



Allianz
Partners



ALLIANZ PARTNERS

Redefining Chronic Care

Global Lessons and MENA Opportunities for a Healthier,
More Sustainable Future

Page 3

Executive summary

Page 4

Chronic conditions as a global health and economic imperative

Page 6

Limitations of traditional chronic care models

Page 7

Evolving models and international approaches

Page 11

From principle to practice: implementing chronic care models

Page 13

From idea to impact, integrated care, proven results

Page 20

Looking ahead: Chronic Care Management a responsibility, not a perk

Page 22

References

Executive summary

Redefining Chronic Care: Evolving Models for a Global Health Imperative

Across the globe, chronic non-communicable conditions such as diabetes, and cardiopathies are exerting unprecedented pressure on healthcare systems, insurers, employers, and individuals alike.

These conditions now account for over 70% of global deaths, and the trend continues upward. Their impact is not only clinical—it is economic, systemic, and societal.

Despite the growing urgency however, the structural models that govern care delivery have remained largely reactive. Most healthcare systems are still configured around episodic interventions, with limited coordination across providers, uneven patient engagement, and scarce use of data to guide treatment decisions. The result is inefficiency, rising costs, and care experiences that often fall short of both clinical goals and patient expectations.

This white paper reflects on the need for a more integrated, anticipatory approach to managing chronic conditions. Drawing on international examples and established evidence, it explores how countries including the United States, Sweden, Finland, and the United Arab Emirates are rethinking care through policy, technology, and patient-centered design. The aim is not to offer a one-size-fits-all solution, but rather to identify adaptable principles that can inform local contexts. Among the common threads is a shift in emphasis: from fragmented to coordinated care, from acute intervention to long-term management, and from provider-centric to patient-enabled models.

In the United States, Medicare's Chronic Care Management (CCM) programme has led to lower hospital admissions and improved medication adherence. Finland's North Karelia Project, meanwhile, demonstrated the power of community-based interventions in reducing cardiovascular mortality. In the MENA region, the chronic care programme implemented for Nextcare portfolio in the UAE adds to this evidence base: by prioritizing telehealth access, centralized case management, integrated services, and medication support, the initiative achieved measurable improvements in diabetes and lipid control, high patient satisfaction, and reduced administrative complexity.

Yet while evidence accumulates, implementation remains uneven. Many organizations still view chronic care as an ancillary service rather than a strategic imperative. Bridging that gap requires more than innovation—it requires alignment: across funding models, care teams, digital infrastructure, and policy frameworks.

This paper concludes by proposing a practical framework for action, tailored to insurers, employers, and policymakers. It suggests that chronic condition management should not be viewed solely through a clinical lens, but as a fundamental element of sustainable health systems and resilient economies. Forward-thinking stakeholders are encouraged to:

- 1. Embed proactive chronic care into standard benefits design.**
- 2. Invest in infrastructure that enables continuity.**
- 3. Promote patient literacy and engagement as essential components of success.**

Chronic disease is now a defining challenge of modern healthcare. How we respond will shape not only the future of care delivery, but the health and productivity of populations worldwide. The path forward lies in integration—of systems, data, and responsibility.

Chronic conditions as a global health and economic imperative

A reframed problem statement establishing context and urgency



Global Landscape

Chronic noncommunicable diseases (NCDs) such as cardiovascular conditions, cancer, chronic respiratory diseases, and diabetes are the leading causes of mortality worldwide. In 2023, NCDs accounted for approximately 74% of all deaths globally, with cardiovascular diseases alone responsible for over 19 million deaths.¹

These conditions are not only a health concern but also impose significant economic burdens. In the United States, for instance, about 90% of the annual \$4.1 trillion health care expenditure is attributed to managing and treating chronic and mental health conditions.²

MENA Region: A Rising Tide

The Middle East and North Africa (MENA) region mirrors global trends but with growing urgency. Recent estimates indicate that 66% of all deaths in MENA are attributable to NCDs—a striking figure that underscores the scale of the region's public health challenge.³

Within this broader burden, diabetes stands out as a condition of particular concern, with prevalence rates reaching 17.6%—the highest in the world. Such figures reveal the deep interconnection between lifestyle, environmental, and genetic factors contributing to NCD vulnerability in the region.

Adding further complexity, the median age in MENA is just 29.4 years, markedly lower than in most developed economies, where it typically exceeds 40. This demographic contrast highlights a paradox: while the region remains comparatively young, it faces a disease profile characteristic of older populations. Without sustained and integrated interventions, the long-term implications for workforce productivity, healthcare costs, and national development could be substantial.

Several factors contribute to this trend:

Aging Population: Advancements in healthcare have increased life expectancy, leading to a higher proportion of elderly individuals who are more susceptible to chronic conditions.

Urbanization and Lifestyle Changes: Rapid urbanization has led to sedentary lifestyles and unhealthy dietary habits, increasing the risk of chronic diseases.

Rising Obesity Rates: Obesity is a key driver of chronic disease in MENA. Between 1990 and 2021, obesity more than doubled among women and tripled among men in the region. In some countries, over 40% of adults are now obese, increasing the risk of diabetes, heart disease, and cancer.⁴

Implications for Stakeholders

The rising burden of chronic diseases in the MENA region has significant implications for insurers, employers, and healthcare providers:

Increased Healthcare Costs

Managing chronic diseases requires long-term care, leading to higher healthcare expenditures.

Productivity Loss

Chronic conditions can lead to absenteeism and reduced productivity among the workforce.

Insurance Challenges

Insurers may face increased claims and need to adjust their models to accommodate the growing demand for chronic care management.

