

PEOPLE AT THE CENTRE OF HEALTH CARE

Harmonizing mind and body,
people and systems

health partners, l.l.c.

— promoting health, providing care —



**World Health
Organization**

South-East Asia Region Western Pacific Region

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TABLE OF CONTENTS

FOREWORD.....	v
EXECUTIVE SUMMARY.....	vii
WHY DOES HEALTH CARE NEED TO CHANGE?.....	1
Introduction.....	2
What is causing the health landscape to change?.....	4
In a globalized world, why is health for all not within reach?.....	8
What do people want from health care?.....	12
Access.....	12
Safety.....	15
Quality.....	16
Affordability.....	17
Satisfaction.....	19
Within the changing landscape of health, how can health care transform itself to satisfy people's needs and improve health?.....	21
WHAT IS PEOPLE-CENTRED HEALTH CARE?.....	25
What does people-centred health care encompass?.....	26
The four domains of people-centred care.....	27
Evolving concepts and models of people-centred care.....	29
What values and principles guide people-centred health care?.....	35
What are the characteristics of people-centred health care?.....	38
Individuals, families and communities.....	38
Health practitioners.....	38
Health care organizations.....	39
Health systems.....	39
WHAT IS CURRENTLY BEING DONE TO PROMOTE PEOPLE-CENTRED CARE?.....	43
DOMAIN 1: Informed and empowered individuals, families and communities.....	45
Achieving access to health care.....	45
Building capacity to make informed health decisions.....	47
Participation at all levels of health care.....	49
Developing leadership to advocate for people-centred health care.....	51

DOMAIN 2: Competent and responsive health practitioners.....	52
Guaranteeing competency in health care service delivery.....	52
Transitioning to a holistic approach to health care.....	55
Reinforcing the capacity for compassionate care.....	58
Developing leadership to advocate for people-centred care.....	61
DOMAIN 3: Efficient and benevolent health care organizations.....	62
Establishing equitable, accessible and good quality health care services.....	62
Providing healing and nurturing environments.....	66
Supporting coordination and continuity of care.....	69
Fostering values-based leadership.....	71
DOMAIN 4: Supportive and humanitarian health care systems.....	73
Ensuring access and equity.....	74
Establishing standards for competence and accountability in health.....	77
Cultivating community-based participation in systems development.....	80
Promoting values-based leadership at the highest levels in health care.....	81
WHAT IS THE WAY FORWARD?.....	87
ACKNOWLEDGEMENTS.....	91

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FOREWORD

Economic progress and globalization made it possible for the average person's income to double between 1984 and 2004. These gains, coupled with advances in education and medical science and improved water and sanitation, have made it possible for today's newborn children to expect to live 20 years longer than those born half a century ago. Smallpox has been eradicated globally, and we are close to eliminating poliomyelitis in the Asia Pacific Region. Health is universally acknowledged as a fundamental human right, and global health expenditures have steadily increased, reaching US\$ 4.1 trillion in 2004.

Presented with such unprecedented resources and opportunities, people today should be healthier in mind and body and more content with the health care they receive.

But this is not necessarily the case. An estimated 10 million to 20 million people attempt suicide every year, resulting in nearly a million deaths. Depression has become a serious health problem in many countries. Health care continues to fall short of people's expectations. There is growing concern about patient safety and the quality and responsiveness of health care. Even in some developed countries, roughly 50% of patients receive unsafe and poor quality health care and often suffer as the result of medical errors. In fact, studies indicate that globally, one half of all patients are dissatisfied with their health care experience.

Why is this so?

Firstly, health has not been given sufficient emphasis, even though health is a resource and a key element of human and social capital. In fact, economic progress is at times pursued for its own sake, at the expense of health and humanitarian concerns.

Secondly, health systems and services are mainly focused on disease rather than on the person as a whole, whose body and mind are linked and who needs to be treated with dignity and respect. This inherent limitation of the narrow biomedical approach has led us to overlook important factors that impact health, such as psychosomatic and social factors.

Thirdly, reliance on science and technology—often perceived as infallible—without due regard to human factors, has had unintended consequences, such as medical errors, unnecessary suffering, disability and death.

Clearly, health care systems have reached a crucial turning point. Now is the time to reflect upon our long-held perception that the advancement of technology and science, as well as continuing economic development, by themselves will solve all the problems of our health care system. It is high time we re-evaluate our values and beliefs.

What do we need to do?

We need to harmonize people and systems, within the health sector and between health and other sectors. We now recognize that health is influenced by a complex interplay of physical, social, economic, cultural and environmental factors. Thus, health must be seen in a broader context, with all stakeholders involved. Multidisciplinary and multisectoral partnerships will be required more than ever to enable people to achieve optimal health and well-being.

On the individual level, we need to harmonize mind and body. A more holistic approach is needed, one that recognizes that the whole person is truly more than the sum of body parts.

Ultimately, we need to re-establish the core value of health care, which is the health and well-being of people as the central goal. This requires us to overcome the limitations of the narrow biomedical approach without losing its benefits. Scientific rigour and a people-centred approach are mutually reinforcing. We need to build upon our achievements. We urgently need to realign our work and our work ethic with the best interests of the people we serve. We must use knowledge and technology rationally, holistically and compassionately, within a system of care that views people not as targets of interventions but as full and equal partners in preventing disease and enhancing health and well-being. That is, health must be the concern of everybody, of every sector in society.

People at the Centre of Health Care: Harmonizing mind and body, people and systems articulates the vision, principles and processes that can drive and sustain people-centred health care. It is our challenge and responsibility to advocate and promote this vision, and translate it into reality through individual and collective action.

If we are successful, it will also be our lasting legacy.

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Dr Samlee Plianbangchang
WHO Regional Director for South-East Asia



Dr Shigeru Omi
WHO Regional Director for the Western Pacific

EXECUTIVE SUMMARY

People today should be healthier in mind and body and more content with the health care they receive than they were in years past. But this is not necessarily the case. If we hope to improve the health status of all people, health care and health systems must embrace a more holistic, people-centred approach.

The global health landscape has been undergoing tremendous change, and development has been its key driver. But development, as it pertains to health, can be a double-edged sword. Globalization, urbanization, technological innovation, environmental change and shifting demographics create opportunities that make better health possible. But these same forces also can increase the complexity of health problems and complicate the process of developing and implementing solutions.

Health systems, unfortunately, have not kept pace with these rapid changes—not at the level of individual health care nor at the level of population health care. Despite biomedical, scientific and technological advances that make it possible to achieve remarkable progress in disease elimination and control, people continue to suffer poor health. Health care systems continue to grapple with issues of health care access, safety, quality, affordability and satisfaction—precisely the issues people look for in health care.

Several important factors have contributed to dissatisfaction with the health sector. The health community has relied heavily on biomedical science and its almost exclusive focus on the physical aspects of health. This perspective has helped propel the growth of specialization, contributing enormously to scientific knowledge and medical and technological breakthroughs. But this approach too often is incapable of understanding health and disease from a broader, holistic perspective. In addition, an over-reliance on science and technology, without regard to human factors, has led to an increase in medical errors. Finally, health hasn't been given sufficient emphasis by governments, communities and individuals.

What changes are needed? To truly improve health at the individual level, interventions that address the physical component—the body—need to work together with interventions that address the psychosocial and cultural component—the mind. In essence, we need to harmonize mind and body.

At the population level, interventions to improve health must go beyond health itself and address the social, political, economic, cultural and environmental determinants that give rise to differences in access to health care and in health status. In other words, solutions that focus on the health of the people need to be balanced with solutions that focus on improving the health of the system. We need to harmonize both people and systems.

The key word is balance. Health systems have been unable to keep up with a rapidly changing world because they are out of balance. Restoring balance requires a shift in values and mindset. Health system reform in the 21st century must begin by reaffirming health care's core values of equity and empowerment and realigning its mission and vision, goals and objectives, strategies and programmes, and methodologies and tools with the desires and best interests of the people it serves.

Health systems in the 21st century demand the rational use of evidence and technology, within a holistic and compassionate system of care that treats patients and people not as statistics and targets of interventions, but as full and equal partners in preventing disease and optimizing good health, in health care settings and beyond. They also recognize that health and well-being must involve everybody and every sector in society.

The essence of people-centred health care and health systems involves a balanced consideration of the values, needs, expectations, preferences, capacities, and health and well-being of all the constituents and stakeholders, and encompasses the ill and those who are well.

Transforming the current health care system towards a people-centred orientation requires comprehensive and positive changes spanning four key policy and action domains: individuals, families and communities; health practitioners; health care organizations; and health systems.

These domains correspond to the key health care constituencies that will continue to drive and sustain the paradigm shift. A people-centred approach addresses the needs of individuals, families and communities in the broader context of their environment, while empowering them to achieve good health. It also gives due consideration to health care providers who should be enabled and supported to provide effective, holistic and compassionate care. Likewise, health care organizations and the larger health system must be designed, developed and managed to provide a conducive and supportive environment for delivering equitable, ethical, effective, efficient and empathic care.

People-centred health care reaffirms these core values, articulated in the constitution of the World Health Organization and other international declarations:

- health as a fundamental human right
- health as a central element in the process of development
- the end of all forms of discrimination
- the participation and inclusion of communities in health and development.

