People-Centred Health Care

TECHNICAL PAPERS

Intenational Symposium on People-Centred Health Care:
Reorienting Health Systems in the 21st Century
The Tokyo International Forum
25 November 2007

World Health Organization
Western Pacific Region

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Acknowledgments

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Robin was closely involved in patient process redesign and quality improvement. He founded the Clinical Leaders Association of NZ (CLANZ) in 1998.

He was Acting Chair of the NZ EpiQual committee in 2006 and played a significant role in shaping the national strategy for quality improvement in health care. He is a member of the new national Quality Improvement Committee (QIC) and also the New Zealand representative on the International Steering Committee for Patient Safety Solutions within the WHO Global Alliance on Patient Safety.

Robin has presented and taught widely on issues of clinical service redesign, patient-centred reform, clinical leadership, patient safety, open disclosure, and compassion in health care.

Chang-Yup Kim
Patient-centred health care: supportive health systems

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Prior to these positions, he obtained specialist certification in family medicine and preventive medicine after completing training at the Seoul National University Hospital. His MPH and PhD were also conferred by the same university. His current research activities include health policy, health insurance, long-term care policy, and equity in health and health care. In addition to academic activities, he has long been actively involved in consultation for the Korean government, including acting as an adviser to the Minister of Health and Welfare.

He was the (founding) Director of the National Health Insurance Research Institute from 2000 to 2001 and has been the (founding) President of the Korean Society for Equity in Health since October 2003.

Background

The global health landscape has been undergoing tremendous change with development as its key driver. Health systems, unfortunately, have not kept pace. Global and regional trends indicate that current health systems have made remarkable progress in access and coverage, but need to be reoriented to promote and preserve health in its fullest sense as defined by WHO. Health care quality and responsiveness to multidimensional needs, legitimate demands and expectations of patients and their families significantly impact health. Thus, the need for innovative, balanced, holistic and people-centred approaches to health care has become a matter of concern for countries and health systems worldwide.

Economic, demographic and social forces have increasingly put pressure on health systems not only to provide universally accessible, effective and scientifically sound health care, but also to ensure that services are designed and delivered in ways that respect patients' rights and suit their needs and preferences for information, psychosocial support and participation in decision-making for their own care.

In the Western Pacific, the Regional Committee, the governing body of WHO at the regional level, has passed various resolutions addressing broader issues and determinants of health as they significantly impact health care, health outcomes, satisfaction with care, and overall population health and well-being. Resolution WPR/RC55.R1 specifically requested the WHO Regional Office for the Western Pacific to support Member States in ensuring that the formulation of health policies gives due consideration to the broader psychosocial determinants of health, and to produce a draft policy framework reflecting the significance of psychosocial factors affecting health outcomes.

Thus, the WHO Regional Office for the Western Pacific embarked on the People at the Centre of Care Initiative. The initiative developed a policy framework through a process involving a reference group of experts as well as stakeholder consultations in selected countries. The policy framework was presented at the fifty-eighth session of the Regional Committee in Jeju, the Republic of Korea, in September 2007. Through resolution WPR/RC58.R4, the meeting endorsed the People-Centred Health Care: A Policy Framework. Intended to serve as a guide for Member States to develop and implement people-centred health care policies and interventions according to their national contexts, it called for policy changes and interventions in four action domains: (1) individuals, families and communities; (2) health practitioners; (3) health care organizations; and (4) health systems.

Resolution WPR/RC58.R4 mandated WHO, among other things, to undertake advocacy and social mobilization activities in consolidating and taking to scale current efforts and initiatives on people-centred health care. This prompted the WHO Regional Office for the Western Pacific to lead the development of a biregional publication entitled People at the Centre of Health Care: Harmonizing mind and body, people and systems, an elucidation in popular language of the principles and proposed actions embodied in the policy document. The advocacy book was launched at the International Symposium on People-Centred Health Care: Re-orienting Health Systems in the 21st Century, held in Tokyo, Japan on 25 November 2007. The symposium reaffirmed the principles and areas of action contained in the WHO publications on people-centred health care and made recommendations on taking the work forward. The publications and the proceedings of the symposium are available online (www.wpro.who.int/sites/pci/publications.htm).

The WHO Regional Office for the Western Pacific commissioned the preparation of four technical papers, each focusing on a particular action domain, which were made available to the participants during the symposium. The contributors were also invited to present PowerPoint versions of their papers during the symposium. This compilation of the four technical papers, published for wider distribution, aims to educate and engage a broad range of stakeholders, thereby encouraging greater understanding of and commitment to people-centred health care.

1 Informed and empowered individuals, families and communities

Introduction

Health systems throughout the world are searching for ways to make their services more responsive to patients and the public. Often there is a perceived need to respond to "consumer" pressure and to make health care more like other consumer experiences. But the need for "patient engagement", in which patients are encouraged to take an active role as key players in protecting their health, coping with acute episodes of ill-health and managing chronic disease, is often ignored. Substantial evidence exists that this not only improves patients' experience and satisfaction, but can also be clinically and economically effective.

Individuals, families and communities can play distinct roles in promoting health in the following ways:

- by understanding the causes of disease and the factors that influence health;
- by self-diagnosing and treating minor self-limiting conditions;
- by selecting the most appropriate form of treatment for acute conditions in partnership with health professionals;
- by monitoring symptoms and treatment effects;
- by being aware of safety issues and reporting them;
- by learning to manage the symptoms of chronic disease;
- by adopting healthy behaviours to prevent occurrence or recurrence of disease; and
- by critiquing and feeding back on the quality and appropriateness of health care services.

Recognizing these roles and seeking to strengthen them is fundamental to securing a more patient-centred approach to health care delivery. It also provides the essential underpinning for strategies aimed at reducing health inequalities and improving health for all.

This paper outlines what the research evidence tells us about the effects of engaging individuals, families and communities in their health care in relation to the following goals:

- improving self-care;
- improving treatment decisions;
- improving health literacy; and

- improving responsiveness.

As part of a wider research initiative to collate and synthesize research on performance, quality and cost effectiveness in health care, we searched the literature for evidence on patient-focused quality interventions. Electronic databases including Medline, Embase, CINAHL, Cochrane Library, Database of Abstracts of Reviews of Effects, World Health Organization and Agency for Healthcare Research and Quality were searched systematically. We also searched specialist websites, including those of patient organizations, and scanned references for key papers. The search was restricted to English-language papers published since 1998. The database can be found at www.health.org.uk/qquip and a full report is available on the Picker Institute website www.pickereurope.org. This report draws on these and other published summaries of the material.[1,2]

Improving self-care

Why is it important?

Self-care – actions that people take to recognize, treat and manage their own health problems independently of the medical system – is the most prevalent form of health care. Most people cope with minor illnesses without recourse to professional help. Those with long-term conditions spend far more time looking after themselves than being under the care of health professionals, yet health service planning tends to ignore this important fact. Failure to recognize and support people's self-care efforts encourages unnecessary dependency on professionals. The result is increased demand for

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1 Coulter A., Ellins J. Patient-focused interventions: a review of the evidence. London, The Health Foundation, 2006.
2 Coulter A., Ellins J. Effectiveness of strategies for informing, educating and involving patients. *British medical journal*, 2007, 335:24–27.

expensive health care resources, which threatens to undermine the long-term sustainability of many health systems.

Much self-care consists of the day-to-day management of long-term and chronic illnesses such as asthma, diabetes and arthritis. The growing case-load of these conditions will be a major future challenge for health services.[3] Self-management is what most people with long-term conditions do all the time. They manage their daily lives and cope with the effects of their condition as best they can, for the most part without any intervention from professionals.

When people with chronic conditions seek professional advice, they need appropriate help and support to enhance their self-management skills. Unfortunately they do not always receive it.[4] Too often, the way in which clinicians and patients interact tends to promote passivity and dependence instead of self-reliance, sapping patients' self-confidence and undermining their ability to cope.[5]

Policy-makers in many countries are now seeking ways to shift resources into the community and away from dependence on the expensive hospital sector. This represents an effort to deal more effectively with chronic problems that affect around 60% of the adult population.[6] The Chronic Care Model developed by Ed Wagner and his colleagues in the United States of America has been highly influential internationally.[7] Empowering people to manage their own health and health care and providing effective self-management support for long-term conditions is a central component of this model.

The principles of self-care have been developed in a number of theoretical models, mostly from the fields of psychology and behavioural science. Of these, it is Bandura's self-efficacy theory that is most widely quoted.[8] Self-efficacy refers to an individual's belief in his or her capacity to learn and perform a specific behaviour successfully. A strong sense of self-efficacy leads to a feeling of control and a willingness to take on and persist with new and difficult tasks. When applied to health, this theory suggests that patients are

3 Von Korff M., Glasgow R.E, Sharpe M. Organising care for chronic illness. *British medical journal*, 2002, 325(7355):92–94.

4 Coulter A., Magee H. *The European patient of the future*. Maidenhead, UK, Open University Press, 2003.

5 Lancaster T., Stead L.F. Self-help interventions for smoking cessation. Cochrane database of systematic reviews, 2002, 3:CD001118.

6 Singh D., Ham C. *Improving care for people with long-term conditions: a review of UK and international frameworks*. Birmingham, UK, Health Services Management Centre, University of Birmingham, 2006.

7 Wagner E.H. Chronic disease management: what will it take to improve care for chronic illness? *Effective clinical practice*, 1998, 1(1):2–4.

8 Bandura A. *Self-efficacy: the exercise of control*. New York, W.H. Freeman, 1997.

empowered and motivated to manage their health problems when they feel confident of their ability to achieve this goal. So interventions for improving self-care should focus on confidence-building and equipping patients with the tools (knowledge and skills) to set personal goals and develop effective strategies for achieving them.

What has been shown to work?

People with chronic conditions, for example depression, eating disorders, asthma, arthritis and hypertension, have benefited from *lay-led self-management education* in which they learn from other people with the same chronic condition.[9] Courses are often run by voluntary organizations. Participants learn about relaxation, managing depression, fear and anger, as well as nutrition, problem-solving, managing medication, sharing treatment decisions and making plans for future care. This type of self-help education can bring benefits in terms of improvements in knowledge, coping behaviour, adherence to treatment recommendations and self-efficacy. It can also bring modest short-term improvements in pain, disability, fatigue and depression, but there is little evidence of a reduction in the number of doctor's visits or hospital admissions.[10],[11]

Self-management education seems to work best when it is integrated into primary and secondary health care systems and the learning is reinforced by professionals. Many *professionally led self-management education programmes* are aimed at specific patient groups. These can be very effective. Diabetes patients have been seen to gain health benefits from self-management education. Moreover, some studies have shown that these can lead to a reduction in health service costs.[12],[13] A review of professionally led self-management education programmes for patients with chronic obstructive pulmonary disease found that they were associated with a reduction in the rate of hospital admissions.[14]

Information-only education programmes (without participative studying) have little effect on self-care, although they can be helpful in building the background knowledge. Written information to reinforce educational

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[9] Lorig K.R., *et al*. Chronic disease self-management program: 2-year health status and health care utilization outcomes. *Medical care*, 2001, 39(11):1217–1223.

10 Newman S., Steed L., Mulligan K. Self-management interventions for chronic illness. *Lancet*, 2004, 364(9444):1523–1537.

11 Foster G., *et al*. Self-management education programmes by lay leaders for people with chronic conditions. Cochrane database of systematic reviews (online), 2007:4.

12 Guidance on the use of patient-education models for diabetes. *Technology appraisal guidance 60*. London, National Institute for Health and Clinical Excellence, 2003.

13 Deakin T., *et al*. Group based training for self-management strategies in people with type 2 diabetes mellitus. Cochrane database of systematic reviews, 2005:1.

14 Effing T. Self-management education for patients with COPD. Cochrane database of systematic reviews (online), 2007:4.

messages about self-care and chronic disease self-management given in clinical consultations, for example *self-management guidelines*, can also be helpful.

Information on its own does not change people's behaviour or produce better health outcomes.[15] Active education, teaching practical skills, is always more effective.[16] This type of active approach can be delivered by computer. Two systematic reviews of *computer-based interactive applications* found that patients' knowledge and abilities increased, they felt they had better social support, and their health behaviours and outcomes improved[17],[18]

The most effective self-management education programmes are those that are longer, more intensive and well-integrated into the health system, and in which the learning is reinforced by health professionals during regular follow-up care. Efforts should be focused on providing opportunities for patients to develop practical skills and the confidence to self-manage their health. Hands-on participative learning styles are better than traditional didactic teaching.

Patient-centred *telecare* – providing people with information, health coaching using motivational techniques, advice and support over the phone to their homes – can reduce social isolation. It can also improve people's confidence and ability to cope, reduce depression and improve quality of life.[19] When it replaces routine personal home visits or clinic visits it can save costs.

Sharing personal medical information and encouraging people to review their records and the advice they have been given can be very empowering. Giving patients *access to personal medical records* has been shown to increase their sense of control, but few other benefits have been proved.[20] Providing *audiotape records of consultations* improves patients' knowledge and recall.[21]

There are few systematic studies on the benefits of *self-help groups, peer support* and other *community development approaches*. Such evidence as there is shows people welcome this type of social support, gain knowledge and improve their coping abilities. But there is little evidence of a lasting impact on

15 Gibson P.G., *et al*. Limited (information only) patient education programs for adults with asthma. Cochrane database of systematic reviews, 2002, CD001005(2).

16 Gibson P.G., *et al*. Self-management education and regular practitioner review for adults with asthma. Cochrane database of systematic Reviews, 2003, CD001117(1).

17 Kaltenthaler E., *et al*. A systematic review and economic evaluation of computerised cognitive behaviour therapy for depression and anxiety. *Health technology assessment*, 2002, 6(22):1–89.

18 Murray E., *et al*. Interactive health communication applications for people with chronic disease. Cochrane database systematic reviews, 2005, CD004274(4).

19 Jennett P.A., *et al*. The socio-economic impact of telehealth: a systematic review. *Journal of telemedicine and telecare*, 2003, 9(6):311–320.

20 Brown H.C., Smith H.J. Giving women their own case notes to carry during pregnancy. Cochrane database of systematic reviews, 2004, CD002856(2).

21 Scott J.T., *et al*. Recordings or summaries of consultations for people with cancer. Cochrane database of systematic reviews, 2003, CD001539(2).

health outcomes.[22],[23] Women may gain more than men, and people who feel isolated gain the most. However, the few studies that have been done tend to focus on well-motivated groups, possibly limiting the chance of demonstrating an effect. There is much interest in using these types of community approaches with disadvantaged groups who perhaps have more to gain.