Chronic diseases represent a growing health and economic burden, particularly in the MENA region. Their effective management is critical to safeguarding health systems, insurers, and labor productivity. Yet, despite the urgency, traditional care models often fall short in addressing these challenges comprehensively. In the next chapter, we undertake a critical analysis of prevailing care structures to understand why conventional approaches struggle to meet the complex demands of chronic disease management. This examination will reveal key gaps that must be addressed to build more resilient, efficient, and patient-centered health ecosystems.

Limitations of traditional chronic care models

A critical analysis of prevailing care structures

Traditional healthcare models, despite their foundational role, traditional healthcare models struggle to meet today's evolving demands. Predominantly reactive in nature, they often initiate treatment only after symptoms manifest. Fragmented services, outdated workflows, and limited patient engagement create gaps in care continuity and accessibility. These systems often prioritize episodic treatment over proactive, holistic health management—resulting in inefficiencies, higher costs, and unmet patient needs.

This chapter dives into the inherent limitations of these prevailing structures, revealing why this approach is particularly inadequate for managing chronic diseases, which require continuous and coordinated care.



- a. **Fragmented Care:** In many healthcare systems, patients navigate through a maze of specialists, diagnostic tests, and pharmacies without cohesive coordination. This fragmentation leads to inconsistent treatment plans, patient confusion, and increased risk of medical errors. Studies have shown that care fragmentation is associated with higher rates of hospital admissions for chronic disease management and psychiatric illnesses.⁵
- b. **Missed Follow-Ups and Poor Adherence:** The lack of structured follow-up strategies and patient involvement results in poor adherence to treatment plans. This not only compromises patient outcomes but also escalates healthcare costs due to preventable complications.⁶
- c. **Duplicate Testing and Inefficiencies:** Inadequate communication among healthcare providers often leads to redundant diagnostic tests and procedures. This not only burdens patients but also strains healthcare resources, contributing to inefficiencies and increased costs.⁷
- d. **Data Silos:** Inadequate data sharing among stakeholders impedes comprehensive care planning and monitoring. Data silos hinder care coordination, leading to fragmented patient records and suboptimal outcomes.⁸
- e. **Economic Implications:** The cumulative effect of these shortcomings is significant. Increased hospitalizations, unnecessary procedures, and poor disease management contribute to higher insurance claims and reduced workforce productivity. Addressing these systemic issues is crucial for improving patient outcomes and optimizing healthcare expenditures.⁹

The shortcomings of traditional healthcare models are no longer just challenges—they are barriers to progress. Fragmentation, inefficiency, and reactive care undermine chronic disease management and inflate costs, demanding bold transformation.

In the next chapter, we critically examine pioneering chronic care models and forward-thinking regulatory frameworks worldwide—blueprints for the future of integrated, value-driven healthcare.

Evolving models of CCM and international approaches

A comparative review of selected national approaches and regulatory innovations

As chronic conditions continue to pose significant health and economic challenges worldwide, several countries have implemented innovative chronic care models. These models offer valuable insights and strategies that can be adapted to address similar challenges in the MENA region.

United States: Medicare's Chronic Care Management (CCM) Program

The Centers for Medicare & Medicaid Services (CMS) introduced the Chronic Care Management (CCM) program to enhance care coordination for Medicare beneficiaries with multiple chronic conditions.¹⁰

Key features of the program include:

- **Comprehensive Care Plans:** Development of personalized care plans that address the specific health needs and goals of each patient.
- **Regular Patient Follow-Ups:** Continuous monitoring and communication between patients and healthcare providers to manage health conditions effectively.
- **Health IT Systems:** Utilization of electronic health records and other health information technologies to facilitate information sharing among providers.¹¹



Studies have shown that the CCM program leads to improved patient outcomes, reduced hospitalizations, and lower healthcare costs.¹²

Nordic Countries: Integrated Care Systems

Nordic countries, including Sweden, Finland, and Denmark, have developed integrated care systems that emphasize preventive measures, patient education, and community-based interventions.

Notable initiatives:



Sweden's Norrtälje Model:

A collaborative approach that combines health and social care services to provide coordinated care for the elderly and those with chronic conditions.¹³



Finland's North Karelia Project:

A public health initiative that successfully reduced cardiovascular disease mortality through community engagement, lifestyle modifications, and risk factor management.¹⁴



Denmark's Health Literacy Programs:

Efforts to improve health literacy among citizens, empowering them to make informed health decisions and engage actively in their care.¹⁵

These integrated care models have demonstrated effectiveness in improving health outcomes and can serve as valuable references for developing chronic care strategies in other regions.

Global Regulatory Landscape: Advancing Chronic Care Management

Chronic Care Management (CCM) has become a central focus for health systems worldwide, with regulatory bodies implementing mandates to enhance patient outcomes, promote preventive care, and transition towards value-based healthcare models. In the following we'll be providing an overview of key regulatory initiatives across various regions, including the Dubai Health Authority's (DHA) 2025 mandates.



Around the world, regulations are advancing value-based, coordinated chronic care—like CMS in the U.S., enabling tech-driven, flexible management to improve outcomes and reduce costs.

Strengthening Value-Based Care through CCM : United States

The Centers for Medicare & Medicaid Services (CMS) have long recognized the importance of Chronic Care Management (CCM) in enhancing primary care. Since 2015, CMS has provided reimbursement for non-face-to-face CCM services for Medicare beneficiaries with multiple chronic conditions. These services include structured recording of patient health information, comprehensive electronic care plans, care coordination, and management of care transitions.

