World Health Organization

Service Delivery and Safety

WHO global strategy on people-centred and integrated health services

Interim Report

WHO global strategy on people-centred and integrated health services

Interim report

World Health Organization

Designed by CommonSense, Greece
Printed by the WHO Document Production Services, Geneva, Switzerland

Contents

Foreword

In recent years, the global community has made laudable progress toward achieving the Millennium Development Goals. Success has been hard earned through integrated investments and comprehensive development strategies. Within the health sector, this has resulted in targeted improvement in health outcomes and the strengthening of health programmes, as well as widening health coverage. Surveying the lives improved by these efforts offers much to celebrate.

Even as we commemorate these improvements, recent reports rightly demonstrate that our successes have been uneven and that we have the potential to improve lives still further, highlighting a clear need for health systems strengthening and emphasizing the paramount importance of primary health care and universal health coverage. These approaches encourage and support the development of health systems over vertical programming in an effort to provide people with the well-planned, integrated health services required to best respond to their health needs across their lifetime and ensure that necessary services reach the most vulnerable.

The global strategy on people-centred and integrated health services builds on the lessons learnt in recent decades and offers a way forward for comprehensive health systems design. Placing people and communities at the centre of health services planning in a way that makes health services more comprehensive and responsive, more integrated and accessible, offers us a coordinated method to address the diverse range of health needs facing humanity. The benefits of a people-centred and integrated approach are well documented: increased delivery efficiency, decreased costs, improved equity in uptake of service, better health literacy and self-care, increased satisfaction with care, improved relationships between patients and their care providers, and an improved ability to respond to health-care crises. The recent Ebola epidemic has further raised our awareness that a health system that is well organized, integrated and able to adapt to the needs of the people it serves is not only better positioned to respond to emerging threats, but is also more resilient to tackling the myriad of chronic diseases which plague our populations.

This includes strengthening core essential services as well as building an integrated approach towards strengthening disease surveillance, health security and health systems.

Recognizing that health systems are highly context-specific, this strategy does not propose a single model of people-centred and integrated health. Instead, a common set of principles and five strategic directions are presented to enhance countries' efforts to better coordinate care around people's needs. Long-term gains toward people-centred and integrated health services in pursuit of universal health coverage will, however, require a paradigm shift in policy action and a genuine commitment to engaging with communities in the attainment and protection of their health.

The present strategy is based on experience gained in different countries over the last few years, as well as on wide-ranging consultation with experts at the global, regional and national level, informed by a number of related global guidelines and policy commitments, regional strategies and initiatives in the area of universal health coverage, primary health care, health systems strengthening and social determinants of health. It should be emphasized that this is still an interim report that will undergo further broad consultation, with a view to being submitted to WHO's Governing Bodies in 2016.

The challenges are many and varied, but we can seek to build on successes and lessons learnt to move towards a future where health services are managed and delivered, with people as the cornerstone. We hereby invite your comments and look forward to working with countries and health-care leaders to shift the management and delivery of health services towards more integrated and person-centred approaches. This strategy represents the clear next step on our journey towards attaining health for all.
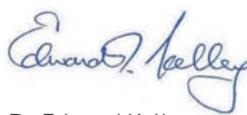
Dr Edward Kelley
Director
Service Delivery and Safety Department
World Health Organization

Acknowledgements

Executive summary

1. The World Health Organization (WHO) global strategy on people-centred and integrated health services is a call for a fundamental paradigm shift in the way health services are funded, managed and delivered. This is urgently needed to meet the challenges being faced by health systems around the world as populations are living longer and the burden of costly long-term chronic conditions and preventable illnesses that require multiple complex interventions over many years continues to grow. It is also essential to better prepare for and respond to health emergency crises through integrated services as became evident in the recent Ebola virus disease outbreak.

2. The strategy presents a compelling vision of a future in which all people have access to health services that are provided in a way that responds to their preferences, are coordinated around their needs and are safe, effective, timely, efficient and of an acceptable quality. A vision where the services available to people are better able to provide a continuum of care that meets all their health needs, in an integrated way, throughout their life course.

3. People-centred health services is an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. It requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases.

4. Integrated health services are health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course.

5. The WHO global strategy for people-centred and integrated health services builds on the universal health coverage and primary health care movements, as well as action on noncommunicable diseases and addressing the social determinants of health, but also on more recent calls to strengthen national health emergency and disaster management and the resilience of health systems. Many existing WHO global and regional strategies also fed into its development.

6. Achieving people-centred and integrated health services can generate significant benefits in all countries, whether low-, middle- or high-income countries, including conflict-afflicted and fragile states, small-island states and large federal states. However, there is no "one model" of people-centred and integrated health services. They have been employed in different country contexts as an effective strategy to meet a range of health system challenges. They should be viewed as a service design principle for strategies to enhance access and encourage universal health coverage, and primary and community-based care.

7. To meet the fundamental challenges faced by today's health systems, the strategy proposes five interdependent strategic directions that need to be adopted in order for health service delivery to become more people-centred and integrated. Interventions in specific country-contexts needs to be locally developed and negotiated. In each specific context, the exact

mix of strategies to be used will need to be designed and developed taking account of the local context, values and preferences.

8. Strategic direction 1 is the empowering and engaging of people through providing the opportunity, skills and resources. It seeks to unlock community and individual resources for action on health, empowering individuals to make effective decisions about their own and become co-producers of health services, while enabling communities to become actively engaged in co-producing healthy environments, providing care services in partnership with the health sector and contributing to healthy public policy.

9. Strategic direction 2 involves strengthening governance and accountability by promoting transparency in decision-making and creating robust systems for the collective accountability of health providers and health system managers that align governance, accountability and incentives.

10. Strategic direction 3 is the reorienting of the model of care so that efficient and effective health care services are purchased and provided through models of care that prioritize primary and community care services and the co-production of health. This encompasses the shift from inpatient to ambulatory and outpatient care, and the need for a fully integrated and effective referral system. It requires investment in holistic care, including health promotion and ill-health prevention strategies that support people's health and well-being. It will create new opportunities for intersectoral action at a community-level to address the social determinants of health and make the best use of scarce resources. The role of multiple sectors in an integrated manner is particularly critical for risk management for health.

11. Strategic direction 4 is the coordinating of services around the needs of people at every level of care, as well as promoting activities to integrate different health care providers and create effective networks between health and other sectors. It seeks to overcome the fragmentations in care delivery that can undermine the ability of health systems to provide safe, accessible, high quality and cost-effective care in order to improve care

experiences and outcomes for people. It entails the integration of key public health functions including surveillance, early detection and rapid emergency response capacity into the health service delivery system to address emergencies due to any hazard faced by the system.

12. Strategic direction 5 is the creation of an enabling environment that brings together the different stakeholders to undertake the transformational change needed. This involves making changes in legislative frameworks, financial arrangements and incentives, and the reorientation of the workforce and public policy-making.

13. Health service reform can be challenging at many levels. Addressing these challenges requires sustained political commitment, transformational leadership, change management approaches, and mobilizing and engaging health professionals and communities. Effective collaboration will be needed between all stakeholders in countries, with the support of WHO and other national and international partners, including development organizations, citizens groups, health provider associations, and academics and researchers.

14. These health reforms represent new directions for many health systems, developed in individual country contexts. To justify and support implementation, countries will need to generate their own evidence in parallel with making the reforms. This will involve the ongoing monitoring of outcome indicators to assess progress towards specific and measurable objectives, the strengthening of information systems, adopting an active learning approach and conducting implementation research on the reform strategies.

1. A new vision for service delivery

1.1 A call for change

The World Health Organization (WHO) global strategy on people-centred and integrated health services is a call for a fundamental paradigm shift in the way health services are funded, managed and delivered. This is urgently needed to meet the challenges being faced by health systems around the world. Populations are living longer and the burden of costly long-term chronic conditions and preventable illnesses that require multiple complex interventions over many years continues to grow. It is also essential to better prepare for and respond to health emergency crises through integrated services as became evident in the recent Ebola virus disease outbreak.

Unless a people-centred and integrated health services approach is adopted, health care will become increasingly fragmented, inefficient and unsustainable. Without improvements in service delivery, people will be unable to access the high quality health services that meet their needs and expectations. By adopting people-centred and integrated health services, health systems will provide services that are of better quality, are financially sustainable and more responsive to individuals and communities.

This strategy presents a compelling vision of a future in which all people have access to health services that are provided in a way that responds to their personal preferences, are coordinated around their needs and are safe, effective, timely, efficient and of an acceptable quality, throughout their life course.

1.2 Focus and scope of the strategy

Through this strategy, and its related support document[1], WHO seeks to:
- set out a compelling case for change towards people-centred and integrated health services
- explain what people-centred and integrated

health services are and the values that underpin them;
- provide evidence and examples of the benefits that a people-centred and integrated approach to health service delivery can bring to people and communities in different countries and regions of the world;
- present five key critical shifts that health systems need to make to become more people-centred and integrated;
- identify approaches to leading and managing this change; and
- outline ways that health systems can monitor, evaluate and learn from their progress towards people-centred and integrated health services.

1.3 A compelling case for change

1.3.1 Unequal progress in health

Despite significant advances in people's health and life expectancy, relative improvements have been deeply unequal both between countries and within them. For example, in 2011, nearly half of all HIV infected people eligible for antiretroviral therapy (ART) were not yet receiving it *(1)*. Only one third of people with mental health disorders in high income countries receive treatment, and this falls to as few as 2% in low- and middle-income countries *(2)*. Just 58% of countries have any form of palliative care programme *(3)*. Even for high priority conditions such as maternal and child health, coverage of basic services such as antenatal care and having a skilled birth attendant present at delivery, remains low. And when people do manage to access health services, lack of cultural acceptability, quality, respect or holistic understanding of their particular situation can make the services provided ineffective and inefficient.

1.3.2 A changing health care burden

The nature of health care problems, which were once focused on the management of infectious disease, has shifted. Health is increasingly shaped by ageing

---

1. People-centred and integrated health services: an overview of the evidence

populations, urbanization and the globalization of unhealthy lifestyles *(4)*, resulting in a transition in the burden of health care towards noncommunicable diseases, mental health and injuries. Many of these conditions are chronic, requiring long-term care, with patients commonly suffering from multimorbidities, adding further complexity and cost to their treatment and care *(5,6)*.

1.3.3 Common preventable causes of ill health

The common causes of many noncommunicable diseases means that a holistic approach to prevention can significantly enhance the health status of populations. Addressing the behavioural and societal causes of ill health such as lack of exercise, poor diet, tobacco use and environmental hazards is key. Effective action in this arena requires a radical reorientation of health services and related sectors, a re-balancing of priorities between treatment and prevention, and acknowledging the critical role that interventions in other sectors can play in influencing health *(7,8)*.

1.3.4 Fragmented health services

Moreover, the fragmented nature of today's health systems means that they are becoming increasingly unable to respond to the demands placed upon them. The focus on hospital-based, disease-based and self-contained "silo" curative care models undermines the ability of health systems to provide universal, equitable, high-quality and financially-sustainable care. This neglects the potential for primary prevention and health promotion to reduce the burden of disease *(9)*, while failing to embrace the benefits of intersectoral collaboration and better coordination of care around people's needs, hampering access to comprehensive, quality services *(10)*.

Fragmented care can also be seen in the many vertical disease-oriented programmes for HIV/AIDS, malaria, tuberculosis and other infectious diseases, and even in some chronic care management programmes. These approaches tend to foster duplication and the inefficient use of resources, producing gaps in the care of patients with multimorbidities and reducing overall health sector capacity by pushing the best health care workers to focus on single diseases. Moreover, vertical programmes cause inequity for patients who do not have the "right" disease. An alternative strategy is therefore needed that rebalances health service delivery and addresses the problem of "inequity by disease".

1.3.5 Meeting the challenges of today and tomorrow

Unless health systems are significantly reformed, it is unlikely that the current shortcomings in health care delivery will be addressed to meet the challenges of the future. Improving health outcomes requires a renewed focus on tackling the social determinants of ill-health and placing health at the centre of all policies through strong stewardship and intersectoral action. Without this, the excessive specialization of health care providers and the narrow focus on disease management programmes that discourages holistic care will continue to predominate. Despite the evidence, many health systems still do not appreciate the importance of continuity of care or the participation of patients, families and communities in the care process *(11)*. Health services for poor and marginalized groups, in particular, are often highly fragmented and under-resourced, with development aid often only adding to this fragmentation *(12)*.

People are often unable to make appropriate decisions about their own health and health care, or exercise control over decisions about their health and that of their communities. This problem is particularly acute among vulnerable and marginalized populations and further exacerbates existing inequities.

Service providers are often unaccountable to the populations they serve and therefore have limited incentive to provide the responsive care that matches the preferences and needs of their users.

Resources are often captured by more powerful and affluent groups and become focused on hospital-based services and curative care. This leaves primary/community care, and prevention and promotion services, underfunded, thereby perpetuating overly-medicalized models of care.

1.4 What are people-centred and integrated health services?

There is therefore an urgent need to encourage health systems to embrace a people-centred and integrated care approach to organizing health services. But what exactly are people-centred and integrated health services?

People-centred health services are an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of

trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases (adapted from *[13,14]*).

Integrated health services are health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course (adapted from *[15]*).

1.5 Core principles

There are many different approaches that can be taken to achieve people-centred and integrated health service delivery. But the goals and aspirations of these reforms should be grounded in a common set of principles. These provide a unifying values framework.

People-centred and integrated health services should be:

Comprehensive – offering care that is comprehensive and tailored to the evolving health needs and aspirations of people and populations, with a commitment to universal health coverage.

Equitable – providing care that is accessible and available to all.

