# World Health Organization

**REGIONAL OFFICE FOR Europe**

# DELEGATE

# BRIEFING NOTE

**Second Technical Meeting on
Coordinated/Integrated Health Services
Delivery: Developing the Framework
for Action in the context of Health 2020**

17-18 February, 2015, Istanbul, Turkey

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Health Services Delivery Programme[1]
Division of Health Systems and Public Health

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# ABSTRACT

This delegate briefing note has been prepared to preface sessions set to take place on 17-18 February 2015 in Istanbul, Turkey at the *Second Technical Meeting on Coordinated/Integrated Health Services Delivery: Developing the Framework for Action in the context of Health 2020*. Convening Ministry of Health appointed representatives from across Member States, as well as partnered international experts and staff from the different technical units of WHO and its offices, the event aims ultimately to examine the continued advancement of key concepts, to facilitate the exchange of experiences and insights across participants and to discuss the onward development of the Framework for Action. In line with these objectives, this briefing sets out to position the following: (1) progress to-date across planned activities in developing the Framework for Action; (2) reflections on feedback from earlier consultations; (3) an overview of concepts in alignment with input received and further reviews undertaken; and (4) an outline of the Framework for Action's action-oriented lens to health services delivery transformations.

## Keywords

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# About this briefing note

In the context of developing the *WHO European Region Framework for Action for Coordinated/Integrated Health Services Delivery towards People-Centred Health Systems* [hereafter referred to as: the Framework for Action], a second technical meeting on coordinated/integrated health services delivery is set to take place on 17-18 February 2015 in Istanbul, Turkey. Hosted by the WHO Regional Office for Europe, the event convenes Ministry of Health appointed representatives for coordinated/integrated health services delivery from across Member States as well as partnered international experts and WHO staff. The event aims ultimately to examine the continued advancement of key concepts and to facilitate the exchange of experiences and insights from countries and participants (Box i). It will also serve as an opportunity to discuss the continued development of the Framework for Action in preparation of its sought endorsement by Member States in 2016 and onward implementation to follow.

This delegate briefing introduces some of the topics that will be explored at the event, and is intended to raise questions and stimulate discussion throughout the days' sessions. To first give context, it begins by reporting on progress in developing the Framework, looking to the advancement of phases from early in-house consultations and its official launch in mid-2013 to the previous year's events; all framed within the strategic priorities underpinning this work. A summary of technical input generated through consultations follows, recounting the themes of key topics signaled through the interventions of participants aligned with the actions taken in response after a period of further reflection. The briefing then sets out a summary of key concepts for people-centred services and coordinated/integrated health services delivery. From this, an outline of the Framework for Action takes shape, with suggested themes for reflection and further discussion seeking a common understanding of topics and consensus on their importance, both as concepts and in practice.

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### Box i. Aims of the second technical meeting

1. To examine core concepts underpinning the Framework for Action from which high-leverage entry points as areas for action to transform health services delivery are defined.

2. To learn from the experiences of countries and experts those strategic choices and options for policy-makers, health management and administration, health professionals and the public and all other stakeholders engaged in transforming health services delivery.

3. To discuss the continued development of the Framework for Action in preparation of the sixty-sixth meeting of the WHO European Regional Committee in 2016 and its implementation to follow.

# 1  Setting the context: from Tallinn 2013 to Istanbul 2015

## 1.1 Health services delivery as a strategic priority

Globally, health and development priorities converge on the importance of health systems strengthening. This consensus is made explicit in WHO's *12th General Programme of Work* for the period between 2014-2019, with a priority cluster of technical activities and corporate services concentrated on strengthening systems; specifically the organization of integrated services delivery as positioned in the forthcoming *Global Strategy for People-Centred and Integrated Health Services*.

In the WHO European Region, the European Health Policy – *Health 2020* – adopted by Member States in 2012, sets out a course of action for realizing the Region's greatest health and well-being potential by year 2020. Within this policy, health system strengthening is firmly rooted as a core strategic priority, promoting people-centred health systems as a forward-looking approach for advancing overarching goals. Transforming services for coordinated/integrated delivery is integral to this, and subsequently, takes part in the implementation of *Health 2020* as a key strategic lever for health system strengthening.

Additionally, across the Region partners including the European Commission and Organization for Economic Cooperation and Development (OECD), as well as professional associations and civil society organizations, have echoed the importance of strong health systems, upholding the principles of people-centred and integrated health services delivery. The European Innovation Partnership on Active and Healthy Ageing (EIP AHA) and health research priorities defined in the programme *Horizon 2020* of the European Commission, for example, too underscore the importance of integrated, sustainable and people-centred care, supporting respective member states to prioritize strong health systems that enable and empower citizens to lead healthy and self-determined lives. The apparent momentum that has been generated across countries can be credited in part to this vision shared among partners, creating a compelling and consistent direction for services delivery transformations.

## 1.2 Development of the WHO European Region Framework for Action

In order to realize these priorities, exchanging the wealth of technical insights and operational know-how for health services delivery transformations in practice, is acutely needed. Despite marked health gains that have been recorded in documented initiatives, the number of available strategic options for transformations appears somehow stunted by the absence of an equally common narrative and analytics for advancing reforms and tackling system-wide change. This is evidenced by the many initiatives to coordinate/integrate health services delivery that remain small-scale and context-specific, often with pre-set timeframes and funding limits, and ultimately constrained in their potential to take on broader health system bottlenecks; particularly alarming as initiatives that take shape as siloed or isolated interventions to the health system itself are fundamentally in contrast to the principles of people-centred and integrated services delivery and pose a major barrier to sustained change. Cultivating a more nuanced understanding of concepts, taking full stock of proven strategies from the experiences of countries and deciphering common denominator lessons learned from implementation is, thus, an imperative.

In the context of this need and in alignment with guiding commitments, in 2013 at the high-level meeting in Tallinn, Estonia, marking the fifth anniversary of the Tallinn Charter, the WHO Regional Office for Europe officially launched the development of an action-oriented framework to support service delivery

transformations. This effort takes form as the forthcoming *Regional Framework for Action for Coordinated/Integrated Health Services Delivery (CIHSD)*. The Framework is envisaged as an operational resource for Member States, setting prioritized areas for action in transforming services delivery. The process of developing the Framework has been defined in a planning document,[2] with activities spanning from its official launch at the event to until the WHO European Regional Committee at the sixty-sixth meeting in 2016.

## 1.3 Milestones marking engagement with partners

Adopting the vision of *Health 2020*, this work places focus firmly on efforts across government and society, recognizing that, for people-centred health services; everyone has a role to play. The Framework for Action itself has promoted participation and collective action in its development, ensuring opportunities for strategic partnerships and the engagement of a number of stakeholders is supported throughout.

To-date, partners have convened in discussions, consultations and reviews that span the involvement of high-level Ministry of Health officials, a forum of Member State technical focal points on coordinated/integrated health services delivery, an advisory team of international experts from academia and organizations at the forefront of work in this domain, and public and professional networks representing patients, health and social care providers and special interest groups and international development partners including the European Commission and OECD, as well as staff from the different technical units of WHO and its offices. At several stages events have convened these partners, meeting for workshops and consultations in Istanbul (Turkey), Brussels (Belgium), Boston (USA), and Copenhagen (Denmark). Key milestones marking the engagement specifically with countries and international partners in the development of the Framework for Action thus far are summarized below (table 1.3).

