World Health Organization

REGIONAL OFFICE FOR Europe

Meeting Report

Second Annual Technical Meeting on Coordinated/Integrated Health Services Delivery (CIHSD)

Istanbul, 17-18 February 2015

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Second Annual Technical Meeting on Coordinated/Integrated Health Services Delivery (CIHSD)

Developing the Framework for Action
in the context of the European Policy Health 2020

Istanbul, 17–18 February 2015

ABSTRACT

The Roadmap to develop a Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) places a strong emphasis on a participatory approach to ensure ownership in the process of its development. This includes input from Member State Technical Focal Points on CIHSD and the Expert Advisory Team. In order to achieve the highest possible engagement, the Second Annual Technical Meeting on CIHSD was called for to report on the progress made since the Kick-Off Technical Meeting in February 2014 and to receive further input. This meeting gave the Member States Technical Focal Points and Expert Advisory Team the opportunity to discuss the continued advancement of key concepts and to facilitate the exchange of experiences and insights from countries and participants. The report at hand and the feedback received during this meeting will be used to further develop and refine the Framework for Action, ensuring the highest possible relevance and practicability for Member States.

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Abbreviations

CEO	Chief executive officer
CIHSD	Coordinated/Integrated Health Services Delivery
EIP-AHA	European Innovation Project for Active and Healthy Ageing
ER	Emergency room
EU	European Union
GP	General practitioner
IFIC	International Foundation for Integrated Care
LDL	low-density lipoprotein (cholesterol)
NGO	Nongovernmental organization
NHS	National health system
OAEE	Insurance Organization for the Self-Employed
OECD	Organisation for Economic Co-operation and Development
OGA	Agricultural Insurance Organization
RIZIV	National Institute of Health and Disability Insurance
SWAT	Strength – Weaknesses – Advantages – Threats
WHO	World Health Organization

1. BACKGROUND

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. This is mirrored on the global level where health and development priorities converge on the importance of health systems strengthening.

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) (hereafter referred to as: the Framework for Action). 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[1], with activities spanning from its official launch at the event until the WHO European Regional Committee at the sixty-sixth meeting in 2016.

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). One of these meetings, the Coordinated/Integrated Health Services Delivery Stakeholder Consultation in Brussels in April 2014, provided our partners from policy, providers and patients with the opportunity to present their perspectives on how to transition towards a coordinated/integrated health services delivery system and discuss the roles these stakeholders play in facilitating the process[2].

In order to report on the progress made since the Kick-Off Technical Meeting in February 2014[3] and to receive further input, a second technical meeting on coordinated/integrated health services delivery took place on 17–18 February 2015 in Istanbul, Turkey. Hosted by the WHO Regional Office for Europe, the event convened Ministry of Health appointed representatives for coordinated/integrated health services delivery from across Member States as well as partnered international experts and

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

[2] WHO Regional Office for Europe (2014). Coordinated/Integrated Health Services Delivery (CIHSD) Stakeholder Consultation. Copenhagen: WHO Regional Office for Europe. http://www.euro.who.int/en/health-topics/Health-systems/health-service-delivery/publications/2014/coordinatedintegrated-health-services-delivery-cihsd.-stakeholder-consultation

[3] WHO Regional Office for Europe. (2014). Coordinated/integrated health services delivery (CIHSD). Kick-off technical meeting. Copenhagen: WHO Regional Office for Europe. http://www.euro.who.int/en/health-topics/Health-systems/health-service-delivery/publications/2014/coordinatedintegrated-health-services-delivery-cihsd.-kick-off-technical-meeting.

WHO staff. The event aimed ultimately to examine the continued advancement of key concepts and to facilitate the exchange of experiences and insights from countries and participants. It also served 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. Specifically, the meeting aimed:

1. To give an overview of the four domains and the corresponding areas for action defined within the Framework for Action, as well as their importance in and contribution to transforming health services delivery.

2. To identify the core components of the areas for action and their unique qualities, serving as entry-points for taking action.

3. To learn from the experiences of countries and experts about those strategies and tools, which have proven effective in transforming health services delivery.

The report at hand and the feedback received during this meeting will be used to further develop and finalize the Framework for Action, ensuring the highest possible relevance and practicability for Member States.

1.1. Meeting Outline

The sessions were organized with utmost consideration for interactivity and input from the Member State technical focal points and the Expert Advisory Team. After an overview of the development of the conceptual underpinnings of the Framework for Action and the milestones achieved so far, the sessions tackled the four domains identified, namely 'People', 'Services', 'System' and 'Change'. To visualize the different components associated with the domains and highlight possible tools for implementation, case presentations and interventions form Member State technical focal points illustrated experiences and good practices, while interventions and comments from members of the Expert Advisory Team gave further feedback and input on the concepts and components presented.

The meeting also gave Member State technical focal points the chance to present their needs and requirements in order to be able to adopt such a Framework for Action, and to further discuss how the Framework for Action will take shape. It consolidated the findings and developments so far and illustrated the way forward until 2016 and beyond.

2. INTRODUCTION

Analysing the reasons why the on-going Ebola epidemic became a global crisis (epidemiology, high mobility, cultural practices and damaged infrastructure) the key role that strong health systems play was highlighted. Central to the strengthening of health systems is the concept of people-centeredness in order to ensure the delivery of services aligns with population health needs. This has been a theme through a number of WHO documents beginning with the Declaration of Almaty in 1978, and reinforced in recent years including the World Health Report 2008 Primary health care: now more than ever[4]; the Tallinn Charter 2008 and the WHO Global Programme of Work 2014 – 2019. These seminal documents reflect the high priority given to people-centred health systems and subsequently led to the development of a WHO global strategy on people-centred and integrated health services[5], which is currently under way.

The Framework for Action builds on these documents with four key objectives:

- Consolidate concepts of health services delivery and update them to reflect the transformation towards coordinated/integrated health services delivery.

- Engage Member States in collecting their experience and use this evidence to inform a global platform.

- Build capacity in the process and work with Member State to understand the process and conditions needed.

- Create partnerships and collaboration in developing this work.

Building on the comments and feedback received during meetings and consultations throughout the last year, the initial concept and areas for action were taken and revised. In some areas there was immediate consensus, some places needed further defining. Fig. 1 illustrates the main feedback received in the Kick-Off technical meeting and how the key entry points for action were further developed.

Fig. 1. Key entry points for action towards coordinated/integrated health services delivery.
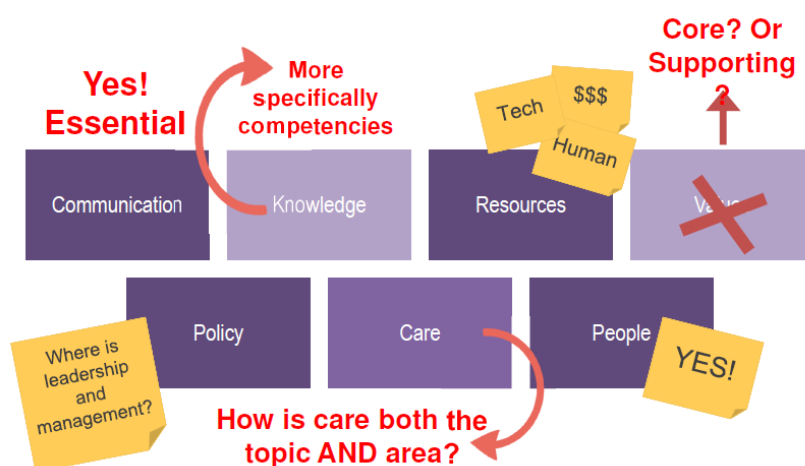
Source: Presentation during the Second Technical Meeting on Coordinated/Integrated Health Services Delivery: Developing the Framework for Action in the context of Health 2020. WHO Regional Office for Europe 2015.

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[4] WHO (2008). The World Health Report 2008 – Primary health care: now more than ever. Geneva: World Health Organisation.
[5] WHO (2015). WHO global strategy on people-centred and integrated health services: Interim Report. Geneva: World Health Organization.

The development of the Framework for Action is guided by taking a health system perspective reflected in the four core functions and their associated subfunctions; mainly:

- Service delivery: selecting services, defining pathways, organizing providers and settings, managing and ensuring quality improvements.

- Governance: setting priorities, implementing and assessing.

- Financing: collecting funds, pooling and distributing.

- Resourcing: Human resources for health, medicines, technologies and innovation.

The final aim of this approach is to build a people-centred system and while this perspective lays out the core functions of a health system, it still needs to be acknowledged that there are many additional factors influencing health. The Framework for Action thus is an action oriented framework, which can be thought of as a checklist that a Member State can use as a reference to evaluate its progress towards the creation of a coordinated/integrated health services delivery. As such, the Framework for Action is results-oriented and uses a root-cause approach to problems, backtracking the root causes for undesirable outcomes from the outcomes itself. Fig. 2 illustrates this approach.