Sustainable – delivering care that is efficient, effective and contributes to sustainable development.

Coordinated – ensuring that care is integrated around people's needs and effectively coordinated across different providers and settings.

Continuous – providing care and services across the life course.

Holistic – focusing on physical, socioeconomic, mental and emotional well-being.

Preventive – tackling the social determinants of ill-health through action within and between sectors that promotes public health and health promotion.

Empowering – supporting people to manage and take responsibility for their own health.

Goal-oriented – in terms of how people make health care decisions, assess outcomes and measure success.

Respectful – of people's dignity, social circumstances and cultural sensitivities.

Collaborative – supporting relationship-building, team-based working and collaborative practice across primary, secondary and tertiary care, and with other sectors.

Co-produced – through active partnerships with people and communities at an individual, organizational and policy-level.

Endowed with rights and responsibilities – that all people should expect, exercise and respect.

Governed through shared accountability – of care providers to local people for the quality of care and health outcomes.

Evidence-informed – so that policies and strategies are guided by the best available evidence and supported over time through the assessment of measurable objectives for improving quality and outcomes.

Led by whole-systems thinking – that views the health system as a whole and tries to understand how its component parts interact with each other and how the system is influenced by factors beyond it.

Ethical – by making sure that care optimizes the risk–benefit ratio in all interventions, respects the individual's right to make autonomous and informed decisions, safeguards privacy, protects the most vulnerable and ensures the fair distribution of resources.

1.6 Benefits

Achieving people-centred and integrated health care would have a dramatic effect upon peoples' experience of health services. It would also offer broad societal benefits by reorienting health service delivery to a model that emphasizes the co-production of care by individuals, communities and health workers. The range of potential benefits are outlined in Box 1.

Box 1. The potential benefits of people-centred and integrated health services

To individuals and their families
- increased satisfaction with care and better relationships with care providers
- improved access and timeliness of care
- improved health literacy and decision-making skills that promote independence
- shared decision-making with professionals with increased involvement in care planning
- increased ability to self-manage and control long-term health conditions
- better coordination of care across different care settings.

To communities
- improved access to care, particular for marginalized groups
- improved health outcomes and healthier communities, including greater levels of health-seeking behaviour
- better ability for communities to manage and control infectious disease and respond to crises
- greater influence and better relationships with care providers that build community awareness and trust in care services
- greater engagement and participatory representation in decision-making about the use of health resources
- clarification on the rights and responsibilities of citizens to health care
- care that is more responsive to community needs.

To health professionals and community health workers
- improved job satisfaction
- improved workloads and reduced burnout
- role enhancement that expands workforce skills so they can assume a wider range of responsibilities
- education and training opportunities to learn new skills, such as working in team-based health care environments.

To health systems
- enables a shift in the balance of care so that resources are allocated closer to needs
- improved equity and enhanced access to care for all
- improved patient safety through reduced medical errors and adverse events
- increased uptake of screening and preventive programmes
- improved diagnostic accuracy and appropriateness and timeliness of referrals
- reduced hospitalizations and lengths of stay through stronger primary and community care services and the better management and coordination of care
- reduced unnecessary use of health care facilities and waiting times for care
- reduced duplication of health investments and services
- reduced overall costs of care per capita
- reduced mortality and morbidity from both infectious and noncommunicable diseases.

The provision of health services must go beyond an emphasis on the hospital sector and specialist services towards a more coordinated approach that embraces primary and community care-led strategies and has the potential to be a more cost-effective way of delivering care.

To make the needed service delivery reforms, it will be necessary to contest current patterns of power, compel changes in provider attitudes and question strongly held beliefs about the types of health services that are most valuable.

This strategy proposes reforms to reorient health services, shifting away from fragmented provider-centred models, towards health services that put people and their families at their centre, and surrounds them with responsive services that are coordinated both within and beyond the health sector.

1.7 A conceptual framework

WHO has developed a conceptual framework to help map the relationships between the different parts of the health ecosystem that provides the context for people-centred and integrated health services (Fig. 1). This framework presents *individuals, families and communities* at its centre, placed within a *service delivery* context that supports *universal, equitable, people-centred and integrated health services*. These are delivered through integrated networks and linkages within the health sector, as well as direct inputs from communities. This happens within the context of the governance, financing and resources of the sector.

The framework acknowledges the need for *intersectoral action* in tackling the structural determinants of health and the close collaboration that is required between health, social care, education and the wider range of local services that can all contribute to better health for individuals, families and communities.

The framework also highlights that progress toward people-centred and integrated health service delivery must be supported by an *enabling policy environment* that promotes healthy public policies, the importance of universal health care and a commitment to equity, and encourages close collaboration between health and other sectors to improve population health.

Finally, the varying country and regional settings in which this strategy will be applied, with their different features in terms of political stability, socioeconomic development, governance, cultures and geographies provide the *environmental context* for the framework.

Fig 1. Conceptual framework for people-centred and integrated health services
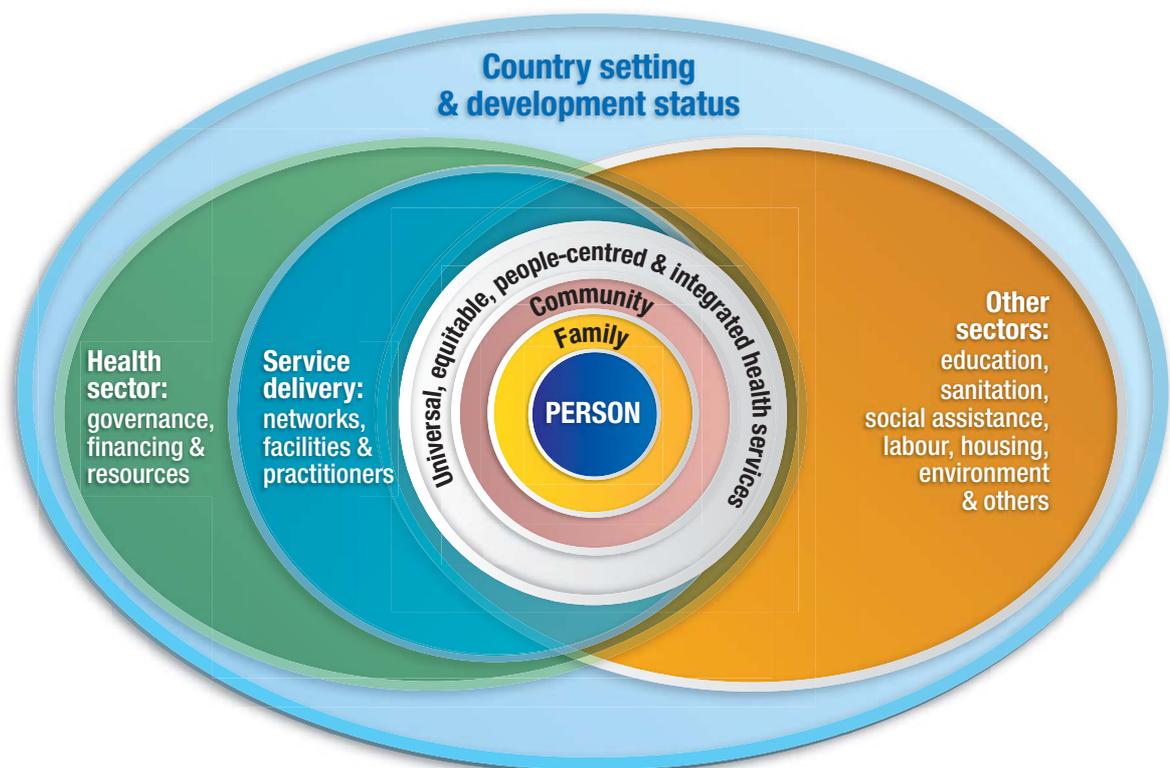
2. Building on a legacy of strategies

2.1 Universal health coverage

The growing movement for universal health coverage builds upon the global community's commitment to health as a human right and the right of everyone to secure the health services that they need without suffering financial hardship. It also builds upon the need to better tackle the social determinants of ill-health and strengthen health care systems based on the principles of equity, disease prevention and health promotion *(16)*.

National governments, as well as the international community, have a responsibility to do this. Indeed, a recent landmark United Nations resolution called upon governments to "urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services", and noted that it was particularly important to take special care of the most vulnerable and marginalized *(17)*.

Universal health coverage will not be achieved without improvements in service delivery so that all people are able to access high quality health services that meet their needs and expectations. Furthermore, service delivery problems such as excessive reliance on referral care rather than primary care, weak coordination between providers and inappropriate patterns of care that force patient readmissions, all inflate health care costs. A key feature of people-centred and integrated health services as a strategy, is how it seeks to align how resources (human and financial) are spent by seeking to provide "the right care at the right time in the right place". This principle is important in countries moving towards universal health coverage since scarce resources are likely to go to waste if governments do not also take action to transform service delivery. Without integration at various levels of the health system, all aspects of health care performance can suffer: patients get lost, needed services fail to be delivered, or are delayed, quality and user satisfaction decline, and the potential for cost-effectiveness diminishes *(18)*.

Universal health coverage and people-centred integrated health services should be regarded as interdependent and mutually reinforcing. Reviews of the evidence have pointed out that the adoption of integrated care strategies is more likely to succeed in systems of universal health coverage that distribute resources according to need *(19)*.

At the same time, the central features of people-centred and integrated health care are essential if the goals of universal health coverage are to be realized.

2.2 Primary health care

Since the 1978 Alma-Ata Declaration, primary health care has remained the cornerstone for action in health sector reforms and has gained many advocates, from governments and civil society organizations to care professionals and service users *(20)*. However, the translation of primary health care values into tangible reforms has been uneven and persistent barriers remain to be overcome in the reorientation and reform of health systems. Moreover, as the World Health Report 2008 made clear, societies' changing values and rising expectations for better and more integrated care include the demand for greater participation in decisions that affect health and well-being *(16)*.

People-centred and integrated health services are therefore needed as a means to strengthen and operationalize moves towards primary health care. This strategy argues that the way forward requires a paradigm shift that strengthens and builds on the primary health care movement. Intersectoral collaboration is needed and health care providers and local communities need to take shared accountability for the quality of care and outcomes. There is a need to enable generalists to work alongside specialists, care transitions from hospital to community-based settings to become more coordinated, and health care to partner with municipalities and local communities to devise new and more effective models of care.

2.3 Action on noncommunicable diseases

Broader intergovernmental attention has also been given to some of the key challenges that people-centred and integrated care strategies seek to address. For instance, the United Nations' General Assembly Resolution 64/265 on noncommunicable diseases in 2010, and the subsequent High-level meeting on the prevention and control of noncommunicable diseases in 2011, highlighted the significant priority that these health problems pose for countries. The meeting report recommended a focus on primary care to deliver "prioritized packages of essential interventions", encouraged the empowerment of people for self-care and underscored the need for an intersectoral response to achieve population wide improvements in noncommunicable disease rates and outcomes *(21)*.

2.4 Addressing the social determinants of health

The people-centred and integrated health services approach extends beyond traditional health system frameworks into broader intersectoral issues. The report of the Commission on the Social Determinants of Health *(22)* emphasized the need to focus on the social, economic and environmental causes of ill health, and underscored how people's individual circumstances, including their access to health services, and the responsiveness and effectiveness of health services, influences their health. Further, the report called for the strengthening of health sector governance and improved participation in decision-making.

2.5 Enhancing health security through resilient health systems

In 2011, the World Health Assembly agreed a resolution on strengthening national health emergency and disaster management capacities and resilience of health systems. In 2014, fragile and poorly integrated health systems were key contributors to the Ebola crisis in West Africa. The need to re-design the delivery of health services with people at the centre was clearly apparent during the initial response, the early recovery phase as well as in long-term planning for health systems resilience in the affected countries. For example, the central role of the community in shaping health services has been highlighted as a critical strategy to ensure trust in and ownership of services by users. A renewed focus on subnational delivery systems, on quality improvement and on strengthening core public health capacities for disease surveillance and response, that are fully integrated into the national health system, also became evident as part of the reconstruction efforts. The experience has had clear implications for integrated health services across the world and in particular in fragile settings.

2.6 Other strategies

In recent years, several WHO regions have developed relevant strategies that this strategy is both informed by and builds upon *(23,24,25,26,27,28,29,30,31)*. Other WHO strategy documents have focused on related issues including people-centred care as one of the four pillars of primary health care, integrated health services delivery networks, the health workforce *(32)*, expanding access to essential drugs *(33)*, health financing *(34)* and more generally, strengthening health systems *(35)*.

3. People-centred and integrated health services in different country contexts

3.1 Relevance in different country contexts

Achieving people-centred and integrated health services is an approach to strengthening health systems in all countries, whether low-, middle- or high-income countries. The approach should not be regarded as only a concern of rich countries, where significant fragmentations in the organization and delivery of care have built up over time. People-centred and integrated health services promote the economic, social and cultural right of everyone to a universal minimum standard of health and health care. Developing more people-centred and integrated care systems can generate significant benefits to the health and health care of all people, whether in high-, middle- or low-income countries. The approach can also lead to a range of beneficial outcomes for the strengthening of health systems.

Within different countries, there are differing socioeconomic, cultural, geographical, political and health system realities that provide the context that must inform the way that people-centred and integrated health care services are adopted. Particularly relevant to this, of course, is the significant variation in resources (both human and financial) that are available.

This section considers the challenges faced in low-, middle- and high-income countries, and also considers the challenges faced in specific circumstances such as in conflict-afflicted and fragile states, small-island states and large federal states with regionalized systems of care and significant in-country variation.