These core values give rise to the seven essential principles of people-centred health care, namely health care that is equitable, engages all stakeholders, promotes empowerment, provides effective care, is evidence-based and empathic, and is efficient and ethical.

Initiating the journey towards people-centred health care requires changes within each of the four domains to create:

- informed and empowered individuals, families and communities
- competent and responsive health practitioners
- efficient and benevolent health care organizations
- supportive and humanitarian health care systems.

If people-centred health care is to be realized in the Asia Pacific Region, action is required within each domain, recognizing that the four domains interact with and relate to each other in multiple ways. Moving towards a people-centred approach requires sustaining a dynamic balance across all four. Leadership within and across all domains will be the ultimate enabler of change.

What is currently being done? There is a growing evidence base to justify a framework of strategic actions. Throughout this book, actual examples are cited, demonstrating rising interest for people-centredness in health care. Changing the culture of health care will be a formidable challenge, but it is inescapable in the face of persistent health disparities. This requires more than reform; it requires transformation. Reform implies changing an existing system. But what we need to do is expand and build upon existing methods and perspectives as we also introduce new approaches that provide appropriate responses to the changing landscape of health care. Transformation means taking health care to the next level. The principles are clear, even if the actions to apply those principles will vary in different settings.

What is the way forward? Firstly, there is an urgent need to disseminate a common vision and framework for policy and action, endorsed by Member States of the World Health Organization, to all the relevant stakeholders. Secondly, key players—people's representatives, health practitioners, health organizations and ministries of health—must advocate for an unwavering commitment to the process of transforming health systems towards people-centredness. Thirdly, in the spirit of true people-centredness, the consultation process must include community voices from across the Asia Pacific Region to help design the details of the road map for health systems transformation. Fourthly, the Region must implement the strategies in the road map and make the transition from intentions to actions at all levels, from the individualized clinical setting to population-based public health. Finally, progress must be monitored carefully, and the lessons learnt from early mistakes must be applied conscientiously to revise and refine the transformation towards people-centred health care.

There is a clear path in front of us. By harmonizing mind and body, and people and systems, we can restore the balance in health care. By putting people at the centre of health care, we can fulfil our vision of health for all.

"In matters of health, I believe our world is out of balance, possibly as never before in history. We have never had such a sophisticated arsenal of technologies for treating disease and prolonging life. Yet the gaps in health outcomes keep getting wider."

Dr Margaret Chan
Director-General
World Health Organization



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WHY DOES HEALTH CARE
NEED TO CHANGE?

1



Introduction

In February 2006, the month cancer-fighting organizations in more than 90 countries observed World Cancer Day, three women in the Asia Pacific Region discovered lumps in their breasts.

Silei* was with her women's group at a village church in American Samoa, where a visiting nurse was teaching them to do breast self-examinations. During their practice session, she felt a lump the size of a marble in her left breast. But her village had no health centre and the nearest clinic was an hour's drive away. By the time Silei found the time, vehicle and driver to take her to the clinic, six weeks had passed.

Staff at the clinic did a biopsy and asked Silei to return after two weeks, since the biopsy material had to be sent off-island for testing. When Silei came back for her results, it was more than a month later.

The doctor gave her bad news. "You have cancer, Silei, and you will need to have surgery and maybe, chemotherapy. We don't have the facilities you need here, and we'll have to get you to New Zealand or Australia for treatment. I'm very sorry."

Like most people in her village, Silei was uninsured. The waiting list for government assistance for off-island care was long. It took another four months to get Silei transportation to a hospital in New Zealand. By that time, tests revealed her cancer had spread to her lymph nodes and liver.

Helen*, a married school administrator in Guam, was scared. It was time for her yearly mammogram, and this year the results showed a new mass in her right breast. A breast ultrasound confirmed that the mass was solid, not a cyst. After a biopsy, Helen's primary care doctor called her in. The doctor told her the biopsy showed she had cancer. The visit lasted a long time. Helen had many questions, and she and her doctor talked about all of her options. "Doctor, I'm scared. Will I die?" she asked. He looked at her directly and replied, "I don't have the answer to that question, and it's normal to be scared. But I can tell you this: Today, we have effective treatments for breast cancer. There's a good chance for a cure. You must believe this, Helen, and you must do all you can to aim for a cure. I'll help you."

* These are actual cases, but names have been changed to protect privacy.

And help her he did. The doctor arranged for Helen to see a cancer specialist and join a support group for women with breast cancer. He also referred her to a social worker to help her deal with all of the forms and insurance requirements. Throughout the process, Helen researched and read everything she could find on breast cancer. She eventually decided to have her breast removed and go through chemotherapy.

It was a difficult period. Often, Helen was too weak to do anything but lie down. But the worst part was when all her hair fell out. To cheer her up, Helen's husband and son shaved off their own hair; it worked. After six months of treatment, with her family and her primary care doctor to support her, Helen's cancer was declared to be in remission. Cautious, but optimistic, Helen returned to work and eventually became a volunteer at her local cancer society, reaching out to other women with breast cancer.

Le* had recently migrated from her native Viet Nam to work in a large, prosperous metropolitan area in a rapidly developing neighbouring country. Through her company's health insurance coverage, she had access to one of the largest hospitals in the area. When she was diagnosed with breast cancer, she comforted herself with the thought that she would be treated by some of the best medical experts in one of the most modern health facilities in the Region.

It was true that she received state-of-the-art care, but the experience was not what she expected. First, she was away from friends and family, and no one was with her throughout the treatment period. Next, navigating the health insurance maze proved to be almost as formidable as going through chemotherapy. Understanding and obtaining insurance pre-authorization for treatment proved overwhelming. Finally, the hospital environment, while efficient and clinical, was also cold and harsh, especially for someone fighting cancer alone in a foreign country. By the time Le was declared cancer-free, she was also experiencing full-blown depression. Unable to keep up with her job, she eventually lost it, returning to her home country healed in body but broken in spirit.

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What is causing the health landscape to change?

The three women we just met shared the same disease—fought using one standardized set of clinical guidelines—yet they experienced completely different outcomes. The differences were due, in no small measure, to the varying landscapes of health care that they encountered.

Ensuring the health of these three women would seem to be a simple task. After all, over the past century, a tremendous body of knowledge has accumulated to guide the prevention and treatment of diseases. Technology has progressed to the point where it is possible to alter bio-molecular targets and to conduct surgical interventions before an individual is born. In many countries, even in the developing world, health infrastructure has grown beyond the rudimentary stage.

Yet, at the individual level, as demonstrated by the real-life stories of Silei, Helen and Le, health outcomes from the treatment of the same disease can be widely divergent. Also, at the population level, differences in health status can be stark and glaring. Life expectancy varies by as much as 40 years between rich and poor countries. And diseases like malaria, which are easily prevented, continue to claim millions of lives each year. In the words of WHO's Director-General, Dr Margaret Chan, "A world that can put a man on the moon should be able to put children under bednets." (1) Today, we have sent several men to the moon, but almost 30 years after the historic Declaration of Alma-Ata that called for "health for all", we are failing to meet that goal.

In large part this is because the landscape of health is changing. Often, the changes occur rapidly, resulting in health consequences that are unpredictable and unexpected. Development is spurring radical transformations in health responses and resources, and changing health risks, capacities, vulnerabilities and needs.

The world is getting smaller. Globalization, technological innovation and ease of travel are contributing to the unprecedented speed and magnitude of the global exchange of goods, services, people, information and technology. Antibiotics are sourced from raw materials in Asia, manufactured and packaged in South America, and shipped for use in Africa. Researchers in Denmark create water purification systems

that are produced in China and used in India. Telemedicine permits medical experts in Australia and New Zealand to provide real-time consultations for patients in Fiji and other small Pacific islands. Nurses trained in the Philippines provide hospital care in Bahrain and London. These examples showcase the potential for technology and globalization to solve many of the world's health problems.

Technology and globalization have their downside, however. The misuse of antibiotics, readily available in many countries through global pharmaceutical distribution networks, has led to the development of "super-bugs"—microbes that have developed resistance to even the most potent drugs. Technological advances have made surgical procedures commonplace, but problems associated with surgical safety in developed countries account for half of the avoidable adverse events that result in death or disability. (2)

As globalization moves people and resources around the world, pathogens, toxins and unhealthy lifestyles are hitch-hiking along. In 2003, severe acute respiratory syndrome (SARS) spread explosively in Hong Kong (China) after emerging in China's Guangdong Province. It rapidly spread to other countries through air travel. Had SARS developed a century ago, before jet travel became ubiquitous, it would likely have remained a local phenomenon. (3) Tuberculosis, previously under control in Scandinavia, is re-emerging as a health threat, transported by immigrants. Food safety is increasingly recognized as a critical global health issue, after outbreaks of hepatitis A, *E. coli* and mercury poisoning have been traced to contamination of food products at their sources. International trade is bringing cigarettes, alcohol and canned ham to Micronesia, facilitating the adoption of unhealthy behaviours and diets. Consequently, while the people of Micronesia today are less concerned with starvation, they are increasingly preoccupied with rising rates of obesity, high blood pressure, diabetes, cancer and heart disease.

Cities, the nodes of global trade, are growing. The rapid growth of cities is a hallmark of modern times and is predominantly a developing world phenomenon. Almost all future population increase is projected to occur in urban areas of less developed regions, particularly Asia and Africa, while rural population growth is expected to remain static. (4, 5) This trend is expected to mirror at country level both the good and the bad consequences of globalization described earlier.

