



**World Health  
Organization**

REGIONAL OFFICE FOR

**Europe**

**By: Health  
Services  
Delivery  
Programme  
Division of  
Health  
Systems  
and Public  
Health**

# Transforming health services delivery towards people-centred health systems

**BRIEFING NOTE**

Working document for the development of the  
Framework for Action towards Coordinated/  
Integrated Health Services Delivery



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## ABSTRACT

The briefing note at hand has been prepared to annotate with further conceptual clarity the structure and organization of the Framework for Action, with the objective of specifying the following: (1) its strategic vision according to the determinants of people-centred health services; (2) how needed transformations are reasoned beginning from a root cause analysis of the function itself; and (3) the translation of the defined vision and reasoned determinants into the core components of the Framework.

The note should be read merely as a positioning of themes, attempting here only to narrate the direction of the Framework as an umbrella-like, all encompassing space for the concept of health services delivery to then be further explored and specified in forthcoming work.

## Keywords

DELIVERY OF HEALTH CARE  
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This working document supports the continued development of the Framework for Action towards Coordinated/Integrated Health Services Delivery, building on concepts and processes first outlined in the guiding document for this work plan, the *Roadmap – Strengthening people-centred health systems in the WHO European Region*<sup>1</sup>.

This work takes shape within the Division of Health Systems and Public Health under the overall direction and leadership of Hans Kluge, Director.

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<sup>1</sup>WHO Regional Office for Europe. (2013). Strengthening people-centred health systems in the WHO European Region: A Framework for Action towards Coordinated/Integrated Health Services Delivery. Copenhagen: WHO Regional Office for Europe.





# 1. Strategic vision on health services delivery

## 1.1 Rationale and aim

In the pursuit of Europe's greatest health potential by year 2020, to accelerate gains in health outcomes and reduce health inequalities the delivery of health services must continuously adapt and evolve according to changing demographics and the epidemiological landscape. Both this context and what changes it calls for are clear. For example, ageing populations have given rise to increases in noncommunicable diseases (NCDs), multi-morbidities and chronicity. This has necessitated a reorientation of services, such that the provision of care is proactive rather than reactive, comprehensive and continuous rather than episodic and disease-specific, and founded on lasting patient-provider relationships rather than incidental, provider-led care.

Adding impetus to this reform agenda are those advancements of research, design and manufacturing that have dramatically changed the way in which we alleviate pain, restore health and extend life. For example, service delivery innovations, like ehealth, mhealth and other remote applications, have made possible more personalized, affordable and effective services in ways previously unimaginable. However, just as many service delivery models have outlived their usefulness in terms of their ability to meet the changing demands of people and populations, out-dated models dually constrain the extent to which systems can capitalize on advancements of the 21<sup>st</sup> century. It is on these limitations of "business as usual" that the urgency for transformative changes to health services delivery are made particularly compelling.

## 1.2 People-centred health services

Responding to this context has necessitated people-centred health services – defined here as the process of service provision that consciously considers and purposefully adopts a person-facing perspective. This orientation is driven by the potential to secure health gains through the provision of services that are tailored to an individual's needs for care that is continuous, appropriate, responsive and acceptable to the population systems aim to serve. Importantly, working towards people-centred health services delivery recalls the principles of a primary health care approach and goals of improving health for all and reducing inequalities – fitting within the vision set out in Health 2020 while further advancing its strategic objectives.

To this end, the function of health services delivery itself must be acted upon. As a core function of health systems, its principle concerns include the selection of which services to provide, how to organize their provision, assure the continuous improvement of this process as well as the task of managerial oversight throughout. From the perspective of the system, people-centred services delivery must strive to provide comprehensive, coordinated, quality, and equitable care and it is in the pursuit of these performance gains that the system must act. Importantly, the provision of services takes direction from the system-at-large and is derived from the conditions it creates. Thus, the success of transformations towards people-centred health services rests on an understanding of both the root causes (determinants) of poor performance of the function itself and the contributions of the health system underpinning the provision of health services.

Ultimately, the process of addressing these causes of poor performance and ensuring the optimal organization of services is more than resolving fragmentation, for example, through the recombination of parts so they behave as a whole, and rather, is a transformative process to challenge the status quo, tackling the entirety of the services delivery function and system in which it takes shape. As a complex and adaptive system, improving the coordination/integration of health services delivery serves as a vehicle or means to people-centric care. Working to transform the health

services delivery function towards coordinated/integrated services is then the direction for changes to support people-centred health services – seeing coordinated/integrated health services delivery (CIHSD) as the means and guiding design principle, rather than the goal in pursuit of in and of itself.