**Table 1.3 Summary of milestones in the development of the Framework for Action**

| Event | Milestone |
|---|---|
| In-house workshops Copenhagen, Spring 2013 | Preparatory meetings at the Regional Office with the Executive Board and across technical units for alignment on topics and strategic planning |
| Tallinn Charter 5th Anniversary Tallinn, October 2013 | Official launch of *Roadmap* to the Framework for Action by the Regional Director with high-level Ministry of Health Officials |
| Kick-off Technical Meeting Istanbul, February 2014 | Development of the Framework initiated with review of concepts and exchange of experiences with Member State focal points and experts |
| 1st Stakeholder Consultation Brussels, April 2014 | Exchange of pertinent topics with representation from the international development, academics, health professionals, patient associations |
| 2nd Technical Meeting Istanbul, February 2015 | Exploration of the Framework's structured areas for action, examining concepts and exchanging experiences with Member State focal points and experts |
| 2nd Stakeholders Consultation Brussels, Summer 2015 | Feedback on the development of the Framework's contents to stakeholder representatives for discussion and further input |

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[2] WHO Regional Office for Europe. (2013). Roadmap – strengthening people-centred health systems in the WHO European Region. Copenhagen: WHO Regional Office for Europe. Retrieved from http://apps.who.int/iris/bitstream/10665/108628/1/e96929.pdf?ua=1

### 1.4 Charting progress across aims set out in the Framework's *Roadmap*

As noted, the phases in developing the Framework have been defined in a planning document – *A Roadmap for strengthening people-centred health systems in the WHO European Region: Developing a Framework for Action towards Coordinated/Integrated Health Services Delivery*. The document serves as a guide for framing phases within a common vision, intending merely to promote coherence in activities while flagging opportunities for ample consultation and engagement with countries and partners.

The aims and objectives for the Framework for Action itself and its development are summarized below (box 1.4) as defined in the *Roadmap*. From this, advancements for each objective can be charted as follows.

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**Box 1.4. Aim and key objectives of the Framework for Action**

**Aim**

To support the coordination/integration of health services delivery towards people-centred health systems such that improvements in health level and equity may be fully realized.

**Key objectives**

1. To consolidate and align literature on health services delivery towards a common analytical understanding on concepts.
2. To provide a consistent approach to accelerate the exchange of experiences across the Region towards more coordinated/integrated health services delivery.
3. To decipher common denominator policy tools and instruments to initiate, implement and/or scale-up services delivery transformations.
4. To support Member States in building technical capacity and necessary leadership and managerial skills for sustainable transformations.
5. To meaningfully engage countries a diverse number of partners in discussions and consultations throughout the phases defined.

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☑ **Consolidation and alignment of literature on health services delivery**

A series of commissioned reports led by staff at the Regional Office and engaging international experts have been conducted for the further review of health services delivery and areas for action signaled as priority entry-points for transformations. The respective authors of these works will present the findings from their reviews during the meeting for discussion that will in turn inform next steps for finalizing and consolidating results.

☑ **Consistent approach to exchange country experiences**

Following the web-based open-call for initiatives to strengthen coordinated/integrated health services delivery, a second stage of data collection has been undertaken. This has included key informant interviews conducted at-distance as well as literature reviews of initiative-specific reporting where

available. Over eighty different experiences have been documented in this process, in twelve different languages and representing forty-seven of the fifty-three Member States in the European Region. Drafted case profiles will be put to key informants and Member State technical focal points for their review and validation of results. This work to document country experiences parallels the development of a web-based platform to support online communities of practice with discussion boards for implementers and a repository of global examples of service delivery transformations being developed by WHO-headquarters.

☑ **Policy tools and instruments for implementing and scaling-up initiatives**

Reviewing lessons from implementation has thus far taken to explore those characteristics of leadership and management and their respective processes that consistently show to influence the rollout of services delivery transformations in practice. With the advancement of concepts and country cases, a further analysis will be conducted to draw common strategies, tools and policy options.

☑ **Technical capacity in countries**

The process of developing the Framework for Action has provided a number of unique opportunities to engage Member States on topics pertaining to health services delivery. These opportunities range from Regional consultations, conferences, round table discussions, policy dialogues and direct technical assistance. As a result, there is an ever-expanding network of technical experts on services delivery, which has proven to facilitate the exchange of insights across countries. Moreover, through regular dialogue and frequent reporting, the evidence-base on health services delivery is continuously advanced.

☑ **Forum of Member States and partners**

Each Member State across the Region has been invited to nominate a representative to serve as a technical focal point for coordinated/integrated health services delivery, providing country-specific expertise and ensuring the interests, experiences and needs of countries are tabled in discussions. As of January 2015, forty-one countries are represented with official appointments and a further eleven are engaged through national experts identified in the field. Other partners include an advisory team of international experts, public and professional networks and international organizations that have been convened in the events noted above.

## 1.5 The Framework for Action and its implementation package

Taking an action-oriented outlook, the Framework identifies a minimum set of those most pragmatic and adjustable or changeable conditions in health services delivery, seeing these as high-leverage entry points for strategizing transformations. Termed *areas for action*, these are further clustered into four principal domains based on their focus and to give structure to their associations: people, families and communities; health services delivery; the broader health system; and the process of change itself. The Framework is accompanied by strategies, techniques and tools that have been found in the literature and from the first-hand experiences of countries, aiming to provide both the technical insights and operational know-how that can be called upon by those leading and managing reforms.

The Framework for Action is backed by a series of resources that serve to support the implementation of transformations in practice. This includes the following:

- **Concept note** on coordinated/integrated health services delivery, summarizing the literature, evidence and the insights of partners expressed in consultations and reviews on concepts underpinning health services delivery.

- **Compendium of documented initiatives** for coordinated/integrated health services delivery in the Region profiling the first hand experiences of Member States captured through country case studies.

- **Guide for developing case studies**, providing a template for drafting cases and surveying resources for collecting information, supporting the practice of sharing experiences in transforming health services delivery for the continued development and dissemination of services delivery and operational research.

- **Catalogue of common tools and instruments** as an inventory of technical know-how developed based on country case findings and the broader evidence-base.

- **Manual for leading and managing change** supporting the process of undertaking services delivery transformations.

- **Guide for monitoring and evaluation** defined for following-up and charting improvements in service processes and outputs towards people-centred health systems.

- **Glossary of terms** as an indexing of key concepts in an effort to improve their consistent use and accuracy in translation.

# 2  Reflections from consultations: key topics and responses

Key topics flagged in presentations and discussions from the kick-off technical meeting (Istanbul, February, 2014)[3] and first stakeholder consultation (Brussels, April 2014)[4], have in turn guided a process of further reflection. This section summarizes these topics as well as the revisions undertaken based on the interpretation of the points noted.

## Topic 1: Integrated care as *means* or an *end*?

Discussions considered the importance of integrated care, with debate as to whether it should be regarded as a *means* (process) to an end or rather as a final *goal*; an attainable achievement in and of itself. While it was recognized that this conceptualization depends on the perspective of the commentator, there was strong consensus on the basis of viewing integrated health services delivery as a *design principle*, differentiated from the overarching goal of improved health outcomes.

This debate sparked further discussion to clarify if integrated care is the means, then 'what sort of care' was being sought: quality, patient-centred, people-centred, community-centred ? This discussion signaled that further clarity was still needed to specify the intended 'impact' – health gains – and the characteristics of services to be delivered to advance them. These measures were deemed necessary for also accurately discerning the 'problem' – the context in which changes are sought – to ensure service delivery bottlenecks are rightly targeted and more generally, that "integrated care is not associated with a cost containment strategy but with improving services."

### *Response*

☑ **Elaborating concepts underpinning people-centred health systems**

To disentangle the means of transforming services delivery from its impact and performance improvement objectives, attention has been given to firmly root service delivery transformations in alignment with the vision guiding people-centred health system strengthening. Coordinated/integrated health services is seen as the means to promote system alignments that support the provision of people-centred services. For measurement, focus is put on monitoring those factors that can be influenced by the system, seeing these as areas where the system's action takes precedence with the greatest potential to improve performance. This is then to the exclusion of those factors that can also be measured from the perspective of the individual; rightly needed for the validation of people-centred services delivery but not within the scope of what the system can actually act upon.