In 2025, CMS introduced Advanced Primary Care Management (APCM) services under the Medicare Physician Fee Schedule. APCM services consolidate elements of existing care management codes—such as CCM, Transitional Care Management (TCM), and Principal Care Management (PCM)—alongside communication technology-based services like virtual check-ins and remote evaluations. Unlike previous codes, APCM services are not time-based, offering providers greater flexibility in billing and documentation. This shift underscores CMS's commitment to longitudinal, outcomes-focused care, aiming to simplify billing processes and enhance patient access to comprehensive primary care services.¹⁶

These developments reflect a broader trend towards value-based care, emphasizing preventive measures and coordinated management of chronic conditions to improve patient outcomes and reduce healthcare costs.



Embracing Integrated Care Models: European Union

The European Union (EU) has been actively promoting integrated care models to enhance the management of chronic diseases across its member states. These models emphasize coordinated care pathways, patient-centered services, and the utilization of health information technology to facilitate communication among healthcare providers.

A significant initiative in this realm is the EU's Reflection Process on Chronic Disease, which underscores the importance of integrated care models for chronic disease management and optimal self-care. This process highlights opportunities for newly added IT systems to support patient monitoring and emphasizes the need for patient-centered, personalized healthcare strategies that integrate preventive approaches.¹⁷

Furthermore, the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) focuses on actions developed around three pillars: prevention, screening and early diagnosis; care and cure (integrated care); and active ageing and independent living. The EIP aimed to increase the healthy lifespan of EU citizens by two years by 2020 and seeks to improve health and quality of life, enhance the sustainability and efficiency of care systems, and create growth and market opportunities for businesses.¹⁸



The EU's integrated care models combine prevention, technology, and personalized strategies to improve health, extend healthy lifespan, and ensure sustainable care.



In addition to these initiatives, the EU has been investing in research to optimize knowledge-based, predictive, patient-centered, and personalized healthcare strategies. This includes improving integrated care models for chronic disease management and exploring the feasibility and effectiveness of self-care, including new forms of self-care and their integration into current regulatory and financing frameworks.¹⁹

Regulatory Mandates for Chronic Care Management: United Arab Emirates

The Dubai Health Authority (DHA) is leading a transformative shift in the emirate's healthcare landscape with its 2025 mandates, aiming to enhance chronic disease management, promote preventive care, and align with global standards of value-based care.

Mandatory Health Insurance coverage came into effect in Dubai in 2013 with all private sector employees and domestic workers required to have basic health insurance coverage. As of January 1, 2025, private sector employers in all Emirates were mandated to provide this coverage as a prerequisite for issuing or renewing residency permits - ensuring broader access to essential healthcare services.

Emphasis on Preventive Care

DHA's 2025 public health law emphasizes disease prevention, early detection, and health promotion. Initiatives under this mandate include public awareness campaigns, vaccination drives, and routine health screenings aimed at early identification and management of chronic conditions.

Integration of Health Systems

To improve patient outcomes and streamline care delivery, DHA is promoting the integration of health systems across the emirate. The Network & Analysis Backbone for Integrated Dubai Health (NABIDH) initiative has unified over 9.47 million patient medical records within an integrated electronic system, linking more than 1,500 healthcare facilities. This integration facilitates seamless data sharing among healthcare providers, enhancing care coordination and enabling more personalized treatment plans²⁰.

Implications for Stakeholders

These regulatory changes signify a paradigm shift in Dubai's healthcare financing, moving towards a model that prioritizes prevention, personalization, and performance. For insurers, employers, and healthcare providers, this evolution underscores the growing importance of establishing structured chronic care management programs that not only align with DHA's integrated vision but also leverage shared data to deliver measurable improvements in outcomes, prevention, and cost efficiency.



DHA's reforms reinforce the need for structured chronic care programs that use shared data to enhance outcomes and efficiency.



From principle to practice: implementing chronic care models

A forward-looking view on key components and benefits

Key Components of Effective Chronic Care Programs

Drawing from global best practices, the following components are essential for successful chronic care management:

- **Personalized Care Plans:** Tailoring treatment strategies to individual patient needs, preferences, and health goals.
- **Remote Patient Monitoring (RPM):** Leveraging technology to track patient health metrics in real-time, enabling timely interventions and reducing the need for in-person visits.
- **Care Coordination:** Ensuring seamless communication among healthcare providers, patients, and caregivers to deliver consistent and efficient care.
- **Patient Engagement:** Empowering patients through education, self-management tools, and active participation in their care decisions.



Implementing these components can lead to improved patient satisfaction, better health outcomes, and reduced healthcare costs.

Clinical and Operational Advantages

- **Preventive Care:** CCM programs focus on early identification of at-risk individuals, allowing for timely interventions that can prevent disease progression.
- **Personalized Interventions:** By leveraging patient history, risk assessments, and behavioral data, CCM enables tailored care plans that address individual needs.
- **Proactive Monitoring:** Regular follow-ups and remote monitoring encourage medication adherence and lifestyle modifications, leading to better disease management.
- **Care Navigation:** CCM facilitates seamless coordination among healthcare providers, ensuring patients receive the right care at the right time.

Economic Impact

Implementing CCM programs has demonstrated substantial cost savings and efficiency improvements:

- **Reduced Healthcare Costs:** A study done by ChartSpan, the largest chronic care management (CCM) provider in the U.S., found that patients enrolled in their CCM programs experienced an average annual reduction of \$3,938 in total healthcare costs, primarily due to decreased inpatient and emergency department visits.²¹
- **Improved Medication Adherence:** CCM initiatives have led to significant improvements in medication adherence, which is crucial for effective chronic disease management.²²
- **Enhanced Telehealth Utilization:** The integration of telehealth in CCM has increased follow-up care and ongoing monitoring, contributing to better patient outcomes and reduced hospitalizations.²³
- **Decreased Emergency Visits:** CCM programs have been associated with a reduction in avoidable emergency department visits, alleviating strain on healthcare systems.²⁴
- **Better Diabetes Management:** Studies indicate that CCM approaches have been effective in managing diabetes, leading to improved clinical outcomes in primary care settings.²⁵

Business Case for Stakeholders

For insurers and employers, CCM programs offer a compelling return on investment:

- **Cost Savings:** By reducing hospitalizations and emergency visits, CCM lowers healthcare expenditures.
- **Productivity Gains:** Improved health outcomes lead to reduced absenteeism and increased workforce productivity.
- **Member Satisfaction:** Enhanced care coordination and patient engagement contribute to higher satisfaction rates.