Fig. 2. Taking a results-oriented approach.
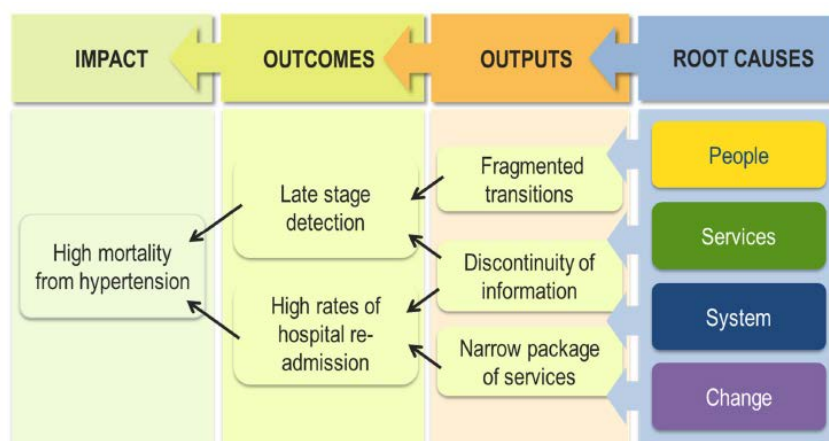
Source: Presentation during the Second Technical Meeting on Coordinated/Integrated Health Services Delivery: Developing the Framework for Action in the context of Health 2020. WHO Regional Office for Europe 2015.

In designing this Framework for Action four domains were identified in which the root causes for health services delivery weak performance could be found, and which thus needed to be addressed during the transformation process towards people-centred health systems. These domains were further defined by breaking them down into areas for action (Fig. 3). For a further definition of the domains refer to the Delegate Briefing Note[6].

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[6] WHO Regional Office for Europe. (2015). Delegate Briefing Note: Second Technical Meeting on Coordinated/Integrated Health Services Delivery: Developing the Framework for Action in the context of Health 2020 . Copenhagen: WHO Regional Office for Europe. Download here: http://www.euro.who.int/__data/assets/pdf_file/0003/270192/CIHSD-Istanbul-mtg-briefing-note-040215f.pdf?ua=1

Fig. 3. The four domains and their areas for action.

Source: Presentation during the Second Technical Meeting on Coordinated/Integrated Health Services Delivery: Developing the Framework for Action in the context of Health 2020. WHO Regional Office for Europe 2015.

Finally, the different components of the Framework for Action were presented, comprising a list of documents and instruments to support Member States in their endeavour to transform health services delivery to create people-centred health systems. These elements are also further described in the Delegate Briefing Note[7].

Concluding the first session, participants were updated on the development of the Global Strategy on High Quality People-Centred and Integrated Health Services. The global strategy aims to provide strategic directions to achieving universal health coverage:

- *Empowering and engaging people* – providing the opportunity for the development of skills and resources that people and communities require.

- *Strengthening governance and accountability* – promoting transparency in decision-making and collective responsibility.

- *Reorienting the model of care* – promoting schemes that prioritize primary health care services.

- *Coordinating services* – Coordinating health services around people at every level of care by building effective networks with other sectors.

- *Creating enabling environments* – helping to facilitate large scale, sustainable and transformative change.

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[7] WHO Regional Office for Europe. (2015). Delegate Briefing Note: Second Technical Meeting on Coordinated/Integrated Health Services Delivery: Developing the Framework for Action in the context of Health 2020 . Copenhagen: WHO Regional Office for Europe. Download here: http://www.euro.who.int/__data/assets/pdf_file/0003/270192/CIHSD-Istanbul-mtg-briefing-note-040215f.pdf?ua=1

3. DOMAIN 'PEOPLE'

The first domain discussed was 'People'. After a definition of the domain, its areas for action, components and suggested tools, a presentation from Greece illustrated how 'People' have been put at the centre of an ongoing initiative within the European Innovation Project for Active and Healthy Ageing (EIP-AHA). Then the floor was opened to the plenary and experts and Member States were asked to reflect on the following questions:

- Definition of area: what does it mean?

- What are the core components for each of the areas identified?

- How can these components be clustered?

- For those components identified, what tools (strategies; techniques) apply?

3.1. Definition of the Domain 'People'

Across a lifespan patients interact with the health services for about 3 hours in acute episodes while the remainder of one's lives one spends caring for oneself. From a health system perspective this underlines the need to think to how people interact with the services, how they take care of their own health and how they can be empowered to better care for themselves. Engagement of people and patients is important for satisfaction but, mainly, because it is linked to better health outcomes including reducing unplanned hospitalizations, increasing self-esteem and increased self-management. So, summarizing, engaging the patient is important for two reasons: improvement of health outcomes and sustainability of the system.

In order to target actions better within this domain, two areas have been defined:

- *Population* revolves around components which are related to the right to health, the choices provided, including the selection of providers, and the health literacy needed to improve lifestyles. Some tools to support these components were thus identified as:

  o Bill of rights for patients, creation confidentiality and safety regulations, charters and entitlements

  o Patient mobility of choice of providers, a network of community representatives, local leaders

  o Health education and health literacy including mass media campaigns, lifestyle support programmes, local councils

- *Patients* are related to the shared decision-making and involvement of the patient in their own care, it further involves the whole planning process of discharge from institutional care and aspects related to self-management
  Tools in these components included:

  o Patient coaching, evidence based patient decisions

  o Decision supports for patient, patient based care planning, medication management, discharge plans

  o Telephone outreach, didactic teaching methods, situational problem solving, self-help groups and self-treatment

An overview of the domain, its areas for action, components and tools is provided in Fig. 4.

Fig. 4. The domain 'People' and its elements.
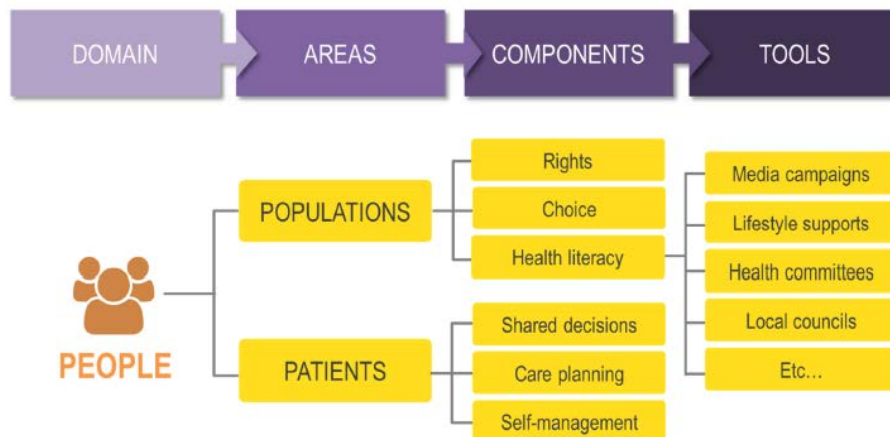
Source: Presentation during the Second Technical Meeting on Coordinated/Integrated Health Services Delivery: Developing the Framework for Action in the context of Health 2020. WHO Regional Office for Europe 2015.

3.2. Illustration in practice: Scaling up EIP-AHA initiative to national level in Greece

The European Innovation Partnership for Active and Healthy Ageing (EIP-AHA) is a network of local initiatives which focus on the improvement of health services delivery to promote healthy and active ageing. Many of these initiatives actively involve patients, family caregivers and the communities in order to strengthen the local resilience and support healthy ageing in the setting of choice. In Greece the aims specifically were to:

- Develop partnerships and a network
- Align activities with EIP-AHA principles
- Work to scale up pilot projects based on recommendations

Work of the initiative began from the belief that the health and social care system needed reengineering, and that the system should focus more on home care of older people. This also included a discussion on how the system was being financed. Specifically, a need was identified to move from a volume to a value-based system, away from fee for service and towards bundled payments. This would support the creation of partnerships between payers and providers. As a result, the Greek initiative worked to implement a national system of ePrescriptions. Work began in 2010 with one of the 35 social security funds, OAEE, and ultimately bringing in other big funds including the OGA, which covered the agriculture and farming industry. By 2011 about 90% of doctors under the national health provider organization had joined. The results to-date included a 50% decrease in expenditure across the board on pharmaceuticals with reduced costs of 1 billion euros attributable to ePrescriptions[8].

Another initiative under this umbrella was a local example, where a hospital in Athens started a programme for chronic patients with coronary heart disease. A work flow for these patients was developed with a team of specialists to create a telemedicine strategy including electronic health records, transmission of data and a connection with the patient through video. Through these tools patients were given encouragement and reassurance online for their compliance with disease

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[8] Galariotis T. The Greek Network of the European Innovation partnership on Active and Healthy Ageing. Presentation during the Second Annual Technical Meeting on Coordinated/Integrated Health Services Delivery, 17th February 2015, Istanbul, Turkey.

management. Home visits were also conducted at specific schedules. The results of this initiative included a reduction of almost 80% in the number of hospitalizations of these patients, an equally high cost reduction on hospitalization and ER visits and improved capacity for patient self-management.

With all of these successful outcomes, there are still some barriers, which need to be addressed in order to make changes sustainable. These include the current legal framework in Greece (e.g. legislation around sharing of data), the persistence of professional silos and fragmented services, and the generation of initial resources to invest in telemedicine tools.

In many ways the crisis worked as a catalyst to push change forward. The Greek EIP-AHA initiatives tapped into the existing potential for community involvement and self-organization and began to engage the grassroots level to change the attitudes of the population towards health and social services delivery. Ultimately, they worked to enable people and family members to better understand and manage their health needs.

3.3. Plenary discussion

In the subsequent plenary discussion the following key points were raised:

- There is a need to keep looking at people within the context of their communities, examining the aspects and social determinants that affect their health – using a public health perspective and from here it is easier to understand how to support people and communities as the primary carers of their own health.

- The Framework for Action should work on the elements of the community, thinking to the culture and context in which people exist – this should also be reflected in how outcomes of this are measured.

- In discussing patient rights, they should also be given the right to not to engage – need to consider both what the rights are of the patient but also what their responsibilities are and how this takes shape as a sort of social pact between society and government. It needs to be ensured that empowerment and engagement of communities become assets.

