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Meeting Report

Coordinated/Integrated Health Services Delivery (CIHSD) Stakeholder Consultation

Brussels, 1 April 2014

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BACKGROUND

In line with the vision of the new European health policy - Health 2020 - for strengthening health system performance through innovative approaches, a Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) is being developed for the WHO European Region in an effort to answer the health challenges of the 21st century, from changing demographics and increases in chronic diseases to the fast evolving technological advances (http://www.euro.who.int/__data/assets/pdf_file/0005/231692/e96929.pdf?ua=1) Strengthening the coordination/integration in the delivery of services is recognised as playing a pivotal role in both responding to these health needs and in overcoming the shortcomings of existing models of care. It is in this context and in response to the calls of Member States for contextualised, evidence-based policy-options to enable system-wide changes that the development of the Framework for Action towards CIHSD has been created. The Framework for Action is developed through a consultative and inclusive process using a participatory approach to include input from Member States, an Expert Advisory Team and representatives of stakeholders, providers, patients and civil society.

A kick-off technical meeting in February 2014 in Istanbul, convened Member State Technical Focal Points and Expert Advisory Team. The meeting was called for to capture views on the first drafts of the concept note and first results from field evidence from these stakeholders and ensure an appropriate country perspective. Discussions were very useful for ensuring relevance for the Member States, actionability and practicability of the Framework for Action towards CIHSD. The feedback and suggestions provided during the Istanbul meeting informed the revision of the ongoing work and are incorporated into the documents circulated during the Brussels Consultation meeting The report of the Istanbul technical meeting is found at the following link: http://www.euro.who.int/en/health-topics/Health-systems/health-service-delivery/publications/2014/coordinatedintegrated-health-services-delivery-cihsd-.-meeting-report.

In line with the wide engagement of stakeholders, the Coordinated/Integrated Health Services Delivery stakeholder consultation called on the 1st April 2014 in Brussels provided our partners from policy, providers and patients with a unique opportunity to engage in the development process of the Framework for Action. In convening this meeting, a focus was placed on bringing together key stakeholders which have a role in transforming health services to become more people-centred. Representatives from European patients, providers and professional associations had the opportunity to present their perspectives on how to transitions towards a coordinated/integrated health services delivery system and the roles these stakeholders play in facilitating this process. This international consultation provided our stakeholders with a forum to exchange ideas and experiences, and discuss important topics with international experts and country representatives.

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 and stakeholders alike.

MEETING OUTLINE

The meeting programme was organised to provide for ample possibilities of interactivity and input from the stakeholder representatives. After a welcome and the official opening by the Belgian Ministry of Health, Food Chain Safety and the Environment, the morning session highlighted the importance of policy setting, leadership and management for change on different levels, emphasised by examples from Belgium, Israel and the Basque Country. Panel discussions held after each keynote speaker gave the stakeholder representatives and the audience the possibility to discuss the roles and responsibilities of the different professionals, providers, patients and family caregivers. In the afternoon session, special consideration was given to the role of leaders and leadership for change. Finally, the approaches and policies of various international organisations were introduced. These examples highlighted the momentum coordinated/integrated health services delivery has garnered across Europe.

In relation to the discussion on roles and responsibilities of the different stakeholders, special attention was paid to define the different levels of leadership needed to guide the transition towards more coordinated/integrated health services delivery. The roles and tasks of leaders on the different levels (macro-, meso-, and micro level) were outlined and possibilities in supporting the change process to sustainable solutions were introduced.

The consultation gave participants ample opportunity to learn and discuss the role of leadership to support transformational change, on different and across different settings examining the respective roles and responsibilities for leading changes towards an integrated system. The morning illustrated this through Rafael Bengoa's presentation of four case studies, in conjunction with the reflections from CIHSD focal points in Belgium and Israel. In the panel discussion following, participants were given the opportunity to define perspectives on how a change in attitudes and skills were necessary to support the coordination and integration of health services. After lunch, Volker Amelung delivered a presentation focusing on the different levels of leadership from an operational perspective. Following a final panel discussion, the day concluded with an overview of the work programmes from the EU, World Bank, OECD and WHO Europe to support the European countries on their way to strengthened, people-centred health services delivery.

The international consultation provided the CIHSD secretariat with vital input and served as a first-hand feedback loop for the development of the Framework for Action. It is expected that this event reflected in strengthening the document and will contribute to the participatory approach laid out by the Roadmap. The leading topic throughout discussions surrounded the resources needed for leading and managing change while addressing the question of how to change health services delivery and discussing the process needed to do so.

OPENING AND WELCOME

The CIHSD Stakeholder Consultation started on Tuesday 01 April 2014 with a welcome note from the Belgian Ministry of Health, Food Chain Safety and the Environment. Key messages from this presentation centred around the definition of integrated care in practice and how the management of chronic diseases often falls short of the many-faceted needs of the patients. It is instead about the psychology of care and the human factor behind morbidity and mortality statistics, including having the ambition to integrate social services, disease prevention and addressing the challenge of equity in society within a new model of care. This importantly calls for a paradigm shift in thinking about the health system, focusing it on peoples' preferences and needs and transforming it from a cure oriented to a care oriented system.

This holistic approach is also reflected in the WHO Europe's definition of coordinated/integrated health services delivery where the full spectrum of care is considered. 'Services' cut across this continuum at the various levels and sites for the delivery of care and 'settings' from the central coordination of primary care, referrals to secondary and specialist care as well as the continuous support of community, home and social care settings, with linkages across these to local pharmacies and the broad scope of public health at the population and individual level. Thinking across this full spectrum of care, it is possible to organise the delivery of services according to an individual's needs as they move through the health system and following a life-course approach towards people-centred health services.

The welcome note by the WHO Regional Office for Europe reinforced the high importance in the WHO European Region for health systems strengthening through the coordination and integration of services, specifically the interest of our stakeholders and partners to transform health services delivery to become more people-centred and to foster universal health coverage in line with our European Health Policy Framework – Health 2020.

I. HEALTH SYSTEM TRANSFORMATIONS ON THE POLICY LEVEL

Evidence has shown that a strong support from the policy level is necessary to reach sustainable coordinated/integrated health services delivery at scale. The approach and endorsement of CIHSD initiatives from the policy level has so far been diverse within the WHO European Region, with some countries implementing comprehensive national strategies, while some focus on providing a legal framework and still others have not yet addressed the issue on a policy level. The following examples illustrate how the policy level can support health system transformation through active planning and strategic approaches on a national level.