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[3] The meeting report from this event can be accessed as follows: WHO Regional Office for Europe. (2014). Meeting report – coordinated/integrated health services delivery kick-off technical meeting. Copenhagen: WHO Regional Office for Europe. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0007/246256/Coordinated-Integrated-Health-Services-Delivery-CIHSD-Kick-off-Technical-Meeting.pdf?ua=1

[4] The meeting report from this event can be accessed as follows: WHO Regional Office for Europe. (2014). Meeting report – coordinated/integrated health services delivery stakeholder consultation. Copenhagen: WHO Regional Office for Europe. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0018/251082/Coordinated-Integrated-Health-Services-Delivery-CIHSD-Stakeholder-Consultation.pdf?ua=1

## Topic 2: What are the key entry-points for strategic action?

Through a first scoping of literature, seven key areas for action were identified and presented at the kick-off meeting and first stakeholder consultation[5]. The discussions generated around these seven areas have been summarized in annex 1. In general, the comments of countries, experts and partners signaled consensus on the themes highlighted and on their relevance. However, the contents within each area for action, their boundaries and associations were challenged. For example, there appeared a challenge to distinguish between communication and knowledge, seeing 'communication' to include information and research, which were considered components also of knowledge. Moreover, 'knowledge' itself was differentiated from 'competencies', seeing this as internalized knowledge *and* its use professionally, raising this specificity as perhaps the orientation to be taken in defining the area. In addition, some areas were observed as more 'actionable' than others. The area of 'values' for example, was viewed rather as a condition for change, essential for sustaining efforts but not necessarily actionable in itself.

### *Response*

☑ **Answering to start: what is services delivery?**

> The processes that feature the provision of services and that are uniquely associated with it were investigated at length Incorporating the comments received and undertaking a further review of concepts, frameworks and tools for health systems. This was a first step to tackle contentious boundaries for instant with the proposed area for action 'care'. Similar considerations were taken across areas that were flagged for further clarification. In doing so, the characteristics of each have been refined and their association with high-leverage entry points for action have been specified with a first look to those relevant strategies or tools that can be called upon for improving coordination and integration of services as a means towards people-centred health systems. This line of thinking leans on the further analysis of associations between areas, explored in relation to topic three below.

## Topic 3: How can the associations between areas of actions be reasoned?

In the first round of consultations, the seven areas for action were presented as a 'flat model'; merely bundling common characteristics within each area without reasoning their dynamics or a hierarchy of associations. However, the challenge to differentiate the boundaries of these areas reminded that the associations between a health system's parts and their adaptive behavior are also at play in the areas identified. Left unaddressed this posed difficulties to anticipate the interactions between areas, which ultimately compromised the practicality of merely pinpointing entry points for strategic interventions.

Moreover, in discussions the difference between areas for action with a 'supporting' versus 'core' role for coordinated/integrated care was raised on a number of occasions. The question put for further review called for reflection on what this means in practice: does the 'importance' of areas as either core or supporting affect their prioritization in planning reforms? What are the differences at the macro, meso and micro level? This was also conveyed in discussing the key challenge of orchestrating services delivery transformations and the difficulty in understanding 'what to do first'. Taken together, this signals the importance of reasoning associations in order to anticipate how different areas interact/interface with one another.

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[5] These areas for action were listed as: (1) communication; (2) knowledge; (3) resources; (4) policy; (5) care; (6) values; and (7) people.

*Response*

### ☑ **Alignment with health systems-thinking**

In response to this, further reflection has sought to anchor prioritized areas in the health system functions of governance, financing, resource generation (human resources for health; information; medicines and health technologies), and health services delivery. Assembling these functions to view their dynamics borrows from health systems-thinking the understanding of how inputs interact and influence the provision of services, ultimately dictating service outputs, performance outcomes and health impact. Structuring areas into 'domains' has been attempted to improve an understanding of these dynamics and also to further collocate how 'people' interface with services and the health system and how considerations of the 'process' of transformations itself weigh on the success of reforms.

## Topic 4: What are the key conditions for successful reforms?

From discussions it was made clear that services delivery reforms have characteristics that weigh on the success of integrated care initiatives; where success is measured as the impact on health and improvements in service outputs and overall health system performance but also is characterized by factors including the scalability and sustainability of changes overtime.

One of the key lessons from implementation emphasized in consultations was the role of management in the process of change. Most initiatives did not develop implementation plans, having taken shape thanks to enthusiastic people who also served as the initiatives' leader. However, some degree of forward planning seems helpful and managing the process well was regarded as a key component to strengthening health systems. Moreover, discussions clearly signaled services delivery transformations need to be led, supported and managed. These characteristics were described as the 'intangibles' – the leadership, management and characteristics of both that underpin the success of implementation.

The question put for further consideration was the alignment of 'process' conditions, to interpret these 'intangibles' and reason their association for action-oriented thinking in practice.

*Response*

### ☑ **Differentiating 'leadership' and 'management' as key areas for action**

As an action-oriented resource, the Framework should address all pertinent dimensions found to dictate the success of transformations in coordinated/integrated health services delivery. Hearing the importance of leadership and management, further review has looked to reason the dependency of reforms on actions taken pertaining to both. Sharing the characteristics of other proposed 'areas for action' as those dimensions where strategic efforts are an imperative and serve as high-leverage entry points for change, leadership and management have then been added as key areas within the domain of 'change'.

# 3 A health systems based, outcomes oriented approach to health services delivery: overview of concepts

## 3.1 What is people-centred health services delivery?

Focused on providing the right care at the right time in the right place, transforming services delivery has called for a focus on services selected, designed, organized and managed keeping the needs of populations and individuals in mind. This is a more significant shift in ideologies than it would seem. What it means in practice is a conscious transition away from isolated services programmed to treat acute needs with solely curative goals, often reactive and triggered by patients' self-referrals, to service delivery systems malleable to adapt to the complexities of real-life and able to provide services along a broad care continuum; necessary to promote optimal health and well-being across life stages.

People-centred *services* are differentiated from people-centred health *systems* as a technical consideration for more operational thinking. Consider, for example, the provision of services can be optimized along a number of fronts for more people-centred delivery, including organizing providers in multidisciplinary teams, risk-stratifying populations for targeted prevention measures or coordinating care planning across multiple providers and services, among others. However, the achievement of optimal outcomes is either advanced or impinged upon by the dynamic processes, relationships and arrangements that meet at the interface of services delivery and the broader health system. Misaligned incentives, incongruent accountability arrangements or a workforce ill-equipped with the skills to respond to the population's needs, are among those leading factors forming the slippery slope of conditions that can constrain or crowd-out people-centred services in failing to set the necessary context for optimal health gains.

What this means for service delivery transformations is, firstly, the recognition that the optimization of the provision of health services will ultimately hinge upon having the supporting health system conditions in place. Secondly, it acknowledges that promoting people-centred health services demands action across society, engaging the general public, service users and carers among others. However, from the point of the steward, only those changes that influence the health system's performance are considered to be 'actionable' and, consequently, people-centred services delivery is featured from a system perspective looking mostly to chart improvements in outputs.

## 3.2 Determinants of people-centred health services delivery

As described, the delivery of health services is enmeshed in a web of interdependencies with other functions of the health system but also other sectors of the economy and a country's broader demographic, epidemiological, economic, environmental, sociocultural, technological, political, and regulatory context. Defining people-centred health services according to key determining factors makes clearer these variables, their importance and their dynamic inter-relations. Figure 3.2 is illustrative of these principle determinants, with the unique characteristics of how each influences people-centred services further described.

▪ **People, their families and their communities.** Put at the centre of health services, people's needs and legitimate expectations should set the content and direction for health services. This means that people should interface with the health system through the delivery of services that are adapted for the course of interventions to best align with their risks or diagnosed illnesses. This ability to personalize care is a key priority not only because people should have the right to determine their own care, but also because

services can be provided more effectively and efficiently if they partner in the delivery. Importantly, this assumes people are supported in being articulate and empowered partners in health, able to take control and be engaged with their families and communities in the delivery of services, making choices about care and treatment options and participating in decision-making.

- **Health services delivery.** The health services delivery function determines the content, design, organization, management and improvement processes of providing services. People-centered health services delivery can then be described as the ability of the function to purposefully consider and adopt a person-facing perspective to match these processes with health needs.

- **Health system.** As described above, the provision of services ultimately takes direction from the health system. Core system functions must then reflect the prioritization of those attributes needed to achieve people-centred services.

- **Other sectors.** Responding to an individual's needs is subject to the interactions between the system and other sectors, seeing social needs, employment or housing, for example, as deterministic of health but beyond the health system itself. For instance, the conditions of the labour, education and housing sectors are important determinants of health outcomes, despite being positioned outside the health system.