3.2 Low-income countries

"In my country, access to treatment is a very big challenge if one is not known by a health worker or comes from a poor society. One may take too long to access the attention of a doctor to prescribe and access drugs for treatment. As a result, women are sexually abused to get treatment favours. Some people use their political power,

economic status or position at work to access treatment"
Patient's brother, WHO African Region

Low-income countries typically face ongoing problems of physical access to public services, shortages of health workers and weak supply chains, although this varies significantly across different low-income country contexts. These problems are most manifest in remote and rural areas, and in general considerable inequities in access to basic services exist, such as for births with a professional delivery attendant, among different socioeconomic groups and between populations located in different regions of a country.

The population often makes extensive use of informal health care, where quality of care may be highly variable or low. Governments typically lack information on private providers (both formal and informal) and the services they provide, and rarely have effective regulatory authority over the private sector *(36)*.

The responsiveness of care is often poor, for example health care facility opening hours may be limited and lines for service long. Studies of the care provided to pregnant women in some low-income countries have highlighted instances of verbal abuse, condescension, intimidation and even physical abuse *(37, 38, 39)*. While the root cause of such problems is not entirely clear, the circumstances in which many health care workers are employed – poor physical environments, weak supervision, low pay and limited accountability to local communities – need to be taken into account.

Referral systems in many low-income countries are weak. Even where there is a formal referral system with guidelines on referral, health workers may not comply with these recommendations, and instead rely more on informal referral systems *(40)*.

Many low-income countries depend significantly on

funding from development partners to support their health services. Such funding is often used to support vertically-oriented services that may be weakly integrated with the country's own health system. While there is a recognized role for such vertical programmes, they may undermine service quality and inhibit service integration *(41)*.

3.3 Middle-income countries

"The health services are focused on treating serious conditions, there is no facility or focus on disease management for my condition. I have to get myself tested and take care as preventive facilities are not available…There should be an emphasis on public health promotion. Health is mainly a matter of personal habits…motivation plays a major role in countering diseases like diabetes and hypertension, which are called lifestyle diseases"
Male patient, WHO South-East Asia Region

As countries become richer, many of the basic problems of geographical access to services are likely to resolve and the overall supply of health workers and the health infrastructure improve. However, there may be significant differences within a country in access to services, such as between affluent and less affluent regions *(42)* and between permanent urban residents and migrant workers *(43)*.

Dynamic emerging economies are often undergoing rapid societal change with far-reaching implications for both disease profiles and health services. An increasing burden of chronic, noncommunicable diseases may drive concerns about improving the technical quality of care. Chronic diseases, particularly when there are multimorbidities, are typically harder to treat effectively than more acute conditions, and require a reorientation of health services. One synthesis of the quality of diabetes treatment in Central and South America concluded that there was "a consistent failure to meet recommended care goals due to multiple underlying social and economic themes" *(44)*. In this setting, barriers to improving provider quality included unclear policy guidance and gaps in service documentation, while among patients, lack of education and low health literacy were perceived to be problematic. In many emerging economies, care pathways or guidelines are not yet established. Further, health care regulatory mechanisms are often weak and there may be persistent problems related to substandard or counterfeit drugs *(45,46)* and poorly trained health personnel.

As populations become increasingly urbanized and more educated, they are likely to aspire to higher standards of care *(47)*. Rising expectations of services may lead people to bypass primary care facilities, believing that service quality is better at hospitals. Also, the private health sector may grow rapidly as the public sector struggles to keep up with increasing demand and expectations. This may be the case particularly in countries where there is a thriving medical tourism industry *(48)*. Uncontrolled private sector growth may shift resources away from public facilities and exacerbate inequity. Urbanization may also disrupt social structures, making it harder to engage communities in decision-making about health services or ensure close patient–provider relationships.

Relatively recent evidence on the responsiveness of services exists from a number of emerging economies. One study from India found that promptness of attention and issues around autonomy of the patient and confidentiality constitute the biggest concerns, but major differences existed between public and private facilities, with private facilities consistently outperforming public ones *(49)*.

While emerging economies can frequently afford to invest more in health services than they have done previously, the combination of rising consumer expectations and aging populations frequently puts considerable pressure on health care costs, and has led many middle-income countries to consider how best to contain costs *(50)*. This has directed attention to ensuring greater use of primary care services and the strengthening of referral systems.

3.4 High-income countries

"[We need] better integration of…specialized care with primary care…We need to use all possible means: experts should move, not always the patients. Data should also move [with patients] and eHealth opportunities [need to also be used] maximally…This is necessary if we want to shorten waiting times and improve patient satisfaction"
Health care manager, WHO European Region

In most advanced economies the basic challenges to service access have been addressed. However, as in emerging economies, significant inequities in health services remain, with marginalized or socially excluded populations having poorer access than the general population *(51)*. Difficulties may also

remain in ensuring access to quality services for those living in remote rural areas and service access disparities persist between more and less affluent communities. Some have argued that the recent economic recession has exacerbated such disparities, but the evidence on this is unclear *(52)*.

The greatest burden of morbidity and mortality in high-income countries is attributable to chronic and noncommunicable diseases. Many people have multiple morbidities that make their care needs complex and the costs of their treatment higher *(53,54)*. A recent survey of people with such needs across 11 advanced economies found substantial gaps in the coordination of their health care. In addition, many individuals with multiple and complex chronic illnesses also require coordination of care with other services such as social care, housing, employment, family welfare and disability support programmes. Prevention of noncommunicable chronic diseases also requires close collaboration with other sectors. Frequently governments are not well-equipped to coordinate such services across sectors. Service integration and coordination therefore often remains problematic, with disease control programmes sometimes poorly integrated into general health services, and poor information flows between different service providers.

3.5 Countries facing special circumstances

"What I value the most [in] my work is good relationships with [the] people we, the nurses and me, care for…We have a post-conflict multi-ethnic population: people who…[sought] refuge [in] other parts of our country (myself [included]) [have] settled here,…a lot of…similar destinies and possibilities for misunderstanding. Once as bad as enemies – now they sit in [the] waiting room together and talk, and understand each other. For us, it is a great responsibility and obligation"
Male general practitioner, WHO European Region

Besides countries' economic status, other factors may affect health service development.

Conflict-affected and fragile states often have very high burdens of ill-health, particularly chronic mental health problems related to previous traumas, coupled with health systems that have suffered years of neglect and/or disruption *(55,56)*. More than 1.5 billion people live in countries affected by violent conflict and these conflict-afflicted and fragile states account for half of child deaths and contain one-third of the world's poor

(57). The basic foundations for effective health service delivery may not be present and supply systems may be disrupted by degraded transport systems. Health facilities may be closed or destroyed by conflict and health workers may have fled the country, or conflict-affected region.

Conflict-affected and fragile states have particularly severe problems in terms of inequity. Existing inequities, for example related to geographical access, are likely to be exacerbated by conflict and the displacement of populations *(56)*. Where conflict occurs in limited resource settings, health services are likely to be particularly weak. Even in higher-income countries, newly established governments, or governments that lack legitimacy, may lack fiscal systems to raise revenues to finance health services, and thus be dependent upon development partners.

One of the greatest concerns in post-conflict situations is the ability to support people with their ongoing mental health problems, an issue that can particularly affect children. There is also concern for the mental health of community-based health workers living through conflict and post-conflict situations. There are significant challenges in relation to recruitment, retention, distribution and management of health workers *(58,59,60)*.

Often, during post-conflict periods there is pressure to scale-up health services rapidly, and this may be accomplished through contracting out services to nongovernmental organizations *(61)* or relying on donor-driven services or focused vertical programmes. Although such strategies may achieve the short-term goal of enhancing accessibility to services, if not carefully managed they can lead to fragmentation and undermine long-term efforts to promote service integration and coordination. These issues may be exacerbated by weak infrastructure (roads, telephone lines) and weak governance.

Fragile states may lack a social and cultural context that is likely to support responsive and people-centred care. After years of strife and conflict, it may be difficult for health workers to appreciate the need to treat patients with respect, or pay appropriate attention to issues of confidentiality and privacy. Furthermore, communities may mistrust government, and by extension the health services provided by government, and this may be particularly acute if health providers come from different ethnic backgrounds *(62)*. Minority groups

may be particularly excluded from the health system, lacking access to services and a voice in health care provision.

Small island states may also face particular challenges related to health service delivery. Many small island states lack access to their own secondary and tertiary care facilities, and must instead purchase these services from outside. This problem is exacerbated by the stagnating economies and high levels of aid dependency faced by many of these states. It is often particularly difficult to train and retain skilled health personnel in these remote locations, and given the small size of the local population, specialist education may need to be pursued overseas. A lack of skilled human resources may also affect the ability to manage and guide the health system. Limited opportunities to benefit from economies of scale can undermine the development of health insurance schemes or more sophisticated drug distribution or information systems.

By contrast, **large federal states** have ample opportunities to take advantage of economies of scale, but their health services may suffer from greater fragmentation, given the difficulties of aligning actions by national and state level governments. This layering of governance structures may also make reform towards more people-centred and integrated health services more difficult to plan and implement.

3.6 One size does not fit all

Whilst some cross-cutting elements to people-centred and integrated health services are relevant to most countries, the evidence for adoption suggests that there is no "one model" of people-centred and integrated health services that can or should be developed *(63)*. In fact, the people-centred and integrated health services approach can, and has, been employed by different countries and regions as an effective strategy to meet a range of health system challenges in varying contexts. People-centred and integrated health services should not be regarded as a new model of service delivery with a set of core components, but as a service design principle that can help to support and improve strategies that seek to enhance access, encourage universal health coverage, and encourage primary and community-based care.

The evidence, however, suggests that it can be very challenging to apply these principles since the process implies transformational changes in the way health systems are funded, managed and delivered that are likely to come up against a range of resistant forces. The next section focuses on this issue by outlining five interrelated strategic directions to support and embed people-centred and integrated care.

4. The way forward: five strategic directions

To meet the fundamental challenges faced by today's health systems, the strategy proposes five interdependent strategic directions that need to be adopted in order for health service delivery to become more people-centred and integrated.

The five strategic directions are:
1. Empowering and engaging people
2. Strengthening governance and accountability
3. Reorienting the model of care
4. Coordinating services
5. Creating an enabling environment

Action on each of these strategic directions is intended to have an influence at different levels – from the way services are delivered to people, families and communities, to changes in the way organizations, care systems and policy-making operate. Put together, the five strategic directions represent an interconnected set of actions that seeks to transform health systems to provide services that are more people-centred and integrated (see Fig. 2).

The five strategic directions should be regarded as interdependent, which means that achieving success requires their simultaneous adoption. The cumulative benefit of the five strategic directions is necessary to help build more effective health systems. This means that lack of progress in one area has the potential to undermine progress made in other areas.

What the evidence strongly suggests is that the development of interventions in specific country-contexts needs to be locally developed and negotiated. In each specific context, the exact mix of strategies to be used will need to be designed and developed taking account of the local context, values and preferences.

Further details on the evidence for each of these strategic directions, along with examples of how they have been put into practice in countries, are provided in the document that accompanies the strategy.

Fig. 2. The interdependency of the five strategic directions to support people-centred and integrated health services

Empowering and engaging people

Coordinating services

Creating an enabling environment

Strengthening governance and accountability

Reorienting the model of care
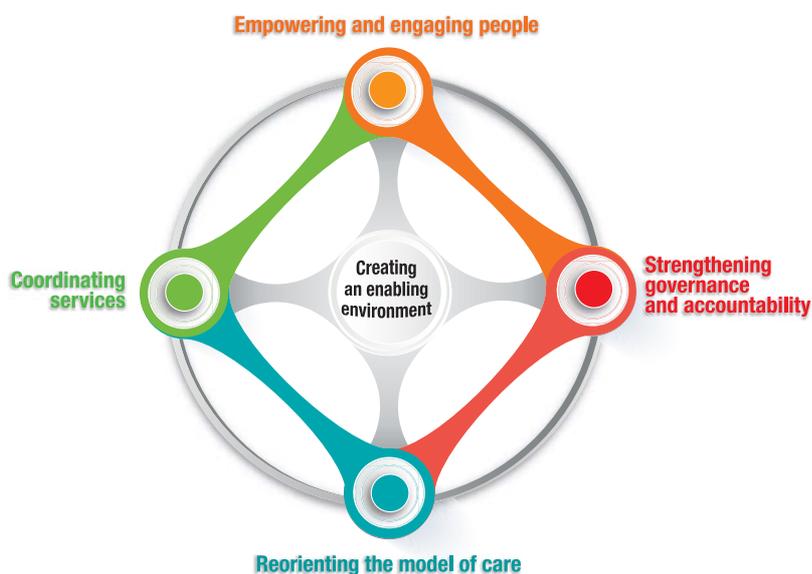
5. Strategic direction 1. Empowering and engaging people

"I value the counselling I received from my peer counsellors … on HIV treatment adherence and other supportive counselling …Health services could be improved if more people living with HIV are empowered to be the centre of the treatment … …Expert patients who act as counsellors and care providers are providing more than HIV services, but are enhancing the quality of treatment, care and support services provided for the patient"
Male patient, WHO African Region

Empowering and engaging people is about providing the opportunity, skills and resources that people need to be articulate and empowered users of health services. The purpose of this strategic direction is to unlock community and individual resources for action at all levels. It seeks to empower individuals to make effective decisions about their own health, becoming articulate and empowered co-producers of health services. Communities are enabled to become actively engaged in co-producing healthy environments, providing care services in partnership with the health sector and contributing to healthy public policy. Special attention is given to engaging and supporting the voices of minorities.

