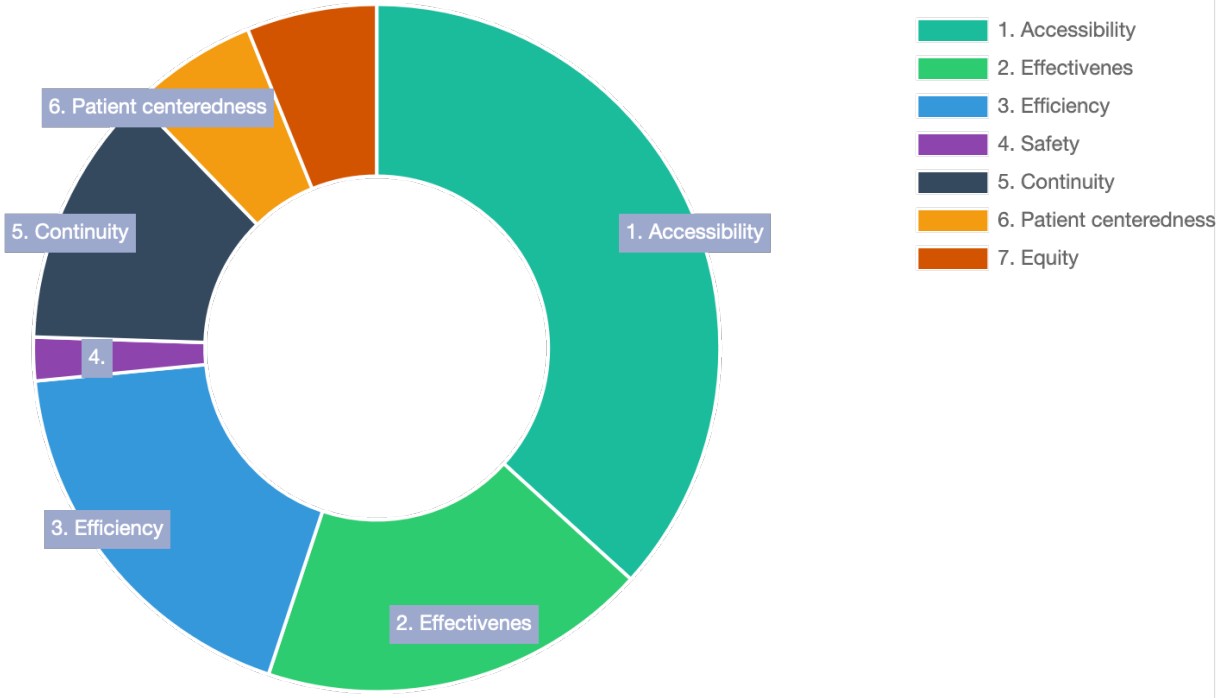
93089cc1 answered 1 day ago

○ 1.3.27 — Quality of care, ranking of the seven dimensions f (Page 3)

EN
Those problems in this country will probably require a broad set of interventions to be fixed. Please rank the seven dimensions of quality chronic care (from 1 being the highest priority to 7 being the lowest priority) as to which would receive priority attention from the health financing community (with the understanding that health financing decisions determine resource allocation resources, specify benefits, use financial contracts to communicate on priorities and set incentives and encourage digitalization). Focus your answers on what health financing policies/strategies can actually do.

Which would be your first choice? [Ranking 1-7]

1.3.27 — Quality of care, ranking of the seven dimensions f

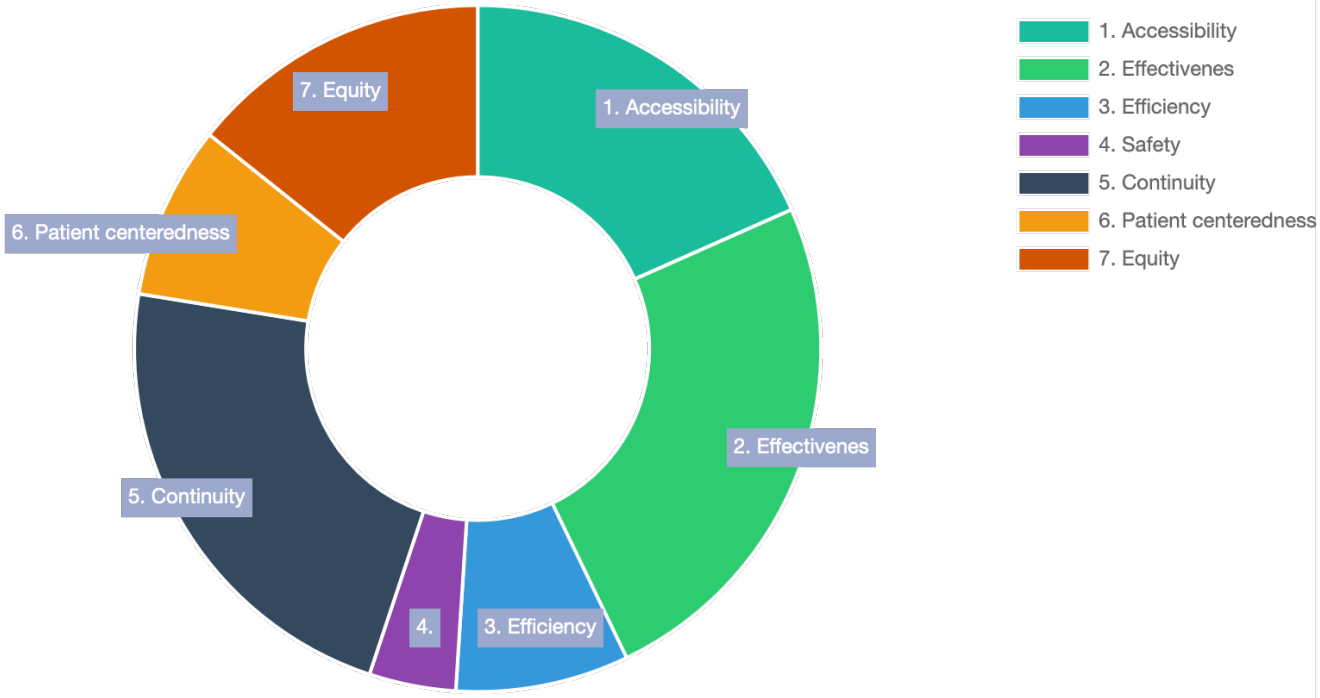


Choices	#
1. Accessibility	18 (36.73 %)
2. Effectivenes	9 (18.37 %)
3. Efficiency	9 (18.37 %)
4. Safety	1 (2.04 %)
5. Continuity	6 (12.24 %)
6. Patient centeredness	3 (6.12 %)
7. Equity	3 (6.12 %)
Total	**49**

1.3.28 — Ranking of dimensions, second choice (Page 3)

EN
On ranking the seven dimensions of quality chronic care (from 1 being the highest priority to 7 being the lowest priority) as to which would receive priority attention from the health financing community, **which would be your second choice? [Ranking 1-7]**

1.3.28 — Ranking of dimensions, second choice

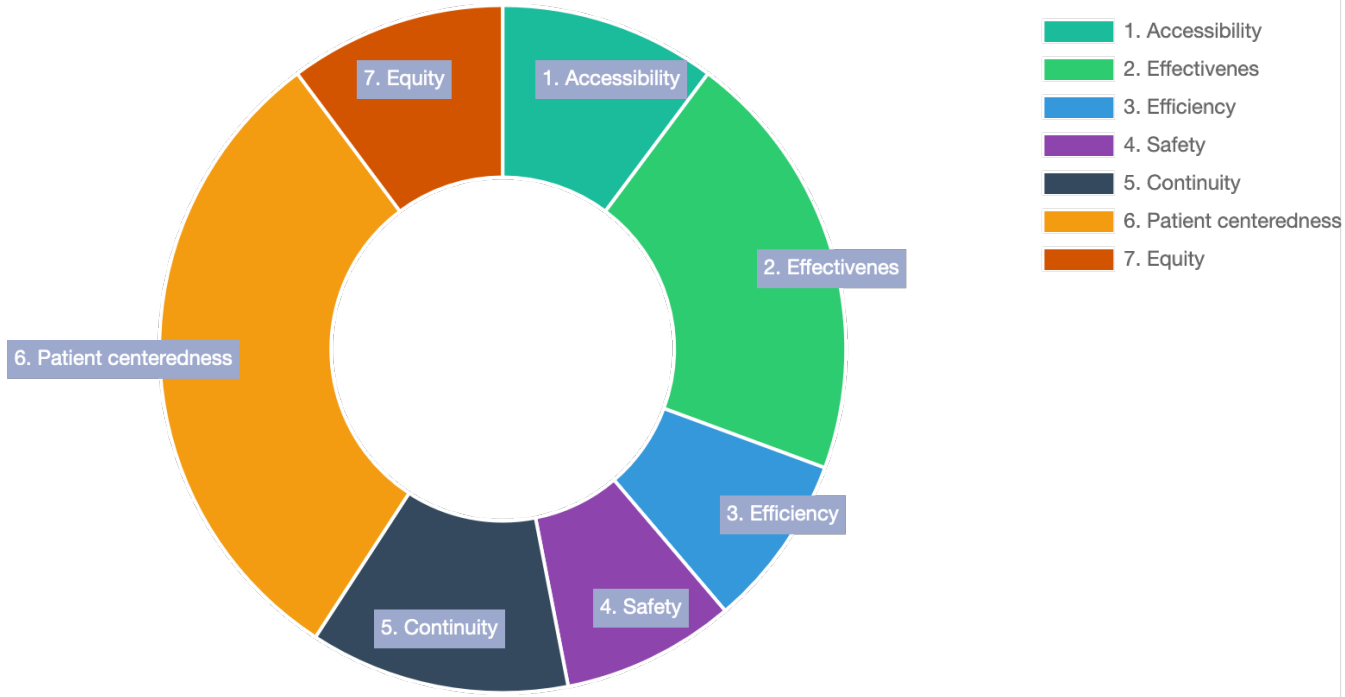


Choices	#
1. Accessibility	9 (18.37 %)
2. Effectivenes	12 (24.49 %)
3. Efficiency	4 (8.16 %)
4. Safety	2 (4.08 %)
5. Continuity	11 (22.45 %)
6. Patient centeredness	4 (8.16 %)
7. Equity	7 (14.29 %)
Total	**49**

1.3.29 — Ranking of dimensions, third choice (Page 3)

EN
On ranking the seven dimensions of quality chronic care (from 1 being the highest priority to 7 being the lowest priority) as to which would receive priority attention from the health financing community, **which would be your third choice? [Ranking 1-7]**

1.3.29 — Ranking of dimensions, third choice



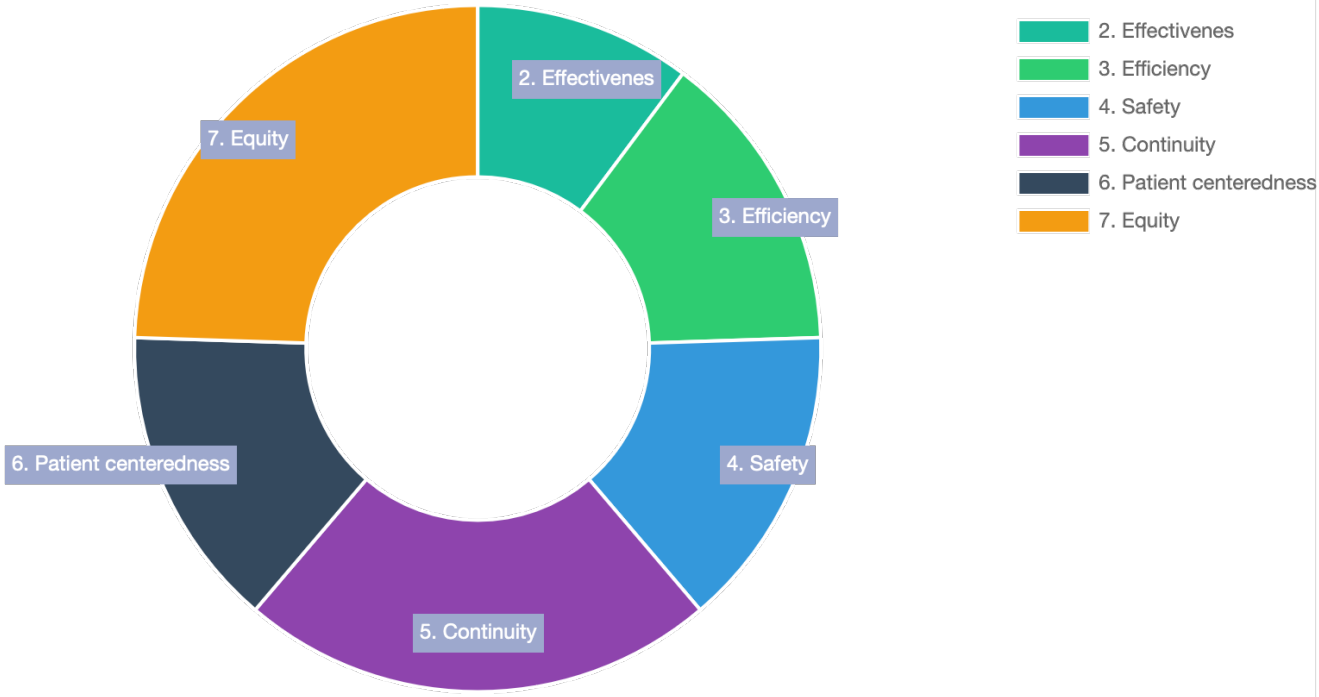
Choices	#
1. Accessibility	5 (10.2 %)
2. Effectivenes	10 (20.41 %)
3. Efficiency	4 (8.16 %)
4. Safety	4 (8.16 %)
Total	**49**

Choices	#
5. Continuity	6 (12.24 %)
6. Patient centeredness	15 (30.61 %)
7. Equity	5 (10.2 %)
Total	**49**

1.3.30 — Ranking of dimensions, fourth choice (Page 3)

EN
On ranking the seven dimensions of quality chronic care (from 1 being the highest priority to 7 being the lowest priority) to which would receive priority attention from the health financing community, **which would be your fourth choice? [Ranking 1-7]**

1.3.30 — Ranking of dimensions, fourth choice



Choices	#
Total	**49**

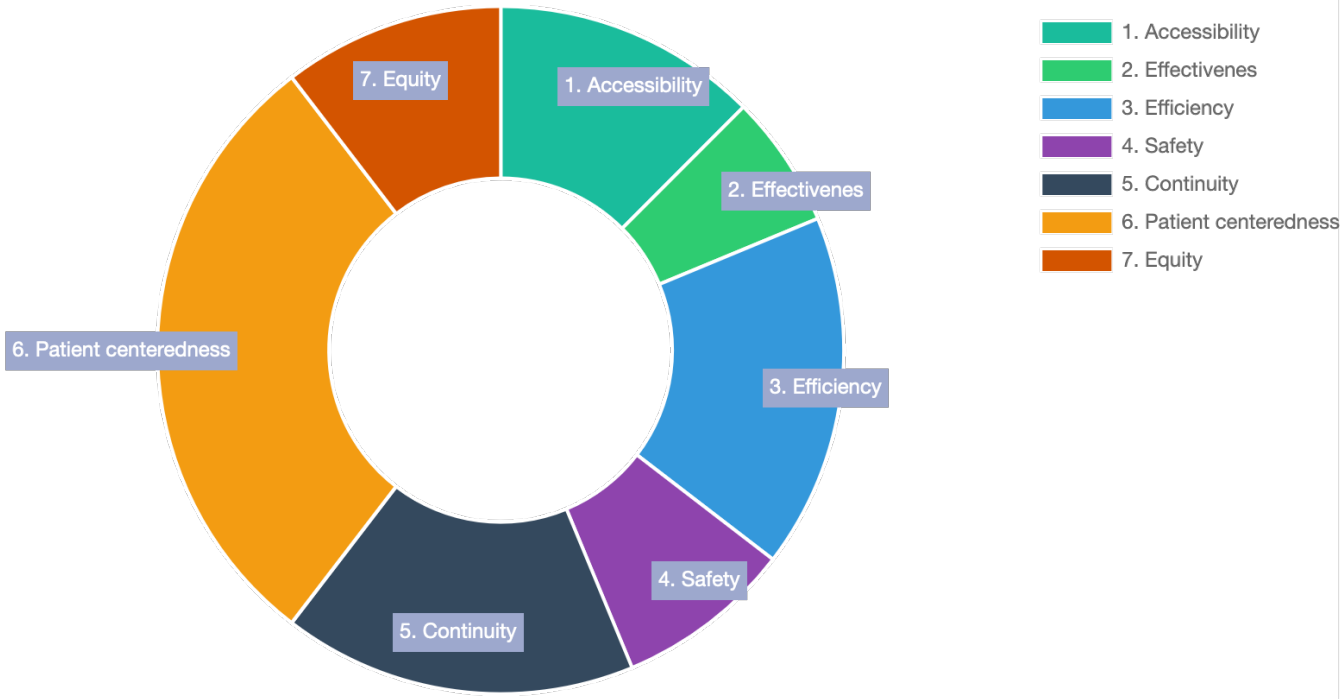
Choices	#
2. Effectivenes	5 (10.2 %)
3. Efficiency	7 (14.29 %)
4. Safety	7 (14.29 %)
5. Continuity	11 (22.45 %)
6. Patient centeredness	7 (14.29 %)
7. Equity	12 (24.49 %)
Total	**49**

1.3.31 — Ranking of dimensions, fifth choice

(Page 3)

EN
On ranking the seven dimensions of quality chronic care (from 1 being the highest priority to 7 being the lowest priority), which would receive priority attention from the health financing community**, which would be your fifth choice? [Ranking 1-7]**

1.3.31 — Ranking of dimensions, fifth choice

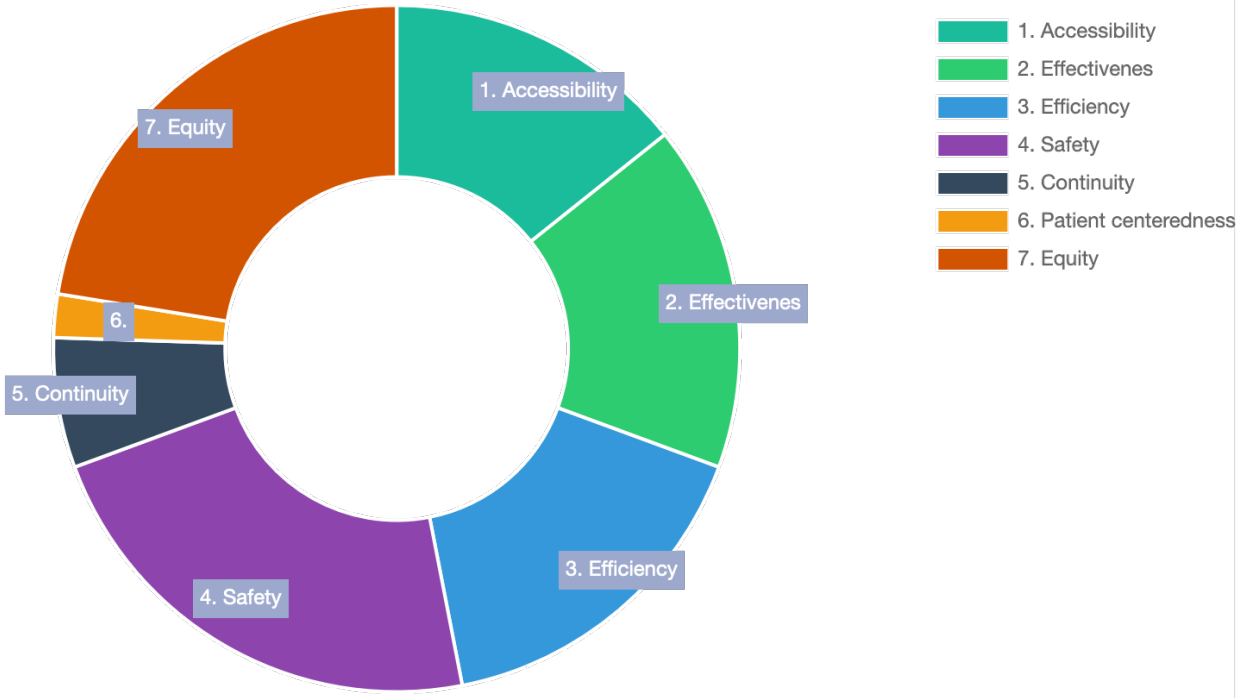


Choices	#
1. Accessibility	6 (12.5 %)
2. Effectivenes	3 (6.25 %)
3. Efficiency	8 (16.67 %)
4. Safety	4 (8.33 %)
5. Continuity	8 (16.67 %)
6. Patient centeredness	14 (29.17 %)
7. Equity	5 (10.42 %)
Total	**48**

○ 1.3.32 — Ranking of dimensions, sixth choice (Page 3)

EN
On ranking the seven dimensions of quality chronic care (from 1 being the highest priority to 7 being the lowest priority) as to which would receive priority attention from the health financing community**, which would be your sixth choice? [Ranking 1-7]**

1.3.32 — Ranking of dimensions, sixth choice

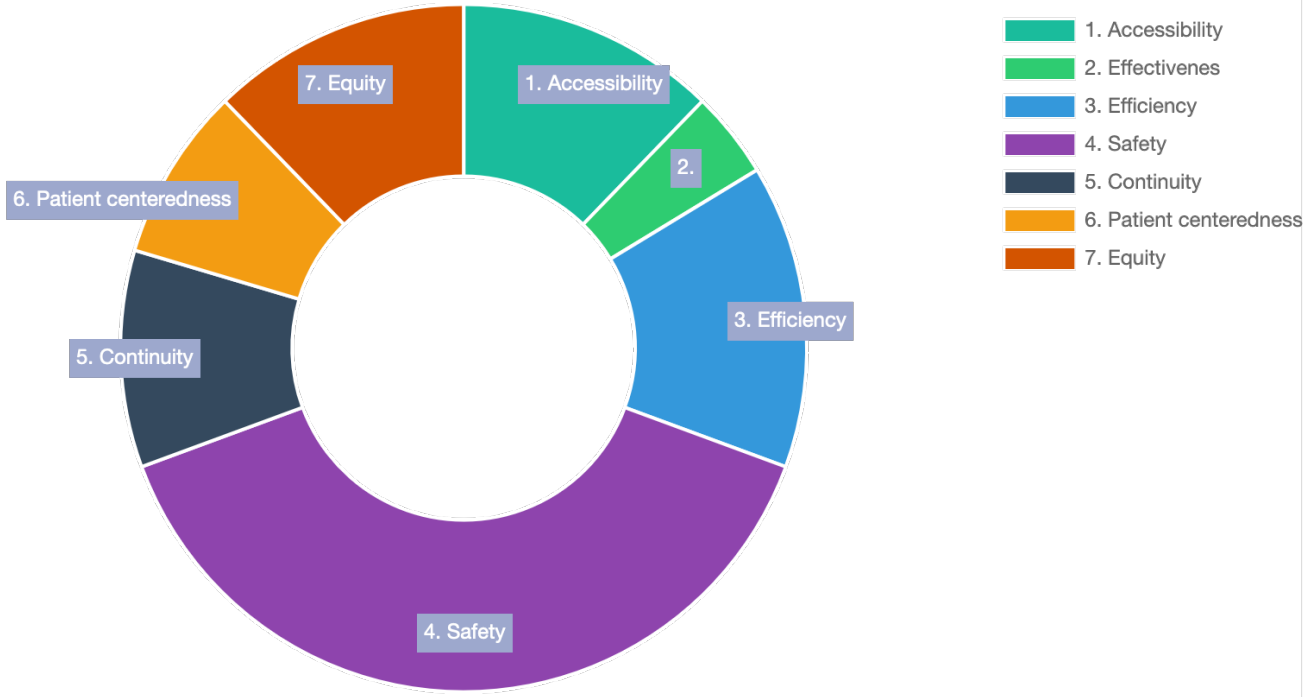


Choices	#
1. Accessibility	7 (14.29 %)
2. Effectivenes	8 (16.33 %)
3. Efficiency	8 (16.33 %)
4. Safety	11 (22.45 %)
5. Continuity	3 (6.12 %)
6. Patient centeredness	1 (2.04 %)
7. Equity	11 (22.45 %)
Total	**49**

1.3.33 — Ranking of dimensions, seventh choice (Page 3)

EN
On ranking the seven dimensions of quality chronic care (from 1 being the highest priority to 7 being the lowest priority) which would receive priority attention from the health financing community, **which would be your seventh choice? [Ranking 1-7]**

1.3.33 — Ranking of dimensions, seventh choice



Choices	#
1. Accessibility	6 (12.24 %)
2. Effectivenes	2 (4.08 %)
3. Efficiency	7 (14.29 %)
4. Safety	19 (38.78 %)
5. Continuity	5 (10.2 %)
Total	**49**

Choices	#
6. Patient centeredness	4 (8.16 %)
7. Equity	6 (12.24 %)
Total	**49**

1.3.34 — Quality of chronic care in general, explanation of (Page 3)

EN
You can provide an explanation for your ranking here below (optional):

1.3.34 — Quality of chronic care in general, explanation of

Work more on strategic planning and setting priorities, as well as improving health care in general. Then, improve the plans for health staff and develop motivational mechanisms for keeping health staff in a country. Equity in itself is an integral part of all the above priorities. Continuous protection can be enabled by strengthening the information system and introducing digitization, where possible.

`9f0db521` answered 2 weeks ago

Effectiveness needs to be first. No point in continuing if ineffective. Equity and access needs to be up there.

`760ac409` answered 2 weeks ago

Within a context of rapidly escalating co and multi-morbidities , it is critical that health financing reflect mechanisms which create access to care for the "person" and not the "disease or conditions" which are achieved through health systems strengthening. Equity is key consideration in a country which while confirming a quadruple burden of disease has prioritised care associated with the prior MDG targets which has substantially benefitted by external donor funding with set agendas previously not inclusive of NCDs.

`17b7b82a` answered 2 weeks ago

It is not easy to indicate such priorities - this is essentially a political question and response depends on whom one represents as societies are invariably stratified. I tried to do this considering my understanding of those who are most in need and my public health research and policy engagement experience that tells me what are general

needs and what can be realistically expected....It is also not easy to tension across these priorities e.g. access to quality chronic care is an issue but more so for certain socially disadvantaged groups - so do I prioritise accessibility or equity? maybe both are important

0415ccbc answered 2 weeks ago

Efficiency combines effectiveness at a more appropriate cost; this can already solve many access issues, namely financial access issues. Equity also encompasses several dimensions of accessibility.

9a5c49a2 answered 2 weeks ago

Service delivery for chronic conditions is absent in primary care. Medicines are not continuously available or not affordable or it is not well explained how they must be taken or adhered to or people receive the inappropriate medicines for their condition. Unequal distribution of Doctors with concentrations in urban areas aggravates access problems.

e39890ca answered 2 weeks ago

Firstly, I would put a premium on empowering patients to be able to do self-care, particularly for interventions that have been proven to be effective. This means increasing health literacy and emphasis on primary prevention. Secondly, I would ensure that services of health providers were generally accessible to all and equitably distributed.

69938cd2 answered 2 weeks ago

Brazil's health system is split between those who use private care almost exclusively and those who rely entirely on the SUS. Health system financing and provision is also fragmented between federal, state, and municipal level services. This leads to extremely large inequities which - because it lacks an overall financial architecture - generates enormous inefficiencies and obstacles to providing quality health care in many ways. Without a single financial architecture, the data systems, continuity of care, patient-centeredness, etc. are all extremel difficult to achieve. Hence, i have place equity as the top priority. Even without tackling the large-scale reforms to address equity, the different segments of the health system could provide better continuity of care, from screening through management through treatment - which would make a big difference to patients. However, other than a few advanced teams of care, this continuity is not taking place. Accessibility is clearly important, but most people in Brazil actually do live within a reasonable distance of health care providers (except for relatively small percentage in the most rural and tropical forest regions). So, achieving adequate financing, continuity and effectiveness would largely address the issue of quality care for chronic disease management in the country. Special programs would be required to address the last mile for particularly dispersed and hard to reach populations.

b0dba773 answered 1 week ago

A lack of continuity of care (contributed to through the absence of good electronic MIS that track the patient) is

currently one of the main reasons patients who accessed the system fall through the cracks. A lack of person-centred care then contributes (on a second order level) to poor outcomes. My understanding is that the effectiveness of care and safey are generally good, therefore placing them last.

bbe6c1f7 answered 1 week ago

Le plus grand défi est d'abord l'accès aux soins de maladies chroniques, pex. le diabète pour tous les patients où il se trouve au vu de la complexité géographique de la RDC. Ensuite, il faut mettre un bon système d'information sanitaire pour assurer le suivi des patients au sein du district. En fonction de plateau technique, construire un système de référence et contre référence à l'intérieur d'un district de santé entre les 2 échelons (CS/CSR et l'hôpital Général de référence appelé autrement hôpital de district pour la prise en charge des complications éventuelles.

6a16d290 answered 1 week ago

Especially when taking the perspective from what health financing policies/strategies can achieve, I believe (from my experience in high income countries) for improved care on chronic conditions we need to achieve the following: - Delivery within integrated care pathways spanning ACROSS care sector and being organised around the patient - Co-development of interventions, Care pathways and treatment plans with patients - Provision of the data, electronic, administrative, and governance infrastructure to enable integrated care for chronic conditions (this will also be important when aiming at implementing a more complex alternative payment model as administrative processes are often more complex as well) - Focus on improving wider determinants of health (housing, social support network, community facilities, education etc) and primary prevention in the patient's community setting. I have chosen my ranking in response to the above outlined factors and to what degree I believe strategic purchasing arrangements/ alternative payment models can have an influence.

18480606 answered 1 week ago

I think access should rank first because it matters most. Patients should access quality chronic care when they need without any barrier. Effectiveness comes second because we need clients to access services/ interventions which are effective (yielding intended results). Since provision of health care need resources, priority should be given to chronic condition management (making efficiency the 3rd in ranking). All the above should benefit all patients who need such care, making equity the 4th in ranking. If the above are all given priority, then we should ensure continuity of care, safe for patient/staff and person-centeredness.

d123bd0f answered 1 week ago

As this is from a health financing perspective selection has been made according to principles of UHC first. Must prioritise equity to ensure it is actually considered. Continuum of care is vital for NCDs as prevention must be considered at the same time as care provision as well as palliative care. Person centeredness allows consideration of multi morbidity. Effectiveness and efficiency are not prioritised as there is already the framework of the Global Action Plan on NCDs - Appendix 3 available as a starting point. Safety could be integral within each of these steps rather than as a separate issue.

a77d36f9 answered 1 week ago

The responses to the above questions may vary depending on the setting within a country (e.g., urban/rural, public/private, lower/higher income households, hospitals/clinics etc.). Most of my answers are 'sometimes', as some settings within a country provide quality services but for other settings in the same country service quality is low for various reasons, e.g., lack of human resources for health, etc.

ccc22852 answered 1 week ago

In Colombia, there is a vast gap between the theoretical coverage of the social health insurance system and the actual coverage, which generates disparities in access to health care in general, particularly for people suffering from chronic conditions. This mainly affects people in rural areas and low-income communes in urban settings. In addition, the passive and disease-focused approach of the healthcare system affects the quality of chronic care, which is often reduced to the belated attention of clinical complications in referral settings and at a high cost.

c8b8aeb4 answered 1 week ago

The greatest current challenge is the lack of financing. Prior to 2019, the health system was under-funded, but accessibility worsened following the political-economic crisis. Inequity has always been a major challenge, not only due to socioeconomic classes, but also due to clientelism practiced by politicians, including health ministers, whereby 'connected' persons had better access to healthcare. Shortcomings on effectiveness and efficiency have been largely due to weak institutional capacities for activities such as cost-effectiveness studies.

81dd720d answered 1 week ago

As the health system is very crowded, continuity of care is probably the major issue regarding chronic diseases. Effectiveness and patient-centered services are also on the top of the list - given the context in which the implementation takes place - with low or middle organizational conditions, lacking material and sometimes motivation from the workforce. safety can be a problem, specially in remote areas and during the spread of diseases - such as and Dengue fever happening now. Access to service is a really in all cities in the country - but some times the hospital is ca be far from the units located in the periphery.

7dba40b8 answered 1 week ago

The ranking is determined based on two criteria: level of priority and feasibility of introducing substantial improvements in the short term.

4773a988 answered 1 week ago

I ranked effectiveness somewhat lower in the rank because that is a tool to me, the how. But the key thing is the principle (the what), and that is the principle of chronic integrated care. Right now we have reactive, short term care and changing that mindset is priority. Right now chronic care is nobody's business which, unfortunately,

means that patients have to do it themselves.

93089cc1 answered 1 day ago

1.4.1 — Community health workers, opt out

(Page 4)

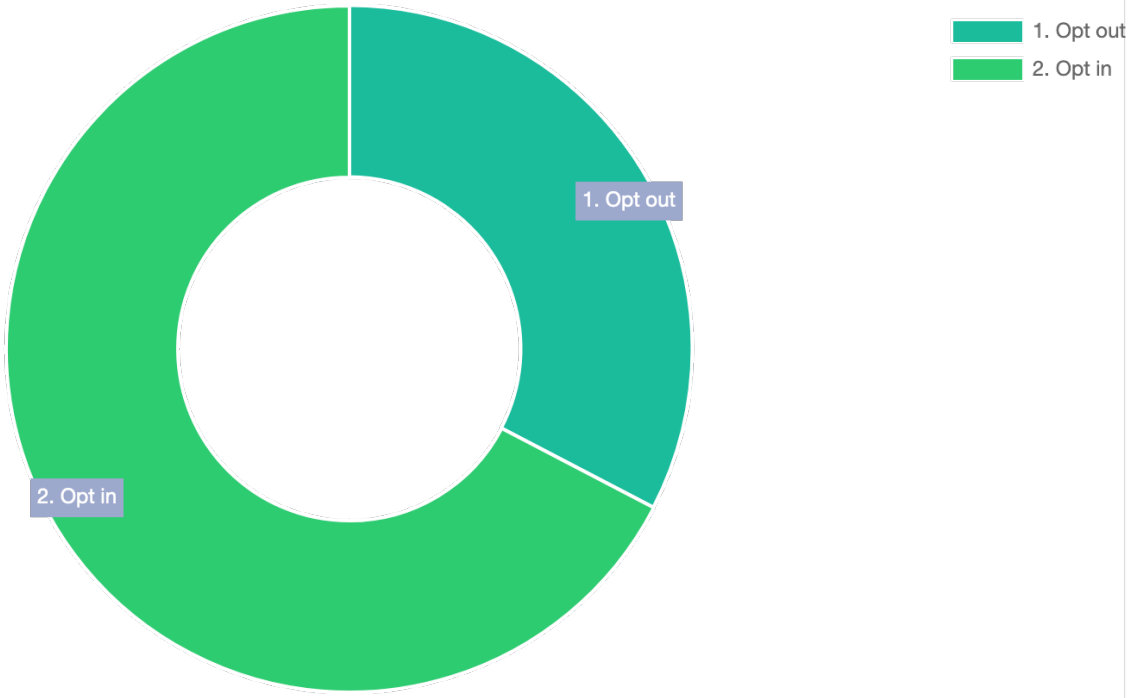
EN

For this question, you can choose to opt-out. Tick below if you choose to opt out or opt in.