- **Context.** Ultimately, prevailing cultural, social and religious norms and political powers, as well as the level and distribution of wealth across the population will shape the dynamics of health services and its degree of people-centeredness. These factors can be described as a country's broader context, setting the epidemiological, cultural, socio-demographic, and economic conditions within which all other determinants take shape. This additionally includes historical considerations that hold influence on the present context according to the principles of path dependency.

**Figure 3.2 The interacting determinants of people-centred health services delivery**
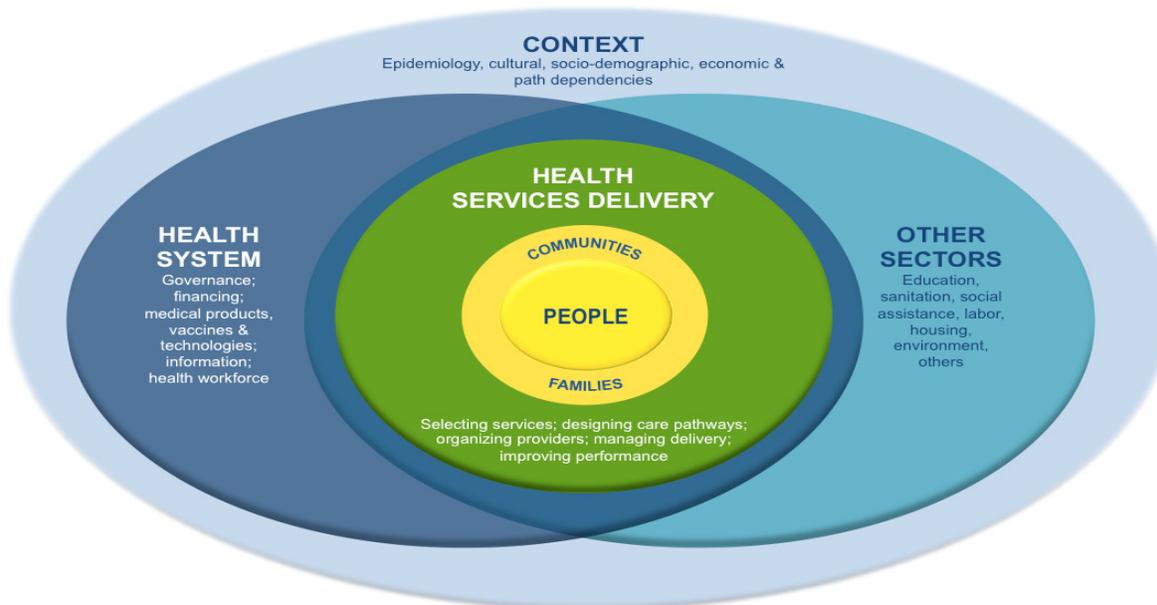


Note: Adapted from WHO-HQ Global Strategy on people-centred and integrated health services [forthcoming]

## 3.3 Attributes of people-centred health services delivery

People-centred health services delivery has a strong basis and the underlying aspirations have a long history. While more than four decades after the 1978 Declaration of Alma-Ata on Primary Health Care, concepts and approaches elaborated continue to remain valid for realizing the fundamental belief that every human has the right to enjoy 'the highest attainable standard of health'. The Declaration identified primary health care as the key approach to realizing this goal, defining it as:

> Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination[6].

Recalling the nature of health services delivery based on the principles of a primary health care approach, people-centred health services can be expected to share the following key characteristics or attributes (box 3.3).

**Box 3.3 Attributes of people-centred health services delivery**

**Comprehensive.** Defined core set of services extends across the care continuum, from health protection, health promotion and disease prevention to diagnosis, treatment, long term care, rehabilitation, and palliative care, as well as across sectors for services delivery that is focused on the whole person; adapting the provision of services according to the complexity of interactions between biological, behavioural and psychosocial factors over the lifetime and according to an individual's needs.

**Population focused.** Demand-driven selection of services, informed by an understanding of population health needs and social perceptions, with attention to different segments of the population.

**Evidence-based.** Best available evidence is applied in the prioritization of services and clinical decision-making according to a patient's needs, linking available evidence for optimum outcomes in consideration of patient-specific needs jointly established through care planning.

**Personalized.** Care is designed with respect to persons' autonomy, dignity and confidentiality and oriented to an individual's legitimate expectations for choice of services, providers and institutions.

**Coordinated.** Providers, information and financial flows are seamlessly interconnected at all cross-sections (interfaces) of the services delivery system. Cross-sectional coordination considers alignment within an episode of care and longitudinal coordination; those qualities are considered over a longer episode of treatment and throughout the life-course, accounting also for the co-occurrence of needs.

**Accessible.** Services are directly and permanently accessible with no undue barriers of cost, language, culture or geography.

**Continuous.** Service provision, exchange of information and interpersonal relations are fluid over time. Individuals customarily receive services from an organized team of providers in an accessible and familiar environment (longitudinal continuity); an organized body of clinical and social history about each individual is accessible to any service provider (informational continuity*)*; an ongoing personal

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[6] WHO. 1978. Declaration of Alma-Ata. Kazakhstan, USSR: World Health Organization.

relationship exists between individuals and service providers (interpersonal continuity*).*

**Technology enabled.** Appropriate technologies and innovative clinical and service delivery resources are fully engaged and embedded within the organizational design for services delivery.

**Intersectoral.** The provision of services meaningfully engages across the public and private sector and with a broad number of partners in health spanning across levels and settings of care.

**Results-oriented.** Health services are well managed with a minimum wastage of resources, made possible by allocating managers the necessary authority to achieve planned objectives and held accountable for overall performance of results.

**Safe.** The provision of services is of a high standard; continuously considering best available evidence and minimizing risk and harm to service users for the optimal performance of services provision.

**Self-learning.** Reflective approaches to evolve and generate higher value in services provision are in place.

## 3.4 How people-centred health services contribute to improving health outcomes?

People-centred health services delivery influences performance in a causal chain linking health system inputs (such as the competencies of the workforce and innovative technologies), with the process of services delivery. The result of this production process is then reflected in outputs (such as the comprehensiveness of interventions and coordination of services) that are in turn reflected in outcomes (such as responsiveness and equity) and health impact (such as morbidity and mortality).

Through this chain of associations, people-centred health services delivery has the potential to advance health and well-being and outcomes of health system performance as illustrated by the following examples.

- **Improving the prevention and control of NCDs.** Actions aimed at improving the prevention and control of NCDs are complemented by people-centred health services delivery, sharing a common focus on caring for people over the life-course and across care sectors (for example public health, clinical service provision, rehabilitative services and social care). The importance weighted to patient empowerment through people-centred services delivery adds value to NCD control strategies by way of involving people in looking after their own health, engaging effectively with health services and technologies (for example m-health, telemedicine and other information and communication technologies) and self-managing their care needs between physician visits.

- **Supporting well-being through healthy ageing.** By way of promoting the improved treatment and management of multi-morbidity which disproportionately affects many older adults, people-centred health services can foster advancements in services provision including the enhanced use of assistive devices, reduced private cost-sharing for long term care and the advanced design of supportive and friendly environments for the elderly. Providing services with greater engagement of individuals can promote a number of benefits including improved adherence to treatment plans and medication regimens, leading to improved outcomes.

- **Advancing universal health coverage.** People-centred services delivery is conducive to universal health coverage for a number of reasons. For example, this approach shifts focus from narrow, isolated disease programmes towards broader, coordinated service platforms that proven to meet population and

individual health needs more effectively and consistently over time. Additionally, bringing services closer to people is at the core of a people-centred strategy, as opposed to conventional system designs in which provider preferences and incentives dictate geographic distribution of services and financial access to care.

- **Improving quality of care.** Lack of coordination is widely considered to be one of the key causes for poor quality in services delivery, with fragmented care or care insufficiently coordinated found harmful to patients and inefficient, due to duplication of diagnostic tests, inappropriate treatment and at times, conflicting rather than complementary services. By better matching the delivery of services with the design of care needed to meet an individual's needs, people-centred health services delivery can advance care coordination. Better coordination not only improves quality but also advances opportunities for the engagement of patients in service decision-making by improving the timely and reliable transfer of needed information.