Unfortunately, globalization and urbanization do not guarantee equitable distribution of resources, including human resources for health. The already uneven distribution of health workers has worsened with unplanned migration from rural to urban areas and abroad. This could create a crisis where the health workforce is depleted in many areas and may be least able to respond at a time of greatest need.

Groups of people that lack the skills, capital and networks to succeed in a globalized and urbanized economy are increasingly marginalized. To illustrate, access to the Internet with its wealth of health information is concentrated in urban areas, but this access is usually unavailable to the urban poor. The latest antiretroviral drug combinations for HIV/AIDS are usually first available in large cities, but the HIV-infected urban poor have some of the worst outcomes from this disease. The coexistence of the “urban health penalty” with the “urban health advantage” testifies to the growing social and health disparities in this setting. (6)

Also, the physical environment is changing. As cities grow, they increasingly put significant ecologic and social pressures on the environment. Increasing dependence on fossil fuels, for example, is having a profound impact on rising temperatures and climate change. Consumerism directly contributes to increased waste, which in many countries is exceeding the capacity of landfills and other waste management systems, resulting in environmental pollution. The ever-increasing need to develop land for commercial and residential purposes encroaches on natural ecosystems. This disrupts the ecologic interphase between humans and animals, and promotes the emergence of new disease pathogens while enhancing the resurgence and expanded transmission of old ones. Not surprisingly, about 75% of new infectious human disease agents detected in the past 30 years originally arose from animals. (7) The impact of these environmental changes is universally felt, and is facilitated by the same forces that generate the conditions for change. In an era of globalization, the consequences of environmental change can no longer be contained within national or regional borders.

People are living longer and growing older. Over the last 50 years, average life expectancy at birth increased globally by almost 20 years, from 46.5 years in 1950–1955 to 65.2 years in 2002. (8) With longer lifespans, the impact of chronic diseases on the health of populations has become substantial. Yet globalization has fostered the emergence of new infectious diseases and the re-emergence of old ones. Thus, ageing populations today suffer from the double burden of infectious and lifestyle diseases. Longer lifespans and higher rates of chronic diseases also imply a radical departure from the usual interactions with the health care system, from the acute-care model to prolonged and repeated contact with multiple health practitioners.

When it comes to health, development is a double-edged sword. Globalization, technological innovation, urbanization, environmental change, and ageing and demographic change create conditions for both health improvement and impairment. They create opportunities that make better health possible. But they also create new health risks and influence the ways in which risk is perceived and managed. They increase the complexity of health problems and complicate the process of developing solutions.

Box 1. Global health is a study in contrasts

While a baby girl born in Japan today can expect to live for about 85 years, a girl born at the same moment in Sierra Leone has a life expectancy of 36 years. The Japanese child will receive vaccinations, adequate nutrition and good schooling. If she becomes a mother, she will benefit from high-quality maternity care. Growing older, she may eventually develop chronic diseases, but excellent treatment and rehabilitation services will be available. She can expect to receive, on average, medications worth about US\$ 550 per year and much more if needed.

Meanwhile, the girl in Sierra Leone has little chance of receiving immunizations and a high probability of being underweight throughout childhood. She will probably marry in adolescence and go on to give birth to six or more children without the assistance of a trained birth attendant. One or more of her babies will die in infancy, and she herself will be at high risk of death in childbirth. If she falls ill, she can expect, on average, medicines worth about US\$ 3 per year. If she survives middle age, she also will develop chronic disease. But without access to adequate treatment, she will die prematurely.

These contrasting stories reveal much about what medicine and public health can achieve, and about unmet needs in a world of vast and growing health inequalities. (8)

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Unfortunately, in this period of rapid change, health systems are not keeping pace. The discrepancy between the response of health systems and the transformation occurring within the health landscape is occurring at both ends of the spectrum: at the level of individual health care (the micro level) and at the level of population health care (the macro level).



In a globalized world, why is health for all not within reach?

In the introductory stories, Helen and Le had access to the latest technology and state-of-the-art knowledge on cancer diagnosis and treatment. Both women eventually saw their cancers go into remission. But what was an empowering experience for Helen left Le dispirited and unable to function. The technical aspect of their health care was equivalent, and their physical outcomes were similar, but something was missing in the quality of care that Le received. The “connectedness” with family and friends and the psychosocial support that they could have given were sadly lacking.

At the population level, the contrasting cases in Box 1 highlight the current disparities in health status between developed and developing countries. In an ideal globalized world, health solutions and standards of care should be globally available, and health improvements should be felt universally. The situation regarding health in today’s world is far from ideal.

Health care is still predominantly influenced by the biomedical model. This model originated from the tenets espoused by Rene Descartes (1596–1650), who taught that the mind and body were completely separate from one another, and that a thorough understanding of the body required objective approaches and methods. Cartesian thinking is mechanistic and reductionist. In other words, the complex human body, like a machine, is best understood by breaking it up into its smaller and simpler component parts.

The biomedical model gained popularity in the 19th century, bolstered by the discoveries of scientists like Rudolph Virchow, who believed that all pathology could be explained at the cellular level, and Louis Pasteur, whose work confirmed the germ theory of disease. During this period, infectious diseases were overwhelming, contributing the major portion of global disease burden. Within this context, the biomedical model proved highly useful, providing the impetus for breakthrough medical discoveries such as the aseptic technique in surgery and the use of antibiotics to treat bacterial diseases.

The biomedical model retains its utility today when addressing diseases caused by identifiable physical, chemical or biologic agents, with acute presentations and specific treatments. But the model's limitations become obvious when applied to chronic diseases, diseases caused by lifestyle or behavioural factors, diseases with non-specific aetiologies and mental illness. By distilling illness into a purely physical phenomenon, we are unable to capture the less tangible but powerful impact of the mind on the body.

At the level of the individual patient, contrary to Cartesian thinking, the whole is truly much more than the sum of its parts. Since the 1970s, the health community has been increasingly confronted with evidence of the critical role of psychosocial and cultural factors in providing contextual background for the experience of illness. Illness is not limited to the physical manifestations of disease, but encompasses the totality of a person's perceptions, attitudes, emotional reactions and behaviours towards sickness. This is best captured by the bio-psychosocial model of illness, in contrast to the biomedical one.

Box 2. The disease called loneliness

The Germans dumped a young Soviet prisoner in my ward late one night. The ward was full, so I put him in my room as he was moribund and screaming and I did not want to wake the ward. I examined him. He had obvious gross bilateral cavitation and a severe pleural rub. I thought the latter was the cause of the pain and the screaming. I had no morphia, just aspirin, which had no effect. I felt desperate. I knew very little Russian and there was no one in the ward who did. I finally instinctively sat down on the bed and took him in my arms, and the screaming stopped almost at once. He died peacefully in my arms a few hours later. It was not the pleurisy that caused the screaming but loneliness. It was a wonderful education about the care of the dying.

*The Foundations of Primary Care:
Daring to be Different (9)*

Scientific approaches and solutions that address the physical component of illness are necessary but insufficient to effect a “total cure”. As J.P. Sturmberg eloquently points out in his book *The Foundations of Primary Care: Daring to be Different*:

“Disease is not an objective state but rather the product of our personal experiences...Understanding illness in this way, accepting that illness is intimately related to the patient’s personality and his life experience, and understanding the doctor’s role as helping patients to come to terms with, i.e. to find personal meaning in, their illness, has a profound impact on the way we organize and deliver health care. Illness is a whole person problem, not a problem of one part.” (10)

For example, a study showed that if people do five simple things—eat healthy, exercise regularly, do not smoke, manage stress and participate in patient support groups—the level of blockage of arteries in the heart could be reduced by as much as 7.9% in five years. On the other hand, more than twice as many cardiac events would occur among individuals who do not observe such discipline. (11) Another study showed that patients who received a coronary artery bypass graft and then suffered moderate to severe depression had a higher death rate than patients who were not depressed. (12)

In other words, to truly improve health, interventions that address the physical component (the body) need to occur together with interventions that address the psychosocial and cultural component (the mind).

This helps to explain the divergence in the health care experiences of Helen and Le in our introductory stories. The diagnosis of breast cancer evokes fear and begins the maneuvering within a technologically sophisticated and complicated health system. Helen received the same diagnostic tests and treatment as Le, but she did so within the context of a respectful and caring relationship with her doctor, and within a supportive health care environment. Le, on the other hand, had the benefit of medical expertise and the best technology, but was without anyone to help guide her through the uncertainty and bewilderment of undergoing cancer treatment. Her health care team treated her cancer, but provided no help managing her fear and loneliness.

On the macro level, the health of a population is determined by more than the collective physical status of the individuals in that population. The “social determinants of health” model articulates this perspective. (13) This model recognizes that within a particular sociopolitical context, structural (e.g. sex, ethnicity, income and education) and intermediary (e.g. living conditions, working conditions and health behaviours) determinants of health can lead to differential health status by creating social inequity and giving rise to differential exposures and vulnerabilities. In turn, differences in health and well-being can aggravate socioeconomic inequalities by adversely impacting an individual’s capacity to work, for example. The health system is an intermediate social determinant of health itself, capable of impacting differential exposures and

vulnerabilities by facilitating equitable access to services, as well as through the promotion of intersectoral action to improve health status. Implicit in this model is the acknowledgement that interventions to improve the health of a population must go beyond health and address the psychosocial, political, economic, environmental and cultural determinants that give rise to inequity and differences in health status. In other words, solutions that focus on the health of the people need to be balanced with solutions that focus on improving the health of the system.

