

# 4th Annual Meeting Report of Integrated Health Services Delivery Focal Points



22–23 June 2017  
Almaty, Kazakhstan





**World Health  
Organization**

REGIONAL OFFICE FOR **Europe**

# **4th Annual Meeting Report of Integrated Health Services Delivery Focal Points**

WHO European Centre  
for Primary Health Care

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Division of Health Systems  
and Public Health

22–23 June 2017  
Almaty, Kazakhstan

## Abstract

Member States unanimously endorsed the approach and areas for action of the WHO European Framework for Action on Integrated Health Services Delivery at the 66th session of the Regional Committee for Europe in 2016. During the three-year period of its development, a forum of appointed technical representatives on integrated health services delivery from all WHO European Member States was established. Meeting annually, together with nominated country delegates and invited guests, this network of focal points serves as a unique platform to share country initiatives, exchange lessons learned and uptake new evidence. This meeting report details the sessions and key discussion topics from the 4th annual meeting of Integrated Health Services Delivery Focal Points, 22–23 June 2017 in Almaty, Kazakhstan. The event's main themes included a focus on performance measurement for health services delivery and, taking a global perspective in partnership with WHO headquarters, a focus on hospital transformations for integrated health services delivery.

## Keywords

HEALTH SERVICES  
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## Abbreviations

EFFA IHSD	European Framework for Action on Integrated Health Services Delivery
IHSD FPs	Integrated Health Service Delivery Focal Points
IPCHS	integrated people-centred health services
LTC	long-term care
PACT	Primary Health Care Performance and Capacity Tool
PHAMEU	Primary Healthcare Activity Monitor Europe
PHC	primary health care
PHCAG	Primary Health Care Advisory Group
PHCPI	Primary Health Care Performance Initiative
QUALICOPC	Quality and Costs in Primary Care
WECPHC	WHO European Centre on Primary Health Care

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## Acknowledgments

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The meeting's technical organization was overseen by Juan Tello with the support of Erica Barbazza, together with other staff and consultants of the WECPHC, including Margrieta Langins, Altynai Satylganova, Ioana Kruse, Evgeny Zheleznyakov, Arnoldas Jurgutis.

The meeting logistics were coordinated by Gaukhar Berentayeva, Rakhat Baibolotova, Connie Petersen, Bakir Bekeshev, Renata Brunner and Susan Ahrenst.

The meeting counted on the participation and technical support of presenters and colleagues at the WHO headquarters and regional offices for Africa, the Americas and Western Pacific.

This report has been prepared by the meeting rapporteur Altynai Satylganova and reviewed by Juan Tello and Erica Barbazza. All photos are by Jerome Flayosc, copyright to WHO.

## Executive summary

In 2016, Member States unanimously endorsed the approach and areas for action of the EFFA IHSD at the 66th session of the Regional Committee for Europe. The Framework calls for action across four domains, upholding the same principles of a primary health care (PHC) approach for people-centred health systems and aligning with the values and strategies developed in the Global Framework on integrated, people-centred health services (IPCHS) and the commitments of the Sustainable Development Goals.

Development of the Framework was supported by inputs from the forum of appointed technical representatives on integrated health services delivery from all WHO European Member States. Meeting annually, together with nominated country delegates and invited guests, this network of focal points serves as a unique platform to share country initiatives, exchange lessons learned and uptake new evidence.

This two-day meeting was held on 22 and 23 June 2017 in Almaty, Kazakhstan. It set out to convene integrated health services delivery focal points (IHSD FPs) and nominated delegates from countries, together with invited experts and WHO staff members, in the tradition of annual meetings and launch the implementation of the EFFA IHSD and Global Framework on IPCHS. The meeting was also organized with a view to the celebration of the 40th anniversary of the Declaration of Alma-Ata in 2018.

Specifically, the meeting had the following objectives:

### 1. Status of PHC in the European Region

- To present the endorsed EFFA IHSD and its implementation package and solicit updates from countries on transforming health services delivery in practice.
- To introduce, discuss and agree upon an approach to describe the capacity and performance of PHC in the European Region.

### 2. Integration of hospitals: global perspective

- To discuss and exchange practices, focusing on integrating PHC and hospitals as a priority gateway for transforming health services delivery in the Region and globally.

Focus of the first day was on updating IHSD FPs on status of the EFFA IHSD, its implementation package and illustrative country practices on putting integrated health services delivery into practice, as well as providing guidance on approaches to depict capacity and performance of the PHC in the Region and its possible application in countries of the European Region. Second day of the meeting had a global focus and set out explore country needs and perspectives on integrating PHC and hospitals.

Key highlights of the discussions can be summarized as following:

- Scope of transformations towards integrated service delivery is highly context specific and change over time but principles in pursuing it are universal; change management and innovation are imperative.
- Ensuring a political buy-in for developing integrated people-centred services delivery requires better evidence on its cost-effectiveness and impact. Investing in ways of



measuring service delivery performance, creating pool of resources and platforms for experience sharing is an important way to introduce, sustain and advance reforms.

- Population and community engagement is not a means to an end in health service delivery transformations but an opportunity to improve access, overcome resistance and improve cultural acceptability of care.
- PHC performance measurement provides an important proxy for diagnosing and tracking country progress in moving towards integrated people-centred health services delivery; new frameworks for performance measurement should build-on the existing ones and be able to capture service delivery capacities in PHC.
- PHC and hospital integration requires finding synergies and exploring innovative models of service delivery where joint accountability for population health outcomes should be a guiding principle and should be outlined in the renewed WHO vision for hospitals.

Outcomes of this meeting will contribute to shaping the agenda of the 40<sup>th</sup> anniversary of the Declaration of Alma-Ata and international conference in 2018, as well as other relevant activities on regional and global levels.

## About the meeting

### Background

The WHO European Framework for Action on Integrated Health Services Delivery (EFFA IHSD) takes forward the vision of Health 2020 and its priority of transforming health services delivery to meet the health challenges of the 21st century. It calls for action across four domains, upholding the same principles of a primary health care (PHC) approach for people-centred health systems and aligning with the values and strategies developed in the Global Framework on integrated, people-centred health services (IPCHS) and the commitments of the Sustainable Development Goals.

In 2016, Member States unanimously endorsed the approach and areas for action of the EFFA IHSD at the 66th session of the Regional Committee for Europe. Its endorsement followed a three-year development and consultation period, first launched in September 2013 in Tallinn, Estonia. During this period, a forum of appointed technical representatives on integrated health services delivery from all WHO European Member States was established.

Meeting annually, together with nominated country delegates and invited guests, this network of focal points serves as a unique platform to share country initiatives, exchange lessons learned and uptake new evidence. In its fourth year, the annual meeting of integrated health services delivery focal points (IHSD FPs) was held for the first time in the context of the implementation of the EFFA IHSD. This meeting was also set in the context of the implementation of the global Framework on IPCHS and with a view to the celebration of the 40th anniversary of the Declaration of Alma-Ata in 2018.

### Rationale

This two-day meeting was set out to convene IHSD FPs and nominated delegates from countries, together with invited experts and WHO staff members, in the tradition of annual meetings and launch of the implementation of the EFFA IHSD and Global Framework on IPCHS.

This Meeting focused on the status of PHC in the WHO European Region to explore demands for tackling acute and chronic care needs in primary care. It was selected in anticipation of the 40th anniversary of the Declaration of Alma-Ata and international conference in 2018 to celebrate this historic event, seeking an evidence-informed understanding of the responsiveness of primary care towards a forward-looking vision for strengthening PHC in the Region.

Priority avenues for transformations towards integrated health services delivery have been outlined in the EFFA IHSD and include integration of PHC and public health services; PHC and hospitals; and health and social services. Given the interest and activity around integrating PHC and hospitals, this stream was proposed as a priority area of focus and was explored from a global perspective during the Meeting.

### Objectives

This Meeting aimed to present and discuss the implementation of the EFFA IHSD, with the following objectives.

#### **1. Status of PHC in the European Region**

- To present the endorsed EFFA IHSD and its implementation package and solicit updates from countries on transforming health services delivery in practice.
- To introduce, discuss and agree upon an approach to describe the capacity and performance of PHC in the European Region with a view to celebrating the 40th anniversary of the Declaration of Alma-Ata in 2018.

## 2. Integration of hospitals: global perspective

- To discuss and exchange practices, focusing on integrating PHC and hospitals as a priority gateway for transforming health services delivery in the Region and globally.