Self-monitoring and *self-administered treatment* includes things such as encouraging patients to monitor their own blood pressure or administer their own anticoagulation therapy. These can lead to positive results.[24],[25] Health status can be as good as when these tasks are undertaken by health professionals, and some cost savings may be possible.

Given the right tools and support, the evidence shows that people can be empowered to set their own self-management goals and devise appropriate strategies for meeting them. Ironically though, it seems that these initiatives work best when integrated into the health system instead of being separate from it. This means that the role of health professionals in guiding patients through the process is essential. The goal is patient autonomy, but responsibility for achieving this must be shared by patients and health professionals alike.

Improving treatment decisions

Why is it important?

Not being properly informed about their condition and the options for treating it is the most common source of patient dissatisfaction.[26],[27] Most patients want more information and a greater share in the process of making decisions about how they will be treated.

Shared decision-making is *"a process in which patients are involved as active partners with the clinician in clarifying acceptable medical options and in choosing*

22 Campbell H.S., Phaneuf M.R., Deane K. Cancer peer support programs – do they work? *Patient education and counseling*, 2004, 55(1):3–15.

23 van Dam H.A., *et al.* Social support in diabetes: a systematic review of controlled intervention studies. *Patient education and counseling*, 2005, 59(1):1–12.

24 Heneghan C., *et al.* Self-monitoring of oral anticoagulation: a systematic review and meta-analysis. *Lancet*, 2006, 367(9508):404–411.

25 Jansen J.P. Self-monitoring of glucose in type 2 diabetes mellitus: a Bayesian meta-analysis of direct and indirect comparisons. *Current medical research and opinion*, 2006, 22(4):671–681.

26 Coulter A., Cleary P.D. Patients' experiences with hospital care in five countries. *Health affairs*, 2001, 20(3):244–252.

27 Grol R., *et al.* Patients in Europe evaluate general practice care: an international comparison. *British journal of general practice*, 2000, 50:882–887.

a preferred course of clinical care".[28] It is closely linked to, but not the same as, the processes of obtaining informed consent and communicating risks.

Shared decision-making is appropriate in any situation where there is more than one reasonable course of action and where no single option is self-evidently best for everyone. This situation is very common since there are often many different ways to treat a health problem, each of which may lead to a different set of outcomes.

Central to sharing is a two-way exchange between the patient and the professional. Health professionals act as experts and share information about their social circumstances, attitudes to illness and risk, values and preferences. These factors may have a strong influence on weighing the appropriateness of any treatment and should be accepted as legitimate in the decision-making process. Also accepted is the patient's shared responsibility for the decision and for any risks taken.

Not all patients want to share in making the decisions. Older persons are more likely to want the doctor to decide. People who are relatively healthy may want to be more involved – in decisions about screening, for instance – than those who are very ill.[29] What is important is that health professionals should not make assumptions, based on their observation of the patient, about the degree of involvement they desire. The professional should always try to find out those preferences through communication.

What has been shown to work?

Well-designed *training courses* can improve the communication skills of doctors, nurses and pharmacists.[30],[31] Patients achieve greater involvement, their knowledge improves, their anxiety lessens and they feel more satisfied. This does not seem to increase costs, and it may bring them down by reducing

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28 Sheridan S.L., Harris R.P., Woolf S.H. Shared decision making about screening and chemoprevention: a suggested approach from the U.S. Preventive Services Task Force. *American journal of preventive medicine*, 2004, 26(1):56–66.
29 Davey H.M., *et al*. Medical tests: women's reported and preferred decision-making roles and preferences for information on benefits, side-effects and false results. *Health expectations*, 2002, 5(4):330–340.
30 Fellowes D., Wilkinson S., Moore P. Communication skills training for health care professionals working with cancer patients, their families and/or carers. Cochrane database of systematic reviews, 2004, CD003751(2).
31 Gysels M., Richardson A., Higginson I.J. Communication training for health professionals who care for patients with cancer: a systematic review of effectiveness. *Support care cancer*, 2004, 12(10):692–700.

the number of prescriptions issued.[32],[33] People stick to their course of medicine better (adherence), thus increasing the chance that treatment will be effective. Clearly, it is possible to make a significant difference to the way professionals communicate with their patients.

Patient empowerment techniques help patients take a more active role. These include coaching to increase people's confidence to take a more proactive role in consultations. They also include cards that prompt them on questions to ask; diaries or topic lists for discussion; and summaries of consultations for later review. Patients' knowledge and recall are improved; they feel more involved and in control.[34],[35] There is no evidence that this active role prolongs consultations – so it does not increase costs. Evidence about whether it improves physical health is mixed.

Patient decision aids are evidence-based tools to supplement the exchanges between patients and professionals. There are more than 400 available internationally (see www.ohri.ca/decisionaid). They use various media (e.g. leaflets, computer programs, audiotapes, compact discs) to help patients review evidence on the effectiveness of different treatments and work out their preferences. Then they can make decisions based on knowledge of the potential benefits and disbenefits of the different options.

Decision aids can be very effective if they are well designed. A set of standards has been developed by an international group to guide the development and evaluation of patient decision aids.[36] Patients' knowledge improves; they achieve greater involvement and a better match between their values and the treatment chosen.[37] Decision aids neither increase nor decrease anxiety, but they do give patients a more accurate perception of risk. The more individualized the risk information, the more likely it is to affect the treatment choice.

There is also evidence that decision aids can be cost-effective, especially if coupled with face-to-face counselling. For example, a large randomized trial of decision support for patients with menorrhagia, which included a video of the treatment options and outcomes, an accompanying booklet, and a structured

32 Stevenson F.A., *et al*. A systematic review of the research on communication between patients and health care professionals about medicines: the consequences for concordance. *Health expectations*, 2004, 7(3):235–245.
33 Cohen D., *et al*. Resource effects of training general practitioners in risk communication skills and shared decision making competences. *Journal of evaluation in clinical practice*, 2004, 10(3):439–445.
34 Griffin S.J., *et al*. Effect on health-related outcomes of interventions to alter the interaction between patients and practitioners: a systematic review of trials. *Annals of family medicine*, 2004, 2(6):595–608.
35 Wetzels R. Interventions for improving older patients' involvement in primary care episodes. Cochrane database of systematic reviews (online), 2007:3.
36 Elwyn G., *et al*. Developing a quality criteria framework for patient decision aids: online international Delphi consensus process. *British medical journal*, 2006, 333(417):419.
37 O'Connor A.M., *et al*. Decision aids for people facing health treatment or screening decisions. Cochrane database of systematic reviews, 2003, CD001431(2).

interview with a nurse to help patients express their preferences, resulted in reduced hysterectomy rates and lower mean overall service costs.[38] Estimates of the effect of using patient decision aids suggest they can lead to reductions of around 25% in elective surgery rates. However, this is obviously dependent on the underlying rates, which are known to vary considerably both between and within countries.

Decision aids should be based on up-to-date reviews of the research evidence. So a national organization, such as a research institute, may be required to host, develop and update the materials.

Despite evidence of benefit, widespread implementation of innovations to improve decision-making and promote greater patient involvement has been slow to occur. However, following policy initiatives in a number of countries, including Australia, Canada, France, Germany, Italy, the Netherlands, the United Kingdom and the United States of America, the pace appears to be quickening.[39,40,41,42,43,44,45,46] Policy-makers and clinicians are now beginning to realize that involving patients as partners with decision-making responsibility makes more sense than treating them as passive recipients of care.

Improving health literacy

Why is it important?

Health literacy is fundamental to patient engagement. If people cannot obtain, process and understand basic health information, they will not be able to look after themselves well or make good decisions. Health literacy is about

38 Kennedy A.D.M., *et al.* Effects of decision aids for menorrhagia on treatment choices, health outcomes, and costs. *Journal of the American Medical Association*, 2002, 288:2701–2708.
39 McCaffery K.J., *et al.* Shared decision-making in Australia. *Z ärztl Fortbild Qual Gesundh wes*, 2007, 101:205–211.
40 Legare F., Stacey D., Forest P.G. Shared decision-making in Canada: update, challenges and where next! *Z ärztl Fortbild Qual Gesundh wes*, 2007, 101:213–221.
41 Moumjid N., *et al.* Shared decision-making in the physician–patient encounter in France: a general overview. *Z ärztl Fortbild Qual Gesundh wes*, 2007, 101:223–228.
42 Loh A., *et al.* Patient and citizen participation in German health care – current state and future perspectives. *Z ärztl Fortbild Qual Gesundh wes*, 2007, 101:229–235.
43 Goss C., Renzi C. Patient and citizen participation in health care decisions in Italy. *Z ärztl Fortbild Qual Gesundh wes*, 2007, 101:236–240.
44 van der Weijden T., van Veenendaal H., Timmermans D. Shared decision-making in the Netherlands – current state and future perspectives. *Z ärztl Fortbild Qual Gesundh wes*, 2007, 101:241–246.
45 Evans R., *et al.* Prominent strategy but rare in practice: shared decision-making and patient decision support technologies in the UK. *Z ärztl Fortbild Qual Gesundh wes*, 2007, 101:247–253.
46 Holmes-Rovner M., Gruman J., Rovner D.R. Shared decision-making in the US – research and development outpaces delivery. *Z ärztl Fortbild Qual Gesundh wes*, 2007, 101:254–258.

empowering people to find, understand and use health information to make sound decisions about their own, their family's or their community's health.

Improving health literacy is critically important in tackling health inequalities. People with low health literacy have poorer health status, higher rates of hospital admission and are less likely to adhere to prescribed treatments and care plans. They also experience more drug and treatment errors, and make less use of preventive services.[47]

People's health information needs are very diverse and vary according to their age, class, gender, beliefs, preferences and coping strategies. They also vary according to their general literacy, first language, skills and abilities. Information needs often change during the course of an illness. When patients first receive a diagnosis, for example, they need practical information to support care decisions. Later, when they focus on the long-term prognosis and self-care, they may have more specific and in-depth information needs.

Health literacy interventions around the world have three key objectives: to provide information; to encourage the appropriate and effective use of health resources; and to tackle health inequalities.

What has been shown to work?

Well designed *written information* (such as leaflets) can be helpful to reinforce professionals' explanations of health problems and treatments. Information works best if it is personalized to the individual, so computer-based materials can be more effective than paper-based information. For example, a trial of *electronic information* linked to cancer patients' medical records found that these were much more highly valued by the patients than booklets or generic computer-based materials.[48]

Low literacy interventions that target health information at people lacking in health literacy have usually involved designing or revising health information for their specific needs. Evaluations have shown mixed results, with some leading to improved knowledge and comprehension.[49] Pictograms and other visual aids are popular with some people, but there is not enough evidence

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47 Institute of Medicine. *Health literacy: a prescription to end confusion*. Washington, DC, The National Academies Press, 2004.
48 Jones R., *et al*. Randomised trial of personalised computer based information for cancer patients. *British medical journal*, 1999, 319:1241–1247.
49 Berkman N.D., *et al*. *Literacy and health outcomes*. Evidence Report/Technology Assessment No. 87. Rockville, MD, Agency for Healthcare Research and Quality, 2004.

to show whether these initiatives have had any effect on health inequalities. People who use computers often like obtaining their health information from the Internet. But reliance on this can reinforce health inequalities by excluding elderly or disabled people, people with low incomes and those from ethnic minorities. However, if access barriers can be overcome, there is reason to believe that people from disadvantaged communities can benefit more than those from affluent groups.[50]

Information in other *electronic formats* – interactive digital television, mobile phone texts, audiotape and web-based data – has shown mixed results for improving knowledge. However, it can have beneficial effects on patients' confidence and ability to be involved in decisions. There is also evidence that it can help to improve clinical outcomes and health behaviour, especially when used to complement health education provided in a clinical setting.[51] Information in electronic formats may be particularly useful for targeting hard-to-reach groups: for example, young people with diabetes. In this instance, mobile phone text messages have been used with some success to reinforce self-management goals.[52]

Mass media campaigns to spread health information can be effective in raising awareness, but evidence of direct effects on behaviour is limited. This is partly because of the measurement difficulties inherent in population approaches to health promotion. Some successes have been reported, for example in reducing smoking among teenagers and encouraging activity among back pain sufferers. Mass media campaigns may work best as a "background" against which other actions to change behaviour can take place.[53],[54]

What people want most of all is health information that is available at specific decision points. It needs to be appropriate, timely, relevant and reliable. The quality of Internet information is very variable and often problematic, so tools for assessing quality and reliability can be useful.[55],[56] Clinicians and policy-makers usually think it is important to provide mainstream medical information, such

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50 Gustafson D.H., *et al.* CHESS: 10 years of research and development in consumer health informatics for broad populations, including the underserved. *International journal of medical informatics*, 2002, 65(3):169–177.

51 *Murray E., et al. Op cit.* Ref 18.

52 Franklin V. A randomised controlled trial of Sweet Talk: a text messaging system to support young people with diabetes. *Diabetes medicine*, 2006, 23:1332–1338.

53 Grilli R., Ramsay C., Minozzi S. Mass media interventions: effects on health services utilisation. Cochrane database systematic reviews, 2002, CD000389(1).

54 Black M.E., Yamada J., Mann V. A systematic literature review of the effectiveness of community-based strategies to increase cervical cancer screening. *Canadian journal of public health*, 2002, 93(5):386–393.

55 Eysenbach G., et al. Empirical studies assessing the quality of health information for consumers on the world wide web: a systematic review. Journal of the American Medical Association, 2002, 287(20):2691–2700.

56 Coulter A., et al. Assessing the quality of information to support people in making decisions about their health and healthcare. Oxford, UK, Picker Institute Europe, 2006.

as the facts about a disease. But patients may be more interested in treatment options and their probabilities of success, or the prognosis, or how to obtain support to manage their condition.[57],[58] A number of quality check-lists have been developed to address concerns about the reliability of health information materials. These include the Health on the Net Foundation Code of Conduct www.hon.ch and the DISCERN quality criteria www.discern.org.uk.

Improving responsiveness through public involvement

Why is it important?

There is increasing recognition that a high quality health service is one that is both organized around, and responsive to, the needs of the people who use it. To this end, lay people should have genuine opportunities for involvement in decisions about the development, planning and provision of health services.