The key word is balance. Health systems are not able to keep up with the changing landscape of public health because they are out of balance. Over-reliance on the biomedical model has led to a mindset that:

- Focuses on controlling disease rather than protecting and promoting health
- Utilizes a piecemeal or reductionist approach when diagnosing illness, leading to an incomplete understanding of the context of illness and the fragmentation of care
- Perceives the individual and the general public as passive targets of intervention who enter the health care system only after they have developed disease and who have little, if any, capacity and control over their health
- Reinforces the paternalistic model where knowledge, skills and decision-making reside predominantly with health professionals who deliver health care services
- Reduces health into a consumer product that is unidirectionally driven by supply and demand, with health professionals as providers/suppliers and individuals and communities as recipients/consumers
- Relies heavily on evidence and technology directed towards medical factors, perpetuating the legacy of ill-health by failing to recognize the critical need to intervene and modify the non-medical factors (behaviours, culture, sociopolitical and economic factors) that predispose people to poor health
- Prioritizes the needs of the health care system at the expense of both the people who run the system and the people whom the system is supposed to serve.

In an increasingly globalized world, where poor health likely results from or is compounded by the stresses of urbanization, environmental change, technological development and demographic change, this mindset is no longer appropriate nor effective. Instead, we need to build on the biomedical model by utilizing its strengths within a broader, more progressive approach that harmonizes mind and body, people and systems.



What do people want from health care?

Recent research in 12 countries has shown that people want health systems to deliver care that respects their needs and preferences, respects their desire to participate in decisions about their health care and in health policy development, and provides accurate information that supports such participation. (14) Concerns over the quality and responsiveness of health care have also led to a growing interest in how to use the contributions of individuals, families and communities in health care decision-making.

When potential health care users (the public) were asked what they expect health care to be, responses ranged from the basics of accessibility, affordability, safety and quality, to higher levels of expectations: responsiveness, flexibility and choice; health promotion; and transparency, accountability and the opportunity to influence health policy and participate in health services planning. Beyond access, patients particularly wanted the following: clear, concise and intelligible information; effective treatments, administered by competent health professionals; emotional support, empathy and respect; continuity of care and smooth transitions; attention to physical and environmental needs; support for self-care; and involvement of family and other caregivers in the care experience. (15)

Various surveys in several countries in the Asia Pacific Region revealed that patients seek similar qualities in their health care, but stated this in slightly different ways: health practitioner knowledge about disease and treatment; full disclosure of diagnosis and prognosis; better communication and information, including being listened to; respect and politeness; privacy, emotional support and assurance; and shared treatment decision-making. (16-24)

Health care has multiple dimensions. The five key issues that consistently emerge in studies of what people want from health care include access, safety, quality, affordability and satisfaction.

Access

Access is the first step towards ensuring “health for all”. Access to health care implies that people are able to command appropriate health resources when needed. This requires health resources to be available, adequate, acceptable and affordable. The concept of access also entails the absence of significant barriers to obtaining needed health care services. (25)

Box 3. Too far for comfort

"It's so hard for the women in my area to come to the hospital... I took the car and took four women from the church to the hospital because I knew they were sick and complained of stomach pains and back pains, even leg pains. It was good that I did because two had cervical cancer from my village. When asked why they didn't go to the hospital, they said that it was too expensive and it was too far."

Torise F. Saifoloi (26)

Despite the considerable advances of the past century, a substantial proportion of the world's population continues to have limited access to health care. In the introductory story, Silei, the woman who lived in American Samoa, postponed seeing a health professional after discovering a breast lump because the health centre was distant and she had no available transport. Her biopsy results were delayed because there were no laboratory facilities on her island to test the biopsy slides. Her experience demonstrates how health care can be delayed because services are not available locally and health resources are geographically inaccessible.

Even when services are available, people may not know how to access them because of personal barriers, organizational barriers and barriers arising from the health system itself. Personal barriers include lack of information and knowledge, language, and personal beliefs and attitudes related to sociocultural and religious background. Organizational barriers arise from the failure to design health programmes and services in health facilities around the needs of the people for whom these programmes and services are intended. Complicated and confusing referral procedures, long waiting lines, an excessive number of forms to be filled out can overwhelm and frustrate people. In turn, this frustration can lead them to forego needed health services.

Box 4. Language barriers and lack of communication can kill

"For Luci's follow-up care here in the U.S. we were lucky that we speak English and could easily communicate with the doctors and nurses. For people who don't speak English, it would have been very different. A lot of Tongans here die of cancer, especially of breast cancer, because they don't complete their treatment protocols...But most of them don't know that. They need someone to explain things to them, like how treatments work, and the importance of completing them. We have so many fatalities from cancer because of the lack of communication. We need doctors to not only be linguistically competent, but also culturally sensitive people working to gain the trust and connect with the different ethnic minorities, not just Tongans."

Leafa Latu (26)

Health systems can sometimes present barriers to health access when health programmes and resources are created without taking into account the specific needs and situation of the populations to be served. For example, when entry into the public health system requires proof of residence (e.g. by requiring presentation of an identification card), slum dwellers and informal settlers who have no official address are immediately excluded. (27) Even the most progressive health care systems, however, will experience problems with access if the political and sociocultural contexts in which they operate continue to harbor values that are counter to equitable access. Gender inequality, racial and religious prejudices, and a social structure that places greater value on specific groups of people over others work against access to health. The lack of balance in health systems today, in part, results from attempts to improve the system efficiency without due regard to external and internal factors that inhibit equity of access.

Safety

“Every point in the process of care-giving contains a degree of inherent unsafety: side effects of drugs or drug combinations; hazards posed by a medical device; substandard or faulty products entering the health system; human shortcomings; or system [latent] failures.”

World Health Organization, 2002

Despite the best intentions, adverse effects do occur. While scientific and medical advances and innovations have contributed tremendously to improvements in health care, there are unintended consequences at times, partly due to factors such as the limits to technology itself and its abuse or misuse.

Patient safety is a global issue. Studies in several countries (Table 1) have documented an adverse event rate from acute care hospitals ranging from 3.2%–16.6%. The World Alliance for Patient Safety reports that at any time, over 1.4 million people worldwide are suffering from infections acquired in hospitals, and up to 10% of patients admitted to modern hospitals in the developed world acquire one or more infections.

In developing countries, many of which are in the Asia Pacific Region, patient safety is an even bigger concern. The risk of health care-associated infection in developing countries is 2–20 times higher than in developed countries. In some, the percentage of patients affected by a health care-acquired infection can exceed 25%. The persistence of such high levels of unsafe care, which is largely avoidable, is alarming. (28)

The Fifty-fifth World Health Assembly in May 2002 adopted Resolution WHA55.18 that drew global attention to the issue of safety in health care. (29) A WHO Report to the Secretariat on this issue concluded:

“Adverse events may therefore result from problems in practice, products, procedures or systems...Enhancing the safety of patients includes three complementary actions: preventing adverse events; making them visible; and mitigating their effects when they occur...Action is also needed at another level, from a broader system perspective viewing the safety of patients as a major element in improving the quality of care and enhancing the performance of health care providers.” (2)

Table 1. Adverse events in health care from several countries

Study	Acute care hospitals (date of admissions)	Number of hospital admissions	Number of adverse events	Adverse event rate (%)
United States of America New York State Harvard Medical Practice Study	1984	30 195	1133	3.8
United States of America Utah-Colorado Study (UTCOS)	1992	14 565	475	3.2
United States of America (UTCOS) ¹	1992	14 565	787	5.4
Australia Quality in Australian Health Care Study (QAHCS)	1992	14 179	2353	16.6
Australia (QAHCS) ²	1992	14 179	1499	10.6
United Kingdom of Great Britain and Northern Ireland	1999–2000	1014	119	11.7
Denmark	1998	1097	176	9.0

¹ UTCOS revised using the same methodology as the Quality in Australian Health Care Study (harmonizing the four methodological discrepancies between the two studies).

² QAHCS revised using the same methodology as UTCOS (harmonizing the four methodological discrepancies between the two studies).

Source: WHO 2002, Quality of care: patient safety—background paper. Report of the Secretariat, A55/13.

Quality

People want good quality health care. While much of the research into patient perceptions of quality health care has been conducted in Western contexts, reflecting the cultural orientation of Western society, the demand for quality health care is universal.

Quality includes both the content (i.e. adherence to evidence-based guidelines and practice recommendations, efficacy in producing improvements in health outcomes) and the process (i.e. efficiency and timeliness and coordination) of care. For both individuals and populations, quality care relates to expectations and experiences of the health system and the extent to which one is empowered to achieve better health. Ironically, the knowledge base on good health practices has grown tremendously, but the delivery of care today is often characterized as fragmented and poorly coordinated.

In recent years, health care organizations and public health systems have become increasingly preoccupied with “quality monitoring”, “quality assurance”, and “quality management”. However, interventions to increase organizational and system efficiency, as reflected in improved service delivery and utilization, and enhanced cost-effectiveness, may not always correspond to people’s perceptions of better care.