- There needs to be a clear definition of who 'people' are: are they defined as individuals or is it a more holistic approach, in that it includes their carers and immediate environment.

4. DOMAIN 'SERVICES'

The next domain presented and discussed revolved around 'Services'.

4.1. Definition of the Domain 'Services'

Following discussions during the kick-off technical meeting of Istanbul in 2014, the area for action "care" was further revised. In order to better describe it contents, the health services delivery function was revised based on the literature and health system frameworks. Subsequently, the domain of 'Services' has been clustered into two areas for action:

- *Care* is the prioritization of interventions for clearly defined populations using a continuum that follows from health promotion to rehabilitation. The components included here are the defined population and prioritization of needs; creating a service package and care pathways, and generating guidelines and decision support tools for health providers.
  Possible tools for these components were suggested as risk stratification, targeting populations, predictive risk modelling techniques; defining service packages for core populations and defined target populations; or decision support systems and practice guidelines.

- *Delivery* ensures that the services are available and that care is delivered to the targeted populations. The components of this area are the definition of the roles of health professionals, the coordination of these providers and the referral and transition across settings.
  Possible tools associated with these components are role expansions; substitution and supplementary roles; mixing disciplines and the colocation of services.

Fig. 5. The domain 'Services' and its elements.
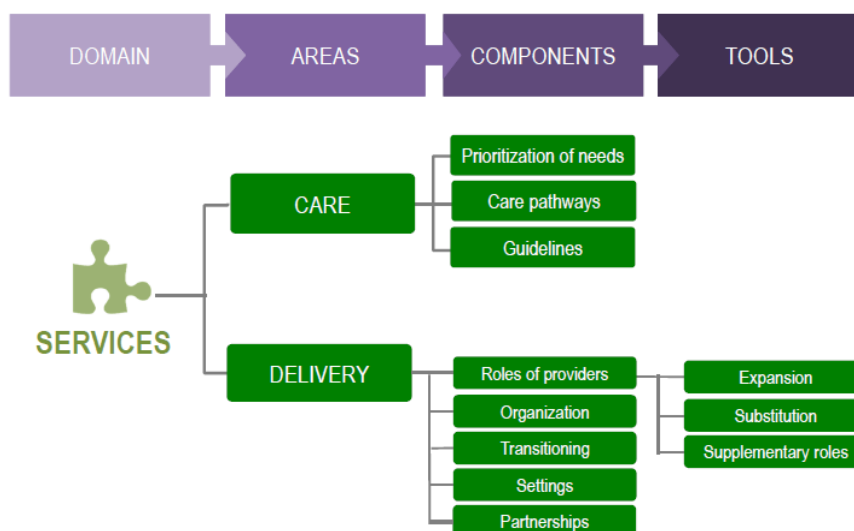
Source: Presentation during the Second Technical Meeting on Coordinated/Integrated Health Services Delivery: Developing the Framework for Action in the context of Health 2020. WHO Regional Office for Europe 2015.

4.2. Illustration in practice: Using population risk stratification to integrate health services delivery in the Regione Veneto, Italy

Work on this project began by understanding that there was a need to look to the major points where current multimorbidity and diseases management programmes were failing people with chronic conditions. The Regione del Veneto began to analyse their population and realized that a tool was needed to stratify the population and assess which type of health management tool was suitable for which individual. After a comparison of various tools, the region eventually selected the Adjusted Clinical Groups developed by John Hopkins University. The initiative created three primary goals:

- To stratify the population and their risk.

- To integrate data and points of health care delivery.

- To improve care coordination and for persons with multimorbidity.

A pilot programme began in 2012 until it was eventually rolled out to the entire region of 21 local health units and five million inhabitants in Veneto. The initiative capitalized on existing resources by focusing on the many avenues where data was already being collected and integrated these to one central information portal. In it 93 categories were defined which split the population in 6 layers with the proportional weight of resources that should be allocated to each level. This approach simplified the overall health planning with an intensive care management and care coordination programme designed to be focused on the upper tiers, notably 4 and 5, trying to mitigate any further migration upwards. After its recent roll-out, the tool is currently being evaluated and necessary adjustments will be identified.

4.3. Plenary discussion

Important points of discussion revolved around the need to for data to inform priority setting as a starting point for a broader cycle of planning delivery and evaluation. This included looking at how to identify population risks and how to enable health services to take health determinants into account. The necessity to create a common frame of reference on which to base the services package was also highlighted. In turn however, to enable the use of this package required health literacy and often cultural or community awareness among providers.

Examples from Belgium focused on three innovations within their health system: (1) a care programme for diabetes patients and renal failure which required the co-management of patients between GPs and specialists for patients who decided they wanted to engage with this programme; (2) the extensive reforms in the mental health sector working with multidisciplinary acute mobile mental health teams to keep patients in their homes and recovering in their communities; and (3) the development of a national integrated care programme in collaboration with regional authorities.

Field evidence from Moldova focused on challenges of high infant mortality rates, which following a problem assessment was shown to be caused by a lack of social support and poor economic conditions amongst vulnerable families. The main responsibilities of both the health and social sectors were maintained but they changed the professionals' roles to require cooperation between the two sectors. They are now required to undertake a full patient assessment which is used to stratify children and mothers in terms of need and refer them based on national guidelines. This example underlined once more the importance of doing root cause analysis and using data appropriately to inform decision-making.

The intervention from France focused on changes to human resources where an influx of new young professionals had changed the hours and mechanisms through which doctors wanted to work, emphasizing collaboration. It was concluded that integral to improving human resources and integration of services was the need to create spaces where professionals could meet and exchange knowledge. In other words a stable and safe environment needed to be created which supportive financial mechanisms for coordination and integration. This conclusion laid a smooth transition to the next domain on the agenda.

5. DOMAIN 'SYSTEM'

This domain looks to the specificities that needed to be in place within the health system to allow for coordinated and integrated services delivery. It involved looking to accountability and frameworks that need to be established, the incentives that need alignment, the competencies and training necessary and further looking to the area of medical, the communication flows to be established and technological innovations to see where this can be used to support and promote integrated care. In total this domain consisted of five areas for action, which were each defined and discussed in detail.

Fig. 6. The domain 'System' and its areas for action.
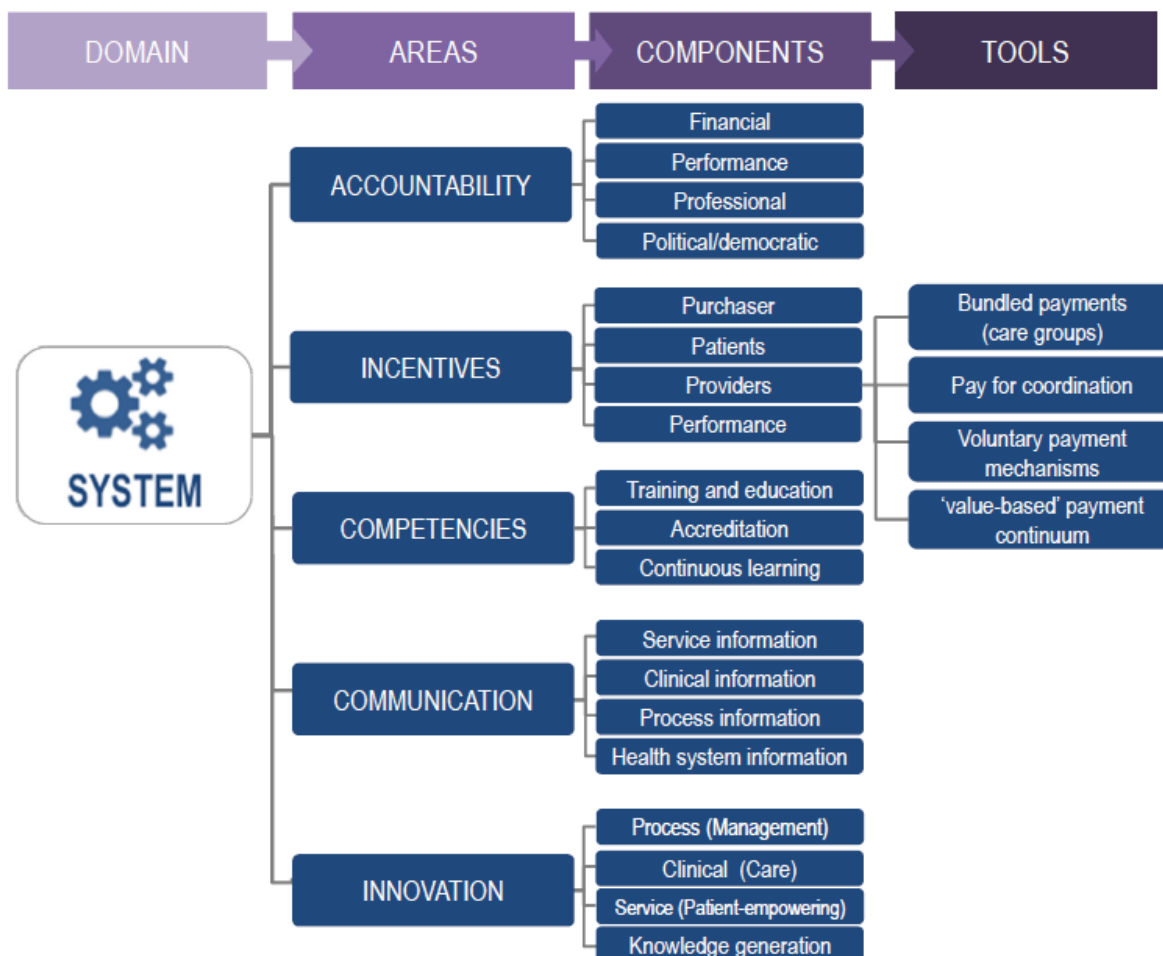
Source: Presentation during the Second Technical Meeting on Coordinated/Integrated Health Services Delivery: Developing the Framework for Action in the context of Health 2020. WHO Regional Office for Europe 2015.