- **Increasing efficiency in the allocation of resources.** Taking a person-facing perspective in decision-making can increase allocative efficiency by ensuring resources are channelled to issues that more commonly or severely impact people's health and well-being. In effect, planning and targeting services oriented to upstream determinants rather than acute, episodic patient needs is made possible and taking this focus is also a know precursor for reducing disparities.

## 3.5 Role of coordinated/integrated health services delivery

Putting people first is not a trivial principle and often requires significant – even if often simple – departures from business as usual. As existing health systems have grown by accretion and often piecemeal alterations, they incorporate legacies of many prior choices about how to approach the selection, design, organization, management and improvement of health services delivery. As a result, financing arrangements, health workforce planning and logistics, the supply of medical products and regulatory frameworks are at times inconsistent across organizations or ineffective in their incongruence to support the system's goals. Indeed, leaders face an indisputably difficult assignment of taking on the intricacies of systems to bring them into alignment, while managers face the equally difficult challenge to bring about people-centred services in their day-to-day functioning for the actual production of services.

Integrated health services delivery enters as a vehicle for tackling system design challenges, providing the blueprint for those conditions needed to advance people-centred health services delivery. Giving direction to the process of transforming the provision of services reflects the very essence of integration coming from the Latin word *integer*, meaning 'whole' or 'entire', which in principle reflects a focus on combining parts so that they work together or form a whole.

Although there are no universal models for health systems, significant strides have been made to decipher the particularities for coordinated/integrated health services. Evidence from research and experience has greatly contributed to this understanding of key components that demand strategic action to effectively deploy integrated services for people-centred care in practice. There is then a growing level of understanding on the various strategic domains that need to be activated, for example, payment and incentive reform; governance and accountability rules; information and communication; inter-professional working and team-building; services delivery models; and supporting users and carers to become active participants in managing their own health and so on. However, insight into transforming health services delivery has huge and untapped potential; first in deciphering the specificities of services delivery according to a common and consistent series of processes, and then in applying this understanding within the broader health system.

# 4  Outlining the Framework for Action

Taking an action-oriented outlook, the Framework for Action identifies a minimum set of those most pragmatic, adjustable or changeable conditions for transforming health services delivery, seeing these as high-leverage entry points for strategizing initiatives. Termed *areas for action*, these are further clustered into four principal domains based on the subject of where they hold greatest influence: people, families and communities; the health services delivery function; the broader health system; or the process of change itself.

Within each area for action, practical strategies, processes, techniques and/or tools found in the literature and from the first-hand experiences of countries are grouped to propose specific actions that may apply. Taken together, the domains and areas identified provide both technical insights and operational know-how to optimally advance reforms.

## Domain 1: People

People-centred health services delivery shifts the production function from confronting population health with prescribed processes to one that holistically considers health needs for personalized care. Fostering the skills and resources so that people can be articulate and empowered partners in health has found strong support. This is increasingly so as a greater number of health decisions are taken outside of the health system and, rather, occur in the home. Supporting health-promoting skills and resources in order to ensure people have the potential to take control of their own health and engaging patients to become active partners in health services delivery, are thus, key areas for realizing people-centred services.

### Area for Action: Populations, Communities, Individuals and their Families

#### *Objective*

To support populations, communities, individuals and their families with the potential to take control of their own health by protecting the rights of the public and patients, empowering individuals and communities to take ownership and authority in services delivery, and promoting health literacy to support health promoting factors including the increased uptake of healthier behaviours and improved potential for individuals to manage their own illnesses.

#### *Relevance to coordinated/integrated health services delivery*

While empowerment cannot be bestowed upon others, health systems have the responsibility to establish the necessary skills and resources in order to ensure people have the *potential* to take control of their own health needs.  There is strong evidence in both developed and developing countries that interventions that seek to empower individuals, their families and communities, have the ability to make a positive impact on a range of outcomes found to include better health outcomes as well as improved patient experience and service utilization by reducing unplanned hospital admissions.

**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Rights of the public and patients**
E.g. privacy and confidentiality laws; safety regulations; patients' rights or charters; entitlements
☑ **Choice in services delivery**
E.g. patient mobility; choice of provider; preferred providers; network of community representatives/local leaders; community health committees or local councils
☑ **Health literacy**
E.g. health education including mass media campaigns, targeted educational packages, lifestyle support programmes; advancing social participation through information sharing and participatory learning in community-based organizations such as community health committees, local councils, youth groups, cooperatives or sports associations

## Area for Action: Patients

### Objective

To engage patients to play an active role in choosing appropriate treatments for episodes of ill-health, providing the means for their strategic role in care planning and decision-making and supporting their self-management, including self-care and monitoring.

### Relevance to coordinated/integrated health services delivery

Considerable evidence suggests that patient engagement can improve their experience and satisfaction and can also be effective clinically and economically. The benefits of engaging patients in decision-making and establishing measures to assess their goals, capabilities, priorities, skills and available supports, has been associated with improved trust and better compliance, as well as greater continuity in delivery. Information tools, such as decision aids for patients, have been shown to improve knowledge, reduce decision conflicts and stimulate patients to be more active in decision-making without increasing their anxiety which ultimately contributes to improvements in self-efficiency, self-esteem and self-management behaviours. Engaged patients also play a crucial role in coordinating their care during transitions, with their active involvement and cooperation being needed to ensure continuity particularly when coordination is insufficient, or to avoid circumstances where patient's behaviour might produce undesirable discontinuity in care.

**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Shared clinical decision-making**
E.g. patient coaching; evidence-based patient decision aids
☑ **Care planning**
E.g. discharge plans; decision supports for patient preference-based care planning; medication management plan
☑ **Supported self-management**
E.g. telephone outreach; printed and electronic educational materials or access to resources; didactic teaching methods (individual patient counseling and/or group counseling); didactic goal setting; goal setting negotiated teaching; situational problem solving; cognitive reframing interventions; self-help groups and volunteer services; self-treatment

## Domain 2: Services

The health services delivery function determines the content, design, organization, management and improvement processes in the provision of services and, therefore, has a unique hold on service outputs and the probability that services meet population and individual needs. Targeting services is then a key component for coordinated/integrated health services delivery and can be acted upon by differentiating between the care or interventions provided and the delivery system arrangements that are put in place and set the conditions for service provision.

## Area for Action: Care [population and individual services and interventions]

### *Objective*

To prioritize health interventions for a clearly defined population in order to equitably promote, preserve and/or restore health throughout the life-course, ensuring a broad continuum of services from health protection, health promotion, disease prevention, diagnosis, treatment, long-term care, rehabilitation to palliative care can be provided, sequenced in service paths personalized to individual's needs and informed by best-available evidence, standardizing for quality.

### *Relevance to coordinated/integrated health services delivery*

While the stratification of populations based on needs will alone not lead to improvements in services delivery, it is rather the ability of this approach to stimulate the prioritization and targeting of services that has been widely acknowledged as a means for systems to reduce disparities and achieve better health outcomes. The benefits of selecting for a comprehensive package of services on health outcomes are also well documented, including greater success of treatment (finding multiple interventions more likely to be successful than single factors), an increased uptake of preventive care, as well as health promotion to reduce risky behaviours improved care-seeking behaviour, as people more readily use services if it is known a comprehensive spectrum is offered, improved cost-effectiveness in the primary care setting, and consistently lower hospitalization rates for preventable complications of chronic, ambulatory care sensitive conditions. Additionally, a comprehensive range of services has been found to minimize the potential for fragmentation resulting from highly specialized, often siloed service packages, contributing for example, to the treatment of an individual's TB without considering their HIV status or whether they smoke.

Moreover, the well-documented implications of systemic, unwarranted variations in medical practice, in part explained by the insufficient or inappropriate use of evidence-based guidelines, underscores the importance of practical, up-to-date resources to support in designing a response to patient needs. In the context of changing patterns of ill-health and disability, increasing multi-drug regimes and parallel treatment plans, the ability to tailor services is of particular relevance, needing guidelines and care pathways that adopt a person-facing orientation.