I lack information on community health worker interventions and prefer to opt-out

If you choose to opt-out on these questions on community health workers, please proceed to section 1.5 on public health centres.

1.4.1 — Community health workers, opt out



Choices	#
1. Opt out	16 (32.65 %)
Total	**49**

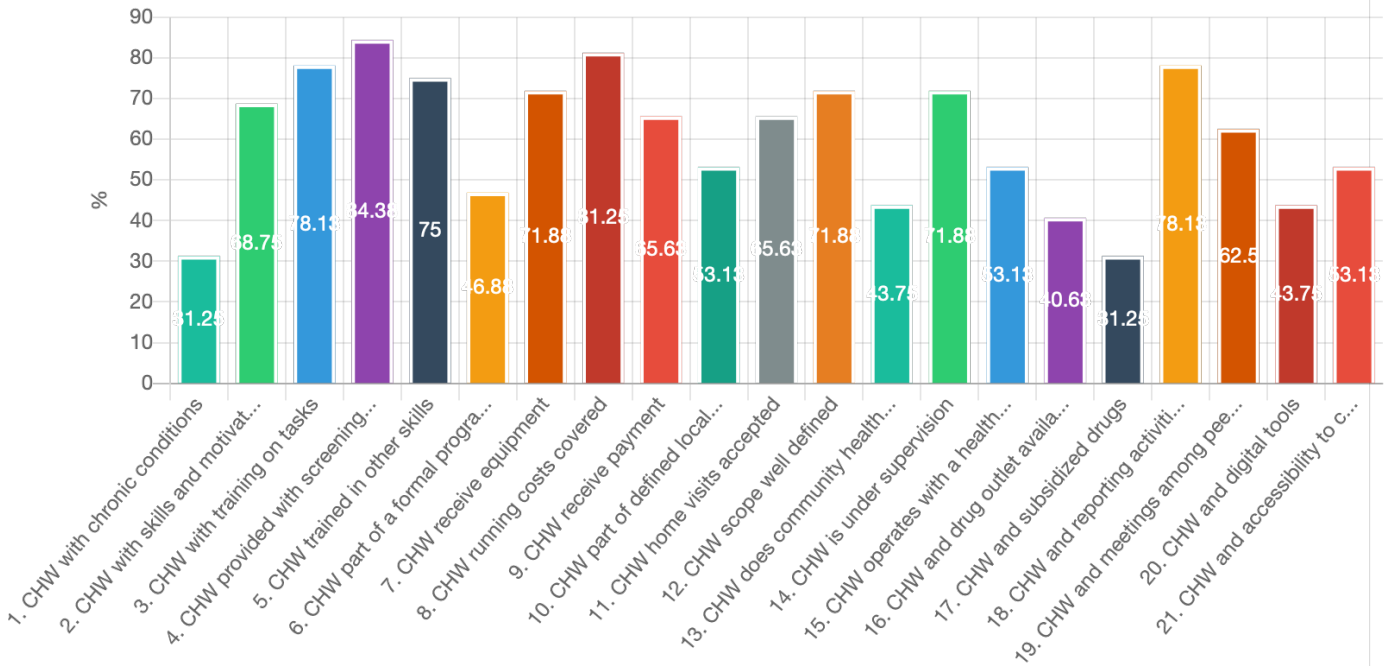
Choices	#
2. Opt in	33 (67.35 %)
Total	**49**

☐ 1.4.2 — Community health workers, conditions/pre-requisite (Page 4)

EN

Among all the following propositions on determinants of quality of chronic care, pick those which should be put in place as a condition/pre-requisite before the community health worker starts any activity in the community. [multiple answers possible]

1.4.2 — Community health workers, conditions/pre-requisite



Choices	#
Participants	**32**
Total	**407**

Choices	#
1. CHW with chronic conditions	10 (31.25 %)
2. CHW with skills and motivation	22 (68.75 %)
3. CHW with training on tasks	25 (78.13 %)
4. CHW provided with screening gu	27 (84.38 %)
5. CHW trained in other skills	24 (75 %)
6. CHW part of a formal program	15 (46.88 %)
7. CHW receive equipment	23 (71.88 %)
8. CHW running costs covered	26 (81.25 %)
9. CHW receive payment	21 (65.63 %)
10. CHW part of defined local comm	17 (53.13 %)
11. CHW home visits accepted	21 (65.63 %)
12. CHW scope well defined	23 (71.88 %)
13. CHW does community health acti	14 (43.75 %)
14. CHW is under supervision	23 (71.88 %)
15. CHW operates with a health cen	17 (53.13 %)
16. CHW and drug outlet available	13 (40.63 %)
17. CHW and subsidized drugs	10 (31.25 %)
18. CHW and reporting activities	25 (78.13 %)
19. CHW and meetings among peers	20 (62.5 %)
20. CHW and digital tools	14 (43.75 %)
Participants	**32**
Total	**407**

Choices	#
21. CHW and accessibility to care	17 (53.13 %)
Participants	**32**
Total	**407**

1.4.3 — Community Health Workers, other prerequisite cond (Page 4)

EN

Suggest other conditions and prerequisites below which should be put in place as a condition/pre-requisite before the community health worker starts any activity in the community:

1.4.3 — Community Health Workers, other prerequisite cond

Note: The scope of the CHW is not restricted to NCDs only but is inclusive relevant functions related to HIV and AIDS, TB, MCWH, NCDs

17b7b82a answered 2 weeks ago

- They shall be paid fair renumeration. They shall have a say in planning of chronic condition care/management in that geography by concerned health centre/authority. Their reporting requirements shall be justified in terms of use of that data by them, patients or their supervisory agencies - it shall not become a burden while data they collect/report are not put to use. There shall be role definition in a way where they may be able to deal with issues other than chronic conditions in some ways but shall not become ones who are accountable for all sorts of health programs or delivery at community level. There shall be some ways in which community health workers shall be introduced to private health systems and their role and interactions shall be mediated/defined.

0415ccbc answered 2 weeks ago

CHWs' tasks should be tailored to their capacities (this is something that should be assessed for each country context). Generally, CHWs' tasks should be limited to screening, some structured health promotion, referral, linking and facilitation of access to services. Support structures incl supportive supervision, and operating guidelines should be in place before the community health worker starts any activity in the community.

560d961f answered 2 weeks ago

They must receive appropriate payment for their time and engagement. They must be trained on the ethics and confidentiality that go with them visiting home and accessing sensitive personal data and information. If this respect for personal data and information is not extremely well enforced, households will reject theù, deny them access to their accurate data and the program will fail.

9a5c49a2 answered 2 weeks ago

I prefer to distinguish between on one hand the CHW as more general health workers who help with a range of public health service priorities and on the other hand "peer educators" who are not involved in that whole range of public health priorities on daily basis but who specialize in a chronic condition. It is possible to have CHW and several Peer Educators every one with their own specialisations who are called upon and referred to in situations where they can be useful.

e39890ca answered 2 weeks ago

There should be an administrative order authorizing community health workers to perform the required tasks

e15461db answered 2 weeks ago

There is a systematic way of engagement and dis-engagement of CHWs based on performance.

69938cd2 answered 2 weeks ago

They need to have a limit degree of studies, for example, community health workers with a very low of studie reveal a lot of challenges to understand more complex themes and issues; They need to be acepted by the community; for some communities is needed a previous contact with the community leader for example to present the community health worker; Do not have others job, to have time to fulfill the health work;

fd6fba5e answered 1 week ago

Formal institutional mechanisms to retain trained CHWs over the longer term and appropriate incentives to motivate and improve their performance.

99c5f18c answered 1 week ago

Il faut définir les critères de choix de ces personnes en condition du diabète : il faut prendre parmi les patients modèles avec bon contrôle de glycémie, ayant un minimum de compétence intellectuelle pour avoir la capacité de transmettre et éduquer les autres. Dans la durée, il sera difficile d'assurer une rémunération mensuelle. Cela reste un travail bénévolat mais prévoir de remboursement de transport pour les VAD ou les appels téléphoniques. Accorder l'accès gratuit ou subventionné au suivi dans les structures de soins pour les pairs éducateurs comme motivation.

6a16d290 answered 1 week ago

They have access to individualized data (service utilization, patient stratification, caregivers, etc.) of their community to plan and better orient their activities

4773a988 answered 1 week ago

The main bottleneck in Peru is that the Ministry of Health can only hire people with a university or technical degree. That limits how can the MoH scale their reliance on CHWs. Right now they cannot. And if you don't pay these people —considering inflation and cost of living— whatever you do with CHWs is bounded to be a pilot and short-term.

93089cc1 answered 1 day ago

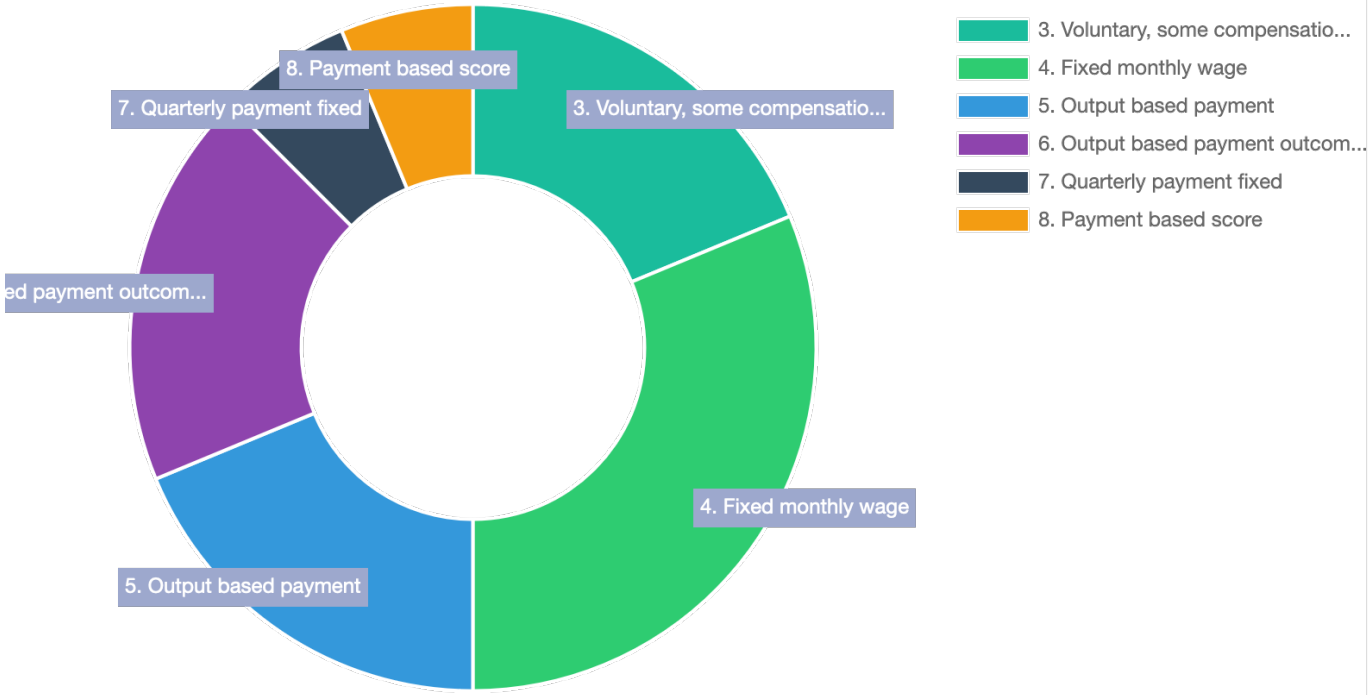
○ 1.4.4 — Community health workers, reward and responsibilit (Page 4)

EN

How do you recommend rewarding a CHW fulfilling these requirements and who would operate in your setting?

Choose one answer only.

1.4.4 — Community health workers, reward and responsibilit



Choices	#
3. Voluntary, some compensation	6 (18.75 %)
4. Fixed monthly wage	10 (31.25 %)
5. Output based payment	6 (18.75 %)
6. Output based payment outcome	6 (18.75 %)
7. Quarterly payment fixed	2 (6.25 %)
Total	**32**

Choices	#
8. Payment based score	2 (6.25 %)
Total	**32**

1.4.5 — Community Health Workers, Reward Model Suggestions (Page 4)

EN

Aside from the previous choices, how do you recommend rewarding a CHW fulfilling these requirements and who would operate in your setting? Suggest other reward models aside from the choices already given:

1.4.5 — Community Health Workers, Reward Model Suggestions

1. Self-Confidence: Presentation at meetings and conferences, participation in other health worker training. 2. Training: access to training offered to other health workers and related accreditation.

17b7b82a answered 2 weeks ago

Recognition in community and health system based platforms for their work; enabling them to progress in their career through some clear pathways within health or social care systems...

0415ccbc answered 2 weeks ago

These options are understandable but should include 'none' as an option. Compensation arrangements are a highly contextualised matter, and the choice I have made above is merely the normative ideal / least unacceptable, and not necessarily the most appropriate. I request the team to revisit this question and the options being offered.

560d961f answered 2 weeks ago

Payment of CHW is an ethical and justice issue; why should you and I receive a salary for the work we do, and CHW will work on a voluntary basis? On what will they raise their kids and give food to their families? It is a denial of basic human rights to deny fair compensation to CHWs for their work. Then, this has to be linked to their

volume of work and to the satisfaction of the persons they work with; the perception of their attitude (supportive, respectful, patient-centered...) should be assessed, and the payment should be aligned with that.

9a5c49a2 answered 2 weeks ago

Promotion or career advancement to the next level of service

e15461db answered 2 weeks ago

Instead of only 1 kind of reward, combinations of different kinds of rewards may work better. Like any human being CHW need to be rewarded, recognized, supported and supervised so they do not operate in a vacuum. Examples can be: benefits in kind like a yearly free laboratory profile, blood pressure meter, blood glucose meter, blood glucose strips, Also, discounts on their own prescriptions, participation in refresher courses, over time they can be paid to participate in meetings where health authorities meet and represent patietns with chronic conditions.

e39890ca answered 2 weeks ago

Fixed base monthly salary mixed with output-based payment linked to persons arriving at health facilities for screening/follow-up.

48319912 answered 2 weeks ago

Provision of bonuses to individuals who reported to have detected and referred a confirmed new positive case and witnessed by the supervisor.

32f8706f answered 1 week ago

Id like a combination between my choice and a payment based on a score on a checklist of several indicators of quality;

fd6fba5e answered 1 week ago

Dans la durée, il sera difficile d'assurer une rémunération mensuelle. Cela reste un travail bénévolat mais prévoir de remboursement de transport pour les VAD ou les appels téléphoniques. Accorder l'accès gratuit ou subventionné au suivi mensuel dans les structures de soins pour les pairs éducateurs comme motivation, et dans la mesure du possible cette subvention peut aller aussi au traitement d'insuline ou ADO (50 % à 80 %). Il faut tout de même garder une part de contribution du pair éducateur pour l'accès aux soins.

6a16d290 answered 1 week ago

A fixed monthly amount (wage) plus a variable amount linked to performance (outputs)

4773a988 answered 1 week ago

I think of a combined: (1) monetary compensation (operating budget) and (2) some form of cash incentives (an output-based payment capturing the outcome or fixed capitation

1b72b6c0 answered 1 week ago

fixed payment, because they come from very poor settings. a form of payment for performance attached to the fix payment - to increment their motivation

7dba40b8 answered 1 week ago

Recognition by community and the organizing/supervising body Ensuring capacity building and growth

db7d89a4 answered 1 week ago

Non-monetary rewards such as a public recognition of good work or effort, especially in home community.

495ce785 answered 6 days ago

pay for performancie

5e94bb18 answered 5 days ago

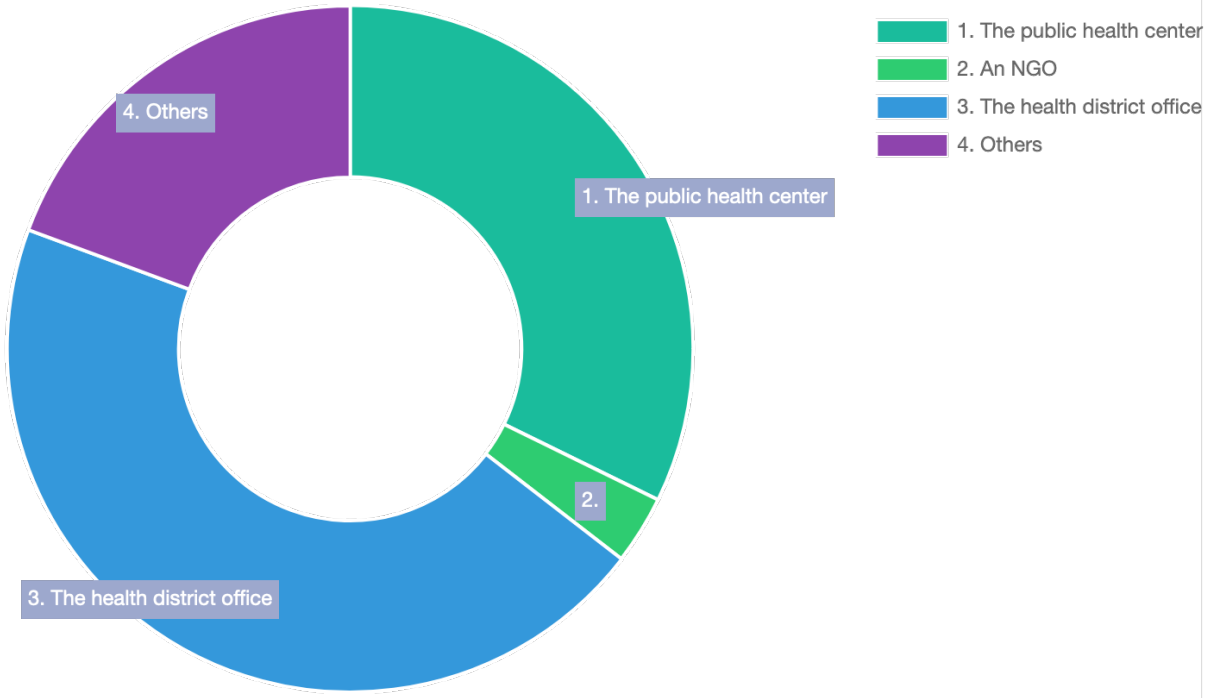
A fixed amount competitive with the market with additional output-based payments. Because these people in the community need to earn a living. We are talking about work, chronic care, support and companionship requires to be THE WORK of someone, it is not charity.

93089cc1 answered 1 day ago

1.4.6 — Community health workers, responsible pay CHW (Page 4)

EN
Who is the best person to pay the CHW?

1.4.6 — Community health workers, responsible pay CHW



Choices	#
1. The public health center	10 (32.26 %)
2. An NGO	1 (3.23 %)
3. The health district office	14 (45.16 %)
4. Others	6 (19.35 %)
Total	**31**

1.4.7 — Community health workers, Others to pay CHW (Page 4)

EN
If you chose Others are to pay the CHW, specify who you mean by others .

1.4.7 — Community health workers, Others to pay CHW

This is tricky - I would have used "Not Sure" option is one was available

0415ccbc answered 2 weeks ago

Anyone can pay; The payment has to follow clear principles that must be defined.

9a5c49a2 answered 2 weeks ago

They are not beer girls who are paid by the makers of the product that they promote. It is very important to help them remain independent from the service providers. As patients they are already dependent on service providers.

e39890ca answered 2 weeks ago

Whoever contracts the CHW. For example, local public administration (commune) contracts and pays.

48319912 answered 2 weeks ago

The government through a line Ministry (apart from Health) that deals with rural and urban development - eg Ministry of iTaukei Affairs in Fiji (for rural villages) and Ministry of Local Authorities (for informal settlements)

32f8706f answered 1 week ago

The one who pay the CHW should be the one responsible for their work, responsible for their supervision and leadership.

fd6fba5e answered 1 week ago

The National Health Service

da55c53c answered 1 week ago

They are supposed to be paid by central government (MOH or Ministry of Finance) as for other public servants. This will formalise their cadre and make it effective. For NGO to pay, makes a project which can not be sustainable.

d123bd0f answered 1 week ago

The local health secretariat could do it as weell -

7dba40b8 answered 1 week ago

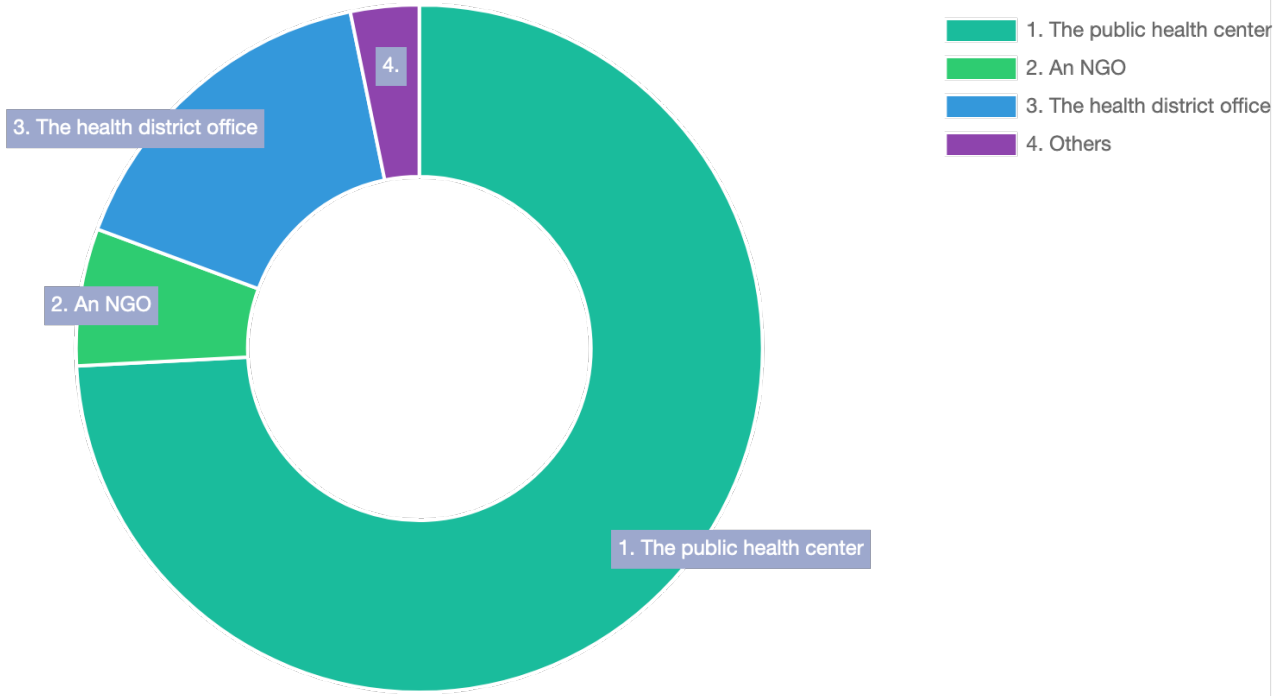
It depends of the configuration of the system. In Peru, I am not sure that payment can be disbursed at the primary care.

93089cc1 answered 1 day ago

1.4.8 — Community health workers, supervise the CHW (Page 4)

EN
Who s the best person to supervise the CHW?

1.4.8 — Community health workers, supervise the CHW



Choices	#
1. The public health center	23 (74.19 %)
2. An NGO	2 (6.45 %)
3. The health district office	5 (16.13 %)
4. Others	1 (3.23 %)
Total	**31**

1.4.9 — Community health workers, Others supervise the CHW (Page 4)

EN
If you chose Others are to supervise the CHW, specify who you mean by others .

1.4.9 — Community health workers, Others supervise the CHW

A dedicated officer operating within the purview of the district health office should supervise CHWs. NGOs could be contracted to supervise, but then they ought to be supervised too.

560d961f answered 2 weeks ago

The roles have to be shared depending on the context. Where an NGO pays, the health district may supervise. They should be a kind of separation of the functions.

9a5c49a2 answered 2 weeks ago

For technical supervision the Health Center, for administrative supervision the lcoal authorities (commune office or something like multisectoral like that).

e39890ca answered 2 weeks ago

A peer, the patients themselves.

93089cc1 answered 1 day ago

1.5.1 — Publich health center, opt out (Page 5)

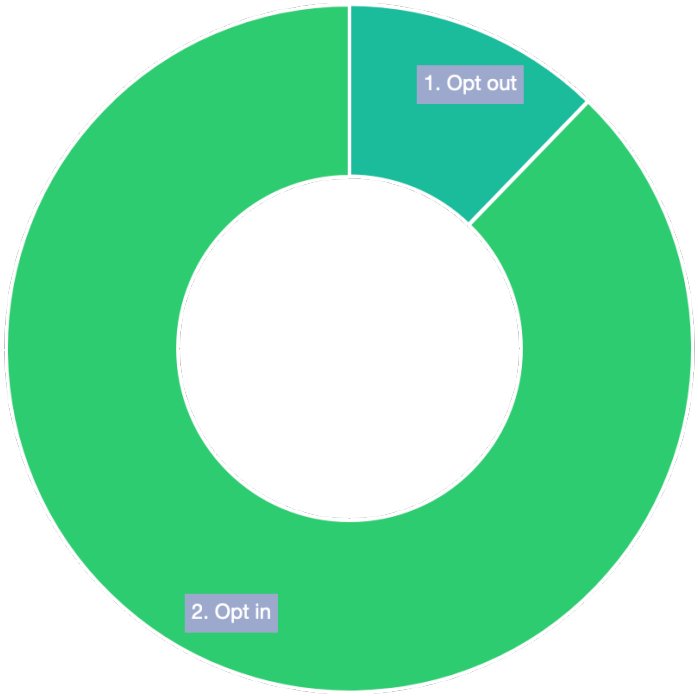
EN

Please tick if you want to opt-out or opt-in for this question.

I lack information on public health centers and prefer to opt-out

If you choose to opt out of questions on public health centers, please proceed directly to section 1.6 on not-for-profit health centers.

1.5.1 — Publich health center, opt out



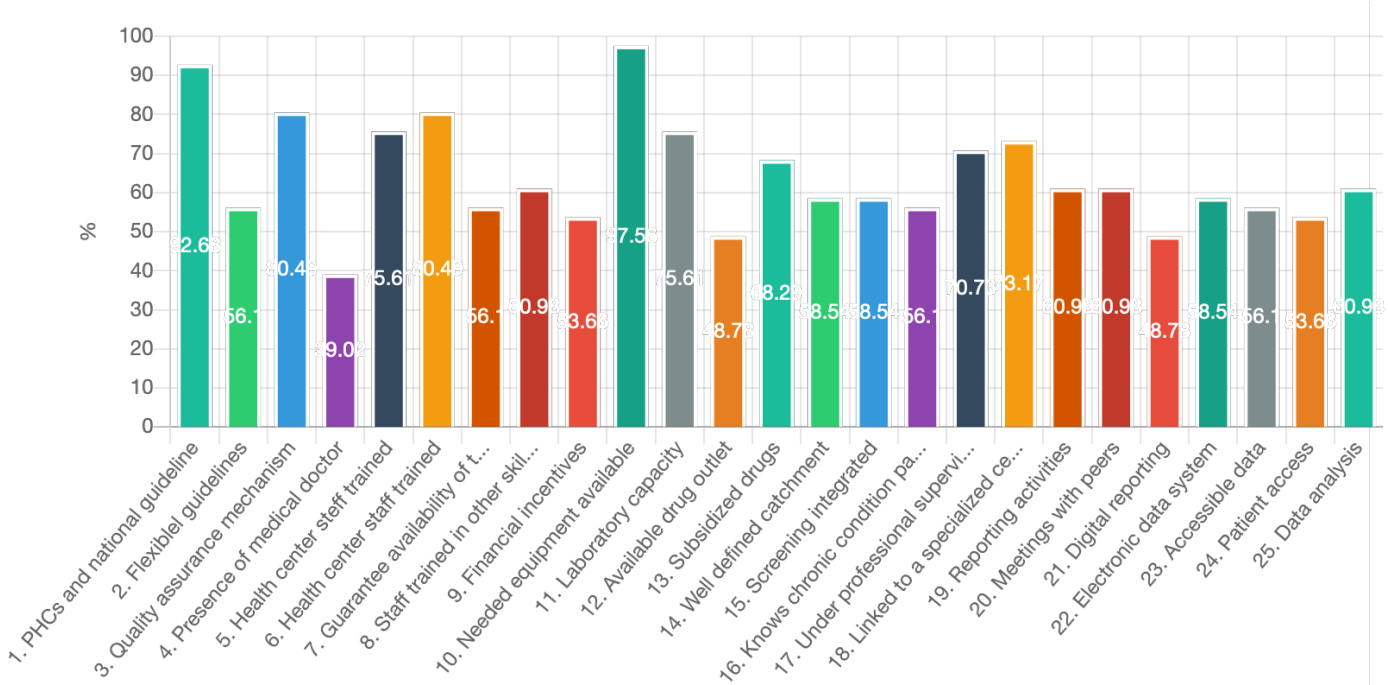
Choices	#
1. Opt out	6 (12.24 %)
2. Opt in	43 (87.76 %)
Total	**49**

☐ 1.5.2 — Public health centers, conditions/pre-requisites t (Page 5)

EN

Among all the following propositions on determinants of quality of care (or actions on these determinants), pick those which should be put as a condition/pre-requisite to ensure that health centers make a quality contribution. [multiple answers possible]

1.5.2 — Public health centers, conditions/pre-requisites t



Choices	#
1. PHCs and national guideline	38 (92.68 %)
2. Flexiblel guidelines	23 (56.1 %)
3. Quality assurance mechanism	33 (80.49 %)
4. Presence of medical doctor	16 (39.02 %)
5. Health center steff trained	31 (75.61 %)
6. Health center staff trained	33 (80.49 %)
7. Guarantee availability of team	23 (56.1 %)
8. Staff trained in other skills	25 (60.98 %)
9. Financial incentives	22 (53.66 %)
10. Needed equipment available	40 (97.56 %)
11. Laboratory capacity	31 (75.61 %)
Participants	**41**
Total	**657**

Choices	#
12. Available drug outlet	20 (48.78 %)
13. Subsidized drugs	28 (68.29 %)
14. Well defined catchment	24 (58.54 %)
15. Screening integrated	24 (58.54 %)
16. Knows chronic condition patien	23 (56.1 %)
17. Under professional supervision	29 (70.73 %)
18. Linked to a specialized center	30 (73.17 %)
19. Reporting activities	25 (60.98 %)
20. Meetings with peers	25 (60.98 %)
21. Digital reporting	20 (48.78 %)
22. Electronic data system	24 (58.54 %)
23. Accessible data	23 (56.1 %)
24. Patient access	22 (53.66 %)
25. Data analysis	25 (60.98 %)
Participants	**41**
Total	**657**

1.5.3 — Public health centers, other suggested conditions/ (Page 5)

EN

You may want to suggest other conditions, pre-requisites or make comments on the list of answers above to ensure that health centers make a quality contribution:

1.5.3 — Public health centers, other suggested conditions/

Ensure sufficient and reliable income for health care workers i.e. good salaries.

59191835 answered 2 weeks ago

In general, public health centers must legally have appropriate staff, space and equipment for a specific municipality/local community. In particular, the health statistical information system is legally established. Therefore, it is a "Conditio sine qua non", but we can discuss the required number of staff, their knowledge and skills, coordination with other health institutions, referral routes, etc.

9f0db521 answered 2 weeks ago

As part of "Ideal" service delivery, PHC facilities offer 3 key components; Chronic care for communicable and Non-Communicable diseases/conditions; Acute Care and Maternal/SRH/Antenatal/Child care. This arrangement is central to person centered care to make access as convenient as possible to persons/patients.

17b7b82a answered 2 weeks ago

The "health" of the health workers must be cared for. Their mental health especially must be cared for. No blind financial incentives should be performed. Private health centers must be engaged too. The health center should be entitled to a population that is vaguely defined by the population living in a catchment area, but rather that this population is identified namely based a very precise nominative list of citizens.

9a5c49a2 answered 2 weeks ago

The health center is rewarded for performance and shares somehow in the revenue based on outputs/outcomes.

e39890ca answered 2 weeks ago

This is a comprehensive list.

48319912 answered 2 weeks ago

There ought to be outreach services by health centre at least for people who can't easily come to health centre; health centre shall ideally have long working hours that include evening hours (if not through the day) to ensure access by those who earn daily wages and can't make it to routine day-time hours; reporting by centre to higher authority has to be accompanied by feedback loops else it becomes a burden where people at centre do not relate with its importance;

0415ccbc answered 1 week ago

Essential services considered above. Electronic medical records a huge asset but not essential if reporting is achieved with a paper based system. Point linked to drug outlet/payment for meds - yes as would call for for essential NCD meds to be inclued within wider UHC country benefit packages.

a77d36f9 answered 1 week ago

The health center actively engages in outreach within its community to increase awareness & accessibility. The health center includes a social services function, or at least is operationally tied to a center that provides social services; this is because health and social conditions are strongly related.

81dd720d answered 1 week ago

OBS - quality of data registration (gaming can be a reality when relating to p4p targeted indicators), sharing of data between levels and accessibility of data to patients are critical issues taking place in my country.

7dba40b8 answered 1 week ago

Chronic care requires integration of care (and care navigation teams) rather than responding to each disease in isolation. I did not mark any of the options above because that FUNDAMENTAL feature of chronic is not listed. It requires integration and a different mindset. Right now, you can read any of the options above and think of is as HIV or malaria, or hypertension, one disease by itself, nothing of integration or chronic care of chronic (non-infectious) conditions. I will admit that I come from the point of view of multimorbidity as well.