There is a wide range of methods for involving members of the public, from information-giving, through consultation, to full user control. These methods can be distinguished in various ways, but most importantly in the extent to which they seek to empower people and democratize the decision-making process.

A distinction can be made between 'consumerist' and 'democratic' approaches to public participation. The first of these focuses on individuals as the users of products or services, and emphasizes *choice* as a driver for quality improvement. The second situates participation within a broader political context, emphasizing democratic accountability or *voice*.

Several factors have been identified that can inhibit efforts to engage members of the public and ensure that services are truly responsive to their needs and preferences. These include lack of clarity about aims and objectives, financial and resource limitations, resistance from health professionals or managers, and concerns about whether people who get involved represent all sections of the community.

If it is not clear what an initiative is intended to achieve, it may be difficult to secure public interest and commitment, gather momentum, produce

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57 Reid J.C., *et al*. Why people don't learn from diabetes literature: influence of text and reader characteristics. *Patient education and counseling*, 1995, 25(1):31–38.
58 Swain D., *et al*. *Accessing information about health and social care services*. Oxford, UK, Picker Institute Europe, 2007.

a coherent strategy of action or maintain momentum. Without adequate resources – including funding, staff time and training – public involvement initiatives are likely to fail or have limited impact on service development. Health professionals may feel threatened by public involvement, undermining the potential for open and trusting relationships. Managers and health professionals often try to retain control of agendas and resources, with lay participants feeling that their role is merely to rubber-stamp decisions that have already been made. Where lay participants are felt to represent only a select group or to be pursuing strong personal agendas, the legitimacy of the initiative may be called into question, particularly if disadvantaged groups are excluded.

What has been shown to work?

There is ample evidence that people generally like having the opportunity to express their views and get involved, at least in theory. In practice, it can be more difficult to secure people's active participation. However, the evidence base on the impact of public involvement is weak. There are many published accounts of public involvement initiatives, but few report on benefits or costs, and hardly any have attempted a formal assessment of outcomes. In part, this is a reflection of the difficulty of evaluating public involvement projects and the lack of an agreed framework for such evaluation.

Patient participation groups, lay membership of policy-making bodies and *public meetings* can help to initiate changes in services. Examples include making services more accessible through simplification of appointment procedures, longer opening hours, improvements in transport facilities and support for people with disabilities.[59] User involvement can also help to broaden understanding of the patient perspective and generate ideas for new services. A number of initiatives to involve service users and their family carers in the planning, delivery and evaluation of mental health services have been evaluated, with mixed results.[60,61,62,63]

59 Crawford M., Rutter D., Thelwall S. *User involvement in change management: a review of the literature*. London, National Co-ordinating Centre for NHS Service Delivery and Organisation R&D, 2003.

60 Crawford M.J., *et al*. User involvement in the planning and delivery of mental health services: a cross-sectional survey of service users and providers. *Acta psychiatrica Scandinavica*, 2003, 107(6):410–414.

61 Rutter D., *et al*. Patients or partners? Case studies of user involvement in the planning and delivery of adult mental health services in London. *Social science and medicine*, 2004, 58(10):1973–1984.

62 Rose D., *et al*. *User and carer involvement in change management in a mental health context: review of the literature*. London, National Co-ordinating Centre for NHS Service Delivery and Organisation R&D, 2003.

63 Simpson E.L., House A.O. Involving users in the delivery and evaluation of mental health services: systematic review. *British medical journal*, 2002, 325(7375):1265.

A variety of methods have been devised for securing public views on policy priorities. These work best when those organizing them are genuine in their wish to know what local people think. When there are specific trade-offs to be made, deliberative methods, for example *citizens' juries*, can be effective. The issues must be pertinent to the participants and the process must be carefully facilitated to avoid dominance by a small number of people with strong views.

Deliberative methods such as citizens' juries can overcome the shortcomings of other public consultation methods, for example public meetings. They can do this by giving participants a clearer role, giving them time and support to make considered decisions, and allowing those decisions to have a clear impact on services. But they are expensive, making cost effectiveness an unresolved issue.[64]

Public views on priorities can be obtained more cheaply using *surveys* and *focus groups*. Various methods have been devised to enable people to express their views on priorities. These include electronic voting systems, ranking, scoring and rating, Delphi methods and economic techniques such as "willingness to pay", "time trade-off" and "standard gamble".[65]

Surveys, focus groups and other market research techniques can also be used to monitor the quality of patients' experience or to determine population needs and preferences. Measurement of patients' experience is a useful component of a broader quality improvement strategy. Publication of survey results has been shown to stimulate quality improvements.[66] Regular *feedback from service users* is a good way to monitor performance and stimulate quality improvement. Coordinated patient survey programmes have been initiated in a number of countries to measure adherence to standards and to enable health care facilities to benchmark their performance against others. Surveys and other market research techniques can also be used to assess the needs and preferences of specific population groups and to seek out the views of disadvantaged or "hard-to-reach" groups.

Other approaches, including *patients' panels* and *consensus conferences*, have been tried. But as yet the evidence is not available to conclude which forms of public participation work best, and in what circumstances.

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64 McIver S. Healthy debate? An independent evaluation of citizens' juries in health settings. London, King's Fund, 1998.
65 Mullen P.M. Public involvement in health care priority setting: an overview of methods for eliciting values. *Health expectations*, 1999, 2:222–234.
66 Davies E., Cleary P.D. Hearing the patient's voice? Factors affecting the use of patient survey data in quality improvement. *Quality and safety in health care*, 2004, 14:428-432.

The best methodology for securing public involvement is a seriously underresearched topic. We lack a coherent and agreed framework for assessing the effectiveness of different methods and there is no consensus on what public involvement is aiming to achieve. A number of goals might be considered important:

- to empower local communities;
- to devolve decision-making;
- to strengthen accountability;
- to improve responsiveness;
- to improve the quality of care;
- to improve health outcomes;
- to reduce complaints and litigation;
- to build partnerships;
- to ensure the legitimacy of policy decisions;
- to determine priorities;
- to enhance democratic involvement; and
- to improve public health.

The challenge of developing an evaluation strategy is not only to identify the criteria against which projects will be judged, but also to define them in such a way that they can be reasonably measured. Funding for monitoring and evaluation should be built into the commissioning, planning and implementation of public involvement initiatives. This will enhance our collective knowledge of how to do it better.

Policy options

Governments, health authorities or payers looking for ways to inform and empower individuals, families and communities need to agree clear goals and a coherent strategy. Actions should be targeted at national, regional and organizational levels.

The range and balance of initiatives should be culturally relevant and locally determined. The vision and strategy must be clearly articulated so that everyone knows what is expected of them. Initiatives at different levels in the system should be mutually reinforcing and well-coordinated. It is not possible to design a universal blueprint for a policy that will work in every setting. However, the following initiatives are worthy of consideration in the light of the evidence reviewed above:

Action at the macro level (e.g. national, federal or state government)

(1)   Patients' rights, charters, health service constitutions

The right to information and engagement of patients is enshrined in the law in some countries. Consideration should be given to the following mechanisms:

- placing a duty on health care providers to protect and promote patients' interests;
- requiring evidence of public and patient involvement at every level of health care commissioning;
- requiring clinicians to ensure the maximum possible level of patient engagement in their own care and treatment; and
- making patient and public involvement a requirement for all oversight and scrutiny arrangements, quality control and other accountability mechanisms.

(2)   Organizational regulation, incentives and contracts

Regulatory bodies can play a key role by insisting on patient and public involvement in service development and performance monitoring arrangements:

- Explicit standards or targets can require evidence of patient and public involvement in setting priorities and in decision-making.
- Standards can also require evidence of support for self-care and provision of health information and decision aids in a variety of formats.
- Incentive-based or competitive systems, including choice mechanisms or specific contractual requirements, can be used to motivate change.
- Coordinated patient survey programmes have been shown to be a useful way of monitoring performance across the system.

(3)   Professional regulation

Professional regulation also has a key role to play:

- Professional "good practice" standards can require clinicians to involve patients in treatment and management decisions, to provide them with education and support in self-care and to build health literacy.
- Standards could also require clinicians to help patients navigate through the system and to signpost them to appropriate sources of health information and decision aids.

- Coordinated patient survey programmes can be used to monitor the performance of clinicians and reward good practice.
- National bodies responsible for professional education, including development of educational methods, curricula and assessment, should ensure that they comply with patient-centred standards.

<u>(4)   Health information materials, websites and health portals</u>

Despite the recent proliferation of consumer health information in written and electronic form, many governments and other official bodies have decided to invest in this field to ensure the availability and accessibility of reliable information:

- Websites or portals can be developed to help people find relevant and reliable information to support their health decisions.
- As well as responding to the general demand for reliable health information, particular attention should be paid to the needs of people with low health literacy.
- Other forms of electronic format information – "virtual communities" or networks, interactive digital television, touch-screen kiosks, wireless hand-held computers, videos, DVDs and audiotapes – can be particularly useful for specific patient groups or disadvantaged communities.
- Coordinated mass media campaigns can be used to broadcast specific health education messages.

Action at the meso level (e.g. regions, health authorities, provider organizations)

<u>(1)   Patient participation groups and lay representation</u>

Despite the existence of patient groups in many countries, reliance on the voluntary sector alone is unlikely to be sufficient to ensure participation throughout the health care field:

- Governments or payers can invest in patients' organizations or establish them from scratch.
- Provider organizations can invite patients and lay people to join their organizations as "members".
- Lay people can become nonexecutive directors on the boards of provider organizations.
- Patients can be invited to work with staff on quality improvement programmes.

- Patient groups should be given guarantees of independence if they are to represent patients' interests effectively.
- Support, both financial and training, may be necessary to enable patients and lay people to participate in policy-making bodies and committees running hospitals or primary care facilities.

(2) Consultation mechanisms, citizens' juries and deliberative events

A variety of methods have been devised for securing public views on policy priorities and service quality:

- public meetings;
- focus groups;
- population and patient surveys (face-to-face, postal, telephone and online);
- rapid appraisal techniques;
- citizens' juries and other "deliberative" methods;
- patient/citizen panels; and
- user-generated online feedback to allow patients to share their views on the quality of care received.

(3) Patients' rights and public involvement

Health authorities and provider organizations can do much to reinforce and legitimize active patient involvement by:

- ensuring that local people are kept informed of their rights and responsibilities;
- monitoring patient experience and publishing the results;
- publishing information on performance and facilitating patient choice;
- holding meetings in public;
- ensuring that policy decisions are open and transparent and involve members of the public whenever possible;
- being prepared to explain the reasons for unpopular decisions (e.g. closure of services) and establishing a formal process of appeal;
- working with local voluntary organizations and patient and community groups; and
- actively seeking the views of minority groups and people who do not belong to patient or community organizations.

Action at the micro level (e.g. clinical teams, group practices, local communities)

(1)   Communication skills training for health professionals

Fostering a culture of partnership between health professionals and patients requires professionals to develop a specific set of skills and attributes. Clinicians will require the following knowledge and skills:

- how to understand the patient's perspective;
- how to guide patients to sources of information on health and health care;
- how to educate them about protecting their health and preventing the occurrence or recurrence of disease;
- how to elicit and take account of patients' preferences;
- how to communicate information on risk and probability;
- how to share treatment decisions;
- how to provide support for self-care and self-management;
- how to work in multidisciplinary teams;
- how to use new technology to assist patients to become more engaged in managing their health; and
- how to manage time effectively to make all this possible.

(2)   Self-care education and support

Self-care education needs to become an integral part of professional–patient interactions. This will require:

- effective professional leadership;
- development, implementation and evaluation of education programmes for patients; availability of telephone and email advice, telephone coaching and counselling;
- text messaging with prompts and reminders;
- "virtual" support (interactive websites, virtual networks);
- assistive technologies and self-monitoring equipment; and
- personal budgets and/or vouchers to purchase support services where appropriate.

(3) Aids to engagement

Encouraging patients to play an active role in decisions about their care can be an effective way of ensuring that treatment and disease management is appropriately tailored to the individual. The following methods have been shown to be useful:

- clinicians "signposting" their patients to useful information sources;
- question prompt cards giving patients examples of questions they

might want to ask about their treatment and care;

- evidence-based patient decision aids to help patients share decisions with clinicians;
- self-management guidelines to help patients with chronic conditions to cope with symptoms, disabilities and emotional problems;
- patient access to paper-based and electronic medical records; and
- referral letters copied to patients.

(4) Community initiatives

Local communities can do much to promote health and self-care and to support patients and individuals with long-term conditions through:

- community action to reduce health risks;
- advocates and advocacy groups;
- self-help groups and support networks;
- rehabilitation, counselling and therapy groups;
- care coordinators and home help;
- wheelchair and equipment provision; and
- advice on social security and employment.

Conclusions

There is now a substantial evidence base on which to build effective strategies for informing and empowering individuals, families and communities in relation to their health and health care. It is important that health policy takes account of, builds on and contributes to this evidence. More robust evidence and experiential learning will be required if health systems are to exploit the many opportunities to build better health.

Because health literacy is central to enhancing involvement of patients in their care, all strategies to strengthen patient engagement should aim to improve health literacy. Health inequalities could widen if the problem of health literacy is not addressed.

Patients' knowledge and understanding improve when health professionals engage them actively in their care, leading to better outcomes. Shared decision-making and self-management are mutually supportive approaches. They should be given equal importance and implemented consistently.

Strategies for informing and empowering individuals, families and communities and improving the responsiveness of health care delivery systems should be high on the policy agenda in all countries. This is important not only because it is the right thing to do, but also because it may be the best way to enhance people's health and ensure the future sustainability of health systems.

2 HEALTH CARE PRACTITIONERS IN A PEOPLE-CENTRED HEALTH CARE SYSTEM

INTRODUCTION

The last decades of health care have seen a literal explosion of research, new knowledge and technology. These have brought the practice and profession of medicine to never before seen heights of expertise, advancement and technological breakthroughs. By having a better understanding of the diseases that have plagued humankind over the centuries and providing better and more effective treatment modalities, medical practitioners were led into a false sense of security that things were getting better for everyone. Perfection and success were the demands of and on everyone. A point has now been reached at which mistakes cannot and will not be accepted or tolerated. Moreover, if they do occur, punishments are imposed on the apparent offender. This has placed the weight of responsibility upon the physician and other health care practitioners to cure the disease, with the dictum that there is no room for error. This in turn has resulted in care that is disease-focused and physician-centred.