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**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Population-focused prioritization of needs**
   E.g. stratifying (targeting) population by needs; predictive risk modeling
☑ **Services package and care pathways**
   E.g. core population and individual service package along broad care continuum; multi-disciplinary service panels or groups; available agent for care coordination
☑ **Guidelines and decision supports**
   E.g. common decision support tools practice guidelines; care protocols; best practice guides

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## Area for Action: Delivery

### *Objective*

To foster the structure and alignment of health professionals, organizations, institutions and service delivery system networks, optimally configuring the roles of health professionals and settings of care, organizing for the meaningful inter-professional coordination across health professionals and sectors and aligning care transition points for connected and coherent services delivery, ultimately seeking to match population interventions and individual service provision with the needed institutional arrangements for people-centred delivery.

### *Relevance to coordinated/integrated health services delivery*

The design of practices or care settings, the structure of access points, and the alignment of providers across these sites, is integral for the translation of service modalities into symmetric organizations, institutions and provider networks. The incongruence of these arrangements resulting in the lack of coordination in services delivery is widely considered to be one of the key causes for poor quality services with fragmented care found harmful to patients and inefficient, due to duplication of diagnostics tests, inappropriate treatment and at times, conflicting rather than complementary services. Furthermore, there is clear evidence to suggest positive associations between improvements in coordination with health status, levels of coverage and quality. Improvements in care processes and outcomes have also been attributed to gains in skill-mix and expanded scopes of practice as well as the benefits of simultaneous interventions across several levers, with the activation of sole interventions being unlikely to achieve the desired health impact.

The benefit of multidisciplinary teams in and created between levels of care including primary, secondary and tertiary service settings are documented in a growing number of intervention studies. These works have found with strong consensus changing the relationship between providers (e.g. care management, multi-disciplinary teams) strongly contributes to health and service user satisfaction. From the provider perspective, studies find the potential for a health professional to increase their medical knowledge to the benefits of their patients as well as developing personal relationships and gaining mutual respect among the key motivators for initiating and continuing to participate in new collaborative care models.

Removing organizational barriers to promote the availability of services in a number of settings has consistently been shown to improve access, reduce socio-economic disparities in health and can lead to improved satisfaction, increased adherence to treatment regimens and better health outcomes. Moreover, in streamlining care transitions and fostering enduring relationships in services delivery has been shown an important determinant of effectiveness, whether for chronic disease management, reproductive health, mental health or for promoting the healthy development of children. In the primary care setting, promoting

continuity and ongoing patient communication has proven a cost-effective intervention associated with a reduction in resource utilization. Contributions to improved outcomes have also been recorded with improved continuity of care contributing to lower all cause mortality as well as reduced hospitalizations, fewer consultations with specialists, better detection of adverse effects of medical interventions and improved prevention services.

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**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Roles for health professionals**
E.g. role expansion; substitution; supplementary roles; nurse/midwife led services)
☑ **Coordination of providers**
E.g. mixing disciplines/multi-disciplinary teams; co-location of services; inter-professional networks; Accountable Care Organizations
☑ **Referring and transitioning across settings**
E.g. discharge/transfer agreements to manage care transitions; care coordinators; centralized referral and intake; gate keeping system
☑ **Re-profiling delivery settings**
E.g. assisted living/care support at home; acute care centres; counseling and care planning in pharmacies; community centres
☑ **Intersectoral partnerships**
E.g. service delivery conferences and discussion platforms

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## Domain 3: System

The provision of health services is closely weaved into and heavily determined by other core functions of health systems and thus, tackling performance improvements in areas other than services delivery itself is key to enabling sustainable, large-scale transformations. While the overall system is dictated by core functions and their interactions, specific aspects of governance, financing and resource generation present as enablers or bottlenecks to transformations. Acting upon these specific high-leverage points for each system function is then integral to improving service provision.

## Area for Action: Accountability

### Objective

To ensure regulatory policy frameworks exist, setting the institutional structure conducive to people-centred services delivery by promoting arrangements that foster financial, performance, professional and political/democratic accountability.

### Relevance to coordinated/integrated health services delivery

Accountability is an essential component of governance, setting out a framework and making explicit the ways in which actors of the health system are expected to perform and interact. Health is not the sole responsibility of the health system and health services delivery is increasingly delivered through decentralized structures responsible for resourcing, financing and delivering care. This means that within the context of coordinated/integrated health services delivery, accountability constitutes a complex web involving many actors across different sectors. Key players span levels of government including the

ministries (health, finance, social care, education), public and private service delivery organizations, regulatory bodies and agencies, service providers and the people/service recipients who are linked through networks of control, oversight, cooperation and reporting. Cross-sectoral service arrangements create ambiguous accountability relationships and potential conflicts as it is not always clear who is responsible for levels of service, quality and outcomes. Failed accountability has been a major impetus for change and health systems improvement and it is thus essential to clarify accountability relations between actors from different sectors and levels for strengthening service provision.

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**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Financial accountability**
E.g. legal frameworks for joint planning; contracting and budgeting across sectors; investment strategies

☑ **Performance [managerial] accountability**
E.g. quality improvement councils; ombudsman; accreditation organizations or other national regulatory agency

☑ **Professional accountability**
E.g. clinical governance; professional associations; medical ethics board; professional code of conduct

☑ **Political/democratic accountability**
E.g. citizen panels; opportunities for public feedback on services; consensus conferences; watchdog committees (political, non-governmental, mass media); publically available budgetary and financial information; inspectorates; fact finding commissions

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## Area for Action: Incentives

### *Objective*

To align financial mechanisms to match the design of services delivery that best serves individuals and populations, incentivizing the optimal delivery of services through purchaser incentives/allocation mechanisms, incentives for patients, payment for providers and performance improvement incentives.

### *Relevance to coordinated/integrated health services delivery*

The design of incentive structures is a key area in the financing of health systems to support immediate and long-term change and improvement within a complex network of individual relations and skills, organizational hierarchies and system frameworks conditions. Financial and resource management are often left untouched in coordinated/integrated care initiatives to date as they usually involve the change of regulations, the amendment of legal and financial frameworks of a health system, and the provision of additional funds and resources – topics that cannot be decided on at the local or regional level and which need a whole-system approach to be achieved. However, while there is no one best way to incentivize services, there is little doubt that payment methods have important implication on the nature and quality of services provided. For example, provider payment systems with financial incentives and performance related pay have been used by countries to develop comprehensive primary care, reorienting primary care towards health promotion, disease prevention and management of chronic illness and to improve the quality of services provided.

In a number of European countries, the dominant payment system does not support adequate management of chronic illnesses. Fee-for-service payment for example promotes individual action but is inherently limited for supporting interdisciplinary care and care coordination activities and providing incentives for effective

performance. It also does not account for many aspects of chronic care including counseling, communication with other team members and development of a comprehensive care plan.

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**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Purchaser incentives [allocation mechanisms]**
E.g. Accountable Care Organizations with population based payment; disease management programmes
☑ **Incentives for patients**
E.g. personal health budgets; compliance incentives for patients/clients; non-financial incentives (discount for gym membership; access to physicians outside normal hours)
☑ **Paying providers**
E.g. bundle payments (care groups); pay-for-coordination; voluntary payment mechanisms; 'value-based' payment continuum
☑ **Performance incentives**
E.g. pay-for-performance; non-financial incentives

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## Area for Action: Competencies

### Objective

To cultivate a skilled workforce of health professionals through trainings and education, professional accreditation and continuous professional development opportunities to promote the core competencies to manage health services and work creatively and effectively across professions and sectors characterized by coordinated/integrated health services delivery.

### Relevance to coordinated/integrated health services delivery

While a workforce in sufficient numbers is a necessary condition for services delivery, continuously cultivating skills is a key element for people-centred service provision. In order to enable health professionals to fill the new roles assigned to them, to manage health and care rather than disease and cure, to work in teams across professions and sectors, they need to acquire different skills from what they have traditionally been taught. In supporting and training staff to work in an inter-disciplinary and integrated environment, a gradual change of organisational and professional cultures may also be achieved, thus enabling the long-term transformation of service delivery.

