Framework on integrated people-centred health services (IPCHS)

Questions and Answers

1. How does the Framework on integrated people-centred health services (IPCHS) relate to other WHO global strategies considered under the 138th Session of the Executive Board and the 69th Session of the World Health Assembly?

   A deep analysis to determine the level of alignment and coherence between the framework and the other five initiatives has been undertaken. Importantly, there exists a significant level of alignment in terms of language, principles and health system elements among all the initiatives. All draft strategies incorporate relevant concepts of people-centred health services and the need to integrate care around the needs and preferences of people.

   The analysis and its results can be found in Annex 1.

2. Why is this document a framework and not a strategy?

   WHO global strategies have traditionally put forth a clear plan for monitoring progress. As the framework represents a new programme of work for WHO, there are no universally accepted indicators to measure progress in establishing integrated people-centred health services. The Global Health Observatory, the monitoring and evaluation frameworks for universal health coverage and the Sustainable Development Goals, and the Global Reference List of 100 Core Health Indicators - none includes measures of integration or people centredness.

3. Why does the WHA document differ from the full document available online?

   The WHA document contains edits to the interim report for consultation that incorporate comments from the global public consultation and input from Member States through Regional Committees. Furthermore, it reflects inputs stemming from Member States on the discussion held at the 138th Session of the Executive Board.

   A report on key issues emerging from the discussion of Member States at the Executive Board can be found in Annex 2.

4. How will progress on the framework be monitored at global level?

   As discussed in question 2, no global consensus for indicators of integration or people-centredness currently exists. Therefore, as stated in the accompanying resolution of the background document, research and development on indicators to track overall progress and progress towards each proposed strategy will be performed as part of the framework's implementation efforts. International partners will be convened to develop appropriate metrics for these critical, but less frequently measured domains of health care.

5. How was the input of regional committees and the public consultation incorporated into the WHA document?

   The current Framework is the result of the inputs gathered through peer reviews and technical consultations from more than 140 experts representing research organizations, ministries of health and academia, among others. Two kinds of consultations were undertaken. On the one hand, a public consultation representing all entities (individuals and organizations) with an interest in people-centredness and integrated health services was carried out; comments were provided through the website of the Service Delivery and Safety (SDS) department. On the other hand, discussions on the framework were also conducted by WHO regions through different formats.

   Two respective reports were compiled representing the comments from both the public and regional consultations. These comments were analyzed by the Secretariat working group with necessary amendments made to the draft for consultation. Consultation reports will be made available upon request.

6. How does the Framework on IPCHS relate to other important work of WHO such as Sustainable Development Goal 3, universal health coverage, health systems resilience, and health systems strengthening?

   Making progress towards the United Nations' Sustainable Development Goal 3 (Ensure health lives and promote wellbeing for all at all ages), including target 3.8 on universal health coverage, requires countries to move towards ensuring that all people and communities have access to health services that are high quality, safe and acceptable. For this to be attainable and sustainable, effective, cost-efficient approaches to service delivery must be maximized. An integrated, people-centred approach is crucial to the development of health systems that can respond to emerging and varied health challenges, including urbanization, the global tendency towards unhealthy lifestyles, ageing populations, the dual disease burden of communicable and noncommunicable diseases, multi-morbidities, escalating health care costs, disease outbreaks and other health-care crises.

7. Why people-centred vis-à-vis person-centred health services?

   People-centred care is an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects their preferences. People-centred care is broader than patient and person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services.

   The Secretariat recognizes that the terms utilized in the title and across the framework might be considered very technical, and therefore this could pose a challenge when it comes to targeting a wider audience. For this reason, a communication strategy is being developed in order to translate technical terminology into plain language that can be broadly understood.

8. What types of WHO Frameworks exist?

WHO produces several types of frameworks including theoretical, policy, monitoring and evaluation, operational and frameworks for action. This framework proposes five interdependent strategies for health services to become more integrated and people-centred. It calls for reforms to reorient health services, putting individuals, families, carers and communities at their centre, supported by responsive services that better meet their needs and respect their preferences, and that are coordinated both within and beyond the health sector, irrespective of country setting or development status. While it is founded in a strong theoretical basis and includes policy actions, it is most closely represents a framework for action, laying out strategic approaches, potential policy options and interventions to be used at the country level, acknowledging the need to design and develop actions for reform according to the local context, values and preferences.

9. What is meant by "primary care based systems"?

   Primary care based systems ensure that health services are founded on accessible primary care that serves as the main entry point and ongoing site of care for the majority of health problems across the life-course. Primary care based systems exhibit high-performance in critical areas: first-contact, continuity, comprehensiveness, coordination, and people-centeredness. This requires that primary care receives adequate resource investment including funding and infrastructure, a workforce with appropriate training and formalized connections to other levels of service and other sectors. Primary care based systems promote coordination and continuity for people with complex health problems, employ interprofessional teams to ensure comprehensive services, and prioritize family and community based approaches to health care. Primary care is a principal element of a continuing health care process that may require integrating and coordinating the provision of secondary and tertiary levels of care.

   Integrated people-centred health services require a service delivery model based upon primary care while incorporating the broader health system principles elaborated as Primary Health Care in the 1978 Declaration of Alma Ata: equity, participation, intersectoral action, and appropriate technology. Primary Health Care provides a chief organizing principle for a nation's health system which applies not only to health service delivery processes (primary care); but also to health system structure, governance and financing; the intersectoral policy environment; and social determinants of health. Successful primary health care requires the institutionalized participation of civil society and the community in policy dialogues and accountability mechanisms.

10. Why is Strategy 2: Strengthening governance and accountability separate from Strategy 5: Creating an enabling environment? And, why is Strategy 4: Coordinating services within and across sectors considered separately from Strategy 3: Reorienting the model of care?

    The five strategies presented in the framework are interdependent. Furthermore, many of the strategic approaches, potential policy options and interventions are cross-cutting for several strategies. As such the organization of the framework seeks to highlight key, often underemphasized elements.

    While strengthening governance and accountability (Strategy 2) could be considered part of creating an enabling environment (Strategy 5) it was separated to highlight this sometimes neglected element that is relevant not only at a national level but across the health system (sub-national, district, facility, clinical). Additionally, coordinating services within and across sectors (Strategy 4) could be considered as part of reorienting the model of care (Strategy 3); however, considering it as a separate strategy permits a discussion of coordination across programmes and levels of care; the administrative, information and funding barriers that prevent coordination as well as the need for further coordination across sectors.

11. How the Framework on integrated people-centred health services relates to regional strategies and commitments on IPCHS?

    Strategic documents and resolutions from all WHO regions and regional committees also call for a more integrated, people-centred approach to health service delivery. Examples can be found in AMRO, SEARO, EURO, EMRO and WPRO. There exists a two-way relationship between the framework on IPCHS and the IPCHS commitments from the regions. On the one hand, the framework is informed by regional strategies and built upon regional experience and evidence to a very significant extent. On the other hand, the framework entails a flexible and widely-encompassing approach applicable to every country setting, irrespectively of development status that can be adapted to regional initiatives when they exist.