93089cc1 answered 1 day ago

☐ 1.5.4 — Public health centers, financing (Page

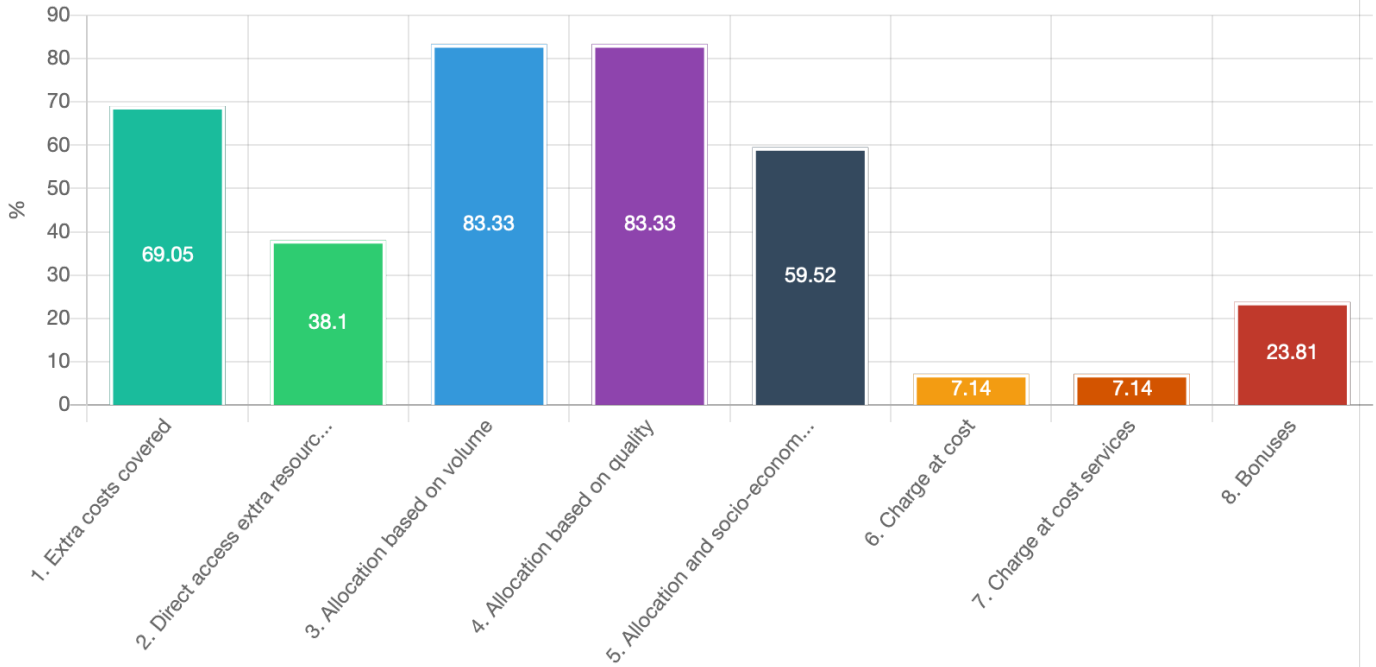
5)

EN

Imagine a public health center adding a chronic care capacity to its existing one in compliance with the requirements you have just proposed. How would you finance the extra costs?

As a baseline position, consider the following: the health center receives its inputs in kind (equipment, medicines, staff...) and has access to a small line-item budget through the district office for some running cost expenses. Please make the combination of options you recommend. [multiple answers possible]

1.5.4 — Public health centers, financing



Choices	#
1. Extra costs covered	29 (69.05 %)
Participants	**42**
Total	**156**

Choices	#
2. Direct access extra resources	16 (38.1 %)
3. Allocation based on volume	35 (83.33 %)
4. Allocation based on quality	35 (83.33 %)
5. Allocation and socio-economic	25 (59.52 %)
6. Charge at cost	3 (7.14 %)
7. Charge at cost services	3 (7.14 %)
8. Bonuses	10 (23.81 %)
Participants	**42**
Total	**156**

1.5.5 — Public health centers, financing, other suggestion (Page 5)

EN

Imagine a public health center adding a chronic care capacity to its existing one in compliance with the requirements you have just proposed. Suggest other models in order to cover the costs or make comments on this list of options:

1.5.5 — Public health centers, financing, other suggestion

Recognizing the need for sustainability and to address the "person" not diseases, A nationally approved standardized funding mechanism which makes provision for certain factors for example incentives for HCWs in rural/remote areas, is non-negotiable.

17b7b82a answered 2 weeks ago

It is very important to work from the beginning on primary and secondary prevention of NCDs, including regular screenings for known risk factors in the development of NCDs. This should be a basic package of health services (screenings) and mandatory for the working population. It is important to define the basic packages of health care services for chronic diseases according to real health needs, which would be financed from NCD funds, which the

state would form. Basic health service packages for NCDs would be ranked according to the type and severity of the disease. These packages would be partly paid from health insurance funds (public or private, depending on what the patient has), and partly would be funds from the state budget. In the same way, local communities/municipalities can form their own funds, from which they would pay health workers, for example home visits to more difficult patients, taking lab samples from immobile patients, transporting patients to health care facilities, etc. The package of services and the price should be defined exactly.

`9f0db521` answered 2 weeks ago

Paying for coordination and continuity via capitated payments at the network level (including the public health center and referral point).

`61e45e05` answered 2 weeks ago

I would suggest that one works with existing care provision models but add capacities and resources to enable the provision of additional services as part of routine work. I would absolutely avoid the introduction of extraneous / additional incentive arrangements (like condition or specific kinds of care linked compensations of whatever/any kind) as evidence suggests that they are very likely to disrupt existing arrangements negatively in the long run).

`560d961f` answered 1 week ago

The best model has to be discussed with the health center stakeholders. The model has to be discussed in line with the context and the expected outcomes. It should be designed in a way to give the health center's staff a strong sense of "I can do".

`9a5c49a2` answered 2 weeks ago

I think the problem is not the charging per se because that creates healthy dynamics between patient and the service provider, however affordability must be planned, monitored and access needs to be safeguarded for those who do not have the required resources.

`e39890ca` answered 2 weeks ago

Support the provision of services through a social insurance mechanism.

`69938cd2` answered 2 weeks ago

Encourage the Board of Visitors to be actively involved in exploring ways of providing the extra costs.

`32f8706f` answered 1 week ago

Possibly contracting an NGO well versed with the community who provide home based care and outreach and mediate/facilitate peoples' access to health centre

0415ccbc answered 1 week ago

The above is very suggestive. The right model depends on the context, and therefore, on path dependency, too. In the case of Cambodia that i use to illustrate and guide my thinking, the above answer is the correct one for that context (and current way of addressing these problems). There is an issue with the benefit package related to chronic care, its financing, and also, equity. Concurrently, the Government should consider contracting the private sector, too.

4be93ebb answered 1 week ago

If provided by the Ministry of Health, the additional sum could be linked to quality metrics to be fully dispersed, but there could also be an element of 'shared savings'. (Shared savings is a payment strategy that offers incentives for provider entities to reduce health care spending for a defined patient population by offering them a percentage of any net savings realized as a result of their efforts. (Bailit and Hughes. 2011. https://bailit-health.com/publications/082111_bhp_key_designelements_sharedsavings.pdf))

18480606 answered 1 week ago

create mutuality between patients

9209cb8f answered 1 week ago

-

a77d36f9 answered 1 week ago

Reallocate the savings from reducing hospitalizations due to better primary care to the health centers.

edc53c5f answered 1 week ago

Charging additional fees to wealthier households for VIP services to subsidize other health centre costs (eg. staff salaries, equipment and supplies, etc.).

98e18de7 answered 1 week ago

I would add an extra payment (bonuses) to the primary healthcare team according to quality chronic care outcomes in a definite population.

c8b8aeb4 answered 1 week ago

Options may include: a. Increasing linkage between municipality and health center, possibly with financial contributions from the former to the latter, or more ideally, mandated by law (e.g. fixed municipal tax dedicated to health center). b. Establish a linkages between casemix and case volume, with the financing health centers.

81dd720d answered 1 week ago

Allocation can be linked to both quantity (volume of services delivered) and quality. In addition, health center staff should also received some incentives but such incentives should be for the whole facility not individuals

1b72b6c0 answered 1 week ago

in my country the health system is free at the service level. It would be very difficult to implements fees for the population. We have a strong collective health society/represent ants all over the country. The service is implemented by all the three federal units, but is the municipality who does the delivery at the front level. Moreover. I don't think it is a good idea to give money direct to the health center as they are organized now. Some of the managers do not hold an specialization or any formation in administration or health. In each city, municipal legislatives "take care" or politically control regions of the cities, include health units. Those politicians in some of the cities - this is very dependent on the context - appoint the managers of the health units. Also, direct transfers to the unit could lead to further corruptions in the system. It is better to first put into place a data platform that actually works and is connected to other units and authorities.

7dba40b8 answered 1 week ago

Obtain financing through public insurance systems

495ce785 answered 6 days ago

Careful with what you pay for. In here you are paying for a service, irrespective of quality, just numbers. I would add emphasis on patient experience and patient satisfaction.

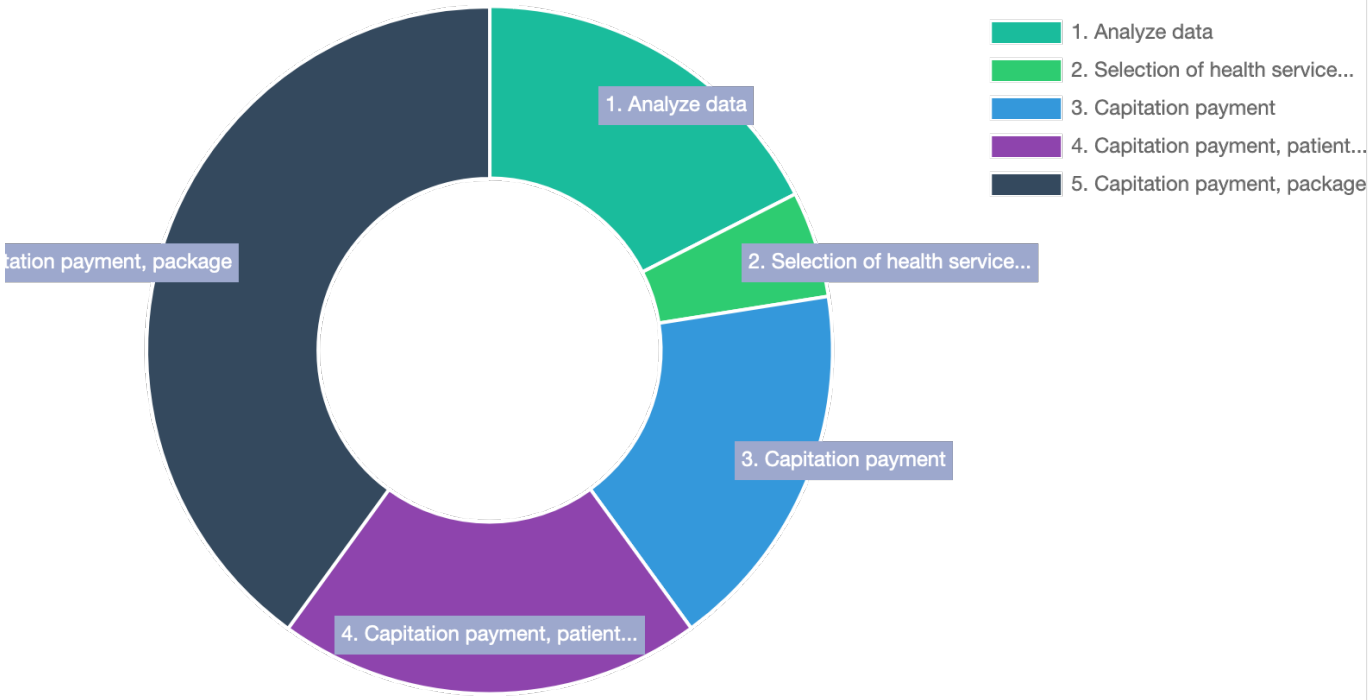
93089cc1 answered 1 day ago

1.5.6 — Public health centers, renumeration according to v (Page 5)

EN

Imagine that there is a remuneration according to quantity of services in a health centre, how would you do that?

1.5.6 — Public health centers, renumeration according to v



Choices	#
1. Analyze data	7 (17.5 %)
2. Selection of health services	2 (5 %)
3. Capitation payment	7 (17.5 %)
Total	**40**

Choices	#
4. Capitation payment, patient da	8 (20 %)
5. Capitation payment, package	16 (40 %)
Total	**40**

1.5.7 — Public health centers, renumeration according to v (Page 5)

EN
You may want to motivate your choice for the question above :

1.5.7 — Public health centers, renumeration according to v

The approach also has to be easily understandable for health care workers

59191835 answered 2 weeks ago

The context of the country does not allow for capitation according to diseases but rather for holistic care.

17b7b82a answered 2 weeks ago

It is very important to have a complete overview of patients with chronic diseases, a defined standardized package of services, and to expand the set of services according to health needs (other direct and indirect costs. The system of community nurses/visiting nurses should be well developed here. These nurses should additionally pay according to the work done and a bonus according to the good outcome.

9f0db521 answered 2 weeks ago

I would not link remuneration to quantity of services along any of the lines/options listed above. In my view, and I think the evidence and theory bear this view out, this is not an effective and sustainable approach in the long run. It creates problematic incentive structures and dynamics and unleashes forces that are negatively disruptive in the long run and at the system level. In my view, and I think the evidence and theory bear out that this is not an effective and sustainable approach in the long run. Not having 'none of the above' (or an option which clearly offers the option of not linking remuneration to performance) as an option as an answer to the question is problematic too.

560d961f answered 1 week ago

There is one single way to do this. The design has to make the users experience the added value of the care provided. This has to depend on the context (poverty, the mix of services needed, available, used by the providers, ..which current level of trust between the providers and the population et...), level of autonomy of facilities as defined the legal framing in application in the country.

9a5c49a2 answered 1 week ago

Incentivizing the whole health centre as a package would be a motivation for the health facility team and lead to improvement of the health facility as a whole rather than focus on specific persons

e15461db answered 2 weeks ago

My choice can maybe help if it is part of other supportive investments into the chronic care such as a monitoring of utilixzation and outcome data. Ideally electronic data make possible to monitor if the capitation payments translate into sufficient utilisation and acceptable outcomes. In addition there has to be supportive supervision mechanism in place and regular trainings etc. In chronic care the quantity (frequency) of utilization is less important than the quality of the contact between the patient and the service. But that is difficult to measure fairly.

e39890ca answered 2 weeks ago

I am trying minimise the data collection, analysis as well as the need to design a complex payment system.

865f9c1e answered 2 weeks ago

Health center should provide comprehensive care for all types of conditions and not just for NCDs.

69938cd2 answered 2 weeks ago

Again, the above is aligned with the current health financing/delivery model in the public sector in Cambodia....

4be93ebb answered 1 week ago

Silo-based approaches to capitation (i.e. only providing capitation payments for chronic care) may be lead to unintended consequeces (negative) for other areas of health delivery.

bbe6c1f7 answered 1 week ago

I chose capitation which involves an estimated population of people with different chronic conditions in the catchment population with other adjustors, because paying per person with a chronic condition is hard due to limited data/ records. The case based payment is okay but works better for inpatient care in higher level facilities (e.g., hospitals) and not practical in most PHC facilities.

d123bd0f answered 1 week ago

As stated above, remuneration is based on quantity of services; therefore, to expand services offered at the health centre (to include chronic disease), this would be the most appropriate way to increase financing. In addition, while capitation payment may be considered a fair way to compensate providers for more complex/high-risk patients, data/information to inform the design of this payment model is unavailable at the local level and there is generally a lack of population rostering/registration in health centres; therefore, it would to be possible to do this.

98e18de7 answered 1 week ago

Reinforcing a primary healthcare approach to chronic conditions is pivotal in promoting holistic care over vertical care. To effectively integrate health promotion, disease prevention, and quality care, it is imperative to ensure the provision of a comprehensive package of first-line health services rather than promoting incentives for fragmentation through vertical programs.

c8b8aeb4 answered 1 week ago

I would pay different rates based on risk-stratification and effective coverage / follow up of the population

4773a988 answered 1 week ago

I think health centers should have adequate baseline funds, to cover acute and chronic conditions, and costs of operating general infrastructure and human resources. In my experience, centers that received capitation payment per condition per patient would commonly shuffle funds across budget lines, to cover other services or costs that were under-funded (whether related to chronic conditions or not). I also would not want centers to possibly engage in upcoding chronic conditions. Instead, I would favor more distance between individual case and its payment, and use whole center packages, possibly combined with casemix index.

81dd720d answered 1 week ago

Chronic care services are often provided with appointments and case-based payment can lead to under services

(shorter period appointment, prescription of medicines). A capitation payment can address the above mentioned problems and promote preventive measures and healthy lifestyle

`1b72b6c0` answered 1 week ago

---

health units provide integrated forms of care. They work with groups for each type of diseases. They hold health promotion initiatives for specific groups, women, old people, and in general. Also, maternal and child care is very important element of service delivery in the country. They need require continuity.

`7dba40b8` answered 1 week ago

I believe it is important to both have the needed services covered and avoid misuse of funds (as is the case in HIC as well). So I would probably patients with chronic diseases screened on time and treated well, while avoiding to have people put too early on drugs or having to undergo unnecessary interventions or being enlisted as a chronic patient while not being one. This would mean paying a basic capitation payment for the whole nr of disease, ensure it is according to the estimated prevalence of chronic disease in the population but add a capitation per person with chronic disease registered in the health center.

`db7d89a4` answered 1 week ago

I am hesitant to focus on just case-based payments on the delivery of services as this could skew incentives. Rather, I feel a quarterly payment to cover the estimated costs is more appropriate.

`495ce785` answered 6 days ago

Emphasis on the person, not the service.

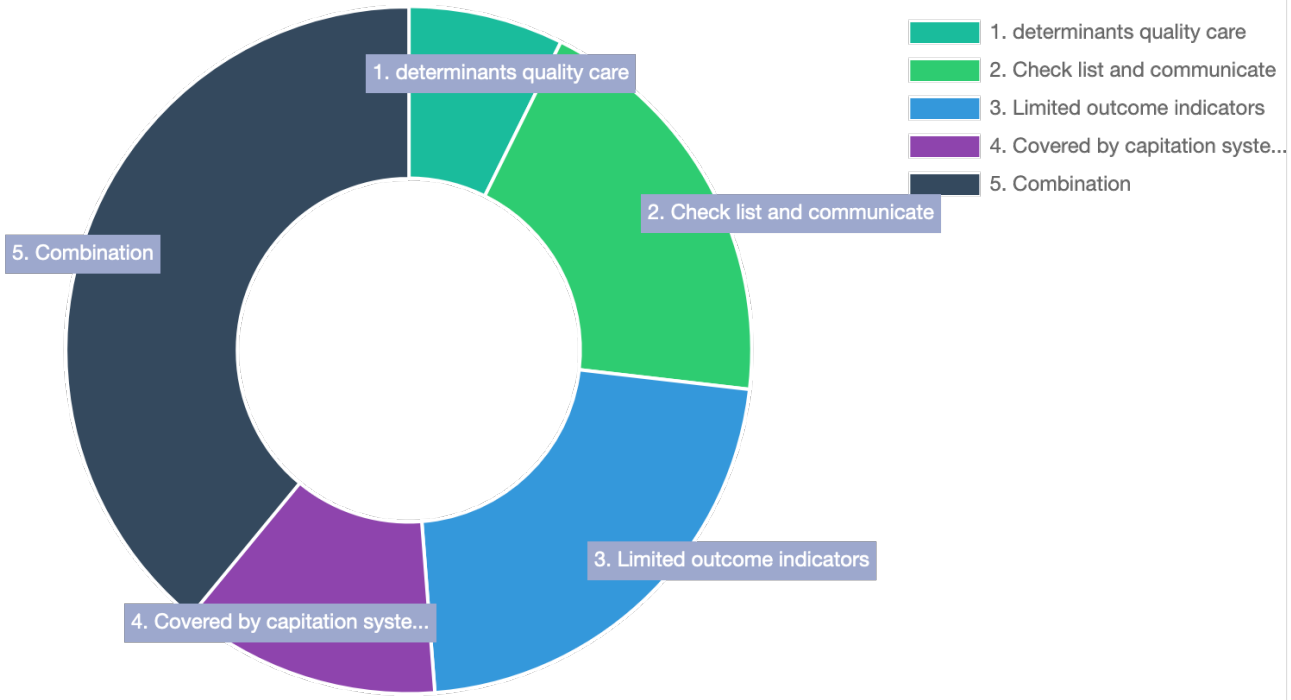
`93089cc1` answered 1 day ago

○ 1.5.8 — Public health centers, renumeration according to q (Page 5)

EN

Imagine that there is a remuneration depending on the quality of services, how would you do that?

1.5.8 — Public health centers, renumeration according to q



Choices	#
1. determinants quality care	3 (7.32 %)
2. Check list and communicate	8 (19.51 %)
3. Limited outcome indicators	9 (21.95 %)
4. Covered by capitation system	5 (12.2 %)
5. Combination	16 (39.02 %)
Total	**41**

1.5.9 — Public health centers, renumeration according to q (Page 5)

EN

If you picked "I would consider a combination of the ideas listed above", please list which combinations you would consider (letters only)___

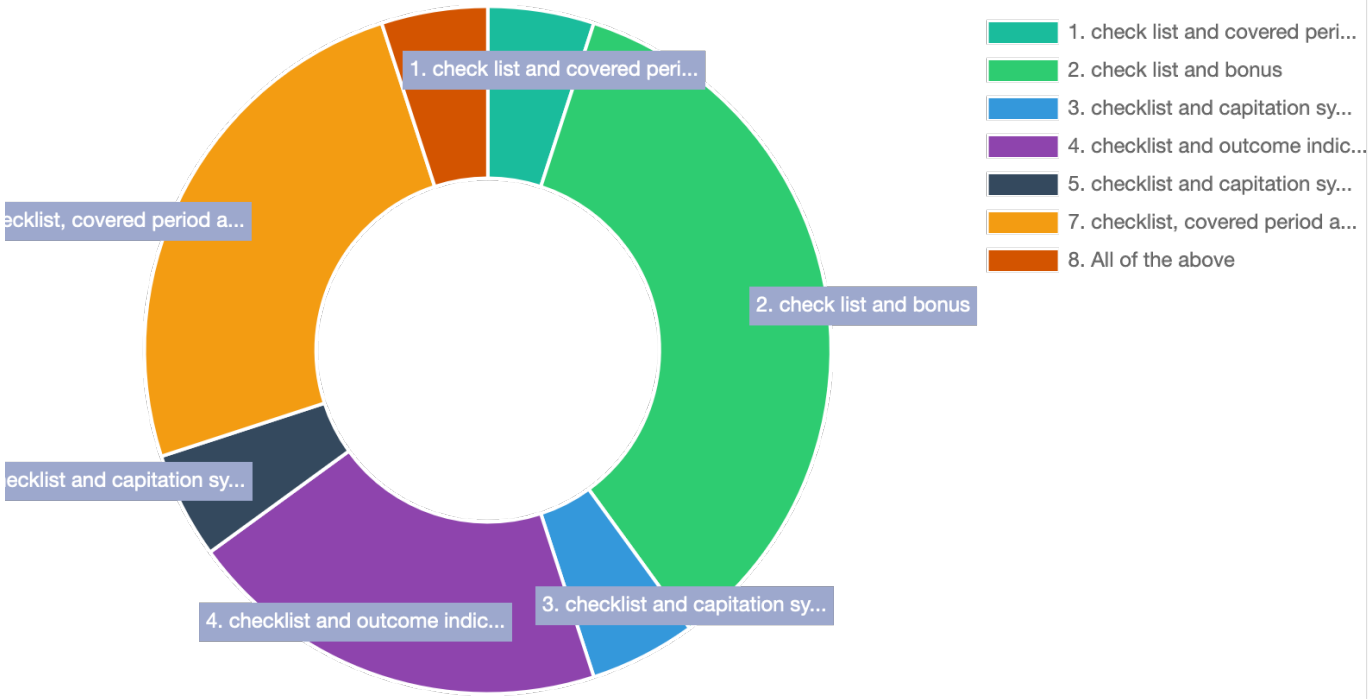
a. I would establish a list of key determinants of quality of care, communicate the list to candidate health centers, organize some independent verification, give accreditation to health centers succeeding the appraisal, and then grant a regular quality payment to the health center for a long period (e.g., 1-2 years)

b. I would establish a list of determinants of quality of care (checklist), communicate the list to candidate health centers, organize independent verification for instance every three months, score the health center, and then grant a quality payment to the health center for the covered period.

c. I would establish a limited list of outcome indicators (e.g., diabetes under control), communicate these metrics to the health centers, review their clinical data (for instance, via the digital system) and then grant the health center a bonus for the covered period of time (e.g., once a year). District office would do spot checks to ensure that data is not gamed by health centers.

d. I would assume that the quality of service objective is covered by the capitation payment system (i.e., the capitation payment incentivizes the health center staff to bring chronic conditions under control) and I would not add any extra payment mechanism.

1.5.9 — Public health centers, renumeration according to q



Choices	#
1. check list and covered period	1 (5 %)
2. check list and bonus	7 (35 %)
3. checklist and capitation syste	1 (5 %)
4. checklist and outcome indicato	4 (20 %)
5. checklist and capitation syste	1 (5 %)
7. checklist, covered period and	5 (25 %)
8. All of the above	1 (5 %)
Total	**20**

1.5.10 — Publich health centers and alternative renumeratio (Page 5)

EN

Motivate your combination of choices or develop an alternative proposition if you want:

1.5.10 — Publich health centers and alternative renumeratio

N/A

17b7b82a answered 2 weeks ago

N/a

9f0db521 answered 2 weeks ago

I would link CHW performance with respect to chronic illness care in community to health centers' quality bonus and probably also to accreditation.

815d558b answered 2 weeks ago

I would not link remuneration to quality of services provided along any of the lines/options listed above. In my view, and I think the evidence and theory bear it out, this is not an effective and sustainable approach in the long run. It creates problematic incentive structures and dynamics and unleashes forces that are negatively disruptive in the long run and at the system level. Not having 'none of the above' (or an option which clearly offers the option not linking remuneration to performance) as an option as an answer to the question is problematic too.

560d961f answered 1 week ago

Mind the fabrication of data that goes with the payment linked to certain indicators. One needs to be flexible, learning, and adaptive. There should be a strong focus on the patient's experience and outcomes.

9a5c49a2 answered 1 week ago

Because it communicates clearly what is expected beforehand, combination of quality + results, and yearly comparison with others, all based on good data, with interim spot checks.

e39890ca answered 2 weeks ago

The evidence on the benefits of verification relative to its costs is not very compelling. I would like options a and b without a necessary verification component.

b0e7e1ac answered 1 week ago

This is the current system in Cambodia. The latest change to it, during the HEQIP2 being introduced, is (a) a rigorous accreditation mechanism for public health centers and public hospitals, (b) content of care metrics (provider knowledge and competencies) are measured and feedback is provided. Combined metrics result in a semi-annual financial payment to the public health institution, which partially is used to pay public health workers bonuses.

4be93ebb answered 1 week ago

I would establish a list of key determinants of quality of care (checklist) AND outcome indicators, communicate the list to candidate health centers, reorganize independent verification for instance every three months, score the health center, and then grant a quality payment to the health center for the covered period.

bbe6c1f7 answered 1 week ago

I chose to account for quality adjustment in the capitation method. It is hard in our setting to have multiple payment methods – this will impose complexity in administration, inefficiencies, and send different signals to providers (as opposite to have one payment method with all corresponding adjustors of interest).

d123bd0f answered 1 week ago

Mix of determinants and outcome indicators considered with regular monitoring activities. Would want to ensure the independent verification also includes a community component e.g. to identify populations not currently accessing care at the center.

a77d36f9 answered 1 week ago

Providing a specific and explicit set of indicators provides useful information to providers and can guide them on how to improve. Capitation alone does not contain such information.

edc53c5f answered 1 week ago

These mechanisms should be established in the short term to ensure continuity of quality improvement. Additionally, independent verification of quality conditions is always advised to avoid corruption. External supervision is a crucial feature of the quality sustainable quality assurance systems.

c8b8aeb4 answered 1 week ago

Although linking a financial incentive to an outcome is appealing, it may also result in unintended consequences. Also, the outcome indicators are partly -if not largely- outside the control of the center itself. Therefore, outcomes do not have to be linked to a financial incentive. Instead, processes that have been demonstratively proven to positively influence these outcomes may be used in e.g. checklists. Checklist results could be used to determine if a center is say on a probation period or not, or (less ideally) receiving additional funds for quality. I prefer not to link remuneration to quality very closely, due to the above reasons. Also, in some cases it may be that a center is delivering lower quality because of its lack of funding, therefore decreasing this further would not be beneficial neither to the center nor the community. A non-financial incentive such as scoring or grading may also be useful.

81dd720d answered 1 week ago

B would be ideal but not sure this is feasable. A. is probably too long a period. C. is insufficient to be sure of the quality. So quality and outcome indicators measures every 6 to 9 months with quality payment granted accordingly for the period and for the score received.

db7d89a4 answered 1 week ago

The selected combination could contribute to deploy a dynamic payment mechanism that encourages improvements in structure, processes and prioritized outcomes. I would also offer health facilities with a self assessment quality tool in order to encourage not only compliance but a sustained commitment with the improvement on chronic care

4773a988 answered 1 week ago

Careful with 'targets' and 'metrics', they are important yes. But for chronic care, the most important is the patient experience, not the metrics. Imagine of this as a situation where currently there is a divorce (between system and patients with chronic conditions)... do you want to put metrics on number of visits that each parent made to the child on a given month? Or do you want to ask the child what is needed to support him in the transition to live without their two parents?

93089cc1 answered 1 day ago

1.5.11 — Public health centers, allow charging user fees, h (Page 5)

EN

If you have selected the option of allowing the health center to charge user fees, can you motivate your choice?

1.5.11 — Public health centers, allow charging user fees, h

N/A

17b7b82a answered 2 weeks ago

N/a

9f0db521 answered 2 weeks ago

charging user fees gives more advantages than disadvantages, as evidence has shown multiple times.

e39890ca answered 2 weeks ago

User fees should be seen as a last alternative to other sources of financing to ensure availability of drugs and other commodities. In the event the health facility does not receive adequate resources (in kind or financial) to ensure sufficient medicines, we do not want to fall in to a situation where people are screened and diagnosed and the health facility cannot provide the required meds. In this case, in addition to existing health financing/protection mechanisms that cover the poor (so would not pay user fees), individuals who are not enrolled in existing insurance schemes such as non-poor informal sector could be asked to pay user fees so that the facility could use this revenue to ensure supply of meds for the population.

48319912 answered 2 weeks ago

Many end-stage chronic conditions are not treatable due to capacity constraints, neither in the public nor in the private systems in this particular context (Cambodia).

4be93ebb answered 1 week ago

I am against user fees, that is what we have right now in Peru and it doesn't work. Corruption comes to mind.

93089cc1 answered 1 day ago

1.5.12 — Public health centers, mechanisms to protect patie (Page 5)

EN

Which mechanisms would you recommend to protect some patients to incur catastrophic health care expenditures or to forego treatment because of these user fees?

1.5.12 — Public health centers, mechanisms to protect patie

Tax based NHS type system for a limited set of highly cost-effective interventions including both NCD and other care.

59191835 answered 2 weeks ago

N/A

17b7b82a answered 2 weeks ago

Catastrophic health care costs should be protected by regular mandatory health insurance and the formation of solidarity funds for serious illnesses.

9f0db521 answered 2 weeks ago

One of the criteria to consider in defining the benefits package is financial protection - essential services that are expensive should be covered via the state either for all, or means-tested vulnerable/poor groups.

61e45e05 answered 2 weeks ago

Provide health Insurance for all

e15461db answered 2 weeks ago

I don't think user fees by themselves create catastrophic health expenditures.,but chronic patients must be protected against: 1) forcing them to come too often to contact the health center (cost of userfee + transport cost + opportunity cost) 2) packages of services that include services that are not necessary 3) inappropriate medicines, inappropriate tests, creating a cost that should not be there. This problem can be created at high central level or locally). 3) All patients with chronic conditions must be protected against unnecessary costly treatments. 4) Peer Educators who have been trained in maintaining and preserving a low cost affordable system that they use themselves also.

`e39890ca` answered 2 weeks ago

The system should be funded by prepayment via taxes (preferably) or national health insurance.

`865f9c1e` answered 2 weeks ago

Social health protection mechanisms such as non-contributory insurance for the poor, SHI, etc.

`48319912` answered 2 weeks ago

Health insurance with premium waivers for those in remote areas and those living elsewhere but falling below a poverty threshold. In addition, cash transfers after natural disasters, etc. could also be considered.

`b0e7e1ac` answered 1 week ago

Allow this with those receiving medical payments from social welfare assistance

`32f8706f` answered 1 week ago

We need major investments upfront in preventative care instead of downstream in curative care for these conditions...

`4be93ebb` answered 1 week ago

---

social health protection schemes or advancing universal health coverage agenda

`99c5f18c` answered 1 week ago

- Health insurance scheme

da55c53c answered 1 week ago

The user fee as out-of-pocket payement has to be removed; and necessary conditions has to be put in place for effective implementation. If any charge has to be made at thepoint of service, it has to be limited and fix, regardless of the externt of service required and received for a certain morbide condition within a certain range of needs. The issue of user fee at the health center level has to be discussed separately from the issue of user fee at the hospital level. Catastrophic cost occurs mainly at the hospital level. The challenge with care for chronicle condition, is also the "chronicle pressure" the disease puts on the family resources, the pressure on the worklife of the patient with a constant risk of pushing the person below the poverty line, or isolating him from his family members, or fragilizing the social support around him. The protection against catastrophic expenditure in that situation should be adapted to that feature of chronicle condition.

9a5c49a2 answered 1 week ago

Inclusion of prevention, early screening and early initiation of treatment with regular follow up i.e. good clinical care to prevent complications including hospitalisation Inclusion of NCDs within UHC health benefit packages (based on WHO Global Action Plan - Appendix 3) Considerations of equity in health system design, multisectoral approach to health and considering social determinants of health).

a77d36f9 answered 1 week ago

Ensuring the health structure staff is not perceiving added interventions to patients as an increased fee for them. So basic capitation payment (depending on prevalence) to ensure health centers can start, add capitation on nr of patients with chronic disease enrolled, but not case-based on services. And add incentives related to quality indicators (which should identify the use of unnecessary prescriptions and interventions)

db7d89a4 answered 1 week ago

Publically-sponsored health insurance that can be enrolled on-site and is cashless (theoretically the PM-JAY in India)

495ce785 answered 6 days ago

Create insurance package with the catastrofic health expenditures services

8781451c answered 5 days ago

Indeed, as above, avoid them.