In the MENA region, adopting CCM aligns with regulatory mandates and addresses the growing burden of chronic diseases. By investing in CCM, stakeholders can achieve better health outcomes and economic efficiencies.

In the MENA region, CCM supports regulatory compliance, tackles rising chronic disease, and delivers both health and economic benefits for stakeholders.



From idea to impact: integrated care, proven results

A pragmatic outline of CCM program available for Nextcare portfolio

The Chronic Care Management (CCM) program available for Nextcare's portfolio, launched in June 2023 was designed to address the multifaceted challenges of chronic care management, and aligns with the global best practices and regional regulatory mandates.

This model, delivered via partnership with a Telehealth provider, replaces fragmented, location-bound care with 24/7 access to virtual consultations, centralized case management, and seamless integration of nutrition, mental health, and prescription services.

The voluntary nature of the program and convenience-driven interfaces ensure members feel empowered, not encumbered.

Delivered via a telehealth-first framework that aligns care provision with cost control the program offers accessible, proactive, and data-driven management of chronic diseases via remote channels.

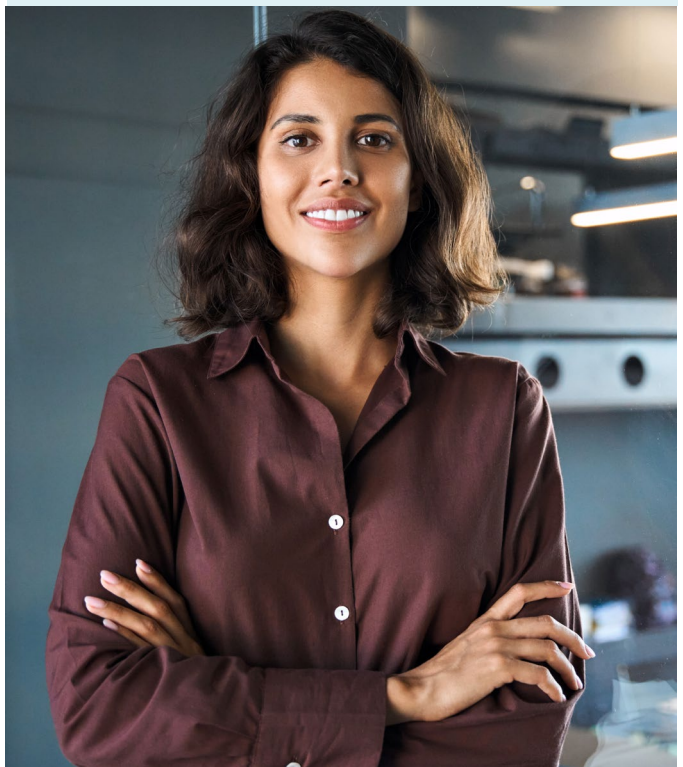
By integrating digital tools, personalized care, and data-driven strategies, it provides a comprehensive solution that benefits both patients and stakeholders. The care journey - from doorstep sample collection to prescription refills - is managed remotely, allowing members to focus on wellness, not logistics.

Enrolment is streamlined via WhatsApp, phone, or email, minimizing friction and boosting uptake. Once onboarded, members access an integrated suite of services:

- Teleconsultations with licensed primary care physicians
- Tailored care plans and nurse-led check-ins
- Prescription delivery and medication adherence support
- Doorstep sample collection for labs
- Nutrition and mental health consultations
- Specialist referrals coordinated directly



Chronic Care Program:
Delivered via a
telehealth-first
framework that aligns
care provision with cost
control



Core Components of CCM Program available for Nextcare's portfolio

This chronic care model delivers end-to-end support through three integrated pillars, ensuring continuity, accessibility, and tailored care at every step.

- a. **Care Coordination:** A dedicated team ensures patients navigate care confidently:
- **Teleconsultation:** Secure, on-demand access to general practitioners and specialists.
 - **Nurse Support:** Ongoing guidance and check-ins to reinforce treatment adherence.
 - **Specialist Referrals:** Seamless connections to in-network specialists for complex care needs.

- b. **Medication Management:** Ongoing care is streamlined by the help of tools that reduce friction and delays:

- **Medication Delivery:** Home delivery of chronic medications to ensure consistency.
- **Labs & Radiology:** Direct scheduling and coordination of essential tests and diagnostics.
- **Appointment Booking Team:** A concierge-style service to manage visits across care providers.

- c. **Patient Education:** Empowered patients lead to better outcomes. Among tools included one can find:

- **Nutrition Support:** Access to licensed nutritionists for condition-specific dietary guidance.
- **Mental Health Support:** Integrated behavioral health check-ins and resources.
- **Tailored Care Plan:** Personalized, goal-oriented care plans designed in collaboration with the care team.