WHO in its 2006 publication *Quality of Care: A Process For Making Strategic Choices in Health Systems* provides insight into how to reconcile this discrepancy:

“Decision-makers cannot hope to develop and implement new strategies for quality without properly engaging health service providers, communities and service users. Health service providers need to operate within an appropriate policy environment for quality, and with a proper understanding of the needs and expectations of those they serve, in order to deliver the best results. Communities and service users need to influence both quality policy and the way in which health services are provided to them, if they are to improve their own health outcomes.” (30)

Affordability

Affordability can be a major factor in health care access, but it also affects the quality of care, and therefore, increases the likelihood of unsafe care. At its extreme, financial barriers can block access to care. A series of epidemiological surveys conducted by Médecins sans Frontières in Burundi, for example, concluded that the institution of user fees for public health services as a government cost-recovery scheme resulted in the exclusion of over 1 million people from health care. Furthermore, utilization of health care services exacerbated poverty by diverting funds from basic needs. In this example, the lack of affordability not only resulted in poorer health outcomes and exclusion from the health care system, but also aggravated the underlying social determinant for poor health: poverty. (31)

Societal affluence does not guarantee that health services are affordable to all unless resources are equitably distributed. The United States of America, for example, has one of the highest per capita health expenditures but life expectancy is lower than would be expected. In part, this is believed to be related to lack of affordability of health care for the uninsured and underinsured. (32)

After gaining entry into the health system, relative financial constraints can influence the quality and safety of care. Research has found that poor populations within the health care system are treated with less dignity and responsiveness, given fewer choices of services and service providers, and offered lower-quality care and amenities. (33)

Even when health services are provided free of charge, the related costs of obtaining care, such as travel costs and the cost of taking time off from work, can still be significant. Noemia Campos, the wife of a stroke victim left completely paralysed and unable to speak, states: "Fortunately his medication and check-ups are free of charge but sometimes we just don't have the money for the bus to take us to the local medical centre." (34)

The issue of affordability, then, is tied into the broader system that determines how equitably resources are allocated in society, as well as the health financing structures that influence the overall cost of health care.

Box 5. Show me the money

"I have an open wound and fractured my femur (thigh bone). In the morning, the people from the church came and took me to the hospital in Gitega where I spent several months.

The nurses finally asked me to pay a sum of money, although I had none. From that day, the nurses stopped treating me properly. My wound and fracture became infected. Nobody came to change the dressing. The nurses isolated me in a room so as to distance me from the other patients because my wound was purulent. The nurse only came to cover the wound. I was expecting to die.

...A social worker from the Ministry of Social Affairs came to the hospital...and she took pity on me. She took care of the preparations for my leaving and told me that she was going to go with me...to the Médecins sans Frontières centre for the wounded where care is free.

Now I believe I will get better because the dressing is changed daily and I am also taking antibiotics."

Deo

Muramvya province, Burundi (31)

Satisfaction

People's reports of their health and quality of life, and their satisfaction with the quality of care and services, are as important as many clinical and population health measures. Of the various dimensions of health care, satisfaction is probably the most complex. It is also notoriously difficult to study and characterize.

According to the International Alliance of Patients' Organizations (IAPO), a multi-country study of the perceptions of health care quality revealed that about half of patients are dissatisfied with current health care and roughly the same proportion see no significant improvement over a five-year horizon. (14) In Malaysia, a survey of 16 723 patients in 19 hospitals demonstrated that less than one third (31.7%) of the respondents were satisfied with the care they received. (35) Most were unhappy about long waiting times and delays in service.

At the level of individual health care, the Picker Institute partnered with Harvard Medical School in the 1990s to study what patients valued about the experience of receiving health care and what they considered unacceptable. The first national survey using this tool involved telephone interviews with 6000 recently hospitalized patients randomly selected from 62 hospitals in the United States of America, along with 2000 friends or family members who served as their caregivers.

The Picker Institute/Harvard Medical School surveys distinguished seven dimensions of care that were relevant to an individual's health care experience:

- **Respect for patients' values, preferences and expressed needs** (including impact of illness and treatment on quality of life, involvement in decision-making, dignity, needs and autonomy)
- **Coordination and integration of care** (including clinical care, ancillary and support services, and front-line care)
- **Information, communication and education** (including clinical status, progress and prognosis, processes of care, facilitation of autonomy, self-care and health promotion)
- **Physical comfort** (including pain management, help with activities of daily living, surroundings and hospital environment)
- **Emotional support and alleviation of fear and anxiety** (including clinical status, treatment and prognosis, impact of illness on self and family, financial impact of illness)
- **Involvement of family and friends** (including social and emotional support, involvement in decision-making, support for caregiving, impact on family dynamics and functioning)
- **Transition and continuity** (including information about medication and danger signals to look for after leaving hospital, coordination and discharge planning, clinical, social, physical and financial support). (36)

WHO in 2000 developed the notion of “responsiveness” in an attempt to characterize satisfaction at the level of population health systems. Responsiveness was defined as a measure of “how the [health] system performs relative to non-health assets, meeting or not meeting a population’s expectations of how it should be treated by providers of prevention, care and non-personal services”. (33)

WHO further characterized responsiveness as having seven distinct elements, which were related to “respect for human beings as persons—which are largely subjective and judged primarily by the patient—and more objective elements related to how a system meets certain commonly expressed concerns of patients and their families as clients of health systems, some of which can be directly observed at health facilities”.

These seven elements of responsiveness are listed under two categories:

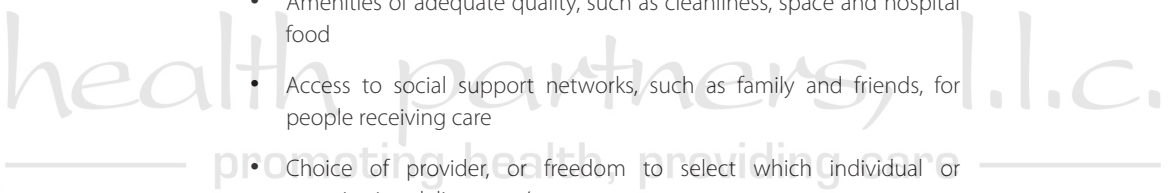
Respect for persons

- Respect for the dignity of the person
- Confidentiality, or the right to determine who has access to one’s personal health records
- Autonomy to participate in choices about one’s own health

Client orientation

- Prompt attention: immediate attention in emergencies and reasonable waiting times for non-emergencies
- Amenities of adequate quality, such as cleanliness, space and hospital food
- Access to social support networks, such as family and friends, for people receiving care
- Choice of provider, or freedom to select which individual or organization delivers one’s care.

The similarities between the Picker Institute and WHO characterization of what people want from health care are striking and articulate the “value added” that people desire from health care, in addition to the necessary dimensions of access, safety, quality and affordability. The challenge for health care in the 21st century is how to achieve satisfaction and measurable improvements in health while adapting to the changing health landscape brought about by development.



Within the changing landscape of health, how can health care transform itself to satisfy people's needs and improve health?



Health systems can address some of the intermediate determinants of health but are limited in their ability to impact the broader sociopolitical, economic and cultural context within which health inequities emerge. To do so requires a concerted multisectoral effort at the local, national and global levels. However, the health sector can and should continually advocate to other sectors in society the fundamental importance of investing in health in the development process. Only then can the goal of "health for all" become reality.

Within the health sector, a radical shift in values and mindset is needed. Health system reform in the 21st century must begin by reaffirming health care's core values of equity and empowerment, and realigning its mission and vision, goals and objectives, strategies and programmes, and methodologies and tools with the desires and best interests of the people it serves.

This requires the public health community to see beyond Descartes and acknowledge the interrelatedness of the mind and body. It demands the rational use of evidence and technology, within a holistic and compassionate system of care that treats people not as statistics and targets of interventions but as full and equal partners in preventing disease and optimizing good health. It also, importantly, recognizes that health and well-being must involve everyone and every sector in society. Thus, it empowers the move from "health for all" to "health for all, by all".


This transformation can happen only if patients are at the heart of individual care and clinical care. At the population level, the public must become the focal point of public health.

In effect, people must be at the centre of health care.