1. Integrated care for chronic and mental diseases in Belgium

Belgium has a long-standing experience with policy initiatives to support CIHSD and has always been an early adapter of WHO Europe's efforts to strengthen health systems. As such, Belgium has already implemented a national strategy to strengthen care coordination for chronic diseases, especially targeting non-communicable diseases, and has started to look at the integration of the patient's perspective and active patient involvement in their care design. In order to bring the different initiatives together, these discussions on improving health services delivery through coordination and integration of care have recently lead to a Belgium conference and action plan working towards integrated care. The aim was to create an integrated vision and improve quality of life, realising that chronic diseases affect not just the health care system but need to be addressed in a multi-sectoral fashion. This understanding importantly included health promotion and primary prevention. The Ministry of Health developed a vision for integrated care inviting external partners and experts to participate in the development process on the assumption that planed changes should take advantage of the existing system and improve its strengths by harmonising practices. Wagner's Chronic Care Model was used as a framework and was adapted to the Belgian context arriving at 6 action based principles:

- *Global medical record.* A tool that supports clinical, non-medical care, patient information, guideline and assessment tools.
- *Care management.* A model that allows patients to stay at home as long as possible by supporting the patient in the organisation of care services and helping them to their entitlements.
- *Multidisciplinary approach.* A principle where health providers cooperate through care coordination both at operational and strategic levels.
- *Quality.* A principle stating that objectives should be defined at the micro, meso and macro level and should not just be focused on medical interventions.
- *Well-trained staff.* Investment in specialised training scheme on integrated health care and also on the empowerment of patients with chronic diseases with access to up to date scientific knowledge.
- *Payment system.* A principle which gives attention to creating incentives to support integrated care.

It was recognized that in order to achieve these aims, Government had to be engaged and co-operation between the federal and regional levels had to be fostered. In a first phase, the integrated care strategy was implemented for mental health care, creating an integrated network of services and including the following domains:

- Promote mental health promotion, disease prevention and early detection.
- Mobile teams for outreach chronic care and acute episodes.
- Functional rehabilitation and re-integration into society.
- Residential care in the community.
- Hospital care.

The aims of the Belgian integrated care strategy were to build on existing infrastructure and bring both residential and hospital care closer to the patient. This enabled providers to better identify and address patient's needs in their own environment. A key enabler of the development and implementation of the Belgian integrated care strategy is the cooperation between all levels of care and of policy making.

Key messages:
- Create a common vision and narrative, which is upheld by all policy makers.
- Define principles and objectives of the integration strategy.
- Build on existing resources and support their strengths.
- Integrate services along a continuum of care (from prevention to rehabilitation).
- Adapt payment mechanisms to incentivise integrated care.
- Start implementation of new integrated care model for a specific patient population.

2. Systems transformations in health services delivery – lessons from implementation strategies

Though health systems stem from differing national contexts, they face similar challenges, including the rise of chronicity and changing epidemiology, ageing populations and restricted resources. To address these, a shift towards a patient-centred system is necessary and has already been initiated in many Member States. The following lessons are drawn from four countries in the Netherlands, Scotland, Northern Ireland and the Basque Country. They reflect the key enablers of transforming those health systems into more integrated and coordinated systems, which focus on the needs and preferences of the patient.

2.1 Centring on the Patient

The foremost component of a successful system transformation towards more coordinated/ integrated health services delivery is an agreement between all stakeholders that care should be centred around patient needs. In order to support this, the following principles were identified as key:

- Patient empowerment
  - Allowing the patient to be as involved or disengaged as they want.
  - Respecting the patient's wishes, not only asking for patient's responsibilities.
  - Including empowerment of the patients' family and informal caregivers.

- Top-down must support bottom-up
  - Especially in mental health, where most of the care is delivered from home through informal channels, the planning of these services needs to start from the bottom-up.
  - Going top-down is too expensive when the quality of care may be higher in the hands of a domestic caregiver.

2.2 Lessons for the policy level

There were common lessons learned and success factors reported by the four leaders responsible for system change in the above-mentioned case studies, which are summarised here:

2.2.1 Create a plan

Implementation of a change process requires a plan. Many describe this as an iterative process but there is a pattern with it. A plan is needed to balance the two different cultures policy makers must balance:
- *Transformative culture.* This concept consists of the big changes needed to actually transform the system.
- *Resist culture.* Its role is to maintain the status quo. Can be addressed by identifying the low hanging fruit and should be represented in a policy maker's

short term agenda, which focuses on pleasing politics and trying to control costs.

2.2.2 Disruptive change

Positive disruption is needed to initiate change, importantly including a power shift from top-level actors towards the patients and the ground level of health services delivery. A key to achieving a positive disruptive change is to know why you are creating change. In order to communicate this, a vision for change needs to be articulated to health system stakeholders.

2.2.3 Packaging

After the policy level has formulated a vision for change, this needs to be packaged and communicated with the reasons for change made clear. For this process to be successful, a broad consultation should be included with health professionals, providers, patients and caregivers as well as local communities to help understand what is needed on each level and how the way forward will take shape. Additionally, this will help to generate the necessary buy-in to create a transformative culture and overcome the resist culture mentioned earlier.

2.2.4 Vision

As outlined, a system transformation process needs a vision to provide structure to the political aims. It must be something that connects with people and communities to create a common understanding and aim, which the relevant stakeholders can all subscribe to.

2.2.5 Better balance of push and pull

In order to achieve change, there has to be a balance between top-down management and the expectation from the bottom-up. An initiative towards more coordinated/integrated health services delivery may be more likely to rise from the bottom-up as these actors are more attuned to local circumstances and are immersed in challenges of the health system on a daily basis. However, the policy level will need to provide a top-down framework and strategy, creating an environment conducive to creativity on the local level.

2.2.6 Distributive leadership

A distributive leadership style shares power across all health system levels, aligning the bottom-up (innovation) and the top-down (standardisation) processes and equip every level with the capacities, power and responsibilities necessary.