## Outline

Sessions throughout two-day meeting took shape according to the announced objectives of the meeting. Focus of the first day was on updating IHSD FPs on status of the EFFA IHSD, its implementation package and illustrative country practices on putting integrated health services delivery into practice, as well as providing guidance on approaches to depict the capacity and performance of PHC in the Region and its intended implementation in countries of the European Region. Second day of the meeting had a global focus and set out explore country needs and perspectives on integrating PHC and hospitals. To support discussions, case presentations and interventions from Member States and invited experts illustrated experiences and good practices, with expert panels, plenary discussions and opportunities for Member State interventions allowing numerous occasions for interactions and discussion among participants. The complete programme for the event can be found in Annex 1.

## Participants

This event targeted a wide audience totalling over 80 participants. Participants represented 27 Member States globally, with representation including WHO national counterparts, national technical focal points, and IHSD FPs. Also among participants were temporary advisers, invited experts, partner organizations, patient representatives, health and social care providers, as well as staff from WHO regional offices and headquarters, and programme managers from technical units in-house. A complete list of participants can be found in Annex 2.



## Day one

### Welcome and opening

Opening the meeting, the Head of the WHO European Centre on Primary Health Care (WECPHC) shared the objectives of the meeting which combine the conventional platform of reporting on the progress achieved in implementation of EFFA IHSD with a new format on exchanging experiences and perspectives on integrating PHC and hospitals, including a global perspective.

In his welcome speech, Director of the Division of Health Systems and Public Health at the WHO Regional Office for Europe reminded of the commitment that Member States made to EFFA IHSD in 2016. In a year since the unanimous endorsement of the Framework, Member States across the Region have shown steady progress in fulfilling their commitments to the IHSD agenda, transforming their health services towards improving health outcomes and responding to population health needs. The vision of the EFFA IHSD and first progress made through the implementation of the EFFA IHSD provide an important input to the agenda of the forthcoming celebration of 40<sup>th</sup> anniversary of the Alma-Ata Declaration in 2018.

These messages were also echoed in the welcome address made by Coordinator of the Services Organization and Clinical Interventions Unit, Department of Service Delivery and Patient Safety at WHO headquarters. Alignment of EFFA IHSD with the Global Framework on IPCHS should extend beyond conceptual alignment within the region, but also across other regions with the aim of ensuring synergies and providing a global platform for sharing and building on implementation experiences.

The welcome address made on behalf of the Primary Health Care Advisory Group (PHCAG) highlighted the importance of the continued innovation of PHC in working towards integrated health services and people-centred health systems in the WHO European Region. The context of service provision has changed in the last decades with rapidly shifting population needs and expectations, as well as new technologies and digital solutions calling for transformations in ways that services are delivered. In 2016, the WHO Regional Director for Europe established the PHCAG with a vision for it to serve as a source of expert advice and advocacy to champion PHC. The PHCAG held its' first meeting on 20 and 21 June 2017 at the WECPHC in Almaty, Kazakhstan. The meeting provided an important platform for exchanging expertise on responsiveness of PHC and inform a vision for renewed PHC in the European Region. On-going work on implementation of people-centred integrated agenda both globally and at regional level provides a unique window of opportunity for revisiting the PHC agenda and taking stock of lessons learnt since 40 years of Alma-Ata Declaration.

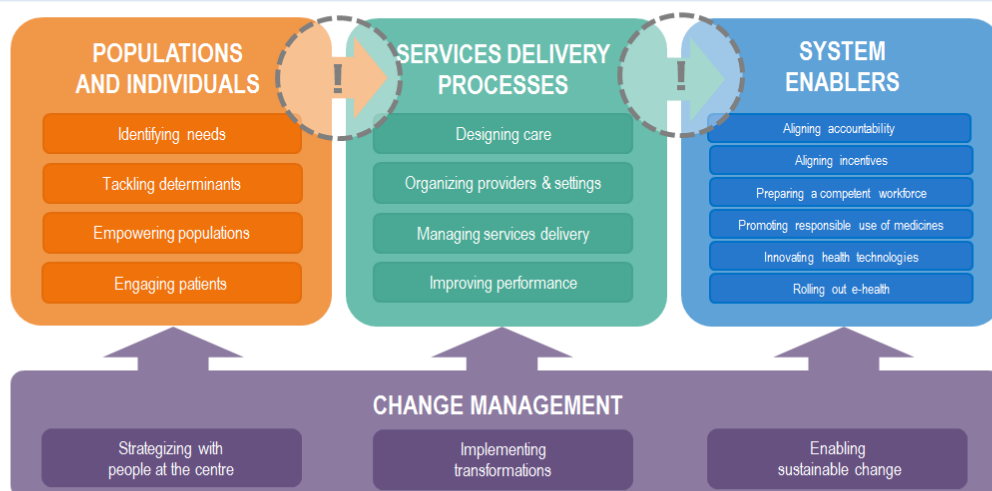
### Address by the WHO European Centre for Primary Health Care

The address by Head of the WECPHC provided an overview of events and activities that took place in the course of one year, setting a scene for the objectives of the Meeting.

In May 2016 a final consultation meeting of the EFFA IHSD has convened over 170 participants from over 30 Member States, as well as wide range of stakeholders such as professional associations, patient organizations and special interest groups. With the inputs of the final consultation, Member States of the European Region adopted EFFA IHSD during Regional Committee for Europe in September 2016. Its unanimous endorsement serves as a

strong evidence of commitment to the IHSD transformative agenda across countries of the Region (Fig. 1).

**Fig. 1. The European Framework for Action on Integrated Health Services Delivery**



Source: WHO Regional Office for Europe

To further support countries in their efforts to put EFFA IHSD into action, an implementation package of relevant resources was produced and launched in 2016. The package consists of policy documents, background briefs, a catalogue of tools, examples of applications and lessons learned, as well as glossary of terms in both English and Russian. Implementation package is a key instrument in strategically and effectively shaping the political narratives required in order to move IHSD forward across the Region and to support decision makers, managers and officials with evidence, experiences and tools in this area (Annex 3).

In this context, operationalization of the WECPHC in Almaty, Kazakhstan and merging with the HSD Programme provided further synergies to the implementation activities of the EFFA IHSD. The Centre's activities cover four core pillars, namely:

1. Knowledge synthesis
2. Country support
3. Policy analysis
4. Alliances and networking

Documenting and sharing the experience on transforming the health services delivery is an important component of EFFA implementation and WECPHC mandate. To date it includes publishing of quarterly newsletters *Crossroads*, annual activity reports (WECPHC 2016) and 'stories from the field' on a dedicated web-page. Collectively, these form a virtual community of practice on IHSD allowing for exchange of ideas with wider range of stakeholders in this area.

This year's annual meeting of IHSD FPs was held for the first time in the context of the implementation of both EFFA IHSD and Global Framework IPCHS and provides unique opportunities for sharing first experiences and lessons learnt. Focusing on the status of PHC in the WHO European Region, it anticipates the 40<sup>th</sup> anniversary of the Alma-Ata Declaration and international conference in 2018 to celebrate this historic event. In this regard, this meeting

seeks to have an evidence-informed understanding of the responsive capacity of PHC in the Region. Integration between PHC and hospitals, given the interest and activity around this area, was another focus area of the meeting.

## **Highlights from countries: transformations in practice**

Avenues for initiating integrated health services delivery transformations provide ways to focus practically on high-leverage entry points in order to accelerate achievement of the desired health and efficiency gains. While their prioritization and dynamics are ultimately context specific, priority avenues for the European Region are in the areas of integrating PHC and public health services, PHC and hospitals, and integration of health and social sectors. This session aimed to solicit updates from countries on putting integrated health services delivery into practice across these focus areas of the EPHA IHSD implementation.

### **Illustrative country case: Comprehensive services delivery reforms in Russian Federation**

The presentation highlighted few examples of IHSD transformations in Russian Federation. Reforms towards integration have been driven by changing population needs, existing large network of facilities with uneven geographical distribution and scarcity of available resources, especially in primary care. Presented examples of service delivery transformations put emphasis on possible variety of solutions and scales in transforming health services delivery in the context of one country. For example, new model of palliative care delivery envisioned integration with social sector and was implemented using a top-down approach, allowing for a rapid country-wide uptake. Other examples aimed at responding to specific population needs in a region like the new models of preventive care for working population in Tomsk region. Multidisciplinary approach to delivery of care has been tested in several pilot projects for mental health and chronic care for multimorbid elderly across the country. Presentation concluded highlighting the importance of comprehensiveness in alignment of wider health system factors for enabling service delivery reforms.

### **Illustrative country case: Integrating primary health care and public health services in Lithuania**

Responding to unhealthy lifestyles, environmental risk factors and the determinants of health calls for integration between individual health protection, promotion, disease prevention services and population-based interventions. In recent years Lithuania has built on experience of service delivery transformations by integrating delivery of PHC and public health services. Transformations were mainly driven by changing population needs and focused on integrated delivery of services at a municipal level. The scale of integration was primarily explained by specifics of health financing in the country and allowed for complementarity of activities at the point of delivery. Experience of integrated service delivery to patients at high-risk of acute CVDs, for example, has shown positive results with 68% of patients reporting improvement in their health status. Other good practice examples include integrated delivery of services to school-aged children and integrated TB care. Alignment of legislation in PHC and public health bureau as well as new accountability arrangements were highlighted as enabling factors for these good practice examples.