93089cc1 answered 1 day ago

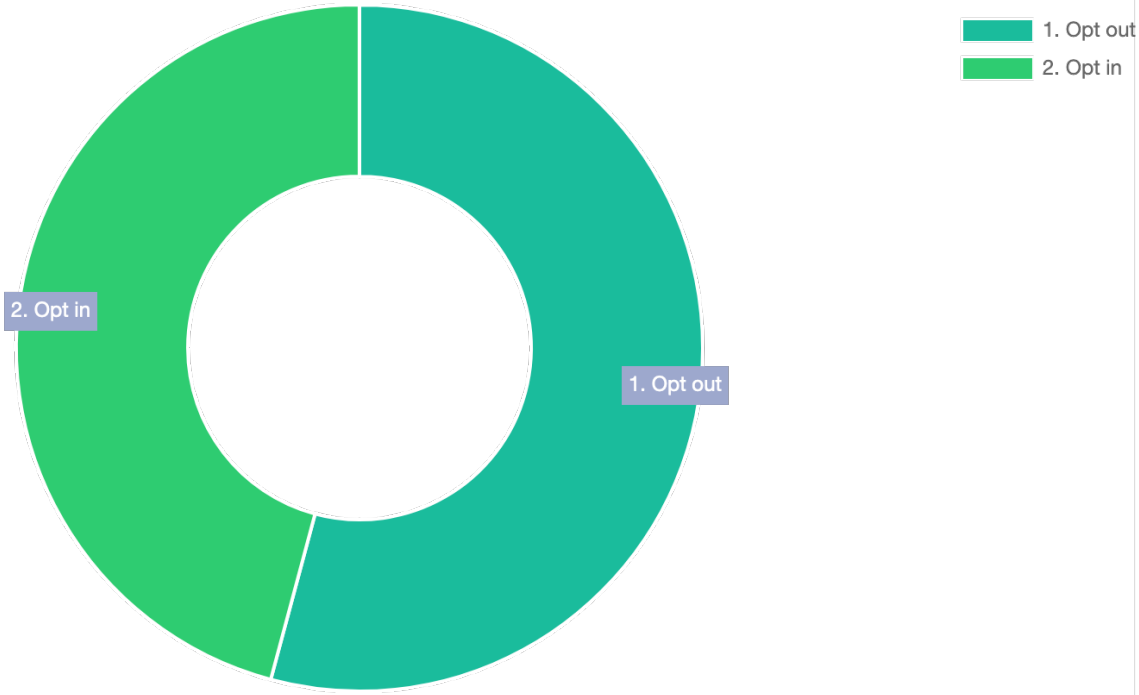
1.6.1 — Private not for profit health centers opt out (Page 6)

EN

I lack information on private not-for-profit health centers and prefer to opt-out

If you choose to opt out of this question on not-for-profit health centers, please proceed directly to section 1.7 on private for-profit health providers.

1.6.1 — Private not for profit health centers opt out



Choices	#
1. Opt out	26 (54.17 %)
2. Opt in	22 (45.83 %)
Total	**48**

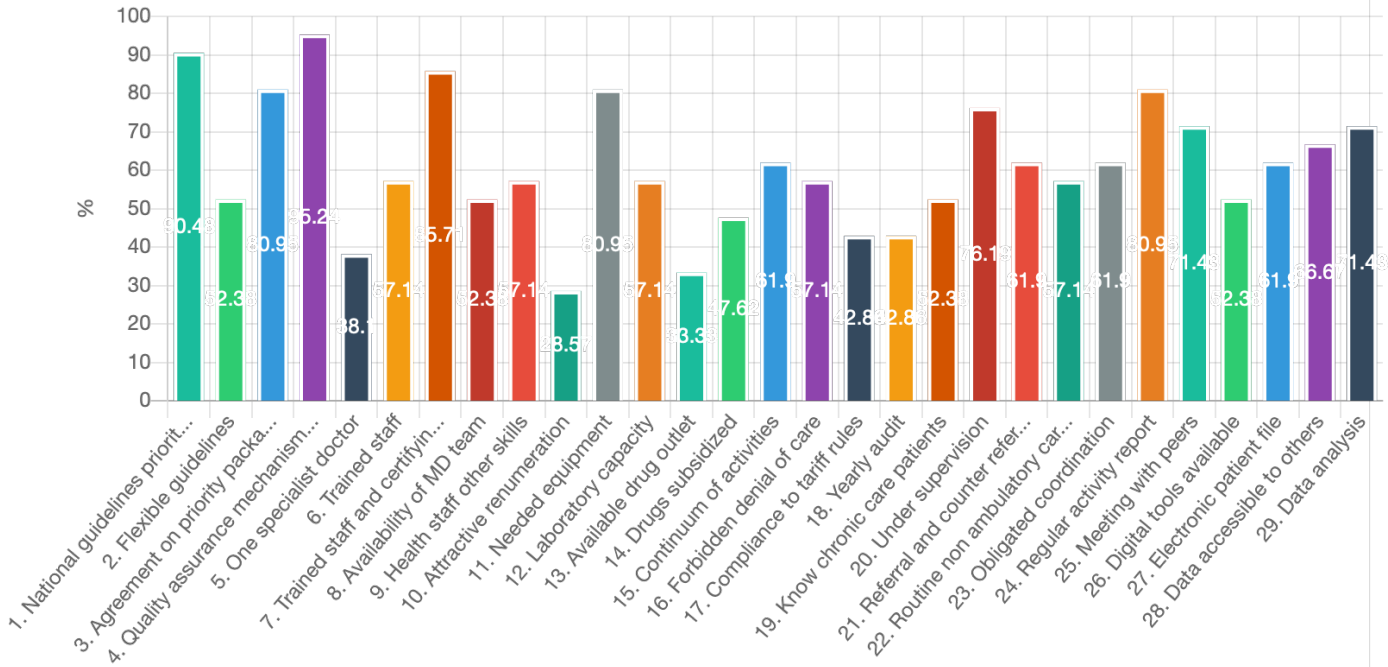
☐ 1.6.2 — Private not for profit health centers specialized, (Page 6)

EN

Among all the following propositions on determinants of quality of care, tick those which should be put as a condition to accept that services provided by these providers are reimbursed from pooled public funds.

[multiple answers possible]

1.6.2 — Private not for profit health centers specialized,



Choices	#
1. National guidelines priority	19 (90.48 %)
2. Flexible guidelines	11 (52.38 %)
Participants	**21**
Total	**373**

Choices	#
3. Agreement on priority package	17 (80.95 %)
4. Quality assurance mechanisms	20 (95.24 %)
5. One specialist doctor	8 (38.1 %)
6. Trained staff	12 (57.14 %)
7. Trained staff and certifying e	18 (85.71 %)
8. Availability of MD team	11 (52.38 %)
9. Health staff other skills	12 (57.14 %)
10. Attractive renumeration	6 (28.57 %)
11. Needed equipment	17 (80.95 %)
12. Laboratory capacity	12 (57.14 %)
13. Available drug outlet	7 (33.33 %)
14. Drugs subsidized	10 (47.62 %)
15. Continuum of activities	13 (61.9 %)
16. Forbidden denial of care	12 (57.14 %)
17. Compliance to tariff rules	9 (42.86 %)
18. Yearly audit	9 (42.86 %)
19. Know chronic care patients	11 (52.38 %)
20. Under supervision	16 (76.19 %)
21. Referral and counter referral	13 (61.9 %)
22. Routine non ambulatory care	12 (57.14 %)
Participants	**21**
Total	**373**

Choices	#
23. Obligated coordination	13 (61.9 %)
24. Regular activity report	17 (80.95 %)
25. Meeting with peers	15 (71.43 %)
26. Digital tools available	11 (52.38 %)
27. Electronic patient file	13 (61.9 %)
28. Data accessible to others	14 (66.67 %)
29. Data analysis	15 (71.43 %)
Participants	**21**
Total	**373**

1.6.3 — Private not for profit health centers specialized, (Page 6)

EN

Suggest other conditions, prerequisites or make comments on this list of propositions that should be put as a condition to accept that services provided by these providers are reimbursed from pooled public funds:

1.6.3 — Private not for profit health centers specialized,

- Accreditation of health centers is a good instrument by which, based on pre-determined quality standards, achievements are established, which can be measured as indicators, and on the basis of which payments can be made according to performance, and bonuses based on health outcomes. The measure is very objective and motivating for health personnel. - When it comes to health care for chronic patients, especially severe cases, it is very important to take into account other services in the patient's home - home visits, patient transport, patient care at home, etc.

`9f0db521` answered 2 weeks ago

Certain chronic conditions (like mental health conditions https://www.nytimes.com/2015/10/12/health/the-chains-

of-mental-illness-in-west-africa.html) are stigmatized by many communities. Their issues are not just on the public health agenda, also because international technical partners do not make those problems a priority. In those settings, community-led initiatives or faith-based initiatives, or even individual philanthropy-led initiatives are the only available response. One must be cautious in the way conditions are put to those initiatives to be supportive rather than constraining and dissuasive.

`9a5c49a2` answered 1 week ago

S'assurer que les intrants (médicaments, réactifs) sont bien conservés dans la pharmacie ou point de vente du CS à température requise (bonne chaine de froid). Mise en place d'un système de tarification forfaitaire pour faciliter l'accès aux soins des patients

`6a16d290` answered 1 week ago

These providers should be supported with the adoption of digital technologies (access to interoperable EHR for free) and trained in the use of clinical guidelines and the implementation of referral and counter-referral procedures. In addition, they have to be regularly audited

`4773a988` answered 1 week ago

The question is about pre-requisites. So for example laboratory services available would be an added value, but it is not a pre-requisite if there are quality lab services available outside of the NGO supported health center. Another example: it would be beneficial if there exist an good functioning referral and contra referral to hospitals for in patient care or further investigations, but the absence of such a hospital or the possibility to refer should not prevent NGO supported health centers that manage patients with chronic diseases to receive pooled public funds if there guarantee quality assurance.

`db7d89a4` answered 1 week ago

Place emphasis on integrated care, patient navigators and patient/caregiver experience.

`93089cc1` answered 1 day ago

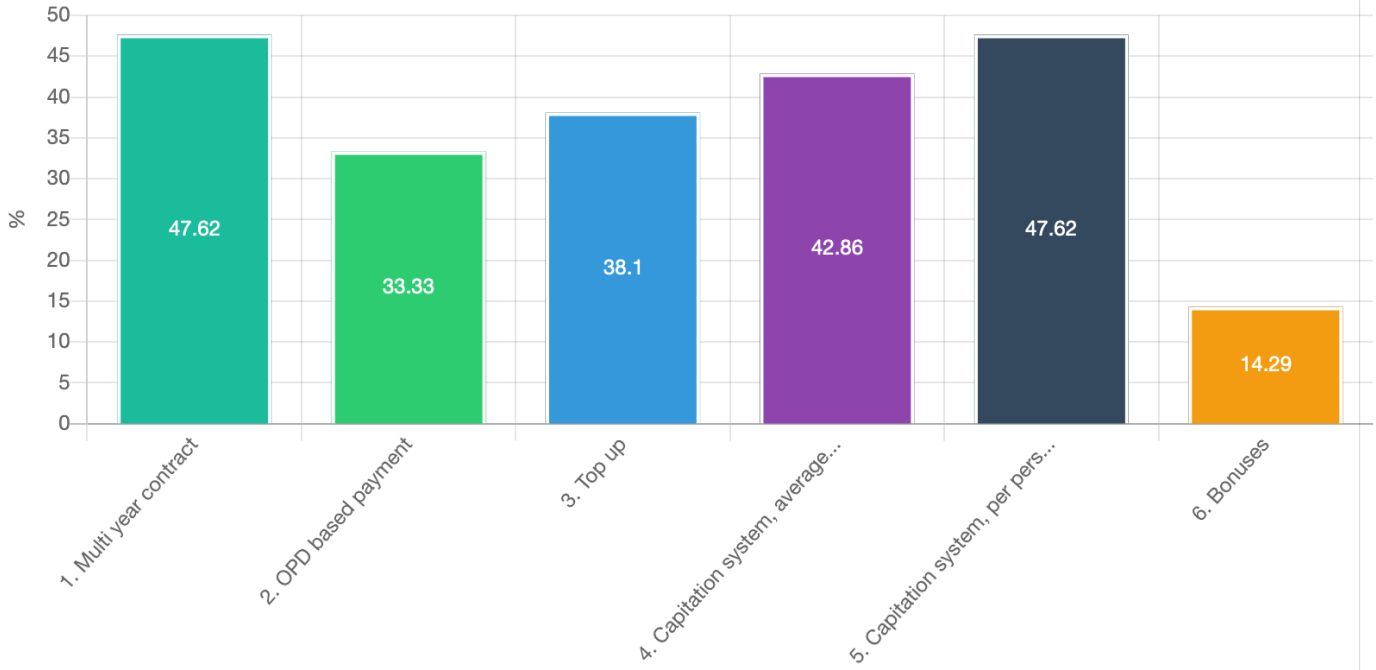
☐ 1.6.4 — Private not-for-profit health centers specialized; (Page 6)

EN

Imagine that you can decide/reform the way this private non-profit health center is funded by any national pooled fund (e.g., public budget, national health insurance). Which option(s) would you recommend?

[Multiple answers possible]

1.6.4 — Private not-for-profit health centers specialized;



Choices	#
1. Multi year contract	10 (47.62 %)
2. OPD based payment	7 (33.33 %)
3. Top up	8 (38.1 %)
4. Capitation system, average ite	9 (42.86 %)
5. Capitation system, per person	10 (47.62 %)
6. Bonuses	3 (14.29 %)
Participants	**21**
Total	**47**

1.6.5 — Private not for profit health centers specialized (Page 6)

EN

Motivate your choice from the previous question:

1.6.5 — Private not for profit health centers specialized

The contract with the private health sector must be clearly defined - type of services, performance, quality, and payment is made based on performance

`9f0db521` answered 2 weeks ago

A multi-year contract with a block grant arrangement (together with regular assessment of fulfillment of contract conditions) is a reasonable way forward. Some sort of top-up for consistent good quality care provision is also a good idea. More complex compensation arrangements (block grants are probably the least complex) would only work in country contexts where robust and agreed upon measurement, monitoring, and governance mechanisms exist. As regards the compensation and bonuses of staff working at these NGOs, I think it should be an internal matter for the NGO to decide.

`560d961f` answered 1 week ago

For chronic conditions a multi year perspective is important. Chronic patients should be registered and serviced as a separate category from acute patients. The data should show the utilization by the registered patients. The regularlity of contacts (not intensity or high frequency) and the outcomes are more important than blindly rewarding frequency of utilization. What matters is quality of the contacts but that is difficult to measure precisely. Patient satisfaction is an important dimension also.

`e39890ca` answered 2 weeks ago

Multi-year block grants, along with necessary oversight, would help the health facilities take the long view in the care they provide rather than have to make short run decisions, which can often be sub-optimal.

`b0e7e1ac` answered 1 week ago

A combination of a captation payment and a quality-linked top-up payment are likely to put in place the best set of incentives for optimal servicing of the population in the catchment area.

`bbe6c1f7` answered 1 week ago

A capitation system may work, with close monitoring of the experience of users including the outcomes of the

services they receive. A clear list of the persons enlisted to that facility should be available.

9a5c49a2 answered 1 week ago

Output-based payment is important for private providers, and similarly the need for capitation payment. The idea is to ensure purchasing of needed services without escalating costs.

d123bd0f answered 1 week ago

Contrat pluri annuel : il faut en même temps contribuer à l'amélioration de l'accès aux soins et d'autre part éviter de mettre en place de structures budgétivore et trop administratif qui au fil du temps ne sera pas pérenne. cette option me parait réaliste : une négociation avec les CS dans lequel les règles de financement, de fixation de tarif et de remboursement ou subventions sont fixés ainsi que les préalables à remplir, le cycle de rapportage régulier.

6a16d290 answered 1 week ago

Same comments as before. Activity, quality, outcome and financial reports would be needed. An isolated financial report with invoices would not be sufficient to understand the performances of the program. Health structures would need a basic funding to maintain activities, topped up with the nr of patients managed and followed to ensure all needed patients can be included and a quality top up to ensure motivation.

db7d89a4 answered 1 week ago

Pay against nationally-established metrics of high quality. Not just service provision, but high-quality service provision. Avoid mediocrity since the inception of this. And these have to reviewed regularly, because things change over time.

93089cc1 answered 1 day ago

1.6.6 — Private not for profit health centers specialized, (Page 6)

EN
Suggest other models of financing:

1.6.6 — Private not for profit health centers specialized,

Reward payment can also be defined, but it only applies to secondary prevention, i.e. necessary screenings according to national plans for NCD control in the adult population

9f0db521 answered 2 weeks ago

RAS

6a16d290 answered 1 week ago

I would pay a capitation payment (on a quarterly basis) with different rates based on risk-stratification and effective coverage / follow up of the population. I would also consider paying a bonus (twice a year) based on performance.

4773a988 answered 1 week ago

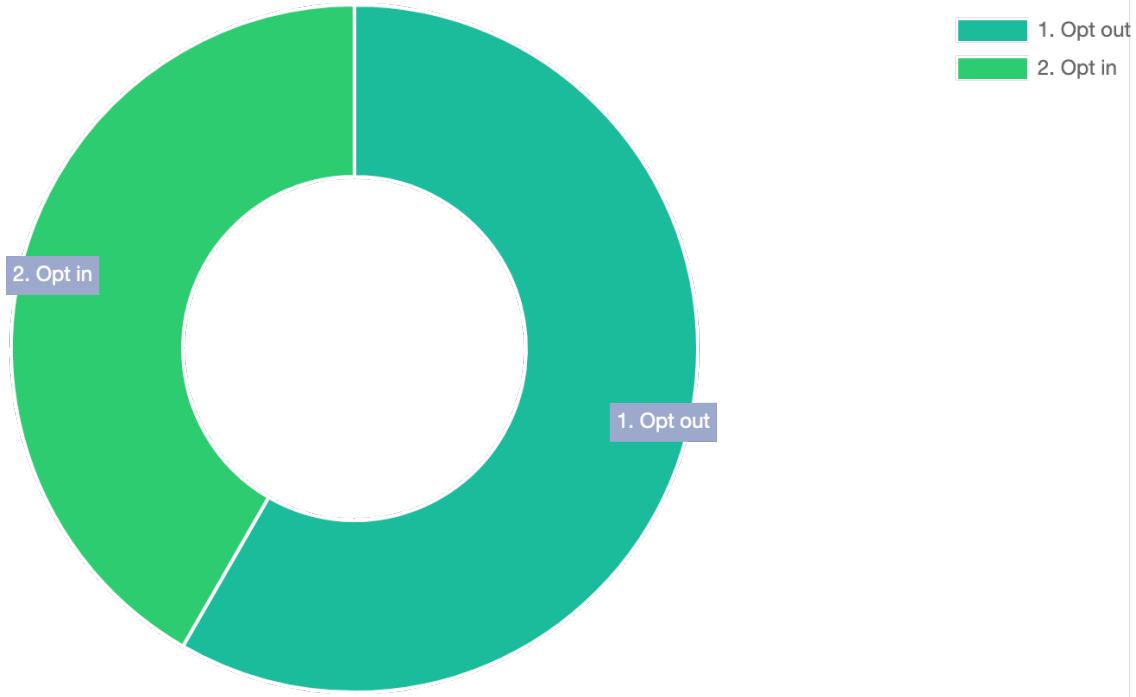
1.7.1 — Private for profit clinics opt out (Page 7)

EN

I lack information on private for-profit clinics and prefer to opt out

If you choose to opt out of this question on for profit clinics, please proceed directly to section 1.8 on hospitals.

1.7.1 — Private for profit clinics opt out



Choices	#
1. Opt out	28 (58.33 %)
2. Opt in	20 (41.67 %)
Total	**48**

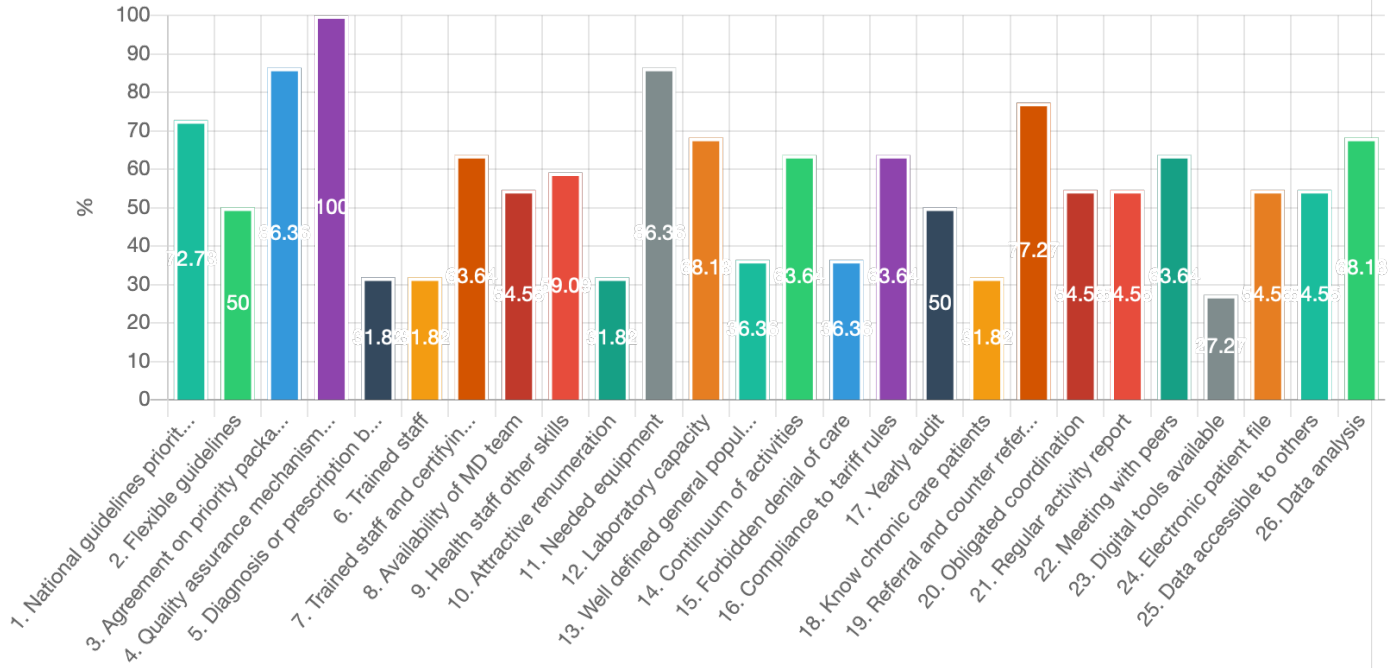
☐ 1.7.2 — Private for-profit clinics, prerequisites to be re (Page 7)

EN

Among all the following propositions on determinants of quality of care, tick those which should be put as a prerequisite for the services delivered by those private providers to be reimbursed on pooled funds.

[multiple answers possible]

1.7.2 — Private for-profit clinics, prerequisites to be re



Choices	#
1. National guidelines priority	16 (72.73 %)
2. Flexible guidelines	11 (50 %)
3. Agreement on priority package	19 (86.36 %)
4. Quality assurance mechanisms	22 (100 %)
5. Diagnosis or prescription by a	7 (31.82 %)
6. Trained staff	7 (31.82 %)
7. Trained staff and certifying e	14 (63.64 %)
8. Availability of MD team	12 (54.55 %)
9. Health staff other skills	13 (59.09 %)
10. Attractive renumeration	7 (31.82 %)
Participants	**22**
Total	**324**

Choices	#
11. Needed equipment	19 (86.36 %)
12. Laboratory capacity	15 (68.18 %)
13. Well defined general populatio	8 (36.36 %)
14. Continuum of activities	14 (63.64 %)
15. Forbidden denial of care	8 (36.36 %)
16. Compliance to tariff rules	14 (63.64 %)
17. Yearly audit	11 (50 %)
18. Know chronic care patients	7 (31.82 %)
19. Referral and counter referral	17 (77.27 %)
20. Obligated coordination	12 (54.55 %)
21. Regular activity report	12 (54.55 %)
22. Meeting with peers	14 (63.64 %)
23. Digital tools available	6 (27.27 %)
24. Electronic patient file	12 (54.55 %)
25. Data accessible to others	12 (54.55 %)
26. Data analysis	15 (68.18 %)
Participants	**22**
Total	**324**

1.7.3 — Private for profit clinics, suggestions on reimbur (Page 7)

EN

Suggest other conditions, and prerequisites or make comments on this list of propositions for the services delivered by those private providers to be reimbursed on pooled funds:

1.7.3 — Private for profit clinics, suggestions on reimbur

N/a

9f0db521 answered 2 weeks ago

To be effective and attractive to the for-profit private sector, contracting arrangements require robust and fair processes for arriving at agreements (about the terms etc), implementation oversight, and arbitration (when there are disagreements between parties). The presence or not of these is a function of the broader public administration and governance environment of a particular country. The nature of these contracting arrangements should be therefore tailored to reflect and account for the local country context. Equally importantly, in many HICs and LMICs, the for-profit private sector can be very powerful and influential - and therefore capable of resource capture, cream skimming, and manipulation. This needs to be carefully taken into account when establishing any contracting arrangements to engage with the for-profit private sector. This becomes particularly important in LMIC contexts as the pooled funds (be they tax based or premium based) available to the health system are very limited, and once one has gone down a path (path dependency), returning and undoing the steps is extremely difficult.

560d961f answered 1 week ago

As most for-profit private clinics work on fee for service model, it is important that patients are assured adequate consultation time and are protected form unnecessary interventions/services

0415ccbc answered 1 week ago

- The Clinic can deny care to patients if they are not enrolled in a particular financing scheme that caters to the cost of medical care for chronic disease patients

da55c53c answered 1 week ago

One should be cautious with the dichotomy of private for-profit versus private-not-for profit. The line between them is blurred. One should always set up strong monitoring and accountability measures to ensure patients are treated in the way to have the best possible benefit for their health, and that other personal or organization

benefits are not the main drivers of the choice of the individuals or of the managers. There should be not blank trust to any type of organisation.

9a5c49a2 answered 1 week ago

Au niveau du patient, s'assurer que leurs dossiers médicaux sont complets et que les prescriptions sont conformes au guides thérapeutiques validés ou ordinogramme au niveau des CS la structure de soins doit tenir à jour sa comptabilité, avoir si possible un compte bancaire et une bonne clé de répartition des recettes entre les primes locales du personnel, le renouvellement du stock des médicaments, le % pour l'investissement ou la réserve.

6a16d290 answered 1 week ago

These providers should be supported with the adoption of digital technologies (access to interoperable EHR for free) and trained in the use of clinical guidelines and the implementation of referral and counter-referral procedures. In addition, they have to be regularly audited

4773a988 answered 1 week ago

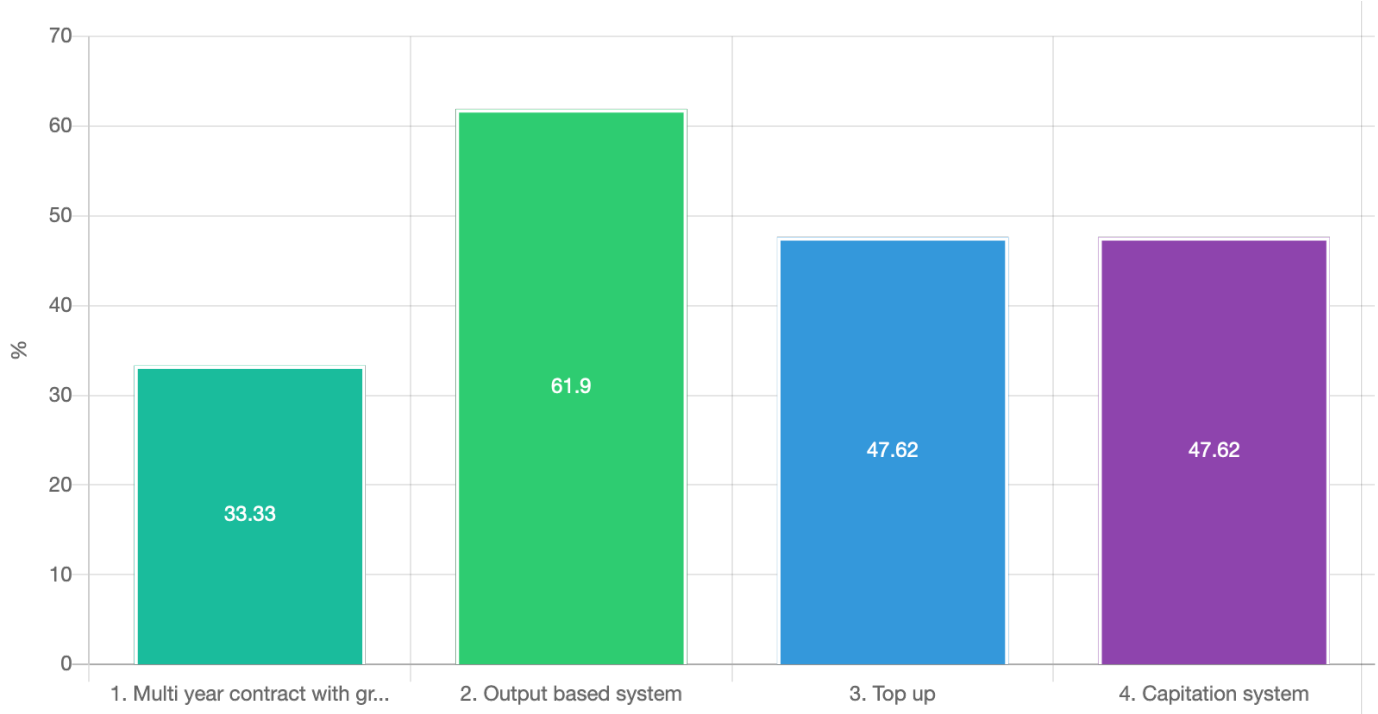
☐ 1.7.4 — Private for-profit clinics, sources of funding (Page 7)

EN

Imagine that this private for-profit clinic is not yet funded by any national pooled fund (e.g., public budget, national health insurance) and that you have to organize this new funding channel. Which option(s) would you recommend?

[multiple answers possible]

1.7.4 — Private for-profit clinics, sources of funding



Choices	#
1. Multi year contract with grant	7 (33.33 %)
2. Output based system	13 (61.9 %)
3. Top up	10 (47.62 %)
4. Capitation system	10 (47.62 %)
Participants	**21**
Total	**40**

1.7.5 — Private for profit clinics, sources of funding, ex (Page 7)

EN
Motivate your choice based on your answer to the previous question

1.7.5 — Private for profit clinics, sources of funding, ex

In these health care institutions, it is necessary to contract/pay for services that are not available on the market,

and payment is per service, based on a pre-agreed price.

9f0db521 answered 2 weeks ago

A multi-year contract with a block grant arrangement (together with regular assessment of fulfillment of contract conditions) is a reasonable way forward. Some sort of top-up for consistent good quality care provision is also a good idea. More complex compensation arrangements (block grants are probably the least complex) would only work in country contexts where robust and agreed upon measurement, monitoring, and governance mechanisms exist. To be effective and attractive to the for-profit private sector, contracting arrangements require robust and fair processes for agreement, implementation oversight, and arbitration. The presence or not of these is a function of the broader public administration and governance environment. The nature of these contracting arrangements should be therefore tailored to reflect and account for the local country context. To repeat, in many HICs and LMICs, the for-profit private sector can be very powerful and influential - and therefore capable of resource capture, cream skimming, and manipulation. This needs to be carefully taken into account when establishing the contracting arrangements to engage with the for-profit private sector. Again to repeat, this needs careful consideration as pooled funds (be they tax based or premium based) available to the health system are very limited, and once one has gone down a path (path dependency), returning and undoing the steps is extremely difficult. As regards the compensation and bonuses of staff working at these for-profit facilities, I think it should be an internal matter for the private provider to decide - some broad-brush oversight to ensure equitable and reasonable compensation across cadres is however desirable.

560d961f answered 1 week ago

Combinations of payment systems may be the most productive and if the clinic services chronic patients then a multi year contract can make it possible to monitor the progress towards complications and good control.

e39890ca answered 2 weeks ago

A combination of option 2 and 3 seems manageable if private facilities agree to quality assessments from the public sector.

48319912 answered 2 weeks ago

All the answers above are possible, and coming from a setting where a health insurance system is in place, and the capitation system has been piloted in one region, I believe a lot of monitoring and supervision has to follow these agreements with the private-for-profit clinics. This will ensure that the clinics declare the actual cost for reimbursement and in the case of a capitation, the lumpsum is used for what is intended for.

da55c53c answered 1 week ago

Same motivation as with the previous similar clinic question: a combination of a risk-adjusted capitation-based payment for the population in the catchment area and a quality-linked payment are likely to create the best set of incentives for optimal care delivery.

bbe6c1f7 answered 1 week ago

Contrat pluri annuel : il faut en même temps contribuer à l'amélioration de l'accès aux soins et d'autre part éviter de mettre en place de structures budgétivore et trop administratif qui au fil du temps ne sera pas pérenne. cette option me parait réaliste : une négociation avec les CS dans lequel les règles de financement, de fixation de tarif et de remboursement ou subventions sont fixés ainsi que les préalables à remplir, le cycle de rapportage régulier.

6a16d290 answered 1 week ago

A capitation payment system favors comprehensive care (health promotion, disease prevention, and chronic care provided simultaneously) but only if coupled with a good quality assurance system. Moreover, event payment could favor perverse incentives to carry out unnecessary activities.

c8b8aeb4 answered 1 week ago

While output-based payment is acceptable, but it may lead to under services for chronic conditions. Capitation payment coupled with a quality payment top up should be considered

1b72b6c0 answered 1 week ago

My feeling is that private clinics will not consistently offer services unless there is a consistent financial incentive to do so. This excludes capitation payments

495ce785 answered 6 days ago

1.7.6 — Private for profit hospitals, other models of fina (Page 7)

EN
Suggest other models of financing:

1.7.6 — Private for profit hospitals, other models of fina

If these institutions are in areas of the country where there are no public health centers, then at least one-year

contracts can be made for the population in that area

9f0db521 answered 2 weeks ago

I think that patient satisfaction become more important to monitor and use to reward the service provider, to the extent the clinic receives pooled funds instead of being paid for services by the patients.

e39890ca answered 2 weeks ago

RAS

6a16d290 answered 1 week ago

I would pay a capitation payment (on a quarterly basis) with different rates based on risk-stratification and effective coverage / follow up of the population. I would also consider paying a bonus (twice a year) based on performance.