2.2.7 High involvement culture

In the process of change, professional groups are often the resistors. In order to address this opposition and get these providers on board, the process of designing the strategy needs a participatory approach, involving all stakeholders in the development and implementation of the change process. Importantly, this approach has two beneficial side effects:

- If professionals take the change up as a cause, the agenda is more likely to outlast political tenure and changes on the policy level as they will gain momentum and drive change on of their own accord.
- It is more likely that mistakes will occur locally. These can be leveraged as additional learning effects without jeopardising the overall strategy.

As outlined above, the policy level should seek early wins by identifying the low-hanging fruit and achieving measurable improvements early on. These will help to convince remaining resistors, garner additional support and provide sustainability for the initiative. Finally, policy makers in charge should aim for the big agenda items by using their political capital and going for a systemic change to strengthen their health services delivery.

2.3 Experiences from Israel

Israel has defined high-quality and efficient health services delivery to all citizens as a priority measure. In order to achieve this goal, it has based its health services delivery on four health management organisations (HMOs), which serve to bring health insurance and health services provision under one organisational roof. Through these HMOs, universal access to a predefined package of services is guaranteed. As the concept of an HMO predetermines integrated and

coordinated services, Israel has also a long-standing experience with designing organisational solutions that answer to the needs of the clients and comply with the regulatory framework of the HMO.

However, the challenges facing the Israeli system are very similar to the one's encountered in other countries, namely:

- Lack of resources.
- Limited staff.
- Inequities in access to care across the country.
- Raid discharge from acute care.
- Fragmented health care services.

In order to tackle these challenges a policy promoting coordinated/integrated health services delivery was introduced and began by allocating funds to the HMOs to reduce re-administration rates. The Ministry of Health soon realised that a reallocation of funds was on its own insufficient to improve health services delivery. In response to these shortcomings, an agreement was made between the Ministry of Health and the HMOs tied to outcomes of medical care. This was accompanied by an evaluation, examining which services could be transferred from the hospital to the primary care setting.

In summary, five main areas were improved by these efforts:

- *Electronic Health Records (EHR).* A national network of EHRs was implemented so that general practitioners could access all the health information from their own work and from the hospital sector.
- *Quality.* The system is based on accreditation, including integrated auditing. This includes that a patient is followed along the care pathway and the flow of care services are examined rather than just looking at the organisation of the system.
- *Mental health.* Mental health services will be added to the HMO portfolio, which currently insures only physical health. This entails a change in the insurance scheme so mental health is provided for.
- *Virtual department.* Creation of a virtual department where morning rounds and check-ups are done virtually with patients in the community, so they don't need to come to the outpatient centre of the doctor's office.

Following this presentation, a plenary discussion reflecting on both the lessons from implementation (2.2) and experiences from Israel (2.3), were highlighted and the key messages of the presentations summarised:

- *Role of the patient.* There was general appreciation expressed that the traditional bureaucratic approach is slowly being replaced by a more inclusive one, better reflecting patients' needs.
- *Complex adaptive approach.* The theory of complex adaptive systems and the practical complex adaptive approach were highlighted as being of value for the design and evaluation of integrated care, giving the flexibility necessary to create an environment conducive for patients to have a steering role in the process. It has been stipulated in research that a complex adaptive system underlies many of the concepts of transition towards more coordination and integration without being explicitly named.
- *Balance between top-down and bottom-up.* Releasing power from the top and transferring it to the bottom makes politicians uncomfortable, yet this is how innovation grows and is a necessary step towards scaled and sustainable system changes.
- *Community care.* There is no one model for good community care and its components are still under development. Some messages are already quite clear such as a need to redistribute services between the hospital setting and the community while at the same time redefining the roles and responsibilities of the different settings. It is also recognised that improvements in community care need to come from grass roots innovation. While the role of the payer is acknowledged, it is emphasised that to design these kinds of integrated care initiatives community members, who know and understand the needs of their local level best, should identify which services are to be put in place and how.

3. The roles of the stakeholders within Coordinated/Integrated Health Services Delivery (CIHSD): working together for people-centred care

A key aim of this meeting was the solicitation of feedback and input from the various stakeholders involved in health services provision, representatives of the European Patients Forum, Eurocarers, the European Forum of Nurses Associations, WONCA Europe, the European Forum of National Nursing and Midwifery Associations, and the European Forum for Primary Care were invited to define their respective roles within a more coordinated/integrated health services delivery system. It is acknowledged here that this is not a comprehensive list and further efforts will be undertaken to receive feedback on the Framework for Action towards Coordinated/Integrated Health Services Delivery from other stakeholders in the future.

3.1 The roles of the stakeholders

One of the key achievements of successful coordinated/integrated initiatives is the definition of clear roles for the stakeholders and partners involved. An agreement on who does what, when and where, and how information is communicated, naming responsibilities and clarifying tasks are vital prerequisites for a coordinated service delivery. But how do the stakeholders themselves see their role within such an integrated system? This question was discussed in detail with a panel of stakeholder representatives

3.1.1 The role of the European Patients Forum

The EPF emphasised the need to approach the reduction of the burden of chronic disease with a whole-of-system perspective and use an upstream view, meaning a bottom-up approach along the patient pathway. Its role is to advocate for the patient, to ensure the health system produces better results and the patient is more involved with their care.

3.1.2 The role of the informal caregivers

As informal caregivers are vital providers of health services, it is especially important to watch for the system being exploitative of carers. Particularly when the quest for efficiency may mean increasing the pressure on informal carers by reducing 'formal' health and social services, caution needs to be paid to adequate support and involvement in the care planning of family caregivers. It is necessary that policy makers and health system actors are aware of this effect, as it raises the risk of the carers themselves becoming chronically ill. To counteract this escalation, it is necessary to allow both models to exist in parallel: one where family members are empowered to take care of their loved ones and one where they are provided with adequate support from the formalised health system. The formal and informal service providers need to blend, calling for flexibility from the engaged professionals. Finally, patients should always be seen in the context of their family and care network.

3.1.3 The role of nurses and midwives

In many systems, nurses are still underutilised in their capacities to manage, inform and support patients and their caregivers. With the need recognized in most countries to have a professional close to the community providing care, the roles and responsibilities of nurses should be redefined and their scope of activities broadened to reflect the demands of integrated health services.

3.1.4 The role of primary care physicians

Physicians should be called on to play an important role with health literacy and health education using an integrated primary care system to address multi-morbidities. Such a system is believed to be the most adequate to accomplish people-centred delivery of health services. Their representatives also call for GPs to advocate for education and equity to politicians, calling upon them to invest in education as it is seen to be the starting point for better and more equitable health.