### **Illustrative country case: Integrating primary health care and hospitals in Israel**

Integration between PHC and hospital plays an important role in ensuring continuity of care across different settings and better health outcomes. In Israel continuity of care after episode of hospitalization remains a significant problem with only 50% of patients reporting back to their GPs within 3 days, 65% - within a week, and 80% - within a month after discharge. The issue is further exacerbated by limited information available in discharge letters and delays in pre-authorizations on prescriptions and diagnostics between hospitals and PHC. To address these issues, Ministry of Health of Israel launched a comprehensive reform process to improve the continuity of care. Health Information Exchange project launched in 2011 aimed at enabling information exchange across all acute care hospitals and health maintenance organizations. Integrated information system enabled fast transmission of discharge letter to primary care physician (within 24 hours) allowing for better counter-referral and follow-up in primary care. To further support the reform, series of legislative changes took place, making health information exchange mandatory for all health facilities, putting emphasis on continuity of prescribed medicines across settings, and recommending establishment of coordination and planned discharge units in hospitals. Finally, the reform envisioned measurement of care continuity as part of quality of care measurement with concrete solutions being currently developed.

### **Illustrative country case: Integrating health services delivery and long-term care in Norway**

Disabilities, ageing and chronicity call for strengthening integration at the intersection of health and social care for delivery of long-term care (LTC) or home care services. This presentation aimed to show practical examples of applying principles set out in EFFA IHSD to development of integrated LTC strategy in Norway. In Norway delivery LTC is a responsibility of local municipalities with separate financial arrangements outside the health sector budget. This, in turn, results in service fragmentations scattered between health and social sectors with little involvement of PHC in provision of care. Current LTC reforms in Norway were informed by the areas for action set out in the EFFA IHSD. Firstly, it focused on identifying LTC user needs and involving them in design of LTC services. These reforms required change in predominantly bio-medical culture and shifting to notion of 'what matters to patients' in delivery of services. To test the new approach to delivery of LTC services, two new models of care were designed and ready to be tested in 2018. One model of LTC is a based on PHC-led approach, where GPs have a central role in coordinating and delivering care; second - is so called model of 'coordination teams', where GPs are part of a multidisciplinary team along with nurses, physiotherapists and social workers. Crucial role in enabling these reforms is given to alignment of broader health system factors such as improving competencies of workforce to enable new models of care and improving information continuity through National programme for Personal and Connected Health and Care. Management of change is highlighted as integral component of the transformation process; it planned to be achieved through variety of pilot projects, establishment of internal and external learning networks, and continuous engagement and dialogue with stakeholders.

## Session one

### Responding to needs 1: exchanging practices on primary health care performance measurement from past to present

This session aimed to provide contextual background to performance measurement in PHC, taking stock of previous and existing initiatives on regional and global levels.

#### Previous initiatives

##### Regional: the European primary health care performance monitor

PHC performance measurement in Europe accounts for several milestones in the past, which provide an important background for further development of this area. In 1993 group of Dutch researchers initiated an international study on profiles of general practice. This study aimed to discover variations in range of services delivered by GPs within and across European countries, as well as variety of factors that influence the variability in profiles. Later in 2009 a multi-country study on Primary Healthcare Activity Monitor Europe (PHAMEU) was launched, aiming to evaluate the strength of primary care structures and the service-delivery processes. Strength of primary care was measured across dimensions of existing governance arrangements, workforce development, and economic conditions for primary care. Its application across 31 European countries provided a solid basis for comparison and analysis of the key functions of primary care in a standardised way. In 2012, Quality and Costs in Primary Care (QUALICOPC) project was launched, aiming to measure performance of primary care in 34 European countries. The particular focus of the QUALICOPC project is to look at primary care performance in terms of quality, costs and equity, and its contribution to overall performance of the health system.

In the context of this experience and ever growing demand in PHC performance measurement, there are several trends that need to be accounted for when designing and/or updating new performance measurement frameworks. Firstly, the overall focus moved from the notion of general practice to primary care, signifying shift towards multidisciplinary in primary care. Secondly, more and more focus is placed on measurement of processes and not merely structures in primary care. Lastly, international learning networks and increasing number of countries willing to share their experiences of primary care reforms provides a broader platform for primary care performance benchmarking, management, and improvement within and across countries.

##### Country: Applying the Primary Care Activity Monitor in Japan

Japanese health system is characterized by universal coverage, direct access to highly specialized outpatient services, and great variability in range and volume of services delivered in primary care. This presentation aimed to introduce the experience of application on PHAMEU tool with the aim of evaluating the strength and measuring performance of primary care in Japan. Overall experience of applying the PHAMEU methodology to Japanese context provided basis for learning global trends and comparing country performance with other high-income countries; however its validity for better understanding primary care performance within country was limited, mainly due to the limitations of methodology. In particular, assessment of certain economic conditions of primary care and comprehensiveness of primary care services was not possible due to absence of clear-cut line between primary and outpatient specialist care



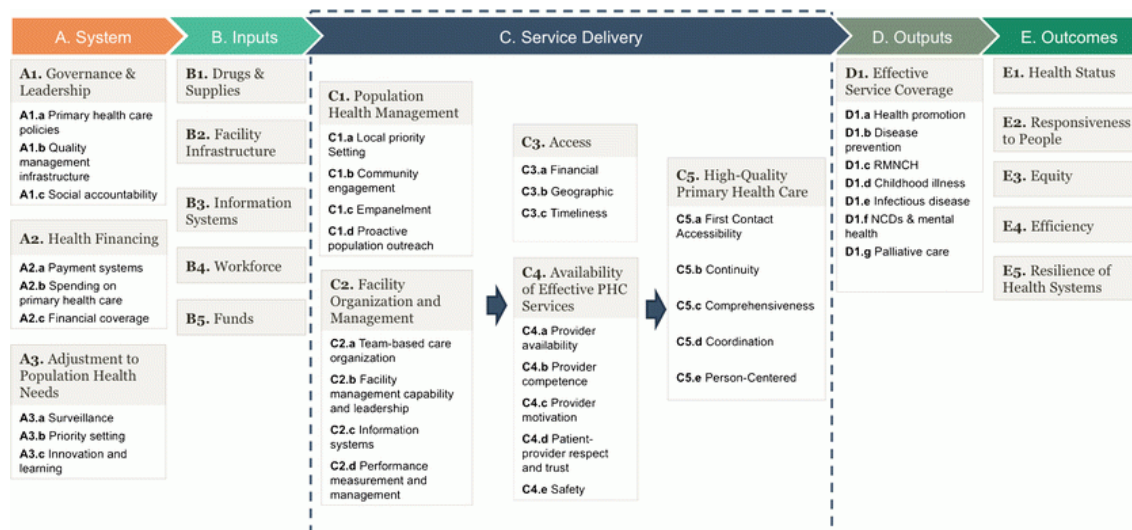
in Japan. Absence of routinely collected and monitored patient satisfaction data in primary care hampered comprehensive assessment of service continuity. Existing methodology of scoring does not necessarily capture specifics of performance and possibly requires a more sensitive approach. Finally, dimensions and indicators of the framework were not able to capture and evaluate newly emerging ways of service delivery such as online consultations and e-prescriptions, which are gradually becoming a common feature of Japanese primary care. These lessons learnt could possibly serve as an input to development of new primary care performance measurement tools and instruments.

## Current initiatives

### Global: the Primary Health Care Performance Initiative

The PHC Performance Initiative (PHCPI) is a new global partnership that brings together country policymakers, health system managers, practitioners, advocates and other development partners to catalyse improvements in PHC in low- and middle-income countries through better measurement and knowledge-sharing. PHCPI aims to help countries track their key performance indicators in PHC, identifying which parts of the system are working well and which ones need attention. It is envisioned to enhance accountability and provide decision-makers with essential information to drive improvements.

**Fig. 2. The Primary Health Care Performance Initiative**



Source: PHCPI website

To guide performance measurement PHCPI Conceptual Framework was developed in order to provide a common definition of PHC components at system, input, and service delivery domains and their influence on outputs and outcomes (Fig. 2). A comprehensive set of core indicators or so called ‘vital signs indicators’ within each domain aim to provide a snapshot of PHC performance in a country. Nationally collected vital signs indicators also provide input into the PHCPI Global Scorecard, which aims to enable international comparisons of PHC performance across countries and over time. First application of the Global Scorecard and input from expert consultation has expanded the number of vital signs indicators to final list of 36 indicators. In light of the upcoming iteration of the Global Scorecard, there a few challenges

that need to be addressed. Firstly, data availability and quality, especially in the service delivery domain, remains a concern with not more than 20 countries globally having complete data available. Secondly, periodicity and modality of data collection needs to be approached with caution in order to avoid burden on countries and allow maximal use of already collected indicators. Lastly, experience of first application showed that single indicators are not able to show an overall performance of the country, so they will be used to produce so called composite indicators that will serve as basis for new edition of the Global Scorecard.