It is on this premise of transforming the provision of services through the optimal conditions of the health system and set according to the design principles of coordinated/integrated health services delivery that the Framework for Action's agenda takes shape.

**Table 1. Definition of key concepts**

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**People-centred health systems.** The arrangement of core system functions of resourcing, financing and steering that reflects a prioritization of individuals, their families and communities, that create the conditions for the provision of services according to the needs and the broader determinants of health for the people and populations the health system aims to serve.

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**Health services delivery function.** A core function of health systems, services delivery concerns the selection of which services to provide, how to organize their provision, how to assure the continuous improvement of care processes and the managerial oversight throughout. Optimizing the services delivery function aims to ensure the selection of a comprehensive range of interventions, delivered in coordination across providers, with continuous monitoring for quality patient care its equitable, efficient/effective delivery.

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**People-centred health services.** The process of services delivery that purposefully considers and adopts a person-facing perspective by ensuring the content and organization of services matches the individual's needs. This process takes direction from the system, being derived from the conditions it creates. Taken from the persons' perspective, people-centredness can be appraised according to the comprehensiveness, continuity, responsiveness and acceptability of services.

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**Coordinated/integrated health services delivery.** A vehicle for improving the arrangement of health systems such that core system functions are optimally conducive to people-centred services delivery; a means to people-centred health systems providing the design or blueprint for those system-conditions needed, specifically: adequate and aligned accountability arrangements; incentive mechanisms; competencies of the health workforce; communication systems; and innovations and research generating processes.

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Own source: Health Services Delivery Programme. Division of Health System of Public Health. WHO Regional Office for Europe.

### 1.3 Determinants of people-centred health services

A framework for reasoning health services delivery transformations is specified to recognize the various determinants of the function and the interactions between the processes involved in the provision of health services and the range of likely or anticipated individual needs it aims to respond to. These determining factors on the function's performance are deduced or extrapolated as the cascade of interactions between the function itself, the system that defines it and by further extension, the other sectors and broader contextual factors whose influences prevail through an all-encompassing and dynamic effect. The figure below (Fig 1.) is illustrative of these determining factors and their inter-relations, reinforcing the importance of taking multifaceted approaches to transform health services delivery.

Beyond the layering of their interactions, how can the determinants of people-centred health services delivery be specified?

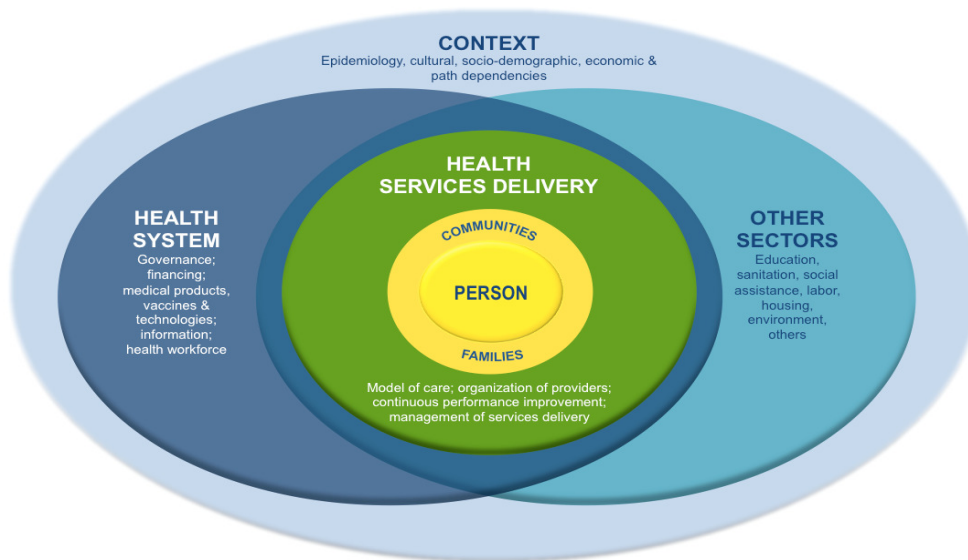
As the figure depicts, at the centre dictating the content and arrangement of services is the individual, their families and their communities. People – both before and after they become patients – interface

with the health system through their contact with services. As described above, the content, organization, quality and management of this process has a defining (determining) hold on the performance of the services delivery and on the extent to which the services purposefully considers and adopts a person-facing perspective.