3.1.5 The role of government and organisations

All stakeholders agree that there is an urgent need to address equity issues on multiple levels, especially considering the following:

- *Social determinants of health*
  There is a huge social gradient, the impacts of which start early in life. We need to reconcile the focus on a healthy life cycle and begin focusing on living circumstances.
- *Too many policy goals are focused on quantity.*
  These goals need to shift towards a focus on quality in terms of the individual patient and see to what extent we can concentrate on reaching these goals. We need to shift our system indicators to reflect these changes.
- *Common challenges*
  The fragmentation of health services and setting is reflected in the structure of the organisations representing patients and caregivers. They fail to speak the same language or to combine their messages to reach common goals. System representatives need to be engaged in dialogue using common terms to all professionals.

3.2 Shifting away from disease-specific focus

For a long time, there has been a focus on integrated care as a disease specific approach and integrating these services within a so-called disease management programme. This approach misses the point of integrated care. Instead, we need to begin applying models that are based on people with multi-morbidities and need to begin considering how these could function according to the needs of the people. It is important to identify the most appropriate care and to understand the aims the patient wants to achieve. The disease-specific focus creates a new kind of inequity – an inequity of disease where the diagnostic label becomes your access ticket to services regardless of your functional status.

Throughout discussions, it was argued however that the disease-focused integrated care should not entirely be dismissed as it may provide learning points from which the system can build. Every opportunity to strengthen and improve health services delivery should be considered, not only those that are perfect. While transformative change is a nice ideal not everyone is convinced that it is a viable response, questioning whether we should be aiming for incremental and more practical changes.

3.3 The challenges of equity and prescription of medication

It is underlined that medicine and medical prices defer drastically across the European region and there is a need to economise by advocating for and incentivising more adequate and rational prescription practices. It is also suggested that we are over-reliant on new technologies and we engaging in thorough assessment as to when these solutions are needed and when a social intervention has a better value. Furthermore, not enough valuable information on the medicines and medications being prescribed is currently available. We need to start collecting better data on the appropriateness of their utilization, enforcing the transparency of clinical trials and the strengthening of health technology assessments.

3.4 Adequate communication strategies

There is an urgent need for the adequate packing of these messages on integrated care and four key parts of which were identified:

- Right to access to European social union to have a salary above the poverty line.
- Strengthening education and investing in inter-professional education.
- Strengthening integrated primary care sector and ambulatory care sector.
- Placing the patient in the centre of the process and move towards CIHSD.

The question remains whether it is possible to package this as one message seeing that the different organisations and stakeholder groups act on different levels and don't start from a common position. It is suggested that these barriers to CIHSD could overcome through the formulation of a social contract.

3.5 The barriers to integrated care

There still remain additional barriers to implementing integrated care. The following have been identified by the stakeholders:

- We are still trying to discover and learn about which models best deal with multi morbidities, and the process is far from being completed.
- A key challenge remains in how to address both the workforce of today and the workforce of tomorrow. This calls for a combined long-term and short-term planning for human resources for health.
- Many health care systems within our region are not yet ready to support and discuss integrated care because they are lacking access to basic services and resources.
- Numerous limits to the scale up of CIHSD initiatives were identified:
    - Small initiatives developed by communities may be difficult to scale up as they are considered the "prize child" of the community, which communities are often resistant to give up in favour of a standardized approach
    - Small and local initiatives may also fly under the radar because they are not promoted. When they do get scaled up they may begin to cause disruption to the political agenda.
    - There is still limited communication between health system actors, providers and users.
    - There is a lack of innovative practices and we are focusing on transferring hospital services to the community when we actually should be thinking bigger than that. We have an opportunity to completely redesign care rather than replicate the hospital.

3.6 Factors for a successful scale-up of CIHSD

Finally, the stakeholder representatives were asked to identify key factors for a successful scale-up of CIHSD initiatives:

- *Account for failure.* Implementation plans need to allow room for things to go wrong.
- *Agree on common language.* Policymakers and stakeholders need to convey the same messages and speak the same language. This includes getting rid of professional jargon and aligning messages to be presented to government and policy makers.
- *Make decisions based on evidence.* Outcomes and performance needs to be measured. Decisions about the system should not be based on what we think makes sense, instead we should be designing the system and its actors based on evidence about what we need.
- *Educate and train empowered professionals.* We need to train professionals to be culturally sensitive and act as change agents. The current professional education and training programmes are not consistent with the services we want delivered.
- *Decentralise care.* Communities need more ownership over their local health care systems, allowing them to foster greater innovation. This reflection ties in well with Rafael Bengoa's lesson of requiring distributive leadership.
- *Allow for strong leadership.* A new generation of leaders is needed to take us through the transformation and change process towards more coordinated/integrated health services delivery. Leaders need to be identified within newly designed systems to sustain and manage these integrated services and systems.

With these key messages the panel discussion on roles of stakeholders was concluded and the ground was laid for the further definition and discussion on leadership and management for change.

II. LEADERSHIP FOR CHANGE

The key enabling factors and essential skills for successful leadership during the change and transition process towards Coordinated/Integrated Health Services Delivery need to be defined and made explicit in order to put the right person at the right place. During the discussions on the different challenges and barriers facing leaders during the change process, stakeholders delineated in more detail the different levels of leadership, how to identify the right persons, how to support them and which challenges need to be overcome on a systems level for successful leadership to take shape.

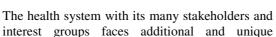## 1. Leadership for Change: how to design and manage CIHSD transition

Looking at the field evidence, successful CIHSD initiatives often relied on a charismatic and inspiring leader to bring about change. These people however were rarely deliberately found or selected, they happen to be in the right position to inspire change based on their own experiences. Is it possible to create an environment conducive for such leaders, and can they be selected and prepared more systematically?

1.1 Theoretical background

Leadership in networks, often found in CIHSD, differentiates itself fundamentally from that of traditional hierarchies. Much has been written on this topic in management literature, with the following overview of key messages from this research.

1.1.1 Leadership vs. management

There still is confusion over the fundamental difference between leadership and management, and they are often confused and misused as synonyms. This difference has very simply been expressed by Peter Drucker: "Management is doing things right, leadership is doing the right thing".