4773a988 answered 1 week ago

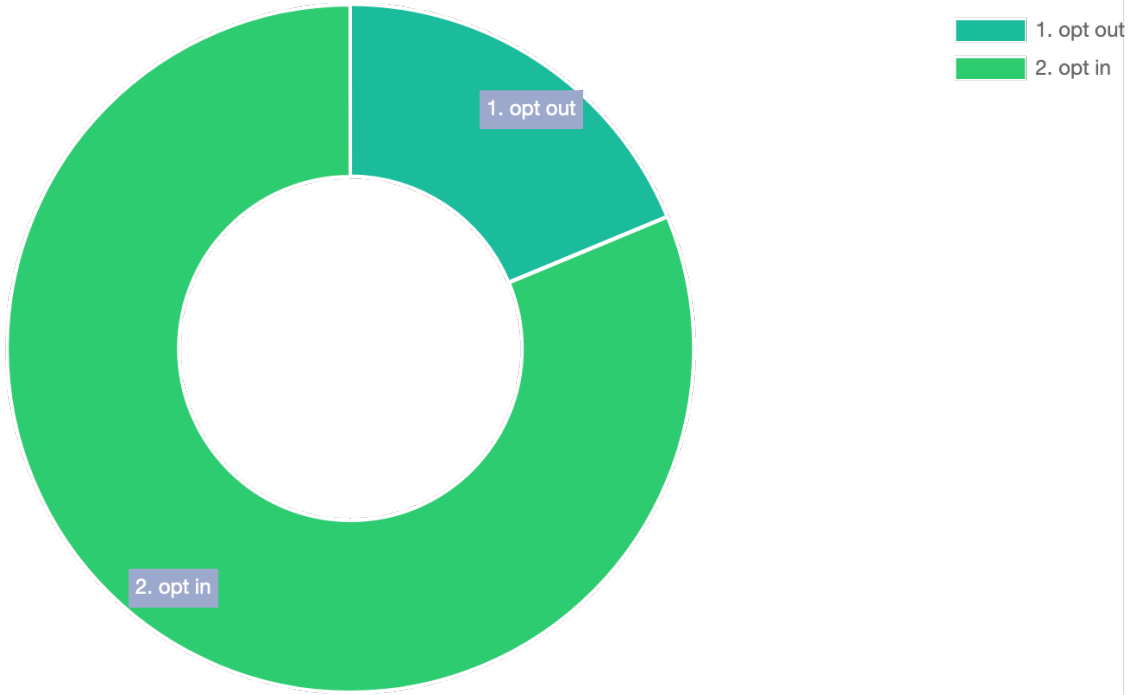
1.8.1 — Hospitals, opt out (Page 8)

EN

I lack information on hospitals and prefer to opt out

If you choose to opt out of these questions on hospitals, please proceed directly to section 1.9 Coordination bodies.

1.8.1 — Hospitals, opt out



Choices	#
1. opt out	9 (18.75 %)
2. opt in	39 (81.25 %)
Total	**48**

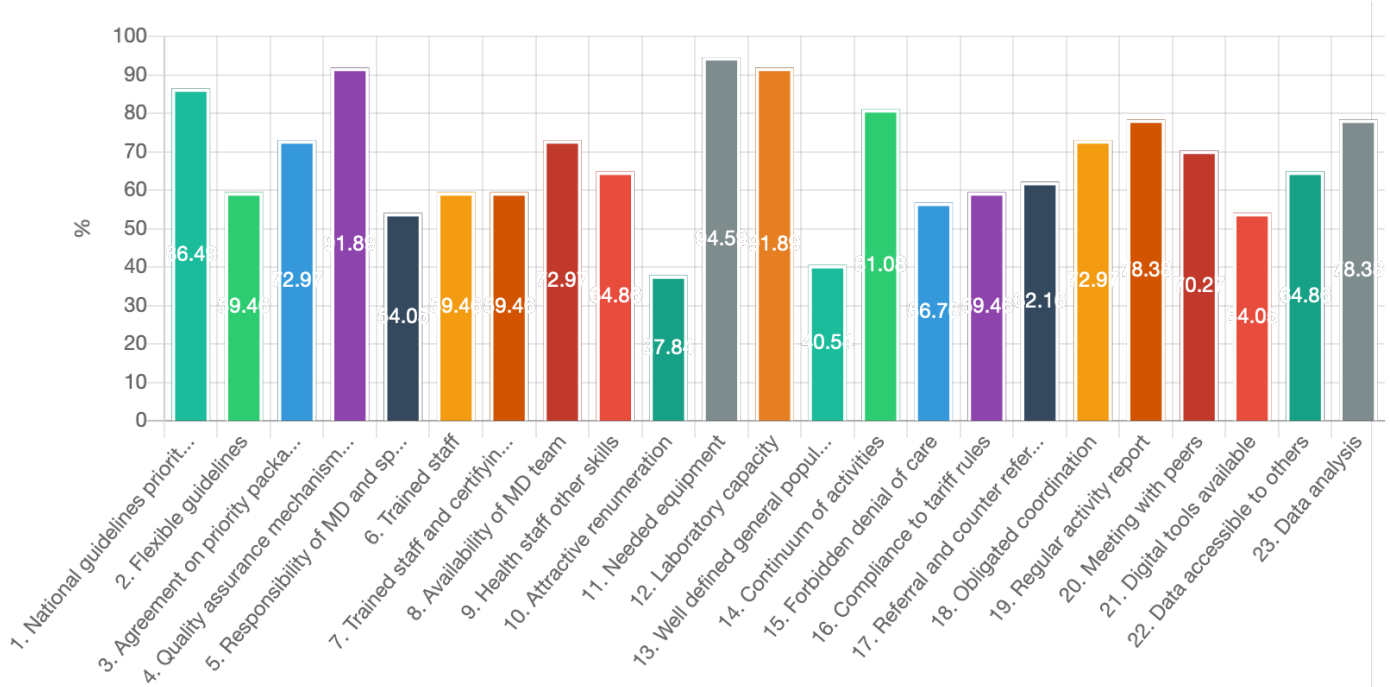
☐ 1.8.2 — Hospitals, determinants of quality of care (Page 8)

EN

Among all the following propositions on determinants of quality of care, pick those which should be put as a condition to ensure that hospitals make a quality contribution.

[multiple answers possible]

1.8.2 — Hospitals, determinants of quality of care



Choices	#
1. National guidelines priority	32 (86.49 %)
2. Flexible guidelines	22 (59.46 %)
3. Agreement on priority package	27 (72.97 %)
4. Quality assurance mechanisms	34 (91.89 %)
5. Responsibility of MD and speci	20 (54.05 %)
6. Trained staff	22 (59.46 %)
7. Trained staff and certifying e	22 (59.46 %)
8. Availability of MD team	27 (72.97 %)
9. Health staff other skills	24 (64.86 %)
10. Attractive renumeration	14 (37.84 %)
11. Needed equipment	35 (94.59 %)
Participants	**37**
Total	**579**

Choices	#
12. Laboratory capacity	34 (91.89 %)
13. Well defined general populatio	15 (40.54 %)
14. Continuum of activities	30 (81.08 %)
15. Forbidden denial of care	21 (56.76 %)
16. Compliance to tariff rules	22 (59.46 %)
17. Referral and counter referral	23 (62.16 %)
18. Obligated coordination	27 (72.97 %)
19. Regular activity report	29 (78.38 %)
20. Meeting with peers	26 (70.27 %)
21. Digital tools available	20 (54.05 %)
22. Data accessible to others	24 (64.86 %)
23. Data analysis	29 (78.38 %)
Participants	**37**
Total	**579**

1.8.3 — Hospitals determinants of quality care, other sugg (Page 8)

EN

Suggest other conditions, prerequisites or make comments on this list of propositions which should be put as a condition to ensure that hospitals make a quality contribution:

1.8.3 — Hospitals determinants of quality care, other sugg

hard to say no to any of the above. The only point to add - minimise/or no out of pocket costs

760ac409 answered 2 weeks ago

N/a

9f0db521 answered 2 weeks ago

Theres a systematic process for reviewing quality, diagnosing problems, and implemnting corretive actions

61e45e05 answered 2 weeks ago

I would add capacities and resources (human, financial, technological, supervisory) to enable the provision of additional services as part of routine work.

560d961f answered 2 weeks ago

From my perspective, the creation of well-defined "catchment areas" is much less important than assuring a well-defined "population". This can be achieved in some systems through the selection of insurers (public, private, non-profit); or through a requirement that patients register with a particular "provider organization". The exact way to assure a well-defined population will vary across countries depending on how their financing and provision is structured.

b0dba773 answered 1 week ago

In the preparation phase, the "journey of patients" in the hospital must be mapped; and all the operations happening at each step must be studied and designed in a way to maximize the positive experience for the patient. That patient experience must be routinely monitored and gaps must be analyzed and corrected. For instance, the average waiting time to see a specialist must be monitored. The hospital must also work within institutionalized networks with lower-level health facilities with shared information to guarantee continuity of care and prevent fragmentation of services. For hospitals, hospital-specialized care should not substitute long-term or long-run case management that requires more family medicine or home-close practitioners. This tension between expensive hospital-based care (sometimes perceived as of better quality) versus close PHC long-run management must be well negotiated and the payment strategy should be designed in a way to guarantee that and provide no perverse incentives. Also, the mental health of providers must be considered.

9a5c49a2 answered 1 week ago

Les hôpitaux doivent fournir la preuve que leurs médecins sont recyclés tous les ans ou tous les 2 ans (définir le crédit, et en fonction du budget disponible) sur un domaine de la médecine dans le service dans le quel il travaille : formation en ligne ou formation en présentiel sanctionné d'une certification. L'absence de formation continu du personnel médical ne contribue pas à l'amélioration de la qualité. L'organisation de journée scientifiques au sein de l'hôpital peuvent aussi être des alternatives. Dans la mesure du possible, on peut organiser également une formation du personnel infirmier, et autres paramédicaux sur le rappel de certaines notions de base.

`6a16d290` answered 1 week ago

Hospitals should support general practitioners and first-line health services to improve chronic care for a well-defined population in their catchment areas. A list of mandatory supportive activities to the primary settings should be set regarding clinical support, training, and shared healthcare that could be verified through clinical and administrative audits.

`c8b8aeb4` answered 1 week ago

The hospitals could have a management agreement with other providers or a common operational planning in which common objectives, complementary actions, communication circuits and evaluation activities are defined. This dynamic can also receive the support of a meso management institution (such as the Regional Health District).

`4773a988` answered 1 week ago

☐ 1.8.4 — Hospitals, financing of extra costs

(Page 8)

EN

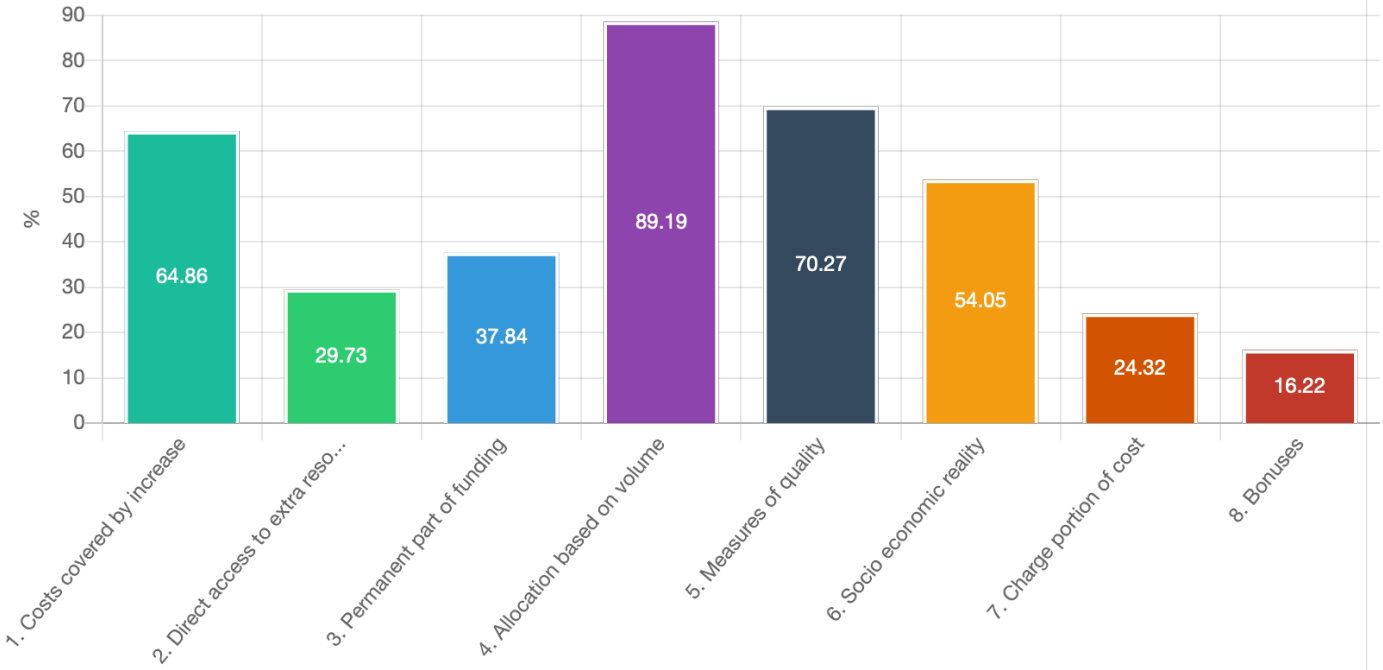
Imagine a hospital adding a chronic care/non-communicable disease capacity to its existing one in compliance with the requirements you have just proposed. How would you finance the extra costs?

As a baseline position, consider the following: the hospital receives its inputs in kind (equipment, medicines, staff...) and has access to a line-item budget for some running cost expenses.

Please make the combination of options you prefer.

[multiple answers possible]

1.8.4 — Hospitals, financing of extra costs



Choices	#
1. Costs covered by increase	24 (64.86 %)
2. Direct access to extra resourc	11 (29.73 %)
3. Permanent part of funding	14 (37.84 %)
Participants	**37**
Total	**143**

Choices	#
4. Allocation based on volume	33 (89.19 %)
5. Measures of quality	26 (70.27 %)
6. Socio economic reality	20 (54.05 %)
7. Charge portion of cost	9 (24.32 %)
8. Bonuses	6 (16.22 %)
Participants	**37**
Total	**143**

1.8.5 — Hospitals and financing of extra costs (Page 8)

EN

Imagine a hospital adding a chronic care/non-communicable disease capacity to its existing one in compliance with the requirements you have just proposed. Suggest other payment models or make comments on this list of propositions:

1.8.5 — Hospitals and financing of extra costs

Bundled payment models. However this wouldbnot ideally be administere dthrough hospital. Need primary care gatekeeper/ budget holder model.

760ac409 answered 2 weeks ago

In general, hospitalizations should be reduced, as up to 80% of requests should be handled at a new PHC. Hospitalizations should be reserved for the treatment of complications of chronic diseases. It is necessary to have contracted packages of health care services and treatments, according to diagnoses and conditions, which of course can and must be flexible, considering the type and nature of the disease, taking into account other determinants of health (age, gender, comorbidity, etc.). These payments can go either from regular health insurance or solidarity funds established in the country.

9f0db521 answered 2 weeks ago

The same network-based payment model recommended earlier for public health centers, including the referral hospital.

61e45e05 answered 2 weeks ago

I would add capacities and resources to enable the provision of additional services as part of routine work. I would absolutely avoid the introduction of extraneous / additional incentive arrangements (like condition or specific kinds of care linked compensations of whatever/any kind) as they are likely to disrupt existing arrangements negatively in the long run.

560d961f answered 1 week ago

-- I would ensure that the financing available to the hospital would not create perverse incentives to poach patients from other levels of healthcare or at-home support services. -- I would ensure that the financing available to the hospital for chronic care/NCDs is one that encourages coordination and shared incentives with the full range of providers involved in identifying, managing, and treating patients with these conditions (that is, to assure patient-centeredness and coordination of care).

b0dba773 answered 1 week ago

---

the additional payment for chronic conditions could be disbursed as a 'bundled or global payment', covering costs for care delivery to all providers involved in the patient's chronic care delivery. This could include primary, hospital, tertiary and social care. Furthermore, this bundled or global payment could have additional quality metrics tied in as well as a 'shared savings' and/ or risk-adjustment for high-cost patients.

18480606 answered 1 week ago

I will ensure the processes for the patient journey in the hospital get mapped explicitly and that all the resources needed for the best possible patient experience get identified and considered in the resources allocated to the hospital.

9a5c49a2 answered 1 week ago

-

a77d36f9 answered 1 week ago

---

1. rich patients pay more 2.organize a system of mutual insurance between patients 3.organize a system of mutual insurance between the families of the patients

9209cb8f answered 1 week ago

En complément aux réponses formulées ci-haut, je pense qu'il faut proposer un modèle mixte d'une part agissant sur la réduction ou suppression de frais de douanes pour l'importation des intrants de prise en charge du diabète afin de contribuer à la réduction du prix de revient, et d'autre part, mettre en place de mesures de solidarités couplées à une subvention plafonnée de l'hôpital moyennant le volume de patients suivis, le volume de cas de complications suivis. Cette subvention plafonnée peut-être également mixte sous forme d'apport en intrants en nature et apport financier pour couvrir les frais de fonctionnement de l'institution pour ne pas influer sur l'accès financier aux soins des patients.

6a16d290 answered 1 week ago

One approach is to have hospital budgets being set e.g. budget = casemix * volume * national standardized base payment. Funding for chronic care services would be integrated alongside other services.

81dd720d answered 1 week ago

payment for performance

7dba40b8 answered 1 week ago

I would pilot a complementary transfer based on performance for example. Hospitals are still financed through global or line-item budgets.

4773a988 answered 1 week ago

Per-service payments would lead to high administrative time and likely hospitals forgoing participation. For this reason, I selected options that are more consistent and permanent.

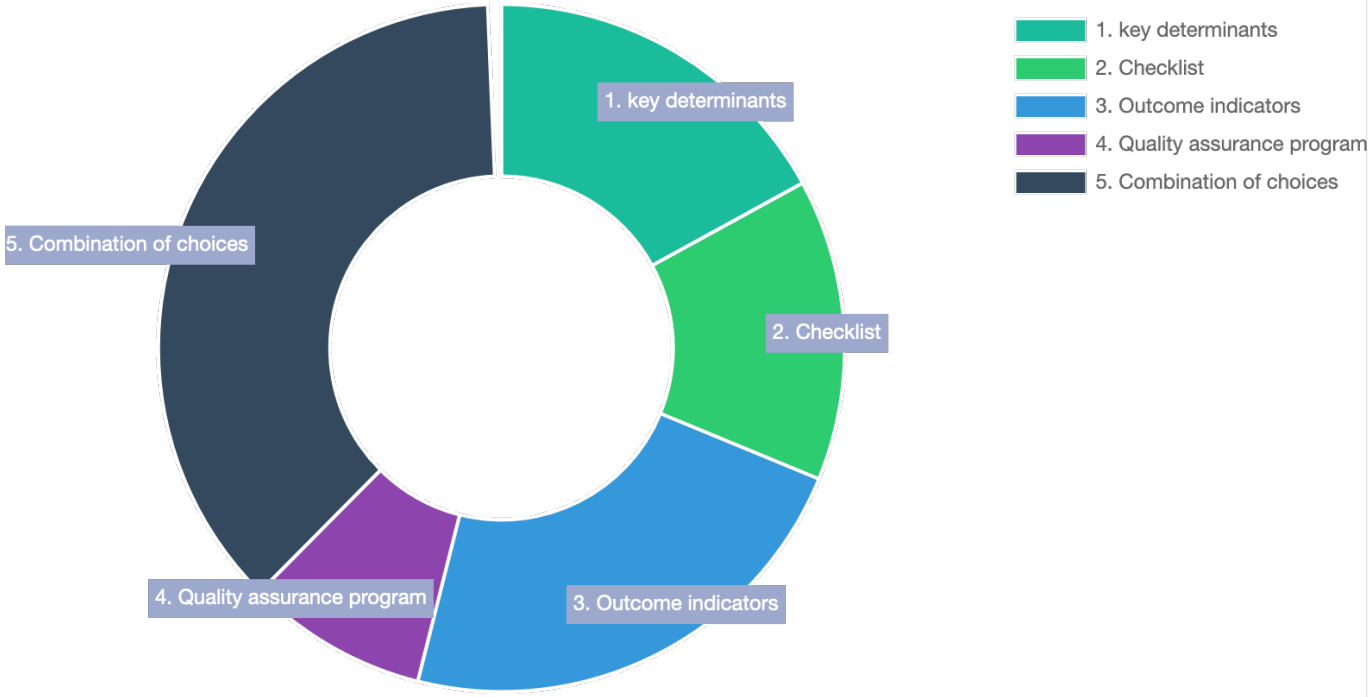
495ce785 answered 6 days ago

○ 1.8.6 — Hospitals, renumeration according to quality (Page 8)

EN

Imagine that there is a remuneration according to quality of services in a hospital, how would you do that?

1.8.6 — Hospitals, renumeration according to quality



Choices	#
1. key determinants	6 (17.14 %)
2. Checklist	5 (14.29 %)
3. Outcome indicators	8 (22.86 %)
4. Quality assurance program	3 (8.57 %)
5. Combination of choices	13 (37.14 %)
Total	**35**

1.8.7 — Hospitals, renumeration according to quality (Page 8)

EN

If you have selected “a combination of the ideas listed above” in the previous question, please report which combination. Feel also free to propose other options.

1.8.7 — Hospitals, renumeration according to quality

I would add capacities and resources to enable the provision of additional services as part of routine work. I would absolutely avoid the introduction of extraneous / additional incentive arrangements (like condition or specific kinds of care linked compensations of whatever/any kind - i.e the kinds of things listed as options above) as they are likely to disrupt existing arrangements (negatively in the long run). Not having 'none of the above' (or an option which clearly offers the option not linking remuneration to performance) as an option as an answer to the question is problematic. I would not link remuneration to quantity or quality of services along any of the lines/options listed above. In my view, and I think the evidence and theory bear this view out, this is not an effective and sustainable approach in the long run. It creates problematic incentive structures and dynamics and unleashes forces that are negatively disruptive in the long run and at the system level. In my view, and I think the evidence and theory bear it out, that this is not an effective and sustainable approach in the long run.

`560d961f` answered 1 week ago

I would combine the first and third proposals listed here. 1. An accreditation system for key determinants (including staffing and demonstrated staff knowledge) that would generate periodic and moderate payments over a 2-3 year period. But I would also include in this an annual (short and low cost) visit by peers to (a) assess the key determinants are in place (b) provide feedback and recommendations on improvements. Then, at the end of the period, the accreditation payments would only continue if in addition to the key determinants, there were progress on the recommended improvements. 2. A limited list of process or outcome indicators would trigger annual bonuses *in proportion* to the progress on those indicators. I think it is essential not to establish thresholds, but rather pro-rate bonuses to the amount of success achieved. The list should be reviewed periodically as hospitals make progress, allowing successful areas to be dropped and new areas to be included. Instead of spot checks, I would establish a much more rigorous and ongoing process of verification. However, I would also assure some annual review with peers or experts to do problem-solving with respect to the degree of success or failure in improving performance.

`b0dba773` answered 1 week ago

In Cambodia there is a mix of the first two options. They are both implemented results-based.

`4be93ebb` answered 1 week ago

The patient experience must be integrated.

9a5c49a2 answered 1 week ago

I would combine: payment of quality of care (checklist) and payment of process/outcome indicators.

d123bd0f answered 1 week ago

As per health center response.

a77d36f9 answered 1 week ago

Je ne suis pas favorable au processus de bonus qualité qui exige d'avoir des hommes honnêtes sinon il va produire un effet contraire à celui recherché. Peut-être pour pousser l'hôpital à maintenir un niveau de qualité raisonnablement bien, il faut peut-être réfléchir sur les accréditations des structures de prise en charge du diabète qui devra prendre en compte des critères suivants : formation et recyclage du personnel de la structure, disponibilité des équipements de diagnostic et de suivi conformément au mandat de la structure avec un personnel capable de manipuler, contrôle qualité ou assurance qualité de service laboratoire (service d'appui à la PEC), etc.... On peut encore discuter sur la durée de cette accréditation sur base de rapport annuel de suivi.

6a16d290 answered 1 week ago

I would establish a quality assurance system for chronic care following regional and international basic standards for groups of risks and diseases. It will be coupled with financial incentives if critical determinants of the quality of regular care are achieved yearly.

c8b8aeb4 answered 1 week ago

One approach is to combine a checklist and process-outcome indicators. Passing the checklist would be a prerequisite for continuing contracting the hospital. A mix of a few well-studied and monitored processes and outcomes would be used to determine hospital performance, and ideally compare the hospital to its own historical self, and incentivize (financially/non-financially) its continuous improvement.

81dd720d answered 1 week ago

Verification of a communicated a list of key determinants of quality of care and outcome indicators on a yearly basis, granting accordingly a quality payment to the hospital for one year.

db7d89a4 answered 1 week ago

I would establish a list of determinants of quality of care (checklist), communicate the list to candidate hospitals, organize independent verification for instance every three months, score the hospital and then grant a quality payment to the health center for the covered period. I would establish a limited list of process or outcome indicators (e.g., proportion of counter-referral feedbacks given to first line facilities, correctly completed patient file), communicate these metrics to the hospital management, review their clinical data (for instance, via the digital system) and then grant the hospital a bonus for the covered period of time (e.g., once a year). Some public officers would do spot checks to ensure that data is not gamed by hospitals (e.g., over-coding under a Disease-Related Group system).

4773a988 answered 1 week ago

1 and 3

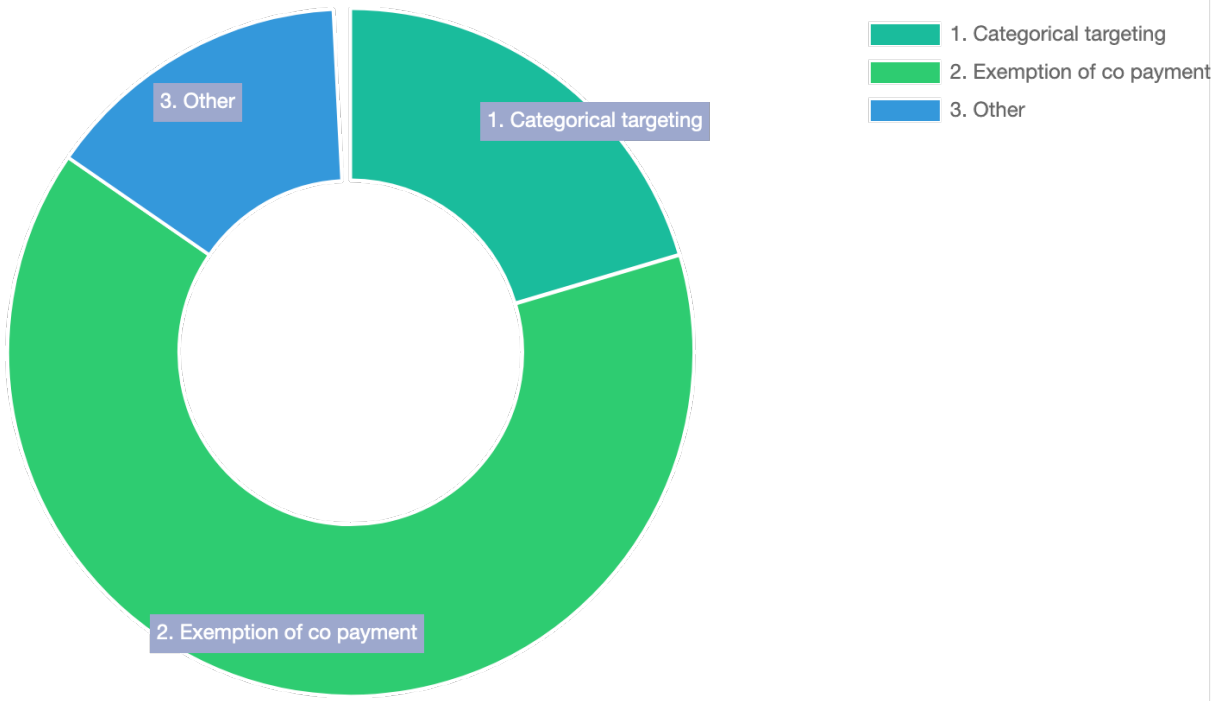
495ce785 answered 6 days ago

1.8.8 — Hospitals and renumeration, avoid catastrophic (Page 8)

EN

If fees are charged, which mechanisms would you recommend to protect some patients to incur catastrophic health care expenditure or to forego/interrupting treatment?

1.8.8 — Hospitals and renumeration, avoid catastrophic



Choices	#
1. Categorical targeting	7 (20.59 %)
2. Exemption of co payment	22 (64.71 %)
3. Other	5 (14.71 %)
Total	**34**

1.8.9 — Hospitals and charging of user fees, avoid catastr (Page 8)

EN

Develop, if 'other'.

1.8.9 — Hospitals and charging of user fees, avoid catastr

No user fees but fax based system

59191835 answered 2 weeks ago

Option 1 is attractive as well, but can only choose one. Would do a combination of 1 and 2.

48319912 answered 2 weeks ago

I would combine expemption of co-payments for patients identified as vulnerable and reimbursement to the hospital by a third-party WITH a direct cash transfer to the patient (possibly conditional on their participation in their care management). Co-payments are only one of the many costs to poor or vulnerable people which lead to catastrophic expenditures or declines in well-being. Transportation costs, time off from work, finding childcare for children, etc. are all burdens on people with multiple vulnerabilities and a cash transfer is the most flexible and empowering way to address this. The cash transfers could be unconditional or conditional on participation in their care management. There are pros and cons associated with each of those options that would have to be assessed in terms of the political, financial, cultural, and psychosocial context.

b0dba773 answered 1 week ago

Co-pay intentionally priced to discourage abuse and consumption of otherwise free services, but not more than that.

925fb5e0 answered 1 week ago

Les deux propositions sont possibles. La subvention publique reste un vrai défi pour les pays revenu, y compris l'exemption de la quote-part pour les patients identifiés comme vulnérables. Je proposerai de coupler ces approches avec des actions en amont : - Agir sur les pesanteurs qui peuvent influer sur le prix (taxes ou frais de douanes, frais de transport ou stockage des intrants ...): l'état peut subventionner à ce niveau - organiser l'assurance maladie des personnes indépendants (économie informelle) qui constitue une majorité de l'emploi dans les pays à faible revenu pour subvention ces mutuelles, et ce paquet de soins spécifiques - Au niveau de la structure, éviter la tarification à l'acte (mais opter pour le forfait). Définir un plafond de subvention à apporter en fx de la taille de l'HGR. Cela ferait partie d'une convention pluri annuelle. - La définition de vulnérables ou indigents est tjrs une casse tête en Afrique. Je n'ai pas la meilleure approche. On peut également soulager les patients en définissant une règle de solidarité dans la fixation de prix. Si on estime que 5% de patients de la structure sont indigents. On identifie un % de patients par ex qui auront besoin d'insuline par mois. On ajoute le coût total de ce patients sur le besoin global de tous les patients. Le prix fixé acheté par un patient permettrait de prendre en charge Ces indigents qui auront gratuitement l'insuline. Cette approche est déjà utilisé en RDC depuis près de 40 ans (dans certaines fosa du réseau BDOM Kinshasa).

6a16d290 answered 1 week ago

○ 1.9.1 — telemedicine consultation for

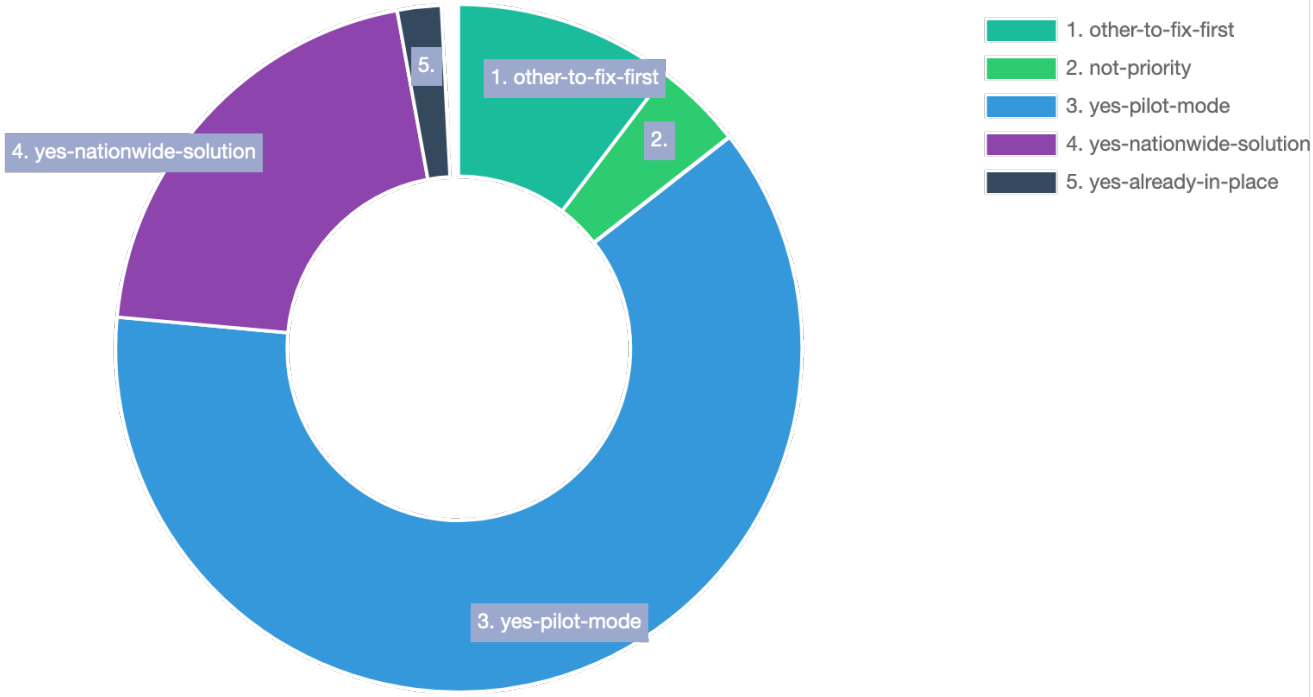
chronic care. (Page 9)

EN

During the COVID crisis, many countries experimented with telemedicine consultation for chronic care.

Do you think that national authorities should now institutionalize this delivery option for persons with a chronic condition, including by purchasing that service with pooled fund?

1.9.1 — telemedicine consultation for chronic care.



Choices	#
1. other-to-fix-first	5 (10.42 %)
2. not-priority	2 (4.17 %)
3. yes-pilot-mode	30 (62.5 %)
4. yes-nationwide-solution	10 (20.83 %)
5. yes-already-in-place	1 (2.08 %)
Total	**48**

1.9.2 — telemedicine consultation for chronic care open (Page 9)

EN

What conditions would you put to ensure that telemedicine supports quality chronic care?

1.9.2 — telemedicine consultation for chronic care open

chronic disease

760ac409 answered 2 weeks ago

1. Infra-structure to deliver telemedicine is not only in place but is accessible and affordable for example data is available 2. Networks are created to ensure care pathways which are most convenient for patients and their families eg accessible up referral 3. HCWs and patients alike are informed of the service. 4. The service is monitored on a quarterly basis and a mechanism is in place to fix challenges

17b7b82a answered 2 weeks ago

Qualified and certified professionals providing this route of care.

59191835 answered 2 weeks ago

Well-educated health staff, primarily nurses, who would have regular contact with chronic patients - consultations, health condition monitoring, triage

9f0db521 answered 2 weeks ago

Define visits that qualify because quality is not significantly impacted, as they do not require physical examinations; introduce clinical audits of random sample of visits; not pay per visit to avoid rewarding quantity over quality; introduce clear guidelines for telemedicine visits.