5.1. Accountability

5.1.1. Definition

Accountability requires being answerable for the decisions and actions made. It encompasses the relationship between those making the decisions and those being affected by those decisions.
Four primary types of accountability were identified:

- *Financial accountability* is everything related to fund allocation and disbursement including the ethical use of resources. For integrated care this is important because funding streams usually exist separately and it needs to be ensured that there is alignment with the right legal framework for joint planning, budgeting and contracting.

- *Performance accountability* is the setting of standards for health system. This type of accountability requires investment in monitoring capacity.

- *Professional accountability* surrounds service delivery through a legal, ethical and professional standard lens and takes shape as a shared responsibility between health organizations and the providers working within.

- *Political and democratic accountability* to people ensures that the government delivers on its commitments. It involves public engagement on all levels. For integration this has special significance because it should support a shift towards collaboration.

5.1.2. Illustration in practice: Slovenia

Slovenia has put some efforts into improving the different aspects of accountability, for example identifying public reporting of health indicators as an area that needed further strengthening. In order to achieve this, Slovenia established a legal framework to support accountability in the health system, but it also realized that such a framework would not be enough. In order for accountability to work in practice, people needed to be convinced of the importance of the proposed measures. As a successful example of how this could be implemented, the development of the Slovenian national strategy on diabetes 2010–2020 was presented to illustrate how the Ministry of Health got stakeholders involved. The Ministry of Health asked the stakeholders what they were going to do to improve the care of diabetes patients in Slovenia and asked them to come up with solutions, which would then be discussed together. It took several years to create the plan but in the end the priorities were not set by the Ministry of Health but by the stakeholders. This is reflected in the format the national plan has taken in that it did not include big changes but rather small improvements, which were more manageable, in particular to improve coordination between stakeholders.

The positive experience with this approach has led to a pilot to create a local actor group trying to reach marginalized groups or individuals. This coalition included the local community centre, NGOs, a centre for social services and many others. These examples of spreading accountability recognize that in a health system the various stakeholders are not directly accountable to each other. By creating an alliance of multiple stakeholders where leadership plays a crucial role progress can be achieved because these institutions and stakeholders realize they need to act for themselves.

5.1.3. Plenary discussion

Key discussions points raised were the following:

- The Framework for Action seeks to promote quality improvements – one important aspect contributing to quality improvements is the possibility to share data, and to compare and act upon the data. This could further lead to the establishment of benchmarking tools to monitor quality and measure improvements, and would encourage transparency in the system. This aspect should be included in the further discussions.

- There is a need to concentrate on performance indicators – accountability requires both bottom-up and top-down approaches.

- Accountability requires identifying the accountability relationship, who is being held to account by whom, and the data/information needed to link the two parties.

5.2. Incentives

5.2.1. Definition

In general, incentives may take the form of rewards or penalizations to inspire and motivate individuals and organizations to work towards defined objectives – usually in a contractual relationship. However, the "underlying goal of incentives is (…) not simply rewarding good performance or punishing bad performance. The goal of using incentives is to support the change in

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the status quo by stimulating both immediate and long-term improvements in performance through reinforcing positive performance by creating alignment between expectations and rewards (financial/non-financial) and removing financial barriers that perversely effect desired performance"[9]. There is an understanding that the usual fee for service models being currently used to compensate physicians and professionals is falling short in efforts to promote integrated care because they too often incentivize a single individual rather than incentivizing cooperation within a team. So some systems have started instead to move towards performance based contracts, bundled payments linked to the treatment of disease or accountable care organizations. When designing a reform it needs to be ensured that the payment and reimbursement mechanisms support that change or at the very least do not detract from it. Consequently it is necessary to design selected group incentives which take into account local needs. However, it has to be emphasized that incentives don't improve patient outcomes but they can act as an important system enabler to improve performance.

In summary, breaking the area for action Incentives down into actionable domains, the following need to be addressed:

- *Purchaser incentives:* e.g. by means of accountable Care Organizations with population-based payment.

- *Incentives for patients:* e.g. personal health budgets; compliance incentives for patients/clients; non-financial incentives.

- *Paying providers:* e.g. bundled payments (care groups); pay for coordination; voluntary payment mechanisms; 'value-based' payment continuum.

- *Performance incentives:* e.g. pay-for-performance; non-financial incentives.

5.2.2. Illustration in practice: Hungary

Hungary experimented with shadow budgets and care coordination through changes to health financing between 1999 and 2004. It was a voluntary system where GPs got a capitation-based collection and they held a virtual budget. Fund holders were expected to develop a local protocol and generate contracts with local services. If they spent under their shadow budget the GP practice would profit. The idea was that if they spent less per year by the end of the year than expected by capitation that percentage would be repaid to them and thus would be an incentive to increase the quality of care. One of the major findings was a reduction in number of strokes showing proper management of hypertension. The results of this pilot were overall evaluated positively, however there may have been an incentive to underprovide. Due to political changes, there was no follow-up after the pilot ended, but there are currently discussions to build on these experiences and revisit the incentive system in Hungary.

5.2.3. Plenary discussion

Key issues raised were the following:

- When aligning incentives it is important to account for the side effects of these incentives and what this might motivate providers to do.

- Data should follow the accountability mechanisms and be consistent with the incentives implemented.

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[9] Custers, T., Klazinga, N.S., Brown, A.D. (2007) Increasing performance of health care services within economic constraints: working towards improved incentive structures, Zeitschrift für ärztliche Fortbildung und Qualität im Gesundheitswesen (ZaeFQ), 101, 381–8.

- Physicians benchmarking against a gold standard and non-financial incentives may be considered to improve performance.

5.3. Competencies

5.3.1. Definition

Competencies are often described as the ability to perform the tasks and roles required to the expected standard. There are three primary areas of competencies mentioned in the Delegate Briefing Note, which include training and education; professional accreditation and continuous professional development including life-long learning. A literature review brought the following eight dimensions of competencies to light:

- *Interpersonal communication* is the ability to effectively communicate with the consumers of health care, their family members and other providers. This includes emphatic learning.

- *Collaboration and team work* is the ability to function effectively as a member of an interpersonal team including the clients and their family members.

- *Screening and assessment* is the ability to conduct brief, evidence-based and appropriate screening and to arrange more detailed assessment when needed.

- *Care planning and coordination* is the ability to create comprehensive care plans.

- *Clinical and non-clinical interventions* is the ability to provide a range of focused treatments spanning prevention, treatment and recovery services as well as long-term services and support.

- *Cultural competences and adaption* is the ability to provide services that are relevant to the culture of the consumer and their family.

- *Practice-based learning and quality improvement* is the continuous improvement of services delivery as both an individual practitioner and as part of an inter-professional team.

5.3.2. Illustration in practice: Romania

The example illustrating the strengthening of competencies in Romania described an initiative which focused on developing capacity for mental health care at the primary care level including depression screening and treatment. Two subregional congresses were organized in 2013 and 2015 to draw attention to the topic and bring international experience to the country and the health professionals. Importantly these efforts included the design of a course for young health professional which addresses psychology and mental health in the scope of family medicine, general practice and those training in midwifery. Courses are being provided by a professional from George Washington University (USA). In the medium term, Romania is working with George Washington University and the National Institute of Public Health in Romania to create a centre on health care integration that will focus on resource and human resource development.

5.3.3. Plenary discussion

During the discussion comments arose regarding both competency development but also the type of competencies that are needed to support integrated care. It was also mentioned that there is a need to think of the competencies required to continue to foster quality of care and incorporating those competencies in job descriptions and profile requirements. When it comes to teaching and training professionals, there are three dimensions that need to be addressed: developing knowledge, skills and attitudes. The discussions so far have mainly revolved around developing additional skills to work within a coordinated/integrated environment, but developing the necessary knowledge base and attitudes is of equal importance and

shouldn't be taken for granted. Only if all three dimensions of knowledge, skills and attitudes address the specificities of coordinated/integrated health services delivery, then competencies may be strengthened and support the transformational change.

5.4. Communication

5.4.1. Definition

Communication was defined as a two way process that requires six elements to come together: the sender, the message, the receiver, the medium, the understanding and the feedback. There is an important difference between communication and information but both of these are cross-cutting and enable the integration of services. Much of the complexity of integrated care surrounds communication because professionals need to change their habits to work together and the manner in which they communicate to each other and to patients. This should include a form of dialogue which enables the patient to participate in it. Attention must also be paid to transitions in care where patients move between settings and at times even move between sectors. This is often where communication breaks down since information is not passed on to the next level or sector and adequate communication channels are not established. While electronic records and other information and communication technologies may help to share information, they are not a panacea but tools that need to be properly used.

Capturing all of these aspects in four domains, the following strategies can be applied to strengthen communication:

- *Service information for patients:* e.g. patient-reported outcome measures, directories of services.

- *Clinical information for providers:* e.g. shared electronic health records, care pathways.

- *Process information for management:* e.g. public reviews and audits, benchmarking.