## **Plenary discussion**

This plenary discussion invited country representatives and experts to share their reflections and further experiences on performance measurement in PHC. The discussion raised the following key points:

- Performance measurement should not be treated as means of benchmarking PHC systems, but rather as mechanism for diagnosing a particular system, and subsequently following the time-trend dynamics of performance change.
- Performance measurement is an important proxy for diagnosing areas of PHC that need improvement in a concrete country, but data should be always interpreted in consideration of contextual factors. Performance data also does not provide information on what should be done and should therefore come hand-in-hand with provision of country-specific policy options.
- In assessing the performance of a system on PHC workforce, there is need to shift focus from a system purely based on health workforce inputs to assessing new modes and dynamics of working in PHC, e.g. presence of certain competencies or PHC capacity to retain its workforce.

## **Session two**

### **Responding to needs 2: measuring the capacity and performance of primary health care**

The objective of this session was to provide rationale of and introduce participants to a newly proposed WHO European PHC Performance and Capacity Tool (PHC-PACT) and collect first round of inputs from country representatives and experts.

### **Measuring the responsive capacity of PHC in the European Region**

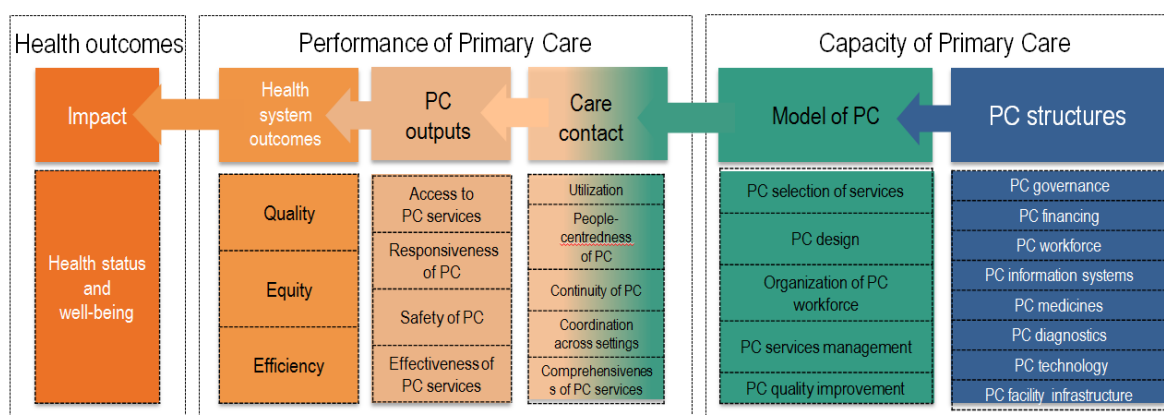
In the context of EFFA IHSD implementation, the Regional Office has responsibility of monitoring its implementation and reporting on its progress every 5 years. Measuring complex interventions such as integrated health services delivery presents methodological challenges. To date, there is no consensus on a specific indicator or framework for its measurement. Nevertheless, there is a tremendous volume of activity and reporting on health services delivery and health outcomes in the context of monitoring frameworks set out within commitments. This includes SDG3, Health 2020 and the recently adopted Global Framework on IPCHS, as well as international initiatives led by development partners, including efforts to measure the performance of primary health care, health care quality and health systems.

In this context, a newly proposed WHO European PHC Performance and Capacity Tool aims to take stock of existing frameworks and experience in implementation of previous monitoring tools, while updating it to capture changes in the model of care over the last years. By doing so, it will draw a harmonized baseline on PHC [IHSD] performance across the region and provide better links between health outcomes to PHC capacity and responsiveness to health and social needs.

### Proposal: A WHO European Primary Health Care Performance and Capacity Tool

PHC PACT is a proposed regional tool for assessment and monitoring of PHC capacity and performance and their contribution to health outcomes (Fig. 3). Assessment of primary care capacity consists of indicators in two distinct areas: structures (e.g. financing or governance arrangements) and service delivery processes that define the model of care (e.g. selection of services or organization of workforce). Performance in primary care is assessed from the perspective of care contact (e.g. continuity) to primary care outputs (e.g. effectiveness) and subsequently health system outcomes (e.g. quality).

**Fig. 3. The Primary Health Care Performance and Capacity Tool**



Source: WHO Regional Office for Europe

A starting point for development of PHC PACT was original outcomes measures of PHAMEU framework and built on experience of previous work on using ambulatory care sensitive conditions (ACSC) as a composite measure of HSD performance in the WHO European Region. To further enhance the applicability of the tool, health outcomes were prioritized according to the existing global commitments and further clustered to identify tracer conditions. Assessing capacity and performance of primary care to respond to needs associated with these tracer conditions will allow to better illustrate association between structures and processes to outputs and outcomes.

### A roadmap to data collection for a region-wide assessment

PHC PACT aims to build on existing performance data collections, avoid duplications and minimize the burden in data collection in countries. To achieve this objective, countries were asked to respond to initial data source scanning questionnaire to understand a baseline of existing data sources and assessments. Together with key informant interviews, this will help in

identification of areas where in additional information needs to be collected. PACT is planned to be first tested in several selected pilot countries to validate and fine-tune the proposed methodology. Results of first application and data analysis will be reported to Regional Committee of the WHO European Region in September 2018 and subsequently presented during 40<sup>th</sup> Anniversary Meeting of the Alma-Ata Declaration in October 2018.

## **Plenary discussion**

This plenary discussion aimed at collecting input from country representatives and experts on proposed objectives and methodology of PACT tool. Following key messages emerged from the discussion:

- Issues of data availability, quality and fragmentation in primary care are similar across most of the countries in the Region. To address these requires indirect methods of data collection (e.g. hospitalization data) and triangulation with data obtained outside the health sectors (e.g. social sector).
- Avoiding data collection burden in countries and building on the existing data sources is essential in success of the tool. Therefore, a suggested set of core and optional indicators can be solution, especially in countries with limited capacities.
- Data and indicator definitions vary greatly within the Region. It requires alignment across countries and a thorough reflection on comparability of data after first pilot studies.
- Numerical data does not always reflect situation in a country, so there should be a way in ensuring an adequate representation of qualitative data in the tool.
- In the context of the EFFA, it is important to further invest in understanding how each domain contributes to the integrated health services delivery. It is, perhaps, needed to create a ‘composite measure of integration’, which will allow presenting and understanding multivariate data.
- Many countries are in process of reforming PHC and establishing respective monitoring systems. It is be therefore important to ensure that they are aligned with those of the PACT tool in order to enable synergies in data collection.

## Day two

### Session three

#### **The role of hospitals in responding to health needs: an overview**

Second day of the meeting set out to discuss and exchange practices, focusing on integrating PHC and hospitals as a priority gateway for transforming health services delivery in the Region and globally. This session aimed to set the scene for the following sessions by providing an overview on the evolving role of hospitals in the context of the integrated and people-centred health services delivery.

#### **Vision and role of hospitals as part and parcel of integrated and people-centred services**

Hospitals as setting of care represent a key component of every health system and their contribution to health outcomes cannot be undermined. However, hospitals, in their existing form, are continuously challenged by changing population needs and expectations, while faced with variety of health system constraints. In the context of UHC and integrated people-centred service delivery agendas, existing role and function of hospitals requires change. Transformations require paradigm shift in how hospital services are organized and delivered, which means that organization of hospitals in traditional 'organ silos' needs to be challenged and transformed to a more responsive model of care that accounts for multimorbidities, engages patients in care process, and works in partnership with community. Transformations also require vertical integration with PHC and addressing growing fragmentation between inpatient and ambulatory settings. WHO's Global Framework for IPCHS provides conceptual guidance on how drive and foster these transformations in practice.

#### **Illustrative case: A patients' story on hospital experiences**

Majority of hospitals do not have culture of and space for engaging patients in the care process, but it has a great potential in doing so and has proven positive effect on health outcomes. There are several examples of how patient feedback can impact hospital transformations, making them responsive to needs. Such examples include Poland where hospitals have so called 'communication corners' or Oman that has 'patient feedback boxes'. However, engaging patients in design and delivery of hospital care requires a more systematic approach and alignment with wider health system factors. Growing burden of chronic diseases, for example, requires shifts in how patients are discharged and prepared to transition to ambulatory settings; growing risks of polypharmacy among multimorbid patients requires that hospitals take an active role in medical reconciliation of prescriptions during episodes of hospitalization.