**Care
Coordination**



**Medication
Management**



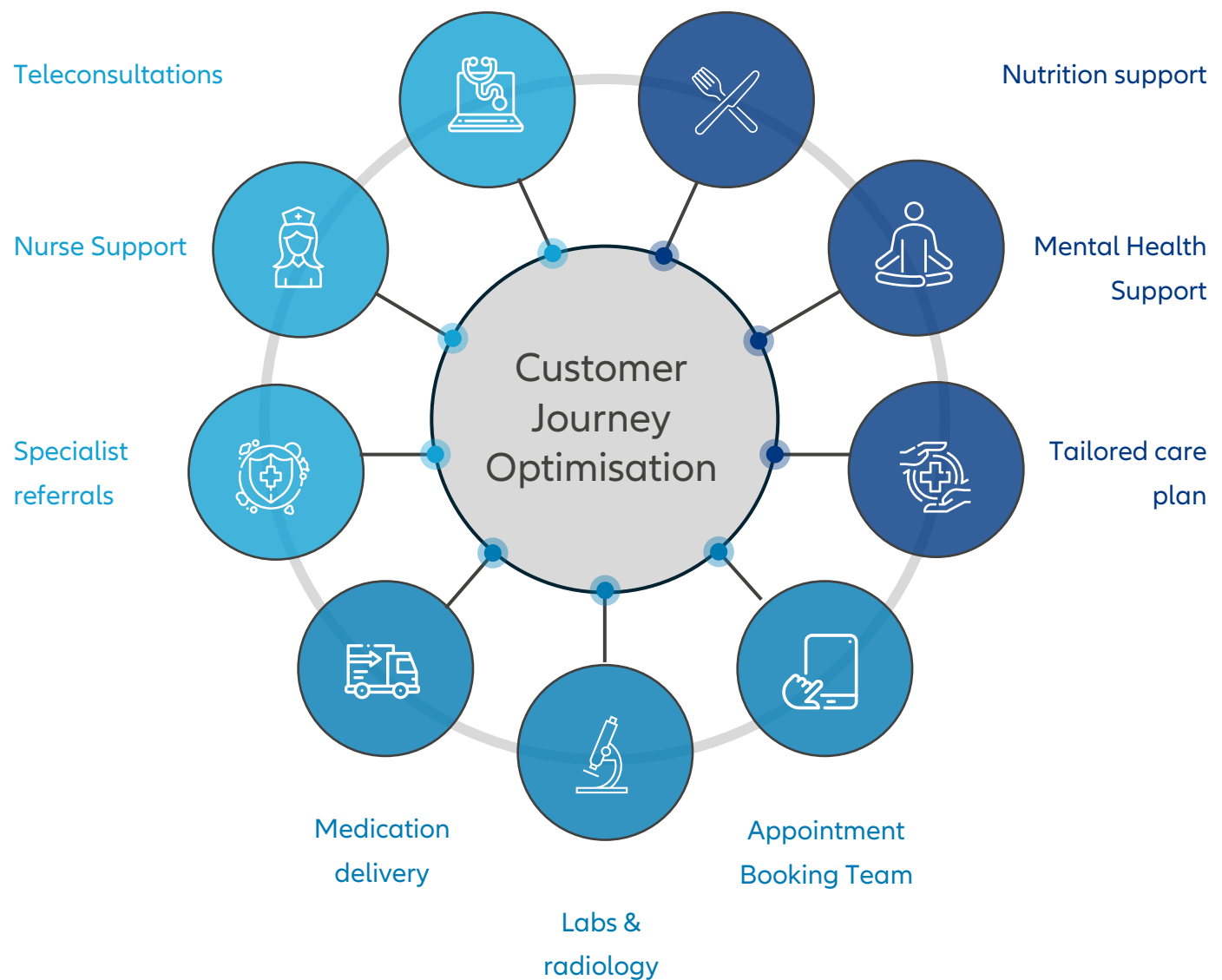
**Patient
Education**



A comprehensive chronic care model built on three integrated pillars for continuous, accessible, and personalized care.

Chronic care program components

Chronic Care that feels like bespoke medicine



CARE COORDINATION



PATIENT EDUCATION



MEDICATION MANAGEMENT

Chronic care program: journey



REFILL REMINDERS

We call the member when it's time for refills



APPOINTMENTS

We schedule their appointment



TELECONSULTATIONS

Our doctors draw up tailored care plans



LAB TESTS

Doorstep sample collection



PRESCRIPTION DELIVERY

Medication is delivered to their doorstep



SPECIALIST REFERRAL

We facilitate referrals as required



NURSE CHECK-IN

Periodic check in with member for treatment adherence



NUTRITION

We book the member in for Nutrition Consultations



MENTAL HEALTH SUPPORT

We book the member if they need additional support



Chronic conditions management via a structured Telehealth approach with personalized care plans, medication management & adherence, nutrition and mental health support, tailored to each member's needs.

Program Tiers

Premium plan inclusions	Gold	Platinum
Teleconsultations	●	●
Medication Management, delivery & labs	●	●
Labs & radiology with home sample collection	●	●
Nurse Checks	●	●
Program Utilization Reports for Payer	●	●
Personalized Patient Health Reports		●
Anonymized Health Reports for Payers		●
Complimentary Nutrition consultation		●
Preferred rates for further Nutrition consultations		●
Complimentary Mental Health Counselling		●
Preferred rates for further Mental Health consultations		●
Complimentary Wellness Screening		●

Key Benefits

For Users

- **Tailored Care:** Comprehensive, personalized support leads to better health outcomes.
- **Proactive Monitoring:** Early detection and intervention empower healthier lifestyles.
- **Lifestyle Change Support:** With timely support, users can adopt healthier habits and improve overall well-being.

For Businesses:

- **Optimized Resource Allocation:** Advanced reports enable efficient targeting of investments.
- **Enhanced Patient Insights:** Deep, personalized data inform strategic care management.
- **Increased Satisfaction:** Premium services boost member loyalty and overall well-being.