12. Is the framework considering traditional and complementary medicine?

    As stated in the WHO Programme Budget 2016-2017, the Secretariat will focus on supporting Member States in fully integrating traditional and complementary medicines of proven quality, safety and efficacy into their health systems as that will contribute to the goal of universal health coverage. In line with this, the framework includes an intervention to integrate traditional and complementary medicine with modern health systems built on the experience gathered from countries such as China, Republic of Korea and Malaysia, among others, under the strategy number 4, "coordinating services within and across sectors".

13. Is the framework backed by scientific evidence?

    Two systematic reviews were undertaken to articulate the existing evidence base on the five strategies proposed by the framework, including selected evidence for the positive benefits of different interventions to support people-centred and integrated health services along with the identification of potential risks.

    However, it must be recognized the existence of multiple evidence gaps in the focus of interventions and how the concept of people-centred and integrated health services has been identified and applied. Research studies have typically focused on the treatment and diagnosis, and adult and elderly care, meaning that the evidence base for other services and on other life stages is less strong. Furthermore, much of the evidence on people-centred and integrated health services is derived from advanced economy settings.

    In an attempt to try to minimize these gaps, further research studies to enrich the evidence base will be carried out as part of the implementation efforts of the framework.

14. Why the proposed policy options and interventions are not differentiated according to country contexts or time frames?

    The framework proposes an array of policy options and interventions that stem from the evidence on integrated people-centred health services, based on positive examples from around the globe that have been implemented in differing country settings. These possible actions are not meant to constitute a recipe for reform, but rather an illustration of potential options that countries may wish to consider, regardless their specific country context. The development of interventions needs to be locally negotiated and co-created. In each specific country, the exact mix of actions alongside their implementation timeline will need to be designed taking into account the local context, values and preferences.

15. Are people's preferences taken into account in the framework?

    As reflected in the definition provided in the background document, "people-centred care is an approach to care that […] respects social preferences". According to scientific literature and the inputs gathered from the public consultation, respecting peoples' communities' preferences is at the core of people-centred care approaches and a consubstantial element that should be emphasized. However, it must be borne in mind that respecting social preferences does not necessarily means that health systems must respond to them but instead, they should take them into account to the greatest possible extent. Similarly, there is need to highlight the role of social preferences versus individual approaches that might eventually lead to undermine public health efforts.

    To avoid misunderstandings and according to Member States' request, the term "preferences" has been removed throughout the framework but it still remains in the definition of people-centred care to highlight its centrality in people-centred approaches.

16. Is the framework considering the role of care givers in promoting integrated people-centred health services?

    The framework sets for a vision in which "all people have equal access to quality health services […] and all carers are motivated, skilled and operate in a supportive environment". Moreover, the framework explicitly recognizes the need to empower and engage informal carers, with family members and other care-givers playing a critical role in the provision of health care. To accomplish this aim, carers must receive adequate training in order to be able to provide high quality interventions, and to serve as advocates for the recipients of care, both within the health system and at the policy level. Additionally, carers have their own needs for personal fulfilment and require emotional support to sustain their role.

17. Which are the key elements that should guide the implementation of the framework?

    Implementation strategies should be achievable given the current health service delivery system and the financial and political resources available. Efforts should primarily concentrate on improving access to services for underserved and marginalized populations, on placing increased emphasis and resources on promotive, preventive and public health services and on strengthening district-level health services, among others. Given that this framework is fundamentally transformative in its implications for the future of health systems, system leaders must adopt strategies for change to ensure the effective alignment of strategies and processes that promote people-centred and integrated care.

    The Secretariat is drafting a "Call for action" to help drive efforts towards the goal of integrated people-centred health services. The document is meant to act as a catalyst to spark ideas and action from policy-makers, health care providers and communities. It identifies concrete actions that can be immediately implemented by key stakeholders as a joint endeavour to initiate progress towards integrated people-centred health services, as well as the core functions that will be performed by the Secretariat in support of the implementation efforts.

    A draft of the "Call for action" will be made available upon request.

World Health Organization

EXECUTIVE BOARD
138TH SESSION

ANNEX 1. ALIGNMENT BETWEEN THE "FRAMEWORK ON INTEGRATED, PEOPLE-CENTRED HEALTH SERVICES" AND THE FIVE STRATEGIES TO BE DISCUSSED AT THE 138TH SESSION OF THE EXECUTIVE BOARD

Background

In the information session on the draft "Framework on integrated, people-centred health services" and the draft "Global strategy on human resources for health: Workforce 2030" that took place on 20th October 2015, a question on the alignment between the "Framework on integrated, people-centred health services" and the five strategies that will be discussed at the 138th Session of the Executive Board ("Global Strategy and Action Plan on Aging and Health 2016-2020", "Global strategy on human resources for health: Workforce 2030", "Global Health Sector Strategy on STIs, 2016-2021", "Global Health Sector Strategy on HIV, 2016-2021" and "Global Health Sector Strategy on viral hepatitis, 2016-2021") was raised, including language coherence among them.

In an attempt to address this concern, a deep analysis of the six initiatives has been undertaken, aiming at identifying common themes and cross cutting issues along several key dimensions.

Below there are two tables:

1. The first one contains a comprehensive analysis of descriptive elements, such as the vision, objectives, principles and informing documents, plus an analysis of the WHO health systems framework' "enriched" building blocks (service delivery, leadership and governance, information, intersectoral action, etc.) that underpin each strategic document.

2. The second table contains a summary of identified commonalities across the five strategies and the Framework that focuses on the "least common denominator" among all/most of them.

In brief, there exists a significant level of alignment in terms of language, principles and health system elements among all the initiatives analysed.