- *Health system information for health planning:* e.g. predictive modelling, situational analysis tools.

5.4.2. Illustration in practice: Denmark

The Danish eHealth strategy had examined three important elements to communication looking at how to communicate between sectors when handing over referrals, how work flows could be improved and the way in which information sharing and communication can add to this, and finally the question of how communication can empower patients. As an answer to these questions, the electronic letterbox was created for all citizens both for the public and private sectors. This tool enabled communication between sectors through a shared database containing information on medicine and practices common to all health providers. It also provides all the health-related information to the patient and helps them manage their own needs.

5.4.3. Plenary discussion

The first topic to be addressed was the use of technology to enable communication and so an overlap with the innovation area was identified. However, it was made quite clear how information and communication can help to empower patients in managing their health. Apart from the apparent usefulness of technologies, it should not be forgotten that communication is about much more than merely using modern technologies. It should also be mentioned that communication enables health professionals to learn from the patient experience and as such is key to create people-centred health services. Reiterating an earlier discussion, the questions around data protection and data security were highlighted as needing further discussion as well. In summary, the following topics were raised to be included in the further development of the area for action:

- It needs to be recognized that communication takes time. If professionals are asked to take their time with patients and communicate more actively with them, then this needs to be reflected in the organizational and financial arrangements.

- Regarding data collection and data utilization, the aim should not simply be to fill electronic databases with as much information as possible, but rather to use information sensibly. Physicians need to understand the data and be able to transform this information into adequate actions, so the tools need to be simple and easy to use.

- Building on this, the evidence and information has to communicated in a language which is targeted to the different audiences, whether professionals, policy-makers or patients. While the health system needs to pick up on the developments in modern information and communication technologies, this should not be the sole purpose of a communication strategy.

5.5. Innovation

5.5.1. Definition

Innovation implies the use of technology but also doing things differently, and it includes creativity. Innovation is often driven by technology but it should not be dependent on it. While technology is a strong driver of change and can alter practices, innovation is absolutely possible without it. Health technology assessment is therefore extremely important. Innovation stands as what is desirable for the user, what is possible and what is viable in the market place. In order to create an innovative environment in practice, one has to:

- Challenge the health system to continuously reflect on resources, care delivery, and management processes promoting integration in ways that offer the greatest potential to the system.

- Equip the system with optimal resources through innovative technologies, systems, and processes.

- Ascertain knowledge on best practices disseminates within the system and across systems.

Translating these bullets into actionable domains, the following four domains can be distinguished:

- *Process (Management-oriented) innovations*: e.g. patient value-driven funding, health technology assessments.

- *Clinical (Care-oriented) innovations*: e.g. multiprovider shared electronic medical records, prevention alerts.

- *Service (Patient-empowering) innovations*: e.g. care-pathway mobile application.

- *Knowledge generation (and evidence collection):* e.g. trials testing the impact of innovations.

Thus, innovation is often driven by technology but it should not be dependent on it. It is the judicious use of technology and the sensible adaptation, which constitute sustainable and innovative solutions.

5.5.2. Illustration in practice: Montenegro

Montenegro was asked to share its experience with using innovative approaches to foster the integration and coordination of services. The intervention recounted the creation of a screening programme for colorectal screening based on the national cancer plan in 2008. The programme began as a partnership between telecommunication companies and the Ministry of Health. Cell phones were used to target individuals between the ages of 60 and 64. A decision was made to shift from a passive approach to an active approach which mobilized the public using SMS via mobile phones. This initiative also exemplified the close relationship between innovation and communication. Some lessons learned from this initiative included the fact that to implement innovation one needed the right

test environment, support from the right individuals, the right timing and a climate for change. Also, the resources for adequate monitoring, evaluation and generation of evidence to support the work were identified as crucial.

5.5.3. Illustration in practice: Norway

Having a long history of coordination and integration of health services delivery and promoting change on all levels of the system, Norway was asked to highlight some of its experiences investing across the areas for action within the domain 'System'. Norway picked one of the more recent examples and explained that efforts to coordinate between primarily health care, which is a municipal responsibility, and secondary or hospital care, which is under the state, began in 2012. This has taken place through the implementation of incentives to transition patients from hospital back to the care of primary practitioners as well as by starting to broaden the competencies for nurses in creating nurse practitioners, providing the necessary technological and information support, and adjusting legal and accountability agreements to reflect the new arrangements. It was acknowledged that actions across the areas were necessary, and that it needed support across the stakeholders and levels of the health system.

5.6. Final considerations about the domain 'System'

Summing up the discussion points and highlighting the most important issues regarding the 'System' domain:

- Thoughts should be put as well to what the link is between innovation and the principle of self-learning, linking both of these elements to continuous performance improvement.

- While the Framework for Action is grounded in conceptual thinking, it is being developed as a practical tool for Member States, it can be used as a linear model to understand the different components that must be considered when transforming health services delivery.

- The main audience for the framework are the meso-level managers, those are the people who transform the services delivery function and who are moving the agenda forward. For this reason, the Framework for Action uses a services delivery perspective.

6. DOMAIN 'CHANGE'

Conditions required for change mentioned during discussions of previous domains were: setting a clear direction for change, creating a participatory approach, generating an environment or appetite for change, creating an environment of experimentation and recognizing the importance of having a planned approach and allowing sufficient time.

6.1. Definition of the Domain 'Change'

The process of change requires understanding of what the end goal is, having a team in which each member has clear responsibilities and the skills to carry out. Change further requires reliable communication and understanding. In this domain there are two areas for action: (1) leadership, which looks to the core components of having a strategic vision and taking a participatory approach; and (2) management, which looks to the process of innovation, piloting and problem solving.

Fig. 7. The domain 'Change' and its elements.
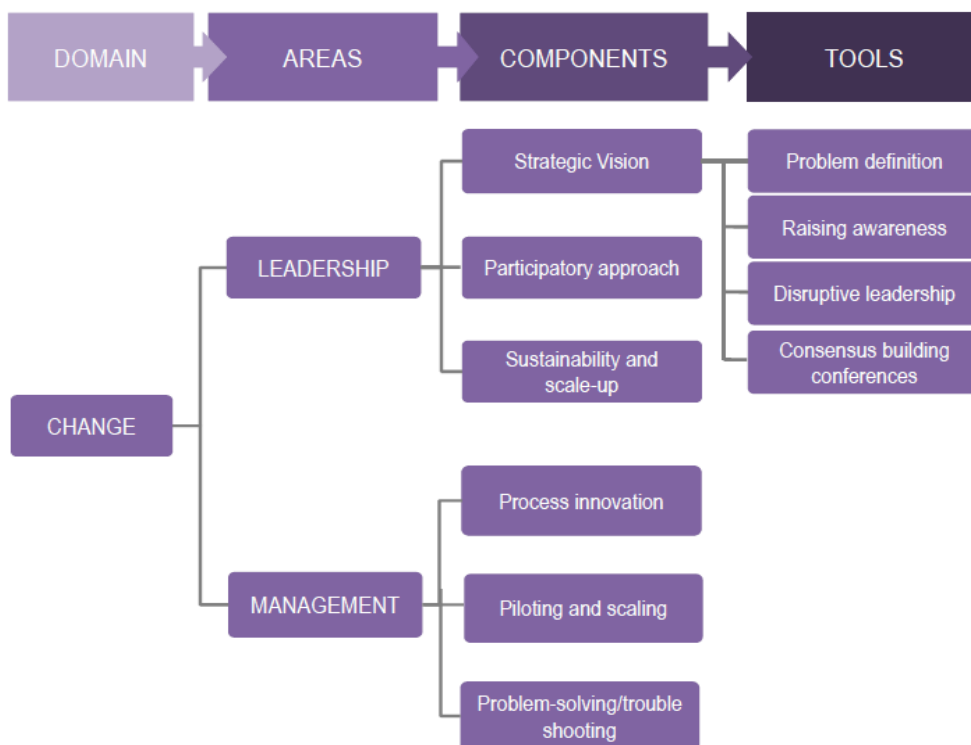
Source: Presentation during the Second Technical Meeting on Coordinated/Integrated Health Services Delivery: Developing the Framework for Action in the context of Health 2020. WHO Regional Office for Europe 2015.

6.2. Overview of change management processes

Nick Goodwin, CEO of the International Foundation for Integrated Care (IFIC), stated that all systems must be managed, lead, nurtured and supported and this can only come through the skills of the managers and leaders at the levels. Two challenges often inhibit the creation of integrated care: a lack of knowledge about how to bring components together (what to first invest in?), as well as a lack of appreciation for the complexity and the time it takes to create change. It is important also to acknowledge that cultures (e.g. professional, organizational) matter, just as much as relationships between professionals and within the community.

In change management you must focus on the technical components without losing sight of the behavioural components of change. The behavioural components deal with engagement to overcome resistance. To start with, a situational analysis should be completed to assess the current starting point and to identify where the gaps are and what investments need to be made. These investments need to promote alignment between the different providers and allow flexibility in working together.

Once there is an understanding of what gaps need to be addressed, establishing a common course that everyone agrees on, creating a local narrative and a burning platform for change should follow. Throughout this process, a guiding coalition should be built which includes all stakeholders under a shared understanding. Another important lesson is that there needs to be an acknowledgement of the possibility of failure of an initiative. Successful change management will anticipate this possibility and will be able to react flexibly to the situation, having a contingency plan or an exit strategy in place.