The health system with its many stakeholders and interest groups faces additional and unique challenges. First of all, health care remains over-managed and under-led. Usually, leadership involves influencing a group and changing group practices but in health care it is also about leading organizations and networks of professionals. The management component in turn focuses on these organization's internal processes: creating the plan, staff and the problem.

1.1.2 Key messages for CIHSD from leadership literature

From the literature, two topics are especially relevant for coordinated/integrated health services delivery:

- *The principles of leadership*
  By means of either looking to empirical data or individual examples (e.g. Steve Jobs, Jack Welch), it is examined whether known leaders think differently than 'regular' people, and what qualities and traits make them successful leaders. These key skills need to be specifically identified for leadership in CIHSD as well.
- *Leading networks*
  Leadership in networks is fundamentally different than leadership required in traditional hierarchies. Leadership in networks, such as an integrated care network, requires a greater focus on negotiation and rules when compared to hierarchical qualities where power is linear. For example, in network leadership there needs to be a focus on leveraging resources to distribute when negotiating between organizations, a very relevant aspect when planning to set up a network providing coordinated health services.

1.1.3 Why is leadership different in health

As mentioned above, the level of complexity in health care is significantly higher because there are four levels to be considered:

- Policy.
- Management.
- Professionals.
- Patients and communities.

The conflicting nature of these levels and managing hierarchies in health care further adds to this complexity. Therefore, it is increasingly suggested to think of the health system, and consequently of CIHSD; as a complex adaptive system, which cannot fully be managed and lead as it is impossible to influence or identify all relevant factors.

1.2 Pitfalls of leadership

Based on this acknowledgment, leaders need to be aware of the following pitfalls and need to take adequate action to avoid or address them.

1.2.1 Avoiding system-related pitfalls

Successful leadership creates a value change within the system, accomplishing this necessitates a look at the policy and management level and the sectors and services that are provided. Two aspects are of particular importance:
- In order to overcome potential opposition from them, integrated care concepts need to be seen as a strategic asset, which garner buy in from the relevant politicians and policymakers.
- Leadership in integrated care is a prerequisite and not an add-on. It cannot be done as extra work on the side, but must be a full time position. This necessitates investing in finding and funding this leader, they can not be relied upon to simply appear.

1.2.2 Avoiding people-related pitfalls

Professional groups need to accept that a transition to CIHSD is a fundamental shift, not only in organisation but also in culture. This includes the support of inter-disciplinary teamwork, and the acceptance of transparency as core principle of communication and monitoring, among other things. In order to be successful and overcome opposition, the following actions must be taken into account:
- The change process must be built on a culture of shared values.
- Leadership is required to reach out to the people and getting them involved in planning and implementation (bottom up engagement).

1.2.3 Avoiding organisational pitfalls

Finally, leaders need to understand that there are different professional cultures all working together. The various organisations involved in providing health services follow different goals, to navigate this challenge, the following should be considered:
- Again, a leader in integrated care requires investment. Money needs to be spent on management but it has to be budgeted for – you do not get this for free!
- Leadership needs time.
- Leadership needs to be data driven.

2. Leadership for Change: stakeholder discussion

Reinforcing the idea of stakeholder involvement in the development of the Framework for Action, representatives from the Belgian National Institute for Health and Disability Insurance, the WHO Collaborating Centre on Evidence-based Health Promotion in Hospitals, the European Union of General Practitioners, and the European Network of Occupational Therapists in Higher Education were invited to discuss in more detail the role of leaders and leadership for change towards more coordinated/integrated health services delivery.

The discussions revolved around the following main topics:

2.1 Creating change

The panellists agreed that there is a general need for leadership in order to support changes in health services delivery and for that to happen, there is also a need to create new entities and structures to anchor the leadership function within the health system. For stakeholders to support this change process and for leaders to be successful, the following issues were identified to be essential:

- Leaders need to look for win-win opportunities to take advantage of.
- Policy makers and managers need to identify someone who is accountable for change.
- Leaders, policy makers and managers need to distribute power so people do not fear losing autonomy.
- Policy makers and stakeholders need to experiment with creating integrated policies and working across ministries before we will be able to create integrated care at a national level.
- Data and evidence needs to be readily available to support any change.
- Stakeholders and policy makers need to recognise the leadership role GP's have within the system: they often act as the gate keepers to the system and are an important connection point.
- Leaders need to align the cultural differences between providers, patients, and civil society.

Considering all of these prerequisites, we need to bear in mind that creating win-win situations isn't always possible in integrated care as much of the process means re-allocating resources. Someone inevitably loses out in this process and it is an important leadership role to smooth this transition and advocate to everyone of the advantages and gains of coordination and integration. Another preeminent issue, which was raised by many stakeholders, was the necessity to integrate social policy and public health policy during this change process. Otherwise important levers for improvement are not available. Finally, experience has shown that leading by encouragement, engagement and supervision strongly supports the establishment of integrated care.

2.2 Investing in change

The second topic, which was emphasized by the stakeholder representatives as being paramount for successful leadership was the need to create flexible financial relations to ensure adequate health services solutions at the local level. Here, investments were considered especially relevant in the following areas:

- Investing money in coordinated themes, as opposed to siloed solutions.
- Investing money in leadership for performance.
- Liability and payment schemes need to be aligned with system goals.
- Need to communicate to public that reduced spending does not mean reduced value.
- Call on politicians to recognize that a good health system is costly and that measures to improve efficiency in the long term typically require an initial capital investment.
- Need to invest in education and training: the model that exists right now in almost all countries is based on experience rather than evidence. Hence, we need to design a model based on evidence before we start implementing.
- Need to ensure that we are creating incentives, both financial and otherwise, to help spur cooperation.

Here, it was especially emphasized that clear roles and responsibilities need to be defined. It needs to be clear who is ultimately responsible for the patient and their outcomes.

2.3 Creating a successful network

The panel discussion continued to explore the many facets of leadership by pointing out the importance of creating successful networks. The key issues to do so were identified thus:

- Health promotion needs to be a vital part of patient pathways.
- The effort needed to create a good network is often underestimated – just because it makes sense does not mean it will be easy.