TABLE 1. ANALYSIS OF DESCRIPTIVE ELEMENTS OF THE SIX INITIATIVES UNDER CONSIDERATION

	Framework on integrated people-centred health services 2016-2026	Global Strategy and Action Plan on Ageing and Health 2016-2020	Global strategy on human resources for health: Workforce 2030	Global Health Sector Strategy on STIs, 2016-2021	Global Health Sector Strategy on HIV, 2016-2021	Global Health Sector Strategy on viral hepatitis, 2016-2021
Vision	A future in which all people have access to health services that are provided in a way that responds to their life course needs and preferences, are coordinated across the continuum of care and are safe, effective, timely, efficient and of acceptable quality.	A world in which everyone can live a long and healthy life. This world will be a place where functional ability is fostered across the life course and where older people experience equal rights and opportunities and can live lives free from age-based discrimination.	Accelerate progress towards UHC and the Sustainable Development Goals by ensuring universal health workers.	Zero complications and deaths related to STIs and zero discrimination in a world where people living with STIs are able to live long and healthy lives.	Zero new HIV infections, zero HIV-related deaths and zero HIV-related discrimination in a world where people living with HIV are able to live long and healthy lives.	A vision of a world where viral hepatitis transmission is halted and everyone living with viral hepatitis has access to safe, affordable and effective care and treatment.
Overall objective and approach	Access to integrated people-centred health services. A multi-level and multi sectoral approach is needed, with the health sector playing a paramount role.	Societal responses to ageing should seek to foster recovery, adaptation and dignity in the face of significant losses, whether of physical or cognitive capacity or of family, friends and the roles they had earlier in life. This requires transformative approaches that recognize the rights of older people and enable them to thrive in the complex, changing and unpredictable environment. The strategy aims to foster the ability of older people themselves to invent the future.	Improve health and socioeconomic development outcomes by ensuring universal availability, accessibility, acceptability and quality of the health workforce through adequate investments and the implementation of effective policies at national, regional and global levels.	End epidemics of STIs as major public health concerns and ensure healthy lives and promote well-being for all people at all ages.	End of the AIDS epidemic as a public health threat by 2030, within the context of ensuring healthy lives and promoting wellbeing for all at all ages, contributing to the attainment of the Sustainable Development Goal on health (SDG 3).	End of the viral hepatitis as a public health threat by 2030, contributing to the attainment of the Sustainable Development Goal on health (SDG 3).
Principles	Equity; participation; goal orientation; country leadership, systems strengthening, iterative learning.	Human rights; gender equality; equality and non-discrimination particularly on the basis of age; equity and intergenerational solidarity.	Right to health; integrated, people-centred health services; empowered and engaged communities; rights of all health workers, including safe and decent working environments and freedom from all kinds of discrimination, coercion and violence; elimination of	Integrated people-centred health services. Health equity, gender equality health and the right to health. Community participation. Meaningful involvement of key populations.	Promotion of a people-centred approach, grounded in principles of human rights and health equity. Action requires "an enabling environment that promotes health equity, gender equality and human rights".	Health equity and human rights.

			gender-based violence, discrimination and harassment; international collaboration and solidarity; ethical recruitment practices in conformity with the provisions of the WHO Global Code; political and financial commitment; collaboration across sectors and constituencies; innovation and the use of evidence.			
Informing strategies & frameworks	UHC, primary care, social determinants of health, non-communicable diseases.	Madrid international plan of action on ageing; WHO's policy framework on active ageing; World report on ageing and health; newly adopted SDGs (in particular 1, 2, 3, 5, 10, 11).	Racife Political Declaration on Human Resources for Health; numerous WHA resolutions on human resources for health including resolution WHA 67.12; World Health Report 2006: working together for health; WHO Global Code of Practice on the International Recruitment of Health Personnel; SDG 3 and other SDGs, UHC, health security and implementation of IHR.	Three organizing frameworks: UHC, the continuum of HIV services, and a public health approach. Aligned with other key global health strategies and plans, including those for sexual and reproductive health and rights, HIV, violence against women and girls, adolescent health, maternal, newborn and child health, non-communicable diseases, WHO global strategy on IPCHS, viral hepatitis, tuberculosis (TB), and blood safety. Progress report of the implementation of the global strategy for the prevention and control of STIs: 2006–2015; global health strategies of key partners including Global Fund to fight AIDS, Tuberculosis and Malaria; the United States President's Emergency Plan for AIDS Relief; Gavi The Vaccine Alliance; and the Global Strategy for Women's Children's and Adolescents' Health (2016–2030).	Three organizing frameworks: UHC, the continuum of HIV services, and a public health approach. The strategy is fully aligned with the SDGs agenda and targets. It is also aligned with other relevant global health strategies and plans, including those for STIs, tuberculosis (TB), viral hepatitis, sexual and reproductive health, and the IPCHS strategy, among others.	Three organizing frameworks: UHC, the continuum of HIV services, and a public health approach. It is aligned with other relevant health strategies and plans, including those for HIV, STIs, safe injections, blood safety, vaccines, tuberculosis and noncommunicable diseases and responds to World Health Assembly resolutions on viral hepatitis in 2010 and 2014.
Overview	STRATEGIC GOALS 1. Empowering and engaging people 2. Strengthening governance and accountability	STRATEGIC OBJECTIVES 1. Commitment to action on Healthy Ageing in every country 2. Developing age-friendly environments	OBJECTIVES 1. To optimize performance, quality and impact of the health workforce through evidence-informed policies	STRATEGIC DIRECTIONS 1. Information for focus and accountability 2. Interventions for impact 3. Delivering for equity	STRATEGIC DIRECTIONS 1. Information for focus and accountability 2. Interventions for impact 3. Delivery for equity	STRATEGIC DIRECTIONS 1. Information for focus and accountability 2. Interventions for impact 3. Delivery for equity

	3. Reorienting the model of care 4. Coordinating services 5. Creating an enabling environment	3. Aligning health systems to the needs of older populations 4. Developing sustainable and equitable systems for providing long-term care (home, communities, institutions) 5. Improving measurement, monitoring and research on Healthy Ageing	on human resources for health, contributing to healthy lives and well-being, effective UHC, resilience and health security at all levels. 2. To align investment in human resources for health on the current and future needs of the population, taking account of labour market dynamics, to enable maximum improvements in health outcomes, employment creation and economic growth. 3. To build the capacity of institutions at subnational, national and international levels for effective leadership and governance of actions on human resources for health. 4. To strengthen data on human resources for health, for monitoring of and ensuring accountability for successful implementation of both national strategies and the global strategy.	4. Financing for sustainability 5. Innovation for acceleration	4. Financing for sustainability 5. Innovation for acceleration	4. Financing for sustainability 5. Innovation for acceleration
Health System	• The fragmented nature of today's health systems means that they are becoming increasingly unable to respond to the demands placed upon them. • The focus on hospital-based, disease-based and self-contained "silo" curative care models undermines the ability of health systems to provide universal, equitable, high-quality and financially sustainable care.	• Building systems that enable the best possible trajectories of functional ability across the life course. • Coordinate health service delivery; across the continuum of care as well as between different service levels and between health and social services by making all services work towards maintaining functional ability. • Include effective strategies for the prevention of declines in capacity across the life course	• Reorient care from hospitals to other settings and deliver it through flexible multidisciplinary teams with appropriate competencies and scope of work. • Collaboration between the public and private sectors is essential to optimize health workforce utilization. • Ensure that all countries have an effective HRH unit or department. • Professionalize the field of	• The keystone of an effective STI response is a strong health system that is capable of providing reliable, effective and equitable people-centred care in both the public and private sectors. • Select the most appropriate combination of screening and diagnostic approaches based on the nature and dynamics of national STI epidemics, the affected populations and the health system. Special efforts are required for the detection and	• Achievement of the 2020 HIV targets will require a robust and flexible health system that is able to engage and retain people along the entire continuum of HIV prevention and care services and includes: a strong health-information system; efficient service delivery models a sufficient and well-trained workforce; reliable access to essential medical products and technologies; adequate health financing; and strong leadership and	• An effective hepatitis response requires robust and flexible health systems that can sustainably deliver people-centred care across the full continuum of services to those populations, locations and settings in greatest need. The hallmarks of such health systems are: a strong health-information system; efficient service delivery models; appropriately trained and distributed workforce in adequate numbers and with an