5.1 Seeing people and communities as assets

Although the Alma Ata Declaration recognized community participation as a core principle of primary health care as long ago as 1978 *(20)*, there has been variation in the extent to which people's participation and empowerment has been truly reflected in health systems. Nonetheless, many countries have recognized the importance of thinking about people and communities as assets and resources that need to be harnessed as a way of achieving better health outcomes and improving efficiency through the co-production of care (see Box 2).

Box 2. Mobilizing communities to reduce maternal and neonatal deaths in partnership with health centres and hospitals: the MaiKhanda programme in Malawi

In 2006, the MaiKhanda programme (meaning "mother and baby" in the local Chichewa language) was established as a five-year project with a consortium of international experts. It aimed to reduce by 30% the number of maternal and neonatal deaths in the Lilongwe, Kasungu and Salima districts of Malawi. Working within the strategy already established by the Malawi Ministry of Health's roadmap for maternal health, the programme mobilized a total of 879 communities and worked with nine hospitals and 29 health centres across three districts to identify and implement local strategies for maternal and newborn health care improvement.

On the primary outcomes, where the programme undertook community mobilization only, it achieved a 16% reduction in perinatal mortality. However, where it focused on community mobilization and health care facility improvement in the same locations, it achieved a 22% reduction in neonatal mortality. In the second half of the programme the intervention was strengthened and rolled-out to other communities. Evaluations showed that in the last 15 months of the programme it achieved an impressive 28% reduction in neonatal mortality.

Source: (64).

5.2 Empowerment, engagement and co-production

The terms "empowerment", "engagement" and "co-production" are often used interchangeably to describe policies or interventions that seek to achieve such goals, but in reality they represent distinct if overlapping strategies.

- *Empowerment* is about supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours, the ability of people to self-manage their own illnesses and changes in people's living environments.

- *Engagement* is about people and communities being involved in the design, planning and delivery of health services, enabling them to make choices about care and treatment options or to participate in strategic decision-making on how, where and on what health resources should be spent. Engagement is also related to the community's capacity to self-organize and generate changes in their living environments.

- *Co-production* is about care that is delivered in an equal and reciprocal relationship between clinical and non-clinical professionals and the individuals using care services, their families, carers and communities. Co-production therefore goes beyond models of engagement, since it implies a long-term relationship between people, providers and health systems where information, decision-making and service delivery become shared *(65,66)*.

5.3 Empowering people

Involving individuals, families and communities in health care has long been considered an essential component of health care services and systems. For example, since 2005, WHO has led global efforts on family and patient engagement through establishing Patients for Patient Safety, a network of patient advocates that serves as a platform to bring the patient's voice to health care. Most recently, WHO has sought to establish a framework for action on patient and family engagement in the knowledge that this can support improved care experiences and outcomes whilst reducing health care costs *(67)*.

Strategies for empowerment and engagement can take place at the level of the individual, the carer and the family or household, but it is also important to develop approaches for specific population groups (such as people living with mental health problems or HIV/AIDS) and for influencing care quality and outcomes for an entire community. Often empowerment at these different levels is mutually reinforcing since empowered communities can help to promote individual motivation and behaviour change *(68)*.

There are several reasons why empowering and engaging people is critical. At the most fundamental level, it is people themselves who will spend the most time living with and responding to their own health needs and will be the ones making choices regarding healthy behaviours and their ability to self-care or care for their dependents. Since people themselves tend to know better the motivations that drive these behaviours, people-centred care cannot be provided without engaging them at a personal level.

5.4 Self-management

Given the right guidance and support, empowered people can address damaging health behaviours and/or challenges in their environment that prevent healthy lifestyles *(69)*. Supporting self-management will be critical for many countries where ageing populations and the growing burden of noncommunicable disease means that there is ever greater demand for health services.

5.5 Health education

Health education can help shape and inform the nature of this demand, for example by encouraging appropriate patterns of care seeking, such as the use of primary care providers, or uptake of the recommended number of antenatal care visits. It has also been argued that patient engagement can reduce pain and discomfort, promote greater adherence to treatment regimes, drive patient satisfaction with services and even reduce costs, although the evidence on this is mixed *(70)*.

5.6 Focusing on the most disadvantaged

There is strong variation by social class as to whether people can sufficiently take control of their own health *(71)*. Higher socioeconomic classes tend to feel more in control and empowered to take active responsibility and ownership for their health, whilst the more economically disadvantaged and elderly are less likely to be active self-carers. It is therefore those from lower socioeconomic groups, and those with the poorest health, that require more specific attention to promote self-care and healthy lifestyles *(64)*.

5.7 Engaging communities

At the level of the community, empowerment and engagement is also about enabling poor or marginalized communities to voice their own needs and so influence the way in which care is funded and provided. Many communities may be disempowered to the extent that they feel that they can exercise no control over their own health, and must rather trust to fate *(72)*. Empowering such communities, through providing opportunities for them to develop knowledge, skills and confidence *(73)* is a necessary step. Involving communities in decision-making will also support public policies that promote health services that better meet their needs.

While the need for community empowerment and engagement is widely recognized, the actual process is fraught with challenges. Whilst such strategies often start from simple information provision or participation, they do not always culminate in true community collaborations and action *(74)*. Enabling true community control is also problematic when health agendas or the objectives of a programme have been set externally.

5.8 Fostering co-production

To achieve a more equal partnership between people, care professionals and care systems, as a way to improve health services and outcomes (co-production), care systems need to be reoriented through:

- *recognizing people as assets*, because people themselves are the real wealth of society;
- *valuing work differently*, to recognize everything that people do to co-produce care as work, such as raise families, look after people, maintain healthy communities, contribute to good governance and support social justice;
- *promoting reciprocity*, because it builds confidence, trust and mutual respect; and
- *building social networks*, because people's physical and mental well-being depends on strong and enduring relationships *(adapted from [75])*.

6. Strategic direction 2. Strengthening governance and accountability

"Treat each patient as if it were your own family. Show compassion, caring and provide positive hope to patients. Don't treat them like cattle. Also, keep patients informed about their disease and options... Spend more time with patients and their families. Help patients learn about their diseases. Encourage patients to ...become their own advocates. Share information about patient groups where they can get support from other patients. Most importantly, don't treat a patient like a number in a factory of patients. Treat them as an individual, like it was your own mother/father/sister/brother. Show compassion, caring and empathy"
Patient's son, WHO Region of the Americas

Strengthening governance and accountability involves promoting transparency in decision-making and generating robust systems for the collective accountability of health providers and health system managers through aligning governance, accountability and incentives.

6.1 The role of governance and accountability

Good governance is key to economic growth, social advancement and overall development, and is particularly important for health systems where the poorest in society appear to have the least influence and are disproportionately affected by corruption *(76)*. As the World health report 2000 argued, governments need to take responsibility for protecting and enhancing the welfare of their populations and build trust and legitimacy with citizens through effective stewardship *(77)*. The stewardship role is the essence of good governance and involves the identification and participation of community stakeholders so that voices are heard and consensus is achieved *(78)*.

Governance and accountability mechanisms are needed to improve policy dialogue on national health policies, strategies and plans with citizens and communities. These are too often dominated by health financing and macroeconomic policies,

disease-specific rather than population-oriented programmes of care and the priorities and frameworks of development agencies and donors *(79)*. Robust governance and accountability mechanisms are required to achieve a coherent and integrated approach in health care policy and planning.

6.2 Governance and accountability of development

There has been particular attention over the last decade to try to bring together the range of disparate strategies affecting health systems. This is needed to ensure that the different goals of donor agencies and vertical programmes tackling specific diseases do not hinder the ability of health systems to focus on community health and well-being for all in an equitable manner. For example, the Paris Declaration on Aid Effectiveness (2005) stressed the need for joint ownership, harmonization, alignment and the development of mutual accountability in relation to meeting the far reaching actions required to meet the Millennium Development Goals *(80)*.

In a similar vein, the Accra Agenda for Action (2008), recognized the need to strengthen country ownership and build more effective and inclusive partnerships with donors, and also to deepen engagement with civil society organizations, regional parliaments and local authorities through a more open and inclusive dialogue for the setting and monitoring of development policies and plans *(80)*. Transparency and accountability to the public for the use of resources and results achieved was recommended, supported by mutual assessments of progress.

Very few development agencies have a specific strategy for health systems governance because they tend to focus on aid management and issues such as the justice system, elections, human rights and security from violence. Where attention is provided to health systems, the focus has been on

specific issues such as health financing or informal payments and corruption amongst service providers, or health systems are subsumed as part of a more general approach to good governance *(80)*.

6.3 Characteristics of effective governance and accountability structures

Effective governance and accountability structures in health systems need to have three characteristics: first, that there are mechanisms through which service providers are held accountable; second, that there is adequate information available to be able to assess the services provided; and third, that patients are empowered to take action. For example, in many conflict-affected and low-income country settings, the simple provision of information on service quality may make a huge difference. Frequently in such settings, information on the quality and equity of health services is unreliable at best, and frequently unavailable.

6.4 The participatory deficit

One of the key challenges posed by people-centred and integrated health services is the need for a paradigm shift in governance arrangements that promotes the development of mutual accountability between those living and working in the community. At present, however, there appears to be in many countries, but especially in low-income countries, a "participatory deficit" in the way health care services are planned and delivered.

For example, a study of community perceptions of health systems in different subregions of Africa found that there was significant potential for better community engagement to facilitate community empowerment and services becoming more responsive to community needs *(81)*. However, the study found that existing levels of community involvement in decision-making about how health services should be funded and delivered were poor. The insufficient inclusion of community members is a cause for concern given the crucial role they play in supporting the delivery of care and providing essential information on the local health situation. Governance reforms are therefore needed to enhance community representation, ownership and participation in health policy formulation, planning, organization and operations *(81)*.

6.5 Promoting accountability

Efforts to strengthen governance and accountability with people and local communities are unlikely to be successful unless they promote shared accountability for care and population health outcomes. Where health service providers do not feel accountable to the people they serve, they are less likely to treat patients with respect or seek ways to support people to achieve their health goals *(82)*.

It is important to understanding the existing set of accountability relationships in a health system. In some contexts, accountability is distorted and the non-responsive behaviours of health workers may simply mirror the unfairness and arbitrariness they have experienced at higher levels of the health care system. An example is the patronage-based approach to the distribution of training opportunities and desirable postings *(83)*.

Accountability is essentially about answerability, and encompasses both the "rendering of the account", that is providing information about performance, and the "holding to account", meaning the provision of rewards and sanctions. Greater accountability and engagement is unlikely to be achieved through any one strategy alone; instead multiple reinforcing strategies will need to be pursued (as illustrated in Fig. 3).

Fig. 3. Accountability relationships in health services

Key relationships of power

The state — Politicians | Policy-makers

Voice

Compact

Long route of accountability

Short route

Citizens / clients — Coalitions / inclusion — Nonpoor | Poor

Providers — Management — Frontline | Organizations

Client power

Services
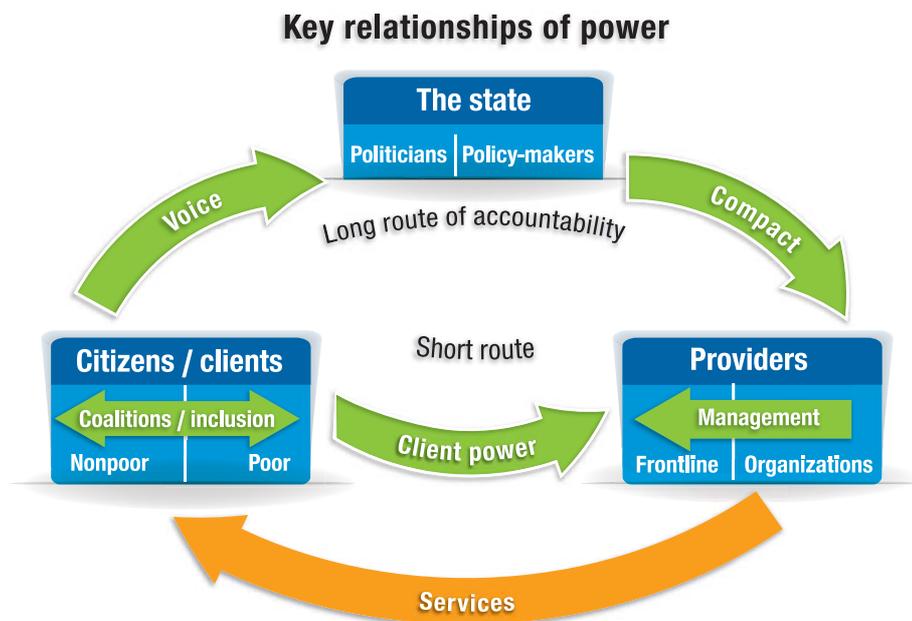
Source: *(84)*.

6.6 Strategies to strengthen governance and accountability

Strategies to focus more specifically on strengthening the governance and accountability of health systems are therefore needed.

This might include specific strategies to:

- initiate policy dialogues on a broad and continuous consultative basis with all relevant social, technical and political stakeholders (beyond health care) at a national and subnational level;

- develop legal frameworks that support effective linkages between strategic and operational planning;

- base national and subnational health policies on the overarching goals of universal health care and people-centred and integrated health services with a consistent focus on meeting the needs of people and communities, and within an overall framework that provides for a comprehensive, balanced and evidence-based assessment of a country's health and its health system challenges;

- ensure that national health policies, strategies and plans are integrated and consistent with those of subnational operational programmes;

- harmonize and align donor programmes with national policies, strategies, priorities and plans;

- regularly monitor and review the effectiveness of national and subnational policies and plans and be transparent and open to the public and other stakeholders in reporting;

- decentralize power and decision-making, where appropriate, to the district and community level;

- promote the engagement and empowerment of all stakeholders, including civil society, the private sector, health professionals and academics, to participate actively in policy dialogue; and

- promote the engagement and empowerment of people and communities to participate actively and efficiently in strategic decisions that impact on the way care is resourced, planned and delivered.