- The importance of defining a common goal and working towards it is underlined, as well as the need to communicate this vision within the network.
- Creating a successful network may also be achieved by setting up forums to share practices and ideas, and demonstrating that working individually will usually lead to each organisation reinventing the wheel, thus wasting scarce resources.
- For a network to be successful, every member needs to feel they have some degree of power or some resources to allocate.
- It is also essential to have a balanced representation when creating network and negotiations need to be balanced across professions.
- It is easier to gain professional agreement when there is proper evidence to support suggestions.

2.4 Leadership vs management

It had been pointed out several times that managers are not automatic leaders, and that it was of utmost importance to view these two roles separately, knowing what to expect from each.

- Leadership is about developing a culture and working with people.
- There is a need to look at how leaders are recruited and how they may be identified.
- For leaders to be successful they need to be granted a certain degree of autonomy and flexibility, otherwise they are over-managed.
- It needs to be recognised that the medical community often wants to steer clear of the management but typically wants to be engaged in the leadership of the health system, without having been trained in either.
- It is important for doctors to be a part of this leadership, as it has been proven that doctor's involvement improves clinical results and financial outcomes.
- A successful leader must have conviction, which is necessary to show that change is possible.

Leadership was also associated with changing values, which lead the panellists to the final discussion point, asking what the difference between values and goals was.

2.5 Values vs goals

Substantial systemic changes necessitate not only the setting of goals, but a change in values more broadly. It is easy during the process of transition to lose sight of these goals amidst the ongoing changes. To keep on track, leaders need to develop common values, which help them to steer towards the final objectives, even if operational goals may change. Values also help to create the cultural change necessary to work towards any long-term objective. It is highlighted that health is part of a broader culture embedded within a specific context. Creating these new system values means understanding the values of the people using the system. Then the next big question arises in how to align provider values with patient values, and how to create a common understanding that can be shared by all stakeholders involved.

III. INTERNATIONAL ACTIVITIES TOWARDS CIHSD

Coordinated/integrated health services delivery has become an integral part of the work plans and strategies of international organisations and institutions. While sharing similar values and reinforcing the necessity for a paradigm shift towards people-centred health services, the scope of work of these institutions may complement each other and provide different angles for similar issues.

1. European Union: Strategies for ageing - Partnership for innovation

The European Union (EU) in its overarching policy 'Europe 2020' has prioritised sustainability and creating new jobs, and identified the transformation of health systems to address the challenges of the populations health needs at present as a key enabler for this policy. This lead to a push towards investment in health, with a focus on developing investment supported by structural funds but also cross border directives; and developing an action plan on the health workforce as part of the social package.

With these measures the aim is to increase the number of healthy life years across Europe substantially. This initiative called 'Health in Europe 2020' is being developed through the European Innovation Partnership for Active and Healthy Ageing (EIP-AHA). Its objectives are to improve the quality of life of Europeans; and to enforce growth.

A bottom up approach to this initiative was taken, intending to identify what is happening on the ground in the EU member states, what is working, what is innovative, and how can these successful examples be scaled up.

Within this Partnership good practices across Europe have already been identified and the practices are currently being analysed to understand how their lessons can help in policy and planning on a European level. The areas of focus are: prescriptions; fall prevention; preventing functional decline; preventing cognitive decline; and age friendly environments.
The Partnership is now working with over 3,000 partners– and has in the process mobilised over 1 billion Euros – to prioritise activities for local implementation, whether it be to improve academia and local knowledge, improve skills and competencies of providers and stakeholders locally, etc. This process has also identified 32 centres of excellence, which work as reference sites for the other partners and support the analysis and prioritisation of local implementation. These centres of excellence emerged out of a scoring of best practices, the ranking being related to whether or not they are achieving specific outcomes related to cost or outcome improvements.
Another aspect of the Innovation Partnership is the twinning of programmes which are working together on similar projects. The idea is to support one another and to share the experiences in scaling up the good practices they have already put in place.

The approach of the European Innovation Partnership for Active and Healthy Ageing is built on the pooling resources and expertise through the platform of over 3000 partners; identifying and recognising excellence and supporting scale up.

The ultimate aim it to have real impact on the triple win, creating benefits of the citizen, the care system, and future growth. As described above this is achieved through mobilising the first hand experiences of countries and sharing these experiences comparably and at scale, using the EIP-AHA platform as a disseminator, multiplier and connector.

Finally, the presentation concludes by mapping out how the programme of the EU will link to national policies. The goal of EIP-AHA is to support and inspire policymakers, managers and health care providers in the EU through the provision of a repository of real practices and first hand experiences. By sharing the lessons learned new priorities for the future may be defined focusing not solely on chronic diseases, but rather on holistic measures towards active and healthy ageing.

2. Organisation for Economic Cooperation and Development: Reviews of health care quality

The Organisation for Economic Cooperation and Development (OECD) has a mandate to support countries in understanding how well they are performing concerning economic and systemic issues. Regarding health, the OECD has prepared a series of reviews based on the indicators for health care quality, with reporting done so far in South Korea, Israel, Denmark, Sweden, and Turkey. In 2014 another 5 reports will be published. Even though these reports are country specific studies, a horizontal analysis is being developed and first lessons learned have already emerged from this exercise.

- *Coordinated/integrated care*
  This topic is much discussed but it has yet to translate into significant benefits and a consideration of the experience of patients with care. These shortcomings may be an effect of the limited ability for these initiatives to scale up the emphasis on local efforts, and a lack of appropriate incentives to pursue integration. In conclusion it can be stated that so far, CIHSD has NOT made a significant difference on the experience of patients with the care delivery system.
  Other challenges remaining are the different types of definitions, concepts and objectives. The example of Norway shows however, that some countries had analysed and structured their problems successfully and thus were able to formulate better responses than others.

- *Primary and community care*
  Every system visited has placed a concerted effort on moving care out of hospitals and instead emphasizing primary care. The challenge here is that the primary care setting is being asked to do more and demonstrate better value for money. The primary health sector too often 'flies blind' in the face of these demands, lacking training, resources and the power to meet system expectations. A good practice was found in Denmark, where through 'DakE', a data repository of common indicators, patients and providers have access to data reported in primary care.

- *Data infrastructure*
  Improving the data infrastructure is seen as the next frontier for sizeable quality gains. There is a clear need for a more systematic approach to care, but databases are limiting the integration of care and countries are still struggling to overcome the legal and technical barriers to coordinated data. As a good example to overcome these challenges, Sweden has linked its different registers so patient records can now be combined vertically across the health system, i.e. from primary health care to specialists, as well as horizontally, i.e. following mental health episodes.