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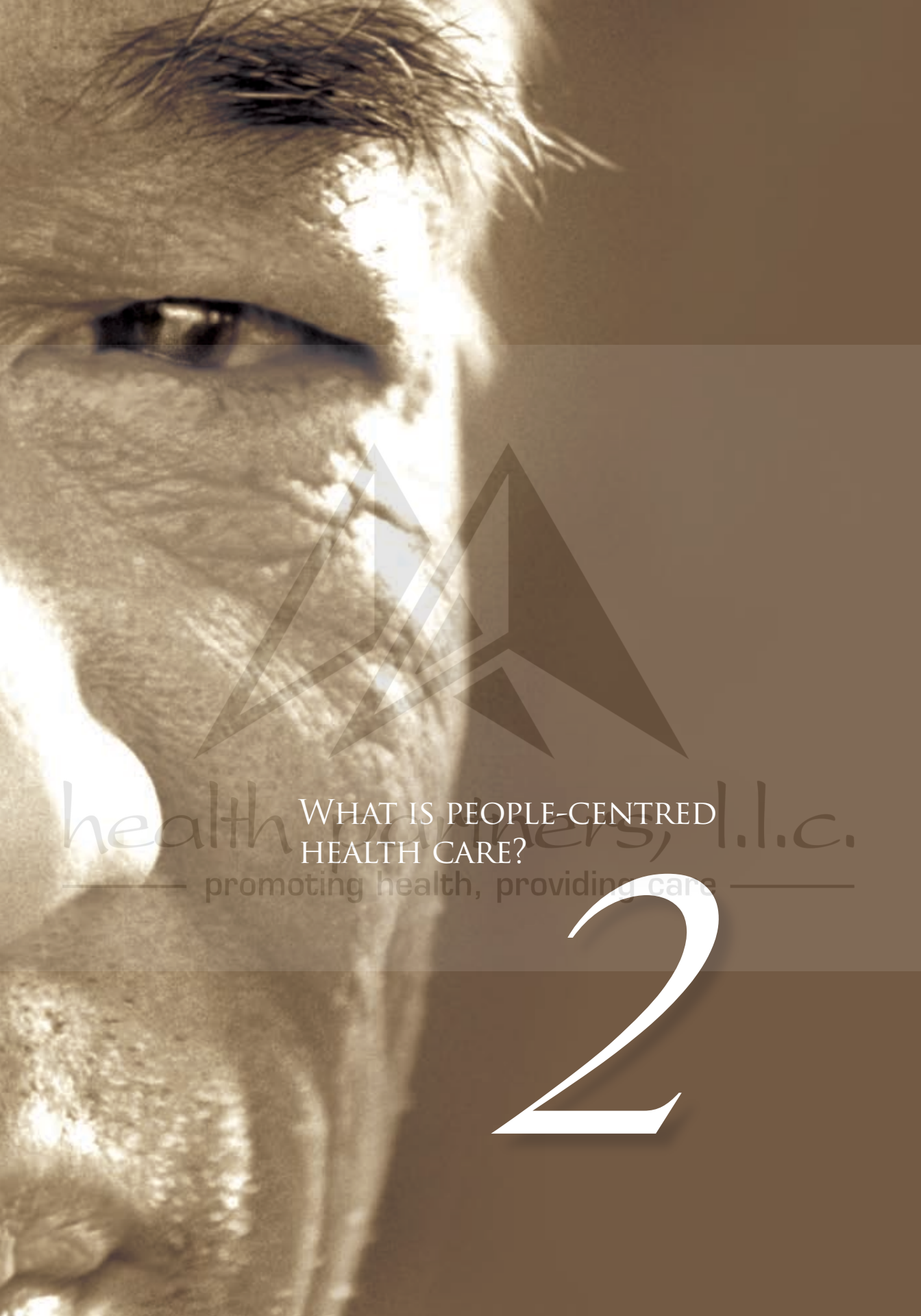
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"People-centredness is a vision of a health care system with not just patients at the centre, but also healthy residents of the region it serves."

Gregg Moor
Project Coordinator
Vancouver Coastal Health
Research Institute

health partners, l.l.c.
— promoting health, providing care —



health partners, l.l.c.

WHAT IS PEOPLE-CENTRED
HEALTH CARE?

— promoting health, providing care —

2



What does people-centred health care encompass?

A people-centred approach involves a balanced consideration of the values, needs, expectations, preferences, capacities, and health and well-being of all the constituents and stakeholders of the health care system.

People may wonder why the paradigm shift in health care is being expanded from a patient-centred approach to people-centred approach for all health care and health systems.

The patient-centred approach primarily focused on patients, their interactions with health care providers and their experiences in the clinical setting. While this approach addressed issues of quality and holistic health care, it did not meet some of the broader health challenges. The people-centred approach meets these broader challenges by recognizing that before people become patients, they need to be empowered in promoting their own health. We have to reach out to all people, to families and communities beyond the clinical setting. In addition, health practitioners are people, and health care organizations and systems are made up of people. Their needs should also be considered, and they must be empowered to change the system for the better. In fact, all people benefit from and contribute to people-centred health care.

Much published literature addresses “patient-centred health care”, which comprises an important part, but not the totality, of a people-centred approach. Patient-centred health care focuses primarily on the interactions of the individual seeking care—the patient—with his or her health providers and the clinical system within which care is sought. The International Alliance of Patients’ Organizations, the Picker Institute, the International Diabetes Federation, the British National Health Service, the Commonwealth Fund, the Institute for Healthcare Improvement in the United States of America and Planetree, among others, have articulated patient-centred care models. The International Alliance of Patients’ Organizations, a global alliance representing patients of all nationalities and promoting patient-centred care worldwide, recently published a report of consultations with their member organizations worldwide regarding the definition and principles of patient-centred health care, resulting in the Declaration on Patient-Centred Healthcare. (1)

In envisioning the future of patient-centred health care, the Picker Institute in its Vision Summit in 2004 recognized the need to broaden the concept of being “patient-centred”.

“Broadening the focus beyond hospitals and beyond treatment to prevention should be part of our vision. The process of

caring begins well before anyone becomes a patient. In this context, 'patient-centred care' has limits as the banner for this movement. The Vision Summit participants offered various alternative terms, such as consumer or citizen-centred care, or health-centred care. These phrases show the growing awareness that care is evolving to include prevention and the role of community in achieving health." (2)

Health care interactions are not limited to the clinical setting. Public health interventions delivered to communities and populations outside of this clinical setting comprise an equally important aspect of health care. If the public health system is effective, its prevention and health promotion efforts should reach people in the general community long before they become patients and enter a clinical health care facility. Within this context, "people-centred" health care is a more appropriate label, implying that health systems need to address the needs and expectations of individuals, families and communities in both clinical and public health settings.

Moreover, the concept of "people-centred health care" has additional utility in that it encompasses not just those who demand and need support to achieve good health but also those who provide the services and who run the organizations and systems within which health services are delivered. After all, if patients are people, then so are health care professionals, health service managers and health policy-makers. Like the general population, they have needs and expectations from the health system. When illness strikes, they become patients. They are among the families and communities that the health system is designed to serve. And they are positioned to transform health care. A truly people-centred approach must extend and cover all these constituencies and stakeholders in health care.

The four domains of people-centred care

Transforming the current health care system towards a people-centred orientation requires comprehensive and positive changes spanning four key policy and action domains:

- (1) individuals, families and communities
- (2) health practitioners
- (3) health care organizations
- (4) health systems.

These domains correspond to the key health care constituencies that will continue to drive and sustain the paradigm shift. The domain of individuals, families and communities represents the point where health care is experienced. The health practitioners' domain is where health care is delivered. The domain of health care organizations represents where health care is facilitated, creating the conditions that

enable health practitioners to deliver health care. Finally, the health systems domain represents where health care is overseen and governed, where decisions are made, policies and programmes are developed, standards and competencies are set, and health resources are allocated, with profound and widespread consequences for the rest of the constituencies. The four domains encompass both clinical and public health settings, although the specific players may vary (Table 2).

A people-centred approach addresses the needs of individuals, families and communities in the broader context of their environment, while empowering them to achieve good health. It also gives due consideration to the needs of health care providers who should be enabled and supported to provide holistic, compassionate care. Likewise, health care organizations and the larger health system must be designed, developed and managed to provide a conducive and supportive environment for delivering equitable, ethical, effective, efficient and empathic care.

If people-centred health care is to be realized in the Asia Pacific Region, action is required within each domain, recognizing that the four domains interact with and relate to each other in multiple ways. Moving towards a people-centred approach requires sustaining a dynamic balance across all four. Leadership within and across all domains will be the ultimate enabler of change.

Table 2. Different players within the 4 domains of people-centred health care

SPECIFIC PLAYERS		
Domain	Clinical Setting	Public Health Setting
Individuals, Families and Communities	Patients and families, patient advocacy groups, patient associations	Communities and populations, nongovernmental health organizations
Health Practitioners	Clinicians and clinical support staff	Public health workers, prevention workers
Health Organizations	Clinics, health maintenance organizations, hospitals	Public health facilities, community health centres
Health Systems	Varies depending on national model of health care	Public health sector, ministry of health

Evolving concepts and models of people-centred care

The notion of people-centred care is still evolving. Several existing models have begun to delineate its characteristics. Most of these models are focused on the clinical experience of health care and are variations of patient-centred care. However, the elements they identify as integral to the patient-centred approach are also valid for the broader concept of people-centredness.

In 1970, Dr Michael Balint and his colleagues introduced the phrase “patient-centered medicine” as an alternative approach to traditional medical practice, which they described as “illness-centred medicine”. Balint believed that:

“A great number of people have lost their roots and connections...The individual thus becomes more and more solitary, even lonely...Any mental or emotional stress or strain is either accompanied by, or tantamount to, some bodily sensation.” (3)

In his view, a significant proportion of patient complaints arise from emotional stress and not physical causes. Thus, his model emphasizes the need for health care providers to listen carefully to their patients and to understand the nature of complaints from the patient’s perspective. Balint believed that a thorough understanding of the patient’s complaints, based on patient-centred thinking, was important in promoting healing. The physician’s role is to help patients to learn from their illness experiences and enable them to prevent what can be prevented and cope as well as possible with what cannot. (4)

One of the first groups in the United States of America to take on the challenge of operationalizing people-centred health care is Planetree. Founded as a non-profit organization in 1978, Planetree works with hospitals and health centres to develop and implement patient-centred care using a model that aims to enhance the health care delivery system’s ability to deliver more personalized care. (5) The Planetree model invests in architectural and interior design to promote health, and the use of nutrition, arts, and spiritual and complementary therapies to facilitate healing. Planetree hospitals encourage patient and family participation in care. (6) In 2005, Planetree had 71 hospitals and health centres in its network across the United States of America and Canada, including the New York-Presbyterian Health System and the University of North Carolina Health Care Systems. (7)

In 1984, Dr Joseph Levenstein developed the Patient-Centred Clinical Method (PCCM), which was subsequently refined by his colleagues at the University of Western Ontario. (8) Levenstein developed his model after listening to over 1000 audiotapes of interactions with patients in his family practice. In essence, he affirmed the importance of exploring both the disease and the illness experience from the patient’s perspective, understanding the patient as a whole person, and empowering patients to form a therapeutic partnership with the clinician.