#### **Illustrative case: A managers' story on hospital transformation journey**

This presentation aimed to share the experience of transformations in Changi General Hospital in Singapore. Changi General Hospital was challenged with high levels of unpredictability due to high numbers of emergency-based hospitalizations due to self-referrals (80-85% of all hospitalizations). Change agenda has been driven by understanding that hospital-centric care is not sustainable and needs to adapt to changing population needs and demands, while acknowledging that community-centred model of care is not viable without integrating hospitals. To address this problem Changi Hospital closely worked with GPs to improve availability and accessibility of services in primary care. Reform has also been supported by

alignment of financial incentives, which resulted in 9.7% decline in number of self-referrals and 92% patient satisfaction.

Another avenue of transformations included development of an integrated model of outpatient care for complex patients. The new model of care envisioned development of an integrated treatment plan, multidisciplinary ward rounds and fast track referrals and resulted in improvement of health outcomes. New technologies are seen as strong driver for transformations in hospital sector: Changi General Hospital has piloted telemonitoring for patients with heart failure at home. In chronic care, telemedicine is used to provide proactive personalized education and support to patients by dedicated trained hospital nurses. These examples show that it is possible to transform hospitals towards more responsive integrated services delivery, but it requires strong leadership and vision for transformations.

### **Illustrative case: Countries' path to hospital sector transformation**

This presentation was set out to provide an illustrative country care on hospital transformations in Estonia. Until recently, hospital reforms have very much focused on structural reforms and far less on service delivery aspects of care. With the launch of the Strategic Plan on Integrated Care in Estonia in 2014, focus has shifted to ensuring integrated approach to services delivery in hospital sector with aim of connecting hospitals and other settings of care. Reform activities were directed towards better linking tertiary care hospitals with smaller county hospitals to enable exchange of practices and improve continuity of care. EU structural funds were used to bring primary care practices together and transforming small county hospitals into outpatient multiprofile clinics that are more responsive to population needs. Improving patient pathways along the continuum of care from community or social care settings to hospitals was also piloted as part of the reform. Sustainability of change and adjustment of wider health system factors were named as one of biggest challenges in hospital sector transformations.

### **Buzz session: Taking stock of innovations in participants' respective countries**

This plenary session aimed to provide a platform for exchange of innovations and ideas on transforming hospital sector by answering the following questions: How have hospitals strengthened internally to deliver highly complex care efficiently, with high quality and positive patient experience? How have they developed new roles and established new ways of crossing professional boundaries and strengthening linkage with primary health care and communities? What are the means of ensuring that hospitals embrace their social responsibility to contribute to the health and development of their local community? Representatives of countries and experts provided succinct interventions on these key questions, raising the following key points:

- **Innovations for better organizing around patients' needs.** Changing patient needs and expectations require innovative ways of organizing and delivering services. Collecting patient feedback by means of collecting routine or ad hoc patient satisfaction data can be an important starting point. But it should come together with a mechanism that allows to systematically analyse collected data to inform service delivery transformations. Enabling an environment where patients can have dialogue with facilities can be a game changer in understanding a direction for transformations, but it requires a substantial cultural change. Transformations also require that culture of collecting patient feedback and engaging patients is translated into communication standards and core service values in hospitals.

- **Innovations for coordinating with other care providers.** Better coordination across providers and levels of care requires challenging of the existing hierarchies and finding new ways of working. Lack of communication between GPs and hospital providers often lead to uncoordinated services delivery, duplication and inefficiencies. Creating a platform that allows for exchange of information between providers is one way of addressing this issue: establishment of professional chats between GPs and hospital physicians in Israel or investing in improvement of patient record interoperability across settings in Spain. Coordination can also be improved by introducing innovations that facilitate patient transitions between settings, such as for example ‘planned hospitalization centres’ currently being piloted in Russia; these centres coordinate hospitalization process by connecting all parties involved. The ultimate objective in improving coordination across providers should be seen from the perspective of its contribution to improving patient outcomes. Netherlands is currently working on extending and standardizing data collections on patient reported experience-PREMs and patient reported outcomes-PROMs beyond hospitals. Joint accountability arrangements can be an enabling system condition for improving coordination and integration across provider groups.
- **Innovations for increased sustainable local development.** Hospitals have a strong leverage to transform health of the local communities. Innovative services delivered in partnership with civil society offer wider service coverage. E.g. integrated service delivery between hospitals and volunteer organizations has shown positive outcomes in current project addressing end of life issues in Hong Kong. Delivery of integrated services can also often mean bringing services outside the hospital walls and designing innovative ways of delivery, such as mobile clinics and medical trains often used in remote areas of Kazakhstan. Village health committees practiced in Kyrgyzstan often partner with hospital providers for early disease detection initiatives, which allows better population outreach. Partnerships and engagement should be however enabled by wider health system arrangements.

## Session four

### Responding to health needs 3: first-referral (district or community) hospitals in practice

First-referral hospitals are also often referred to as district or community hospitals and provide services at the interface of PHC and highly specialized care. Proximity and accessibility of this type of hospitals make them a critical component for a well-functioning health system. In the context of current hospital reforms, the role of first-referral hospitals have been continuously questioned, forcing them to restructure or take up new roles. The focus of this session was to explore and understand the role and characteristics of integration between first-referral hospitals and PHC and their unique value-added in achieving UHC and SDG goals.

### Review of literature on the role of district hospitals: key findings

This presentation introduced results of a literature review on role and function of first-referral hospitals across high-, middle- and low-income countries. There is a significant variability across countries in size of serviced population and range of services delivered in first-referral hospitals, which in turn defines the role that they play in overall architecture of the health services delivery. In some countries district hospitals provide a wide range of outpatient services

such as rehabilitation or palliative care, while in others provide more specialized clinical care with heavy focus on provision of surgical care. Research findings also show that district hospitals have a unique flexibility in adjusting and transforming themselves according to population needs: in some countries they are moving away from delivery of purely clinical services to becoming ‘community hubs’ that deliver services across health and social sectors, closely linking with local communities. Examples of such good practices show that district hospitals have a great potential in driving the integration initiatives and have a coordinating role between PHC and highly specialized hospitals. In the context of rising healthcare cost, role of hospitals should not be just seen from the perspective of economies of scale, but also from its unique and symbolic role at the forefront of integrated care and achievement of UHC. Such transformations require sustainable hospital policies specifically addressing issue of small district hospitals, development of specific competencies and retention policies for health workforce, and new financial arrangements.

### **Illustrative case: Community engagement and patient-centredness in a district hospital in Thailand**

This presentation shared an experience of transformations in Wangpa District Hospital in Thailand. The community engagement activities of this district hospital included a wide range of areas such as prevention of NCDs, delivery of people-centred palliative care services and capacity training for patients with blindness. A distinct feature of these transformations was their ability to account for cultural and religious factors and using them to improve acceptability and effectiveness of interventions. For example, co-participation of religious leaders in delivery of tobacco cessation programmes has resulted in 59% of success rate among participants of the programme. Creating an environment, where patients and their families can have a dialogue with care providers, has allowed a more patient-centred model of palliative care. The overall outcome of reforms has increased community capacities in articulating their needs, providing input to the design and delivery of care, and established networks with local governments and other stakeholders.

### **Plenary discussion: Functions and features of a well-functioning first-referral hospital**

Country representatives and experts were invited to share their perspectives on topics pertinent for a well-functioning district hospital with discussion focusing on experiences of transformations and health system factors that facilitate or impede their effective work. Interventions following touched upon lack of common understanding in role and functions of first-referral hospitals, competition for resources with PHC, and the unique role that district hospitals can play in provision of services in mental health, chronic and long-term care. Key messages of discussion were following:

- **Flexibility and responsiveness as distinctive features of first-referral hospitals.** Functions and model of care to be delivered in district hospitals is a context-specific issue and depends much on the population health needs and wider health system factors. Depending on those needs district hospitals can acquire variety of roles in provision of services, e.g. in provision of first line inpatient care such as acute or elective surgical care, while in some countries district hospitals will need to transform in delivery of palliative, rehabilitative or long-term care services.
- **Standards of care need to be clearly defined.** Role of district hospitals can be strengthened by developing clear standards for their work and defining type of



workforce competencies that should be aligned to those standards. This, in turn, can address current issues of quality and overprovision of hospital care, as well as improve overall continuity of care.

- **Community collaboration is a key avenue for transformations.** Collaboration with community leaders and alignment with traditional and religious norms has a high potential to improve awareness of community expectations and cultural acceptability of care.
- **Financial sustainability.** There are perceived financial risks of integrating PHC with district hospitals, which might require finding new ways of financing. Integration with social sector, for example, may bring new ways of joint financing.