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**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Trainings and education**
E.g. standardizing core competencies for coordinated/integrated health services delivery; simulation methods; learning in the community; inter-professional education; admission procedures; faculty development
☑ **Professional accreditation**
E.g. clinical licensing; certifications
☑ **Continuous professional development and life long learning**
E.g. professional self-regulation; fellowships

## Area for Action: Communication

### *Objective*

To ensure information is effectively gathered, shared and used, facilitating information flows for informed patients and evidence-based decision-making among health professionals, performance measurement for health managers and administrators and priority setting and planning for decision-makers.

### *Relevance for coordinated/integrated health services delivery*

The delivery of health services is information intensive. Data is needed in many directions: informing policy and planning efforts for strategic decision-making; monitoring the performance of providers and implementation of regulatory measures; and developing evidence-informed tools for the high quality and consistent delivery of services. Integrated care has the challenge of requiring more dynamic information about health/health services. The effective gathering of information is therefore, essential to the provision of services. However, it is rather the use and exchange through the communication of data generated that is ultimately determining of factors including the continuity of services and their appropriateness according to needs.

The lack of access to data is often cited as a key challenge to health system improvement, and data protection often used as an excuse not to analyze data at all. Hence, the ways of information generation and information transfer need to be properly defined and managed in order to reach a meaningful understanding within the context of coordinated/integrated health services delivery.

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**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Service information for patients**
E.g. Patient reported outcome measures (PROMs); satisfaction surveys; opportunities for public consultation or feedback; user-friendly complement and complaint system
☑ **Clinical information for providers**
E.g. Shared electronic health records
☑ **Process information for management**
E.g. Periodic audits; Public expenditure and performance reviews
☑ **Health system information for health planning**
E.g. internationally recognized tools for conducting a situation analysis (Health Metrics Network; Health Information Systems Situation Assessment Tool); health impact assessment; environmental impact assessment; geographic information system or health needs assessment

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## Area for Action: Innovations

### *Objective*

To equip the system with the optimal processes, service resources, clinical and medicinal products, and research to ensure the supportive structures, pathways and channels for the provision of people-centred services are in place.

***Relevance for coordinated/integrated health services delivery***

The area of innovation challenges the health system to continuously reflect on resources that offer the greatest potential as inputs to the system as well as to generate research for a continuously evolving and expanding evidence-base. New inputs like integrated information communication technology, have proven an accelerator for improved service outputs, promoting local integrated information communication and a key element for integrating patient care across the continuum.

Innovations enable the system as a whole to focus on the various ways in which it can better manage patient and population risk; enabling acute, primary, and community care providers to access more accurate and detailed clinical information to inform clinical decision-making including, medication changes, blood pressure over time and reduced duplication in tests. Service innovations, for example, have proven to assist in inter-professional communication across organizational boundaries. Advancements have also provided a useful way to manage performance and achieve high-quality health care improvement in their ability to improve data management and effective tracking of utilization and outcomes.

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**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Process [management] innovation**
E.g. knowledge driven programmes/service delivery; data-driven prioritization of services
☑ **Clinical innovations**
E.g. personal health monitoring devices; non-invasive clinical procedures; diagnostic equipment
☑ **Service innovations**
E.g. electronic patient records/shared electronic health record (SEHR); online appointment registries; telephone helpline; eHealth; mHealth tools; IT tablets for remote access health records; SMS reminder systems
☑ **Knowledge generation**
E.g. Service/operational, action, and implementation research

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# Domain 4: Change

Given the complex nature of health systems, efforts to transform services delivery can easily become overwhelmed by a blurring of entry points and absence of direction, compromising the degree to which root cause determinants of poor performance are identified and tackled. Moreover, in the context of increasingly decentralized health service delivery models and heterogeneous settings for the provision of services, both the role of leading and managing the system at the macro, meso and micro levels, demands new or renewed mechanisms, competencies and schemas for strategizing processes in transforming services.

## Area for Action: Leadership

*Objective*

To steer service delivery transformations, setting the direction and defining clear priorities for change by creating a compelling vision and cultivating a climate for change that promotes the participation of all key stakeholders, with mechanisms in place for sustainability and scale-up.

*Relevance for coordinated/integrated health services delivery*

Service delivery transformations are no easy task. Existing systems have grown by accretion and piecemeal alterations incorporating legacies of many prior choices about how to approach the organization and management of services. The overriding fact that many different priorities and initiatives are competing for funding and approval, each generating their own approaches to problem solving, and pursuing often distinct agendas, makes the task of leading change all the more difficult.

Signaling priorities is a critical task, demanding strong technical and social arguments about the importance of each potential priority. Setting a strategic vision among competing claims is then far more than a technical exercise, and in fact, a highly political process of advocacy and negotiation. Building broad coalitions with actors at many levels is important for contributing to and supporting priorities and ensuring that sufficient momentum and resources are put in place. Importantly, leading service delivery transformations does not imply pushing policies onto the system, but rather, setting the conditions for local improvement as a key mechanism to ensure implementation, sustainability and scale-up.

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**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Strategic vision**
  E.g. problem definition; raising awareness; disruptive leadership; consensus building conferences
☑ **Participatory approach**
  E.g. shared governance, shared accountability, decentralization
☑ **Sustainability and scale-up**
  E.g. supporting conditions for piloting; demonstration cases and projects

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## Area for Action: Management

*Objective*

To oversee operations in the delivery of services towards a common goal, ensuring targets are set, and steps to achieve these are defined and resourced, that organizational structures for meaningful working relations are established, and that deviations from plans are responded to through regular trouble shooting and problem-solving.

*Relevance for coordinated/integrated health services delivery*

Experiences from recent years demonstrate that initiatives to strengthen coordinated/integrated health services delivery fail due to management topics rather than with regards to content, emphasizing its pertinence to the overall performance of service delivery transformations. Change management is also made an essential area recognizing that changes are more likely to require incremental and continuous maintenance overtime. Management guides these changes, ensuring adaptions in the face of challenges and new circumstances by sparking a high-involvement culture where the energy of professionals is exploited for making change happen. In doing so, management of transformations has reinforced the continuity of projects beyond political cycles by ensuring the circumstances for their continued implementation.

Moreover, the literature demonstrates that high levels of synergy are associated with management that effectively facilitates productive interactions among partners by bridging diverse cultures, sharing power, facilitating open dialogue and revealing and challenging assumptions that limit thought and action. In

services delivery, a results-orientation is principal to the management of change that purposefully promotes quality through the critical review of processes. Importantly, the task leans on accountability arrangements, requiring that management as the 'translation of policies into practice' has the mandate, information and resources (financial and non-financial) to hold actors accountable for their performance. Evidence and survey data suggesting few providers in practice have the tools, authority (e.g. budget control or hiring-and-firing ability) to effectively take on the task of operations management, calling attention to the under-valued importance of management in health services delivery.

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**What tools (strategies; techniques) apply for strengthening this area?**

☑ **Process innovation**
   E.g. planning; organizing; performance monitoring and evaluation
☑ **Piloting and scaling-up**
   E.g. implementing demonstration cases, experimental projects
☑ **Problem-solving/trouble shooting**
   E.g. discussion platforms; opportunities for continuous performance improvements

# Annex 1

## Overview of feedback from consultations

Reviewing discussion points pertaining to each area has taken structure to reflect upon the following key questions, as initially posed for critical group discussion and review, as well as those factors that rose from discussions.