(Adapted from *[79]* and *[85]*).

Strengthening the governance and accountability of health systems requires joint action by health and non-health sectors, public and private sectors, and citizens, towards a common goal *(86)*.

7. Strategic direction 3. Reorienting the model of care

"We need more support from the government to adopt more family medicine [and to] increase the budget for primary health care in the public sector [in] collaboration with different parties to support our specialty"
Female primary health care provider, WHO Eastern Mediterranean Region

Reorienting the model of care means ensuring that efficient and effective health care services are purchased and provided through models of care that prioritize primary and community care services and the co-production of health. This encompasses the shift from inpatient to ambulatory and outpatient care, and the need for a fully integrated and effective referral system. It requires clear investment in holistic care, including health promotion and ill-health prevention strategies that support people's health and well-being. Reorienting models of care will also create new opportunities for intersectoral action at a community-level to address the social determinants of health and make the best use of scarce resources. The role of multiple sectors in an integrated manner is particularly critical for risk management for health.

7.1 Rebalancing health services towards primary and community-based care
Medical advances and rising social expectations have led to increasingly complex, technically challenging and expensive hospital-based care. However, given the rising burden of chronic, noncommunicable disease, preventive and health maintenance services are becoming ever more important, and it is increasingly recognized that hospitals are not the best institutional setting from which to manage such care. Accordingly, many countries are seeking to rebalance services towards high quality, effective primary and community-based care.

This reorientation of the health service model is needed to ensure the availability of quality and effective services, as well as to contain health care costs. Primary care services can also promote coordination and familiarity for patients with complex health problems, address an increasing need for preventive services *(87)* and promote intersectoral involvement in health.

7.2 Challenges to reorienting the model of care
Reorienting the model of care towards people-centred and integrated health services, however, is likely to be very challenging. As Table 1 describes, different types of care facility are currently faced with many challenges and barriers to promoting people-centred and integrated health services. This means that the reorientation of care delivery will require transformational change sustained over many years. The process may threaten the autonomy of highly trained health professionals and care providers, questioning their role and challenging the current dominance of hospitals within health systems (see Box 3).

Medicalized and institutionally-based models of care that are highly reliant on medical specialists need to be transformed into models that embody a more holistic understanding of the individual, take into account patients' needs, and employ inter-professional teams at a community-level to provide comprehensive and integrated services.

However, the people-centred and integrated health services approach is not about substituting one form of care with another. In finding the right balance between generalist and specialist care, and between primary care and hospital-based care, it is important to recognize that each will retain an important role in the health care ecosystem. People-centred and integrated health services will require effective coordination of services between the different levels of care in order to achieve their objectives.

Table 1. Current challenges by type of health facility in reorienting the model of care towards people-centred and integrated health services		
Type of facility	Some current challenges	Implications of the people-centred and integrated health services approach
Hospital	• Hospital "dominance" in terms of service organization and budget allocation • Poor access and long waiting lists • Inappropriate admissions of primary care-sensitive conditions and high re-admission rates • Care that is predominantly inpatient, curative and fragmented • Poor quality, safety and clinical effectiveness • Weak coordination with rest of care providers • Poor efficiency, low occupancy ratios and long lengths of stay • No accountability for results • High costs, underfunding and in some cases high debt • Managers lack leadership and managerial competencies	• Hospital part of a coordinated/integrated health services delivery network that balances budget allocations across all care settings • Service substitution and rationalization of care that promotes alternative ambulatory settings and services when appropriate • Inpatient services limited to acute conditions that require highly costly and sophisticated infrastructure and services • Improved coordination with rest of care providers to ensure continuity of care for patients • Clinical governance with increased focus on quality, safety and person-centred care • Greater accountability for population health outcomes and clinical results • Improved efficiency of the delivery system as a whole by shifting patients and resources to more appropriate sites of care
Health centre/clinic	• No assigned population and weak health intelligence • No accountability for results • Poor access due to inconvenient hours of operation and limited offer of services, including emergency care services • Care that is predominantly reactive, curative and disease-specific • Poor quality of care and low resolution capacity that leads to people bypassing to secondary and tertiary care facilities • Inappropriate referral systems and weak coordination with other care providers • Lack of multidisciplinary and genuine teamwork • Poor community participation and intersectoral collaboration	• Population based-care that also focuses on health and access disparities • Improved health and clinical outcomes at the population level • Intensive use of health intelligence to tailor services according to population needs, demands and expectations • Improved access to comprehensive, quality and people-centred services through ensuring first contact with multi-disciplinary, family and community-oriented primary care • Expanded hours of operation and availability of after hour services for emergency services • The primary health care team, including social workers, as a gate-opener and hub of coordination of care with other service providers • Co-production of health and increased social participation • Intersectoral collaboration and action on determinants of health
Long-term care (e.g. nursing home, hospice)	• Poor access to quality and safe services and lack of adequate funding for chronic, long-term and end-of-life conditions • Weak coordination with rest of care providers, including home care • No accountability for results	• Long-term care facilities are expanded and form an integral part of the health services delivery network • Care is coordinated to ensure continuity of care for patients • Quality and safety are routinely monitored and reported
Home care	• Poor quality and safety of care • Weak coordination with other care providers and informal caregivers • Lack of patient and family involvement • Burden to family members that is not duly compensated	• Key setting in addressing transitional care needs • Home care services incorporated into patient's health care plan • Improved coordination with rest of service providers • Improved supervision for quality and safety • Family and patient are empowered through self-care, self-management strategies and due compensation when needed

Sources: WHO elaboration based on (16,88,89).

Box 3. Future trends that will affect hospital evolution

Hospitals are a very important part of the health care system and are central to the process of building people-centred and integrated health systems. They have been changing over recent decades and are expected to continuously evolve to better respond to patients' needs. Hospitals will play their part within a more integrated context that puts people at the centre of the health equation. Several trends are having an impact on the configuration of hospital services.

1. Care coordination
The hospital should be considered one link (albeit, a very important one) in a complex continuum in which patients move between different levels, types of care and even sectors. As a consequence, the hospital should be embedded in a delivery network that is able to provide a defined population in a geographical coverage area with promotion, prevention, diagnosis, treatment, disease management, rehabilitation and palliative services to cover their health needs. In order to be effective, health networks must ensure that necessary coordination mechanisms and processes are in place so that continuity and people centred care are achieved. Tasks and responsibilities must be clearly defined and supported by all providers, not just within the health domain but also with the social sector when it comes to tackling the complex needs of the most vulnerable patients.

2. Service substitution and rationalization
Service substitution is the process of replacing some forms of care with those that are more efficient for the health system. In line with this, the total number of beds has been significantly reduced over recent years across Europe. Domiciliary hospital care and nursing home care schemes have been implemented to treat patients who otherwise would need to go to hospitals, a trend that will be further developed in the future. For example, in mental health, community psychiatric services have made possible a de-institutionalization process that has simultaneously contributed to reinforcing patients' dignity. As a result of this, not only is a considerable reduction of costs taking place, but services are also felt to be more appropriate in those countries that have undertaken this approach.

3. Super-specialization
Hospitals with a capacity to provide numerous specialized services will remain an important element in health networks. There will always be a need to treat complex conditions and serious emergencies in settings with high resolution capacities and this will tend to concentrate services for efficiency purposes. There will also be a tendency to have certain hospitals assume responsibility for providing care for the most complicated cases, with the remaining cases referred to monothematic centres, building a network of "centres of reference". Hybrid centres, such as "one-stop-shops" and "high-resolution centres" are also emerging as a means to increase efficiency. However, according to the literature they do not necessarily lead to more effective continuity of care.

4. Clinical governance and accountability
Clinical governance involves the bringing together of management and quality assurance activities so that all those working in a hospital are involved in fostering quality of care within the wider framework of the health network. Clinical governance requires integrating financial control, clinical quality and service performance. It helps hospitals to be accountable for their outcomes, not as an isolated organization but as part of a network that must seek to maximize the health of the population that it serves.

There are several factors that will help to speed up these trends. New technology, including information and communication technologies, is allowing new types of services such as the use of electronic medical records that can be accessed at any point in the health network and can be a tool for reorganizing health services around the patient's needs. Payment systems can be carefully designed so that incentives ensure services are aligned with the population health approach. An organizational culture supportive of a systemic and comprehensive approach, along with other drivers of change, including the health workforce, will also have an important role to play.

Source: WHO elaboration based on *(88,90,91)*.

8. Strategic direction 4. Coordinating services

Coordinating services

"[We need] better integration of…specialized care with primary care…We need to use all possible means: experts should move, not always the patients. Data should also move [with patients] and eHealth opportunities [need to also be used] maximally, etc. This is necessary if we want to shorten waiting times and improve patient satisfaction"
Health care manager, WHO European Region

Coordinating services involves coordinating care around the needs of people at every level of care, as well as promoting activities to integrate different health care providers and create effective networks between health and other sectors. The core purpose of this strategic direction is to overcome the fragmentations in care delivery that can undermine the ability of health systems to provide safe, accessible, high quality and cost-effective care in order to improve care experiences and outcomes for people. It entails the integration of key public health functions including surveillance, early detection and rapid emergency response capacity into the health service delivery system to address emergencies due to any hazard faced by the system.

8.1 The need for service coordination
Traditional developments in service delivery have focused on episodic and vertically-oriented interactions between individuals and health care providers. These service arrangements miss the opportunity to respond to the inherent complexity of people's health problems, often failing to deliver holistic and needs-focused services. Systems that evolve to embrace coordination of services can be better equipped to respond to these.

In advanced and emerging economies, with commitment, improved service planning and a small additional investment, services and sectors can be aligned to offer care that is more responsive to the demands of complex health problems (see Box 4). However, in low-income countries, problems of care coordination may be exacerbated by development partners that support vertically-oriented initiatives, with differing mandates and objectives that may not always align well with government objectives or each other's *(92)*. The situation is often even more acute in fragile or conflict-affected states, where multiple nongovernmental organizations may be operating, trying to fill gaps left by the state, and coordination challenges are exacerbated by breakdowns in communication systems, transport infrastructure and information systems *(93)*.

8.2 Achieving successful coordination
Successful coordination involves multiple actors both within and beyond the health system *(94)*, and requires the functional alignment of activities and communication. Coordination does not necessarily require the merging of the different services or workflows, but rather focuses on improving the delivery of care through the alignment and harmonizing of the processes of the different services. A key part of this will involve improving continuity of care and relationships with people. This will not only help to improve the care experience, but will also help to ensure that gaps in care are overcome through proactive care coordination. This in turn, will lead to more appropriate utilization of services.

Box 4. Developing integrated health service networks in Chile as part of the AUGE reforms

The universal health care reforms in Chile, known as the AUGE reforms (a Spanish acronym for *Acceso Universal con Garantias Explicitas*), aim to guarantee the right to access care for a specified package of services. The reforms seek to provide health services through integrated health care delivery service networks based on primary health care. Organizational reforms at the ministerial level have created a Sub-Secretariat for Public Health and a Sub-Secretariat for Health Care Networks. The Sub-Secretariat for Health Care Networks is mandated to coordinate and develop health care networks, as well as to develop service delivery norms and standards.

The health service networks, which can combine public and private providers, are based on the principles of primary health care and are intended to overcome some of the existing fragmentation in health services where different provider systems are run by different operators. The reforms also seek to improve referral between facilities, with treatment guarantees specifying the nature of services that should be offered at each level of the health service network and the type of follow-up required by the primary care level.

Barriers to implementation of the reforms have included the prevailing medical and organizational culture that favours a hospital-centred approach, resistance from physicians and the lack of family medicine doctors.

Sources: (95,96).

9. Strategic direction 5. Creating an enabling environment

"I think we have made several leaps with regards to primary care services...but we still have a long way to go. The politicians need to understand that primary care is the backbone of any health system and getting it right will lead to cost–benefits, healthier populations and public faith in the system"
Male general practitioner, WHO Region of the Americas

In order for the four previous strategies to become an operational reality, there is a need to create an enabling environment that brings together the different stakeholders to undertake transformational change. Inevitably, this is a complex task involving a diverse set of processes to bring about the necessary changes in legislative frameworks, financial arrangements and incentives, and the reorientation of the workforce and public policy-making. Such fundamental changes are challenging, no matter the country context, and many care systems have yet to reap significant benefits from their efforts (for example, in the case of Canada, Box 5).

The aim of this strategic direction is to create an enabling environment for change that promotes population health in a participatory and inclusive manner. This can be done through adopting and managing strategic approaches that facilitate the large scale, transformational changes that are needed to support people-centred and integrated health services for all.

Many of the features needed to create such an enabling environment for change are known to us, including:
- the configuration of political forces around health care reform, including domestic stakeholders and foreign donors and other states;
- the quality and inclusiveness of the national health policy conversation;
- the degree to which there is a shared vision for health care and health system development;
- health policy capacity in government, the health sector and the community;
- the level and relevance of health policy research and the engagement of various networks in research;
- prevailing standards of integrity, accountability and transparency; and
- leadership in government, industry, academia and the community (97).

Box 5. Reflecting on a decade of health reform in Canada

In 2003 and 2004, the Canadian government created an agenda to strengthen the quality, accessibility and sustainability of health services. Reflecting on this agenda ten years later, the Health Council of Canada concluded that "a decade of reform under the health accords led to only modest improvements in health and health care. The transformation we hoped for did not occur." The Council's reflections on why this large scale health system transformation did not occur, and what factors might enable such reforms, are instructive for other governments considering reform of their service delivery systems.