61e45e05 answered 2 weeks ago

Managers (and the powerful accountants) of/at insurance companies (public pooled funds and private insurance companies alike) are likely to easily narrowly see telemedicine as a cost cutting opportunity. While telemedicine does offer efficiency (and accessibility) related benefits, the risks to quality of care and responsiveness of services need to be systematically carefully looked at before institutionalizing this delivery option. Robust checks and balances should be in place to check (both public and private insurers) tendencies to narrowly focus on cost related efficiencies at the expense of quality of care, people-centeredness, and responsiveness of services.

`560d961f` answered 1 week ago

It should be for continuing care for clients how have had an initial specialist assessment in person. It can also been used to discuss cases with primary care.

`865f9c1e` answered 2 weeks ago

That all the pre-requisites for providing quality care at the levels of care engaged in telemedicine are ensured prior to starting telemedicine. For example ensuring qualified professionals are providing the services, quality assurance would need to happen on a regular basis, etc.

`48319912` answered 2 weeks ago

---

i don't believe this leads to better care. It should only be used if a physical encounter is not possible but it should not be promoted as alternative to a physical encounter.

`e39890ca` answered 2 weeks ago

Accessibility to the necessary technological tools in parallel to mechanisms to guarantee access to in person care when necessary. In parallel training for healthcare workers and information to populations about this new mode of delivery of care.

`9ec4643f` answered 2 weeks ago

I would institute a system to regularly survey and study the health *outcomes* for people using telemedicine supports and conduct research or investigations for individuals or groups whose health outcomes are not demonstrating the expected benefits from care. This would generate immediate benefits from telemedicine while establishing a critical learning loop. I much prefer this to holding off on using this technology UNTIL it is proven effective. We know it was used effectively for many people during the pandemic, so we have proof of concept. It is now time to roll it out but with a strong learning, adaptation, correction, cycle in place.

`b0dba773` answered 1 week ago

In my country there are a lot of logistics challenges, to ensure telemedicine is put in place with quality: - power instability - human ressources lack informatic knowledge - informatic equipments - internet capacity on services - health workers motivation - health authorities engagement

fd6fba5e answered 1 week ago

A side note on this: there are various solutions to telemedicine, some of which can be guided through handheld devices. In Cambodia we are implementing low dose high frequency type of trainings for a set of frequent conditions, including non-communicable diseases such as chronic care conditions, and accidents. We use handheld devices for these, and incentivize good performance by linking results of these knowledge and competency assessments to health facility financing (and trickle down incentives for health workers)

4be93ebb answered 1 week ago

Standardized guidelines, flexibility for appropriate referrals for severe illness, to ensure equity infrastructure development to promote telemedicine, trained health care providers and running campaigns among target users to sensitize them about telehealth approaches, benefits, and costs involved.

99c5f18c answered 1 week ago

- Evidence on the effect of telemedicine on chronic care is still inconsistent in these settings. This should be the first step towards using telemedicine to support chronic care. - Health staff should be properly trained, with good referral systems in place - The necessary facilities needed to ensure smooth and effective operationalization of telemedicine should be in place

da55c53c answered 1 week ago

Any chronic condition to ensure continuous patient engagement in managing their disease, medicine adherence, opportunity to ask questions and communicate exacerbations and worries, nutritional and psychological support. Electronic option for patients to track symptoms and outcomes, e.g. in form of patient diary which can be shared with the clinician remotely.

18480606 answered 1 week ago

There needs to be a good electronic MIS in place that follow the patient. Providers of telemedicine services need to be able to refer upstream and downstream for chronic care services needed.

bbe6c1f7 answered 1 week ago

Not sure as I am not that familiar with telemedicine

d123bd0f answered 1 week ago

Basic standards for good outcomes from the telemedicine, partly to educate (eg stipulation that resolutions must be adequate for visual diagnosis where needed) and partly to enforce (eg to avoid rank malpractice).

925fb5e0 answered 1 week ago

Prioritisation would depend on country context. Overarching need to prioritise population's left behind and telemedicine risks further impeeding access to care for at risk populations. Need for strong referral mechanisms. For continuum of care (prevention through to palliative care) to be considered in any telemedicine support - including diagnostics and access to medicine.

a77d36f9 answered 1 week ago

Key NCDs that benefit from behavioral change and self-management, e.g., hypertension, diabetes

edc53c5f answered 1 week ago

Physical appointments/assessments should still be required, but on a less frequent basis (eg. yearly or as needed). Digital literacy and subsidies for digital devices should be provided to low income households (if considering publicly managed finances) to improve equity in access. Payment should be tied to quality outcomes rather than volume of services.

98e18de7 answered 1 week ago

Legal frameworks that ensure the ethical use of telemedicine and link ethical usage to contract arrangements can improve the (ethical) quality of telemedicine services, e.g., protection of privacy, information security, etc.

ccc22852 answered 1 week ago

the presence of electricity the presence of internet connection

9209cb8f answered 1 week ago

La RDC a un vrai défis pour améliorer la couverture géographique de l'accès aux soins de qualité des maladies chroniques. Il y a des initiatives de ce genre mais c'est surtout envers un patient connu du CS et déjà suivi dans une formation sanitaire. Cette approche pourrait être intéressante surtout pour les cas de référence des centres

de santé vers l'HGR. Les distances sont parfois énormes (50 à 100 km). A l'instar d'autres approches similaires expérimentées par Memisa belgique dans la zone de santé de Kingandu (au Bandundu) en santé maternelle. ce serait une belle initiative. Les conditions préalables et défis restent la couverture en internet de bonne qualité (au- moins 4G), l'électricité pour charger les téléphones. L'usage de VSAT serait très couteux et insupportable financièrement pour les équipes locales.

`6a16d290` answered 1 week ago

- Telemedicine could not be the only way to provide chronic care and can not replace primary healthcare teams. - In Latin America, Telemedicine could be particularly useful in providing specialized support for better chronic care in rural settings and urban disadvantaged populations. - A robust primary healthcare team should coordinate telemedicine services for its population in charge. - The rules for telemedicine must aim to reinforce team-based care in the PHC teams and between them and the specialists. - Telemedicine should also be used to enhance the quality of continued medical education in quality chronic care.

`c8b8aeb4` answered 1 week ago

Above all, the infrastructure available, including internet, interface and electricity.

`81dd720d` answered 1 week ago

To be part of a comprehensive approach that includes the following elements: - Proper regulatory framework - Clear care pathways - Clinical guideline to perform telehealth - Training HR - Explicit inclusion of telehealth services into Benefit Packages and aligned financial incentives - Interoperable electronic patient record system - Formal definition of roles and responsibilities among health facility staff - Change management strategy - Patient education

`4773a988` answered 1 week ago

- Infrastructure to support telemedicine roll out - Train and equip health workers with the capacity to deploy telemedicine - Budgetary allocation to support telemedicine -Collaboration between the various MOH and the health departments with the various telcos to ensure access to internet and other telecommunication services

`b06feadc` answered 1 week ago

When we don't have a specialization in the unit and or are/or city. for dialogue or 2nd diagnoses/ discussions of selected cases to better support the health team at any time to develop capacity of the workforce to disseminate and tech new and revised protocols

`7dba40b8` answered 1 week ago

- Telemedicine expert responders have the appropriate expertise in NCD and communication skills. - A system to update the services/packages and referral/contra referral possibilities of the different health centers is in place. - Indications for use of the telemedicine platform are clear. - Medical confidentiality and data protection are ensured; - Consent procedure from patient is in place - There are no financial links between the health staff asking for advice/support and the telemedicine expert responders - There is a feedback mechanism - health staff asking for advice/support can comment on the advice received, - health staff asking for advice/support can report patient outcome to the experts, - Expert responders can have peer meetings and with the health authorities about major challenges/constraints encounters

db7d89a4 answered 1 week ago

Random audits of the consultation (with patient consent) and patient surveys

495ce785 answered 6 days ago

Many! Chronic care requires largely care navigation and companionship and little of 'clinical' care. I am thinking of diabetes, dementia, rheumatological conditions, mental health conditions, etc.

93089cc1 answered 1 day ago

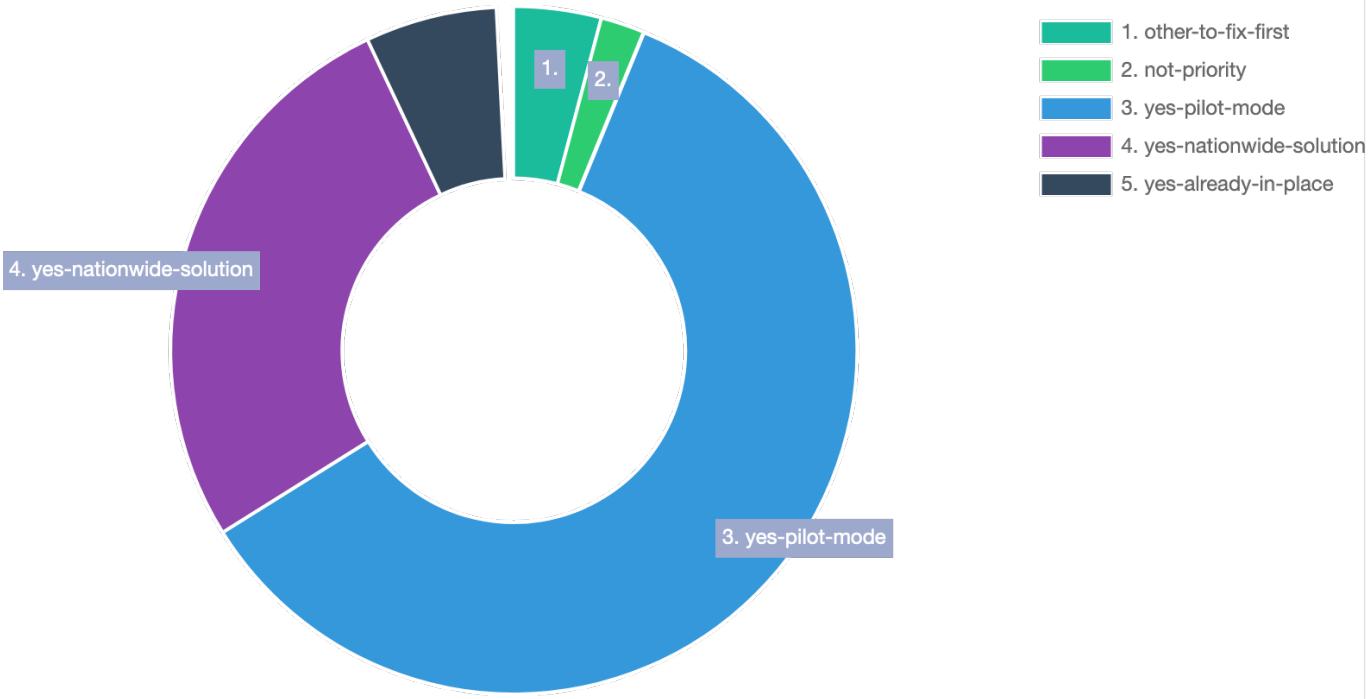
1.9.3 — telehealth interaction between frontline (Page 9)

EN

Another track, for instance for health facilities in isolated areas, is to favor telehealth interaction between frontline doctors and specialists as a support for better diagnosis.

Do you think that national authorities should institutionalize this model by purchasing that service with pooled fund (including possibly from specialists based abroad)?

1.9.3 — telehealth interaction between frontline



Choices	#
1. other-to-fix-first	2 (4.17 %)
2. not-priority	1 (2.08 %)
3. yes-pilot-mode	29 (60.42 %)
4. yes-nationwide-solution	13 (27.08 %)
5. yes-already-in-place	3 (6.25 %)
Total	**48**

1.9.4 — telehealth interaction between frontline other (Page 9)

EN
What conditions would you put to ensure that such telehealth support contributes to quality chronic care?

1.9.4 — telehealth interaction between frontline other

Chronic conditions

760ac409 answered 2 weeks ago

1. Buy in from all relevant health care workers and patients/families alike 2. Involvement of non-governmental/patient organizations 3. Involvement of professional associations/ societies 4. Certification mechanisms for participation by specialists 5. Consider lessons from existing platforms example ECHO

17b7b82a answered 2 weeks ago

Well-educated health staff, primarily nurses, who would have regular contact with chronic patients - consultations, health condition monitoring, triage

9f0db521 answered 2 weeks ago

Outline cases where this interaction is recommended or required; delimit excluded cases; provide financial incentives for participation where necessary; introduce clear guidelines and train.

61e45e05 answered 2 weeks ago

In contexts where the provision of care in rural and remote areas is a big challenge, telemedicine certainly offers a way out. Robust checks and balances should however be in place to ensure the quality and responsiveness of services, and to also ensure that telemedicine is not used as a way to do away with/not provide regular in-person services.

560d961f answered 1 week ago

shared documentation ehr/access to results between primary care and hospital care.

865f9c1e answered 2 weeks ago

That all the pre-requisites for providing quality care at the levels of care engaged in telemedicine are ensured prior to starting telemedicine. For example ensuring qualified professionals are providing the services, quality assurance would need to happen on a regular basis, etc.

48319912 answered 2 weeks ago

For medical staff in remote areas, a connection to specialists based abroad may not be very helpful, but regular connection to more experienced colleagues in the capital or provincial capitals might. It would have to be tried out to find out what the best format is: vignettes, casestudis, theoretical, Q & A, colloquia, and which combinations of material, length, timing, and feedback/rewarding of the specialists.

`e39890ca` answered 2 weeks ago

First of all, I don't think it should just be between front-line doctors and specialists. I think it should also include front-line health or social workers and doctors in those areas where doctors are unavailable or health and social workers are helping patients managing their illnesses. The critical factor for me in this kind of financing arrangement is to make sure that it is demand-driven by the rural medical (or social) staff and to ensure that specialists and doctors who are being consulted do not have the capacity to induce demand. There are many ways to address this - none are perfect - but one promising thing to try is to give the rural staff a budget that can be used to pay for this kind of support. After receiving the support, their confirmation could trigger a payment from a third-party directly to the specialist.

`b0dba773` answered 1 week ago

At some of the places such arrangements are in place but not as a nation-wide policy/scale. Also, many times such arrangements are done through support from charities or corporate-social-responsibilities rather than through public policy as a rights-based approach

`0415ccbc` answered 1 week ago

The same conditions that the firts one. In my country we already have telemedicine with Portugal, but we can enhance this techonologie inside the country, for example between district and Principe.

`fd6fba5e` answered 1 week ago

---

see previous response

`4be93ebb` answered 1 week ago

Very similar criteria to the above response.

`99c5f18c` answered 1 week ago

---

any but especially for those conditions which include complex diagnosis and treatment pathways, as well as rare diseases with lack of local experience.

18480606 answered 1 week ago

There needs to be good internet services available as well as a functional electronic health information system that both frontline doctors and specialists are able to access. Providers of telemedicine services need to be able to refer upstream and downstream for chronic care services needed.

bbe6c1f7 answered 1 week ago

Maybe to ensure internet connectivity and availability of electronic devices, ensure capacity in using electronic devices.

d123bd0f answered 1 week ago

Prioritisation would depend on country context. May help in ensuring equity in access to quality services.

a77d36f9 answered 1 week ago

Routine screening and monitoring with established technology, e.g., eye exams

edc53c5f answered 1 week ago

Accreditation, licensing, use of clinical guidelines, and linking accreditation, licensing and use of clinical guidelines to contractual arrangements can ensure quality in telemedicine delivery. Use of health technology assessments in the decision-making process for the inclusion of certain types of telemedicine in the benefit packages of healthcare financing mechanisms (i.e., prepayment systems) can contribute to the effective use of telemedicine.

ccc22852 answered 1 week ago

the presence of electricity the presence of internet connection

9209cb8f answered 1 week ago

Cf. commentaires supra

6a16d290 answered 1 week ago

- Telemedicine services should accomplish clear indicators according to the chronic disease profile of definite populations. - The primary health care staff and the patients should periodically assess telemedicine services. - Supportive activities and continued training from telemedicine specialists to PHC staff should be mandatory and the subject of audits.

c8b8aeb4 answered 1 week ago

Above all, the infrastructure available, including internet, interface and electricity.

81dd720d answered 1 week ago

in critical cases, in emergencies, when the person is not able to travel to meet the specialized doctor

7dba40b8 answered 1 week ago

A comprehensive strategy as described in the previous answer. Telemedicine should not be considered as an isolated new tool but as a key component of the new care system. A well-oriented financing strategy that encourages the use of telehealth could be of great value but not sufficient.

4773a988 answered 1 week ago

- Telehealth supporters have sufficiently understood the local context: community/population groups; health sector and its resources (infrastructures, equipment, drug availability.... and the number and education level of staff) and options for referral and contra referral) - Language barriers are avoided or limited - Making use of telehealth support does not become a pre-requisite to obtain public funds.

db7d89a4 answered 1 week ago

Strong capacity to regulate online services.

5e94bb18 answered 5 days ago

As above.

93089cc1 answered 1 day ago

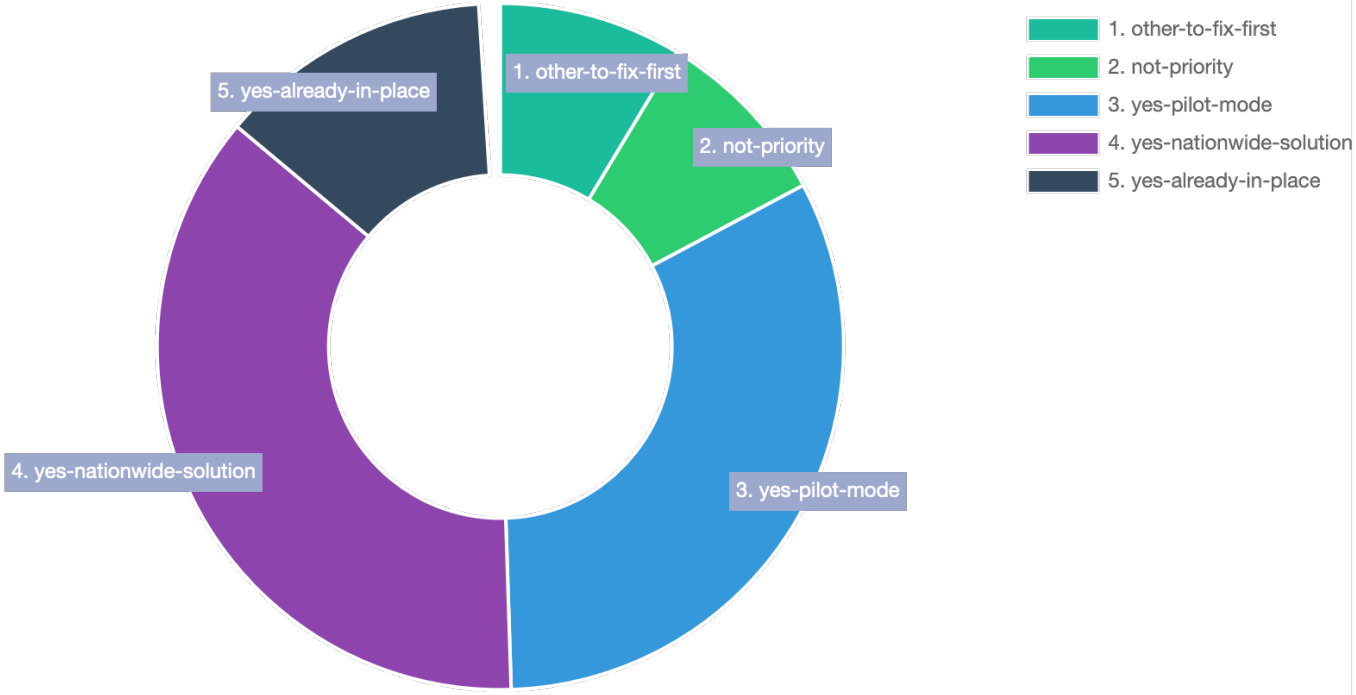
1.9.5 — Private retail pharmacies are important sources of (Page 9)

EN

Private retail pharmacies are important sources of treatment in LMICs, but often with little integration within the pooled fund system.

Do you think that national authorities should work on setting up arrangements to ensure that medicines bought there by persons with a chronic condition are at least partly covered by pooled fund?

1.9.5 — Private retail pharmacies are important sources of



Choices	#
1. other-to-fix-first	4 (8.7 %)
2. not-priority	4 (8.7 %)
3. yes-pilot-mode	15 (32.61 %)
4. yes-nationwide-solution	17 (36.96 %)
Total	**46**

Choices	#
5. yes-already-in-place	6 (13.04 %)
Total	**46**

1.9.6 — Private retail pharmacies are important sources of (Page 9)

EN
What conditions would you put to ensure that the pooled fund pays for quality medicines and quality services by retail pharmacies?

1.9.6 — Private retail pharmacies are important sources of

all conditions

760ac409 answered 2 weeks ago

All medicines on the National Essential Medicines List

17b7b82a answered 2 weeks ago

Defining the essential list of medicines, according to the real health needs and morbidity of the population, which is financed from public funds (insurance and/or budget)

9f0db521 answered 2 weeks ago

At least for prevalent NCDs, clinical guidelines to specify recommended medicines which informs reimbursement decisions by the purchaser via the essential list, including of prescriptions. E-prescriptions promotes monitoring of prescribing practices and makes approvals more efficent/easier to guard for quality. Requiring electronic prescriptions can be helpful.

61e45e05 answered 2 weeks ago

In most LMICs, private pharmacies are poorly regulated, and in many contexts, unregulatable given how things

stand. More upstream pharmaceutical supply chain related solutions are likely to be more feasible if one's intention is to ensure the quality of medical products and medicines. As regards the quality of services provided by retail pharmacies, pooled funds could attempt this, but it will probably be too much to take on / bite off for any pooled fund in most LMIC contexts. Perhaps at a later stage after some experience has been gained, and after some successes have been had.

`560d961f` answered 1 week ago

There is a defined list of benefits and conditions for authorising medicines.

`865f9c1e` answered 2 weeks ago

Entry requirements for retail pharmacies well-defined and communicated to candidate pharmacies; coordination mechanisms between public facilities and local pharmacies well defined (in both directions - pharmacies could refer patients to facilities for screening, and facilities to pharmacies for meds in the absence of meds at the public facility); some form of price negotiation and setting; pharmacies allowing some form of independent verification of quality/service delivery as part of the requirements. Figuring out what the effective carrots would be for retail pharmacies to be motivated to enroll would be important.

`48319912` answered 2 weeks ago

Only do this if adherence can be adequately monitored.

`e39890ca` answered 2 weeks ago

This is something I would recommend to start as a pilot because it is difficult to anticipate all the aspects of the contracts that need to be written, the types of funding required, and the kinds of institutional review and regulations that will be necessary. Nevertheless, in countries where people purchase their medications from private retail pharmacies AND in which government policy is aiming to take advantage of the benefits of incorporating private retail pharmacies, it is essentioal to have such mechanisms in place and to eventually make it available nationally. (The benefits can include lower prices due to competitive pressures and innovations in supply chain management, and greater resilience through diversified supply chains. Nevertheless, these benefits are not automatic. They probably require agile regulatory systems to prevent the emergence of monopolies and anti-competitive practices).

`b0dba773` answered 1 week ago

Purchase of medicines from private pharmacy is the driver for impoverishment - this must be covered given that medicines at public facilities are often out of stock or in deficits. However, unsure of best approaches. In India, governments have started a model wherein private pharmacy outlets are supported to provide generic medications or low-cost brand alternatives but clinicians often stick to brands and do not encourage generic prescriptions .....there seems to be huge profit margins on drugs as competitions in private pharmacy retail markets have opened up room for discounts offered by private pharmacies and an unfolding online retail

pharmacies...

0415ccbc answered 1 week ago

Need to have a supervision mechanism and a strong coordination across the services.

fd6fba5e answered 1 week ago

- Effective monitoring and evaluation

da55c53c answered 1 week ago

Conditions which allow for diagnostics, treatment and monitoring in retail pharmacies.

18480606 answered 1 week ago

Retails pharmacies should have access to the centralised patient health information system (parts of it) and there should be smart contracting in place between the pooled fund and retail pharmacies. Payment needs to support optimal levels of servicing and there should not be discrimination against public sector clients.

bbe6c1f7 answered 1 week ago

Data verification to avoid gaming/ false reporting Timely reporting/ data availability

d123bd0f answered 1 week ago

Would need to be linked to doctor's diagnosis and prescription, supporting regular review of the patient and quality assurance mechanisms for medicines and retail pharmacy.

a77d36f9 answered 1 week ago

Focus on generics; eliminate copays

edc53c5f answered 1 week ago

Accreditation and licensing of pharmacists/chemists/drug stores is important in the selection and contracting of service providers and to ensure service quality.

ccc22852 answered 1 week ago

---

this should be done with pharmacies in health centers or hospitals

9209cb8f answered 1 week ago

Il faut que le niveau national puisse accréditer des pharmacies provinciales ou zonales où une assurance de qualité des MEG a été certifiée. ce contrôle de certification devrait être réalisé tous les ans ou 2 ou 3 ans. Pour le cas de la RDC, il y a le Système nationale d'approvisionnement en médicament qui certifie uniquement les centrales de distribution régionale en médicaments (CDR) mais il faut refléchir sur la possible de définir les conditions de certification d'autres structures qui accepteraient de rejoindre ce standard. Quamed est expérimenté et peut apporter une expertise en la matière pour l'établissement des conditions optimales

6a16d290 answered 1 week ago

- Having a clear and strict policy for medicines' price control. - Formally integrating retail pharmacies with primary healthcare teams. - Determining clear supervision and control procedures for retail pharmacies to ensure the quality of medicines, the correct procurement, availability, and price control.

c8b8aeb4 answered 1 week ago

Besides infrastructure, there should be a strong emphasis on generics, and monitoring of patient fees at pharmacies to prevent abuse.

81dd720d answered 1 week ago

In the management of chronical diseases, patients spent time and money with transport and travels. it is easier for the patient to go to just one unit or small number of places. They should be placed locally - more than one in a region

7dba40b8 answered 1 week ago

- Quality assurance for procured NDC drugs and medical material. - Compliance with Good Storage and Distribution Practices. - Control (patients' feedback - cross sectional controls) of drug delivery to patients : drugs following prescriptions AND information/communication/education to the patient about the delivered drugs

db7d89a4 answered 1 week ago

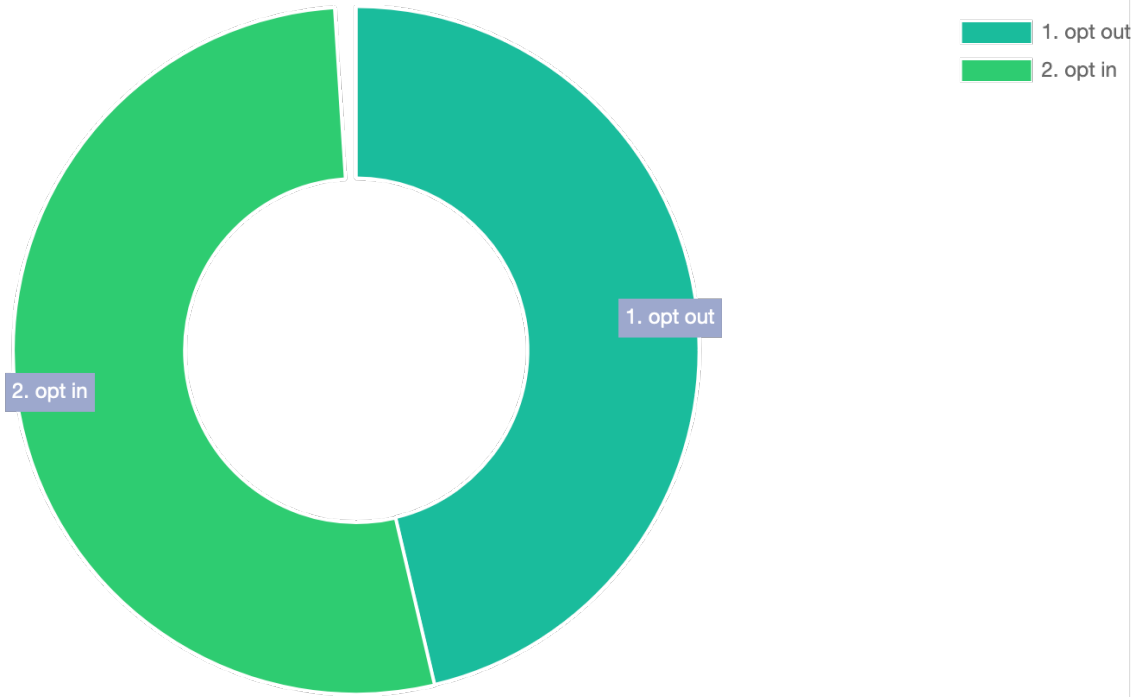
1.10.1 — Decentralized coordination bodies, opt out (Page 10)

EN

I lack information on decentralized coordination bodies and prefer to opt-out

If you choose to opt out of this question on coordinating bodies, please proceed directly to 1.10. on patients and caregivers

1.10.1 — Decentralized coordination bodies, opt out



Choices	#
1. opt out	22 (46.81 %)
2. opt in	25 (53.19 %)
Total	**47**

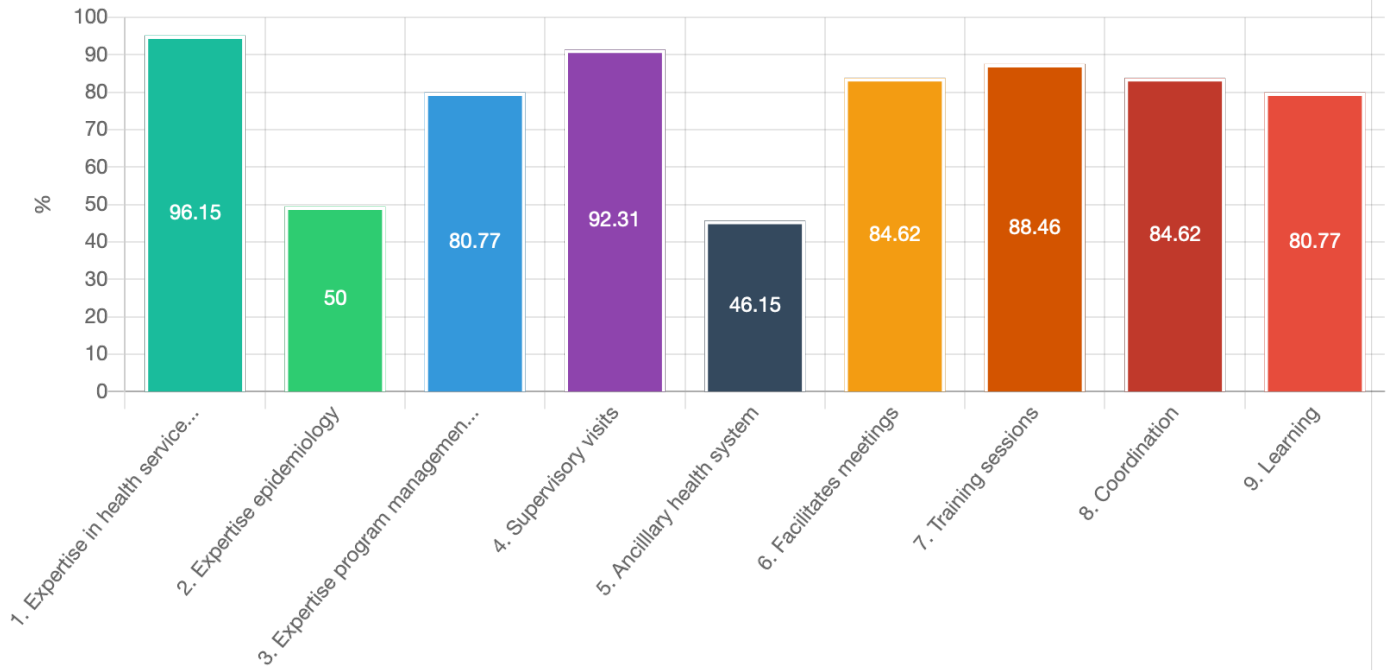
☐ 1.10.2 — Decentralized coordination bodies, determinants of (Page 10)

EN

Among all the following propositions on determinants of quality of care, tick those which should be put as a condition to ensure that coordination bodies make contributions to quality chronic care.

[multiple answers possible]

1.10.2 — Decentralized coordination bodies, determinants of



Choices	#
1. Expertise in health service de	25 (96.15 %)
Participants	**26**
Total	**183**

Choices	#
2. Expertise epidemiology	13 (50 %)
3. Expertise program management	21 (80.77 %)
4. Supervisory visits	24 (92.31 %)
5. Ancilllary health system	12 (46.15 %)
6. Facilitates meetings	22 (84.62 %)
7. Training sessions	23 (88.46 %)
8. Coordination	22 (84.62 %)
9. Learning	21 (80.77 %)
Participants	**26**
Total	**183**

1.10.3 — Decentralized coordination bodies, other condition (Page 10)

EN

Do you see other conditions which matter for coordination bodies to make contributions to quality chronic care? Feel free also to comment the list above.

1.10.3 — Decentralized coordination bodies, other condition

The coordinating body: 1. supports local health actors to find sustainable, systems based solutions to challenges for example poor clinical governance or lack of accountability to respond to patients with ongoing poor health outcomes/lack of control. 2. enables and supports multi-sectoral action at a local level. 3. regularly monitor medicine supply, maintenance of equipment etc.

17b7b82a answered 2 weeks ago

Coordination bodies like district offices, inter-local health zones are central to ensuring the provision of good quality care generally. Their role is particularly important for Chronic illness care as it requires ensuring that variety of providers work in coordination to deliver good quality care at appropriate level over extended periods of time. The currently existing bodies need to be strengthened to enable them to support the delivery of good quality care for chronic illnesses. new bodies / new platforms should only be created if careful examination suggests that current bodies are unlikely to be able to perform the new roles.

560d961f answered 1 week ago

The last two are the most important ones: to promote learning across the local health system and to facilitate coordination between healthcare providers.

b0dba773 answered 1 week ago

Often such coordination body limits its actions and oversight to public providers even though their mandate might include oversight of private providers - they often lack competence and legitimacy to deal with private providers... similarly, such coordination body often limits its function to coordinating health care with very limited or no coordination with social care provision including voluntary community resources....there has to be a body that coordinates, mediates and regulate all care providers in a given geographic/administrative area...