The context to this is given by or rather, structured according to the health system – its core functions of resourcing, financing and steering determining the conditions in which the processes of services delivery take place. The prioritization of individuals, their families and communities thus weighs on the realization of people-centred services delivery in practice. Importantly, an adequate response to an individual's needs is subject to the interactions between the system and other sectors, seeing for example, social needs, employment or housing, as deterministic of health but beyond the health system itself.

These dynamics are contextualized according to prevailing cultural norms, economics and the development status of any given nation. These factors are recognized in the outermost ring to remind of those context-specific variables that underpin across the determining factors described.

**Figure 1. The interacting determinants of people-centred health services**



Source: Adapted from WHO-HQ Global Strategy on People-Centred and Integrated Health Services [in progress].

## 2. Strengthening health services delivery

### 2.1 Root cause approach to health services delivery transformation

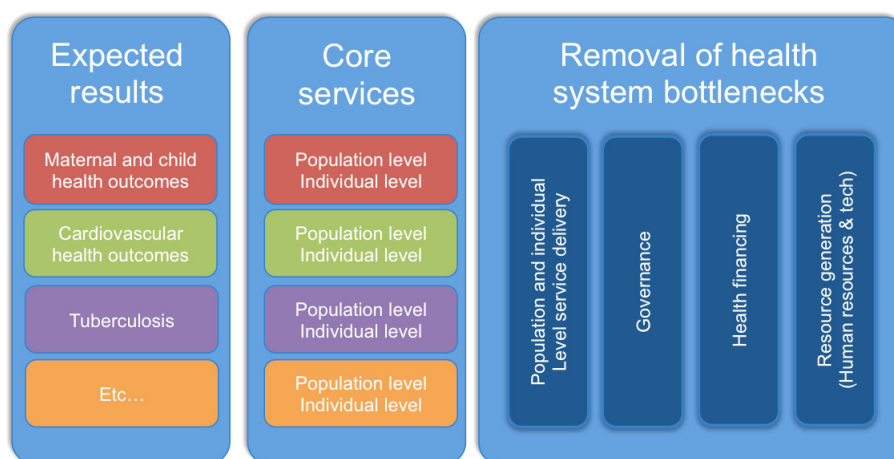
Just as the principal objective of a health system is to improve people's health and well-being, the primary function the system needs to perform is to deliver health services. Each system function contributes to the provision of services – for example, the financing function determining available funds or the resource function determining qualities of the workforce, medicines and technologies. However, even when these needed inputs exist and the system arrangements for people-centred

services are in place, the performance of the provision of health services will ultimately be what determines the actual realization of a people-centric orientation.

Through a root-cause approach attention is called to those minimum set of operations observed *within* the function of health services delivery as subsidiary to this (sub-functions), that exist in any health system: modelling care; organizing providers; continuously improving performance; and managing the provision of services.

Thinking to this in practice recalls the operational thinking set out in the health system strengthening approach of the Regional Office for Europe (Fig 2). The approach is structured according to three pillars: (i) specification of priority health improvement areas; (ii) ensuring high levels of effective coverage for core services in priority health improvement areas defined; and (iii) removing health system barriers that limit the coverage of core services. Viewed through a health services delivery lens, persisting bottlenecks are looked to *within* the services delivery function itself, tackling these to optimize performance while keeping a systems-orientation (recognizing barriers affecting one improvement area are likely to affect others as well).

**Figure 2. Operational approach of health systems strengthening**



Source: WHO Regional Office for Europe. (2014). Towards people-centred health systems: an innovative approach for better health outcomes. Copenhagen: WHO Regional Office for Europe. Adapted from operational approach to health system strengthening in the WHO Regional Office for Europe [http://www.euro.who.int/\\_data/assets/pdf\\_file/0018/172152/Presentation-of-the-operational-approach-to-health-system-strengthening-in-the-WHO-Regional-Office-for-Europe.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0018/172152/Presentation-of-the-operational-approach-to-health-system-strengthening-in-the-WHO-Regional-Office-for-Europe.pdf?ua=1)

## 2.2 Structuring a Framework for Action towards coordinated/integrated health services

The Framework for Action towards Coordinated/Integrated Health Services Delivery, in line with its founding premise to support Member States as an actionable resource for strengthening health services delivery, takes its structure from the conceptual framework depicted above (Fig 1). While working towards systems that adopt the design principles of coordinated/integrated services delivery, the Framework directs action to the functions, working within the services delivery function and across the health system for systemic transformations at scale and sustainably embedded within the health system.