While the Canadian programme of reforms made progress on specific areas – such as uptake of electronic health records, and reduction of waiting times – they failed to have a significant impact on health outcomes or health equity. The Health Council of Canada attributed this lack of impact to a focus on addressing specific elements of the service delivery system rather than on articulating a clear vision for the system as a whole complemented by a balanced set of goals. A more systemic approach to service delivery reform was needed.

The report articulated five critical enablers for such broad-based service delivery reform.

- *Leadership* at all levels of the health system, so as to manage change processes, facilitate collaboration and undertake course correction where necessary.
- *Policies and legislation* that articulate the vision and mechanisms for change, and align people behind that vision.
- *Capacity-building* for health professionals, health managers, patients and communities so that all key actors are equipped with the necessary skills to strengthen health services.
- *Innovation and spread* to promote systems and organizational cultures that support experimentation and the diffusion of good ideas.
- *Measurement and reporting* so that there is continuous measurement against targets, and feedback and reporting to health service managers and communities.

Source: *(98)*.

10. Leading and managing change towards people-centred and integrated health services

"Reinventing myself over the years has been an absolute necessity, taking stock and asking myself: what does our organization need now, and working with my immediate leading group and support staff to change accordingly. That also means personal growth. Through the changes, staying true to my values and beliefs about humanity has sometimes been an added challenge. I am sure that I began my leadership journey with an amount of naiveté, and am maybe a bit more realistic today. I have come to accept that self-interest, indeed destructive forces, do exist and have to be countered with an amount of courage. Using leadership knowledge and experience without succumbing to manipulation [by] others, and thereby losing one's soul, is important to me"
Female manager, WHO European Region

10.1 The challenge of service delivery reform

Previous efforts to strengthen health services have met with only partial success at best. For example, initiatives to introduce quality assurance mechanisms, promote adherence to clinical guidelines, or expand the application of electronic health records may achieve specific health service objectives, but often fail to achieve high-level goals concerning health outcomes and equity *(98, 99)*. Of the five actions identified in the Ottawa Charter for Health Promotion, the fifth, "Reorienting health services", has been the most challenging, achieving partial success at the level of individual health organizations or health networks, but rarely reorienting whole health systems *(100)*. Why is service delivery reform so difficult?

Reorienting health services toward a people-centred and integrated model is a fundamentally political act that challenges existing interests. For many years health systems have largely been organized around a medicalized model whereby decision-making power rests primarily with medically-trained individuals *(101)*. Efforts to change this model in order to empower patients and their families

in health service decision-making, and to empower communities to engage with health professionals in the co-production of health, will question many of the beliefs and values of the existing medicalized model.

A number of key challenges exist to our ability to make the changes needed for people-centred and integrated health services:

- *System-related challenges* where pre-existing legal, governance and accountability structures have developed, such as those that focus on separate targets within specific and often disease-based health care divisions, and organizational structures that continue to divide and fund services by specific levels of health care (including primary, community, hospital, tertiary care) and fail to support intersectoral collaboration (for example, with social care, housing and municipal care).

- *People-related challenges* where existing professional groups and cultures have become increasingly specialized and seek to differentiate their activities rather than work together in interdisciplinary ways that include patients and the community as equal partners in the care process.

- *Organizational-related challenges* where different stakeholders do not share a common goal to promote the welfare of people and where different values and goals are held by regional authorities, non-profit organizations and private businesses. There is therefore a need to understand and manage the divergent values and goals of the organizations that people-centred and integrated health services strategies may seek to bring together.

In moving forward with a strategy of this nature, it is important to acknowledge the lessons of history: the successful reorientation of health services will

most likely be a long journey requiring sustained political commitment *(102)*. To secure and maintain this commitment, those who stand to benefit, such as communities and patient groups, will need to be mobilized and engaged in decision-making.

Ultimately, each country or local jurisdiction needs to set its own goals for integrated and people-centred health services, and develop its own strategy for achieving these goals. The goals must respond to the local context, existing barriers and the values held by people within the state, and should be achievable given the current health service delivery system, and the financial and political resources available to support change.

10.2 Leadership for change

This strategy, in common with previous approaches for universal health coverage and primary health care, is fundamentally transformative in its implications for the future of health systems. Such strategies, therefore, require new forms of collaborative leadership that help to bring together multiple stakeholders through an effective policy dialogue. Indeed, what is required is *transformational leadership* that goes beyond understanding how to bring together stakeholders with competing views and mind-sets, but which pro-actively communicates the goals and values of the strategy and seeks to mobilize others through a more emotional involvement in the need for change *(103)*.

Delivering high-quality, people-centred and integrated health services requires the creation and nurturing of collective engagement, commonly-held values, good communication, teamwork and transparency. However, organizational and professional cultures are powerful and political leadership is needed to address barriers to collective action *(104)*. It is for this reason that all health care professionals, and especially clinicians, need to be engaged in management and leadership for change in a collaborative partnership with local communities. What is needed is a model of "distributed leadership" that involves multiple actors working together collaboratively across organizational and professional boundaries *(105)*.

10.3 The role of key stakeholders
10.3.1 Countries

Moves towards people-centred and integrated health services need to be country-led in a process of co-production between governments and the people that they serve. The role of countries is therefore essential in overcoming some of the key challenges to implementation. In support of this, WHO and other partners have important roles to play.

Whereas the need for better health services is universal, the path to achieving more people-centred and integrated services is likely to be unique in each different country context. Countries committed to this path should be sure to develop and communicate a clear vision and strategy for what they wish to achieve. This vision and strategy are likely to be stronger if developed in a manner that engages a variety of stakeholders, both from communities (such as community leaders, elected local officials, representatives of patient groups and nongovernmental organizations) and from among the health workforce (including community health workers, managers, physicians and other professionals).

People-centred and integrated services should, in the longer term, offer greater value for money *(106)* through minimizing duplication, reducing waste through improved coordination across care providers and transparently setting priorities that take account of service cost-effectiveness and values. However there will inevitably be costs associated with reforming health services, such as staff training, and strengthening or realigning information systems. Ministries of health will generally need to negotiate actively, presenting these arguments about enhanced value for money to ministries of finance in order to secure funds to support successful reform. In some countries with high levels of external support to the health system, donors may already be moving towards supporting more integrated services *(107)*, and countries may be able to take advantage of this momentum to further their own integration goals.

National and local governments should play the lead role in setting and overseeing an implementation research agenda to support more people-centred and integrated care. Engaging researchers, programme beneficiaries, health providers and other key stakeholders in the implementation research agenda will provide a basis for assessing the effects of the strategy in a timely way and identifying the processes through which these effects are occurring and how context is affecting implementation *(108)*. This approach promotes ongoing learning, transparency and accountability in pursuit of people-centred and

integrated health care, as well as improved health outcomes.

10.3.2 WHO

Across the diverse contexts in which this strategy is to be both adopted and adapted there will be constant challenges to implementation given the alterations required in the balance between international organizations and national governments, regional and local authorities, health and social care providers, and communities and individuals. The adoption of people-centred and integrated health services, and the five key strategic directions identified in this strategy, will therefore require sustained advocacy. The role of WHO will be to drive policies that can support the development of people-centred and integrated health services across the world. This will happen though its core functions as outlined below.

Providing leadership and engaging in partnerships
- Guiding and facilitating the development of country strategies for people-centred and integrated services, where requested to do so.
- Supporting the development of regional and global partnerships that can help share knowledge and collaborate on advocacy. This might include, for example, the development of a consortium that brings together all leading partners in the field, in order to support the implementation of the strategy.

Shaping the research agenda and stimulating the generation, translation and dissemination of knowledge
- Developing a prioritized research agenda in support of integrated and people-centred health services at global and regional levels, and mobilize resources to help support the realization of such a research agenda.
- Providing support to national governments as they develop and pursue their own implementation research agenda through sharing of knowledge, materials and technical assistance.
- Sharing knowledge about people-centred and integrated services, through hosting regional and global meetings on the subject.
- Collaborating with partners to summarize and share emerging evidence about strategies to promote people-centred and integrated services, particularly in fragile states and low- and middle-income country contexts, where the evidence is most scarce.
- Creating a web-platform to support the promotion of the strategy including access to a range of

evidence, case examples, support tools and communities of practice.

Providing technical support, catalysing change and building sustainable institutional capacity
- Training and equipping staff within WHO to be able to provide technical support and guidance to countries on people-centred and integrated services.
- Strategically building organizational capacity and developing collaborating institutions on people-centred and integrated services, particularly in fragile states, and low- and middle-income countries, so as to develop local sources of advice and guidance.

Monitoring and assessing trends
- Supporting countries to assess where they are in the continuum of patient-centred and integrated health services, and assisting them to conduct their own monitoring.
- Monitoring trends in country universal health care strategies and how they support people-centred and integrated services, in ways that are oriented towards supporting country initiatives as a primary focus, and to demonstrate, with international comparisons and benchmarking, where they are on the continuum of people centred and integrated services, while limiting the risk that international monitoring would distort national efforts.
- Collating country monitoring reports to share progress in developing people-centred and integrated health services.
- Identifying and disseminating good practices for the standardization of indicators, measurement methods and reporting methods for people-centred integrated health services.
- Reviewing indicators of responsiveness in the World Health Survey and other tools used by WHO to ensure that appropriate indicators of service quality, particularly encompassing service integration and people-centredness, are collected on a regular basis.

10.3.3 National and international partners

Achieving people-centred and integrated health services will involve many national and international partners.

- *Development partners* should, except under exceptional circumstances where very rapid or unique action is required, seek to integrate their support to health service delivery into countries' own health systems. They can also provide

support and help to share technical knowledge about different approaches to promoting more people-centred and integrated services.

- *Citizens' groups* from international networks such as the International Alliance of Patients' Organizations and the People's Health Movement to local organizations such as the Grassroots Health Organization of Nigeria, or women's health groups across the world, have an important role to play in advocating for more people-centred and integrated health services, as well as in empowering their members to be able to better manage their own health concerns and engage with the health system.

- *Academics and researchers* have an important role to play in providing analytical, educational and implementation skills. There is a need to enhance understanding of strategies to support people-centred and integrated health services through health systems research and implementation research efforts. Such efforts will require collaborating closely with service providers. Developing local (national) capacity to lead such efforts will be key.

- *Provider associations* can play important roles in adopting and endorsing new practices, and in providing support to their members. Organizations such as the International College of Person-Centered Medicine, and its international and national provider organizations, have an interest in pursuing an agenda to advance scientifically-based person-centred medical practice, but it is even more important that powerful and well-established provider organizations adopt the people-centred and integrated health services agenda.

10.4 Effective collaboration

As noted, actions at the country level to achieve integrated and people-centred health services are likely to involve multiple stakeholders, from national governments to provider organizations, consumer associations, community groups, local government, health insurance agencies and regulators. At the international level, WHO has a commitment to this vision, but so too do other agencies. Effective collaboration across these many partners will be essential. Collaboration will be most effective if it:

- *Is country-led.* Strategies for pursuing people-centred and integrated health services should be

developed and led by countries, with external support where necessary, and should respond to local conditions and contexts. While this strategy may stimulate thinking about key challenges, and strategies to address them, in order to effect change it will be critical that processes are led by country actors, with support from international partners.

- *Is equity-focused.* Efforts to enhance equity are a required part of people-centred and integrated health care strategies. Efforts can target immediate factors driving inequitable service utilization (such as geographical accessibility and acceptability of care), but may also address more fundamental social determinants (such as education and social support networks).

- *Ensures that people's voices are heard.* The notion of people-centred and integrated health services puts informed and empowered people at the centre of the health system. Accordingly, processes to develop national strategies for such services should ensure accountability to local stakeholders and give a voice to disadvantaged populations in particular.

- *Recognizes interdependence.* Service delivery depends on effective information and financing systems, and the availability of skilled and motivated health workers. Changes made to service delivery will inevitably have ramifications across the entire health system. It is critical that health planners and policy-makers recognize these interdependencies and take action in the relevant parts of the health system.

- *Shares knowledge.* This can be done through the development of national and international communities of practice in order to share experiences and strategies in the effective implementation of people-centred and integrated health services. Example of these communities of practice are those being developed by the Community of Practitioners on Accountability and Social Action in Health (COPASAH), the European Innovation Partnership on Active and Health Ageing, WHO European Region's Framework for Action towards Coordinated/ Integrated Health Services Delivery and by a range of other international organizations.

- *Adopts learning/action cycles.* Evidence on the effectiveness of strategies to achieve people-centred and integrated health care is still being

accumulated. Where such evidence does exist, it frequently comes from different contexts and/or interventions that have been pursued as part of a reform package that differs from those now being adopted. Accordingly, strategies to promote people-centred and integrated health services may lead to unpredictable effects or not achieve anticipated outcomes. Success is most likely when there are iterative learning and action cycles that track changes in the service delivery system, identify emerging problems and bring stakeholders together to solve problems. Indeed the very philosophy of people-centred health care emphasizes empowering and engaging people – health sector managers, providers and communities – to innovate and drive system performance.

11. Monitoring, learning and evaluation

11.1 Gathering evidence

A core requirement for strategies promoting people-centred and integrated health services to succeed will be the gathering of evidence and learning to justify and support implementation. A key focus should be on the ongoing monitoring of progress within a framework that includes specific and measurable objectives. Attention needs to be paid to understanding the extent to which each of the five interlocking strategic directions are being met and, as countries seek to implement reform, to identifying the technical and political obstacles to their progress and supporting managers and leaders to make effective adjustments so that progress can be sustained.