	• This strategy calls for reforms to reorient health systems and services, shifting away from fragmented supply-oriented models, towards health services that put people and communities at their centre, and surrounds them with responsive services that are coordinated both within and beyond the health sector, irrespectively of country setting and development status.	including preventing and treating diseases and managing impairments. • Develop a comprehensive system for long-term care that can be provided at home, in communities or within institutions. • Orient health systems around intrinsic capacity and functional ability.	health workforce planning and management as part of the public health workforce • Develop capacity to align incentives for health workforce education and health care provision to public health goals.	management of asymptomatic STIs in key populations, adolescents and young adults, and pregnant women, with enhanced interventions for reaching sexual partners. • Ensure that STI diagnosis is accessible, and also in ensuring the quality of diagnostic tools and services, to minimize risk of misdiagnosis. • Strengthen national laboratory capacity through quality assurance and the introduction of point-of-care diagnostics to ensure routine monitoring of STIs and antimicrobial resistance to N. gonorrhea.	governance.	appropriate skills mix; reliable access to essential medical products and technologies; adequate health financing; and strong leadership and governance.
Service Delivery	• There is need to reorient the model of care so that efficient and effective health care services are designed, purchased and provided through innovative models of care that prioritize primary and community care services and the co-production of health. • This encompasses the shift from inpatient to comprehensive and integrated outpatient and ambulatory care. It requires both gender and cultural sensitivity in the design and operation of health services. • Service delivery models must take into account the creation of new opportunities for intersectoral action, including with the private health sector, and also at a community-level to address	• Ensure affordable access to integrated services that are centred on the needs and rights of older people across the spectrum of intrinsic capacity and functional ability. • Design services around older people's needs and preferences, including involving older people in service planning. • Situate services as close as possible to where people live, including delivering services in their homes and providing community based care. • Ensure the establishment of formal me for integrated person-centred long-term care, for example through case management, advance care planning and collaboration between paid and unpaid caregivers.	• Extending services to all socioeconomic groups of the population and ensuring equity for poor and marginalized populations will require maintaining a diverse and sustainable mix of skills, as well as maximizing the potential of community-based and mid-level practitioners. • Excessive reliance on specialist and tertiary care may limit access to primary health care services. Conversely, expansion of the health resource envelope must also lead to more cost-effective resource allocation: in line with the framework on integrated people-centred health services. • Critical to ensuring equitable deployment of health workers are the	• Ensure service delivery models are developed for the context. • Develop and disseminate guidance and tools to strengthen STI service integration within health systems: develop tools on laboratory capacity strengthening for STI and HIV testing; develop tools to strengthen programme management and supervision through a health systems approach; involve partners, civil society and community representatives in the development of guidelines and tools for the provision of STI services. • Use service delivery methods and approaches that provide equitable and effective services for all, particularly for key or neglected populations. • Build on existing guidance to better define essential packages	• Define a set of essential HIV interventions, services, medicines and commodities to be included in its national health benefit package. • Service delivery models for different population and settings must be defined. • All people should receive the services they need, which are of sufficient quality to have an impact. HIV services must be person-centred and integrated; must be linked to HIV and TB services; should ensure community engagement and be community-based; and should also target the needs of special settings.	• Each country needs to define a set of essential viral hepatitis interventions, services, medicines and commodities relevant to the country context that should be included in the national health benefit package. • All people should receive the services they need, which are of adequate quality. Viral hepatitis services must be tailored to different populations and locations; must be linked and integrated with other health services; should strengthen a community-based approach; must involve people living viral hepatitis and must ensure the quality of interventions.

	the social determinants of health.	• Services and staff need to treat older people with respect, including communicating in ways that are effective and that take account of common visual, hearing or other impairments.	selection of trainees from and delivery of training in rural and underserved areas, financial and non-financial incentives, regulatory measures or service delivery reorganization.	and service delivery models for specific populations, locations, situations and settings; provide and disseminate guidance on clinical management of rape among adolescents and children, and promote the uptake of guidance on health sector response to partner violence and sexual violence among women in STI programmes and service delivery settings. • Greater integration and linking of STI services and programmes with those for other relevant health areas i.e. comprehensive primary healthcare and other sectors must be emphasized.		
Leadership & governance	• Strong leadership and vision are critical to successful change management within a health system. • Establishing a strong policy framework and a compelling narrative for reform will be important to building a shared vision, as well as setting out how that vision will be achieved. Development of an organizational culture that supports monitoring and evaluation, knowledge sharing and a demand for data in decision-making is also a prerequisite to move towards integrated people-centred health care. • Furthermore, new forms of collaborative leadership that help to bring together multiple stakeholders are needed for successful reform of health	• Establish national frameworks for action on Health Ageing. • Strengthen national capacities to formulate evidence-based policy. • Combat ageism and transform understanding of ageing and health. • Enable older people's engagement. • Governments in all settings also have a role to play in ensuring that the numerous components of the system are in place, including a sound regulatory framework, training and support for caregivers, coordination and integration across various sectors (including with the health system), and mechanisms such as accreditation and monitoring to ensure quality.	• Develop a global mechanism for HRH governance for high-level political engagement, inter-sectoral and multi-lateral policy dialogue, and to foster global coordination and mutual accountability. • Establish the national business case for HRH as a vital component of UHC, use it for demanding plans and budgets to mobilize adequate resources, and support it by necessary regulations and mechanisms for policy coordination and oversight. • Strengthen the institutional environment for health workforce production deployment, retention and performance management. • Regulating and incentivizing the private	• Strengthen the governance and accountability of programmes relating to STIs and conduct regular programme reviews to help ensure that national strategies, plans and resource allocation reflect actual country needs as they evolve. • A mutual accountability process benefits from strong leadership and governance that features genuine engagement with relevant stakeholders; clear national targets that reflect the 2030 Agenda for Sustainable Development and other pertinent global commitments; appropriate indicators on the availability, coverage, quality and impact of interventions to track progress; and transparent and inclusive assessment and reporting procedures.	• National HIV governing structures, such as national HIV programmes, HIV commissions and country coordination mechanisms, play a critical role in advocating for an effective response, national strategic planning and resource allocation, promoting policy coherence, coordinating roles and actions across different stakeholders, aligning the HIV response with broader health programmes and ensuring that an enabling environment is in place • National government leadership is essential for achieving coherence and coordination of efforts, although the importance of decentralized decision-making, where appropriate, should also be recognized.	• The national hepatitis response should be guided by a national plan with a well-defined governance and management structure that can ensure a coordinated and efficient response and clear accountability. Strategic planning processes should enable meaningful inputs from all key stakeholders on policy development, service planning and resource allocation • Such plans should be fully aligned and appropriately integrated with broader national health and development strategies and plans, with the goal of achieving UHC. • Concerted advocacy efforts, particularly by political and community leaders, and a sound communication strategy are required to increase public