We became so dependent on technology that we ended up treating the medical records and lab results rather than the patient. There was a period of time in many countries when, in response to the rising number of litigations and medico-legal issues brought about by the actual and perceived increasing number of medical errors and debacles, many health care professionals practised so-called "defensive medicine". The need for laboratory tests was dictated by the fear of being wrong rather than by justified need as guided by a proper and timely patient evaluation. This has resulted in diagnostic examinations being "overindicated" and the cost of health care becoming very high.

This system of health care has made perfection the norm and errors unacceptable. The system has evolved to become so complex that, rather than making it flawless, unfortunately the reverse has resulted. This has been described as "the myth of perfect performance". If the health care profession

has little room for mistakes, health care organizations and society as a whole have even less. Because individuals expect perfect performance of themselves, the organizations for which they work do likewise.[1] Blame and punitive actions changed the players, but error-conducive situations persisted.

Specialization that was intended to improve care via focused training and management of diseases has (ironically) fragmented care for the patient. Patients were segmented according to their diseases or by organ systems. In many instances, no one integrated the care and "saw" the totality of the patient. A disease-centred or disease-focused system was prevalent. Practitioners are all victims of the complexities that we ourselves have created.

In 1999, the Institute of Medicine published the report *To err is human: building a safer health system*. This brought about the realization that more people die directly or indirectly due to medical errors in hospitals than from motor vehicle and airline accidents.[2] As many as 100,000 people die because of medical errors. The Institute for Healthcare Improvement estimates that 15 million instances of medical harm occur in the United States of America each year. The World Health Organization deduces that in developing countries, these figures may be proportionally higher. Contrary to the promise of the medical profession *"to do no harm"*, the hospital can unfortunately be a very dangerous place.

The need to look seriously at patient safety and the quality of health care delivery has been the focus of many accrediting agencies for health care facilities. Errors have to be uncovered, defined, analysed and addressed proactively. This entailed a major shift from the "culture of blame" existing in the majority of organizations to a "culture of safety". This then recognized that the problem emanated not from the individual but from the existing systems and processes that allowed errors to happen. This was not easy to accept and accomplish because the approach required a major paradigm shift in the way of life and thinking that had long existed in the medical profession. The doctor-centred care and culture of blame that have prevailed can be traced back partly to the time-tested "traditional" method of teaching and education in medical schools and postgraduate hospital-based medical training programmes. This tradition was reinforced by the hierarchal system that espoused fear among subordinates. This allowed the sources of flaws and errors in the system to remain, to be repeated and propagated.

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1 *Sentinel events: evaluating cause and planning improvement.* Oakbrook Terrace, IL, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), 1998.
2 Institute of Medicine. *To err is human: building a safer health system.* Washington, DC, National Academy Press, 1999.

Culture of safety and patient-centred care

The shift to a "culture of safety" has reoriented the health care system from that taught by traditional medical education to a system that has been advocated by other industries, particularly the aviation industry. It promotes a blame-free attitude in addressing safety and quality issues in the workplace. It allows a voluntary mechanism of reporting faults and errors for analysis and problem-solving from a systems standpoint. One important component of this type of approach lies in actively involving the patient in the health care system and processes. By placing the patient at the centre of care, the care processes revolve around the patient. This makes the patient–doctor interaction, and in turn the treatment, more efficient, timely, coordinated and integrated.

Communication issues have been identified among the major safety issues that affect the quality of care processes. They can occur at any point of the patient's stay in hospital. The spectrum of problems can include, to name a few: improper evaluation, poor/incomplete documentation (to include illegible handwriting), delayed responses and consequently timely treatment, medication errors, handover issues, or simply the failure to understand and respond to the needs of the patient. Involving the patient and his or her family is one of the first major steps in resolving many of these issues. This involvement, complemented by proper and timely education, provides a clear line of communication between the patient and health care providers. With patients being more knowledgeable on the plans, directions and expectations of care, they become partners in preventing unexpected and unforeseen deviations and errors in the process. They can do this by immediately alerting the health care team to deviations from the pre-agreed plans. A genuine and honest feedback from the patient's perspective is provided and collated. The organization can then generate and evaluate valuable information on providing better care and service to the patient. Minimizing the uncertainties perceived by the patient improves communication and interaction between patients and health care providers.

Importance of communication in preoperative evaluation

I can cite a personal encounter I had with a patient in the era before laparoscopic cholecystectomy:

> The patient was referred to me after having already been evaluated by two other specialists, with the recommendation for open cholecystectomy. He was complaining of right upper quadrant abdominal pain, but a review of the ultrasound showed a small lesion

that could be a small stone or polyp. I was actually discouraging surgery and suggested observation. But because of his fear of progressive discomfort brought about by the gallstone, he insisted. It was then that I went through a very thorough review and evaluation of his past medical history. In response to a specific question about childhood illnesses, he suddenly recalled one doctor telling him when he was a child that his heart was "inverted". No one in the care team had been able to pick up and document this information. Upon auscultation, his heart sounds were predominantly on the right. Since his ultrasound had been carried out in another facility, I had the ultrasound of the gallbladder repeated and, sure enough, it was located in the *left* upper quadrant. The patient had situs inversus (congenitally reversed location of the organs). This was the period when we did gallbladder surgery using a right upper quadrant transverse incision. So if I had not spent time sitting down and talking to him, I would have performed surgery on the wrong side of the patient. Since it appeared to be an asymptomatic gallstone, he finally agreed to postpone the surgery. Through proper communication and interaction with the patient, I was able to avoid surgery at the wrong site.

The need to shift from disease-centred care to patient-centred care with appropriate integration of care processes was an important step in improving the system. This was particularly important in the management of patients with several concomitant diseases, the elderly or those requiring chronic care. Even when patients seek treatment for one complaint, they need to be thoroughly evaluated for the presence of other less apparent problems. A holistic (or total) look at the patient is imperative.

From patient- to people-centred care

Health care organizations, health managers and health practitioners have begun to realize that the needs of patients go beyond just their medical needs and requirements. These remain the priority, but auxiliary matters such as comfort, psychological, social, cultural and spiritual needs should likewise be addressed. The focus should include not only the disease and the individual's needs as a patient, but also his or her needs as a person. Many are subconsciously doing this, but in this age of advancing and ever changing science and technology, with our continuous quest for medical perfection, this has somehow been relegated to the background.

But for this patient-centred approach to succeed, the other components of what some refer to as the "cycle of care", should also be addressed. The people providing care (health care practitioners), the people that make up a health care organization or system (employees and managers) and the general

public, even before they become patients – should all be involved. This means looking into public health education and disease prevention as well. This constitutes the proposed expansion of the health care environment by WHO, from a patient-centred to a people-centred system. This comprehensive transformation encompasses four domains:

(1) individuals, families and communities;

(2) health care practitioners;

(3) health care organizations; and

(4) health systems.

It is the aim of this paper to present and share the past and current status, continuing challenges and possible interventions in the area of people-centred health care. These will be examined in the context of quality and patient safety, from the domain of the health care practitioner.

Health care practice in a tertiary referral academic hospital

Medical practice in the private or public sector in a tertiary referral academic hospital in an urban area of the Philippines involves a combination of clinical practice with an academic function. As an academic teaching institution, the hospital may serve as the training centre of a medical school or the base hospital of several nursing or paramedical schools with accredited residency and fellowship training programmes. As a referral centre, the hospital generally admits patients who have the more complicated diseases and medical problems that make the day-to-day operational system proportionately very complex. The specialization of practice in many of these hospitals makes the care of the patient more problem-specific and disease-directed. A new and different problem will require the services and expertise of an equally new specialist. Several physicians may end up attending to a single patient, but there are situations when coordination and integration of care may be lacking or deficient. There could be fragmentation of care when the patient is not seen and treated in a holistic manner. This situation contributes to issues of quality and safety as well as care integration. In the public (government) hospital sector, overcrowding, limited staff and structural and financial resources further aggravate the situation.

Fragmented and uncoordinated care is not uncommon in the Philippine health care system. This compromises the quality and safety of health care delivery. Generally contributing to this situation are, among other factors: inaccuracy and inconsistency of documentation, staff communication issues

and faulty handover procedures. There are also medication errors, infection control issues and a lack of coordinated and integrated care plans, especially in multidisciplinary cases. Further contributing to the problems are the migration of health care workers out of the country and a decline in interest and enrolment in medical and paramedical courses, with the exception of nursing. In a people-oriented health system, these issues are addressed and the various health care practitioners are engaged in improving quality and safety in the delivery of care.

Health care practitioners

Physicians

Competence was seldom questioned in the past, as traditionally, the medical profession has been considered honourable and noble. But with the expanding needs and higher expectations of health consumers, the continued economic progress and ease of travel and globalization, the competence of physicians has been brought into question. The need to review and confirm the competence of a physician in this age of new and emerging technologies in the medical field, especially in specialized procedures and interventions, becomes paramount. It is now vital to verify the adequacy and quality of training of physicians. Checking credentials and verifying sources have become standard procedures in many hospitals to ensure patient safety.

Protocols and clinical practice guidelines have also allowed the standardization and monitoring of outcomes. Physicians have been generally successful in this because of the traditional attitude of finding ways to improve their patients' outcomes. More recently, physicians have been asking what they can do to prevent harm to their patients.[3] They realize the need to expand the scope of their responsibilities not only prospectively, but also in a harm prevention aspect. As complexity increases, the need to monitor safety and system failures becomes vital. A proactive approach to surface failures, with all the members of the health care team participating in a suitable forum, must be formulated and put in place. Caregivers need to understand the issues and know that they are not the problem, but are in fact part of the solution.[4] Patients and their families must also be involved in these discussions, thereby ensuring the empowerment of key individuals in the health care cycle.

Proper collaboration, integration and coordination of care with the other care team members must follow. Collaborative meetings and conferences are

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3 JCAHO. Engaging physicians in the performance improvement process. *Joint Commission perspectives*, 2001, 21:8–9.
4 Ketring S.P., White J.P. Developing a systemwide approach to patient safety. *Joint Commission journal of quality improvement*, 2002, 28:287–295.

encouraged on a regular basis, especially in care involving several physicians. The patient and the family should be informed and updated on the consensus of findings and actions resulting from these meetings. Finally, the physician should consider, recognize and respect the non-health-related needs of the patient. These may be matters pertaining to family traditions, religion, ethical or cultural aspects. As long as they will not directly affect or delay the delivery of appropriate care, they should be addressed, as they may improve the overall well-being of the patient over and above traditional medical interventions.

Comprehensive breast cancer care in the Philippines

Breast cancer is the number one cancer affecting women and is, understandably, a major concern with regard to evaluation, diagnosis, treatment and peripheral support. By creating a dedicated centre for breast diseases and cancer, we provide a venue for inquiries, initial evaluation, second opinions, screening, diagnosis (to include imaging and biopsies). Multidisciplinary consultations (surgical, medical and radiation oncology, plastic and reconstructive surgery, pain management and psychiatry) can also take place there. The Breast Center is staffed by physicians, nurses, radiation technicians and other support personnel on an on-call basis. It is referred to as a "one-stop shop" for all concerns pertaining to the breasts.

After carrying out an initial evaluation, a breast centre physician can immediately request imaging tests or biopsies, which can be performed on-site. When a diagnosis of cancer is made, appropriate referrals are made to the specialties, and the patient is properly informed and educated in the process. This empowers the patient to participate in an intelligent discussion and in decision-making with the physicians on the final plan of treatment. At any point during the treatment (before, during or after surgery or other adjuvant treatment), referrals can be made to people who can provide psychological, emotional, spiritual or even "well-being" support (e.g. addressing concerns on aesthetics of losing hair, or skin changes because of chemo- or radiation therapy).

The Breast Center provides a venue for integration and coordination of comprehensive care. This care addresses not only the needs of a breast cancer patient brought about by the disease itself, but also other needs, over and above the medical concerns, which are equally important to the patient. This holistic approach shortens the waiting time – often emotionally draining for a patient – for definitive treatment to be started and completed. Further, by being involved more actively in the planning and decision-making process, the patient becomes an integral, contributing part of the care cycle. We hope, in time, to be able objectively to demonstrate the favourable outcomes from this approach. But at present, subjectively, patients consistently verbalize their appreciation for the immediate and "personalized" approach.

Nurses and paramedical support team members

The nurse's role as the "front-liner" in patient care continues to be of primary importance. Nurses spend the most time with the patient for the duration of his or her stay in hospital. The attention they provide, or the lack of it, constitutes the patient's lasting impression about his or her hospital experience. Thus, the patient's perception of the expertise, skill and empathy of the nurse is valuable in the care cycle. Nurses have always been the principal advocates for safe and compassionate care.[5] Unfortunately, what is affecting the status of nursing care all over the world is the shortage of nursing staff. This may be in the form of an actual shortage, of nurses taking jobs outside health care, or of migration above manageable levels. Estimated conservatively, among nursing graduates in the Philippines, only 81% are employed as nurses, and only 59% (of the 81%) remain in a hospital setting.[6]

Nurses from the Philippines in particular find easy employment abroad because of their relatively good command of English and familiarity with the Western type of medical care. The economic situation likewise makes the prospect of working and earning a salary that is 10 times higher, very attractive. From 1999 to 2003, 56,000 nurses migrated, while the Philippine nursing schools produced only 27 342. It is estimated that 100 000 nurses left the country between 1993 and 2003.[7] In many urban-based hospitals, an acceptable nurse to patient ratio is still maintained in the general nursing units, but expertise is severely compromised by a high turnover rate. The average stay of a staff nurse is two years, and it is not uncommon for a nurse with one year's experience to be given supervisory responsibilities. This is where interventions in terms of human resource and logistical support for the traditional nursing responsibilities are necessary.

Clinical pharmacists to the rescue

In St. Luke's Medical Center in the Philippines, one major strategy to address the shortage of nurses is to provide support to the nurses by deploying clinical pharmacists on every nursing floor for two shifts. They primarily address medication reconciliation, prescribing, dispensing and other medication safety issues. By doing complementary work, they also unburden the nurses from these traditional nursing responsibilities and take the lead in preventing medication errors (not only by the nurses but also by the physicians). This has allowed the nurses to concentrate on the more important nursing duties. Joint Commission

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5 Sample S. Front line of defense: the role of nurses in preventing sentinel events. Oakbrook Terrace, IL, JCAHO, 2001.

6 Health Resources and Services Administration. 2000 National sample survey of registered nurses. Washington, DC, HRSA, 2000.

