

PUTTING CIRCULATORY DISEASES AT THE HEART OF UNIVERSAL HEALTH COVERAGE

A number of countries across the globe made commitments to progressively achieve Universal Health Coverage (UHC). To achieve UHC, countries need to decide on essential health services that are effective, taking into account the national burden of disease, financial protection, and overall impact on society and the economy.

Providing a well-defined package of essential health services at the primary health care level, either for free or at a low cost, is essential for achieving UHC. Expanding these services, including for circulatory diseases, could save millions of lives.

Why?

Circulatory diseases pose significant financial burdens on individuals and communities, due to their chronic nature and the need for frequent visits to health centres, undermining social and economic development.

They contribute to poverty due to high costs of care, particularly in the absence of a national health insurance scheme or when services for circulatory diseases need to be paid for out-of-pocket. Medicines and outpatient care, critical components of circulatory disease management,

are the main drivers of households' catastrophic health expenditures.

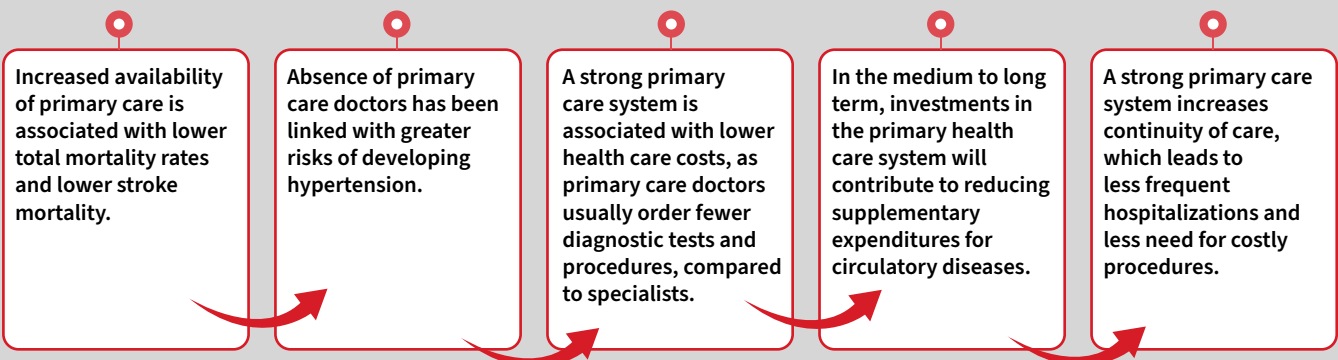
As a result, individuals are confronted with the difficult choice of prioritizing medical treatment over meeting other critical needs and accessing essential services, such as food and education.

This should not be the case: efforts should be made to ensure that access to health services for circulatory diseases is affordable and does not impose such burdensome trade-offs on people's lives.



Benefits of a strong PHC for circulatory health

Several studies have demonstrated an association between expanding primary care, better population health, fewer hospital visits, lower health costs and generally increased health equity:

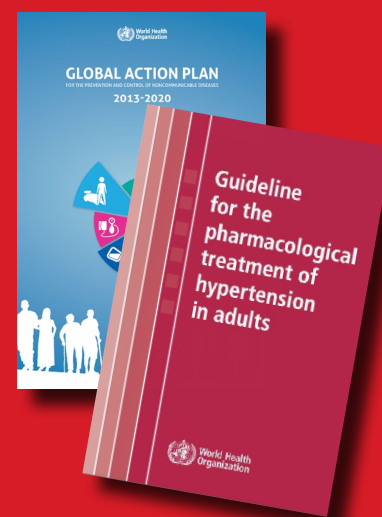


It is essential to move towards comprehensive models of PHC based on multidisciplinary approaches to health care. In this context, countries should invest in the health workforce, strengthen education, remove unnecessary barriers to working to full scope of practice and support the implementation of evidenced based practice. As largely demonstrated, health care providers other than physicians, such as nurses and pharmacists, can play a critical role in the management of circulatory conditions, including hypertension and diabetes, at primary care level, through proper training and standardized protocols.

How?

Several resources, such as **Appendix 3** of the **WHO Global NCD Action Plan**, the **HEARTS Technical Package**, the **WHO Package of Essential NCD interventions for PHC (PEN)** and the **Disease Control Priorities 3rd edition**, support countries in determining what interventions for circulatory diseases should be included in essential health service packages at the primary care level. These key documents include a set of

interventions that are considered cost-effective for the management of circulatory conditions. In addition, the **Guidelines on the Pharmacological Treatment of Hypertension in Adults (2021)** provide new recommendations for hypertension treatment, including the involvement of inter-professional healthcare teams, as a viable strategy to provide hypertension care at the PHC level.



What?

Based on the available resources listed above, the GCCH recommends countries ensure the following interventions are included in essential health benefit packages, as part of national efforts to achieve UHC:

Primary prevention:

1. Optimising health lifestyle: promoting healthy diet, physical activity, avoiding harmful levels of alcohol and tobacco smoking cessation.
2. Opportunistic screening for major circulatory disease risk factors, including hypertension, dyslipidaemia and smoking and subsequent cardiovascular risk assessment, if risk factors are present, using free apps such as QRisk2 (or similarly validated digital tools) in all individuals, regardless of their level of cardiovascular risk.
3. Glucose screening test for diabetes, including for all pregnant women.

4. Testing for kidney function and albuminuria in people with diabetes, hypertension and cardiovascular disease and women who have experienced preeclampsia.
5. Pharmacological treatment of hypertension should be available at primary healthcare level, with the following drugs (depending on availability):

a. thiazide and thiazide-like agents;

b. angiotensin converting enzyme inhibitors;

c. angiotensin receptor blockers;

d. calcium channel blockers.