11.2 Monitoring

A key action for policy-makers will be to develop systems that monitor outcomes. The complexity of people-centred and integrated health services as a strategy means that monitoring will be needed at several levels: at the micro-level to examine whether citizens are receiving more people-centred care that is coordinated around their needs; and at the meso- and macro-levels to assess whether care is being reoriented towards people-centred and integrated health services, and an enabling environment is being created.

Monitoring of people-centred and integrated lhealth care should be led by country actors and designed to reflect country-specific strategies and institutional processes. Countries should develop their own strategies, adapting WHO and other international guidance according to their needs and contexts.

Monitoring provides important opportunities to improve how a health system functions. Data should not only provide a basis for problem-solving and decision-making by managers and policy-makers, but can also be a way of engaging communities and civil society organizations, promoting accountability of health service providers through disclosure of performance and strengthening health services. Monitoring processes should not simply focus on average levels of performance, but should rather analyse leading and lagging performances, and be employed in ways that promote learning and accountability.

11.3 Choosing quality measures

The monitoring of national data on the coverage of health services, financial protection and health status outcomes, as well as indicators to assess their equitable distribution and the social determinants of health, is important in supporting a country's aspirations to achieve universal health coverage. It can stimulate learning and change across countries. It will be important, therefore, for countries to adopt and use a set of indicators that reflects the main elements of a national strategy for person-centred and integrated health care. There are potential benefits from the international standardization of indicators and data collection, analysis and reporting methods, which can facilitate learning across countries, and should be supported by WHO and other international agencies. A reasonable range of indicators should be selected, and within each country, should be validated and used in a standardized and consistent way. Further details on choosing quality measures and indicators is given in the technical support document that accompanies this strategy.

11.4 Learning and evaluation

While much is known about the building blocks of people-centred and integrated health services, as set out in the five strategic directions of this strategy, less is known about how to effectively implement complex service innovations. In any particular country, there are major uncertainties about how different strategies to strengthen people-centred and integrated health care will work out. In most cases, countries will need to implement efforts to generate their own evidence while proceeding with reforms.

Active learning and feedback throughout the reform process is an important way of sharing information. Sometimes small-scale pilots or comparisons of different interventions will make sense, but in other circumstances reforms can only be made on a system-wide scale. In these contexts, it will be important to have reliable quantitative data about the changes implemented, as well as more qualitative data that explains how and why changes have occurred *(109)*. Strengthening information systems so that they can deliver timely and reliable data about the nature of services delivered, and data that can be disaggregated to relatively small geographical areas, would be a very useful part of preparing for reform.

Much of what country decision-makers will need to guide national strategies will take the form of "implementation research". Implementation research seeks to address questions of implementation, such as how, why and what types of interventions work in particular contexts *(110)*. It is increasingly recognized for its potential to enable interventions – including policies, programmes and individual practices – to work better, reach targeted populations, scale-up coverage and impact, and be sustained *(108)*. Hence, implementation research is an important tool for identifying and revising strategies to achieve people-centred and integrated health care. It can be used to demonstrate how effective the strategy is from the perspective of different stakeholders and can shed light onto the organizational culture of an organization. Moreover, it can provide insights into how implementation is happening (or not), by examining so-called implementation variables, such as those related to the acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, coverage and sustainability of an intervention.

12. The future

"I really value the long term relationship I have with many patients...I also know their families and the community well. I think I get as much from my patients as I have ever given, including relationships, although limited to the practice and occasional home visits. I also really value the freedom to choose the best way to manage patients, within the limits of what is ethical, guidelines and the need to provide services to a reasonable number of people within the time I have. I also value the relationships with, and contributions from, other members of the primary health care team"
Female general practitioner, WHO Western Pacific Region

The core principles and five strategic directions articulated in this strategy for people-centred and integrated health services seek to build upon and enhance the ongoing commitment of WHO to universal health coverage and primary health care.

Today, in response to changing demographics, social expectations and technological advances, these principles are becoming widely shared across the world as WHO regional offices and countries have sought to develop strategies that fundamentally recalibrate health systems. Efforts are already underway in many countries to channel energy and resources into creating more equitable, accessible and sustainable health services that seek to better coordinate care around people's needs and to secure improved health for individuals and populations.

Across these reforms, the ability to engage people as co-producers of care has become a core commitment, not simply as a means to promote active and healthy living and reduce the reliance on institutional and specialist care, but also as a way to pull health systems away from a supply-driven approach that has become disconnected from people's expectations.

Applying the principles of people-centred and integrated health services, and the five strategic directions outlined in this strategy, will help health systems to respond more effectively to the challenges that lie ahead.

References

1. World health report 2013: research for universal health coverage. Geneva: World Health Organization; 2013.

2. Eaton J, McCay L, Semrau M, Chatterjee S, Baingana F, Araya R, et al. Scale up of services for mental health in low-income and middle-income countries. Lancet. 2011; 378 (9802): 1592–1603.

3. Basu A, Mittag-Leffler BN, Miller K. Palliative care in low- and medium-resource countries. Cancer J. 2013; 19 (5): 410–3.

4. Chan M. The rising importance of family medicine. Keynote address at the 2013 World Congress of the World Organization of Family Doctors, Prague, Czech Republic (http://www.who.int/dg/speeches/2013/family_medicine_20130626/en/, accessed 16 February 2015).

5. Mohan V, Seedat YK, Pradeepa R. The rising burden of diabetes and hypertension in southeast asian and african regions: need for effective strategies for prevention and control in primary health care settings. Int J Hypertens. 2013; 2013: 409083.

6. Beaglehole R, Epping-Jordan J, Patel V, Chopra M, Ebrahim S, Kidd M, et al. Improving the prevention and management of chronic disease in low-income and middle-income countries: a priority for primary health care. Lancet. 2008; 372 (9642): 940–9.

7. Fried LP, Piot P, Frenk JJ, Flahault A, Parker R. Global public health leadership for the twenty-first century: towards improved health of all populations. Glob Public Health. 2012; 7 (Suppl 1): S5–15.

8. Kim JY, Farmer P, Porter ME. Redefining global health-care delivery. Lancet. 2013; 382 (9897): 1060–9.

9. World health report 2002: reducing risks, promoting healthy life. Geneva: World Health Organization; 2002.

10. Walley J, Lawn JE, Tinker A, de Francisco A, Chopra M, Rudan I,et al. Primary health care: making Alma-Ata a reality. Lancet. 2008; 372 (9642): 1001–7.

11. Starfield B, Shi L. Policy relevant determinants of health: an international perspective. Health Policy, 2002; 60: 201–218.

12. Shiffman J. Has donor prioritization of HIV/AIDS displaced aid for other health issues? Health Policy Plan. 2008; 23 (2): 95–100.

13. People-centred health care. Manila: WHO Regional Office for the Western Pacific; 2007.

14. National Ageing Research Institute. What is person-centered health care? Melbourne: Victorian Government Department of Human Services; 2006.

15. Integrated health service delivery networks: concepts, policy options and a road map for implementation in the Americas. Washington, DC: Pan American Health Organization; 2011.

16. World health report 2008: primary health care; now more than ever. Geneva: World Health Organization; 2008.

17. Global health and foreign policy. New York: UN General Assembly; 2012.

18. Kodner DL, Spreeuwenberg C. Integrated care: meaning, logic, applications, and implications: a discussion paper. Int J Integr Care, 2002; 2:e12.

19. Goodwin N, Ferrer L. People-centred and integrated care: what the evidence may look like. Unpublished report to the WHO, 30 June 2013.

20. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978 (http://www.who.int/publications/almaata_declaration_en.pdf, accessed 16 February 2015).

21. Prevention and control of non-communicable diseases: report of the Secretary-General. New York: UN General Aessmbly; 2011 (A/66/83; http://www.un.org/ga/search/view_doc.asp?symbol=A/66/83&Lang=E).

22. Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: World Health Organization; 2008.

23. Ouagadougou declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium. International Conference on Primary Health Care

and Health Systems in Africa, Ouagadougou, Burkina Faso, 28–30 April 2008 (AFR/RC58/R3; http://www.who.int/management/Ouagadougou DeclarationEN.pdf, accessed 16 February 2015).

24. Resolution CD49. R22. Integrated health service delivery networks based on primary health care. Washington DC: Pan American Health Organization; 2009 (CD49. R22; http://new.paho.org/hq/dmdocuments/2009/CD49. R22%20%28Eng.%29.pdf, accessed 16 February 2015).

25. Resolution CD52.R11. Social protection in health. Washington DC: Pan American Health Organization; 2013 (CD52.R11, http://www.paho.org/hq/index.php?option=com_content&view=article&id=8833:52nd-directing-council&Itemid=40033&lang=en, accessed 16 February 2015).

26. Health 2020: a European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013.

27. Resolution EM/RC59/R.3. Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action. Cairo: WHO Regional Office for the Eastern Mediterranean; 2012 (EM/RC59/R.3; http://applications.emro.who.int/docs/RC_Resolutions_2012_3_14693_EN.pdf?ua=1, accessed 16 February 2015).

28. Resolution EM/RC60/R2. Universal health coverage. Cairo: WHO Regional Office for the Eastern Mediterranean; 2013 (EM/RC60/R.2; http://applications.emro.who.int/docs/RC60_Resolutions_2013_R2_15135_EN.pdf?ua=1, accessed 16 February 2015).

29. Resolution SEA/RC65/R6. Regional strategy on universal health coverage. New Dehi: Regional Office for South-East Asia; 2012 (SEA/RC65/R6; http://www.searo.who.int/about/governing_bodies/regional_committee/65/rc65_r6.pdf?ua=1, accessed 16 February 2015).

30. Resolution SEA/RC61/R3. Revitalizing primary health care. New Dehi: Regional Office for South-East Asia; 2008 (SEA/RC61/R3; http://www.searo.who.int/entity/primary_health_care/documents/rc61_r3.pdf?ua=1, accessed 16 February 2015).

31. People-centered health care: a policy framework. Manila: WHO Western Pacific Region; 2007.

32. World health report 2006: working together for health. Geneva: World Health Organization; 2006.

33. Continuity and change: implementing the third WHO medicine's strategy: 2008–2013. Geneva: World Health Organization; 2009.

34. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.

35. Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action. Geneva: World Health Organization; 2007.

36. Bennett S, Lagomarsino G, Knezovich J, Lucas H. Accelerating learning for pro-poor health markets. Global Health. 2014;10; 54.

37. Yakong, VN, Rush KL, Bassett-Smith J, Bottorff JL, Robinson C. Women's experiences of seeking reproductive health care in rural Ghana: challenges for maternal health service utilization. J Adv Nurs. 2010; 66 (11): 2431–41.

38. Mrisho M, Obrist B, Amstrong Schellenberg J, Haws RA, Mushi AK, Mshinda H, et al. The use of antenatal and postnatal care: perspectives and experiences of women and health care providers in rural southern Tanzania. BMC Pregnancy Childbirth. 2009; 9: 10.

39. Moyer CA, Adongo PB, Aborigo RA, Hodgson A, Engmann CM. 'They treat you like you are not a human being': Maltreatment during labour and delivery in rural northern Ghana. Midwifery, 2013; 30 (2): 262–8.

40. Nakahara S, Saint S, Sann S, Ichikawa M, Kimura A, Eng L, et al. Exploring referral systems for injured patients in low-income countries: a case study from Cambodia. Health Policy Plan. 2010; 25 (4): 319–27.

41. Mussa AH, Pfeiffer J, Gloyd SS, Sherr K. Vertical funding, non-governmental organizations, and health system strengthening: perspectives of public sector health workers in Mozambique. Hum Resour Health. 2013; 11 (1): 26.

42. Liu S, Griffiths SM. From economic development to public health improvement: China faces equity challenges. Public Health. 2011; 125 (10): 669–74.

43. Meng Q, Zhang J, Yan F, Hoekstra EJ, Zhuo J. One country, two worlds - the health disparity in China. Glob Public Health. 2012; 7 (2): 124–36.

44. Mudaliar U, Kim WC, Kirk K, Rouse C, Narayan KM, Ali M. Are recommended standards for diabetes care met in Central and South America? A systematic review. Diabetes Res Clin Pract. 2013; 100 (3): 306–29.

45. Nayyar GML, Breman JG, Newton PN, Herrington J. Poor-quality antimalarial drugs in southeast Asia and sub-Saharan Africa. Lancet Infect Dis. 2012; 12 (6): 488–96.

46. Bate R, Jensen P, Hess K, Mooney L, Milligan J. Substandard and falsified anti-tuberculosis drugs: a preliminary field analysis. Int J Tuberc Lung Dis. 2013; 17 (3): 308–11.

47. Chang J, Wood D, Xiaofeng J, Gifford B. Emerging trends in Chinese healthcare: the impact of a rising middle class. World Hosp Health Serv. 2008; 44 (4):11–20.

48. Pocock NS, Phua KH. Medical tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia. Global Health. 2011; 7:12.

49. Malhotra C, Do YK. Socio-economic disparities in health system responsiveness in India. Health Policy Plan. 2013; 28 (2):197–205.

50. Tang S, Tao J, Bekedam H. Controlling cost escalation of healthcare: making universal health coverage sustainable in China. BMC Public Health. 2012; 12 (Suppl 1): S8.

51. Poverty, social exclusion and health systems in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2010.

52. Suhrcke M, Stuckler D. Will the recession be bad for our health? It depends. Soc Sci Med. 2012; 74 (5): 647–53.

53. Schoen C, Osborn R, Squires D, Doty M, Pierson R, Applebaum S. New 2011 survey of patients with complex care needs in eleven countries finds that care is often poorly coordinated. Health Aff (Millwood). 2011; 30 (12): 2437–48.