## Session five

### Responding to health needs 4: transformation from within – making it happen at the hospital levels

Focus of this session was on sharing experiences and exploring different perspectives on role of hospital governance and management in driving transformations within.

#### **How can hospitals cross boundaries to integrate vertically and horizontally?**

This intervention aimed to give an overall perspective on role of hospitals in driving vertical and horizontal integration in health systems. Integration in common thinking is usually perceived as a pyramid with hospitals on top and PHC at the bottom and no clear understanding of patients role in it. Transformations towards people-centred services require shifting towards service delivery that places person at the centre and organizes services around those needs. It also calls for departing from the hierarchical notion on integrating levels of care towards developing networks of integration. In the context of changing needs, models of hospital care require constant adjustment and alignment with PHC. Hospitals have also strong levers for driving changes beyond its own boundaries such as, for example, demanding certain volume and quality of care from PHC. Recognizing the role of hospitals in developing integrated care networks and enabling integration at health system level is an important step toward achieving integrated people-centred care.

#### **How can hospitals be better organized and managed for increased patient-centredness?**

Aim of this intervention was to provide a perspective on role of hospital executives and management in hospital transformations. While there is no common recipe for success in how to drive patient-centred agenda, there are few key aspects to be accounted for from a managers perspective. Firstly, transformations towards patient-centredness require changes in interrelations between patient and providers. Engaging patients in the institutional life of hospitals and making them an important stakeholder in the governance process is an important step for driving transformations. Having series of interactions with patients on specific needs and areas of focus and going beyond mere ‘box ticking’ aspect of patient engagement ensures better responsiveness and acceptability of new service delivery models. Secondly, patient-

centredness can only be achieved by means of enabling environment and in that matter role of hospital managers becomes crucial. Competencies required for hospital management are distinct of those used in clinical practice and require professionalization and specific training. Lastly, aligning management capacity and system factors such as adequate governance arrangements will enable the shift towards patient-centred approach.

### **How can nurses support people-centred models of care by working in multidisciplinary teams in hospitals?**

Nurses represent largest group of health workforce globally and their area of activities extends far beyond the health sector (e.g. school nurses, occupational nurses). Patient-centredness in nursing is not a new concept: its core principles can be found in majority of professional codes of conduct. Integrated services delivery envisions application of these principles beyond boundaries of one professional silo, but applying them across independent roles to achieve a common goal. Nurses as a professional group have a key role in creating a shared value with patients, their families and communities in general: their capacity to account for wider determinants of health and disease helps patients to understand, articulate and advocate for their needs. In the context of changing population needs, more and more nurses are taking the role of care coordinators and *health system navigators* for patients with a responsibility in building care packages and ensuring continuity of care. From a systems perspective, transformative role of nurses needs to be supported by investing in development of their professional identities and career paths, as well as enabling mobility within and beyond health sector.

### **Panel discussion: Hospital pathways to transformations**

During this session, hospital managers from across wide variety of hospitals have shared their perspectives and experiences on transforming hospitals in practice. Reflections and country interventions converged to the following key messages:

- **Role of robust governance and leadership.** Majority of hospital management nominations are highly political, but there should be a system in place that allows cultivating core values of integrated people-centred service delivery among hospital managers.
- **Partnerships within and outside the health sector.** Transformations are as a rule challenged by institutional and cultural resistance and therefore need to be driven by shared vision and values. On an institutional level it requires moving away from blame shifting and finding a common ground across providers for achieving better outcomes. Importance of having a dialogue with public and providing a platform for input can be a way for increasing cultural acceptability of care. There are examples of how role of traditional healers was acknowledged and included in the mental health patient pathways in Ghana.
- **Identity and standards.** Experience shows that transformations are more successful when they resonate with how hospital identifies itself. It is a managers' role to ensure that hospital has a clear identity in what kind of hospital it is (e.g. teaching, general, or district), what kind of services it delivers and how it positions itself in community that it serves. Introducing and embedding principles of integration and people-centredness into service standards is another key strategy for driving transformations internally.

- **Hospital networks.** While transformations are often context specific, it is important to create space for experience and good practice sharing. Participation of stakeholders such as patient or PHC representatives in work of those networks provides an important input for developing hospital policies.

## Session six

### Responding to needs 5: creating the enabling environment for transformation

This session aimed at sharing different perspectives and experiences on mechanisms for enabling service delivery transformations in hospitals; it focused on such issues as policies for hospital autonomy, planning, infrastructure and payment mechanisms in practice.

#### **A hospital manager, policy-maker and researcher's perspective on hospital reforms, an illustration on use of policy levers to drive changes in Hong Kong**

Provision of health services in Hong Kong is characterized by fragmentation with both public and private providers offering services to population. To improve coordination and responsiveness of hospital services, series of reforms have taken place since 1999. The starting point for reforms was reorienting model of care towards population needs and shifting care towards community- and primary-care oriented services. With the aim of improving comprehensiveness and continuity of care after episode of hospitalization, reforms have focused on creating provider networks within communities – so called ‘hubs’. Hospital hubs focus on provision and coordination of care within hospitals, patient discharge and transition to sub-acute services; primary care-led hubs serve as focal points for coordinating a diverse range of outpatient and community services, and providing links to social services where necessary. Reforms have also included initiatives for horizontal integration (harmonization of nursing services in community), vertical integration (effective transitions from inpatient to sub-acute care), and temporal integration (referral and follow-up with social services).

Reforms in funding have focused in changing governments’ role from a passive funder to an active and strategic purchaser to address population health needs. Examples of reforms included partnerships between private and public providers in provision of outpatient services for chronically ill and healthcare vouchers for elderly. While funding arrangements vary significantly between countries and therefore require context-specific measures, reforms in Hong Kong show that strategic population-based funding can serve as a prerequisite and driver for service delivery integration. Success and sustainability of reforms required comprehensive set of alignment processes to enable change: strengthening of managerial capacities, developing information system, alignment of regulatory frameworks, and reorienting health workforce.

#### **Panel discussion: lessons learnt on facilitator/inhibitor for hospital transformations towards IPCHS**

Transformations towards integrated people-centred health services are placed high on the agenda globally, calling for systematic adjustment of health system functions that stand at direct intersection with health services delivery. This panel discussion focused on exploring regional and country experiences in enabling transformations from a policy perspective. The discussion raised following key points:

- **Managing complexity.** Transforming health services delivery is a multistage process often occurring in a stepwise manner along a continuum of development and requires activation of different levers across the health system. To enable sustained change, a continuous alignment between service delivery processes and health system functions should be managed accounting for competing interests and a turnover of key actors.
- **Ensuring participatory process in transformations.** Redefining hospitals in terms of population health requires participatory process involving community representatives, PHC and social sector. Needs of local populations should be a driving force behind adjustment of hospital model and requires paradigm shift in how services are organized and delivered. Provision of care with little accountability beyond a specific episode of illness is not a responsive solution to population with growing chronicity and multimorbidity.
- **Documenting and reporting experience in countries.** To ensure a political buy-in for developing integrated people-centred services delivery, there is need to improve evidence on its' cost-effectiveness and impact. Investing in ways of measuring service delivery performance, creating pool of resources and platforms for experience sharing is an important way to introduce, sustain and advance reforms for IPCHS.
- **Integration in training.** Integrated approach should be at the outset of the education and not merely changing mind-set of the existing workforce. Introducing concepts of integrated care, sharing examples and good practices should be also complemented by integrated approaches to training. Multi- and interdisciplinary in training of clinical and social providers can provide additional levers for transformations.

## Final remarks and closing

The two-day meeting explored wide range of topics with experiences shared by Member States, invited experts and other stakeholders, resonating similar key messages and indicating the urgency for scaling-up the transformations towards integrated health services delivery globally. It also provided an opportunity to take stock of first experiences and lessons learnt in the context of the EFFA IHSD implementation. Focus on PHC and hospital integration as a key avenue for achieving integrated health services delivery provided a global platform for exchanging practices.

Recalling the objectives of the meeting, key messages can be concluded as:

- Scope of transformations towards integrated service delivery is highly context specific and change over time but principles for pursuing it are universal; change management and innovation are imperative.
- Ensuring a political buy-in for developing integrated people-centred services delivery requires better evidence on its' cost-effectiveness and impact. Investing in ways of measuring service delivery performance, creating pool of resources and platforms for experience sharing is an important way to introduce, sustain and advance reforms.
- Population and community engagement is not a means to an end in health service delivery transformations but an opportunity to overcome resistance and improve cultural acceptability of care.
- PHC performance measurement provides an important proxy for diagnosing and tracking country progress in moving towards integrated people-centred health services delivery; new frameworks for performance measurement should build-on the existing ones and be able to capture service delivery capacities in PHC.
- PHC and hospital integration requires finding synergies and exploring innovative models of service delivery, where joint accountability for population health outcomes should be a guiding principle, and should be outlined in the renewed WHO vision for hospitals.