6. Pharmacological treatment of diabetes mellitus: initiate with metformin if no contraindications have been identified. Multitargeted treatment (blood pressure, lipid, glucose, foot care for people with diabetes, healthy lifestyle counselling) should be provided for all people, particularly in those with an elevated cardiovascular risk.

7. Polypills for individuals at intermediate absolute risk of cardiovascular disease, where possible.
8. Treatment of streptococcal pharyngitis with antibiotics for the prevention of rheumatic fever and rheumatic heart disease.
9. Pharmacological treatment of albuminuric kidney disease with renin angiotensin system blockade and SGLT2 inhibitors.

Secondary prevention:

1. Aspirin should be available for suspected cases of myocardial infarction.
2. Management of ischemic heart disease, heart failure, stroke and peripheral artery disease with antiplatelet, anticoagulant, blood pressure lowering, diuretics and blood lipid lowering drugs.
3. Assessment of patients with a history of cardiovascular complications for social vulnerability and, if necessary, inclusion in programs covering cost of pharmacological treatment.

The main roadblocks to implementing cost-effective interventions:



- Interventions are not implemented due to lack of awareness, commitment, capacity, and action among policymakers, as well as economic and commercial factors.
- Gaps in investments for non-communicable diseases at national and international levels, coupled with poor technical and operational capacity of the healthcare system, undermine the implementation of effective policies.
- Inadequate prioritization of funding for cardiovascular and non-communicable diseases, which has persisted over time, is important, particularly in low- and middle-income countries. This problem is often exacerbated by the influence of external donors.

- Shortage of health workers, including general practitioners and specialists, pose challenges to dealing with non-communicable diseases and hinder access to care, particularly in remote areas.
- Lack of awareness and delayed inclusion of circulatory diseases in primary care service packages are further obstacles.

The solutions:

- Overcoming context-specific barriers requires collaborative efforts involving multiple stakeholders from various sectors, including the business sector, media, civil society organizations, religious leaders, and regulatory and financing bodies



as well as implementation research to identify barriers and test solutions.

- Strengthening advocacy and communication efforts, including educating policymakers on the burden of circulatory diseases through evidence and surveillance data and savings (lives and financial), is important.
- Roundtables and multistakeholder dialogues can be effective in understanding and addressing challenges related to the implementation of cost-effective interventions for circulatory diseases.

KEY RECOMMENDATIONS FOR POLICYMAKERS:

Take action to expand coverage of essential health services for circulatory conditions to all by 2030, with the aim of reducing catastrophic out-of-pocket expenditures and increasing availability of and access to quality health services in line with the SGD 3 target.

1

As the fulcrum of Universal Health Coverage, primary care should be made a priority for public health funding and health workforce allocation.

2

Prioritize the list of evidence-based cost-effective interventions in the design of health benefit packages for primary healthcare at the national level.

3

CONCLUSIONS

To achieve UHC and improve health and development, it is crucial to expand coverage of essential services for circulatory conditions at the primary health care level, by including existing evidence-based interventions in national health benefit packages. In addition, it is crucial for governments to prioritize PHC in public health funding and health workforce allocation to improve access to quality health services for circulatory conditions for all by 2030.

Definitions:

Circulatory diseases: Circulatory diseases are conditions affecting the heart and blood vessels. These include, but are not limited to, heart disease, stroke, diabetes, chronic kidney disease, heart failure and hypertension. Together, they cause over 20 million deaths and 374 million years of life lost every year, affecting young and old, rich and poor, in rural and urban settings, in all continents.

Non-communicable diseases (NCDs): NCDs are conditions that are not spread through infection. These diseases are the leading global cause of death and pose significant risks to health and development, especially in low- and middle-income nations. The most common NCDs include cardiovascular diseases, diabetes, cancer and chronic respiratory diseases.

Universal Health Coverage (UHC):

The three dimensions defining UHC are:

- 1. Population coverage:** Everyone who needs health services should be able to access them, regardless of their ability to pay for such services or their geographical location.
- 2. Service coverage:** Availability of a full range of quality essential health services, from health promotion, prevention, treatment, rehabilitation and palliative care should be guaranteed.
- 3. Financial protection:** When accessing such health services, individuals and communities should not suffer financial hardship to pay for them.

Primary health care (PHC): PHC is a health system pillar focusing on making sure that people are as healthy as they can be and that they have access to the care they need, from staying healthy and preventing diseases to getting treatment and support when they are sick or need help. The goal of PHC is to provide quality care as close to where people live as possible. A strong PHC is therefore essential to make UHC truly universal.

Catastrophic health expenditures (CHE): Catastrophic health expenditure (CHE) occurs when a household spends more on out-of-pocket payments for healthcare than they can afford based on their income or ability to pay.

Primary prevention: Primary prevention involves actions taken by the individual to address unhealthy behaviours, such as smoking, lack of exercise and unhealthy diet, that are known to be among the main causes of circulatory diseases.

Secondary prevention: Secondary prevention of circulatory diseases involves early diagnosis and taking steps to prevent an existing condition from getting worse or occurring again. With early diagnosis, individuals can receive the necessary treatments and lifestyle counselling, leading to an improved quality of life.

Polypill: A polypill can be defined as the combination of two or more medications in fixed doses provided in a single pill. Polypills are generally prescribed for the prevention of circulatory conditions, by controlling risk factors, such as hypertension and/or high cholesterol.





**THE ROAD TO UHC:
WHY INTEGRATION OF CIRCULATORY HEALTH
INTERVENTIONS IN PRIMARY CARE IS ESSENTIAL –
SUMMARY PAPER**



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