- *Governance*
  The way care is delivered increasingly pulls away from the local context. One can observe a rise of the regulatory state, and since the delivery of care continues to be fragmented central authorities play an increasingly prominent role. But the benefits of this tendency are unclear.

3. WHO Regional Office for Europe: Healthy ageing strategy

Aligning with and complementing the EU's activities, the WHO Regional Office for Europe established a Strategy and Action Plan for Healthy Ageing 2012-2016, which encompasses four strategic pillars:
- healthy ageing over the life course;
- creating supportive environments;
- addressing gaps in evidence and research; and
- ensuring people-centred health systems for ageing populations.

People-centred health systems call for coordinated/integrated health services delivery in order to provide care along a continuum and according to the needs of the individual. In the context of healthy ageing this translates into ensuring partnerships while maintaining a link to a basic package of care to provide support at home and considering the quality of home care services. In providing adequate and people-centred services the conditions needed should be the first consideration, e.g. a strong nursing profession is needed before one can establish a home care sector.

In the WHO European Region even the 'younger' countries are facing ageing challenges with the fading availability of informal care givers and the transformation of family dynamics necessitating more formal arrangements, which still recognise that home care is often most conducive to providing care to family members.

Concerning the interrelationship between healthy ageing and coordinated/integrated health services delivery, the following questions are particularly relevant:

- How to bridge the gap between health and social care when working in different models of care and governance?
- How to integrate/coordinate between formal and informal care and involvement?

Ultimately, it is all about creating supportive environments and here the network of European Healthy cities merits a closer look to receive inspiration. This network is being developed in cooperation with the EU and currently has approximately 100 cities participating, each striving to develop concepts of health and sustainability for their local communities.

4. WHO Regional Office for Europe: A framework for action towards coordinated/integrated health services delivery

In the last presentation of the day, an overview of the further development process for WHO Europe's Framework for Action towards Coordinated/Integrated Health Services Delivery was provided. This Framework is developed in alignment with WHO Headquarters Global Strategy for People-Centred Integrated Health Services, which is currently being revised. The Global Strategy will provide WHO Member States and Regional Offices with an overarching vision of people-centred and integrated health services, whereby all people have access to promotive, preventive, curative, rehabilitative and palliative health services that are provided in a way that responds to their personal needs and preferences, are coordinated across providers, and are of an acceptable quality, effective, timely and efficient.

Currently, WHO Europe is working towards the refinement of the conceptual backing note for the Framework for Action and the country work, while the gathered field evidence generated through case studies will provide practical lessons learned. Another focus has been laid on the process of change management; elaborating on the key issues of leading and managing change towards coordinated/integrated health services delivery as outlined in the discussions throughout the Stakeholder Consultation. Ultimately, the Framework for Action will serve as a resource for technical assistance provided to countries, as well as supporting self-assessment in the Member States to strengthen health services delivery.

In a final plenary discussion, the importance of indicators for integrated care was underscored, but the challenge remains that systems are often not equipped with the right tools to measure this. The added value of CIHSD seemed was easily communicated to all participants of the meeting recognising that there is a whole spectrum of services and settings that can be tailored around the individual's needs. When doing so, one needs to consider the different entry points dictated around the community. Answering the question of how to reach CIHSD, the need to focus on specific goals was endorsed by everyone, followed by the setting of three or four strategic directions towards reaching those goals. Also, it was commonly agreed to use indicators to help create a momentum for change.

CONCLUDING REMARKS

The closing remarks were provided by the host of the event, the Belgian Ministry of Health, Food Chain Safety and the Environment, that reflecting on the presentations and discussions of the meeting recalled the:

- *Need to make a team stronger*
  A strong team requires a common voice and an investment in skills. Active network management is a challenge, but one that needs to be taken on. The process of doing so takes time and requires an understanding of what the end goal is. Leadership is needed to see through this process.

- *Need to develop Networks based on a new culture*
  Networks also need resources and investment but need anchoring to culture and values. This cultural change is needed to create win-win situations.

- *Need to generating evidence and share data*
  The importance of getting the files when and where needed has also been highlighted throughout the meeting. In order to make CIHSD work it is vital to share and exchange data, improve data quality and learn from data analyses.

- *Need to reorganise care models towards integrated care*
  Ultimately, creating integrated care means reorganising care along a continuum, taking a holistic people-centred approach and involving all levels and stakeholders, as well as the local communities to define common goals and values for better and healthier lives.

Annex 1. Scope and Purpose

Background

In line with the vision of Health 2020 for strengthening health system performance through innovative approaches, a Framework for Action towards Coordinated/Integrated Health Services Delivery (CIHSD) is in the process of development by WHO European Region to provide response to the health challenges of the 21st century, from changing demographics and increases in chronic diseases to the fast evolving technological advances. Strengthening the coordination/integration in the delivery of services is recognised to play a pivotal role in both responding to these needs while overcoming the enduring shortcomings of existing models of care. It is in this context and in response to the calls of Member States for contextualised, evidence-based policy-options to enable system-wide changes, that the development of the Framework for Action towards CIHSD has been shaped. To this purpose, a Roadmap has been defined to guide the development process from 2013 until RC66 in 2016, and the process was officially launched by the Regional Director in Tallinn in October 2013.

The Framework for Action is developed through a consultative and inclusive process and a participatory approach which includes input from Member States, an Expert Advisory Team and representatives of stakeholders, providers, patients and civil society. The Coordinated/Integrated Health Services Delivery high-level international consultation called for on the 1st April 2014 in Brussels will provide our partners with a unique opportunity to actively take part in the development process for the Framework for Action.

Purpose

During the Coordinated/Integrated Health Services Delivery (CIHSD) high-level international consultation in April 2014, a focus will be laid on bringing key stakeholders together, which have a role in transforming health services to become more people-centred. Representatives from European patients, providers and professionals associations will have the opportunity to present their perspectives on how to create a coordinated/integrated health services delivery system and which roles and responsibilities pertain to these stakeholders. This international consultation will provide our stakeholders with a forum to exchange ideas and experiences, and discuss important topics with international experts and country representatives.

In relation to the discussion on roles and responsibilities of the different stakeholders, special attention will be paid to define the different levels of leadership necessary to guide the change management process towards more coordinated/integrated health services delivery. The roles and tasks of leaders on the different levels (macro-, meso-, and micro level) will be outlined and possibilities in supporting the change process to sustainable solutions will be introduced.