Concluding remarks highlighted that the level of progress already achieved towards more integrated people-centred care inspires further change and political commitment. Sharing experiences beyond the context of one region provides an important global learning platform and creates a common vision for working in partnerships.

Outcomes of this meeting will also contribute to shaping the agenda of the 40<sup>th</sup> anniversary of the Declaration of Alma-Ata and international conference in 2018, as well as other relevant activities on regional and global levels.

## Annexes

### Annex 1. Provisional programme

Thursday, 22 June 2017	
00:00–11:00	Travel
11:00–12:00	Registration and networking lunch
12:00–12:30	<p>Welcome and opening</p> <p>Moderator. <i>Juan Tello</i>, Head of Office, WHO European Centre for Primary Health Care (WECPHC), Division of Health Systems and Public Health (DSP)</p> <p>Addresses</p> <ul style="list-style-type: none"> <li>▪ <i>Hans Kluge</i>, Director, DSP, WHO Regional Office for Europe</li> <li>▪ <i>Hernan Montenegro</i>, Coordinator, Services Organization and Clinical Interventions, WHO headquarters</li> <li>▪ <i>Nick Goodwin</i>, Chief Executive Officer, International Foundation for Integrated Care, on behalf of the Primary Health Care Advisory</li> </ul>
12:30–13:15	<p>Address by the WHO European Centre for Primary Health Care</p> <ul style="list-style-type: none"> <li>▪ Implementing health services delivery transformations a forward-looking perspective to the WHO European Framework for Action on Integrated Health Services Delivery. <i>Juan Tello</i>, Head of Office, WECPHC, DSP</li> <li>▪ Question and answer (Q&amp;A)</li> </ul>
13:15–14:00	<p>Highlights from countries: transformations in practice</p> <ul style="list-style-type: none"> <li>▪ Comprehensive services delivery reforms. <i>Irina Son</i>, Federal Research Institute for Health Organization and Informatics, Ministry of Health, Russian Federation</li> <li>▪ Integrating primary health care (PHC) and public health services. <i>Edita Bishop</i>, Ministry of Health of Lithuania</li> <li>▪ Integrating PHC and hospitals. <i>Niva Azuz</i>, Head of Department for Standards in the Community, Ministry of Health Israel</li> <li>▪ Integrating health services delivery and long-term care. <i>Maren Skaset</i>, Deputy Director General, Ministry of Health and Care Services, Norway</li> </ul> <p>Awards of recognition</p>
14:00–14:30	Break and group photo
14:30–15:30	Responding to health needs 1: exchanging practices on PHC performance

measurement: past to present

Moderator. *Anna Korotkova*, Deputy in International Affairs, Federal Research Institute for Health Organization and Informatics, Ministry of Health, Russian Federation

#### Previous initiatives

- Regional: the European primary health care performance monitor. *Michael van den Berg*, Senior Researcher, Academic Medical Centre, WHO Collaborating Centre for Quality and Equity in Primary Health Care Systems
- Country: Applying the Primary Care Activity Monitor in Japan. *Shinichi Tomioka*, Department of Public Health, University of Occupational and Environmental Health, Japan

#### Current initiatives

- Global: the Primary Health Care Performance Initiative. *Hernan Montenegro*, Coordinator, Services Organization and Clinical Interventions, WHO headquarters

Plenary discussion

15:30–15:40

Technical pause

15:40–17:30

Responding to health needs 2: measuring the capacity and performance of PHC

Moderator. *Michael van den Berg*, Senior Researcher, Academic Medical Centre, WHO Collaborating Centre for Quality and Equity in Primary Health Care Systems

- 40-years on from the Alma-Ata Declaration: a platform for measuring the responsive capacity of PHC in the European Region. *Juan Tello*, Head of Office, WECPHC, DSP
- Proposal: A WHO European Primary Health Care Performance and Capacity Tool. *Erica Barbazza*, Technical Officer, WECPHC, DSP
- A roadmap to data collection for a region-wide assessment. *Ioana Kruse*, Consultant, WECPHC, DSP

Plenary discussion

17:30

Closing day one

Friday, 23 June 2017

9:30–11:00 What is the role of hospitals in responding to health needs: an overview

Chair. *Michelle Kearns*, Chief Information Officer, Caredoc, Ireland

- Introduction, *Juan Tello*, Head of Office, WECPHC, DSP
- Vision and role of hospitals as part and parcel of Integrated and People Centred Services (IPCHS). *Hernan Montenegro*, Coordinator, Services Organization and Clinical Interventions, WHO headquarters
- A patient's story on his experiences with hospitals. *Jolanta Bilinska*, Chair of the Board, International Alliance of Patients' Organizations (IAPO)
- A managers' story on his hospital transformational journey. *Lee Chien Earn*, Hospital CEO Singapore
- Countries' path to hospital sector transformation. *Kaija Lukka*, Adviser, Ministry of Social Affairs, Estonia

Buzz session: Taking stock of innovations in participants respective countries

Facilitator. *Viktoria Stein*, International Foundation for Integrated Care

- Innovations for better organizing around patients' needs. How have hospitals strengthened internally to deliver highly complex care efficiently, with high quality and positive patient experience?
- Innovations for coordinating with other care providers. How have hospitals developed new roles and established new ways of crossing professional boundaries and strengthening linkages with PHC and communities?
- Innovations for increased sustainable local development. How have hospitals embraced their social responsibility to contribute to health and development of their local community?

11:00–11:30 Break

11:30–13:00 Responding to needs 3: first-referral (district/community) hospitals in practice

Chair. *Miguel Lopez*, Portuguese Association of Hospital Directors

- Introduction by the Chair: Signification and relevance of first-referral hospitals in WHO European context
  - Review of literature on role of district hospitals: key findings. *Hamid Ravaghi*, WHO, Regional Adviser Hospital Care and Management, WHO EMRO
  - Community engagement and patient centeredness in a district hospital in Thailand. *Direk Suddaen*, District Hospital CEO, Thailand
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Plenary discussion: Country perspectives on first-referral hospitals

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Facilitator. *Viktoria Stein*, International Foundation for Integrated Care

- Functions and key features of a well-functioning first referral hospital: why it matters for UHC and what is expected from this hospital category in a transformed health system for IPCHS.
- What has worked/not worked to integrate at the district level
- Specific challenges and opportunities in rural/urban settings
- Attracting and retaining staff in first referral (district/community) hospitals

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13:00–14:00

Lunch

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14:00–15:15

Responding to needs 4: Transformation from within – Making it happen at the hospital level.

*Hospital governance, management, and clinical care in practice*

Chair. *Azhar Tulegalieva*, Ministry of Health of Kazakhstan

- How can hospitals cross boundaries to integrate vertically and horizontally? *Ricardo Fabrega*, Regional Advisor, Integrated Health Services, Pan American Health Organization
- How can hospitals be better organized and managed for increased patient centeredness? *Eric de Roodenbeke*, Chief Executive Officer, International Hospital Federation
- How can nurses support people centred models of care by working in multidisciplinary teams in hospitals? *Howard Catton*, Director, Nursing and Health Policy, International Council of Nurses

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Panel discussion. Hospital pathways to transformation

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Moderator. *Nick Goodwin*, Chief Executive Officer, International Foundation for Integrated Care

Topics to be covered: How to make it happen through accountability and transparency, Community participation, Clinical governance, Performance monitoring and reporting, etc.

- *Gilbert Buckle*, Hospital CEO Ghana
- *Salim Hashim*, Former Hospital Group CEO Pakistan, Kenya, Afghanistan
- *Qasem Al Salmi*, Hospital CEO Oman

Plenary discussion

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15:15–15:45

Break (and “post it session”)

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15:45–17:00 Responding to needs 5: Creating the enabling environment for transformation

*Policies, for hospital autonomy, planning, infrastructure investment and financing (payment methods) in practice*

Chair. *Pia Vracko*, Head of NCDs Prevention and Management, National Institute of Public Health, Slovenia

- A hospital manager, policy-maker and researcher's perspective on hospital reforms, an illustration on the use of policy levers to drive changes in Hong Kong, Special Administrative Region, China. *Yeoh Eng Kiong*, Chinese University of Hong Kong, SAR, China

Panel discussion. Lessons learnt on facilitator/inhibitor for hospital transformation towards IPCHS

Moderator. *Jerry La Forgia*, CTO, Aceso Global

Topics to be covered: Why is it needed to revisit the concepts of hospital autonomy, planning and contracting hospital services at the national and sub-national level, decision-making process for investing in infrastructure, and regulation, and how?