0415ccbc answered 1 week ago

The coordination bodies help define monitoring indicators for chronic diseases and put them in place at the health worker level.

fd6fba5e answered 1 week ago

In Cambodia, district and provincial health offices are subject to an internal performance contract with the Quality Assurance Office/MOH. Performance indicators relate to the execution of key administrative and health system functions, and also to supervision, and the semi-annual accreditation score assessments and knowledge and competency tests. The accreditation scores are based on a prior self-assessment of the health facility, and a counter-assessment of the conformity as assessed by the health administration (districts do health centers; provinces do hospitals). There is a third-party counter-verification of the district/province scores for both accreditation and knowledge/competency tests. The scoring/weighting is as follows: (1) Self assessment is 20% (the level of conformity between the self assessment and the "external" assessment by the district/province. This score is based on an 'all or nothing' criterion of the discrepancy between self-assessment and 'external' assessment being 5% or less); (2) accreditation "external" assessment 50% (administration's assessment); (3) And Vignette and Competency tests are 30%.

4be93ebb answered 1 week ago

Need for financial support to cover some of the duties in ensuring proper coordination (e.g. supervision, training, transport, etc.)

d123bd0f answered 1 week ago

l'équipe de coordination devra contribuer à la mise en place de l'information sanitaire qui soit capable de capter les informations pertinentes de suivi de patients : adhérence au traitement (régulier, perdue de vue, contrôle de la glycémie, contrôle de complications aigue ou chronique (Hypoglycémie, acido cétose, pied diabétique, ..), diabète gestationnel, ... L'équipe de coordination devra introduire l'analyse de l'information sanitaire lors de monitorage de zones, ou revue des zones

6a16d290 answered 1 week ago

The coordination bodies should fulfill surveillance, supervision, and control activities. In addition, they should count on legal instruments to lead and coordinate the different actors involved in chronic care, being able to take corrective measures. They should also oversee the quality assurance programs and the continued training of the PHC teams on quality chronic care.

c8b8aeb4 answered 1 week ago

To play this role, Coordinations bodies need to be strengthened in terms of budgets and they should evolve in terms of organizational architecture, managerial capacities and tools

4773a988 answered 1 week ago

for critical cases (people living alone, in poor conditions, for instance) - the coordination body could have a group of managers helping people to manage their diseases (making appointments in units with distinct levels of care (social care included, if needed), making sure they get to appointments - follow up in many forms).

7dba40b8 answered 1 week ago

Coordination is funded.

5e94bb18 answered 5 days ago

☐ 1.10.4 — Decentralized coordination bodies, financing (Page 10)

EN

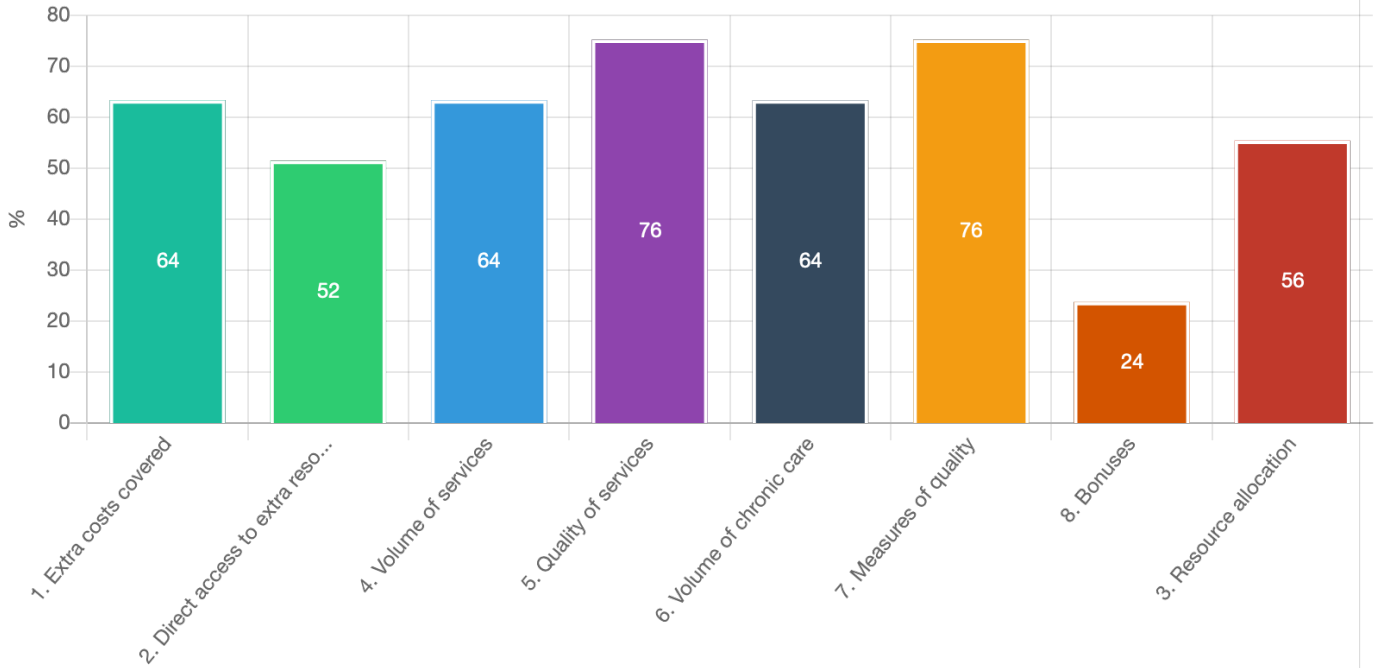
Imagine a decentralized coordination body developing leadership and skills on chronic conditions in compliance with the requirements you have just proposed. How would you finance the extra costs?

As a baseline position, consider the following: the district office receives its inputs in kind (vehicles, equipment, staff...) and has access to a line-item budget for running cost expenses (e.g., fuel, maintenance).

Please make the combination of options you prefer.

[Multiple answers possible]

1.10.4 — Decentralized coordination bodies, financing



Choices	#
1. Extra costs covered	16 (64 %)
Participants	**25**
Total	**119**

Choices	#
2. Direct access to extra resourc	13 (52 %)
4. Volume of services	16 (64 %)
5. Quality of services	19 (76 %)
6. Volume of chronic care	16 (64 %)
7. Measures of quality	19 (76 %)
8. Bonuses	6 (24 %)
3. Resource allocation	14 (56 %)
Participants	**25**
Total	**119**

1.10.5 — Decentralized coordination bodies, financing (Page 10)

EN

Aside from those listed above, please write down other conditions you have in mind which would matter for coordination bodies to make contributions to quality of care. Please feel free to also comment on the list provided.

1.10.5 — Decentralized coordination bodies, financing

(Contributions must be systems based and encompassed in national policy)

17b7b82a answered 2 weeks ago

A yearly independent financial audit; Published Finances and annual accounts on a website After its first year a mixed methods survey on the functioning and added value of the coordination body interviewing main stakeholders with recommendations.

e39890ca answered 2 weeks ago

The coordination bodies must be entitled to a nominative list of citizens.

9a5c49a2 answered 1 week ago

Need to ensure strategic allocation of resources – account for volume and quality of care

d123bd0f answered 1 week ago

Une seule crainte est la verticalisation des appuis. Essayons de proposer un modèle d'appui du système dans lequel on souhaite la prise en charge des MNT est prise en compte autant que les pathologies transmissibles.

6a16d290 answered 1 week ago

They should be highly qualified and recruited by merit through a nationwide recruitment process. In addition, they must be well-paid and also supervised by territorial health authorities to ensure motivation and quality performance.

c8b8aeb4 answered 1 week ago

1.10.6 — Decentralized models of care, financing (Page 10)

EN

If you have selected options 3, or 4, or 5 or 6 among your choices, please explain how you would do that.

Reminder of the choices:

( ) 3. I would ensure that the allocation to the coordination body takes into account the volume of services it delivers for or on behalf of the local health system under its responsibility (e.g., the number of supervision visits).

( ) 4. I would ensure that the resource allocation to the coordination body takes into account the quality of services it delivers for or on behalf of the local health system under its responsibility (e.g., completeness and timeliness of data reported to the national NCD program.

( ) 5. I would ensure that the resource allocation to the coordination body takes into account the volume of chronic care services delivered by facilities under its responsibility.

( ) 6. I would ensure that the allocation to the coordination body takes into account some measures of the quality of the chronic care services delivered by facilities under its responsibility (e.g. availability of medicines for chronic conditions).

1.10.6 — Decentralized models of care, financing

N/A

17b7b82a answered 2 weeks ago

resource allocations should be linked to improve the causes or modulators behind low service volumes and sustain needed capacities needed to ensure high service volumes don't exhaust facilities.

815d558b answered 2 weeks ago

For 3) it relates to a workplan For 4) based on indicators for timeliness and completeness For 5) based on a high estimate that is an average of several existing models For 6) patient satisfaction surveys, outcome data, service spot check data, analysis of supply data.

e39890ca answered 2 weeks ago

[#4 and #5 seem to be reversed so I'm copying out the answer that i checked here: I would ensure that the

resource allocation to the coordination body takes into account the quality of services it delivers for or in behalf of the local health system under its responsibility (e.g., completeness and timeliness of data reported to the national NCD program.] I would recommend providing the coordinating body with a 3-part annual payment: 1. The largest share would be a fixed payment. 2. An additional share would be contingent on certain threshold requirements like completeness and timeliness of data reporting, financial reporting, staffing, and activities. 3. The final share would be a bonus in proportion to progress on a small number of quality indicators. Initially, these might include things like share of population that has been screened for diabetes and hypertension and who have started their disease management regimen. If the area is actually achieving high rates of identifying and starting patients, the indicators should instead reflect the share of those under care who have achieved appropriate health indicators (blood sugar, blood pressure).

`b0dba773` answered 1 week ago

---

3. A good M&E Framework 4. An independent committee to oversee the whole plan 5. Maintain a good communication strategy

`32f8706f` answered 1 week ago

Need to have a strong health information system, that provide information basis on the surveillance chronic care for the facilities indicators defined by the national guidelines. Need to measure the work performed by the health facilities and then define the allocation according with the propositions above.

`fd6fba5e` answered 1 week ago

I take the Cambodian use case here. Geographical equity adjustments and size of districts and travel times are important cost factors for the District. Health services are delivered by the health facility and NOT by the administrative entity, and therefore, holding the administrative entity responsible for volume of service delivered by the public health facility, is not logical.

`4be93ebb` answered 1 week ago

The coordination bodies must be entitled to a nominative list of citizens. The coordination body must be held accountable for the health outcome of each citizen on his list. Timely high-level aggregate indicators must be computed and compared across coordination units to bench-mark performance across coordination units.

`9a5c49a2` answered 1 week ago

Need data/ information (volume and quality of services) from facilities under district management which can be used to calculate payment rate. District body should also report their volume/ quality of services (e.g. supervision visits) they offer to their respective facilities.

`d123bd0f` answered 1 week ago

---

l'allocation forfaitaire doit prendre en compte le nombre de structures de soins sous sa responsabilité ayant intégré le suivi, le management de MNT, possédant les compétences / capacités médico-techniques par rapport à leur mandat et renseignant sur les activités qui s'y déroulent. Il sera nécessaire de développer des outils pour catégoriser les districts sanitaires et allouer les ressources sur cette base

6a16d290 answered 1 week ago

The allocation of coordination bodies should be grounded in a comprehensive understanding of the assigned territory and its population. Furthermore, it should be informed by a thorough analysis of the quality of healthcare currently available to the people. The roles and responsibilities of coordination bodies should be legally established at both the national and provincial levels. This would enable setting clear rules and designing appropriately sized coordination bodies, composed and equipped to carry out their functions effectively based on a sound preliminary analysis.

c8b8aeb4 answered 1 week ago

This can be assured developing indicators speaking to availability of medicine or any other criteria. A price should be attached to the specific indicator and the indicator should be clearly defined with verification mechanisms. The verification should be done preferably by independent body on a quarterly basis.

29826a7e answered 1 week ago

I would do implement a pilot that defines: - Organizational and managerial changes at the Coordination Body - A chain of Management Agreements between the Ministry of Health and the Coordination Body and and between the latter and its facilities - Define and facilitate to the Coordination body individualized and risk stratification information using and integrating multiple clinical and administrative databases that are already available - Introducing changes in the PPM. In principle I would explore a combination of line item budget and capitation payment adjusted based on performance. - Insuring provider autonomy to allocate the obtained resources (within an agreed investment plan) - An intense training program in chronic diseases management and close supervision from the central level (MOH).

4773a988 answered 1 week ago

Quarterly reports by the coordination body would support informing on the services delivered (supervision, trainings given, support delivered etc.) by the coordination. Verification of the quality determinants and outcome indicators of the health structures covered by the the coordination body would support a scoring system calked on the one for the health structures and leading to a quality payment.

db7d89a4 answered 1 week ago

---

3 & 5. The total number of services and the likelihood of needing coordination should form the basis for

calculating the work related to the coordination of services. This should form the dominant share of payment for coordination. 4 & 6. The quality and responsiveness of services should be assessed using a metric. The result of the evaluation should be used for adjusting payment for the coordination body. This should be a complementary part of payment for coordination.

5e94bb18 answered 5 days ago

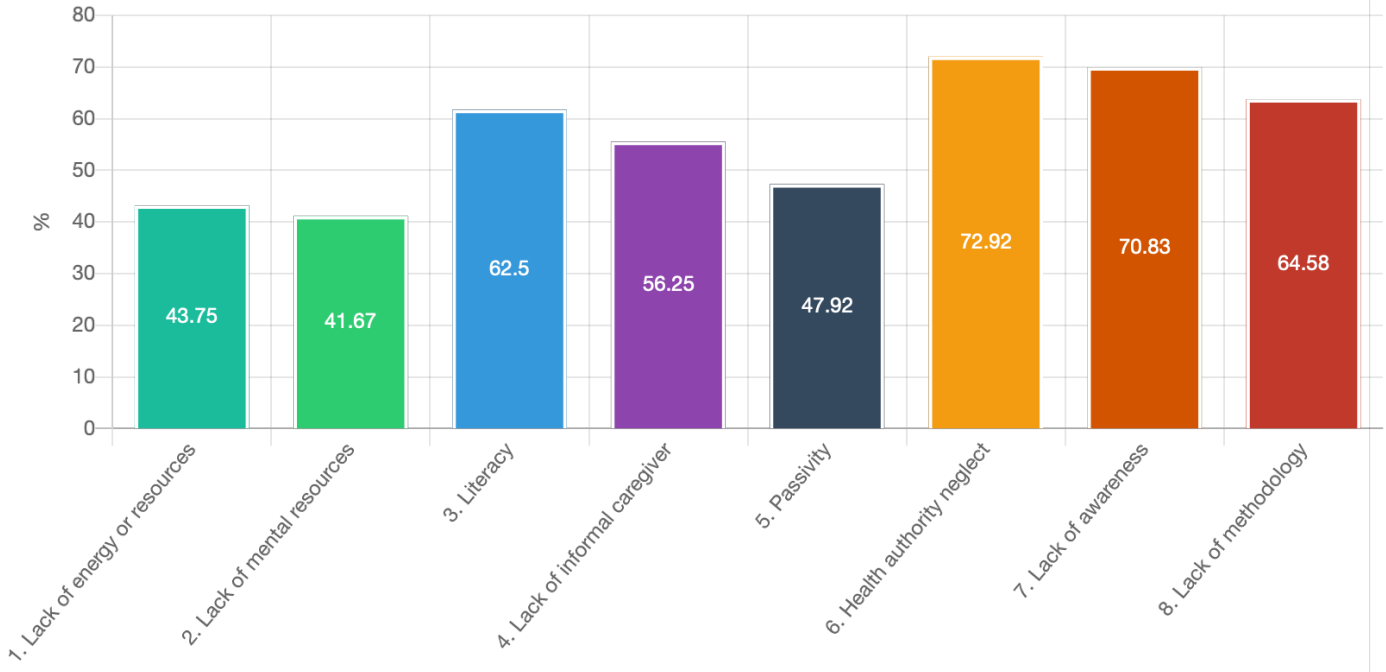
☐ 1.11.1 — Patients and relatives, determinants of quality se (Page 11)

EN

Among all the following propositions on determinants of quality self-care, tick those which are a bottleneck in the setting you know the best.

[multiple answers possible]

1.11.1 — Patients and relatives, determinants of quality se



Choices	#
1. Lack of energy or resources	21 (43.75 %)
2. Lack of mental resources	20 (41.67 %)
3. Literacy	30 (62.5 %)
4. Lack of informal caregiver	27 (56.25 %)
5. Passivity	23 (47.92 %)
6. Health authority neglect	35 (72.92 %)
7. Lack of awareness	34 (70.83 %)
8. Lack of methodology	31 (64.58 %)
Participants	**48**
Total	**221**

1.11.2 — Patients and relatives, determinants of quality ca (Page 11)

EN

Aside those possible constraints for quality self-care, do you see other possible constraints?

1.11.2 — Patients and relatives, determinants of quality ca

1. Prioritization of family needs (finance + time) for example when taking care of orphan children 2. Context of poverty & impact of other determinants 3. Limitations in allocation of tools (sticks + HgT devices) for self management 4. No access to digital tools for self monitoring in public sector 5. Limited awareness of their condition or consequences of continuous care even if HCWs are trained to inform patients 6. Limited multi-sectoral action to support non-adherence

17b7b82a answered 2 weeks ago

A significant weakness is the coordinated continuous care of the chronic patient. This especially stands out as a problem if it is a single household, or more precisely people who live alone. This needs to be reinforced through national guidelines and strategic planning of health personnel.

`9f0db521` answered 2 weeks ago

In the contexts I know, the situation is rather that patients (with chronic illnesses) and their family members receive very little support (guidance, support, care) from the health system, and are left to find their own way and to fend for themselves. To me therefore, the biggest issue in many LMIC health systems is the lack of understanding about and attention by health authorities and facilities to patient side and demand-side constraints and barriers (e.g. transportation to the facility).

`560d961f` answered 2 weeks ago

---

household constraints (eating what everyone eats). shame/stigma (e.g. no one else exercises) related to culture lack of practical tools that are helpful for self management (for example a pill box, a glucose meter etc.) no smart phone etc.

`e39890ca` answered 2 weeks ago

Financial barriers.

`9ec4643f` answered 2 weeks ago

There are many more related to sociocultural perceptions and practices and some sort of assurance, peer support and training/advisory input at individual level and focused interventions at community/group level might help overcome some of these barriers

`0415ccbc` answered 1 week ago

Excessive dependency from the donors; Too vertical programs that do not integrate the patient life and health problem; Lack of professional ethics in health workers; Insuficient capacity for building trust with the population by the health services; Lack of humanity in the care providers;

`fd6fba5e` answered 1 week ago

- Lack of social/ family support - Poverty

`da55c53c` answered 1 week ago

Lack of digital alternatives to support patients in their homes. Lack of digital literacy on patient/ clinicians side.

18480606 answered 1 week ago

Lack of funds for access to good, healthy diets.

bbe6c1f7 answered 1 week ago

Existence of some cultural behaviours and myths.

d123bd0f answered 1 week ago

Lack of support within the community. High out of pocket expenses impacting ability of people living with NCDs to provide quality self-care (due potentially negative coping strategies).

a77d36f9 answered 1 week ago

Factors influencing quality self-care may include: mechanisms for the procurement of medical products in the health system, which can affect the availability of necessary medicines at nearby health facilities and pharmacies; the knowledge of medication by patients and caregivers; the adequacy of explanations given by the health professionals who prescribe medicines to patients on how medicine should be taken.

ccc22852 answered 1 week ago

RAS

6a16d290 answered 1 week ago

Limited communication skills and poor doctor-patient relationships

c8b8aeb4 answered 1 week ago

Lack of external support such as: - Lack of sensitization of the patient (and family) on the importance of self care; - Lack of training on self-care. - Lack of means to support motivation, to give incentives

db7d89a4 answered 1 week ago

Lack of trust in home or self-care: people perceive hospital-based care as more efficacious

495ce785 answered 6 days ago

Yes, the burden of treatment, the load that 'we' (the system) gives the patient. If I ask you, do you want to receive another e-mail... most probably you will say no. The same for patients, we keep on adding tasks to them. And some of the statements above are very patronising giving the perception that patients do not want to care for themselves, it is very difficult! And time consuming! And costly! And annoying! And the systems does it poorly! Think of it as getting a new laptop, a MacBook Air, seamless... we have to imagine the same level of consumer experience for health. Right now our laptop is crap and we keep 'selling' it.

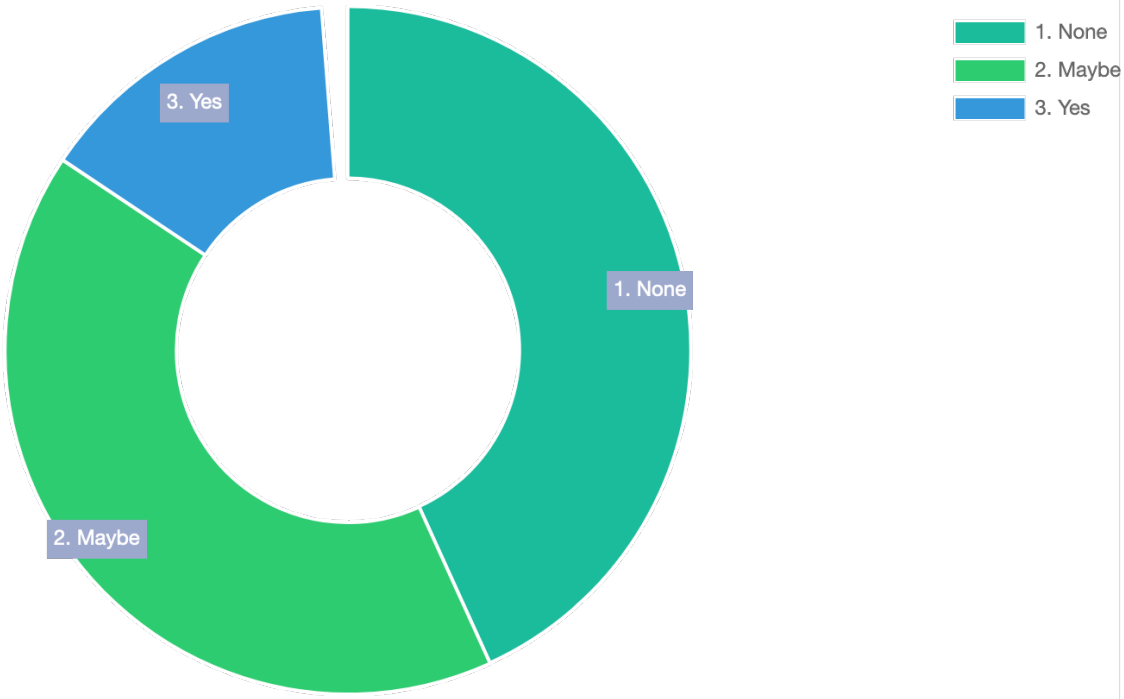
93089cc1 answered 1 day ago

1.11.3 — Patients, mechanisms to compensate pa (Page 11)

EN

Do you think that there should be mechanisms to compensate patients to take care of themselves?

1.11.3 — Patients, mechanisms to compensate pa



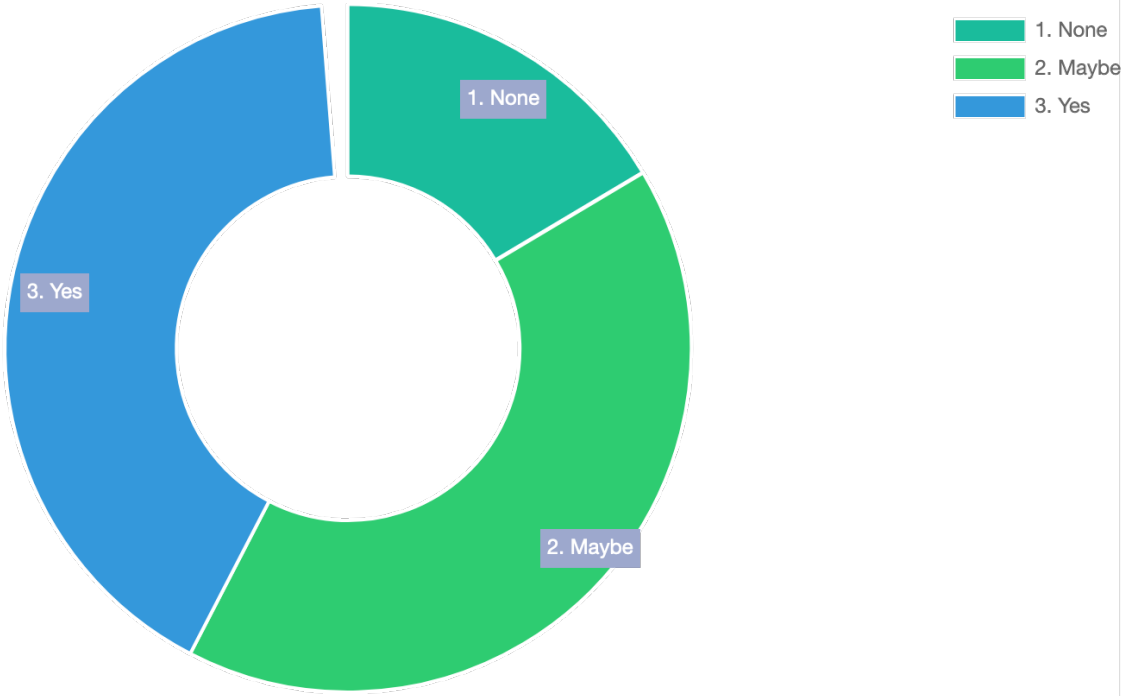
Choices	#
1. None	21 (43.75 %)
2. Maybe	20 (41.67 %)
3. Yes	7 (14.58 %)
Total	**48**

○ 1.11.4 — Informal caregivers, mechanisms to compensate in (Page 11)

EN

Do you think that there should be mechanisms to compensate informal caregivers to take care of their relative with chronic conditions?

1.11.4 — Informal caregivers, mechanisms to compensate in



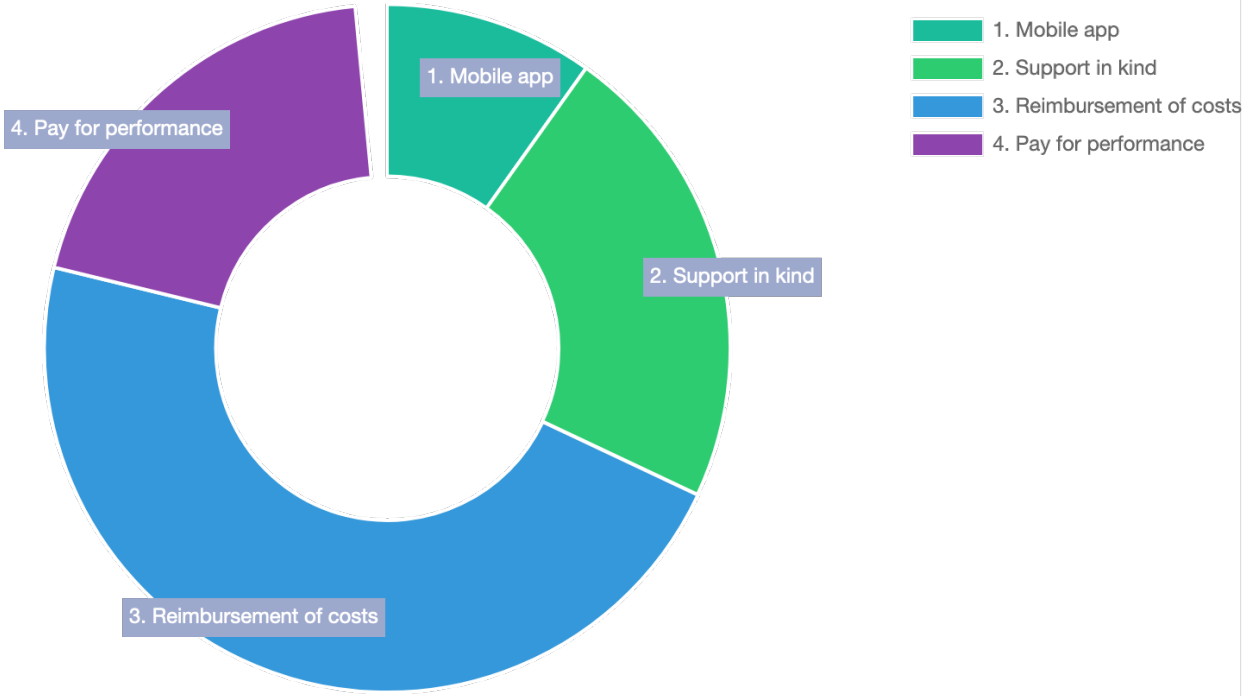
Choices	#
1. None	8 (16.67 %)
2. Maybe	20 (41.67 %)
3. Yes	20 (41.67 %)
Total	**48**

1.11.5 — Mechanisms to compensate patient and informal care (Page 11)

EN

If you have answered “Yes” or “Maybe” to compensate the patients and/or informal caregivers, how would you do that?

1.11.5 — Mechanisms to compensate patient and informal care



Choices	#
1. Mobile app	4 (10 %)
2. Support in kind	9 (22.5 %)
3. Reimbursement of costs	19 (47.5 %)
4. Pay for performance	8 (20 %)
Total	**40**

1.11.6 — Patients and informal caregiver, mechanisms to com (Page 11)

EN
Feel free to motivate your view on the **compensation of the patient** or the **compensation of the informal caregiver.**

1.11.6 — Patients and informal caregiver, mechanisms to com

Ideally through teh social welfare system - income supplement for people caring for someone with long term condition and higfh level of dependence.

760ac409 answered 2 weeks ago

Provision for compensation must be part of a national policy to ensure equity and standardization to prevent exclusion.

17b7b82a answered 2 weeks ago

N/a

9f0db521 answered 2 weeks ago

Support in kind could include - caregivers who are willing to take up the responsibility are registered. They can be given priority attention from health care providers whenever they approach or contact the health staff for assistance

e15461db answered 2 weeks ago

Some sort of compensation to cover the costs to patients and accompanying informal caregiver/relative (e.g., transport to visit the counsellor) especially for most economically vulnerable patients is important to have. How this is organized should be according to the local context. The options above need not be mutually exclusive - in-kind support for accompanying persons could/should go together with some systematic monetary support for the patient and their informal provider. A pay for performance arrangement is however not desirable in my view as it connotes the assignment of monetary value to what is usually an emotional, moral, and very personal role. A pay for performance arrangement would undermine the intrinsic motivation that drives the performance of informal caregiver roles.

560d961f answered 1 week ago

i think those 4 possibilities are not alternatives but complementary tools that can all be useful.

e39890ca answered 2 weeks ago

I didn't like the list of choices you have p;rovided here because they ignore the individual and household's socioeconomic level and the range of options for motivating patients. Based on my experience, I would begin by doing the following: 1. For most people with chronic conditions, I would encourage seeking positive social reinforcement methods to promote self-care. This might include offering in-person support groups, social media, or game apps. But without in-kind or financial incentives. 2. For people with chronic conditions who face

difficulties in taking care of themselves, due to mental conditions, homelessness, poverty, family pressures, etc. I would create programs that link people to programs that can deal with those obstacles. Depending on the particular context, in-kind services (transport) or cash transfers (conditional or unconditional) might also be appropriate for some part of this diverse group of people. 3. For informal caregivers, I would be inclined to propose direct financial support - a stipend or even salary that gets paid in return for a simple verification that the person with a chronic condition is in contact with the appropriate caregiver (social worker, medical professional, etc.). It's possible that such a stipend could be offered without determining income eligibility since the value might be insignificant to wealthier households. Alternatively, it could be structured as an additional payment to existing social protection cash transfer programs where these are effectively administered. 4. For informal caregivers, support groups, social media, or phone apps can also be helpful. But they should be complements to financial support.

`b0dba773` answered 1 week ago

Pay-for-performance for patients is an interesting idea but I don't think the public health system is ready for it yet (there are good results on its impacts for private health insurers). On compensation: a combination of reimbursements for patients and informal caregivers/relatives could support healthy increased health-seeking behaviour. It could be coupled with in-kind support (e.g. a healthy meal) too.

`bbe6c1f7` answered 1 week ago

I think it is relatively possible to incentivise a patient than caregiver or family overall. A patient can work out to ensure caregiver is helping to control/ manage his/ her disease for rewards.

`d123bd0f` answered 1 week ago

With self care, important not to put emphasis of quality of care coming from the patient/caregiver themselves as a principle mechanism - risk to detract from the need for system wide support for people living with NCDS e.g. consideration of wider social and commercial determinants of health alongside work on a quality healthcare system founded on principles of UHC - equity, finacial risk protection, access to quality care.

`a77d36f9` answered 1 week ago

If patients and/or informal caregivers incur huge income losses due to illness or the demands of providing care to family members and/or relatives, there should be a social safety net to support the household income.

`ccc22852` answered 1 week ago

On peut motiver les patients ou leurs membres de leur famille à travers d'autres initiatives pex une consultation gratuite à 5 patients ou à 5 membres de leur famille à la fin de l'année pour les patients qui ont adhéré au traitement et dont le suivi montre un meilleur contrôle par exemple de leur tension artérielle ou diabète.

`6a16d290` answered 1 week ago

In Latin America, particular attention is required to subsidize transportation and diet-related expenses associated with self-care for chronic diseases.

c8b8aeb4 answered 1 week ago

Compensation may be a useful tool. However, for persons who are less able to care for themselves, this may present some complications. In such cases, the emphasis should be on informal caregivers/relatives, which may also result in strengthened social bonding.

81dd720d answered 1 week ago

both the 1st and 2nd options above

7dba40b8 answered 1 week ago

For patients: Financial rewards should not be in place, but support for transport to the health center should be considered, especially for economic vulnerable patients. Other types of rewards should be considered (gamification?) but this will be very context /community /population specific. For caregivers: Caregivers who spend an important nr of hours or part of the day in supporting patients should be supported as they are compensating for what the health sector should do. This compensation would rather be in-kind and depending on the context /community /population group. Financial compensation for transport to the health structure is needed should be considered especially for economic vulnerable patients.

db7d89a4 answered 1 week ago

I feel this would have to be done very delicately as paying for informal care could be seen as breaking the implicit social contract between family members or friends. It could also lead the person receiving care to feel like a burden.

495ce785 answered 6 days ago

Add payments for the time of caregivers, irrespective of achieving 'control' of disease. Reaching control in diabetes, for example, may be related to multiple things from diet to physical activity in addition to drugs. Drugs only will not do the trick for chronic conditions.