54. Burgers JS, Voerman GE, Grol R, Faber MJ, Schneider EC. Quality and coordination of care for patients with multiple conditions: results from an international survey of patient experience. Eval Health Prof. 2010; 33 (3): 343–64.

55. Newbrander W, Waldman R, Shepherd-Banigan M. Rebuilding and strengthening health systems and providing basic health services in fragile states. Disasters. 2011; 35 (4): 639–60.

56. Bornemisza O, Ranson MK, Poletti TM, Sondorp E. Promoting health equity in conflict-affected fragile states. Soc Sci Med. 2010; 70 (1): 80–8.

57. Fragility, conflict and violence overview. Washington DC: The World Bank; 2014 (http://www.worldbank.org/en/topic/fragilityconflictviolence/overview#1, accessed 16 February 2015).

58. Macrae J, Zwi AB, Gilson L. A triple burden for health care reform: post conflict rehabilitation in Uganda. Soc Sci Med. 1996; 42 (7): 1095–1108.

59. Pavignani E, Vio F. Mozambique 1990–2002: restructuring the health workforce after the war, Health in Emergencies. 2003; 18: 12–13.

60. Witter S, Sok S, Samai M, Namakula J, Chirwa Y. Understanding health worker incentives in post-conflict settings: research summary, project 2, health worker incentives. ReBUILD Consortium; 2011.

61. Soeters R, Griffiths F. Improving government health services through contract management: a case from Cambodia. Health Policy Plan. 2003; 18 (1): 74–83.

62. Luta X, Draebel T. Kosovo-Serbs' experiences of seeking healthcare in a post-conflict and ethnically segregated health system. Int J Public Health. 2013; 58 (3): 377–83.

63. Curry N, Ham C. Clinical and service integration: the route to improved outcomes. London: The King's Fund; 2010.

64. Improving maternal and new born health in Malawi. London: The Health Foundation; 2013.

65. Bovaird T. Beyond engagement and participation: user and community co-production of public services. Public Administration Review. 2007; 67 (5): 846–860.

66. Realpe A, Wallace L. What is co-production? London: The Health Foundation; 2010.

67. Patients for Patient Safety: partnerships for safer care. Geneva: World Health Organization; 2014.

68. Wallerstein N. Powerlessness, empowerment, and health: implications for health promotion programs. Am J Health Promot. 1992; 6 (3): 197–205.

68. Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, 21 November 1986. Geneva: World Health Organization; 1986 (http://www.who.int/healthpromotion/conferences/previous/ottawa/en/, accessed 16 February 2015).

70. Smith M, Saunders R, Stuckhardt L, McGinnis JM, Committee on the Learning Health Care System in America, Institute of Medicine. Best care at lower cost: the path to continuously learning health care in America. Washington DC: Institute of Medicine; 2012.

71. Foot C, Gilburt H, Dunn P, Jabbal J, Seale B, Goodrich J et al. People in control of their own health and care: the state of involvement. London: The King's Fund; 2014.

72 Baatiema L, Skovdal M, Rifkin S, Campbell C. Assessing participation in a community-based health planning and services programme in Ghana. BMC Health Serv Res. 2013; 13: 233.

73. Rifkin SB. A framework linking community empowerment and health equity: it is a matter of CHOICE. J Health Popul Nutr. 2003; 21 (3): 168–80.

74. Arnstein S. A ladder of citizen participation. Journal of the American Planning Association. 1969; 35 (4): 216–224.

75. Boyle D, Harris M. The challenge of co-production: how equal partnerships between

professionals and the public are crucial to improving public services. London: NESTA; 2009.

76. Siddiqi S, Masud TI, Nishtar S, Peters DH, Sabri B, Bile KM, et al. Framework for assessing governance of the health system in developing countries: gateway to good governance. Health Policy. 2009 Apr; 90 (1): 13–25.

77. World health report 2000. Health systems: improving performance. Geneva: World Health Organization; 2000.

78. Saltman R, Ferroussier-Davis. The concept of stewardship in health policy. Bull World Health Organ. 2000; 78 (6): 732–9.

79. Health system strengthening: improving support to policy dialogue around national health policies, strategies and plans. Report by the Secretariat, 128th Session of WHO Executive Board, 29 December, 2010. Geneva: World Health Organization; 2010.

80. The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. Paris: Organisation for Economic Co-operation and Development; 2008.

81. Health systems in Africa: community perceptions and perspectives. The report of a multi-country study. Brazzaville: WHO Regional Office for Africa; 2012.

82. Berlan D, Shiffman J. Holding health providers in developing countries accountable to consumers: a synthesis of relevant scholarship. Health Policy Plan. 2012; 27 (4): 271–80.

83. Cleary SM, Molyneux S, Gilson L. Resources, attitudes and culture: an understanding of the factors that influence the functioning of accountability mechanisms in primary health care settings. BMC Health Serv Res. 2013; 13 (1): 320.

84. World development report 2004: making services work for poor people. Washington DC: World Bank; 2004.

85. WHO Executive Board 128th Session provisional agenda item 4.5 EB128/8 on health system strengthening: improving support to policy dialogue around national health policies, strategies and plans. Geneva: World Health Organization; 2010 (http://apps.who.int/iris/handle/10665/3205, accessed 16 February 2015).

86. Kickbusch I, Gleicher D. Governance for health in the 21st century. Copenhagen: WHO Regional Office for Europe; 2012.

87. Beaglehole R, Epping-Jordan J, Patel V, Chopra M, Ebrahim S, Kidd M, et al. Improving the prevention and management of chronic disease in low-income and middle-income countries: a priority for primary health care. The Lancet. 2008; 372 (9642): 940–949.

88. McKee M, Healy J, editors. Hospitals in a changing Europe. Buckingham: Open University Press; 2002.

89. Genet N, Boerma W, Kroneman M, Hutchinson A, Saltman RB, editors. Home care across Europe: current structure and future challenges. Geneva: World Health Organization; 2012.

90. Artaza O, Méndez CA, Holder R, Suárez JM. Redes integradas de servicios de salud: el desafío de los hospitales. Santiago: Pan American Health Organization; 2011.

91. Pan American Health Organization, Escuela Andaluza de Salud Publica, Técnicas de Salud. Evolution and future trends of hospitals: systematic literature review. Washington DC: Pan American Health Organization; 2012 (http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=19082&Itemid=270, accessed 16 February 2015).

92. Travis P, Bennett S, Haines A, Pang T, Bhutta Z, Hyder AA, et al. Overcoming health-systems constraints to achieve the Millennium Development Goals. Lancet. 2004; 364 (9437): 900–6.

93. World Health Organization, The World Bank. The high level forum on health Millenium Development Goals: selected papers 2003–2005. Geneva: World Health Organization;2005 (http://apps.who.int/hdp/publications/hlf_volume_en.pdf?ua=1, accessed 16 February 2015).

94. Goodwin N, Sonola L, Thiel V, Kodner DL. Co-ordinated care for people with complex chronic conditions: key lessons and markers for success. London: The King's Fund; 2013.

95. Méndez CA. Los recursos humanos de salud en Chile: el desafío pendiente de la reforma [Human resources in health in Chile: the pending challenge of the reform]. Rev Panam Salud Publica. 2009; 26 (3): 276–280.

96. Bitran R. Explicit health guarantees for Chileans: The AUGE benefits package. Washington DC: The World Bank; 2013.

97. Legge D, People's Health Movement. Health system strengthening: a theory of change. Unpublished communication, 2014.

98. Better health, better care, better value for all: refocussing health care reform in Canada. Toronto: Health Care Council of Canada; 2013.

99. Schoen C, Osborn R, Squires D, Doty M, Rasmussen P, Pierson R, et al. A survey of primary care doctors in ten countries shows progress in use of health information technology, less in other areas. Health Aff (Millwood). 2012; 31 (12): 2805–16.

100. Wise M, Nutbeam D. Enabling health systems transformation: what progress has been made in re-orienting health services? Promot Educ. 2007; Suppl2: 23–7.

101. Clark J. Medicalization of global health 1: has the global health agenda become too medicalized? Global Health Action. 2014; 7 (23998): 1–6.

102. Lawn JE, Rohde J, Rifkin S, Were M, Paul VK, Chopra M. Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise. Lancet. 2008; 372 (9642): 917–27.

103. Den Hartog D, Koopman P. Leadership in organizations. In: Anderson A, Ones DS, Sinangil HK, Viswesvaran C, editors. Handbook of industrial, work and organizational psychology: volume 2. London: SAGE Publications; 2001.

104. Schmitz C, Berchtold P. Managing professionals: führung im krankenhaus. In: Amelung V, Sydow J, Windele, A, editors. Vernetzung im gesundheitswesen: wettbewerb und kooperation. Stuttgart: Kohlhammer; 2009.

105. Turnbull J. Leadership in context: lessons from new leadership theory and current leadership development practice. London: The King's Fund; 2011.

106. Epstein RM, Fiscella K, Lesser CS, Stange KC. Why the nation needs a policy push on patient-centered health care. Health Aff (Millwood). 2010; 29 (8): 1489–95.

107. PEPFAR guidance on integrating prevention of mother to child transmission of HIV, maternal, neonatal, and child health and pediatric HIV services. Washington DC: The United States President's Emergency Plan for AIDS Relief. The United States President Emergency Plan for AIDS Relief; 2011.

108. Peters DH, Tran NT, Adam T. Implementation research in health: a practical guide. Alliance for Health Policy and Systems Research. Geneva: World Health Organization; 2013.

109. Best A, Greenhalgh T, Lewis S, Saul JE, Carroll S, Bitz J. Large-system transformation in health care: a realist review. Milbank Q, 2012. 90 (3): 421–56.

110. Peters DH, Adam T, Alonge O, Agyepong IA, Tran N. Implementation research: what it is and how to do it. BMJ. 2013; 347: f6753.

Annex 1. Glossary of key terms

Accountability: the obligation to report, or give account of, one's actions – for example, to a governing authority through scrutiny, contract, management, regulation and/or to an electorate

Ambulatory care sensitive conditions: chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management in primary care settings – for example, vaccination, screening, self-management and lifestyle intervention

Amenable morbidity: disease state or the incidence of illness in people and communities considered avoidable by health care interventions

Amenable mortality: deaths considered avoidable by health care interventions

Care coordination: a proactive approach in bringing care professionals and providers together around the needs of service users to ensure that people receive integrated and person-focused care across various settings

Case management: a targeted, community-based and proactive approach to care that involves case-finding, assessment, care planning and care coordination to integrate services around the needs of people with long-term conditions

Change management: an approach to transitioning individuals, teams, organizations and systems to a desired future state

Collaborative care: care that brings together professionals and/or organizations to work in partnership with people to achieve a common purpose

Community health worker: people who provide health and medical care to members of their local community, often in partnership with health professionals. Alternatively known as a: village health worker; community health aide/promoter; lay health advisor; expert patient; and/or community volunteer

Continuity of care: the degree to which a series of discrete health care events is experienced by people as coherent and interconnected over time, and consistent with their health needs and preferences *(15)*

Continuous care: care that is provided to people over time across their life course

Co-production of health: care that is delivered in an equal and reciprocal relationship between professionals, people using care services, their families and the communities to which they belong. Co-production implies a long-term relationship between people, providers and health systems where information, decision-making and service delivery become shared

Chronic care: medical care which addresses the needs of people with pre-existing or long-term illnesses

Disease management: a system of coordinated health care interventions and communications to populations with conditions in which people's self-care efforts are significant to managing their health

E-health: information and communication technologies that support the remote management of people and communities with a range of health care needs through supporting self-care and enabling electronic communications between health care professionals and patients

Empowerment: the process of supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours or the ability to self-manage illnesses

Engagement: involving people and communities in the design, planning and delivery of health services that, for example, enable them to make choices about care and treatment options or to participate in strategic decision-making on how health resources be spent

Goal-oriented care: each individual is encouraged to achieve the highest possible level of health as defined by that individual

High quality care: care that is safe, effective, people-centred, timely, efficient, equitable and integrated *(15)*

Holistic care: care to the "whole person" that considers psychological, social and environmental factors rather than just the symptoms of disease or ill-health

Indicators: explicitly defined and measurable items which help to assess the structure, process or outcomes of care

Integrated health services: the management and delivery of health services such that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course *(15)*

Intersectoral action: the inclusion of several sectors, in addition to health, when designing and implementing public policies that seek to improve health care and quality of life

Mutual (shared) accountability: the process by which two (or multiple) partners agree to be held responsible for the commitments that they have made to each other

Noncommunicable disease: a medical condition or disease which is non-infectious and non-transmissible among people

People-centred care: an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases *(13,14)*

Person-centred care: care approaches and practices that see the person as a whole with many levels of needs and goals, with these needs coming from their own personal social determinants of health.

Population health: an approach to health care that seeks to improve the health outcomes of a group of individuals, including the distribution of such outcomes within the group

Primary care: a key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated care to people and communities

Primary health care: refers to the concept elaborated in the 1978 Declaration of Alma-Ata, which is based on the principles of equity, participation, intersectoral action, appropriate technology and a central role played by the health system

Stewardship: an ethical responsibility for the effective planning and management of health resources to safeguard equity, population health and well-being

Supported self-care: individuals, families and communities are supported and empowered to take responsibility to manage their own health and well-being

Transformational change: a complete paradigm shift in the underlying strategies, cultures and processes within which a system operates in order to bring about significant and enduring improvements

Universal health coverage: ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship

Vertical programmes: focused on people and populations with specific (single) health conditions, vertical programmes have three core components: intervention strategies, monitoring and evaluation, and intervention delivery

Whole-system thinking: the process of understanding how things, regarded as systems, influence one another within a whole