Health Outcomes of Telehealth-Delivered Chronic Care

The Chronic Care program exemplifies how telehealth can drive meaningful improvements in health outcomes for patients managing non-communicable diseases (NCDs). By leveraging personalized coaching, patient education, medication management and the added convenience of virtual consultations, the program empowers patients to take control of their health while enabling insurers and employers to reduce long-term costs and improve workforce well-being.

With a program retention rate of 90% and member satisfaction reaching 95%, the initiative reflects both sustained engagement and high perceived value among participants.

Among patients enrolled for at least 6 months in the program:

- 62% showed measurable improvement in glycemic control.
- Average HbA1c reduction of 1.6% - a clinically significant change.
- 59% had lowered LDL (Low-Density Lipoprotein or 'Bad Cholesterol')
- Average LDL reduction was 31mg/dl

These outcomes align with fewer hospitalizations, reduced cardiovascular risk, and lower claims downstream. Furthermore:

- High program retention and satisfaction rates underscore proven patient engagement
- Each 1% improvement in HbA1C in patient population significantly lowers risk reduction of myocardial infarction, diabetes related deaths and microvascular complications. ([Source](#))
- Every 39mg/dl reduction of LDL leads to 20% lower cases of Cardiovascular Diseases ([Source](#))

90%

program retention rate since launch

95%

member satisfaction since launch

Source: Health at Hand data (June 2023 – December 2024)

	A1c	LdL
Number of patients	382	656
Patient with >1 health reading	119	195
% reduction in health reading	62%	59%
Avg change in health reading	-1.6	-33
Avg days taken for change (days)	255	244

“

The program’s **positive impact** is particularly evident in the management of **high-burden conditions** such as Type 2 Diabetes Mellitus and Hyperlipidaemia.

Financial and Utilization Impact of Chronic Care Management

Chronic Care Management (CCM) is not only about better health outcomes—it's about smarter, more sustainable use of healthcare resources.

A study comparing 536 members enrolled in the CCM program on the GN/GN+ network (where the burning cost and need for cost containment are the highest) with a control group of members living with similar conditions but receiving standard care provides compelling evidence.

Key financial Insights

- **Consultations:** Members in a CCM program had a 34% higher cost per consultation.
- **Prescriptions:** Despite higher consultation costs, the average cost per prescription was 66% lower.
- **Lab Encounters:** Average cost per lab encounter was 60% lower.
- **Overall Impact:** Taken together, CCM participants achieved an overall 63% lower cost per member per encounter compared to the control group.

66% lower

average cost per prescription

60% lower

average cost per lab encounter

Why these savings occur

1. Personalized Care

- Doctors with access to complete patient histories can fine-tune treatment plans with precision. Prescriptions are optimized to patient needs, using bioequivalents where appropriate, delivering both cost efficiency and optimal outcomes.
- Evidence-based guidelines are followed rigorously: high-cost medications, such as injectables, are only prescribed after suboptimal responses to gold-standard treatments.

2. Care Coordination

- Every patient's records are shared across the care team. Continuity is maintained regardless of which clinician is available, reducing duplicated lab tests and ensuring treatment plans remain uninterrupted.
- Governance models ensure consistent adherence to international standards across all touchpoints.

3. Proactive Monitoring and Patient Empowerment

- Chronic conditions often carry a heavy psychological burden, leading some patients to avoid care. CCM addresses this by removing uncertainty: dedicated care teams monitor patients, issue reminders for prescriptions, schedule lab tests, and coordinate referrals automatically.
- By reframing care from "Why should I do this?" to "Why not?", CCM enhances adherence and engagement, ensuring patients receive timely, effective interventions.



Through **personalized care, coordinated delivery, and proactive patient engagement**, CCM drives better outcomes while reducing avoidable costs.

Looking ahead: chronic care management is a responsibility, not a perk

The systemic, financial, and societal burden of chronic disease makes it imperative to target these conditions through coordinated and forward-thinking solutions. Noncommunicable diseases (NCDs) claimed at least 43 million lives in 2021—representing approximately 75% of all non-pandemic-related deaths worldwide²⁶—underscoring the scale and urgency of the challenge.

But no single entity can address this challenge alone.



To fully unlock the benefits of digital health, employers and insurers must place chronic condition management at the center of their wellbeing strategies. This goes beyond asking, “How will chronic illness impact our people or portfolios?” It requires continuous, cross-functional collaboration—with clinical, operational, and employee stakeholders—through every phase of designing, implementing, and managing digital health solutions.

Throughout this report, we outline key steps organizations can take to embed effective Chronic Care Management (CCM). But the starting point is a mindset shift: both employers and insurers must adopt an integrated approach—one that aligns culture, policies, and tools to actively support individuals living with long-term conditions.

This is no longer just a health issue—it’s a business-critical one. Chronic diseases are responsible for the bulk of healthcare spending and productivity losses. But when people feel supported—through coordinated care, access to digital tools, and preventive services—they stay healthier, more engaged, and less likely to drive up long-term costs.

The wider responsibility is also clear. In a world where expectations of corporate responsibility are shifting, CCM is not a value-add—it’s a baseline. Forward-thinking organizations understand that enabling healthier lives strengthens both retention and reputation.

As employers once took accountability for workplace injuries, and insurers for covering them, today’s leaders must confront the less visible but more pervasive burden of chronic illness—hypertension, diabetes, mental health conditions—and use digital innovation to intervene early, not react late.

Healthcare providers, regulators, insurers and employers must come together to embed CCM into the core of regional health systems.