The patient-centred clinical method has been evaluated extensively, especially in family medicine. For example, M. Stewart and colleagues evaluated the efficacy of the patient-centred clinical method in 2000. Using a sample of 39 family physicians and 315 of their patients, they conducted an observational cohort study in which they examined the interrelationships between three elements: patient perceptions of patient-centredness; observed communication behaviours; and subsequent health and resource utilization. When patients perceived the visit to be patient-centred they experienced better recovery, better emotional health, and significantly fewer diagnostic tests and referrals two months later. (9)

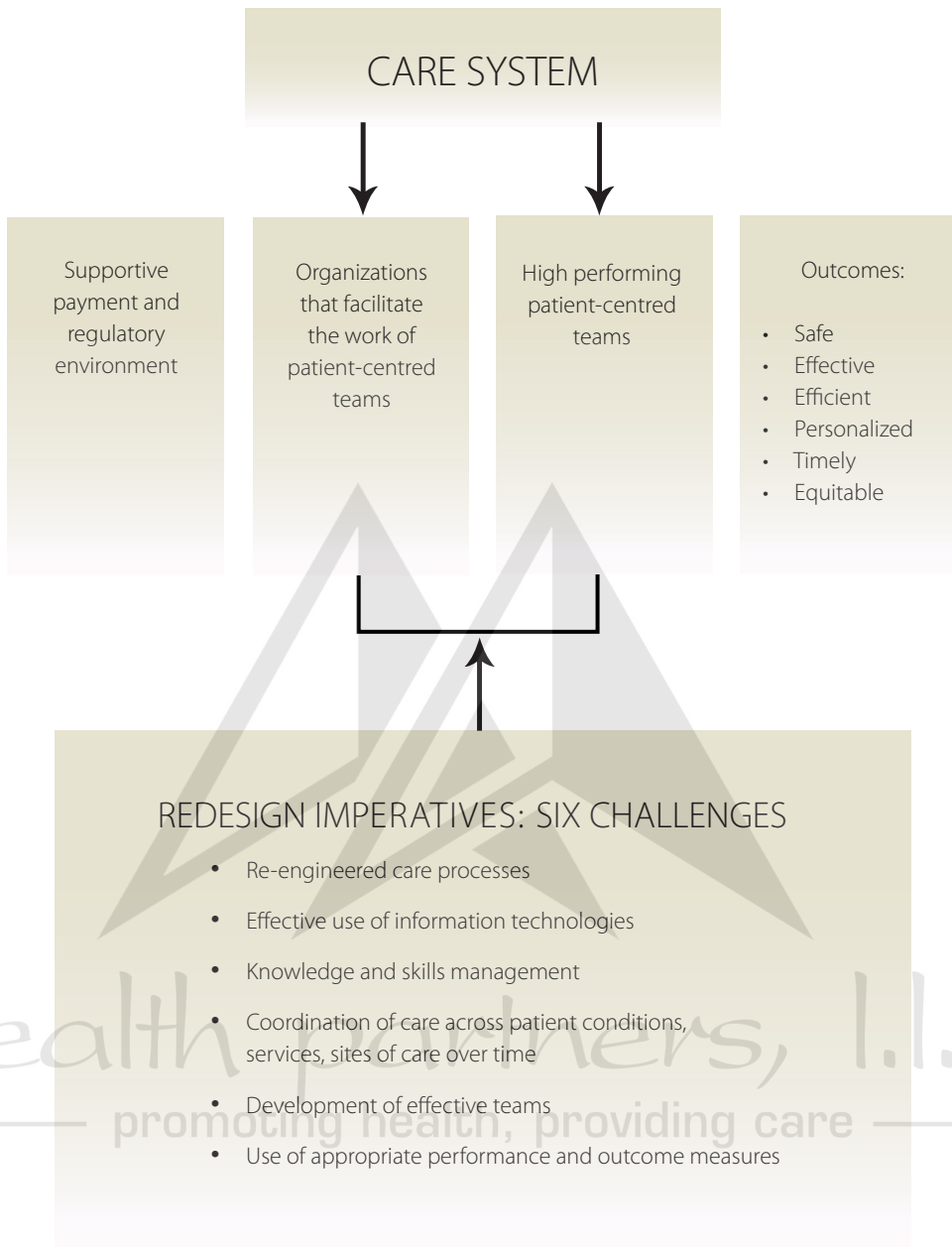
In 1988, the Picker Commonwealth Program for Patient-Centered Care, which eventually became the Picker Institute, introduced the phrase “patient-centred care”. Dr Harvey Picker, the founder of the institute, defined patient-centered care as “understanding and respecting patients’ values, preferences and expressed needs”. (10)

Unlike the models of Balint and Levenstein, which delineate pro-patient approaches in a one-to-one setting, the Picker Institute proactively sought to obtain patient perspectives on ideal health care in a broad and systematic manner. The Picker Survey today is considered by many to be the gold standard in patient care survey instruments and methodologies. The results of Picker surveys on what patients want and what they have experienced from health care were described in Chapter 1. (11) The Picker Institute surveys are conducted periodically in the United States of America, Canada and Europe.

The Institute for Healthcare Improvement (IHI), a non-profit organization, extended the concept of patient-centred care to “patient and family-centred care” in 2000, building on the earlier work of the Picker Institute and others. The IHI model acknowledged the essential function of families in ensuring the health and well-being of patients, recognizing that the most vulnerable groups in society—the very young, the very old and the chronically ill—who are most dependent on the health care system are also heavily dependent on their families for caregiving. (12)

The Institute of Medicine (IOM) in 2001 published *Crossing the Quality Chasm: A New Health System for the 21st Century*. Moving beyond the early models that focused on patients and their families, IOM approached the concept of patient-centered care from a health systems standpoint. In the IOM model, the care system is comprised of high-performing patient-centred teams and organizations that facilitate the work of other patient-centred teams operating within a supportive payment and regulatory environment to produce health care that is safe, effective, patient-centred, timely, efficient and equitable.

The IOM model emphasizes applying evidence to health care delivery, using information technology, aligning payment policies with quality improvement and preparing the workforce as the four key strategic areas for health systems improvement towards patient-centred care.



Making change possible.

Figure 1. Institute of Medicine's Model

From Institute of Medicine. 2001. *Crossing the quality chasm: A new health system for the 21st century*. Washington: National Academies Press.

Also in 2001, E.H. Wagner and his colleagues developed the Chronic Care Model (CCM) to increase guideline-directed care for chronic diseases. While not primarily identified as a people-centred approach, it emphasized collaboration between informed patients and caregivers and a proactive team of health care professionals, within a health system that made links with community resources. Thus, this model extended the stakeholders for patient-centred care from the individual, the family, the health professional and the health system to include the community. Subsequent evaluations of this model demonstrated improved disease control and better health outcomes for diabetes, hypertension and lipid disorders; higher patient satisfaction; enhanced adherence to disease management guidelines; more efficient health service utilization; and improved post-treatment functional status. (13, 14)