To this end, the Framework is structured according to the following three objectives.

### **Objective 1: Optimizing the health services delivery function**

**To promote a common understanding of the health services delivery function.** A core aim of the Framework is to promote a common understanding of health services delivery concepts. This includes its sub-functions and attributes for optimizing performance, investigating: how can the health services delivery function be defined according to a discrete number and clustering of core subsidiary functions? What are those dimensions of distinguished importance or significance, as features of each? What are the qualities, as values or attributes for improved performance that guide actions to promote the delivery of people-centred health services? To this end, the Framework aims to provide a common platform to reason the functional components of the services delivery function, measure its performance, and monitor its improvement.

### **Objective 2: Enabling people-centred health systems**

**To highlight those key system levers for enabling transformations that are supportive of people-centred health services delivery.** Transforming the provision of health services delivery calls for a system-lens. In other words, strengthening health services delivery looks to tackle those features of the health system functions that are determining of the way in which the function of services delivery behaves, answering: how can core health system functions be specified to draw in close association, those factors of the health system that support the conditions for the optimal delivery of health services? To this end, the Framework aims to position possible interventions across health system functions that are enabling or catalysing of the conditions needed to support the sustainability and scale of transformations.

**Figure 3. Objectives of the Framework for Action towards CIHSD**



Own source: Health Services Delivery Programme. Division of Health System of Public Health. WHO Regional Office for Europe.

### Objective 3: Leading health services delivery transformations

**To learn from the process of leading health services delivery transformations, deciphering key success factors of instituting change.** To support linkages between concepts and practical actions – from ‘what’ to ‘how’ – the Framework aims to narrate the *process* of transformations through the first hand experience of Member States, answering: what are the determining process factors for the success of transformations at scale, pace and fully embedded within the health system to achieve measurable health gains? Backed by lessons from implementation, this final component of the Framework intends to detail the change process in a clear and step-wise approach relevant to leaders and managers across the Region.

### 2.3 Methods in developing the Framework for Action towards coordinated / integrated health services

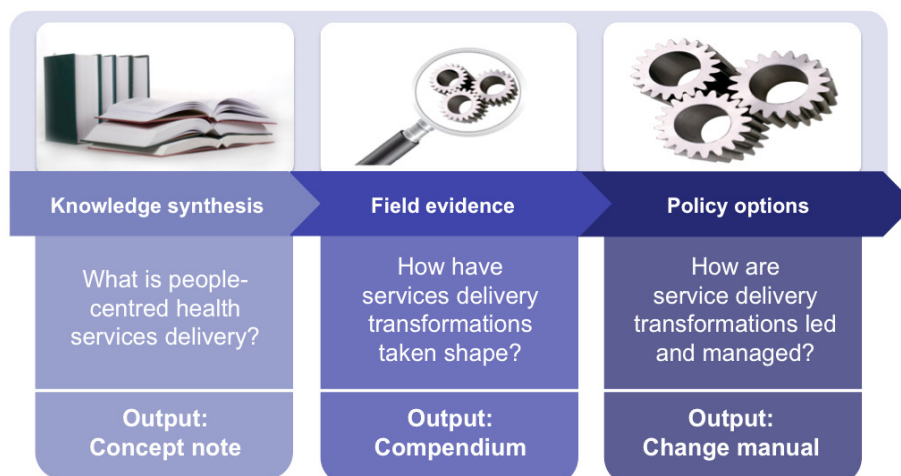
Three key strands of work inform the activities undertaken in developing the Framework, dictating how information is generated and what directions it informs. These take shape as follows:

**Knowledge synthesis.** Activities to include literature reviews, scoping studies and other methodologies for consolidating existing documents, strategies and thinking of relevant topics (e.g. regional and global strategies and guiding commitments; health services delivery; systems-thinking; coordinated/integrated health services delivery; vertical services delivery programmes of HIV, TB, maternal and child health, NCDs, mental health, etc.).

**Field evidence.** An investigation of first-hand experiences from countries in transforming the health services delivery function, reflecting on: what changes took place within the services delivery function and across the health system as well as what processes were undertaken to challenge the status quo to lead and manage the change process.