7 Philippine Overseas Employment Agency data, 2004.

International cited this initiative as an exemplary quality programme in its last re-accreditation survey visit in 2006. The clinical pharmacists likewise provide patient education upon discharge, complementary to instructions given by the physicians and nurses. Other trained personnel have likewise been deployed to monitor, correct and educate everyone on the health care staff on proper compliance with infection control standards. This has allowed nurses more time to be at the bedside and attend to the actual nursing and other needs of the patient.

Health care practitioners as educators

Medical education in the Philippines is patterned after the American system and *"has traditionally emphasized the teaching of a core knowledge focused largely on the basic mechanism of disease and pathophysiologic principles"*.[8] The curriculum involves two years of basic sciences and two years of clinical training. Once trained in the basic principles, physicians are granted moral autonomy and are expected to learn from their mistakes. For the most part, they are answerable only to themselves.[9] In residency and fellowship training in the surgical specialties, the traditional model is grounded on the "Read one, see one and do one" principle and the "Blame and train" approach. These begin with the concept that human error is the source of the problem and that this error is the result of the inattentiveness or insufficiency of practitioners.[10]

With the personal desire and institutional directives to provide the most advanced and specialized care, medical specialists have inadvertently brought work to a level of complexity that leaves them little time to sit down and "connect" with the patient. Consultant (attending) physicians have delegated patient education, securing informed consent, and care planning to the trainees (medical students, residents and training fellows) and paramedical staff (nurses, technicians) in the context of training and education. They occasionally fail to supervise trainees closely even in very difficult procedures, because they are too busy to do so. It is convenient to justify these actions and the deficiency in the oversight function as part of the training of residents.

8 Institute of Medicine. *Crossing the quality chasm: a new health system for the 21st century.* Washington, DC, National Academy Press, 2001.
9 Sharpe V.A. "No tribunal other than his own conscience": historical reflections on harm and responsibility in medicine. Paper presented at Enhancing Patient Safety and Reducing Errors in Health Care, Rancho Mirage, CA, 8 Nov 1998.
10 Cook R.I., Woods D.D. Operating at the sharp end: the complexity of human error. In: Bogner M.S., ed. *Human error in medicine.* Hillsdale, NJ, Lawrence Erlbaum Associates, 1994:301.

The newer teaching and education techniques are addressing issues of quality, safety and other nonmedical needs of the patient. These new approaches emphasize systems rather than humans as causative factors for errors, as well as the critical preventive role performed by humans.[11] One example of this is the use of simulated or situational training incorporating error training, exploratory approaches and error prevention. This may include training not only on how to do things but *how not to do* things.[12] This can happen not only in hospital-based training programmes for doctors, nurses and paramedical support staff, but may be expanded to the medical or nursing school curriculum.

Finally, everyone in the health care profession has the responsibility for lifelong commitment to continuing medical education (CME). We owe it to our patients to remain updated and assimilate the new and growing knowledge in our area of specialization. The orientation of the traditional CME conferences, like the morbidity and mortality (M&M) audits, needs to be redirected from a "witch-hunt" to an opportunity for participants to address *"adverse outcomes [which] are inevitable and can and should be used in a positive way"*.[13] We should likewise resist discussions directed solely at explaining and understanding the disease. We should instead address all the needs of the "person" behind the patient, and address the illness experience rather than just the disease, in these meetings and conferences.

Health care practitioners as leaders

The physician practitioner has traditionally assumed and maintained a leadership role in patient care. But advancement and complexity demand that health care should be an interdisciplinary process. The leadership role includes the need to be integrative and collaborative in the care process. But the leadership roles of health care practitioners across the health care organization – be they physicians, nurses or other paramedical staff members – may go beyond clinical work. They may also include administrative, managerial, quality and performance improvement, organizational and strategic planning responsibilities. There are many hospitals that are providing short or medium-term courses in management to physicians holding key administrative positions. This is to orient and align them to the management directions. In the interests of addressing the issues of quality and safety for the patient, as well as the concerns of clinical and administrative staff in the organization,

11 JCAHO. *The physician's promise: protecting patients from harm.* Oakbrook Terrace, IL, Joint Commission Resources, 2003.
12 Leape L.L. Errors in health care – problems and challenges. Paper presented at Enhancing Patient Safety and Reducing Errors in Health Care, Rancho Mirage, CA, Oct 1996.
13 Harbison S., Regehr G. Faculty and resident opinions regarding the role of morbidity and mortality conference. *American journal of surgery*, 1999, 177:36–39.

there should be a close, collaborative and strategic partnership between the medical and administrative divisions of the health care facility. This is important in establishing a mindset of quality and a culture of safety across the organization. It is the responsibility of the leadership to involve and engage all stakeholders in the care cycle (physicians, nurses, paramedical support staff and employees) and to collate and evaluate their feedback and needs so as to drive performance improvement.

One major senior hospital leadership initiative is to perform and collect patient satisfaction surveys and data. Eliciting patients' perceptions of the medical care and service they receive constitutes a major source of quality information. This can be used for the development of improvement strategies. The patient's perceptions of quality of care can be affected by both the quality of care received and the quality of the organizational system in which that care is delivered.[14] It has likewise been found that compassionate, patient-focused delivery of care is the *most important* factor in influencing patient intentions to recommend or return for future care.[15] Engaging patients and their families in the care process (patient-oriented) and being part of the care cycle, and asking for feedback on the delivery of care and their recommendations for improvement constitutes one way to demonstrate "consumer-oriented" (or customer-oriented) care. Likewise, this clearly illustrates senior leadership's and the organization's commitment to quality.[16]

It is the responsibility of the leadership, as physicians, medical heads, administrators and managers, to ensure that the needs of the different participants and stakeholders in the care cycle in a people-centred health care system are addressed. This will ensure the delivery of good quality and safe care.

Addressing human resource issues in the face of health care worker migration

Socioeconomics make it difficult to stop the wave of migration, primarily affecting nurses, radiation technicians and pharmacists in the Philippines, from seeking "greener pastures" abroad. This high workforce turnover impacts not so

14 Barr D., *et al*. Problems in using patient satisfaction data to assess the quality of care provided by primary care physicians. *Journal of clinical outcomes management*, 2000, 7(9):19–24.

15 Burrough T., *et al*. Understanding patient willingness to recommend and return: a strategy for prioritizing improvement opportunities. *Joint Commission journal on quality improvement*, 1999, 25:271–287.

16 Sidhu M., *et al*. The patient visits program: a strategy to highlight patient satisfaction and refocus organizational culture. *Strategies for building a hospitalwide culture of safety*. Oakbrook Terrace, IL, Joint Commission Resources, 2006.

much on the numbers but on the experience and expertise on the ground. One of the interventions contemplated is the principle of "Guided managed migration". This entails working together with established nursing recruitment groups in the United States of America. These groups will recruit the nurses that have been trained by the hospital. They will provide the standards and requirements, and will even provide and align the training programmes to comply with these requirements over a predetermined length of time (e.g. three years). This will ensure a more predictable turnover of nurses. It will also guarantee the competency and quality of the nurses because they will undergo the final evaluation and successful completion or "graduation" from the programme. Quality nursing care is made available to the patient for the three-year duration of the programme, with the hope that a percentage of this group will decide to stay and not to migrate. For those who still decide to migrate, their successful completion and endorsement by the source hospital will assure them of more favourable employment conditions (better pay, benefits and location) in the United States of America.[17]

Conclusion

Through the years, in the quest for more knowledge and better skills and in trying to help patients get better faster, we failed to realize (and lost) the true essence of holistic health care. Its essence lies in addressing the needs of the person behind the patient, the person behind the health care practitioner and the people that comprise the health care system and organization. Among health care practitioners, the value and importance of putting the patient at the centre of care are increasingly being recognized. We have to address the patient's other needs, above and beyond what is dictated by the disease process. Emotional, cultural, ethnic, psychological and spiritual needs have to be addressed with equal importance in a sick, distressed and frightened patient. The advocacy and initiative of WHO towards a people-centred or -oriented health care system can make all this a reality. It is imperative that we continue this advocacy and help create not only a mindset of quality and safety in the organization and health care system, but also a people-centred approach across all health care domains and levels.

We can summarize this advocacy for people-centred care by quoting the current President of the American College of Surgeons, Dr Gerald Healy in his Inaugural Address during the Annual Convocation in October 2007: *"Patients do not care how much you know until they know how much you care"*. This is the "totality" of care that should address the needs not only of the patients, but also of all the "people" involved in providing quality and safe health care in the hospital, in the home and in the community. We have to restore the balance and bring back the harmony of mind and body, people and systems.

17 Workshop output. *People competitiveness summit: creating sustainable multi-cultural partnerships*. Makati City, Philippines, October 2007

3 THE ORGANIZATIONAL DOMAIN OF PEOPLE-CENTRED HEALTH CARE

INTRODUCTION

Transforming the current health care system towards a people-centred orientation requires action at four levels of the system:

(1) individuals, families and communities;

(2) health practitioners;

(3) health care organizations; and

(4) health systems.

Although there are many interdependencies between changes at different levels, some required actions can only be organized at the level of the health care organization – the subject of this paper.

Health care organizations are a mirror. The experience of people and their families seeking care is a reflection of how the organization treats its own employees. The leaders of the very best health care organizations provide a role model for the values and principles underlying people-centred care. That is, they are deeply respectful, humane and compassionate towards their employees. They celebrate diversity; they act fearlessly against bullying, abuse or discrimination; and they listen closely. They also provide a role model for openness and integrity, and they are not afraid to say sorry.

Such organizations create a strong sense of community and shared purpose, and they provide opportunities for employees to express the spiritual side of their work. The leaders at the new Waitakere Hospital in New Zealand brought such a spirit to the development of new services for a culturally diverse and underprivileged community in West Auckland.

Two hundred staff began their new jobs all on the same day, two weeks before the new hospital opened. For three whole days, this large group of nurses, doctors, physiotherapists, clerks, porters, technicians, cleaners and all the other professionals needed for a hospital were welcomed and oriented in a large group process. It began with a sacred ritual according to the customs of the indigenous Maori people, the thrilling call of the "karanga", the acknowledgements to the living and the dead, the sky father and earth mother, the hospital buildings and the land. The ceremony concluded with a kiss or a "hongi" (pressing of the noses) by each leader for every single new member of staff.

The medical director and the nurse leader made a joint presentation on the four roles and contributions they expected of each staff member:

- the professional, technical contribution;
- compassion and loving kindness;
- humility, the ability to listen and learn from others; and
- advocacy, being the best friend of the person in need.

These roles, it was explained, should be applied to fellow workers – not just to patients and families. This was a collective emotional experience of profound significance, reflected in the compassionate culture of the hospital as experienced by patients and families of many different backgrounds. This creation of shared meaning, purpose and collective identity is an important role for health care leaders, a theme that will be developed further.

The introduction to *People at the centre of health care*[1] identified a fundamental mind shift. The shift was away from the biomedical, disease-oriented and technically driven model of care towards a more holistic approach that validates the personal experience of illness and comprehends the complex cultural, psychosocial and environmental determinants of health and well-being. This shift in emphasis is a major challenge for the health professions, questioning as it does centuries of Western thinking about mind–body separation, the importance of clinical detachment and the power of reductionist analysis.

No less a paradigm shift is required for the managers and leaders of health care organizations to meet the challenge of people-centred care. Much as our health professions are steeped in rituals, culture, language, unspoken assumptions and mental models, the world of management and leadership has its own distinctive culture, language and world view.

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1 *People at the centre of health care: harmonizing mind and body, people and systems*. World Health Organization, 2007. Website: http://www.wpro.who.int/sites/pci/publications.htm.

Our language dictates much of our thinking. We can hardly expect to develop people-centred health care when our daily talk is full of military and machine language that has cross-contaminated health care from the business world. Consider the vocabulary we use every day, so pervasive it has become invisible. We talk about workforce and manpower; we have chief executive officers and director-generals of health; we triage patients; we manage outputs; we implement strategic plans; we use improvement toolkits. Moreover, to command attention, we use bullet points on PowerPoint slides!

These unconscious mindsets combine with corporate models of accountability such that shareholder values (expenditure and outputs) dominate health care rather than the values of a much wider set of stakeholders in the community. While there is every good intention to engage health care consumers in planning and to respond to the wishes of communities, the usual management process is to "consult" with community when the strategic plan is already written. The generals, not the troops, write battle plans.

In support of people-centred care and better outcomes, health care leaders and managers must reinvent themselves to support a paradigm shift in organizational design:

Old mode	New mode
Machine thinking, command and control mechanisms	Complexity of human dynamics, focus on meaning and relationships as much as structure
Technical problem-solving and use of authority to direct resources	Leading adaptive change that requires a shift in values, beliefs and behaviours
Providing a service	Being of service to individuals, families and communities
Detachment and defensiveness	Empathic support, apology and open disclosure
Management (shareholder value)	Stewardship (wider stakeholder value)
Individual competence	Organizational capability
Clinical facilities	Healing environment

From machine thinking to complex human dynamics

Despite extensive scientific knowledge and technical solutions for problems such as health care error and patient injury, ethnic differences in health status, the burden of infectious and chronic diseases, and now the impact of "lifestyle"

diseases such as obesity, our interventions fail at the level of whole populations. These seem to be "wicked" problems that defy rational analysis and resist almost every strategy for improvement, even though substantial resources are applied in a determined way.

As Albert Einstein said, *"We can't solve problems by using the same kind of thinking we used when we created them"*. Fortunately there is a large body of knowledge, residing almost completely outside the world of health care, which allows us to reframe these wicked problems. It allows us to interpret and understand examples of successful change, and to make specific recommendations for future strategy.

This knowledge includes the theories of complexity and system dynamics, of learning organizations,[2] of organizational culture and leadership[3] and the roles of leadership in adaptive change.[4]

The core problem is that we have in our heads a completely unrealistic model of health care systems, whose archetypal model is a hierarchical, organizational chart. In reality, health care is a highly complex, nonlinear system characterized by multiple feedback loops and self-reinforcing modes of behaviour. The system *is* the people and the real dynamic is the interaction of their thoughts, beliefs, emotions and behaviours. This is why health care systems will never be fully effective until they are people-centred.

Paul Plsek explores the application of complexity science to health care:[5]

"Management thinking has viewed the organisation as a machine and believed that considering parts in isolation, specifying changes in detail, battling resistance to change, and reducing variation will lead to better performance. In contrast, complexity thinking suggests that relationships between parts are more important than the parts themselves, that minimum specifications yield more creativity than detailed plans. Treating organisations as complex adaptive systems allows a new and more productive management style to emerge in health care."

