THE WORLD MEDICAL ASSOCIATION, INC.

WMA STATEMENT
ON
THE GLOBAL BURDEN OF CHRONIC DISEASE

Adopted by the WMA General Assembly, Montevideo, Uruguay, October 2011

INTRODUCTION

Chronic diseases, including cardiovascular and circulatory diseases, diabetes, cancer, and chronic lung disease are the leading cause of death and disability in both the developed and developing world. Chronic diseases are not replacing existing causes of disease and disability (infectious disease and trauma), but are adding to the disease burden. Developing countries now face the triple burden of infectious disease, trauma and chronic disease. This increased burden is straining the capacity of many countries to provide adequate health care services. This burden is also undermining these nations' efforts to increase life expectancy and spur economic growth.

Ongoing and anticipated global trends that will lead to more chronic disease problems in the future include an aging population, urbanization and community planning, increasingly sedentary lifestyles, climate change and the rapidly increasing cost of medical technology to treat chronic disease. Chronic disease prevalence is closely linked to global social and economic development, globalization and mass marketing of unhealthy foods and other products. The prevalence and cost of addressing the chronic disease burden is expected to rise in coming years.

POSSIBLE SOLUTIONS

The primary solution is disease prevention. National policies that help people achieve healthy lifestyles and behaviors are the foundation for all possible solutions.

Increased access to primary care combined with well designed and affordable disease-control programs can greatly improve health care. Partnerships of national ministries of health with institutions in developed countries may overcome many barriers in the poorest settings. Effective partnerships currently exist in rural Malawi, Rwanda and Haiti. In these settings where no oncologists are available, care is provided by local physicians and nurse teams. These teams deliver chemotherapy to patients with a variety of treatable malignancies

Medical education systems should become more socially accountable. The World Health Organization (WHO) defines social accountability of medical schools as the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public. There is an urgent need to adopt accreditation standards and norms that support social accountability. Educating physicians and other health care professionals to deliver health care that is concordant with the resources of the country must be a primary consideration. Led by primary care physicians, teams of physicians, nurses and community health workers will provide care that is

driven by the principles of quality, equity, relevance and effectiveness. [see "WMA Resolution on Medical Workforce"]

Strengthening the health care infrastructure is important in caring for the increasing numbers of people with chronic disease. Components of this infrastructure include training the primary health care team, improved facilities, chronic disease surveillance, public health promotion campaigns, quality assurance and establishment of national and local standards of care. One of the most important components of health care infrastructure is human resources; well-trained and motivated health care professionals led by primary care physicians are crucial to success. International aid and development programs need to move from "vertical focus" on single diseases or objectives to a more sustainable and effective primary care health infrastructure development.

Note: Depending on the country, different stakeholders will assume greater or lesser responsibility for change.

For World Governments:

1. Support global immunization strategies;
2. Support global tobacco and alcohol control strategies;
3. Promote healthy living and implement policies that support prevention and healthy lifestyle behaviors;
4. Set aside a fixed percentage of national budget for health infrastructure development and promotion of healthy lifestyles.
5. Promote trade policy that protects public health;
6. Promote research for prevention and treatment of chronic disease;
7. Develop global strategies for the prevention of obesity.

For National Medical Associations:

1. Work to create communities that promote healthy lifestyles and prevention behaviors and to increase physician awareness of optimal disease prevention behaviors;
2. Offer patients smoking cessation, weight control strategies, substance abuse counseling, self-management education and support, and nutritional counseling;
3. Promote a team-based approach to chronic disease management;
4. Advocate for integration of chronic disease prevention and control strategies in government-wide policies;
5. Invest in high quality training for more primary care physicians and an equitable distribution of them among populations;
6. Provide high quality accessible resources for continuing medical education;
7. Support establishing evidence-based standards of care for chronic disease;
8. Establish, support and strengthen professional associations for primary care physicians
9. Promote medical education that is responsive to societal needs;
10. Promote an environment of support for continuity of care for chronic disease, including patient education and self-management;
11. Advocate for policies and regulations to reduce factors that promote chronic disease such as smoking cessation and blood pressure control;
12. Support strong public health infrastructure; and
13. Support the concept that social determinants are part of prevention and health care.

For Medical Schools:

1. Develop curriculum objectives that meet societal needs; e.g., social accountability;
2. Focus on providing primary care training opportunities that highlight the integrative and continuity elements of the primary care specialties including family medicine;
3. Provide community-oriented and community-based primary care educational venues so that students become acquainted with the basic elements of chronic care infrastructure and continuity care provision;
4. Create departments of family medicine that are of equal academic standing in the university; and
5. Promote the use of interdisciplinary and other collaborative training methodologies within primary and continuing education programs.
6. Include instruction in prevention of chronic diseases in the general curriculum.

For Individual Physicians:

1. Work to create communities that promote healthy lifestyles and prevention behaviors;
2. Offer patients smoking cessation, weight control strategies, substance abuse counseling, self-management education and support, and nutritional counseling;
3. Promote a team-based approach to chronic disease management;
4. Ensure continuity of care for patients with chronic disease;
5. Model prevention behaviors to patients by maintaining personal health;
6. Become community advocates for positive social determinants of health and for best prevention methods;
7. Work with parents and the community to ensure that the parents have the best advice on maintaining the health of their children.
8. Physicians should collaborate with patients' associations in designing and delivering prevention education.

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