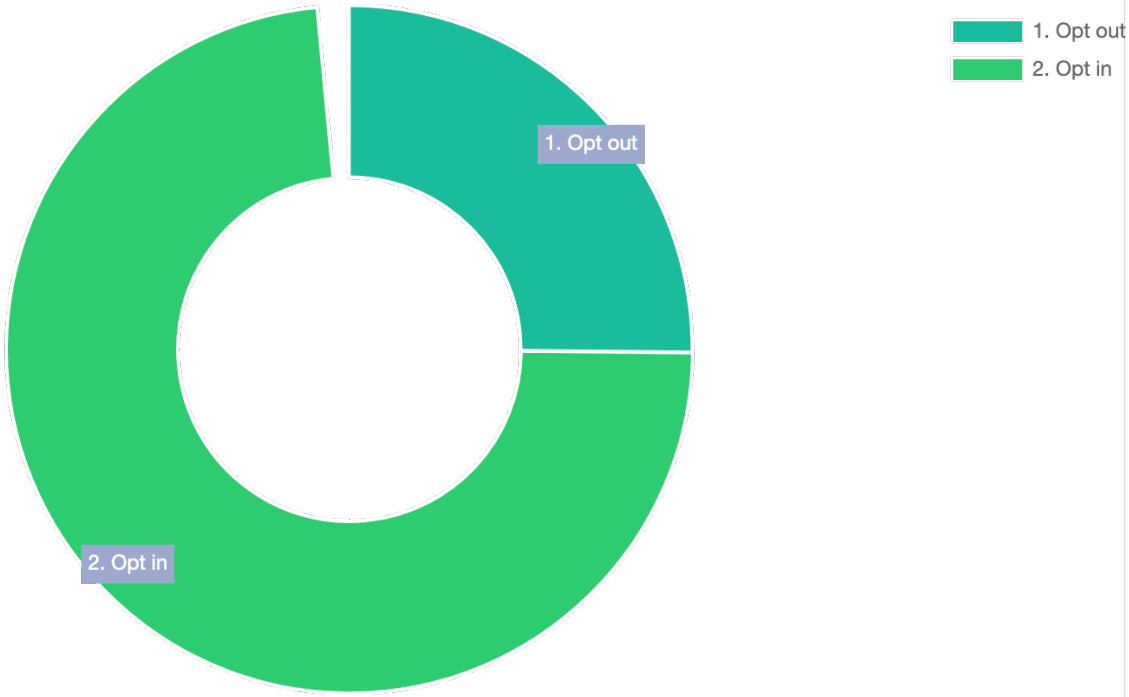
93089cc1 answered 1 day ago

1.12.1 — Delivery system, bundled payment opt out (Page 12)

EN
I would prefer to opt out of these questions on **bundled payment**

If you prefer to opt out of these questions on bundled payment, please proceed directly to section **1.11.7 Ceiling on aggregated payments.**

1.12.1 — Delivery system, bundled payment opt out



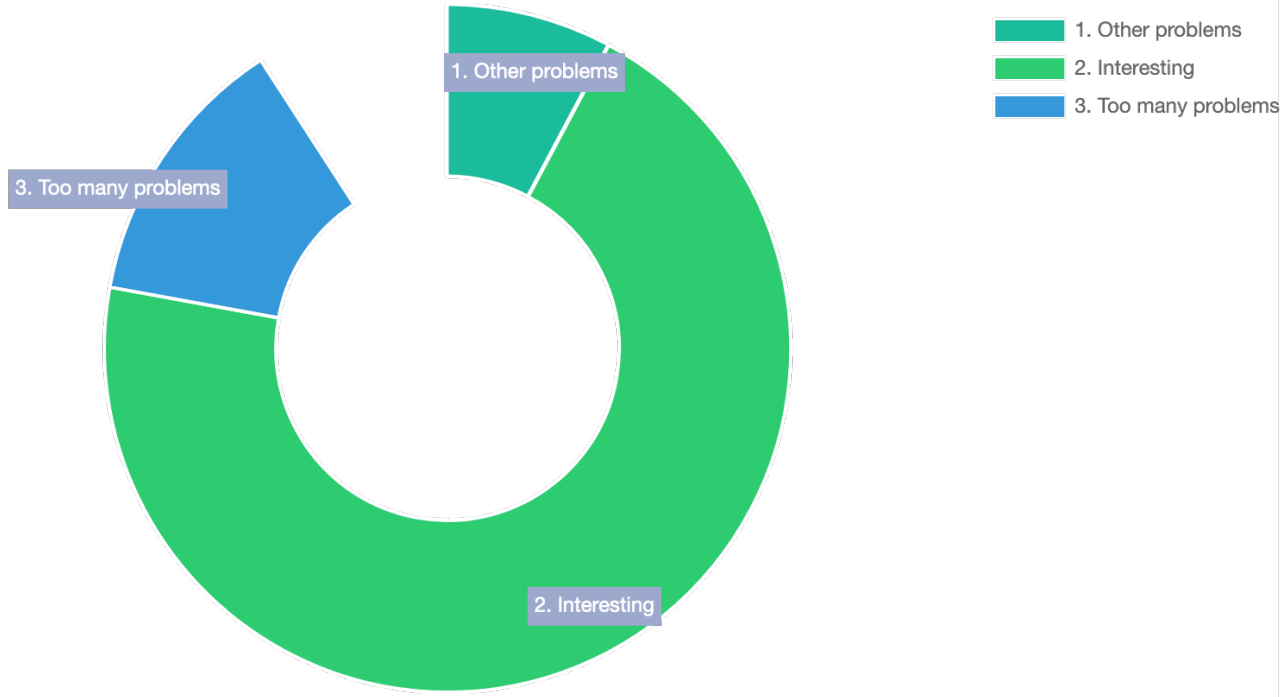
Choices	#
1. Opt out	12 (25.53 %)
2. Opt in	35 (74.47 %)
Total	**47**

1.12.2 — The delivery system as a whole (Page 12)

EN

How would you assess the relevance of bundled payment for the country you are familiar with:

1.12.2 — The delivery system as a whole



Choices	#
1. Other problems	3 (8.57 %)
2. Interesting	27 (77.14 %)
3. Too many problems	5 (14.29 %)
Total	**35**

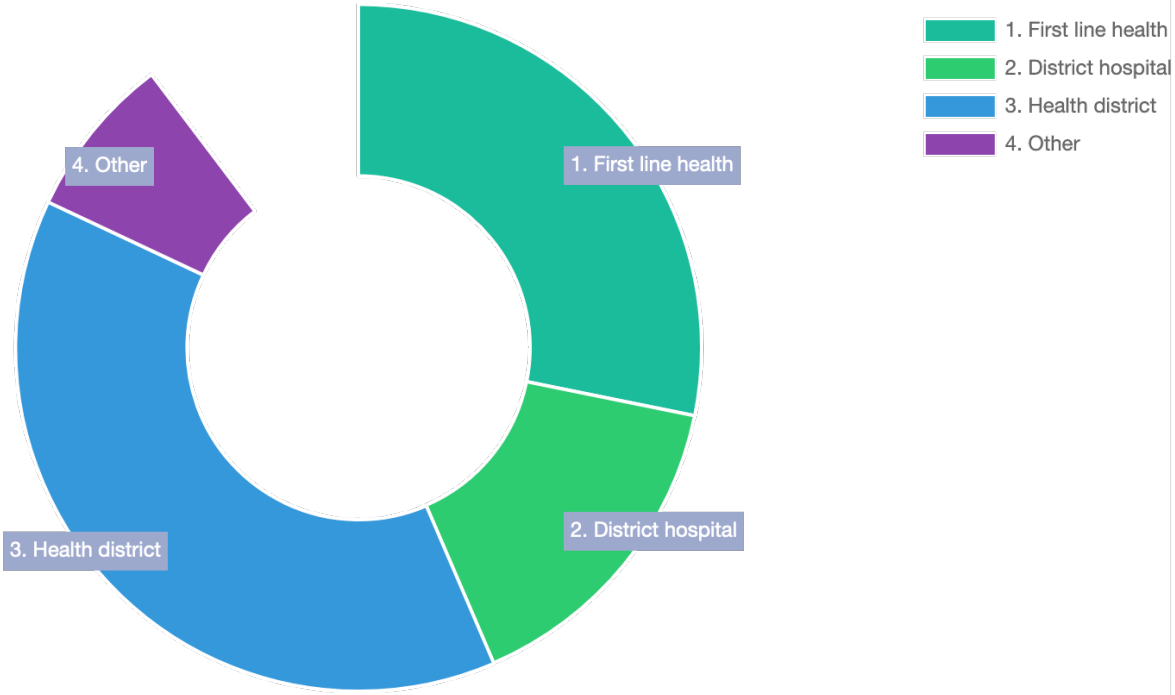
1.12.3 — The delivery system, the best actor

(Page 12)

EN

Who would be the best actor to receive the grant on behalf of the 'network' and then take the responsibility to share it among different providers contributing to integrated care?

1.12.3 — The delivery system, the best actor



Choices	#
1. First line health	11 (31.43 %)
2. District hospital	6 (17.14 %)
3. Health district	15 (42.86 %)
4. Other	3 (8.57 %)
Total	**35**

1.12.4 — The delivery system, comment on other (Page 12)

EN

Feel free to comment on your answer above (required, if you have answered “Other”)

1.12.4 — The delivery system, comment on other

Ideally primary care

760ac409 answered 2 weeks ago

I think bundling is a flawed strategy in the context of multimorbidity which is the rule, not the exception,in our system. Bundling privileges certain conditions and diminishes the importance of others and is often conceptualized in the absence of lived experience of patients.

edf03eea answered 2 weeks ago

While bundling arrangements do have the potential to make a difference, putting them in place within public services will require undoing existing (often traditional line budgeting) arrangements, and therefore would be difficult to initiate. However, these arrangements can be part of how pooled funds organise their contracts with private providers (for profit and non-profit alike).

560d961f answered 1 week ago

A pilot would be useful to explore how the dyamics play out specifically for chronic care inside the context of the operational district in Cambodia. The district office is by design the institution that should manage those dynamics but they have not been prepared or trained for this.

e39890ca answered 2 weeks ago

There are lots of issues that should be considered before answering this question definitively. For example: - managing funds is time-consuming and requires special (non-medical) training (some front-line facilities may be too small or have limited capacity to take on such a function). - being closer to the patient (front-line facilities are an excellent place for managing the budget because they should be in regular contact and can perhaps best determine which services are needed and whether they are having the desired impact. However, they also may lack the range of diagnostic or expertise to do so, which would suggest the hospital. I selected "Health District Office" because in Brazil, on average, that may be the level which could have the scale to run and manage such programs while also being closer to the patients.

b0dba773 answered 1 week ago

This is an appealing proposition and is in place in a very controlled private settings (mainly hospitals) but is very challenging given that our health service system remain highly fragmented - there is poor coordination across levels and providers within public system leave aside the private system. Patient pathways routinely cut across public and private systems including different levels of care and systems of medicines - so some approach and practice of integration is needed before trying out bundled payments

`0415ccbc` answered 1 week ago

I have chosen the first line health facility as I believe the main 'care giver', for chronic conditions, this is often primary care, should be in charge of receiving and distributing the bundled payment to other providers included on the patient's care pathway. I am aware though that often primary care facilities may not have enough staff to take on the additional administrative burden of doing so. The hospital may be better placed in that case if they can offer more admin staff to submit payment claims, coordinate across providers, and disburse the bundled lump sum (or if not the hospital another provider with available staff to take over these roles).

`18480606` answered 1 week ago

The patient's PHC contact who plays a key role in integrating the contribution of all the parties to the care process of the patient.

`9a5c49a2` answered 1 week ago

Bundled payments must be accompanied by better integration of health systems. Just integrating the payment while the remainder of the system is not aligned will unlikely lead to success.

`edc53c5f` answered 1 week ago

Bundled payment and integrated care are very useful approaches. However, in low and middle-income countries it also presents strong challenges, as the infrastructure may not be favorable (yet), and individual providers not capable to sufficiently integrate with others. Piloting would be useful, and necessarily accompanied by increased investment in infrastructure and training.

`81dd720d` answered 1 week ago

I prefer first line but health district office can also be an option

`1b72b6c0` answered 1 week ago

The district hospital is the most likely to have various NCD related services, multidisciplinary teams and a network of health structures with referral and contra referrals.

db7d89a4 answered 1 week ago

I personally think the health system in the Indian context, especially urban Indian, is too fragmented at this stage for a bundled payment approach to work.

495ce785 answered 6 days ago

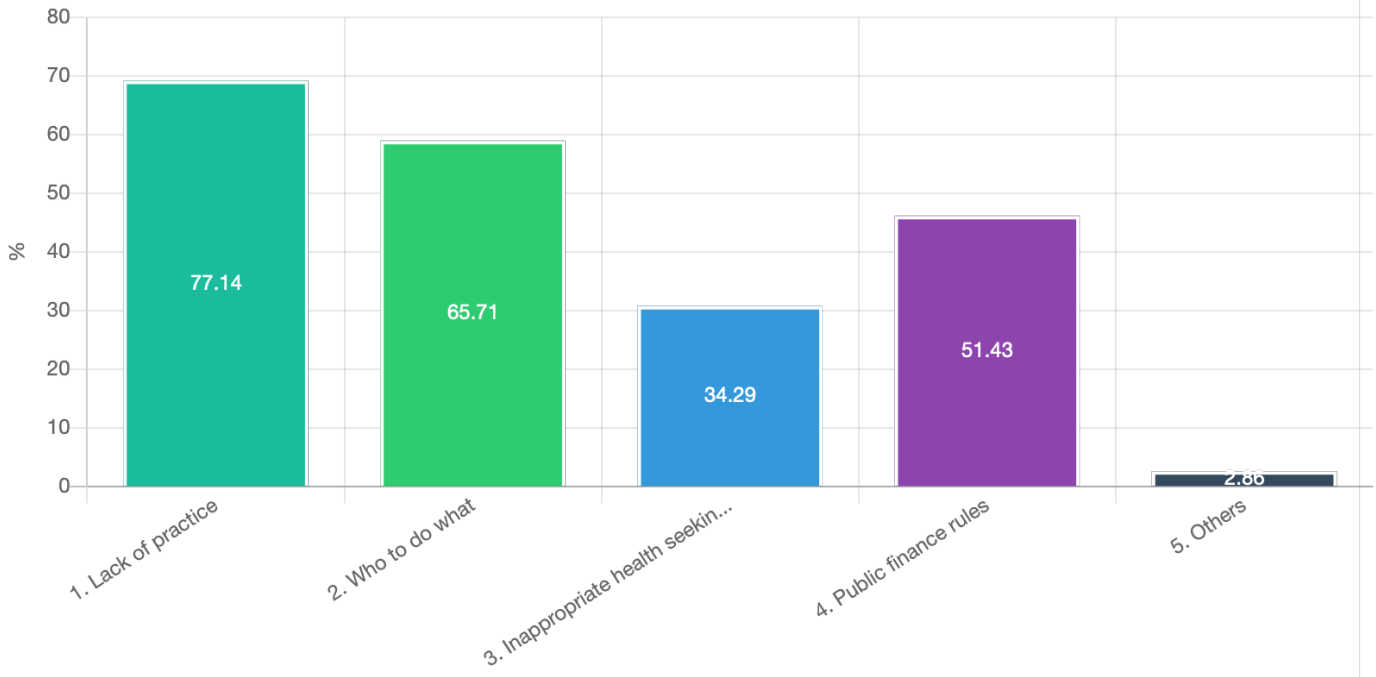
☐ 1.12.5 — The delivery system, challenges

(Page 12)

EN

What would be the biggest challenges to introducing such a scheme in your country? (multiple answers possible)

1.12.5 — The delivery system, challenges



Choices	#
Participants	35
Total	81

Choices	#
1. Lack of practice	27 (77.14 %)
2. Who to do what	23 (65.71 %)
3. Inappropriate health seeking	12 (34.29 %)
4. Public finance rules	18 (51.43 %)
5. Others	1 (2.86 %)
Participants	**35**
Total	**81**

1.12.6 — The delivery health system, others

(Page 12)

EN
Feel free to comment (required, if you have answered "Other")

1.12.6 — The delivery health system, others

Federal state responsibilties

760ac409 answered 2 weeks ago

While bundling arrangements have the potential to make a difference, putting them in place within public services will require undoing existing (often traditional line budgeting) arrangements, and therefore would be difficult to initiate. However, these arrangements can be part of how pooled funds organise their contracts with private providers (for profit and non-profit alike).

560d961f answered 1 week ago

A well prepared pilot with commitment from central level/provincial level would uncover multiple bottlenecks but if well designed, and now with smart phones and social media, I think it could be very interesting and useful to pilot this. extra money is needed for the meetings and per diems and the survey's etc.

e39890ca answered 2 weeks ago

- Lack of coordination and misappropriation if effective monitoring systems are not in place

da55c53c answered 1 week ago

1.12.7 — Ceiling on aggregated payments; opt out (Page 12)

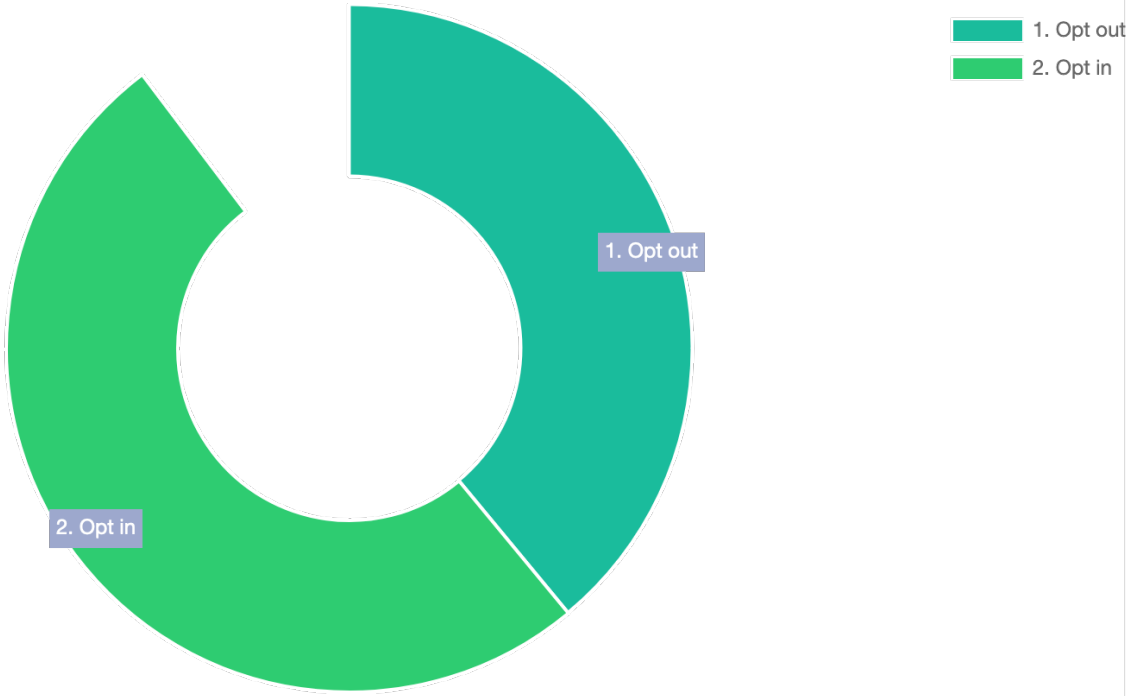
EN

Ceiling on aggregated co-payments

Another strategy is to set a ceiling to the aggregated co-payments paid by the patient across providers for a given time period. Above a given ceiling, possibly set according to the household income, patients are exempted from co-payment (or all co-payments are reimbursed). This solution allows to protect persons with a chronic condition from catastrophic healthcare expenditure and poverty and secures good continuity of care.

Please choose to opt in or opt out of this question. If you choose to opt out, please proceed directly to 1.12.1 The purchasing agency, opt-out

1.12.7 — Ceiling on aggregated payments; opt out

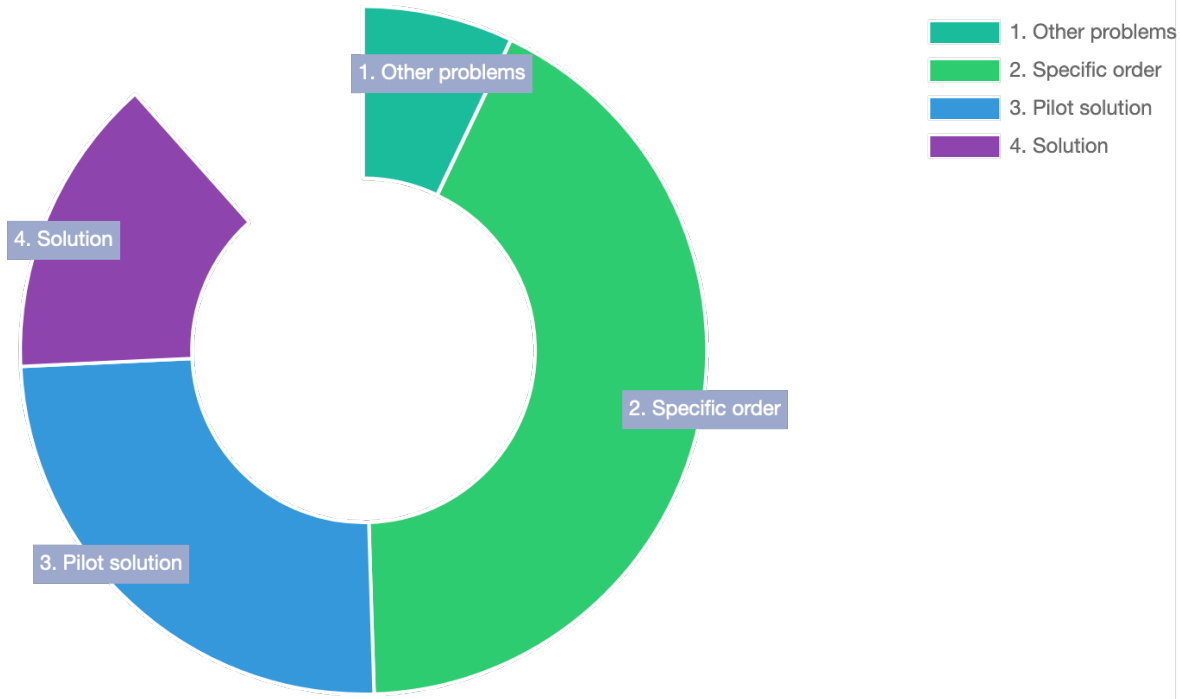


Choices	#
1. Opt out	20 (43.48 %)
2. Opt in	26 (56.52 %)
Total	**46**

1.12.8 — The delivery system, ceiling on aggregated payment (Page 12)

EN
How would you assess the relevance of this solution in the country you are familiar with: (one answer only)

1.12.8 — The delivery system, ceiling on aggregated payment

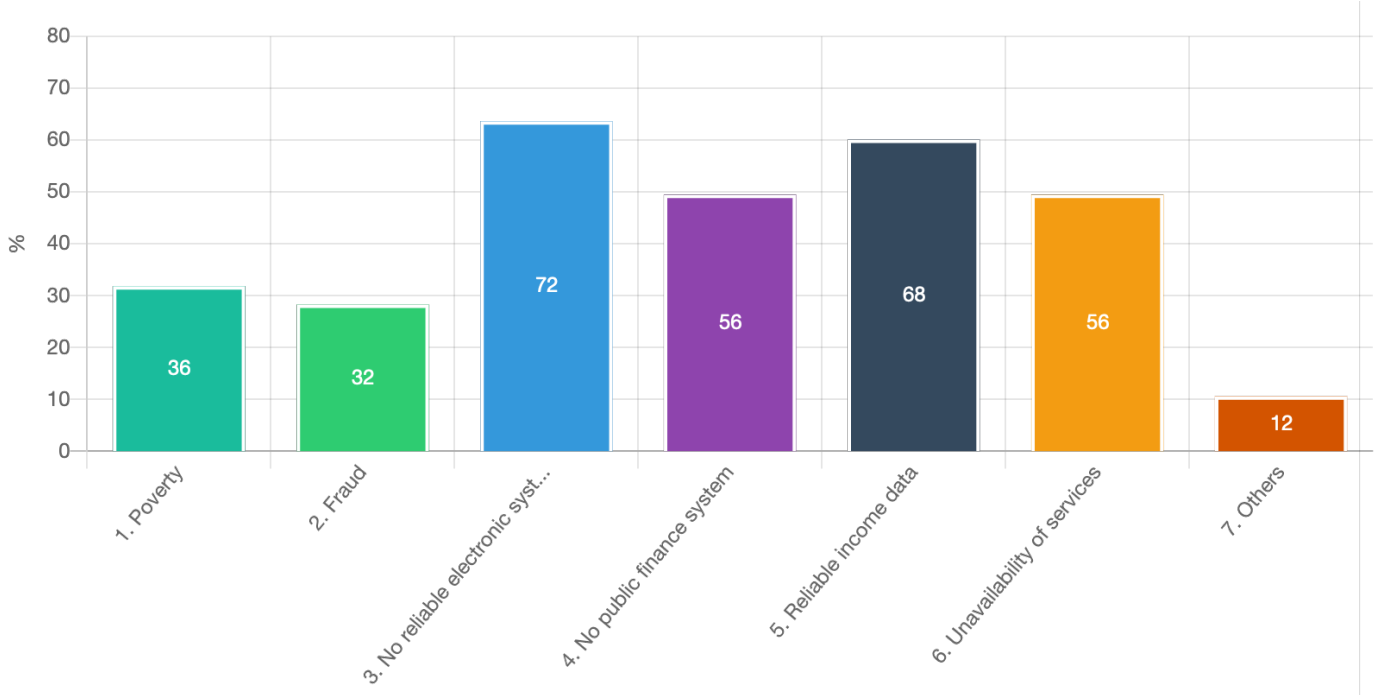


Choices	#
1. Other problems	2 (8 %)
2. Specific order	12 (48 %)
3. Pilot solution	7 (28 %)
4. Solution	4 (16 %)
Total	**25**

☐ 1.12.9 — The delivery health system, challenges (Page 12)

EN
What would be the biggest challenges to introducing such a scheme in your country? (multiple answers possible)

1.12.9 — The delivery health system, challenges



Choices	#
1. Poverty	9 (36 %)
2. Fraud	8 (32 %)
3. No reliable electronic system	18 (72 %)
4. No public finance system	14 (56 %)
5. Reliable income data	17 (68 %)
6. Unavailability of services	14 (56 %)
7. Others	3 (12 %)
Participants	**25**
Total	**83**

1.12.10 — The delivery system, introducing, others (Page 12)

EN

What would be the biggest challenges to introducing such a scheme in your country? Feel free to comment (required, if you have answered "Other")

1.12.10 — The delivery system, introducing, others

We already have these in Australia. they are called Medicare and Pharmaceutaical Benefits saftety nets.

760ac409 answered 2 weeks ago

In case the ceiling is exceeded, there will be way to extract more money from the patient anyway OR the patient will be made to understand that the theory is not going work....

e39890ca answered 2 weeks ago

It requires strong motivation and political will.

9a5c49a2 answered 1 week ago

Just exempt the relevant services from copays to avoid the administrative hassle/cost of the copay ceiling.

edc53c5f answered 1 week ago

According to my studies and other available evidence, in Colombia, a high proportion of the OOPE for chronic care is related to direct non-medical expenses such as buying food as a dietary requirement for clinical control and paying for transportation costs to attend healthcare facilities. However, the biggest challenge for our health system is that the most deprived families are not identified, and no subsidies are in place for these expenses, exposing them to catastrophic health expenditures.

c8b8aeb4 answered 1 week ago

Data protection in general and specifically in countries with conflicts (national , local or international).

db7d89a4 answered 1 week ago

1.13.1 — The purchasing agency, opt out

(Page 13)

EN

I lack information on purchasing agencies and prefer to opt-out

If you choose to opt out of these questions on purchasing agencies, please proceed directly to the end of this survey.

1.13.1 — The purchasing agency, opt out

Choices	#
1. opt out	18 (37.5 %)
2. opt in	30 (62.5 %)
Total	**48**

1.13.2 — The purchasing agency, constraints

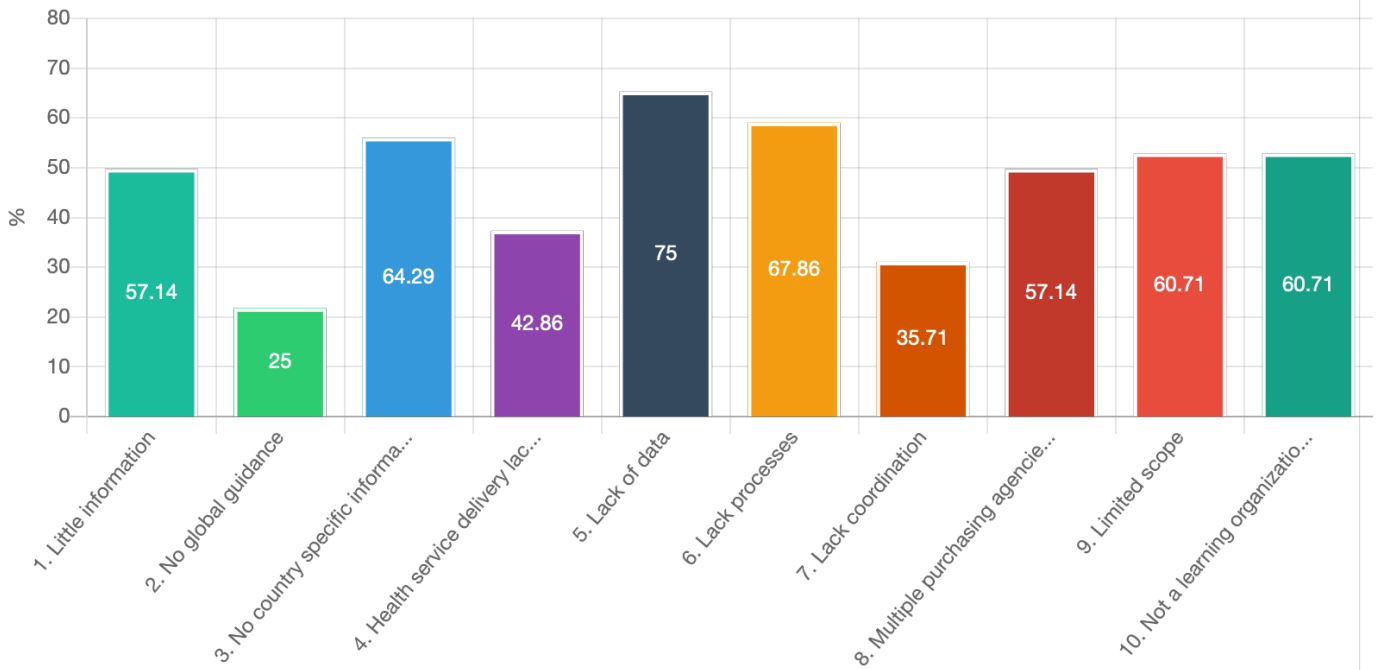
(Page 13)

EN

Among all the following possible issues, identify those in the low- and middle-income countries you are familiar with, that are constraining most purchasing agencies from making a valuable contribution to better quality chronic care.

[multiple answers possible]

1.13.2 — The purchasing agency, constraints



Choices	#
1. Little information	16 (57.14 %)
2. No global guidance	7 (25 %)
3. No country specific informatio	18 (64.29 %)
4. Health service delivery lackin	12 (42.86 %)
5. Lack of data	21 (75 %)
Participants	**28**
Total	**153**

Choices	#
6. Lack processes	19 (67.86 %)
7. Lack coordination	10 (35.71 %)
8. Multiple purchasing agencies	16 (57.14 %)
9. Limited scope	17 (60.71 %)
10. Not a learning organization	17 (60.71 %)
Participants	**28**
Total	**153**

1.13.3 — The purchasing agency, constraints

(Page 13)

EN

Suggest other bottlenecks preventing purchasing agencies from making a valuable contribution to better quality chronic care.

1.13.3 — The purchasing agency, constraints

Lack of experience/capacity in contracting and monitoring Corruption/governance Cultutal shift amongst providers difficult to effect

760ac409 answered 2 weeks ago

Purchasing is passive and not informed by goals for the health system; the role of the purchaser in shaping arrangements (contracts, benefits, payments) in coordination with other agencies to improve quality is unclear

61e45e05 answered 2 weeks ago

There is are many issues with respect to the access to the medicines. e.g. There are too many intermediary cost-raising steps between the patient and the daily medication.a c e.g. Public Service should have a continuous flow of

all the necessary basic low-cost bulk medicine for Cardio Vascular / Endocrin chronic conditions in hospital formula packaging, but instead there is an irregular supply : this makes providers + patients turn to high cost registered expensive medicines. * Adherence and Satisfaction and reasonable outcomes are the core indicators of success, not frequency of utilization and frequency contacts with the providers but quality of those contacts.

`e39890ca` answered 2 weeks ago

I have chosen to Opt-In although I do not really have in-depth insights. The little I have realised/understood based on my limited interactions in two countries (1 in Africa and 1 in Asia) is that while the above listed options may all be true, the problem might be that we expect the purchasing agency to have all these attributes and properties. Perhaps we should not. Many of these functions/attributes/properties probably best lie outside of the purchasing agency, and with existing actors within the health system, public finance system, public administration system, research system, and political system. The power struggles that I have noticed are somehow underpinned by the tendencies of purchasing agencies to try and control everything and become too big for their boots. Limiting their mandates to perhaps accounting+ and keeping a focus on the core functions may help ensure that purchasing agencies do not step on other powerful actors' toes, and thus do not get mired in unnecessary and often paralysing power politics.

`560d961f` answered 1 week ago

Purchasing agencies still have to consider themselves as having a role in shaping quality of chronicle care.

`9a5c49a2` answered 1 week ago

The purchasing agency avoids purchasing chronic care services to avoid cost escalation, because most chronic care are done routinely and often very expensive. Limited coverage of pre-payment mechanisms such as voluntary health insurance, which are vulnerable to adverse selection, meaning that most insured people are not working (retired for example), have low income (limits premium affordability), and experiencing chronic conditions (frequent service utilisation).

`d123bd0f` answered 1 week ago

Our purchasing agency, the public fund called ADRES, transfers the money to diverse health insurance companies and loses control over the shared resources. The payments to the intermediaries' health insurance companies are not conditioned to health results in the population. It is an overall lack of governance of the purchasing agency. A lot of corruption scandals for millionaire payments without requirements have arisen. Hence, a lack of control and stewardship functions aside from payments to the health insurance companies before service delivery without quality care requirements would be the most critical failures of our purchasing arrangements.

`c8b8aeb4` answered 1 week ago

The quality of data varies widely among the different purchasing agencies. This greatly limits national initiatives. There is a strong need for standardization among these agencies, and ideally unification of agencies at some

point.

81dd720d answered 1 week ago

Some other bottlenecks are the lack of managers with the needed technical and managerial competences and a strong fragmentation with multiple purchasing agencies. In my opinion, one of the most clear challenges in several countries for developing a strong chronic care strategy is the lack of a comprehensive and long-term approach mainly due to organizational weaknesses at the Ministries of Health. We have "organizational silos'' (too many vertical programs with multiple and not connected agendas) and "organizational limbos'' (core functions are not created or well defined like data governance, strategic purchasing, comprehensive human resources policies, network governance, long etc.). The care model will not evolve if first does not evolve the organizational and managerial model of our ministries of health, specifically in those that manage and finance health facilities.

4773a988 answered 1 week ago