The benefits are threefold:

**Alignment with
Regulatory Requirements**

**Enhanced Health
Outcomes**

Optimized Costs

- **Alignment with Regulatory Requirements:** Dubai's 2025 Public Health Law mandates enhanced healthcare standards, including comprehensive care for chronic diseases. Implementing CCM programs ensures compliance with such regulations, positioning stakeholders at the forefront of healthcare excellence.²⁷
- **Enhanced Health Outcomes:** CCM programs provide patients with personalized care plans, continuous monitoring, and education, leading to improved disease management and quality of life. Evidence suggests that such programs can reduce hospitalizations and emergency department visits, thereby improving overall patient health.²⁸

- **Optimized Costs:** By focusing on preventive care and efficient resource utilization, CCM programs can significantly reduce unnecessary healthcare expenditures. For example, care management programs have demonstrated a 20% reduction in hospitalization rates and a 13% decrease in emergency department utilization.²⁹

Embedding CCM in digital health strategies ensures that the future of work and care is not only more efficient—but also more equitable, sustainable, and human.



Strategic adoption of Chronic Care Management (CCM) programs, presents a clear path forward. These programs align with evolving public health mandates, deliver measurable improvements in patient outcomes, and contain rising healthcare costs.

References

1 <https://pmc.ncbi.nlm.nih.gov/articles/PMC10530322/>

2 [Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area](#)

3 [WHO EMRO - Turning Resolutions into Results: Accelerating Action on Noncommunicable Diseases in the Eastern Mediterranean Region](#)

4 [Global, regional, and national prevalence of adult overweight and obesity, 1990–2021, with forecasts to 2050: a forecasting study for the Global Burden of Disease Study 2021 - PubMed](#)

5 Care fragmentation and hospital admissions in chronic disease: Reference: Chen, A. H., Murphy, E., Yee, H. F., & Yee, H. F. (2017). Care Fragmentation, Health Care Utilization, and Costs among Older Adults with Multiple Chronic Conditions. *Medical Care*, 55(5), 420–428.

Summary: This study found that higher care fragmentation in patients with multiple chronic conditions correlates with increased hospital admissions and healthcare costs.

Fragmentation leading to inconsistent treatment and medical errors: Reference: Saultz, J. W. (2003). Defining and Measuring Interpersonal Continuity of Care. *Annals of Family Medicine*, 1(3), 134–143. Summary: Highlights that fragmented care decreases continuity, leading to inconsistencies in treatment and increased risk of medical errors.

Fragmented care and psychiatric hospital admissions: Reference: O'Malley, A. S., & Reschovsky, J. D. (2011). Referral and Consultation Communication Between Primary Care and Specialist Physicians: Finding Common Ground. *Archives of Internal Medicine*, 171(1), 56–65.

Summary: Demonstrates how lack of coordination between providers contributes to fragmented care and elevated hospitalization rates among psychiatric patients.

6 Poor adherence due to lack of follow-up and patient involvement: Reference: Osterberg, L., & Blaschke, T. (2005). Adherence to Medication. *New England Journal of Medicine*, 353(5), 487–497. Summary: This comprehensive review highlights that inadequate follow-up and limited patient engagement are major contributors to poor adherence across multiple conditions.

Impact on patient outcomes: Reference: DiMatteo, M. R. (2004). Variations in Patients' Adherence to Medical Recommendations: A Quantitative Review of 50 Years of Research. *Medical Care*, 42(3), 200–209.

Summary: Demonstrates that non-adherence significantly worsens health outcomes, including increased morbidity and mortality.

Escalated healthcare costs due to preventable complications: Reference: Iuga, A. O., & McGuire, M. J. (2014). Adherence and Health Care Costs. *Risk Management and Healthcare Policy*, 7, 35–44. Summary: Details how poor adherence leads to costly complications and hospitalizations, driving up overall healthcare expenditure.

7 Redundant testing due to poor communication: Reference: Gandhi, T. K., Sittig, D. F., Franklin, M., Sussman, A. J., Fairchild, D. G., & Bates, D. W. (2000). Communication breakdown in the outpatient referral process. *Journal of General Internal Medicine*, 15(9), 626–631. Summary: Demonstrates how communication failures during referrals often lead to repeat diagnostic testing, delaying care and adding unnecessary procedures.

Impact on healthcare resources and costs: Reference: Berwick, D. M., & Hackbarth, A. D. (2012). Eliminating waste in US health care. *JAMA*, 307(14), 1513–1516. Summary: Highlights that unnecessary and redundant testing due to communication gaps is a major contributor to healthcare inefficiencies and excess spending.

Patient burden from redundant procedures: Reference: Lohr, K. N., & Zebrack, B. (1997). Using clinical practice guidelines to improve care. *JAMA*, 278(8), 663–664. Summary: Discusses how fragmented communication among providers burdens patients with unnecessary tests and increases the risk of adverse events.

8 Data silos impede care coordination and comprehensive care planning: Reference: Vest, J. R., & Gamm, L. D. (2010). Health Information Exchange: Persistent Challenges and New Strategies. *Journal of the American Medical Informatics Association*, 17(3), 288–294. Summary: This paper discusses how poor data sharing and siloed health information systems limit effective care coordination and comprehensive care planning.

Fragmented patient records and suboptimal outcomes: Reference: Adler-Milstein, J., Embi, P. J., & Middleton, B. (2014). Improving Patient Safety and Quality of Care through Health IT: The Next Frontier. *Journal of the American Medical Association*, 312(14), 1447–1448. Summary: Highlights how data silos contribute to incomplete patient records, which in turn compromise clinical decisions and patient safety.