- *Lee Chien Earn*, Hospital CEO Singapore
- *Tarcisse Elongo*, WHO Regional Office for Africa
- *Miguel Lopez*, Portuguese Association of Hospital Directors
- *Maria Chiara Corti*, Veneto Region, Health and Social Welfare, Italy

17:00–17:30 Summary of the day and concluding remarks

Closing address

Synthesis of “post-it session”: take home messages and WHO Member States agenda on hospitals

- *Hernan Montenegro*, Coordinator, Services Organization and Clinical Interventions, WHO headquarters
- *Juan Tello*, Head of Office, WHO European Centre for Primary Health Care (WECPHC), Division of Health Systems and Public Health (DSP)

## **Annex 2. Final list of participants**

### **Country participants**

#### **Albania**

Eralda Mariani  
Head  
Sector for Prevention and Early Diagnoses  
Ministry of Health

#### **Austria**

Claudia Habl  
International Affairs & Consultancy  
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#### **Azerbaijan**

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Ministry of Health

#### **Belarus**

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#### **Bulgaria**

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Ministry of Health

#### **Estonia**

Kaija Lukka  
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Health System Development Department  
Ministry of Social Affairs

**Georgia**

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Quality Assurance of Medical Services  
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Ministry of Health

Modesta Visca  
Health Economist  
Directorate General for Health Planning  
Ministry of Health

**Israel**

Niva Azuz  
Head  
Department for standards in the community  
Ministry of Health

**Kazakhstan**

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Department of Medical Services Provision  
Ministry of Health

**Kyrgyzstan**

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Chairman  
Mandatory Health Insurance Fund

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**Lithuania**

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International Cooperation Division  
Ministry of Health

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Vice Minister  
Ministry of Health

**Latvia**

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Health Policy Affairs  
Ministry of Health

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Institute of Public Health

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Federal Research Institute Health Organization and Informatics, Ministry of Health

Irina Son  
Federal Research Institute Health Organization and Informatics, Ministry of Health

**Spain**

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Head  
Area of Clinical Information Systems  
Ministry of Health, Social Services and Equality

**Serbia**

Milena Vasic  
Head  
Department for European Integrations, International Cooperation and Project Management  
Institute of Public Health of Serbia

**Singapore**

Chien Earn Lee  
Chief Executive Officer  
Changi General Hospital

**Slovenia**

Pia Vracko  
Head  
NCDs Prevention Program for Adults  
Center for Prevention and Promotion Programs Management

**Tajikistan**

Bunafsha Dzhonova  
Head  
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Republican Family Medicine Clinical and Training Center

**Thailand**

Derek Sutdan  
Chief Executive Officer  
Thawang pha Hospital

**Turkey**

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Public Health Institution of Turkey

**Ukraine**

Vadim Yavorsky  
Chief  
Kharkiv Regional Center of Blood

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Royal Hospital, Oman

Jolanta Bilinska  
International Alliance of Patients' Organizations

Bettina Borisch  
World Federation of Public Health Associations

Gilbert Buckle  
Korle-Bu Teaching Hospital, Ghana

Howard Catton  
International Council of Nurses Foundation

Maria Chiara Corti  
Medical Director, Veneto Region

Eric de Roodenbeke  
International Hospital Federation

Nick Goodwin  
International Foundation for Integrated Care

Salim Hasham  
Mediheal Group of Hospitals, Nairobi

Michelle Kearns  
Caredoc, Ireland

Maksut Kulzhanov  
WHO Executive Board

Peter Lachman  
International Society of Quality in Health Care

Jerry la Forgia  
Aceso Global

Jose Miguel Lopez  
Portuguese Association of Hospital Managers

Sevil Salakhutdinova  
World Bank

Viktoria Stein  
International Foundation for Integrated Care

Shinichi Tomioka  
University of Occupational and Environmental Health

Michael van den Berg  
National Institute for Public Health and the Environment

Ethan Wong  
Bill and Melinda Gates foundation

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#### **Headquarters**

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Margrieta Langins  
Technical Officer, WHO European Centre for Primary Health Care



Connie Petersen  
Programme Assistant, WHO European Centre for Primary Health Care

Altynai Satylganova  
Consultant, Health Services Delivery Programme

Juan Tello  
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Evgeny Zheleznyakov  
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**Regional Office for Western Pacific**

Anjana Bhushan  
Technical Officer, Division of Equity and Social Determinants

**Interpreters**

Olzhas Galymzhan

Timur Nurpeissov

Batyrkhan Zhulamanov

### **Annex 3. List of relevant resources**

#### **Policy documents**

Strengthening people-centred health systems in the WHO European Region: framework for action on integrated health services delivery. Copenhagen: WHO Regional Office for Europe; 2016([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/315787/66wd15e\\_FFA\\_IHSD\\_160535.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/315787/66wd15e_FFA_IHSD_160535.pdf)).

EUR/RC66/R5 Resolution: strengthening people-centred health systems in the WHO European Region: framework for action on integrated health services delivery. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0016/319111/66rs05e\\_IHSD\\_160764.pdf](http://www.euro.who.int/__data/assets/pdf_file/0016/319111/66rs05e_IHSD_160764.pdf)).

#### **Background documents**

Lessons from transforming health services delivery: compendium of initiatives in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0014/303026/Compendium-of-initiatves-in-the-WHO-European-Region-rev1.pdf](http://www.euro.who.int/__data/assets/pdf_file/0014/303026/Compendium-of-initiatves-in-the-WHO-European-Region-rev1.pdf)).

Integrated care models: an overview. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0005/322475/Integrated-care-models-overview.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf?ua=1)).

Integrating diet, physical activity and weight management services into primary care. Copenhagen: WHO Regional Office for Europe; 2016 (<http://www.euro.who.int/en/health-topics/Health-systems/health-services-delivery/publicatons/2016/integrating-diet,-physical-activity-and-weight-management-services-into-primary-care-2016>).

#### **Tools**

A step-by-step guide for developing profiles on health services delivery transformations. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/298297/Step-by-step-guide-developing-profiles-HSD-transformatons.pdf](http://www.euro.who.int/__data/assets/pdf_file/0010/298297/Step-by-step-guide-developing-profiles-HSD-transformatons.pdf)).

Assessing health services delivery performance with hospitalizations for ambulatory care sensitive conditions. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/305875/Assessing-HSD-performance-with-ACSH.pdf](http://www.euro.who.int/__data/assets/pdf_file/0010/305875/Assessing-HSD-performance-with-ACSH.pdf)).

Catalogue of resources to support health services delivery transformations. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/317791/Catalogue-resources-support-HSD-transformatons.pdf](http://www.euro.who.int/__data/assets/pdf_file/0010/317791/Catalogue-resources-support-HSD-transformatons.pdf)).

Frequently asked questions. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0020/318323/FAQ-FFA-IHSD.pdf](http://www.euro.who.int/__data/assets/pdf_file/0020/318323/FAQ-FFA-IHSD.pdf)).

Glossary of terms: English-Russian version. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0020/318152/Glossary-of-terms-AIHSD-E-R-versions.pdf](http://www.euro.who.int/__data/assets/pdf_file/0020/318152/Glossary-of-terms-AIHSD-E-R-versions.pdf)).

### **Applications**

Ambulatory care sensitive conditions in Portugal. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0007/307195/Ambulatory-care-sensitive-conditions-Portugal.pdf](http://www.euro.who.int/__data/assets/pdf_file/0007/307195/Ambulatory-care-sensitive-conditions-Portugal.pdf)).

Review of the National Programme on the Development of Family Medicine 2011-2015 in Tajikistan. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0018/314433/Review-of-the-National-Programme-on-the-Development-of-Family-Medicine-2011-2015-in-the-Republic-of-Tajikistan-rev1.pdf](http://www.euro.who.int/__data/assets/pdf_file/0018/314433/Review-of-the-National-Programme-on-the-Development-of-Family-Medicine-2011-2015-in-the-Republic-of-Tajikistan-rev1.pdf)).

Strengthening the model of primary health care in Estonia. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0007/321946/Strengthening-model-primary-health-care-Estonia.PDF?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0007/321946/Strengthening-model-primary-health-care-Estonia.PDF?ua=1)).

### **Meeting and activity reports**

WHO European Centre for primary Health Care. Annual report of activities 2016. Copenhagen: WHO Regional Office for Europe; 2017 (<http://www.euro.who.int/en/health-topics/Health-systems/health-services-delivery/publications/2017/who-european-centre-for-primary-health-care-annual-report-of-activities-2016>)

Final consultation meeting of the European Framework for Action on Integrated Health Services Delivery. Meeting Report. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/316228/Final-consultation-EFFA-IHSD-report.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/316228/Final-consultation-EFFA-IHSD-report.pdf))

## 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.

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