	services.		sector to align more closely to public sector health goals; regulatory mechanisms to promote patient safety • Accreditation mechanisms for health training institutions • HRH plans should be costed, financed, implemented and continually refined so as to address (a) estimation of number and category of health workers required to meet public health goals and population health needs; (b) capacity to produce sufficient qualified workers (education policies); and (c) labour market capacity to recruit, deploy and retain health workers. • Link the training of and investments in health personnel with population needs and health system demands, including an adequate and gender-balanced education pipeline of qualified trainees from rural areas, and encouraging inter-professional education and collaborative practice.			and political awareness of the public health importance of viral hepatitis, generate resources and mobilize action.
Health workforce	• Special attention needs to be given to reorienting the health workforce to meet the requirements of service delivery reforms. It requires health workers to approach patients, users and communities differently; be organized around teams and supported with adequate processes of work, clear roles	• All service providers require the competencies appropriate to addressing older people's needs. These include gerontological and geriatric skills, as well as other more general competencies that are needed to provide integrated care. • Ensure that the supply of geriatricians and other	Entirety of strategy dedicated to health workforce.	• Equip health workers with the skills and commodities to rapidly expand primary prevention, testing and treatment of STIs; use service delivery methods and approaches (including marshalling private sector providers and pharmacies into the STI response) that provide equitable and effective services for all, particularly for key or	• New models of service delivery for meeting more ambitious targets will require strengthening the health workforce, reviewing the roles and tasks of health workers and their deployment across different services. In addition to the provision of routine HIV services, there will be an increasing need for health	• Health workers should be knowledgeable about viral hepatitis risk and infection, and the package of essential hepatitis interventions. • They should be competent to work with people living with chronic hepatitis infection and key populations. • Provide health workers with free immunization against

	and expectations, guidelines, opportunities to correct competency gaps, feedback, fair wage, and a suitable work environment and incentives. • Moreover, data must be used more effectively and they must be willing to innovate in their practice to better match patients' needs and preferences.	professionals, meets population needs for a specialist workforce and encourage the development of multi professional and multi-disciplinary specialized units for the management of complex cases. • New workforce cadres (such as care coordinators and self-management counsellors) and appropriate career paths will also need to be considered, as will options for extending the roles of existing health workers. • Ensure that paid long-term-caregivers are accorded the status and recognition that their contribution deserves. • Ensure that formal and informal in the long-term care system have access to resources, information and/or training they need. • Employment models that foster retention of ageing skilled workers will need to be explored.		neglected populations.	workers to be competent in delivering services to key and marginalized populations and in providing chronic care for people living with HIV. • A comprehensive national health workforce plan should address the needs of the overall health system, along with what is required to deliver the full HIV service continuum. • Health workers should be protected by comprehensive occupational health and safety programmes, which promote universal precautions, access to prevention commodities such as condoms, post-exposure prophylaxis following significant exposure to HIV, confidential HIV testing and treatment and care for health workers living with HIV.	vaccine-preventable diseases, including, where appropriate HBV vaccine, and provide HBV post-exposure prophylaxis when necessary. • Defining the core hepatitis competencies of different cadres of health workers at different levels of the health system will help define what tasks can be shifted and to what level, along with defining training, accreditation and supervisory needs. • Issues related to viral hepatitis should be included in pre- and in-service training for health workers. • Community-based and peer-support workers play an important role in reaching marginalized groups, linking people with chronic hepatitis to care, supporting treatment adherence and providing chronic care. They should receive regular training, mentoring and supervision and appropriate compensation for their work.
Infrastructure	• Shifting towards more outpatient and ambulatory care. Service substitution is the process of replacing some forms of care with those that are more efficient for the health system. The approach means finding the right balance between primary care, specialized outpatient care and hospital inpatient care, recognizing that each	• Actions to create age-friendly environments can target different contexts (the home or community) or specific environmental factors. • The investment in infrastructure to foster Healthy Ageing will have direct benefits for other sections of the population. Improved access to transportation, public buildings	• Invest strategically through long-term (10–15 years) public policy stewardship and strategies in decent conditions of employment that respect the rights of workers, a safe work environment and better working environments, including at the very least the provision of a living wage, and incentives for equitable	• Use subnational data collection and mapping techniques to detect deficiencies in service provision and infrastructure, and to help inform decisions made on where to place additional services. • Invest in laboratory capacity strengthening for STI and HIV testing; develop tools to strengthen programme management and supervision	• Augmenting investments in the HIV response, and focusing resources on the most effective services and interventions and on the populations and geographical locations where HIV transmission and burden is greatest will be needed.	• Strategies to increase investments in hepatitis need to be part of broader efforts to increase overall investments in health, so that all priority health services can be scaled up towards UHC. • Investments in hepatitis programmes may also facilitate the prevention and management of other major health conditions.

	has an important role within the health care delivery system.	and spaces, or information and communication technologies can facilitate inclusion and participation of all people.	deployment and retention .	through a health systems approach.		
Medical products, vaccines & technologies	• Innovating and incorporating new technologies. Rapid technological change is enabling the development of increasingly innovative care models. New information and communication technologies allow new types of information integration. When used appropriately, they can assure continuity of information, track quality, facilitate patients' empowerment and reach geographically isolated communities. • shared electronic medical record • telemedicine • m-health	• Medical products and assistive devices that are necessary to optimize older people's intrinsic capacities and functional ability will need to be identified and made accessible. • Harnessing technological innovations (including assistive technologies and information and communication technologies) may be particularly useful. Technological innovation, or the convergence of existing technologies, may also help lower-resource countries to develop service models that "leapfrog" models delivered in other settings. • Encourage the voluntary sharing of knowledge, technologies and other information, across countries, to support wider uptake of innovation that supports functional ability of older adults.	• Technological advances, including internet connectivity, open-source technology and the emerging trends in the era of "big data", are breaking new ground in improving the quality and use of data on human resources for health.	• Effective STI programmes are dependent on the uninterrupted supply of quality-assured vaccines for human papillomavirus and medicines, diagnostics and other commodities for other STIs. • Robust procurement and supply management systems are required to ensure that the right products are selected, purchased at a reasonable price and efficiently delivered to the point of service delivery.	• Rapid expansion in coverage of HIV prevention, diagnosis and treatment interventions is dependent on the availability and secure supply of affordable and quality HIV medicines, diagnostics and other commodities. • To ensure their long-term secure supply the procurement and supply management of HIV commodities should be integrated into the broader national procurement and supply management system.	• Effective hepatitis programmes are dependent on the uninterrupted supply of quality-assured vaccines, medicines, diagnostics and other commodities. • Robust procurement and supply management systems are required to ensure that the right products are selected, purchased at a reasonable price and efficiently delivered to the point of care. • The procurement and supply management of hepatitis commodities should be integrated into the broader national procurement and supply management system.
Knowledge & information	• Strengthening information systems and knowledge management. Development of information systems and an organizational culture that supports monitoring and evaluation, knowledge sharing and using data in decision-making is also a prerequisite	• Transparent discussions on values and priorities are needed to inform how operational definitions and metrics on a long and healthy life can be constructed and implemented within monitoring, surveillance and research. • Significant changes to the	• Health workforce registries to track health workforce stock, distribution, flows, demand, supply, capacity and remuneration. • National health workforce accounts to report to WHO Secretariat on core health workforce indicators.	• Strengthen and integrate STI surveillance into the national health information system, using standardized indicators and methodologies as guided by WHO; ensure high-quality data collection and ethical standards • Increase the "granularity" of data including through: enhanced	• A robust and flexible strategic information system is the cornerstone for advocacy, national strategic planning and ensuring accountability for best and fairest use of resources. Such an HIV information systems must be integrated within the broader national	• Timely and reliable data, with an adequate level of 'granularity', are essential to identify 'hotspots', the main modes of transmission and risk factors, the specific populations that are vulnerable, at risk and affected, the health burden in terms of cirrhosis and