6.2.1. Illustration in practice: Andorra

The entry point for the reform in Andorra was the realization that primary care could not fulfil its intended gate keeping role. The first step in the change process was to define a clear vision and action points of the model. Three new professional roles were created in consultation with providers, including a primary care team. Pathways and a framework for the intervention were created with the means for continuous monitoring. The main lever however was a shift from fee for service to pay for performance payment. The initiative further included a link with Toulouse hospital in France which added valuable external expertise to the initiative, as well as prestige. The model was first piloted with diabetes patients in an effort to demonstrate its capability to improve the system. Throughout the implementation of this initiative the need for the leaders to be resilient and have a recognized professional reputation was seen as an asset both in their ability to network and reassure other professionals. A common vision helped to align professional goals with ministry and government priorities.

6.2.2. Illustration in practice: Belarus

Belarus had a positive experience in working towards a reduction of infant mortality, using a bottom-up approach. A political commitment had been established through the Millennium Development Goals, however prior efforts had not shown the expected effects. To rectify this a monitoring system was put in place to help ensure that medical supervision and delivery in public hospitals was available to all pregnant women and the provision of post-partum care and medical follow-up both for the mother and child was readily available. The monitoring system assessed the birth and death registry data in addition to internal data sources from select medical facilities to help identify service gaps and better target the efforts.

6.3. Local perspective: piloting and scaling of initiatives

Liesbeth Borgermans, professor of family medicine and chronic care at the Free University of Brussels, had participated in the process of scaling up pilot projects in Belgium and was invited to outline her experience. In 2009, after analysing their data and finding that 50% of the Belgian patients with type 2 diabetes were not on target and were failing to reach goals for LDL cholesterol, the National Institute of Health and Disability Insurance (RIZIV) in Belgium decided to fund a four year research project to develop an integrated diabetes care programme linking hospitals and primary care[10]. Getting started in a programme required to "think global but to act local" creating a compelling case for change. In the Belgian case it was started through a conversation with strong local GP's who were invited to discuss the challenges they felt existed in the system. These conversations also served to gather physicians in one location and encourage discussion among them. The following steps involved a situation analysis through a local SWAT (Strength – Weaknesses – Advantages – Threats)

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[10] Borgermans L. Implementation of integrated diabetes care in Belgium: What did it take? Presentation during the Second Annual Technical Meeting on Coordinated/Integrated Health Services Delivery, 17th February 2015, Istanbul, Turkey.

analysis and the identification of local clinical champions and designated change agents who were able to build bridges and create relationships with the target population, explaining and communicating the importance of the project. Patient participation emerged from the start as an important lever for change and their input, as well as that of all local stakeholders, was used to design protocol changes to current practices and to ensure there was clear feedback on performance. In addition, the following qualities helped to ensure some stability and sustainability within the programme:

- *Having rapid access to peer support*: specialists were available to answer questions from GPs; the initiative also provided a network for professionals to share insights and provide support for changing practices.

- *High quality post-graduate training*: regular trainings of physicians where information was given and any discussion on challenges could take place.

- *Right financial incentives were in place*: important that the extra activity professionals were engaged in was properly compensated.

- *Investments in human relationships*: understanding that trust between stakeholders and individuals working within the programme is vital to success and important in trying to make integrated care a social movement.

The advantage of piloting was underlined by several comments, since pilots often have a greater flexibility to work around strict legal frameworks and then can use a rippling effect if successful to advocate for greater expansion.

6.3.1. Illustration in practice: Integrated care pilots in the NHS England

The NHS England has experienced several phases of integration and reorganization of health services delivery. One of the most successful initiatives was the selection of integrated care pilots, which were given the flexibility and the resources to integrate the services according to the needs of their local communities. They were monitored and evaluated on a regular basis and if their actions could be proven successful, transferability within the NHS was discussed. The New Health and Social Act of 2013 called for a new responsibility to make integration work and so a variety of partners agreed to collaborate and signed up to a number of commitments to look at the national enablers. Throughout this process it was emphasized that the ultimate goal was the promotion of patient-centeredness. The key messages of this national change process were presented as follows:

- The vision was to allow areas to determine what patient-centred care meant for each community. As a result the National Voices programme is working with people across the country to develop their own strategies, hoping ultimately to gain some consistency across the country and the use of a common language.

- The biggest lesson was that there are considerations for change which should be nationally set, such as global ideas and a vision that would unite the community. Equally however there were considerations that needed to be completed at the local level. These included the creation of their own narratives within this broader vision. It was acknowledged that there is a need to be grounded in one's own environment.

- It was also recognized that there was a need to improve the methodology to manage change and it was integral to remember that "culture eats strategy for breakfast".

- A cultivation of this partnership and willingness for providers to work with patients has developed over the past 10–15 years. If one wanted providers to work together one needed to learn to facilitate this process and create spaces for them to interact.

6.3.2. Illustration in practice: Finland

Finland has a long experience with changing its health and social services towards more integration and coordination by means of national policies. This is due to the fact that after a first integration phase, they were looking to further integrate social care, primary health care and secondary care with the system facing patients with multimorbidities, a challenge the system was unprepared for. To answer to these challenges, Finland sought out a new role for nurses providing patient management and created integrated care plans for frail and elderly patients. Finland began piloting the initiative and managed to cover a fifth of the country with over 60 primary health care units working within a model of chronic coordination by nurses working in primary health care. But the Ministry of Health soon realized that an expansion of the pilots and roll-out in the whole country would require a tailoring of the message to each of the stakeholders involved. This entailed a different positioning of the initiative for local government, professionals and for patients as at each level a different concern was the main focus. Further, there was a recognition that a sense of urgency had to be created. Another challenge concerning the integration of health and social care arose however because the two sectors communicated using very different languages and defined care based on different frameworks. In order to overcome all of these issues, major efforts were undertaken to create a comprehensive communication strategy involving all stakeholders and trying to address these issues. The efforts are on-going.

6.3.3. Illustration in practice: Spain

In Spain the approach to coordinated/integrated of health services delivery was defined by strong regional initiatives, which were supplemented by national policies, due to the devolution of power in many areas to the 16 regions. As such, there are many initiatives going on depending on the priorities of the regional governments. For example, work in Catalonia was concentrating on risk stratification based on clinical results and adjusted for morbidity groups. As this measure has already proven successful, they are now looking to codify and include social services within this system. Further work towards this has focused on designing pathways for different diseases based on national recommendations in collaboration with a variety of stakeholders including physicians and patient groups. Another very active region is the Basque country, where the approach concentrated on asking local communities to design their own integrated health services. This bottom-up approach was supported by a regional research institute which monitored progress. The regional initiatives are supported on the national level by regular meetings convened by the Ministry of Health and including public administration, professional associations and patient representatives to discuss the burning issues and how they may be addressed on the national and regional levels.

6.4. Leading and managing change

In a final round of discussions and country examples aimed at highlighting how leaders and managers could influence change towards coordinated/integrated health services delivery.

6.4.1. Illustration in practice: Serbia

In Serbia, everything started with a congress held in Belgrade in 2005. This national congress on palliative care was used to unite the government and community around the need for palliative care in Serbia. It was followed by a national strategy and action plan with the objective of including palliative care principles across all levels of the health system. Engagement of local communities was created by local government in line with the national palliative care strategies, health and social care professionals were reached through trainings and the public through information and education campaigns. All of these activities and many more were coordinated by a strong project team, which was closely collaborating with the Ministry of Health and which also secured EU funds to support implementation.

6.4.2. Illustration in practice: Slovakia

The Slovakian health system is divided into eight regions all of which are quite separate and independent. In an effort to integrate service providers in primary health care, a reform started in 2014 to implement 134 integrated centres across Slovakia based on the individual needs of each community in which they will be placed. In order to initiate change, work began through communication with GPs and hosting a large conference where the idea was first presented to professionals and politicians. Based on these initial discussions, national standards for interventions across each integrated centre were created to ensure a similarity or base level of care was provided. This work has required discussions and engagement across partners at all levels of the health system from the European Union and European Commission down to local level practitioners and patients to start removing resistance and unite individuals behind a common idea. The efforts are on-going.

6.4.3. Illustration in practice: Turkey

In Turkey, work has focused on a number of changes surrounding governance and finance within the health system. In order to properly implement them there was a need for political commitment. This commitment provided credibility within the community and helped to ease resistance. Also integral was the monitoring and evaluation of the initiatives, and an analysis of the data gained to understand the arising problems and be able to react accordingly. Within the current reforms field coordinators, or managers, are in regular communication with the Minister of Health reporting on monitoring outcomes.

Turkey itself has a long history of making top-down decisions and strong centralized programmes. This has worked well in certain circumstances but others including public health planning have required a bottom-up approach. Again it involved knowing the context of change that was being made. The ability to shift between democratic bottom-up examples and more autocratic styles of leadership require different skills and different levels of the health system to be involved.

7. FINAL REMARKS

In each of the country examples presented during the meeting, different types of leadership and leaders involved were mentioned. However all of them conceded that there was a burning platform and the creation of urgency for change. What is often missing are examples of national scale up, so the framework should think to how the meso-level can be linked back to the macro-level to establish the conditions for sustained and implementation at scale. It needs to be recognized that some of these are initiatives that don't need to be scaled up. This links to what defines a successful CIHSD initiative.

Four elements were quite salient throughout the discussions:

- *Creating a common vision*, i.e. the need to have a common narrative that is localized and contextualized so that reasons for change and direction are known.

- *Building relationships*, both formal and informal, and thus establishing trust between stakeholders and enabling them to hold each other to account.

- *Addressing language barriers*, the importance of establishing common communication channels and common definitions between providers, patients and policy-makers. This goes further to the dissemination of work using a media that is used by everyone involved.