**Policy options.** Building on the lessons learned from the first and second strands of work, this last strand calls for further reflection on findings and interpretation of the process as lessons learned. This work should communicate to policy-makers and management the “how to” process of practically integrating concepts and experiences into their service delivery reform efforts.

**Figure 4. Recalling core pillars of the Roadmap to developing the Framework for Action**



### 3. Core components of the Framework for Action towards coordinated/integrated health services

#### 3.1 Knowledge synthesis about health services delivery

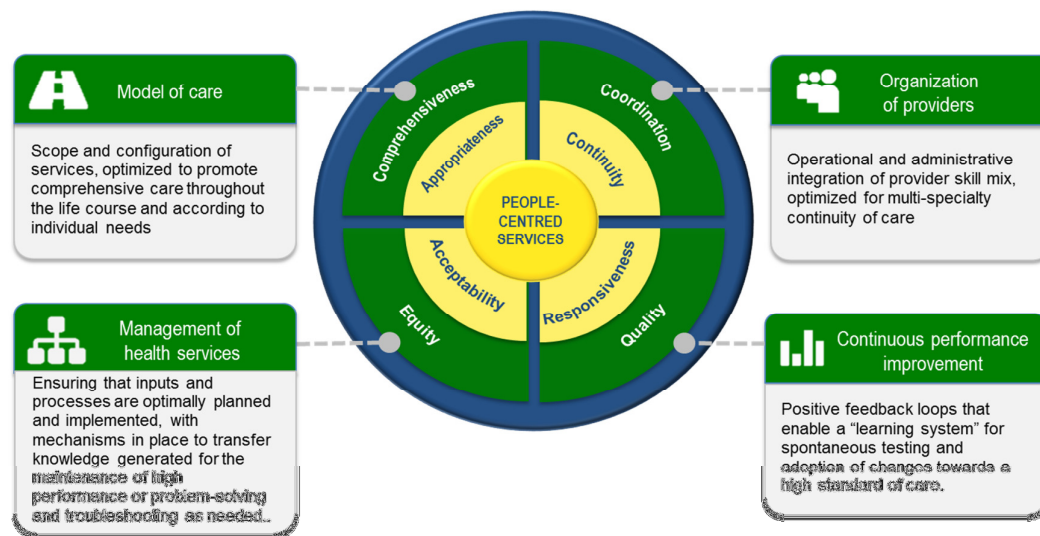
In line with the above, to embark on service delivery transformations we must first have clarity on *what* is the health services delivery function, defined according to those components subsidiary to it that have a significant and causal effect on how services are provided in a comprehensive, coordinated, quality and equitable manner. In other words, those sub-functions that matter significantly to the performance of services and which additionally are subject to change when acted upon across other health system functions.

In the absence of conceptual clarity on the function of services delivery itself, actions to strengthen its capacity will quickly be overwhelmed by the interrelated system functions that have a determining effect on the conditions within which the provision of services takes shape. With no structure for reasoning how the system interfaces with the service delivery function, the logic argument for thinking through system interventions is feeble and lacks the specificity for strengthening services for measurable gains.

The task of this strand of work is then to convey a structure for thinking to the services delivery function that is actionable in its ability to quantify the performance of the sub-function to then be acted upon. In the context of the Framework for Action, the sub-functions are intended as *areas for action*, as an organizing device for identifying causes of health services delivery performance that can then be turned into the basis for policy action.

Through an initial review of the literature, synthesizing existing frameworks and tools, four core sub-functions have been identified and defined as the following, guided by those attributes listed below.

**Figure 5. Health services delivery sub-functions and attributes**



Own source: Health Services Delivery Programme. Division of Health System of Public Health. WHO Regional Office for Europe.

**Table 2. Sub-functions and features of the health services delivery function**

<b>Sub-function 1: Designing models of care</b>
1. Choosing interventions
2. Defining pathways directing the structure of services
<b>Sub-function 2: Organizing providers</b>
3. Aligning structures [referral systems; gatekeeping]
4. Configuration of providers [arrangement; scope of practice]
5. Flow of information in services delivery
<b>Sub-function 3: Improving performance</b>
6. Auditing of services
7. Self-learning mechanisms (opportunities for continuous learning)
<b>Sub-function 4: Managing services</b>
8. Planning services
9. Supervising services delivery
10. Monitoring and evaluation

Own source: Health Services Delivery Programme. Division of Health System of Public Health. WHO Regional Office for Europe.