The conventional tools of management – strategic planning, project management, authority, measurement and control – are largely useless in this domain of complexity. Such techniques are valuable approaches for a subset of "technical" problems within the system (see definition later), but they do not help us solve "wicked" problems.

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2 Senge P. The fifth discipline: the art and practice of the learning organisation. New York, Doubleday/Currency, 1990.
3 Schein E. Organisational culture and leadership, 2 ed. San Francisco, CA, Jossey-Bass, 1992.
4 Heifetz R. Leadership without easy answers. Cambridge, MA, Harvard University Press, 1994.
5 Plsek P. Complexity, leadership, and management in healthcare oganisations. British medical journal, 2001, 323:746–749.

In contrast, a system dynamic approach can give us great insight into the underlying patterns of behaviour and why these wicked problems are so persistent. The important insight is that the unspoken assumptions, beliefs and behaviours – what Ed Schein describes as "culture" – are inherently part of the system dynamic.[6] The beliefs and behaviours of the different stakeholders interact in powerful ways to sustain extremely robust modes of system behaviour that continually reinforce the status quo.

In other words, people are already at the centre of health care systems, but we persist in an illusion that management hierarchies and organizational charts describe the real system in any meaningful way.

A common example of the system dynamic is the response to accidental patient injury. Doctors and health care executives often exhibit a defensive response. This is framed in terms of professional and organizational liability as opposed to a compassionate, person-centred approach. Fearful of being sued or of admitting liability, the doctors, lawyers and administrators close ranks and deny the patient apology, explanation or emotional support. The natural consequence is for patients to feel abandoned, to believe that the doctors and the organization do not care about their injury, and to pursue all mechanisms for holding the doctor and organization to account. These actions only serve to reinforce the defensive responses from the organization.

To break this vicious circle, leaders need to engage in potentially risky behaviour: empathic support, apology and open disclosure of errors. This giving away of power and trusting to the motives of external stakeholders is the kind of courageous leadership needed to uphold a person-centred health care system.

Apology and open disclosure fundamentally change the belief of the injured patient about the motives and intent of the doctors and the hospital managers. The modified behaviour of the patients, in turn, affects the beliefs of the medical practitioners who become less defensive and more open to sharing learning on errors.

This system dynamic approach, which includes the beliefs and behaviours of the key players, is really just a holistic approach to health care organizations. It incorporates the mental, emotional and cultural dimensions of organizational reality. Much as the narrow, biomedical model of medicine fails to address many chronic health problems, the management approach to health care systems is similarly restricted in its application.

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6 Schein, E. Op cit. Ref 3.

We might look to cultures outside the Western world for more appropriate frameworks. The indigenous Maori people in New Zealand have a conceptual model called "*Te Whare Tapa Wha*", the four cornerstones of health.[7] It includes the physical domain [*taha tinana*], the mental [*taha hinengaro*], the social/emotional [*taha whanau*] and spiritual [*taha wairua*] domains. A person-centred approach to health care organization requires leaders to address all these dimensions of organizational health to align structure, knowledge, relationships, meaning and purpose. All these aspects profoundly affect the system behaviour and dynamics.

Indigenous cultures have theories of knowledge that relate closely to the natural world, and therefore have an innate understanding of complexity and interdependence. Cross-cultural approaches have the potential to overcome the limitation of Western mental models. For instance, the Maori models of engagement and dialogue are much better adapted to complexity than Western ways of doing business by committee.

These approaches allow us to tap into the very positive and powerful motives of health professionals – a deep desire to care, to be compassionate, to help, to prevent harm and to achieve better health outcomes. Compassion becomes a valid concept in organizational development. Interventions that align with these "natural properties" of the system lead to powerfully self-reinforcing and sustainable improvements. Through such approaches, we might create a safer and healthier work environment in which all professionals find deep meaning, purpose, joy and satisfaction in their work.

From technical problem-solving to leading adaptive change

Ronald Heifetz is the Director of Leadership Programmes at the John F. Kennedy School of Government at Harvard. Unlike many writers on leadership, Heifetz has little interest in the business world. He concentrates his work in the complex and messy spheres of government, public leadership and politics. "Wicked" problems are his specialty and his book is called *Leadership without easy answers*.[8] He is a physician and classical musician who brings wide-ranging mental models and analogies to his work.

Heifetz differentiates between "technical" and "adaptive" problems. In technical problems, the problem definition is clear and there is probably an agreed approach to the solution and implementation. An example is the

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7 Durie M. Mauri Ora: the dynamics of Maori health. Auckland, Oxford University Press, 2001.
8 Heifetz, R. Op cit. Ref 4.

implementation of a computerized clinical information system. The desired end solution is known in precise detail, even if many thousands of people are involved in the change. Making progress on technical problems is the domain of *management*. We can look to authority figures to provide solutions.

In adaptive problems, there is no clear definition of the problem because multiple stakeholders have different world views and assumptions. An example is the lifestyle problem of obesity and diabetes. Even coming to a shared agreement on a definition of the problem requires learning. Is this a biomedical phenomenon or a complex, culturally determined issue? Making progress on adaptive problems necessarily involves conflict and loss. Unspoken assumptions need to be exposed and challenged. Resources must be redirected. Authorities must give up power. Facilitating adaptive work is the role of *leadership*. Adaptive work requires participants to change their values, beliefs and behaviours.

Heifetz uses examples from medicine to illustrate his teaching. Curing disease is a technical approach in which the primary locus of responsibility for the work lies with the physician. Healing the whole person is adaptive work and the patient, not the physician, is primarily responsible for the work.

Reframing health care from a biomedical, disease-oriented and technically driven model of care towards a more holistic, person-centred process is a major adaptive challenge. Thus a new style of health care leadership is required in which leaders influence the community to face its problems and develop its own solutions, rather than imposing their own vision – or strategic plan!

The skill set required for leading adaptive change is very different from the tools and techniques of business administration. The focus shifts from the use of authority, planning and strategy to softer skills. The leaders must create safe learning environments to contain the stresses of change, where conflicting assumptions and beliefs can be explored among diverse stakeholders. Through deep dialogue they facilitate the development of shared meaning and purpose for united action. Margaret Wheatley captures this sense in arguing that leaders need to be "hosts" rather than "heroes".[9]

To illustrate this approach, consider the "wicked" problem of the relentless rise in Caesarean section birth rates. This change is costly in terms of resource use. Moreover, large studies have now identified a threefold increase in postpartum mortality rates of mothers undergoing C-section compared with vaginal birth.[10] The drivers for increasing C-section rates are a complex

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9 Wheatley M. *Finding our way: leadership for an uncertain time*. San Francisco, CA, Berrett-Koehler Publishers Inc, 2006.
10 Deneux-Tharaux C., *et al*. Postpartum maternal mortality and Caesarean delivery. *Obstetrics and gynecology*, 2006, 108:541–548.

set of interacting beliefs and behaviours among the main players. Technical approaches to this problem – for instance, evidence-based guidelines – have largely failed to influence this dynamic.

Many maternity hospitals in Australia and New Zealand benchmark outcomes and rates of intervention. One hospital has demonstrated a 30% fall in C-section rates over a two-year period while improving neonatal outcomes.[11] Hospital leaders did not explicitly set out to reduce Caesarean section rates. The intervention was in response to a crisis of confidence and the breakdown in relationship between independent midwives and hospital specialists.

Increasing fear and conflict led to a rapidly rising rate of medical interventions and poor neonatal outcomes. It became apparent that the driving force for the crisis was a set of mutually reinforcing beliefs and behaviours arising out of a series of crises.

Independent midwives came to believe that hospital clinicians just wanted to perform operations. With this belief, they "protected" patients from medical intervention by keeping the doctors away from their labouring mothers in the hospital. Poor management of labour complications eventually led to crisis situations when the midwife had no option other than to call the obstetrician to rescue the situation. Faced with dire emergency situations, the obstetricians had little choice other than to recommend immediate C-section. This behaviour further reinforced the beliefs of the independent midwives.

Obstetricians and anaesthetists came to believe that independent midwives had no concern for patient safety. They blamed midwives for putting them in situations of professional risk by having to deal with sudden emergencies without any prior warning or patient preparation. This blaming further heightened the tensions and inhibited teamwork in managing developing labour complications.

Hospital leaders designed a series of interventions to expose and explore the dynamic of beliefs and behaviours by using role-play. The beliefs of key participants were challenged in a one-day workshop, using skilled facilitation. The core principle of this process was putting mothers and babies, rather than professional interests, at the centre of concern. No matter what the professional background, all could agree that caring better for mothers and babies was a shared goal. The consequent alteration in behaviour created a ripple of change across the whole system, even affecting the beliefs of those who were not part of the workshop. A self-governing process of quality improvement was set up including hospital clinicians, independent midwives and consumer representatives.

11 Youngson R., Wimbrow T., Stacey T. A crisis in maternity services: the courage to be wrong. *Quality and safety in health care*, 2003, 12:398–400.

No direction for improvement was imposed by hospital managers, who gave complete autonomy to the inter-professional maternity forum ("giving work back to the people", in Heifetz terminology). The professional group used a number of technical approaches, including clinical audit, case reviews and evidence-based practice within the context of trusting relationships and shared goals.

There is continuing mutual respect and shared learning on the basis of trust. The system dynamic has been flipped into a self-reinforcing "safe" mode. The cost of the interventions was vanishingly small compared with traditional models of breakthrough change. The 30% fall in the Caesarean section rate was a by-product of the process of conflict resolution. Every other measure of system performance showed breakthrough improvement. Staffing levels recovered from critical shortage to full staffing. The rate of patient complaints fell threefold.

This process represented a dramatic shift from a professionally centred conflict to a person-centred facilitation of shared values and goals. One of the emergent outcomes was agreement on a "code of conduct" that set out expectations for standards of behaviour for all those visiting or working in the maternity unit.

From providing a service to being of service

There is a world of difference between *providing* a service and being *of* service. Providing a service is a technical task; it is about helping and fixing. The person or organization providing the service has technical knowledge, skill and resources that are exchanged for some other form of value, often financial payment. The provider retains power through exclusive access to the technical knowledge and resources. It is a transactional, customer relationship.

When health care practitioners provide a service, it works well for specific problems for which there is a cure or technical fix – such as hip joint replacement. For the overwhelming burden of global health problems, chronic disease, risky lifestyles, mental illness or prolonged disability, there is no fix or cure. In these circumstances, helping and fixing disempower the person because of the power imbalance. The provider retains the expert knowledge and control. Then, all too often, a professionally oriented disease focus, rather than the needs and priorities of the person, controls the agenda.

A research group in New Zealand made a bold attempt to put people at the centre of care in a trial of integrated care planning for a group of older

persons with multiple medical problems.[12] These senior citizens suffered from, on average, six medical problems and took 13 different medications. Each patient wrote a detailed self-assessment of his or her various health problems. The researchers asked each subject which single thing could be improved that would really make a difference to their health or life. The patient goals were modest and achievable – not *"cure my arthritis"*, but *" if you could improve my mobility a bit, I could get into the garden and that would transform my life"*.

For each subject, all the caregivers, including the family doctor and hospital practitioners, met to consider the information and to write an integrated care plan in a form that could be shared with the subject. However, the outcomes of the research were as unexpected as they were dismal:

- Only 52% of the problems considered most important by the subject were discussed at the planning meeting by the health professionals.
- Only 35% of the problems considered most important by the subjects were included in the planned interventions.
- Only 14% of the problems considered most important by the subjects were actually addressed in the implementation of the care plan.

Surely this must be an aberrant result! Yet research in the United States of America examining primary care of older patients found a strikingly similar result.[13] They found that 45% of patients over 70 had severe physical limitations. Of those, 80% said their doctor was aware of the problem, 50% remembered that the doctor had treated it, and only 15% indicated they were much better as a result.

Being *of* service, rather than *providing* a service, has profoundly different implications. Person-centred health care means serving individuals in accordance with their own preferences and priorities. The person being served, rather than the provider, sets the agenda. The hallmark of service is that the person being served grows in his or her own capacity to manage life's problems, to be more resilient and to take greater responsibility for his or her own health and well-being.

Serving, rather than helping or fixing, is a challenge for health professionals. It requires the development of humility, respect, patience, non-judgementalism, empathy and compassion. For many of our frail older citizens, serving their needs requires a complex coordination of many different professionals and agencies. Thus the health care organization needs a collective approach to service.

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12 Mahoney F. Older people as the centre of the care and services. Presentation to CLANZ/ NZIHM Conference, Auckland, 16 November 2001.
13 Nelson E., Wasson J. Using patient-based information to rapidly redesign care. *Healthcare forum journal*, 1994, July/August.

How well the organization serves is a reflection of how well it serves its own employees. The hallmark of the best health care organizations is that the employees continually grow in their own capacity to solve problems, to improve services, to be more responsive and to find deep meaning, satisfaction and joy in their work.

At the level of the organization, there is a structural aspect of *providing* a service versus being *of* service. In a tale of two hospitals, a single health care organization had responsibility for health care in two very distinct communities within one city. One was privileged and the other was disadvantaged. Each had its own hospital. A growing shortage of hospital doctors was one signal that persuaded hospital management to restructure the organization in a bid to improve efficiency. The institutional leadership roles at each hospital (both medical and managerial) were abolished and substituted with cross-site roles. As a consequence, the smaller hospital in the less well-off community began to lose resources. Behind this change lies an unspoken assumption about the logical unit of health care organization.

In this instance, the managers and medical directors had a very internal, hospital-based view of the world. They were taking what they perceived to be logical steps to preserve an acute medical hospital service in the face of shortages. This is the "providing a service" view of the world with an internal model of accountability.

The alternative viewpoint – being of service to the community – is that a more appropriate unit of health care organization is an integrated whole, centred on a community that makes sense. In this view, the combination of local hospital services with primary care and community services is the logical frame in which to develop solutions. The accountability is to a community.

Just such an approach in a rural community in Germany led to a new model of acute care in which family doctors and hospital doctors shared the same roster for after-hours care. The quality of care improved markedly and the total number of doctors on duty in the whole system overnight was halved, solving the workforce problem.[14] This was an approach to serving the community rather than "providing a service". The foundation of the change was putting people, rather than professional and departmental interests, at the centre of concern. The breakthrough meeting occurred when both family doctors and hospital specialists talked together of their own experience of being patients in their own system. This constituted a profound shift from a professional perspective to an experiential, person-centred perspective.