- *Applying management tools*, using those that already exist such as situation and stakeholder analysis, action plans, protocols, guidelines.

The meeting was another important milestone and provided additional inputs that will further inform the development of the Framework for Action. The shared experiences from Member States and international experts resonated similar key messages and shown the necessity and appropriateness of the Framework for Action towards Coordinated/Integrated Health Services Delivery.

8.ANNEXES

Annex 8.1 – Scope and Purpose

Background

In the pursuit of Europe's greatest health potential, strengthening people-centred health systems to accelerate gains in health outcomes and reduce health inequalities has arisen among the top priorities of the Health 2020 agenda. In line with this, the health sector requires innovative approaches of organizing and actively involving providers and stakeholders, articulating the provision of health services from the perspective of the person and the systems.

Adopting an action-oriented approach, transforming the provision of health services calls attention to the selection of interventions, their organization in the system's network of providers, the processes in place for the maintenance and continuous improvement of performance and the managerial oversight of these processes in accordance to the population's needs. For a person, interventions are expected to be appropriate, continuous, responsive and acceptable according to their needs. From the system's perspective this means ensuring access to a full range of promotive, preventive, curative, rehabilitative and palliative high-quality services by providers that are coordinated and integrated.

In order to support Member States to achieve those transformational changes, a WHO European Centre for Primary Health Care has been established in Almaty, Kazakhstan, supporting the implementation of coordinated/integrated health services delivery (CIHSD) throughout the European Region based on the values of renewed primary health care.

The work on coordinated/integrated health services delivery will be guided by an overarching evidence-based Framework for Action shaped along three pillars: (1) knowledge synthesis in form of a concept note; (2) gathering of information about Member States CIHSD initiatives to be published as a compendium of field evidence; and (3) formulation of policy options by means of a change management manual. This articulated Framework for Action was officially launched during the Health Systems Tallinn Charter conference in October 2013.

Rationale

Input from Member State technical focal points on CIHSD and an Expert Advisory Team are invited throughout the development process of the Framework for Action towards Coordinated/Integrated Health Services Delivery through regular meetings and virtual consultations. In order to achieve the highest possible engagement, the annual technical meeting is called for to capture feedback and input from these groups and to ensure the country perspectives are reflected in the Framework for Action. Relevant stakeholders, such as patient's organizations, professional associations, representatives of payers and international institutions, are also invited to provide their input and are regularly informed of the progress made in consultations and through presentations at topical conferences and meetings. Further information and the meeting reports for the CIHSD Kick-Off Technical Meeting in Istanbul as well as the CIHSD Stakeholder Consultation in Brussels, are available for download here:
http://www.euro.who.int/en/health-topics/Health-systems/health-service-delivery/publications

In the context of this participatory approach, the CIHSD Annual Technical Meeting will give the Member State focal points and Expert Advisory Team the opportunity to discuss the progress made since the Kick-Off Technical Meeting in Istanbul in February 2014. In particular, the final drafts for pillar 1 (concept note) and for pillar 2 (field evidence) will be presented and feedback solicited.

Objectives

The meeting seeks to

1. Present and solicit feedback for the final draft of the Concept Note (pillar 1).
2. Present and discuss the compendium of field evidence representing the experience across the WHO European Region, including lessons learned from implementation (pillar 2).

3. Outline the further steps in the development of the Framework for Action on Coordinated/Integrated Health Services Delivery.

Target Audience

The meeting will be attended by Member State technical focal points on CIHSD, members of the Expert Advisory Team and the HSD/DSP team for CIHSD.

Annex 8.2 – List of Participants

Country Participants

Andorra
Cristina Santarrosa Mateo
Adviser
Ministry of Health and Welfare

Anna Nerin
Adviser
Ministry of Health and Welfare

Austria
Herwig Ostermann
Head of the Department of Health Economics
Gesundheit Österreich GmbH

Belarus
Alena Leonidovna Bogdan
Chief of Department of Medical Services Provision
Ministry of Health

Belgium
Saskia Van den Bogaert
Head
Health, Food Chain Safety and Environment (FPS)

Bosnia and Hercegovina
Drazenka Malicbegovic
Assistant Minister for Health Sector
Ministry of Civil Affairs of B&H
Department of Health

Czech Republic
Oldrich Pospisil
Dept. of Advisors and Strategies
Ministry of the Czech Republic

Denmark
Sven Erik Bukholt
Senior Adviser
Ministry of Health

Finland
Taina Mäntyranta
Medical Counsellor
Ministry of Social Affairs and Health

France
Yann Bourgueil
Director
Institute for research and information in health economics

Georgia
Nino Beridze
Specialist
Division for Regulation, Department of Health Care
Ministry of Labour, Health and Social Affairs

Hungary
Ildikó Kissné Horváth
Head, Health Policy
Ministry of Human Resources

Italy
Maria Chiara Corti
Medical Director
Sezione Attuazione Programmazione Sanitaria
Agenzia alla Sanita'
Regione del Veneto

Kyrgyzstan
Dinara Aldasheva
Ministry of Health

Latvia
Kristine Klavina
Head, Division of Strategic Planning
Ministry of Health

Lithuania
Rima Vaitkienė
Head, Health Policy and Planning
Ministry of Health

Luxemburg
Martine Debacker
Head of Department
Ministère de la Santé – Direction de la Santé

Montenegro
Natasa Terzic
Director of the Center for Health System Development
Institute of Public Health of Montenegro

Norway
Maren Skaset
Deputy Director General
Department of Municipal Health Services
Royal Ministry of Health and Care Services

Poland
Tomasz Pawlega
Deputy Director
Health Insurance Department
Ministry of Health

Republic of Moldova
Rodica Scutelnic
Head of Department for Hospital and Emergency Health Care
Ministry of Health of the Republic of Moldova

Romania
Claudia Dima
Senior Public Health and Management MD
National Institute of Public Health

Serbia
Gordana Belamaric
Ministry of Health of the Republic of Serbia

Milena Vasic
Chief of Department for Research in the Field of Public Health
Institute for Public Health of Serbia "Dr Milan Jovanovic Batut"

Slovakia
Miroslav Cangár
Institute for Health Policy
Ministry of Health of Slovak Republic

Slovenia
Mircha Poldrugovac
Medical Doctor
National Institute of Public health of the Republic of Slovenia

Spain
Marian Angeles Lopez Olive
Directorate-General for Public Health, Quality and Innovation
Ministry of Health Social Services and Equity

Sweden
Jens Wilkens
Health Economist
National Board of Health and Welfare

Tajikistan
Shaidullo Sharipov
Head of Department for Medical Care Provision
Ministry of Health and Social Protection

Turkey
Seda Usubütün
Senior Advisor
General Directorate of Foreign and EU Affairs
Ministry of Health

Turkmenistan
Ashir Mammedorazovich Atayev
Deputy Minister of Health and Medical Industry
Ministry of Health and Medical Industry

Uzbekistan
Doniyor Mirazimov
Chief of Treatment and Prevention Department
Ministry of Health

Observers

Chandra Cohen-Stavi
Health Policy Research and Planning
Clalit Health Services
Israel

Theodore Galariotis
Founding Member
Greek Network EIP on AHA
Belgium

Siegfried Walch
Professor
Management Center Innsbruck
Austria

Jacquie White
Deputy Domain Director
NHS England
United Kingdom

Temporary Advisors

Ran Balicer
Director
Health Policy Research and Planning
Clalit Health Services
Israel

Liesbeth Borgermans
Professor
Vrije Universiteit Brussel
Belgium

Antoni Dedeu
Director
Digital Health Institute
Scotland

Thomas Ernst Dorner
Professor
Medical University Vienna
Austria

Lourdes Ferrer
Managing Director
International Foundation for Integrated Care
United Kingdom

Nicholas Goodwin
Chief Executive Officer
International Foundation for Integrated Care
United Kingdom

Kai Leichsenring
Senior Researcher
European Centre for Social Welfare Policy and Research
Austria

Leo Lewis
Senior Fellow
International Foundation on Integrated Care
United Kingdom

Mary-Jo Monk
Senior Policy Analyst
Primary Health Care Branch
Nova Scotia Department of Health and Wellness
Canada

Irini Papanicolas
Lecturer
London School of Economics
United Kingdom

Esther Suter
Director
Workforce Research & Evaluation
Alberta Health Services, Calgary
Canada

Maria Luisa Vazquez
Head Research and Development
Consortium for Health Care and Social Services of Catalonia
Spain

World Health Organization, Secretariat

Erica Barbazza
Consultant, Health Services Delivery Programme, Division of Health Systems and Public Health

Rafael Ferrer
Volunteer, Health Services Delivery Programme, Division of Health Systems and Public Health

Paulina Miskiewicz
Head of Country Office, WHO Country Office in Poland

Ellen Nolte
Coordinator, European Observatory on Health Systems and Policies

Katharina Viktoria Stein
Consultant, Health Services Delivery Programme, Division of Health Systems and Public Health

Juan Tello
Programme Manager, Health Services Delivery Programme, Division of Health Systems and Public Health

Nuria Toro
Consultant, Health Services Delivery and Safety Department, WHO headquarters

Kerry Wadell
Consultant, Health Services Delivery Programme, Division of Health Systems and Public Health