	for transformational change: • development of information systems • systems research • knowledge management	collection, recording and linkage of health and administrative information, which is currently often condition- or intervention-based are needed. • Information on trajectories of functioning should be routinely collected at each encounter with the system to allow trends in functioning over time to be routinely determined. • New analytical approaches are also needed to obtain more robust and comprehensive economic assessments of the impact of poor health on older people and the benefits of population-wide and clinical interventions. • Fostering Healthy Ageing also promoting innovation, voluntary knowledge exchange and technology transfer, and attracting resources (people, institutions and financing) to address the major challenges faced. • Encourage multi-country studies and other forms of research such as through longitudinal cohort studies that are inclusive of older adults that document structural, intermediary, and other determinants of healthy ageing and evaluate interventions to support intrinsic capacity and functional ability particularly of older adults. • Gather and synthesize global evidence on what can be	• Harness information and communication technology (ICT) opportunities, in particular in relation to e-learning, electronic health records, clinical decision-making tools, supply chain management, performance management and feedback loops and service quality control. • Strengthening health workforce assessment and information exchange.	STI related disaggregated data collection based on different stratifiers that include age, sex, population and location; involve affected communities and key populations to achieve high-quality data and analysis. • Identify populations most at risk for STIs and places where most of the transmission is occurring; establish mechanisms to promote the participation of affected communities; describe the STI epidemics and measure the impact in terms of sequelae and cost; include data on the risk factors and determinants of STIs in order to understand and address these determinants. • Knowing the epidemics includes understanding where, how and among whom new infections are occurring, and identifying the factors that facilitate STI transmission or limit access to and use of appropriate services. Prevention, treatment and care programmes can then be prioritized and focused accordingly.	health information system. • High-quality 'granular' data, disaggregated by sex, age and other population characteristics, across the different levels of the health care system make it possible to focus HIV services more precisely and effectively, and to deploy or adapt services to reach greater numbers of people in need. Greater community and stakeholder involvement in collecting and analysing the data has the potential to improve the quality and effective use of the information. • Monitoring and understanding the HIV response at country and global levels is critical for informing more strategic investments in HIV programmes, and for maximizing their effectiveness, responsiveness and cost-effectiveness.	hepatocellular carcinoma and the coverage and quality of essential hepatitis services. Such data make it possible to proactively focus high-impact interventions more precisely and effectively, and to deploy or adapt services to reach greater numbers of people in need. • Monitoring and understanding the response to viral hepatitis is critical for informing more strategic investments in hepatitis services, and for maximizing their effectiveness, responsiveness and cost-effectiveness. • The hepatitis information system should be fully integrated into the broader national health information system to ensure standardized and coordinated reporting and to maximize efficiencies.

		done to foster healthy ageing in diverse contexts. • Better clinical research is urgently needed on the etiology of, and treatments for, the key health conditions of older age.				
Financing	• Improving funding and reforming payment systems. Changes in the way care is funded and paid for are also needed to promote adequate levels of funding and the right mix of financial incentives in a system that supports the integration of care between providers and settings and protection of patients against undue out-of-pocket expenditures on health. • assuring sufficient health system financing and aligning resource allocation with reform priorities. • mixed payment models based on capitation bundled payments.	• Mechanisms to ensure that older people can access services without financial burden will be crucial. Sustainable financing models are urgently needed to underpin the comprehensive and integrated services that older people require. • These should consider the need to minimize out-of-pocket spending and fragmentation within the health system. • The remuneration of and incentives for care providers could be oriented towards enabling the best possible trajectories of functioning, rather than the provision of specific interventions. • Further progress towards Healthy Ageing, regionally and nationally is dependent on the amount of additional resources available and allocated to this area, All stakeholders to mobilize resources at all levels.	• Ministries of Health, civil service commissions and employers should adapt employment conditions, remuneration and non-financial incentives to ensure fair terms for health workers. • Funding levels should reflect the value of effective HRH to the country's economy by factoring the potential for improved worker productivity in other sectors. • WHO should also advocate with global and regional financial institutions, development partners and global health initiatives for adoption of macro-economic and funding policies conducive to greater and more strategically targeted investments in HRH.	• Countries need to build a strong, comprehensive case to justify the use of domestic resources for STI prevention and care, and to mobilize external resources. • Financing for a sustainable response requires action in three areas: (1) Increasing revenue through innovative financing and new funding approaches; (2) Financial risk protection and pooling, and (3) Reducing price and costs and improving efficiency. • Develop a costed investment case for STIs to ensure adequate allocation of domestic and external resources. • Implement health financing systems, financial protection schemes and other mechanisms. • Pursue comprehensive strategies to reduce prices of STI commodities. • Increase efficiencies through improved planning and more efficient procurement	• Implementing fast track actions to end the AIDS epidemic by 2030 will require major new global investments, increasing from US21.7 billion in 2015 to US$32 billion in 2020. By front-loading investments the full continuum of HIV interventions and services can be rapidly taken to scale. • Financing for a sustainable HIV response requires action in three areas: (1) Revenue raising to pay for HIV interventions and services with an emphasis on improving domestic tax collection (2) financial risk protection and pooling (3)improving efficiency in the use of health system resources to enable greater effective coverage of HIV services.	• Unlike the other major communicable diseases, such as HIV, tuberculosis and malaria, there has been very little external development assistance funding for comprehensive viral hepatitis responses. • Adequate investments in the full continuum of hepatitis services is necessary to achieve the targets for 2020 and 2030, and to promote UHC. A sustainable response will require funding the essential hepatitis package through the national health financing system, mobilizing new and predictable funding, minimizing the financial burden for individuals and households through prepayment and pooling, achieving savings and avoiding wastage, and using available funds efficiently and equitably. • Financing for a sustainable hepatitis requires action in three areas: (1) Revenue raising to pay for viral hepatitis interventions and services, with an emphasis on improving domestic tax collection (2) Financial risk protection and pooling (3) Improving efficiency in the use of health system