1. How relevant is this area for coordinated/integrated health services delivery?
2. What are its key characteristics?
3. How is this area associated with other areas defined?
4. How does this area influence the 'process' of transformations?
5. What specific aspects of this area are most pertinent to countries?

| COMMENTS | RESPONSE |
|---|---|
| **1 Communication** | |
| **1.1 Relevance.** Considered an essential area, yet strongly suggested that the difference between information, communication and knowledge should be made explicit | Through the system-lens, 'information' has now been differentiated as a system input and 'knowledge' pertaining to the process of information transfer is captured within the area of 'innovation' |
| **1.2 Characteristics.** To further delineate this area, 'research' was proposed as a key component, especially for implementation | 'Knowledge generation' has been highlighted within the added health system area of 'innovation' prioritizing this point raised consistently |
| **1.3 Associations.** Suggested communication seemed more a 'supportive' factor from the level of the system | Viewing the associations between areas, the 'enabling' role of information is recognized according to its alignment with the system domain |
| **1.4 Change.** Information considered a critical success factor for transformations, where decision-making hinges on the ability to draw information on outcomes and performance | This has been highlighted in viewing performance information as an input, collocated within the area of 'information'; its function pertaining to transformations is highlighted within the 'process' domain |
| **1.5 Countries.** Information infrastructure seen as a key lever for performance gains and country examples emphasize ICT as an 'enabler' of CIHSD; where is this addressed? | The importance of the optimal use of resources is considered within the area of 'innovations' in its function of supporting structures, pathways and channels for services delivery as a system input |
| **2 Knowledge** | |
| **2.1 Relevance**. Considered highly relevant; suggested to rename as competencies, seeing knowledge alone does not equate to the abilities of professionals | 'Knowledge' has been specified as 'competencies' in alignment with the system input of human resources for health, for emphasis on a 'competent' workforce |
| **2.2 Characteristics** All items for patient education need to be described; seeing here the overlap between knowledge and 'care' for shared decision-making | Overlaps have been addressed by collocating aspect of public health education and health literacy within 'people' domain, promoting their engagement and empowerment |
| **2.3 Associations.** Includes not only clinical competencies but also inter-disciplinary training; management; use of data; leadership | To further specify, 'core competencies' for CIHSD have been explored, charting beyond clinical practice; importance of leadership/management highlighted in 'change' domain |

| | |
|---|---|
| **2.4 Change.** Educating/training professionals as a key success factor for implementation noted and should be emphasized | Promoting a competent workforce has been weighted priority within the health system domain, as a key 'touch point' between services delivery and resource function |
| **2.5 Countries.** The training/education programmes in place often not entirely consistent with the services we want to deliver; need to consider how to update | The structural shift to reason services delivery and system factors has aimed to support this potential system constraint if not adequately anticipated/planned |

### 3 Resources

| | |
|---|---|
| **3.1 Relevance**. Lack of resources considered a common failure of initiatives; particular attention noted within financial resources to 'incentives' | The need to differentiate resources for financing was made apparent. In aligning with system functions, incentives as a key aspect of financing has been noted |
| **3.2 Characteristics.** Proposed focus should look rather to *management* of resources (e.g. joint procurement boards) rather than quantity/volume of goods | To emphasize improved processes for resources (e.g. contracting, incentives, intersectoral action) this has been highlighted within management and leadership |
| **3.3 Associations.** Overlap between resources (technologies, pharmaceuticals, information), human resources for health, and financing appear blurred in reasoning | The need to disentangle 'resources' has been addressed in differentiating 'system' versus 'services' delivery determinants and prioritized areas for action |
| **3.4 Change.** Resources (lack of) seen as a common reason underpinning the failure of initiatives; need to anticipate how to ensure sustainability | To be emphasized in the planning phase of service delivery transformations |
| **3.5 Countries.** Interest specifically in the different payment options/models. What are they? How do they work? | To further unpack this, the area of 'incentives' has looked to investigate those models, the different subjects they pertain to (e.g. patients, providers, performance) and their impact |

### 4 Policy

| | |
|---|---|
| **4.1 Relevance**. Considered a 'core' component for sustained, system transformations; however description has framed topic rather as 'leadership' | Policy as its importance for system change and regulatory frameworks is regarded within 'accountability'; this being differentiated from the importance of 'leadership' considered rather as a process factor |
| **4.2 Characteristics.** Should include priority setting, scaling-up and sustainability, regulation/governance, creating alliances beyond the health system | Disentangled, leadership has taken on the qualities of stewardship and the area of 'accountability' those other properties described |
| **4.3 Associations.** Clear alignment with the health system, but success felt also to hinge upon implementation of policies, for their adoption in practice | The emphasis put to implementing policies reflected in the 'process' domain related to 'leadership' and 'management' for oversight and adoption respectively |
| **4.4 Change.** Should extend beyond regulations; is about 'putting a vision in place' | Characteristics described here are considered rather the qualities of 'leadership'; this has been differentiated from the intended focus on accountability and institutional arrangements set through policy |
| **4.5 Countries.** Need to address how to integrate across vertical programmes and those institutional arrangements that may impinge upon CIHSD | Responding to the importance weighted to differentiate institutions from regulatory constraints and those process factors, revisions distinguish between 'accountability' and process factors (e.g. participation; intersectoral action) |

### 5 Care

| | |
|---|---|
| **5.1 Relevance**. Considered at the 'heart' of the Framework; some confusion on failing to differentiate from other areas; subject for all other areas | Attention given to differentiate 'care' as the core characteristics unique to the services delivery function has looked to specify services relative to the system |
| **5.2 Characteristics.** Should consider what the 'problems' are; who or which actors are involved; what is provided along a continuum of care and across settings/levels | Aligned as principal domain, services delivery has been further specified according to key areas, differentiating services (content and design) from delivery (organization of providers and management) |

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| **5.3 Associations.** New roles of health professionals; what does this change? (e.g. new curriculums; how to overcome professional stigmas) | Associations with the health system have been delineated with consideration to core competencies as a system area |
| **5.4 Change.** Need a clear understanding of the context to appreciate what works/doesn't; what resources are needed; how incentives should align; etc. | Considerations for change found to pertain across a number of areas and these associations have been simplified when viewed through the 'system' domain |
| **5.5 Countries.** Care spans all levels (macro; meso; micro [clinical]) how is this accounted for? | Those system factors found commonly to determine the success of transformations (e.g. alignment of incentives; core professional competencies) have been specified from those which are 'services delivery' [organization] and further, those at the interface of services and people |

## 6 Values

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| **6.1 Relevance**. Highly relevant but considered 'not enough', needs a change in professional culture and attitudes; often felt this is not explicit | While noting the importance weighted to values in relation to supporting change, the quality of behavioural and cultural factors as a key success factor rather than area for action has informed the direction of the process [change] domain |
| **6.2 Characteristics.** Found difficult to understand and a challenge to change, seeing different values between actors; the importance of common values to give direction to changes noted with consensus | Seeing values as a tool for setting a vision, generating buy-in, building momentum etc., these characteristics have been given attention in defining 'people-centred' services and those qualities of leadership and management that support change |
| **6.3 Associations.** Should not be considered as an area and rather as a specific topic of another section or as a driver for change | In realigning with the process of change, values, behavior change and new cultural/professional norms are subsumed within this |
| **6.4 Change.** Needs to be framed as a characteristic for success, with consideration for 'bottom-upping', building social capital | Those characteristics for success are reflected within the domains of leadership and management and aligned strategies that are 'actionable' in this regard |
| **6.5 Countries.** Common values should explicitly underpin efforts (e.g. strategically targeting populations to for improvements of those worse off) | Attention has been given to specific people-centred services according to a set of attributes that communicate a shared vision and are also measureable for monitoring and evaluating performance |

## 7 People

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| **7.1 Relevance**. Considered a key component; impacts both on the process of change and delivery of services itself | The interacting quality of people taken into consideration to view 'people' as a determinate of people-centred services delivery and also key 'domain' |
| **7.2 Characteristics.** Should highlight the patient and their experiences, how this can be adapted. Needs to consider informal caregivers | In further specifying, 'people' have been clustered to target both 'populations – individuals, their families and communities' and 'patients' |
| **7.3 Associations.** Further distinction needed between patient (their experience, their communities) and leadership (their role in orchestrating change) | Different actors found to cluster within this area; to disentangle, those factors that influence the process are distilled from the intended focus on people (individuals, service users, etc.) and characterized by 'leadership' and 'management' |
| **7.4 Change.** Need to highlight the roles of health professionals, specifically GPs to support advocacy and education with patients and care givers | Actions to promote the engagement and empowerment of patients have been aligned within the areas in the clustered domain of 'people' |
| **7.5 Countries.** What tools can be used to engage patients, so they can make decisions themselves? | Reoriented, the intention remains to specify those tools that serve to advance engagement and empowerment |