Annex 8.3 – Programme of the Event

Tuesday, 17 February 2015	
08:00 – 08:30	**Registration**
08:30 – 09:30	**Opening and welcome address** The introductory session will provide an update of the progress accomplished since the initiation of the development of a Framework for Action towards Coordinated/Integrated health Services Delivery (CIHSD), its underpinning concepts and outline. The session will provide an overview of the agenda of the event and define the scope of work. • Development of a Framework for Action towards Coordinated/Integrated Health Services Delivery in WHO European Region: Overview (Juan Tello, 40') • Question and answer session (5') • Update on the development of WHO global strategy towards people-centred and integrated health services delivery (Nuria Toro, 5') • Technical Meeting Agenda and Objectives (Viktoria Stein, 10')
09:30 – 10:30	**Framework for Action towards Coordinated/Integrated Health Services Delivery: "People"** In this session the Areas for Action of the domain "people" of the Framework for Action will be presented and discussed. Chair: Maria Luisa Vazquez • Presentation of the domain "People" (Juan Tello, 15') Short question and answer session (5') • Illustration of how the domain may be addressed in practice (10'): Greece: Scaling up EIP AHA initiatives to national level Short question and answer session (5') • Interventions and discussion o Expert: Lourdes Ferrer (5') o Plenary Discussion (10') o Summary of Discussion Points and Open Questions (5')
10:30 – 11:00	**Coffee break**
11:00 – 12:30	**Framework for Action towards Coordinated/Integrated Health Services Delivery: "Services"** In this session the Areas for Action of the domain "service" of the Framework for Action will be presented and discussed. Chair: Ellen Nolte • Presentation of the domain "Services" (Juan Tello, 20') Short question and answer session (5') • Illustration of how the domain may be addressed in practice (10'): Italy: Using population risk adjustment tool to integrate health services delivery Short question and answer session (5') • Interventions and discussion o Expert: Mary-Jo Monk (5') o CIHSD Focal Points: Belgium, France, the Republic of Moldova (15') o Plenary Discussion (20') • Summary of Discussion Points and Open Questions (5')
12:30 – 13:30	**Lunch**

13:30 – 14:45	**Framework for Action towards Coordinated/Integrated Health Services Delivery: "System"**
	Briefly introduced in the first session, the health system enablers are those core health system functions needed to promote the context for optimal, coordinated/integrated health services delivery. In this and the following sessions, the Areas for Action of the "system" domain will be introduced and discussed.
	Chair: Mary-Jo Monk (TBC)
	• Presentation of the domain "System" (Viktoria Stein, 5')
	• **Accountability**: relevance for CIHSD
	   o Expert: Esther Suter (15')
	   o CIHSD Focal Point: Slovenia (5')
	   o Plenary Discussion (10')
	   o Summary of Discussion Points and Open Questions: Irini Papanicolas (5')
	• **Incentives**: relevance for CIHSD
	   o Expert: Kai Leichsenring (15')
	   o CIHSD Focal Point: Hungary (5')
	   o Plenary Discussion (10')
	   o Summary of Discussion Points and Open Questions: Mary-Jo Monk (5')

14:45 – 15:15	**Coffee break**

15:15 – 16:30	**Framework for Action towards Coordinated/Integrated Health Services Delivery: "System" – cont.**
	Chair: Thomas Dorner
	• **Competencies**: relevance for CIHSD
	   o Expert: Liesbeth Borgermans (15')
	   o CIHSD Focal Point: Romania (5')
	   o Plenary Discussion (10')
	   o Summary of Discussion Points and Open Questions: Thomas Dorner (5')
	• **Communication**: relevance for CIHSD
	   o Expert: Leo Lewis (15')
	   o CIHSD Focal Point: Denmark (5')
	   o Plenary Discussion (10')
	   o Summary of Discussion Points and Open Questions: Lourdes Ferrer (5')

16:30 – 16:45	**Coffee break**

16:45 – 18:00	**Framework for Action towards Coordinated/Integrated Health Services Delivery: "System"– cont.**
	Chair: Lourdes Ferrer
	• **Innovations**: relevance for CIHSD
	   o Expert: Ran Balicer (15')
	   o CIHSD Focal Point: Montenegro (5')
	   o Plenary Discussion (10')
	   o Summary of Discussion Points and Open Questions: Toni Dedeu (5')
	• Reflections on the domain related to System
	   o Expert: Maria Luisa Vazquez (10')
	   o CIHSD Focal Point: Norway (5')
	   o Plenary discussion (10')
	• Wrap-up of Day 1 (Viktoria Stein, 5')

19:30	**Social Dinner**

Wednesday, 18 February 2015	

09:00 – 10:00	**Framework for Action towards Coordinated/Integrated Health Services Delivery: "Change"**
	In this session the outline of the Areas for Action of the domain "change" of the Framework for Action will be presented and discussed.
	Chair: Erica Barbazza
	• Presentation of the domain "Change" (Erica Barbazza 5')
	• Overview of change management processes in integrated care (Nick Goodwin 10')
	Short question and answer session (5')
	• Interventions and discussion
	   o Expert: Mary-Jo Monk (5')
	   o CIHSD Focal Points: Andorra, Belarus (10')
	   o Plenary Discussion (10')
	   o Summary of Discussion Points and Open Questions (5')

10:00 – 10:15	**Coffee break**
Wednesday, 18 February 2015 – cont.	

10:15 – 11:15	**Framework for Action towards Coordinated/Integrated Health Services Delivery: "Change"– cont.**
	Chair: Toni Dedeu
	• Local perspective: piloting and scaling of initiatives (Liesbeth Borgermans, 10')
	Short question and answer session (5')
	• Illustration of how the domain may be addressed in practice (10'):
	United Kingdom: The development and experiences with integrated care pilots
	Short question and answer session (5')
	• Interventions and discussion
	   o Expert: Nick Goodwin (5')
	   o CIHSD Focal Points: Finland, Spain (10')
	   o Plenary Discussion (10')
	   o Summary of Discussion Points and Open Questions (5')

11:15 – 11:30	**Coffee break**

11:30 – 12:30	**Framework for Action towards Coordinated/Integrated Health Services Delivery: "Change"– cont.**
	Chair: Irini Papanicolas
	• Leading and managing change (Juan Tello, 10')
	Short question and answer session (5')
	• Interventions by experts and CIHSD Focal Points
	   o Expert: Ellen Nolte (5')
	   o CIHSD Focal Points: Serbia, Slovakia, Turkey (5' each)
	   o Plenary Discussion (10')
	   o Summary of Discussion Points and Open Questions (5')

12:30 – 13:30	**Lunch**

13:30 – 14:30 (including coffee)	Introduction to small group work (Viktoria Stein, 5') **Training Session 1: How to engage and empower people to participate in health services delivery** Looking at the different elements of the Framework presented during the last days and applying it to the specific country context, tools and approaches to actively involve people and work towards change will be discussed in small groups and in the plenary. Moderator: Nick Goodwin • Small group work (20') • Presentation of small group work and Plenary discussion (30') • Summary and transition (5')
14:30 – 15:30 (including coffee)	**Training Session 2: How to promote leadership for change** Continuing the capacity building exercise, different aspects of leadership for change will be discussed in small groups and in the plenary. Moderator: Viktoria Stein • Small group work (20') • Presentation of small group work and Plenary discussion (30') • Summary and wrap-up (5')
15:30 – 16:00	**Closing of the Second Annual Technical Meeting on Coordinated /Integrated Health Services Delivery** The last session will wrap up the meeting and summarize open questions. Chair: Viktoria Stein • Closing remarks (Hans Kluge, via Webex, 5') • Open questions (10') • Summary of discussion points and wrap-up (Juan Tello, 5')
	Departure

Annex 8.4 – List of presentations

- Development of a Framework for Action towards Coordinated/Integrated Health Services Delivery in WHO European Region: Overview (Juan Tello)

- Presentation of the domain "People" (Juan Tello)

- Greece: Scaling up EIP AHA initiatives to national level (Theodore Galariotis)

- Presentation of the domain "Services" (Juan Tello)

- Italy: Using population risk adjustment tool to integrate health services delivery (Maria-Chiara Corti)

- Presentation of the domain "System" (Viktoria Stein)

- Accountability: relevance for CIHSD (Esther Suter)

- Incentives: relevance for CIHSD (Kai Leichsenring)

- Competencies: relevance for CIHSD (Liesbeth Borgermans)

- Communication: relevance for CIHSD (Leo Lewis)

- Innovations: relevance for CIHSD (Ran Balicer)

- Presentation of the domain "Change" (Erica Barbazza)

- Local perspective: piloting and scaling of initiatives (Liesbeth Borgermans)

- United Kingdom: The development and experiences with integrated care pilots (Jacquie White)

You can download the presentations here: https://euro.sharefile.com/d/se1b291cf5d245978

Or you may also contact the CIHSD Secretariat at cihsd@euro.who.int and we will send the presentations to you.

The Roadmap to develop a Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) places a strong emphasis on a participatory approach to ensure ownership in the process of its development. This includes input from Member State Technical Focal Points on CIHSD and the Expert Advisory Team. In order to achieve the highest possible engagement, the Second Annual Technical Meeting on CIHSD was called for to report on the progress made since the Kick-Off Technical Meeting in February 2014 and to receive further input. This meeting gave the Member States Technical Focal Points and Expert Advisory Team the opportunity to discuss the continued advancement of key concepts and to facilitate the exchange of experiences and insights from countries and participants. The report at hand and the feedback received during this meeting will be used to further develop and refine the Framework for Action, ensuring the highest possible relevance and practicability for Member States.

World Health Organization
Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00   Fax: +45 45 33 70 01   Email: contact@euro.who.int
Website: www.euro.who.int