## Designing models of care

*Selecting interventions and defining pathways for interventions along a broad continuum of care promoting comprehensive services delivery throughout the life course and according to individuals' needs.*

This sub-function calls attention to the selection of what services are provided and how chosen interventions are constructed according to care pathways, protocols or guidelines for the delivery of comprehensive population and individual health care services. With finite resources, there will always be some form of rationing or priority setting needed in selecting what services to devote resources to (ideally on the basis of best available evidence). Where these boundaries are drawn is a first and determining factor for the health services delivery function and its potential to respond to the population's needs.

Historically, selected interventions have taken a reactive orientation, in which patients have an episodic relationship with the health system dictated by acute care needs. This approach to services delivery, however, is incongruent with morbidity and mortality trends at present which demand regular and continuous care with a focus on needs rather than priority diseases. It is well documented the strength of the service delivery function in this regard can be attributed to the spectrum of selected interventions across the full continuum of care – from preventive/promotive services, to diagnosis, treatment, rehabilitation, long-term and palliative care – adopting an active approach to manage physical and social exposures and decrease biological, behavioural and psychosocial risks to ill-health.

In addition to selecting interventions, systems must dictate a path for these services, visualizing how patients flow, making this common and known. How the parameters for this pathway are defined will weigh on the degree to which the design of interventions is flexible and responsive to an individual's needs – the difference between illness or disease-specific service provision and people-centric models.



In the absence of clearly defined models of care, challenges are commonly found to include: discrepancies in core services in terms of both what is provided and how care is delivered; poor adherence or adoption to newly legislated protocols; or limited coverage of services across the continuum of care, most often to the exclusion of public health and social services, or end-of-life palliative care.

## **Organizing providers**

*The coordination of providers to ensure the alignment of mechanisms and structures (e.g. referral systems, gatekeeping arrangements), their configuration (e.g. scope of practice, skill mix) and supporting channels of communication to facilitate the organizational arrangements defined, promoting longitudinal, relational and informational continuity in the provision of services.*

The organization of providers refers to the structure and arrangement of the ‘hardware’ of the system – the who and the where in the production of services – looking specifically to the design of practices or care settings, the alignment of providers across these sites, and how communication flows within and across these networks. The organization of providers is a determining factor for ensuring models of care are actualized, and thus, the extent to which needed services are received at the right time and in the right way, optimizing health results and improving the patient experience.

To treat a patient’s full health care needs, numerous health care providers may be called upon and in different settings – from primary care centres, clinics and community facilities to district hospitals, emergency departments, and highly specialized centres. This network additionally includes outlets for health-related goods (such as pharmacies, informal drug outlets) and other entities (such as mobile teams, community health workers, vaccination campaign teams); each of these providing services in different capacities – for consultation in diagnosis, the development of a treatment plan, counselling or rehabilitation, to name a few. Organizational strategies, like the introduction of multidisciplinary teams and group practices in primary care, or the expansion of provider profiles and their alignment for shared-care tasks may be called upon to optimize these processes and promote the structures and arrangements of providers conducive to coordinating care around the patient.

Challenges to transform the organization of providers may include for example, failure to align payment systems in order to motivate shared responsibilities and linkages between different levels and types of providers, impeding collaboration between primary care services with hospital, social and mental health care.

## **Improving performance**

*Positive feedback loops that enable a ‘learning system’ for spontaneous testing and adoption of adjustments to improve the quality of care made possible through the regular monitoring of services and opportunities for professional development as well as institutional enhancement and engagement of the public to continuously expand and promote health literacy as well as patient and community empowerment.*

Processes for continuous performance improvement refer to those efforts that aim to safeguard the delivery of services, creating a learning system through the monitoring of standardized models of care with systematized feedback loops allowing a continuous critique of the provision of care, as well as opportunities and resources (skills, time, authority) for improvement. The continuous improvement of performance runs counter to the approaches that direct blame for medical errors and compromised patient safety onto individual providers and their performance, rather than calling focus to limitations in the system of service delivery itself.

Creating a system of learning calls attention to the principles of collegiality and autonomy, fuelled by a sense of responsibility, peer pressure and a common transformative culture. Core activities to cultivate this have been described to include regular and reliable reporting on services delivery,

available opportunities for professional development, and for the public, support and resources to promote their active engagement in services, expand health literacy and be empowered to manage their care.

Challenges to continuously improve performance may include: a lack of trainings that are systematized and regulated or trainings that are out-dated and overly medical, rather than supporting non-clinical competencies (e.g. patient-centred care, safety, teams and multi-cultural settings) or an over reliance on technologies and standards, rather than behaviours and processes.