Impact of data silos on health outcomes and coordination: Reference: Raghupathi, W., & Raghupathi, V. (2014). Big Data Analytics in Healthcare: Promise and Potential. *Health Information Science and Systems*, 2(3). Summary: Reviews the challenges posed by fragmented data sources in healthcare, emphasizing how data silos impede integrated care delivery and worsen patient outcomes.

9 Increased hospitalizations and healthcare costs due to poor disease management: Reference: Bodenheimer, T., & Berry-Millet, R. (2009). Care Management of Patients with Complex Health Care Needs. Robert Wood Johnson Foundation. Summary: This report highlights how inadequate care coordination and poor chronic disease management lead to avoidable hospitalizations and elevated healthcare spending.

Unnecessary procedures and higher insurance claims: Reference: Shrank, W. H., Rogstad, T. L., & Parekh, N. (2019). Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA*, 322(15), 1501–1509. Summary: Identifies unnecessary medical procedures as a major driver of increased costs in the US healthcare system, inflating insurance claims significantly.

Reduced workforce productivity linked to poor health outcomes and economic burden: Reference: Goetzel, R. Z., et al. (2004). Health and Productivity Cost Burden of the "Top 10" Physical and Mental Health Conditions Affecting Six Large U.S. Employers. *Journal of Occupational and Environmental Medicine*, 46(9), 398–414.

Summary: Quantifies the economic impact of poor disease management on workforce productivity, emphasizing lost workdays and reduced output.

Systemic issues leading to inefficiencies and increased healthcare expenditure: Reference: World Health Organization (WHO). (2016). *Global Spending on Health: A World in Transition*.

Summary: Discusses how fragmented care systems contribute to inefficiencies, resulting in excessive healthcare spending globally.

References

- 10 [How Medicare's Chronic Care Management Works](#)
11. [Health literacy in the Nordic countries - Not only a determinant of health, but also a tool for health promotion](#)
- 12 [How Medicare's Chronic Care Management Works](#)
- 13 [The Norrtälje model: a unique model for integrated health and social care in Sweden - PMC](#)
- 14 [North Karelia Project - Wikipedia](#)
- 15 [Health literacy in the Nordic countries - Not only a determinant of health, but also a tool for health promotion](#)
- 16 [Advanced Primary Care Management Services | CMS](#)
- 17 [reflection_process_final_report_stakeholder_consultation_2012_en_0.pdf](#)
- 18 [GEN](#)
- 19 [reflection_process_final_report_stakeholder_consultation_2012_en_0.pdf](#)
- 20 <https://www.dha.gov.ae/en/media/news/970>
- 21 [cEffectivity of Chronic Care Management Programs - ChartSpan](#)
- 22 [CDC Grand Rounds: Improving Medication Adherence for Chronic Disease Management — Innovations and Opportunities | MMWR](#)
- 23 [4 Ways Telehealth Improves Chronic Care Management](#)
- 24 [Using Chronic Care Management Visits to Reduce the Number of Frequent Emergency Department Visits: A Pilot Study - PMC](#)
- 25 [The Chronic Care Model and Diabetes Management in US Primary Care Settings: A Systematic Review - PMC](#)
- 26 [Noncommunicable diseases](#)
- 27 [Dubai's 2025 Public Health Law | DAMAC Properties](#)
- 28 [Care Management: A Critical Component of Effective Population Health Management](#)
- 29 [Care Management: A Critical Component of Effective Population Health Management](#)

About the authors

This white paper was authored by a multidisciplinary team bringing expertise in marketing, data science, and clinical leadership

Peggy Chamoun – Head of Marketing and Communications, Nextcare

Peggy drives the vision and execution of strategic marketing and communications for digital health services, turning complex healthcare solutions into clear, engaging narratives.

Cynthia Mascarenhas – Customer Marketing Manager, Health at Hand

Cynthia bridges customer insights with marketing strategies, shaping campaigns that highlight the value of digital health services in everyday care.

Alexandra Alexe – Content Marketing, Nextcare

Alexandra crafts clear, evidence-driven narratives that bring complex healthcare topics to life, ensuring communications resonate with both B2B and B2C audiences.

Sameer Mankani - General Manager, Health at Hand

Sameer drives Health at Hand's growth by scaling digital health solutions and fostering strong collaborations across insurers, providers, and patients.

Dr. Divya Bansal - Medical Director, Health at Hand

Dr. Bansal ensures clinical quality and governance, aligning Health at Hand's digital services with international standards for safe, patient-centered care.

Minaz Faiyaz - Operations Manager, Health at Hand

Minaz oversees the seamless delivery of digital health services, ensuring operational excellence and a smooth experience for patients and partners alike.

Alexander Yakovlev - Data Scientist, Nextcare

Alexander leverages advanced analytics and machine learning to transform healthcare data into actionable insights that improve outcomes and efficiency.



For more detailed information on chronic care management, please contact your regional account manager or contact us at the following email address:
marketing&communications@nextcarehealth.com

Disclaimer & Copyright
Copyright © 2025 Allianz Partners.

The material contained in this publication is designed to provide general information only. While every effort has been made to ensure that the information provided is accurate, this information is provided without any representation or warranty of any kind about its accuracy and neither Allianz Partners, nor any other company of Allianz Group can be held responsible for any errors or omissions.

All descriptions of insurance coverage are subject to the terms, conditions and exclusions contained in the individual policy. Any queries relating to insurance cover should be made with your local contact in underwriting and/or broker. Any references to third-party websites are provided solely as a convenience to you and not as an endorsement by Allianz of the content of such third-party websites. Neither Allianz Partners, nor any other company of Allianz Group is responsible for the content of such third-party websites and neither Allianz Partners, nor any other company of Allianz Group does make any representations regarding the content or accuracy of materials on such third-party websites.

October 2025