						resources to enable greater effective coverage of hepatitis services.
Public Health Functions	• Appraise the package of health services offered at different levels of the care delivery system, covering the entire life course, using a blend of methods to understand both the particular health needs of the population, including social preferences, and the cost-effectiveness of alternative health interventions, guiding decision making on allocation of resources to health care. It also includes health technology assessment. • Revaluing promotion, prevention and public health by placing increased emphasis and resources on promotive, preventive and public health services. Public health systems include all public, private, and voluntary entities that contribute to the delivery of essential public health functions within a defined geographical area. • Strong primary care services are essential for reaching the entire population and guaranteeing universal access to service. This approach promotes coordination and continuous care over time for people with complex health problems, facilitating intersectoral action	• Approaches to engage with conditional specific programmes and or other sectors, as in many cases, the most effective approach to enhance intrinsic capacity and or functional ability, will be to integrate evidence-based actions within the work of other health programmes and partnerships, or within other sectors' policies and laws, for example those dealing with housing, transportation, social protection, education and employment. • Monitoring, surveillance and reporting of intrinsic capacity and functional ability at population, community and clinical levels, over time and disaggregated by age - well into oldest age groups -, sex, place of residence, and markers of socio-economic position. • Health systems and policy research to support healthy ageing in a sustainable and ethical manner, in diverse contexts, that for example, addresses the needs and rights of different age groups and different age cohorts.	• Radical improvements in the quality of the workforce are possible by implementing a transformative education agenda, based on competency-based learning, and which should equip health workers with knowledge and skills on social determinants of health and public health. This must include epidemic preparedness and response to advance the global health security agenda and the implementation of the International Health Regulations. • Ensure that the public health workforce links health workforce development efforts with the social services workforce and the wider social determinants of health, including access to housing, food, education and the local environment conditions. • Develop capacity to align incentives for health workforce education and health care provision to public health goals.	• The draft strategy is rooted in a public health approach that is concerned with preventing disease, promoting health, and ensuring quality of life among the population as a whole. It aims to ensure the widest possible access to high-quality services at the population level, based on simplified and standardized interventions and services that can readily be taken to scale, including in resource limited settings. Through adopting a public health approach, the strategy proposes: • Standardized, simplified protocols and guidance; • Integrated people-centred health services; • Decentralized service delivery; • A focus on equity; • Community participation; • The meaningful involvement of key populations; • Leveraging public and private sectors; • Ensuring services are free or affordable; • Moving from an individual clinical focus to population-based national plans.	• HIV is an area of public health in which major inequities exist in terms of vulnerability and risk, service access, and health and social outcomes. Countries need to strike a balance between focusing their HIV responses for maximum impact and ensuring that no one is left behind, particularly children and adolescents, girls and women, key populations and people living in remote areas. • The strategy is rooted in a public health approach that is concerned with preventing disease, promoting health, and prolonging life among the population as a whole. It aims to ensure the widest possible access to high-quality services at the population level, based on simplified and standardized interventions and services that can readily be taken to scale, including in resource-limited settings.	• A reorientation of hepatitis programmes towards a comprehensive public health approach will be critical if hepatitis elimination is to be achieved. This will require people-centred health services that can reach those populations most affected, well-functioning laboratories to ensure high quality screening, testing and treatment monitoring, a secure supply of affordable medicines and diagnostics, an appropriately trained health workforce, adequate public funding for essential interventions and services and active involvement of affected communities. • The strategy is rooted in a public health approach that is concerned with preventing infection and disease, promoting health, and prolonging life among the population as a whole. It aims to ensure the widest possible access to high-quality services at the population level. • A public health approach aims to achieve health equity and promote gender equality, engage communities and leverage public and private sectors in the response.

	in health. It prioritizes community and family-oriented models of care as a mainstay of practice.					
Intersectoral action	• Successful coordination in health matters involves multiple actors, both within and beyond the health sector. It encompasses sectors such as social services, finance, education, labour, housing, the private sector and law enforcement, among others. • Integrate health care providers within and across health care settings, develop referral systems and networks among levels of care, and create linkages between health and other sectors. It encompasses intersectoral action at the community level in order to address the social determinants of health and optimize use of scarce resources, including, at times, through partnerships with the private sector. • Reaching the underserved and marginalized is of paramount importance for guaranteeing universal access to health services. It requires actions at all levels of the health sector, and concerted action with other sectors and all segments of society, in order to address the other determinants of health and health equity.	• Enabling all people to live a long and healthy life requires a multisectoral approach with strong engagement from diverse sectors and different levels of government; and between government and nongovernmental actors, including service providers, product developers, academics and older people themselves. • In many cases, the most effective approach will be to integrate evidence-based actions within the work of other health programmes and partnerships, or within other sectors' policies and laws, for example those dealing with housing, transportation, social protection, education and employment. • When age-friendly actions are coordinated across multiple sectors and levels, they can enhance a range of domains of functional ability, including the "abilities" to meet basic needs; to be mobile; to continue to learn, grow and make decisions; to build and maintain relationships; and to contribute.	• Catalyse multi-sectoral action on health workforce issues to generate required support from ministries of finance and labour (or equivalent), and to ensure alignment of different sectors and constituencies and stakeholders in society to the national health workforce strategies and plans. • Inform and inspire the development of national health and HRH strategies, and also broader socio-economic development frameworks that countries adopt. • Strengthen contents and implementation of HRH plans as part of national health policies and strategies. This will benefit from intersectoral dialogue and alignment among relevant ministries (health, labour, education, finance, etc.), other constituencies and the private sector, and local government authorities.	• Greater integration and linking of STI services and programmes with those for other sectors (such as school health education programmes targeting adolescents, and occupational health) have the potential to reduce costs, improve efficiency and lead to better outcomes. • Coverage of treatment services can be increased through collaboration with other health programmes, government sectors (for example, education, occupational health, prison services, migration), as well as with community-based organizations and private health care providers. • Strategy promotes the principle of health in all policies through, where necessary, legal, regulatory and policy reforms. It aims to strengthen integration and linkages between STI and other services, improving both impact and efficiency.	• An effective HIV response requires action across many sectors, the health sector strategy aims to describe the specific health sector contribution to a multisectoral response and to the multisectoral UNAIDS strategy. • The Joint United Nations Programme on HIV/AIDS (UNAIDS) provides the framework for multisectoral action within the United Nations system, with WHO taking the lead on the health sector response.	• As with other public health programmes, the hepatitis response requires an enabling environment of policies, laws and regulations that support the implementation of evidence-based policies and programmes and promote and protect human and health rights, reduce stigma and ensure health equity.