**Table 3. Core attributes of health services delivery**

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**Comprehensiveness.** Interventions meet the needs of the entire population, extending across a continuum, from prevention to diagnosis, treatment, long-term care, rehabilitation, palliative and social care services, for services delivery that is whole-person-focused, facilitating 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 in the context of other needs.

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**Appropriateness.** Appropriate services are those which meet the health needs of the population, with interventions defined such that care provided does not cause harm or suffering and are allocated and organized for the individual.

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**Coordination.** A service characteristic resulting from the well-aligned interface at different cross-sections in the provision of services, ensuring various processes are arranged and evolve to the optimum benefit of the whole. 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.

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**Continuity.** *Informational continuity* relates to an organized body of medical and social history about each patient, accessible to any health care professional caring for the patient; *longitudinal continuity*, which points to a specific locus where a patient customarily receives health care from an organized team of providers in an accessible and familiar environment; *interpersonal continuity*, which is defined as an on-going personal relationship between the patient and the care provider, is characterized by personal trust and respect.

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

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**Responsiveness.** The provision of services that are directly and permanently attuned to an individual's needs and ensure that these are addressed accordingly.

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**Equity.** Health services are managed to achieve equity in access, needs and utilisation through managers that are assigned the necessary authority to pursue planned health objectives and are held accountable for overall performance of results for the population's health and catchment area they serve with a minimum wastage of resources.

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**Acceptability.** The overall provision of services which takes into account the individual service users, to match the provision of care with the persons' needs.

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## **Managing services**

*The oversight of services delivery, managing the content, organization and quality of services to ensure equitable care through inputs and processes are optimally planned and implemented, with mechanisms in place to transfer knowledge generated for the maintenance of high performance or problem-solving and troubleshooting as needed.*

The management of service delivery refers to the oversight of operations in the delivery of care – ensuring desired outcomes are attained, that for a given jurisdiction (facility, municipality, district, region) services are running smoothly, that the right people are in the right jobs, that people know

what is expected of them, that resources are used efficiently and that all partners in the production of services are working together to achieve a common goal. The task of management comprises the thoughtful planning and resourcing (encompassing all resources; human, financial, consumables and technologies) to best direct the provision of care, whether it be for an oblast level tertiary hospital or a singular health house or polyclinic in a rural area. Regardless of the setting, the management function calls attention to how services are planned and the supervisory function of this process ensuring services are produced and delivered with a spotlight on technical efficiency and effectiveness in this process.

The strength of this area's performance weighs in part to the level of autonomy held by managers, dictating their decision-making authority related to budgeting and hiring for example which is ultimately determining of the degree to which services and arrangements are tailored to the community's needs. The authority to trailer services to targeted or stratified segments of the population is one determinant to strengthening the effectiveness of services, ensuring what is provided and how things are organized is in accordance with an individual's clinical risk, health and socio-health needs.

### 3.2 Enabling factors towards people-centred health systems

Transforming the arrangements or conditions of the system for the optimal provision of health services calls on the fundamental design principles of coordinated/integrated health services delivery – a core property for structuring the design of people-centred health systems. While more than the sum of a range of organizational processes (the often-cited notion of care coordination), coordinated/integrated health services delivery is seen here as the process mediating organizational changes in the health systems for more people-centred health services delivery, the vehicle by which people-centred services may be realized (rather than an end in itself).

Health system enabling factors are proposed as those core health system functions specified according to the design principles of coordinated/integrated health services delivery, needed to promote the context for optimal services provision. Through the lens of core system functions, key system enablers and their relevance to health services delivery are proposed in Table 2.

**Table 4. Enabling factors towards people-centred health systems described**

System function	Enablers	Relevance to services delivery
Governance	Accountability	Policy frameworks set the institutional settings in which the service delivery function takes shape. Ensuring the accountability arrangements that are defined are sufficiently dynamic and inter-sectoral, well resourced and tended to through supervision, is a key area to create an environment that is conducive to people-centred services delivery.
Financing	Incentives	Financing systems are determining of the provision of services, incentivizing the use and/or misuse of services. Aligning financial mechanisms that match the design of services delivery that best serves individuals/populations is then a key priority area.