Finally, an overview will be presented on the progress done so far in the development of the Framework for Action towards CIHSD. Additionally, Belgium as the hosting country for this event will share their recent reform efforts on patient empowerment.

The international consultation will provide the CIHSD secretariat with vital input and will serve as a first-hand feedback loop for the development of the Framework for Action. It is expected that this event will reflect in strengthening the document and will contribute to the participatory approach laid out by the Roadmap.

Main objectives

The meeting will:

1. connect with high-level representatives from stakeholders, Member States, policymakers, and international experts to receive their input and perspective on the Framework for Action;
2. discuss stakeholders' perspectives and roles in supporting CIHSD;
3. present the different levels of leadership for change towards CIHSD; and
4. inform on the progress of the Framework for Action towards CIHSD.

Target Audience

The meeting will be attended by high-level representatives of Member States, international experts, as well as representatives of patients, care givers and provider organisations.

Annex 2. Programme

Tuesday, 1 April 2014

09:00–09:15   **Welcome note and Opening of the Meeting**

- Welcome note by Christiaan Decoster
  Director-General, Department of Healthcare, Federal Public Service Health, Food Chain Safety & Environment, Belgium

- Welcome note by Hans Kluge
  Director, Division of Health Systems and Public Health, WHO Regional Office for Europe

09:15–10:00   **Systems transformations in health services delivery - lessons from implementation strategies**

Chair/Facilitator: Nigel Edwards, Nuffield Trust

The keynote presentation will introduce 10 lessons which can be drawn from analysing different implementation strategies and will thus outline how coordinated/integrated health services delivery can be achieved in practice. It will also highlight the role that policymakers and decision makers need to play in order to support bottom-up initiatives to be sustainable. The discussion will be opened by a statement from the Israeli focal point on coordinated/integrated health services delivery.

- Keynote Presentation by Rafael Bengoa, DEUSTO University

- Intervention by Arnon Afek
  Member State focal point for Israel
  Director, Department of International Relations, Ministry of Health

- Plenary Discussion

10:00–10:30   **Integrated care for chronic and mental diseases in Belgium**

Chair/Facilitator: Liesbeth Borgermans, Vrije Universiteit Brussel

This session will give an overview of the national strategies for chronic diseases in Belgium, which has been developed including all stakeholders and regional representatives. The national strategy on mental diseases is currently being implemented, strengthening patient involvement and redefining the roles of primary and secondary care providers.

- Presentation by Christiaan Decoster
  Member State focal point for Belgium
  Director-General, Department of Healthcare, Federal Public Service Health, Food Chain Safety & Environment, Belgium

- Plenary Discussion

10:30–11:00   Coffee break

11:00–12:30   **The roles of the stakeholders within Coordinated/Integrated Health Services Delivery (CIHSD): working together for people-centred care.**

Chair/Facilitator: Martin McKee, London School of Hygiene and Tropical Medicine

In line with the participatory approach in developing the Framework for Action towards Coordinated/Integrated Health Services Delivery, this session will give the floor to patients, providers and hospital representatives to share their perspectives on how integrated care can be realised and what role they play.

Panellists:

- o Kaisa Immonen-Charalambous, Senior Policy Adviser, European Patients Forum

- o Frank Goodwin, President, Eurocarers

- o Paul de Raeve, Secretary General, European Forum of Nurses Associations

- o Job Metsemakers, President, WONCA Europe

- o Mervi Jokinen, Member of the Steering Committee, European Forum of National Nursing and Midwifery Associations

	o Jan de Maeseneer, President, European Forum for Primary Care
12:30–13:30	Networking Lunch
13:30–15:00	**Leadership for Change: how to design and manage Coordinated/Integrated Health Services Delivery transition** Chair/Facilitator: Elizabeth Bradbury, Advancing Quality Alliance This session will first present key ingredients and essential skills for successful leadership during the change and transition process when implementing Coordinated/Integrated Health Services Delivery. After the keynote presentation, the panel will be given to discuss in more detail the different levels of leadership and how to put the right person at the right place. This panel discussion will include input and questions from the plenary. • Keynote presentation Volker Amelung, Hannover Medical School • Panellists: o Jo de Cock, Administrator General, NIHDI, Belgium o Hanne Tønnesen, President, Health-promoting Hospitals o Katrin Fjeldstedt, President, Standing Committee of European Doctors o Judith de Jong, European Public Health Association (tbc) o Renata Papp, Secretary General, European Union of General Practitioners o Brian Ellingham, President, European Network of Occupational Therapy in Higher Education
15:00–15:30	Coffee break

15:30–16:45	**Activities towards Coordinated/Integrated Health Services Delivery**
	
	Chair: Ellen Nolte, RAND Europe
	
	This session will give an overview of the activities set by different international organisations on supporting integrated care. It will present what WHO Europe and development partners are doing to strengthen health services delivery and answer to the challenges of the 21st century.
	
	• European Strategies for Ageing: Partnership for Innovation
	  Maria Iglesia-Gomez, Head of Unit, DG SANCO
	
	• The Healthy Ageing Workplan of WHO Europe
	  Manfred Huber, Coordinator, Healthy Ageing, Disability, Long-term Care
	
	• Presentation of relevant OECD policies
	  Ian Forde, Policy Analyst in the Health Division
	
	• Development of the Framework for Action towards Coordinated/Integrated Health Services Delivery
	  Hans Kluge, Director, Division of Health Systems and Public Health, WHO Regional Office for Europe
	
	• Plenary Discussion

16:45–17:00	**Closing of the Meeting** Christiaan Decoster Director-General, Department of Healthcare, Federal Public Service Health, Food Chain Safety & Environment, Belgium

Annex 3. List of participants

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav
  Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

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. The Coordinated/Integrated Health Services Delivery stakeholder consultation called on the 1st April 2014 in Brussels provided our partners from policy, providers and patients with a unique opportunity to engage in the development process of the Framework for Action. In convening this meeting, a focus was placed on bringing together key stakeholders which have a role in transforming health services to become more people-centred. Representatives from European patients, providers and professional associations had the opportunity to present their perspectives on how to transitions towards a coordinated/integrated health services delivery system and the roles these stakeholders play in facilitating this process.

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