TABLE 2. SUMMARY OF COMMONALITIES ACROSS THE FRAMEWORK AND THE FIVE STRATEGIES

	Framework on integrated people-centred health services 2016-2026	Global strategy and action plan on ageing and health 2016-2020	Global strategy on Human Resources for Health: Workforce 2030	Global health sector strategy on STIs (STIs), 2016-2021	Global health sector strategy on HIV, 2016-2021	Global Health Sector Strategy on viral hepatitis, 2016-2021
Vision	People centred-care					
Overall objective and approach	Contributing to the attainment of the Sustainable Development Goal on health (SDG 3) thorough transformative approaches					
Principles	Health equity, human rights, right to health, people-centredness					
Informing strategies & frameworks	UHC and SDGs					
Health System	A strong health system that is capable of providing reliable, effective, equitable, comprehensive and coordinated people-centred care in both public and private sectors will be required					
Service Delivery	All people of all ages should receive access to quality and integrated services that are centred on their needs, rights and preferences, including neglected or marginalized populations					
Leadership & governance	Focus on high-level political engagement, participation and leadership, intersectoral policy dialogue as well as global coordination and mutual accountability					

Health workforce	New models of service delivery will require strengthening the health workforce, with the necessary review of competencies, roles and tasks; a suitable work environment and incentives must be in place
Infrastructure	Emphasis on using resources in the most effective and efficient settings, services and interventions
Medical products, vaccines & technologies	Focus on harnessing technological advances and innovations, particularly in the realm of information and communication technologies; furthermore, ensure availability of relevant medical products through reliable supply management systems
Knowledge & information	A robust and flexible health information system to support monitoring and evaluation, self-management, knowledge sharing and decision-making will be cornerstone to all initiatives; participatory development of metrics to assure critical domains are monitored and improved
Financing	Sustainable financial models to underpin the needed reforms must be also in place; moreover, financial risk protection to ensure people can access services without assuming catastrophic expenditure will be crucial
Public Health Functions	Emphasis on a public health approach that is concerned with preventing disease, promoting health and functioning, and prolonging life among the population as a whole; addressing social determinants of health is critical to obtaining the targets set in all initiatives
Intersectoral action	A multisectoral approach with strong engagement from diverse stakeholders and the people themselves is required to move all initiatives forward; this includes health labor, education, finance, housing, social protection and transportation

World Health Organization

EXECUTIVE BOARD
138TH SESSION

ANNEX 2. EB DISCUSSION ON THE "FRAMEWORK ON INTEGRATED PEOPLE-CENTRED CARE" AND ITS ACCOMPANYING RESOLUTION "STRENGTHENING INTEGRATED PEOPLE-CENTRED HEALTH SERVICES"

Background

The "Framework on integrated people-centred health services" along with its accompanying draft resolution "Strengthening integrated people-centred health services" were discussed under the agenda item 10.1 in combination with the "Global strategy on human resources for health: Workforce 2030" at the 138th Session of the Executive Board on 28 January.
Prior to the EB, the draft resolution had been supported and co-sponsored by Andorra, Chile, Estonia, Finland, Japan, Latvia, Liberia, Luxembourg and Thailand.

Key issues emerging from Member States

Overall, both the framework and its accompanying draft resolution received very positive feedback during the discussion and encouraging statements and messages were conveyed by Member States that clearly emphasised the need to instil a people-centred and integrated approach to organizing, managing and delivering health services around the world.

The final list of Member States that supports the framework (and its accompanying resolution) includes: Andorra, Chile, Estonia, Finland, Japan, Latvia, Liberia, Luxembourg and Thailand (list of countries co-sponsoring the draft resolution) as well as USA, UK, China, Jordan (on EMRO's behalf), Namibia (on AFRO's behalf), Canada, Kuwait, Democratic People's Republic of Korea, Sweden on behalf of Nordic countries (Denmark, Finland, Iceland and Norway) and the Baltic countries (Estonia, Latvia and Lithuania), Republic of Korea, Philippines, India and Indonesia.

Among all the statements and comments by Member States, those that will have implications for the Secretariat in terms of documents refinement and actions to be taken will be emphasised in chronological order (not necessarily verbatim):

China: “In relation to the Framework, short-term and long-term strategies should be identified to ensure its sustainable implementation”.
Jordan (on behalf of EMRO): “[The Secretariat] should add a column for policy choices [for each context: conflict, low income countries, etc.]. And we have to come up with indicators to follow and understand how things are evolving”.

Namibia (on behalf of AFRO): “[The Framework] should underscore a comprehensive community-based approach to health care with prevention and health promotion as key components and health districts as fundamental units in its implementation. Monitoring and evaluation should be emphasized in the Framework and funding disparities between curative and public health interventions addressed. More emphasis is needed to address better services provision to promote health for marginalised populations. [In relation to the vision] we prefer it reads as “provision should be based on needs and in interest of the public and not on individual preferences”. Being more explicit on efforts at country level for change management initiatives towards front line service provision and improvement of patient experience will be needed. This will require up-skilling, process reengineering, task shifting and multidisciplinary teams”.

Kuwait: “However, the document does not take into account the scientific elements to strengthen the Framework”.

Sweden (on behalf of Nordic and Baltic countries): “[In regards to monitoring and evaluation] We would like to support work with broad science and relevant institutions, such as OECD, to develop indicators without imposing an unnecessary burden on Member States”.

Japan: “Since there are not universally accepted indicators, at this moment it’s not clear how the Framework will be monitored and how achievement will be measured. Indicators need to be researched and developed in a timely manner”.

India: “The Framework does mention integration of traditional and complementary medicine with modern health systems; however, the related resolution does not have any reference to this subject. [Furthermore] the role of family members in providing health care and the training for this purpose requires clear annunciation”.

Liberia: “[In relation to the draft resolution] we would prefer that the terms” preferences” and “expectations” be deleted from OP2.3”.
As a result of discussions, two main conclusions should be highlighted. In relation to the Framework, further refinement with mutual consultations among Member States and the Secretariat is expected to take place between the EB and the 69th WHA. With regard to the draft resolution, it was approved as amended by the EB.

Implications for the Secretariat

According to the above mentioned comments and suggestions, the background document should be refined taken into account the following elements:

TABLE 1. KEY ASPECTS TO BE REFINED IN THE BACKGROUND DOCUMENT ACCORDING TO MEMBER STATES

	Elements to be added	Aspects to be removed
Framework on IPCHS	• A column for policy options according to different country contexts • Scientific elements to strengthen the Framework • More emphasis on: ○ a comprehensive community-based approach to health care with prevention and health promotion as key components and health districts as fundamental units in its implementation ○ addressing funding disparities between curative and public health interventions ○ better services for marginalised populations ○ actions for change management ○ role of family members in providing health care and training for them • M&E should be underscored and indicators to measure progress should be developed along with relevant institutions (e.g. OECD)	•The term “preferences” from the vision