System function	Enablers	Relevance to services delivery
Resourcing: workforce	Competencies	While a workforce in sufficient number/availability is a necessary condition for services delivery, continuously cultivating skills for example, to manage health services, work creatively and effectively, are a key element to strengthening services delivery. This area concerns in particular: the enhanced profiles of professionals; patient health literacy (as a provider of personal care services); strengthened communication skills; and strong leadership and managerial competencies at various levels and settings of care.
Resourcing: information	Communication	The effective gathering of information is essential to the provision of services, however, it is 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 area concerns for example: the coordinated generation of clinical data, the use of information technologies, and the monitoring and feedback of performance information.
Resourcing: Technology and Pharmaceuticals	Innovations	Equipping the system with optimal resources, including ICT, medicines, medical technologies, is central to ensuring the supportive structures, pathways, and channels for the provision of services are in place. 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.

Own source: Health Services Delivery Programme. Division of Health System of Public Health. WHO Regional Office for Europe.

### 3.3 Leading transformations

Given the complex nature of health and 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 for transformations.

#### **Lessons learned from implementation – key success factors in the process of change**

Drawing from country case studies, those key factors found determining of the success of implementation efforts are summarized as follows – noted then as key areas in the process of transformations where attention is needed and where the Framework for Action will call attention.

**Table 5. Key success factors in the process of change**

<b>Factor</b>	<b>Purpose</b>	<b>Key actions</b>
People	Engage and empower people for active health and wellbeing	Encouraging people to take active interest in the design and organization of the health system, motivating professionals to lead change; empowering people to make healthy choices and actively engage in building healthy communities; involving people in the planning and designing of the health system as a whole, as well as their own care.
Culture	Change and transform values, cultures and behaviours	Transforming and fostering attitudes, values, organisational and professional cultures conducive to holistic and integrated service delivery, thus ensuring sustainable change; enabling distributive and inclusive leadership to support the change process and inspire people to work towards a common goal and creating a common narrative and a common sense of purpose.
Leadership	Cultivate a bottom-up, top-down approach	Packaging and communicating extensively the reasons for change; taking a 'planned' approach to change; meaningfully engaging, empowering and continuously motivating management as the implementers for reforms; and avoidance of change silos.

Own source: Health Services Delivery Programme. Division of Health System of Public Health. WHO Regional Office for Europe.

### **Change management: step-wise approach to transformations**

To proactively support linkages to concepts and practical actions informed by the experiences of others, this last strand of work seeks to convey a prioritized list of tasks (as a manual for change), validated by and enriched through the first-hand experiences of countries.

In preparing, this work aims to narrate the following three key processes for leading and managing services delivery transformations. These processes are backed by the literature on leadership and governance and further specified through the synthesis of country experiences in leading and managing service delivery transformations as those tasks where policy makers and managers need to concentrate their efforts to steer services delivery towards improved performance. Core processes to be described:

#### **Driving and designing**

What makes an idea's time come? How do transformations take shape? In health, signaling priorities is a critical issue, given the large number of diseases that compete for treatment, research, funding, the variety of facilities and protocols for treatment, and the multiple economic and social determinants of disease. Setting priorities, proposing a solution which is technically feasible and aligned with commonly accepted priorities, and cultivating a climate for change, by garnering the interest/buy-in of stakeholders, are among those key technical and highly political processes of advocacy and negotiation to be undertaken.

**Figure 6. Leading health services delivery transformations**



Own Source: Adapted from WHO Regional Office for Europe (2013). WHO EURO Health Systems Governance Learning Package. Participant Handbook. Copenhagen: WHO Regional Office for Europe.

### **Implementing and enabling**

What are those system-enabling factors, activities, or processes that support the organization and management of change; the roll-out of processes? How can a ‘high involvement culture’ be established to ‘channel’ leadership across health professionals and local managers as key agents of change? This second area calls attention to the actions to be taken across core areas of the services delivery function and those system-enabling factors for efforts that are systemic, at-scale, and sustainably embedded within the system.

### **Monitoring and feeding-back**

How can transformations be sustained through the active monitoring of performance? How can stakeholders be held accountable for their actions? This last process calls attention to monitoring and evaluation systems, the production and analysis of information and the use of this to ensure on-going adjustments of services for policy-making, troubleshooting, operational improvement and sustainability. This calls for the conscious measurement and monitoring/evaluation of measures, not as a residual activity but rather one that is defined and integral in the process of transformations. Often leaders are not in a position of having control over the production or flow of information and analysis, and the challenge is then ensuring the feedback of performance is occurring and being acted upon.

## **The WHO Regional Office for Europe**

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