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14 Kaeufer K., Scharmer C., Versteegen U. Breathing life into a dying system – recreating healthcare from within. *Reflections: the SoL journal*, 2003, 5(3).

From management to stewardship, from shareholders to stakeholders

This mind shift challenges assumptions about control, ownership, authority and boundaries. Managers defend boundaries. They live within hierarchical authority systems that define their authority, their span of control and the ownership and use of resources. The ultimate accountability is to shareholders, whether health insurance companies or shareholding ministers in taxpayer-funded systems.

Stewardship is an ethic whereby leaders hold in trust the knowledge, power and resources on behalf of the wider community, for the greater good:

"Stewards recognise the need to transcend the boundaries of their organisation and to include other stakeholders in creating a learning community. They gain a sense of what needs to emerge for the greater good, realising that not all visions are created equal."[15]

Stewards recognize a broad accountability to the health and well-being of the community they serve, for present and future generations. Rather than defend boundaries, they invite participation and share power and resources with a wide range of stakeholders. The focus is on the people rather than the organization.

When health care leaders act as stewards, they do the "right thing" according to a deeply held set of values and principles, such as respect for human rights and dignity and opposing all forms of discrimination.

From individual competence to organizational capability

International research into professional subcultures shows that hospital specialists strongly prefer individualized forms of accountability. They are opposed to the systematization of work processes through tools such as clinical guidelines and protocols.[16] Underlying these strong preferences is a belief that variation in patient outcomes is explainable in terms of

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15 Gauthier A. The challenge of stewardship: building learning organisations in healthcare. Chapter 25. In: Chawla and Renesch, eds. *Learning organisations: developing cultures for tomorrow's workplace.* New York, Productivity Press, 1995.
16 Degeling P. A comparison of the impact of hospital reform on medical subcultures in some Australian and New Zealand hospitals. *Australian health review*, 1999, 22(4).

individual competence. Unfortunately, the evidence from research into health care quality and patient safety shows that the major defects are the result of system failures, not individual malpractice.[17] It is estimated that about 95% of unintended patient injuries during health care have their root causes in system problems. Given that the vast majority of health professionals are highly trained and competent, only strategies that address system failures can have an impact on the pandemic of overuse, underuse and misuse of health care resources and the resulting harm to patients.

Only health care organizations can solve this problem. The most powerful strategy for understanding system failures is to consider the process of care from the perspective of individuals seeking health care. This is a person-centred approach rather than a departmental or professional approach. Techniques such as root cause analysis give painful insights into how multiple latent errors combine to cause disaster.

Health care organizations provide the context in which health practitioners perform their work. High quality health care requires that a wide variety of resources and expert practitioners should be brought together in a coordinated way to meet the needs of individuals. Only organizations can perform this function, whether in acute care settings or in community coordination of preventive health care, lifestyle change and support of people with complex needs.

Health care organizations also have a duty of care to individuals and their families when system failure and error lead to unintended patient injury. To apology, open disclosure and compassionate caring must be added practical support and the marshalling of resources needed to support recovery.

From clinical facilities to healing environments

I remember, as a junior doctor, being struck by the sudden change in status of one of my patients. The rather small, insignificant, wrinkled old patient in hospital pyjamas sought me out to give thanks as he was about to go home. Here stood a self-assured business leader, resplendent in his immaculate pinstriped suit and silk shirt. He had an air of confidence and authority. Standing equal to my height, he looked me right in the eye and gave me a firm handshake.

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17 Committee on Quality of Healthcare in America. *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC, National Academies Press, 2001.

I began to ponder on what powerful environmental influences and subtle cues had turned this confident and accomplished person into something much less – a "patient".

Many of our health care facilities are intimidating and the clinical environment is alien and comfortless. To reinforce the sense of being lost in a strange land, the hospital signs are in a language incomprehensible to most visitors. The harshness of the physical environment mirrors the cool, clinical detachment and depersonalized language of the staff. We talk of the "appendix" on ward six and the "breast cancer" on ward nine. Personal identity is stripped away with the clothes. Otherwise capable patients are forced to lie in a bed or be pushed in a wheelchair.

Yet small changes to the environment can make an overwhelming difference. At Waitakere Hospital in New Zealand, a set of principles – including putting the person and family at the centre of care and creating a healing environment – governed the design of the new building.[18]

An award-winning eco-building, the hospital was the first to incorporate principles of environmental sustainability, efficient energy use, recycling and waste reduction. Alignment of the building and windows to maximize natural sunlight created a comfortable environment that related to the outside world. Art and gardens were incorporated in the design to create a healing environment. Windows were set low in the wall so that even the sickest patient lying in bed could connect with the outside world. The palette of colours was chosen from the natural forest environment. Wards were named after local beaches and meeting rooms had the Maori names of plants with medicinal properties.

It was discovered that the building code and contemporary hospital designs had very inadequate specifications for disabled access – important when 47% of hospital visitors have at least temporary disability. People with disabilities were invited to join the hospital design team and some of their stories were almost too awful to contemplate. They included the profoundly deaf mother who gave birth alone at the locked door of the maternity unit because she could not respond to the intercom. If anyone has ever felt impatient waiting at a counter to be noticed, imagine the experience of a wheelchair-bound person who is completely invisible to the person behind the high desk.

Simple solutions included split-level counters at all reception desks, ingenious bi-folding toilet doors that could be pushed open from either direction, and colourful decorating schemes on the walls and floors that gave clear visual cues to the partially sighted.

18 Waitakere City Council. Sustainable buildings in the Auckland region: foundations for a better future. 2005, Waitakere City Council website: www.waitakere.govt.nz.

To the physical design features were added other human touches reflecting the people-centred values. Priority was given to family support areas close to patient care space, rather than doctors' offices. Specific areas were set aside for cultural support services and customized meeting areas. A deliberate "*recruitment for diversity*" strategy ensured that there was a strong sense of community identity reflected in the skin colour and faces of the hospital staff.

Precious artwork was donated to the hospital and is mounted unprotected in the public areas of the hospital. The security presence is almost invisible.

Hospital leaders took a leap of faith in assuming that the community would respect these treasures and keep them safe and undamaged.

A final touch is the constant presence of volunteer guides at the front door of the hospital. Visitors and patients alike are greeted with a warm smile and a helping hand.

There is a deep congruence in the values expressed through these many subtle changes. The environment feels warm and welcoming. The hospital relates to the natural environment in a way that signals a concern with the health of future generations and the healing of the present ones. These many aspects create a healthy and happy work environment. The hospital leaders believed that their patients would not be safe and healthy unless the same was true of their employees.

A final story from this remarkable hospital development tells of spiritual values that span two cultures – those of the Maori and the European settlers. Before the new hospital was opened, a sacred ceremony took place in the cold hours before dawn. Four hundred hospital staff and community members gathered at 05:00 to take part in a blessing ceremony. Led by Maori elders chanting prayers and incantations, each person entered every room of the new building, touching the walls and fittings to add the warmth of their human spirit to the cold walls. The procession took two hours and was concluded with a feast as the sun rose. In turn, this sacred building touches all who enter it.

Building the leadership for such a paradigm shift

To become an anaesthesiologist, I trained for 14 years from the day I began at medical school to the day I completed the fellowship requirements of a prestigious medical college. Training among peers of the highest intelligence and education, I went through a system that nonetheless failed fully 70% of exam candidates at each attempt. The final exam was an exhausting process, with three days of being individually challenged and assessed on a wide

variety of clinical skills and complex problem solving. Having graduated, I became a member of an organization committed to public good, which sets the highest professional and ethical standards, and which continually pushes forward the boundaries of knowledge and practice through active research and development. This is necessary because I hold the life of patients in my hands.

No less do health care leaders and managers hold the lives of people in their hands. Defects in health care systems and organizations lead to millions of patient injuries, whole populations with premature mortality, gross inequality in health status and the squandering of scarce resources on many treatments of no benefit.[19]

Such is the complexity of the system that the skills, knowledge and capabilities required to practise competently as a senior manager or leader are as demanding as those of a highly trained medical specialist. Furthermore, these leaders need to act in the public good, to demonstrate the highest ethical standards and to be accountable in a professional sense for their actions and omissions. An MBA is hardly a qualification for such a role.

This author recommends that health leadership and management should evolve to become a prestigious health profession. Appointment to senior roles should be contingent on gaining fellowship of a college of health leadership. Continuing professional development should be mandatory. Moreover, regulatory mechanisms should be developed to hold such leaders and managers accountable for their technical competence and ethical standards.

Given the paradigm shift identified in this paper, the professional curriculum for such training needs to move right away from existing business and management models. Perhaps the single most important attribute is that leadership training is provided in a cross-cultural setting. The World Health Organization might consider sponsoring the development of international colleges of health leadership and management to meet this pressing need.

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19 *Degeling P. Op cit.* Ref 16.

4 PATIENT-CENTRED HEALTH CARE: SUPPORTIVE HEALTH SYSTEMS

INTRODUCTION

Patient-centred health care (or more broadly, people-centred health care) has attracted increasing attention from health care organizations and providers as well as consumers since the 1990s. However, there has been insufficient discussion from either theoretical or practical perspectives about building a supportive health system, which is one of the main factors underlying the implementation of patient-centred care. Moreover, discussions from a health-system perspective on supporting patient-centred care have mainly been in the context of developed economies, rather than emerging or less developed ones.

If the national health system infrastructure is underdeveloped and a public health policy is not provided, the attractive concept of patient-centred care represents rhetoric rather than reality. Undoubtedly, patient- or people-centred care is mainly determined by the characteristics and behaviours of patient and health care providers. But these are affected by the environment in which a health care organization operates. Eventually, patients, health care providers and health care organizations can be strongly influenced by the infrastructure of the national health system and the health policies derived from it. Therefore, the absence of systematic development and support of a national health system often results in only anecdotal and fragmented examples of patient-centred care at individual provider level.

Patient-centred care has recently been regarded as an essential aim of a national health system. This was highlighted by the 2001 report of the United States Institute of Medicine, entitled *Crossing the quality chasm*.[1] However,

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1 Institute of Medicine. *Crossing the quality chasm: a new health system for the 21st century.*
Washington, DC, National Academies Press, 2001.

essential aims of a national health system have multiple dimensions that are sometimes contradictory and always context-sensitive. This means that although it is a fundamental element, patient-centred care should be highlighted from the perspective of the entire national health system.

Elements of patient-centred care and components of the health system

Most of the diverse definitions of patient-centred care that have been used since the early 1980s share common features. A recent study considered the following elements to be the main characteristics:[2]

- education and shared knowledge;
- involvement of family and friends;
- collaboration and team management;
- sensitivity to nonmedical and spiritual dimensions;
- respect for patient needs and preferences; and
- free flow and accessibility of information.

From a health systems perspective, these elements, as objectives or goals of a health system, should be related to health system functions to be realized in a specific setting.

The *World health report 2000* (WHR) classified the functions of a health system into four categories: (1) delivering personal and nonpersonal services (delivering services), (2) raising, pooling and allocating revenues to purchase those services (financing), (3) investing in people, buildings and equipment (creating resources), and (4) acting as the overall stewards of the resources, powers and expectations entrusted to them (stewardship).[3] Although this conceptual framework has developed in many ways, it is not very different from previous proposals. For instance, in a classical conceptualization, Kleczkowski *et al*. (1984) proposed five similar major components of national health system infrastructure. These were: development of health resources, organized arrangement of resources, delivery of health care, economic support, and management.[4]

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2 Shaller D. *Patient-centered care: what does it take?* Revised report. Oxford, UK, Picker Institute, and New York, Commonwealth Fund, 2007.
3 The world health report 2000 – health systems: improving performance. Geneva, World Health Organization, 2000.
4 Kleczkowski B.M., et al. National health systems and their reorientation towards health for all. Geneva, World Health Organization, 1984.

In both of the above-mentioned proposals, the functions (or components) are related to one another and to the objectives of the system, but in a rather narrow way. For example, in the WHR proposal, responsiveness (an objective of the system) is only related to stewardship (a function of the system) and not to other functions. But responsiveness, irrespective of how it is defined, cannot be achieved without considering functions of the system such as creating resources, service provision and financing, at least indirectly. As a result, it is reasonable to relate every function of the health system to the objective of achieving patient-centred care.

Hence, although many different specific policies have been proposed in terms of their level of intervention as well as the implementation strategies, these policies should be organized within the framework of comprehensive functions of a national health system. At policy level, many different strategies and health and public policy have been proposed for promoting patient-centred care. For example, Davis considered that the following five public policy strategies would be the most promising:[5]

- public reporting of patient-centred care;
- pay for performance that explicitly includes patient-centred care rewards;
- coverage of shared decision-making aids;
- direct payment for care coordination function and establishment of care coordination standards; and
- support for diffusion of modern health information technology with functionality that permits patients to be engaged as partners in their care.

In a different way, the World Health Organization (Offices of South-East Asian and Western Pacific Regions) indicated four main areas of strategies for promoting people-centred health care, focusing more on macro-level strategies:[6]

- ensuring access and equity;
- establishing standards for competence and accountability;
- cultivating community-based participation in systems development; and
- promoting values-based leadership at the highest levels in health care.

5 Davis K. A patient-centered health system. Paper presented at the Roger Larson Memorial Lecture, American Hospital Association, 2 May 2006.
6 People at the centre of health care: harmonizing mind and body, people and systems. World Health Organization, 2007. Website: http://www.wpro.who.int/sites/pci/publications.htm.

In relation to these strategies, and reflecting health system components, the key characteristics of people-centred health care were described in the same report as follows:[7]

- primary care as the foundation for better health;
- financing arrangements for health organizations that support partnership between health practitioners and people accessing health care;
- investment in health professional education that promotes multidisciplinary teamwork, good communication skills and an orientation towards prevention, and integrates evidence about psychosocial dimensions of health care;
- ability to develop standards and protocols, and to disseminate guidelines and standards for good care;
- collaboration with local communities;
- commitment to a process of ongoing evaluation and improvement;

- involvement of communities and other stakeholders in health governance and policy development;
- transparency; and
- accountability.

These policies and strategies should be organized around the main functions of a national health system. This does not mean that making specific policies or strengthening characteristics is not worthwhile. But these should be strategically arranged to lead to a bigger step towards assumed goals. On the other hand, it is often a long-term and arduous process to make and implement a policy, even if strategically designed, which is effective at the system level. It is therefore sometimes more realistic to focus on "triggering policy change". That is, instead of fragmented policies that are not interconnected, strategies that employ catalytic changes to facilitate patient-centred care should be emphasized.

Triggering policy changes to promote patient-centred care

It is not easy to simplify the factors underlying the health system changes needed to promote patient-centred care. This is because every national health system has its own priorities for the goals as well as the

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7 *Ibid.*

strategies required to achieve these goals. This paper covers only a selection of strategic policy proposals.

Building infrastructure for more equitable health care

The effects of health and health care policies on health inequity are somewhat controversial. This is due to uncertainty about the causal relationship between health care and health outcomes. Despite this, many discussions on patient-centred care have focused on assuring equitable access to health care. In addition to unmet needs exacerbating poor health conditions of patients, access to appropriate health care has been regarded as a fundamental human right.

Well-designed health care policies, including health insurance programmes, could help to reduce health inequity by improving access to health care. For example, the Korean National Health Insurance (NHI) scheme established in 1989 covers the entire population, and has significantly improved health care access. However, due to its dependency on the private sector and the remaining heavy burden of out-of-pocket payments, NHI has not completely removed inequity in access to health care.

A supportive health system can also promote health equity by addressing population health.[8] However, it is also well known that population health programmes can actually widen the discrepancy between the worse-off and better-off due to differences in access to resources such as time, information and providers. For example, community-based smoking cessation programmes may be more accessible to those who are better-off (e.g. nonmanual workers), who have more information, knowledge and flexible leisure time. Indeed, the discrepancy in smoking rates between higher and lower income groups in some countries continues to widen, although this is not only attributable to community-based programmes. Therefore, in designing population health programmes, vulnerable groups should be targeted to reverse the ever widening discrepancies.

When developing generic policies to reduce inequity in health, the importance of a firm basis for sound policy-making cannot be overemphasized. First, inequity needs to be quantified at the system level from diverse viewpoints. In particular, national projects can overcome the shortfalls of fragmented and small local investigations. Second, national objectives and goals of health equity that are quantifiable should be formulated within the framework of a comprehensive national policy. This requires multiple governmental

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8 Kim C.Y. Equity in health: a global perspective. *Journal of National Institute of Public Health*, 2007, 56(2):68–74.

sectors to collaborate to develop policies centred on health equity. Finally, governmental initiatives should be integrated and supported by partnerships with nongovernmental sectors.

Sound basis of primary (health) care

The key role of primary health care (PHC) in providing patient-centred care can be emphasized by incorporating personal care with health promotion, the prevention of illness and community involvement. Recent improvements in the understanding of health and health care from social, economic, cultural and political perspectives have provided a stronger framework for patient-centred care. However, because the significance of the PHC approach is now well known, this paper focuses on primary care with a narrower focus than PHC.

The reasons why primary care should be the main component of a national health system infrastructure have been considered since the (United Kingdom) Dawson report in 1920.[9] The traditional justification of primary care as a cornerstone of the national health system is consistent with recent concerns about patient-centred care in terms of its focus on continuity, comprehensiveness, coordination, family-oriented and community-oriented care. Unfortunately, not all countries have the quality of infrastructure needed for effective primary care, although many have subscribed to the principles emanating from international organizations or alliances.

The absence of well-developed primary care systems in many countries results in the fragmented and disorganized provision of health care. For example, in many developed economies such as Japan, Germany, France and the Republic of Korea, specialists often practise in individual clinics. These clinics are not usually grouped together and are not affiliated with any hospital. As a result, a significant proportion of their work is presumed to overlap with that of *de jure* primary care providers. There are many problems associated with these so-called primary care physicians. These include inefficient human resource development, inefficient allocation of health care budgets and low quality of care. Compared with trained primary care physicians, specialists are not trained in the basic principles of primary care covering the provision of coordinated, comprehensive, continuous, family- and community-oriented care. Moreover, specialists often exhibit worse clinical performance in the primary care setting. It is well known that primary care providers often become involved in managing multiple diagnoses and undifferentiated problems, and

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9 Starfield B. Primary care: balancing health needs, services, and technology. New York, Oxford University Press, 1998.

this requires a different sort of expertise. Specialists are familiar with well-established diagnoses for advanced disease states, and they may not provide high-quality primary care in a different setting.

In spite of its huge potential in providing patient-centred care, it appears that effective primary care cannot be provided in a deregulated health care market. Governments must therefore intentionally intervene in the allocation of specialized human resources. They must give priority to restructuring national health system infrastructure so as to strengthen the primary care base. When a health system operates within a weak public sector, compared with a strong private one, this limits the ability of government to become directly involved in the development of the primary care profession. However, the failure of a scheme should not discourage a government from devising policies to make primary care more attractive to policy clients. Among these, more favourable reimbursement for those involved in primary care would be a powerful incentive.

Another strategy is to focus on how to make people put primary care first. This can be difficult due to widespread distrust of primary care among the public. The main source of this distrust is presumed to be the perceived low quality of primary care, which is accentuated by ever advancing technology and intensified care, with poor communication between patient and care providers. In addition to improving the communication of medical information, any policy aimed at enhancing primary care should focus on how to encourage primary care providers to improve the quality of their service. Various strategies have been proposed for this, including practice guidelines and continuous quality improvement. Governments could attempt to stimulate the quality of activities using techniques such as reimbursement, direct investment in clearing houses, or practice guidelines, sanctions and the public disclosure of information on quality.

Making health care organizations quality-sensitive

There is empirical evidence that accreditation and the use of report cards and practice guidelines are useful strategies for making health care organizations more supportive of patient-centred care. Accreditation refers to the official recognition and approval of a health care organization as fulfilling particular quality or performance standards. Accreditation programmes for health care organizations have had a huge impact on the performance of health care organizations in several developed countries. A voluntary programme for hospitals began in 1917 in the United States of America. But many countries (including underdeveloped and emerging ones) have not fully drawn up such programmes until recently.

For example, the Japanese government supports the so-called Hospital Function Evaluation Program initiated by a private voluntary organization in the mid-1990s.[10] In Shanghai, China, a programme was implemented in 1989 by the Hospital Grade Appraisal Committee of the Health Bureau. In Singapore, the Medical Accreditation and Audit Unit of the Ministry of Health organized a programme in 1991. In the Republic of Korea, a critical review of the pre-existing Hospital Standardization Program resulted in the government proposing a new one. The new Hospital Performance Evaluation Program was proposed in 1995. This new programme was designed to employ assessment indicators that were more outcome- and patient-oriented, and to induce voluntary quality monitoring activities in each hospital.

It is clear that accreditation programmes improve the overall quality of a health care organization. Patient-centredness is then promoted by including relevant indicators in the accreditation. However, accreditation appears to be insufficient to persuade health care organizations to put quality (including patient-centredness) first. The relatively volatile nature of voluntary programmes – which are mainly driven by consumer pressure on the voluntary participation of health professions – could be strengthened by other measures. These would depend on the characteristics of the health care organizations and the extent to which the health care system was organized.

Few hospitals have formal voluntary quality management programmes in countries with a dominant private sector and low pressure for quality, where the role of government is limited and indirect. Reorientation of the payment system towards one that more sensitively reflects quality has been considered a potentially effective driving force for providers. Governments are attempting to improve the quality of care by structuring financial incentives and/or disincentives in payment schemes. A few countries (including the United States of America and the United Kingdom) are experimenting with new payment schemes based on "pay for performance" (P4P). This could be defined as a system involving *"use of payment methods and other incentives to encourage quality improvement and patient focused high value care"*.[11]

Countries with public sector-dominated health care systems appear to be in a different situation. Here, quality-related activities have been promoted by the government primarily through legislation, organization and regulation. Their approaches can be characterized by measures that are more pervasive, more systematic and direct. However, it cannot be concluded that these systems are more likely to result in the development of a quality-oriented health care system.

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10 Country information is based on personal communication.
11 Centers for Medicare and Medicaid Services. State Medicaid Director, letter # 06-003, 6 April 2006.

The public disclosure of information on quality has been regarded as a strong driver to change the behaviours of health care providers. This approach, often called a league table, consumer report or report card, is not limited to a specific type of care. It is widely applied by comparing diverse indicators, including traditional quality indicators (on the structure, process and outcomes of care) along with new ones (e.g. patient-centredness, functional status, and even administrative indicators). This approach has been advocated by consumer groups, policy-makers and insurers on the assumption that consumer guides can improve health care quality and reduce costs. Well-known evidence for its effectiveness comes from the observed improvement in the outcomes of coronary artery bypass surgery in New York state, United States of America.

However, there is still little empirical evidence of the effectiveness of this approach in assuring patient-centred care. Furthermore, the available data apply only to a small number of providers and indicators in most countries, and the factors contributing to changing the behaviour of providers have not been adequately delineated. In spite of these limitations, the results of many studies suggest that the public release of information can improve patient-centred care. For example, in the Republic of Korea, the annual public release of Caesarean rates since 2000 has led to continuous decreases in hospital rates.[12]

This change can be attributed to the public release of information, since this was the first downward trend in rates since 1985, and no other interventions were made during this period.

Patient-centred health information systems

From the perspective of patient-centred care, a health information system and supportive information technology must exhibit the following characteristics:[13],[14]

- shared decision-making;
- patient–provider communication;
- personal longitudinal health records; and
- integration of patient information across different areas of care.

12 Kim C.Y., Ko S.K., Kim K.Y. Are league tables controlling epidemic of caesarean sections in South Korea? *British journal of obstetrics and gynaecology*, 2005, 112(5):607–611.
13 Haux R., *et al*. Health care in the information society. A prognosis for the year 2013. *International journal of medical informatics*, 2002, 66(1-3):3–21.
14 Detmer D.E. Building the national health information infrastructure for personal health, health care services, public health, and research. *BMC medical informatics and decision making*, 2003, 3:1.

Among these characteristics, the centrepiece of the system would be integrating health information about patients and providers that was diffused across diverse organizations, particularly from the health-system perspective. Above all, seamless information transition will be facilitated by efficient management of the generated information through publicly funded health care utilization, often systematically governed by the public sector. The potential value of public health insurance, which often involves collecting and storing information nationwide, should be considered. From the initial design and implementation of public health insurance, how and what information should be generated and managed must be determined.

Concluding remarks

Patient-centred care is a relatively recently coined term. But it is not an innovative proposal, and could be adopted as a new strategy for reconstructing health care in a rapidly changing care environment. Although the empirical foundation needs to be further explored, patient-centredness (or people-centredness) has a solid philosophical and theoretical basis and is widely accepted.

However, if challenges from patients, health care organizations and health systems are not dealt with adequately, the attractiveness of patient-centredness will simply represent rhetoric. Above all, the environment of care is becoming more specialized and oriented towards high technology. The strengthening

role of the private sector is hampering the adoption of patient-centred care due to its focus on profit-making. Even adopting strong measures to improve patient-centredness, such as the public release of quality information or P4P, could become a battlefield of providers heavily armed with high-technology services for profit-making, without empowering people and patients.

The above considerations indicate that patient-centred care should be approached using multidimensional strategies. These could range from empowering individual patients to changing the entire health system. The strategy of making the health system more favourable to patient-centred care should have the highest priority. This is because patients and providers are becoming more tied to the system in terms of the determinants of behaviour, including economic incentives. Future discussions should therefore attempt to determine how best to change the system in this direction.

People at the Centre of Care Initiative

The Regional Committee,

Recalling previous resolutions by the Regional Committee for the Western Pacific, particularly WPR/RC55.R1, WPR/RC54.R2 and WPR/RC53. R6, calling attention to the need to improve the quality of health care and to consider the broader psychosocial, cultural, ethical and social determinants of health, including the principles of biomedical ethics, fairness, equity and human rights;

Further recalling resolution WPR/RC55.R1, requesting the Regional Director to produce, in collaboration with Member States and the WHO Regional Office for South-East Asia, a draft policy framework reflecting the significance of psychosocial factors affecting health outcomes and to present it to the Regional Committee at the appropriate time;

Emphasizing the relevance of accelerating people-centred care to the strengthening of primary health care and health promotion;

Appreciating the significance of broader psychological, cultural and social determinants of health and their impact on health care outcomes and on overall health and well-being;

Realizing the need for health care approaches that harmonize mind and body, and people and their environment;

Noting that while health systems have diverse socioeconomic, cultural and political contexts, a people-centred, patient-empowering approach to health care is relevant to all forms of health systems at all stages of their development;

Mindful that effective and sustainable health care reform and reorientationtowards people-centred health care require multisectoral participation and commitmentby all;

Recognizing the importance of people-centred health care to the range of programmes: prevention, primary health care, health promotion and other individual-based approaches;

Acknowledging that people-centred health care is having some positive impact on patient safety, adherence to care plans, treatment and health outcomes, satisfaction with care, and quality of life, as well as provider satisfaction, patient trust and loyalty, good public reputation, and a cost-effective and sustainable health system resulting from appropriate health care use by empowered patients;

Emphasizing the need to consolidate, build on and scale up current efforts in taking the people-centred movement forward and achieving the desired changes to health systems;

Having considered the draft People-centred Health Care: A Policy Framework;[1]

1. ENDORSES the draft People-centred Health Care: A Policy Framework as a guide for Member States to develop and implement people-centred health care policies and interventions according to their national contexts;

2. URGES Member States:

    (1)   to consider initiating national, multisectoral action to review existing health policies and programmes in the light of the Policy Framework;

    (2)   to critically assess the policy options and interventions, and prioritize adoption and implementation according to their relevance and applicability to national and local situations;

    (3)   to cooperate with WHO in strengthening the evidence base and in pursuing advocacy and social mobilization activities to institutionalize the people-centred approach in health systems;

3. REQUESTS the Regional Director:

    (1)   to continue to work with the WHO Regional Office for South-East Asia and relevant experts in developing international standard guidelines and providing practical guidance to Member States in the reorientation of health systems towards people-centred health care;

    (2)   to undertake advocacy and social mobilization activities in consolidating and taking to scale current efforts and initiatives on people-centred health care;

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1 Annex to document WPR/RC58/11.

(3)   to support and work with Member States in developing action plans and implementation tools, including monitoring and evaluation mechanisms, to ensure that health policies and interventions lead to more people-centred health care, better health outcomes, and improved health and well-being;

(4)   to report to the Regional Committee on the progress of the initiative at the appropriate time.

Eighth meeting, 14 September 2007
WPR/RC58/SR/8