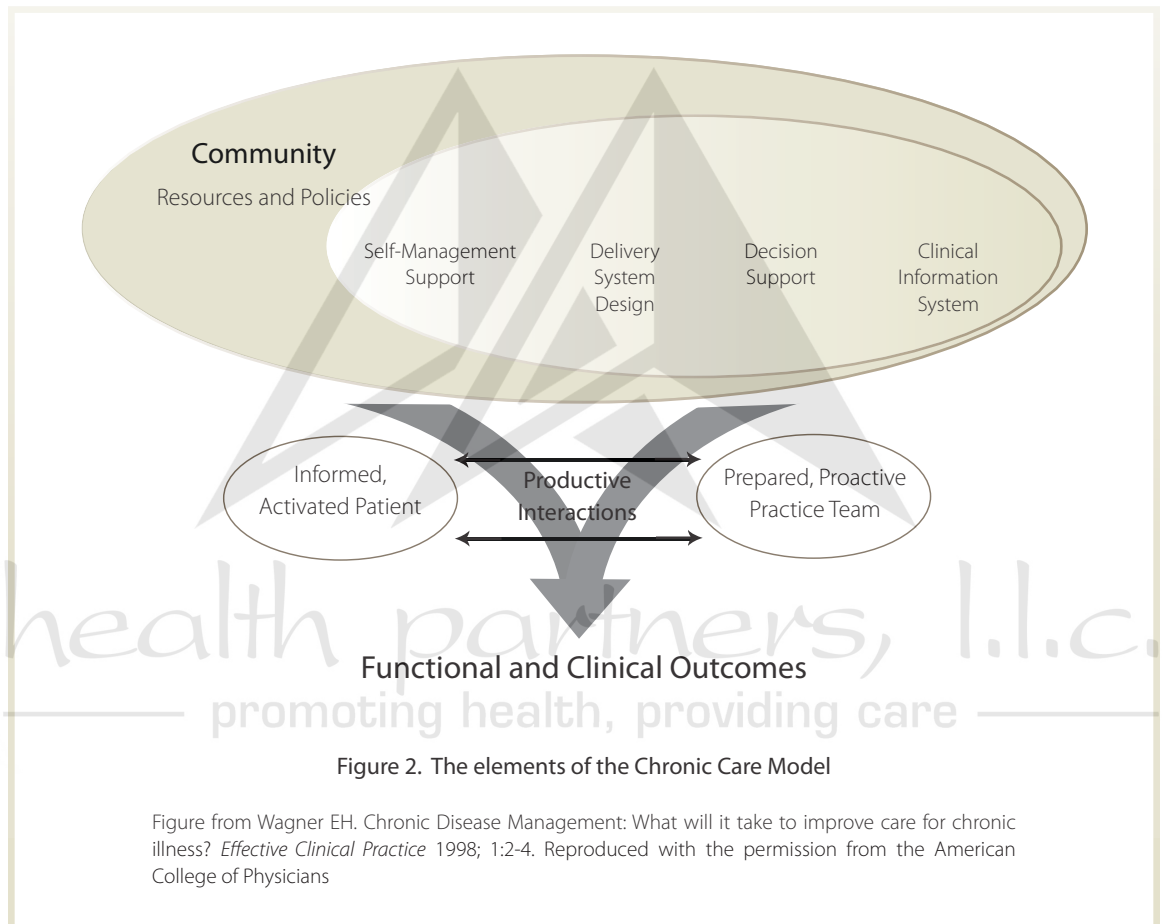


Figure 2. The elements of the Chronic Care Model

Figure from Wagner EH. Chronic Disease Management: What will it take to improve care for chronic illness? *Effective Clinical Practice* 1998; 1:2-4. Reproduced with the permission from the American College of Physicians

WHO has published relevant studies and reports addressing the issues and challenges faced by today's health care systems, particularly in relation to putting people at the centre of health care. Key considerations include the importance of mental health issues (15), patient-centredness as a core competency of health workers (16), and being patient-centred as a key dimension of health care quality. (17)

WHO developed the Innovative Care for Chronic Conditions (ICCC) framework in 2005 as an expanded, internationalized version of the Chronic Care Model developed by Wagner and colleagues. Patients and their families are at the centre of the health care system in this framework. Communities connect with health care organizations in providing chronic care. The framework recognizes the importance of a supportive policy environment that organizes the values, principles and general strategies of governments working to reduce the burden of chronic conditions. (18)

The phrase “people-centred health system” first emerged in a 2005 book by Dr Vaughan Glover that articulates his proposal for health care reform for Canada. Glover argues that the current Canadian health system has already met its two initial goals of providing all its citizens with access to a universal level of health care and providing the financial coverage for this health care. However, the changing nature of health and health care requires the health system to move towards a higher level of functioning. (19)

Glover’s model, graphically depicted, consists of four concentric circles with the informed person as the core, surrounded by providers or “coaches.” The third circle is made up of support groups, and the fourth encompassing circle is made up of management and legislation. While the model was developed specifically for Canada, it adds to the previous models by highlighting the dynamic interrelationship between the various stakeholders in health care.

In 2006, the International Alliance of Patients’ Organizations, launched its landmark Declaration on Patient-Centred Healthcare. This publication contains the first globally articulated definition of patient-centred health care developed by patients’ organizations from around the world.

Earlier in 2005, the International Alliance of Patients’ Organizations published the results of a survey of definitions and models of patient-centred care. They concluded that “there are numerous proposed definitions of patient-centred health care, which encompass many of the same core principles, but no globally accepted definition”. Further, they recommended that patient-centred health care incorporate respect for patients’ rights, delineation of patients’ responsibilities for their own health care, provision of evidence-based care, and consideration of patient safety as core elements. (20)

The International Alliance of Patients’ Organizations also recognized, in its report, the inherent limitations of the phrase “patient-centred”, acknowledging the critical role for prevention and community health promotion in health care. However, the full transition from “patient-centred” to “people-centred” health care was first articulated by WHO’s People at the Centre of Care Initiative. (21)

For the first time, people-centred health care was not just about clinical medicine but also about public health. The People at the Centre of Care Initiative is the beginning of a process of defining what people-centred health care entails throughout the entire spectrum of health care—from communities to clinics, from programmes to policies. Through this biregional initiative, the WHO Regional Offices for the Western Pacific and South-East Asia are assuming a more people-centred approach to health

care. This book articulates in greater detail the vision of the future of people-centred health care in the Asia Pacific Region.

Very likely, numerous other people-centred models and initiatives for health care exist. The examples described above represent a small fraction that are easy to access because they have been reviewed in published journals and have a significant presence in media, professional networks and the Internet. During a series of country consultations, work at the national level that embodies the concept of people-centredness in several countries was examined.

Box 6. Examples of people-centred approaches at the national level in Asia

Home-based health records in Malaysia

As a means to empower and encourage people to take responsibility for their health records, every person in Malaysia has their own home-based health card, which stores all of their health information. This allows them to have ready access to their health records and gives them the option to obtain health care at any facility. The card also reduces waiting time at health care facilities. (22)

Holistic medical education in Thailand

Thailand's medical curriculum has undergone transition, moving from being clinically oriented to one which is more people-oriented. Previously, subjects included traditional physiology and anatomy-based subjects. Today, the focus is on a "bio-psycho-social-spiritual" approach, with subjects such as Doctor and Society, Critical Thinking and Community Way of Thinking. Medical students are involved in local communities during their entire medical education and must undertake community placement to practice community medicine. The nursing curriculum incorporates health promotion and disease prevention. Skills to maintain student well-being, such as Buddhist meditation, are also taught. (23)

What values and principles guide people-centred health care?



The various models of patient- and people-centred care share many similar guiding principles and core values. The underlying values and principles of people-centred health care have been articulated in WHO and other international declarations that contribute to global welfare and are of significance regionally. Table 3 highlights the major relevant declarations.

TABLE 3. Key WHO and international declarations

1948	<ul style="list-style-type: none"> • Universal Declaration of Human Rights • WHO Constitution
1978	<ul style="list-style-type: none"> • Alma-Ata Declaration
1994	<ul style="list-style-type: none"> • Cairo Declaration on Population and Development
1995	<ul style="list-style-type: none"> • Beijing Declaration and Platform for Action, Fourth World Conference on Women • Yanuca Healthy Island Declaration
1997	<ul style="list-style-type: none"> • Declaration for health development in the South-East Asia Region in the 21st century
1999	<ul style="list-style-type: none"> • Copenhagen Declaration on Social Development
2000	<ul style="list-style-type: none"> • United Nations Millennium Declaration

The core values embedded in these declarations are:

1. Respect for human rights and dignity
2. The central role of health in any process of development
3. An end to all forms of discrimination
4. The importance of participation and inclusion of communities in health and development.

The right and duty of people to participate individually and collectively in all aspects of their lives, and the integral role of health in development, are the foundations of the people-centred approach. People have the right and duty to participate in making decisions about their health care, not only in issues of treatment and management, but also for broader issues of health care governance, planning and implementation. Even when these individuals and communities do not initiate the interaction with the health care system, they must remain the face and soul of the system. Health must become the “heart of development” (24) and the development process must directly contribute to supporting people to attain the freedom from disease and premature death (25) that is among the most basic of all freedoms. These underlie the people-centred approach to health care, and demonstrate that this concept is not new, but originally stems from the human rights movement articulated over half a century ago.

These core values give rise to the seven essential principles of people-centred care:

1. **People-centred care is equitable.** In a global community where boundaries are disappearing, there should be no boundaries preventing people from the opportunity to improve their health.
2. **People-centred care engages all stakeholders.** The four domains represent the key constituencies that must participate actively in the process of transforming the health care system. This implies that the needs, perspectives and wishes of all stakeholders must receive thoughtful consideration and that the decision-making process for health care reform should be shared across the domains.
3. **People-centred care is about empowerment.** Stakeholders, who are all people within the health care system, should direct the process of change. At the same time, these stakeholders need to be supported and their capacities enhanced to permit them to make the appropriate choices that will move the health system forward. For individuals and communities, people must be given the opportunity and the means to take responsibility for their health.

Health practitioners must be assisted to acquire the knowledge and skills to provide good quality and humane care. Health organizations and health systems need to be supported to make operational and governance decisions that will promote healthier communities and populations.

4. **People-centred care is effective care.** Interventions should lead to better health outcomes, both quantitatively and qualitatively. This requires care, whether in the clinical or public health setting, to address the five key issues identified in Chapter 1, namely, access, safety, quality, affordability and satisfaction.
5. **People-centred care is evidence-based and empathic.** The people-centred approach requires health providers, organizations and systems to approach health care holistically, balancing the biomedical model with a humanistic perspective. Evidence and technology must be used within the context of compassionate and caring relationships that value people and the totality of their health experience and include provisions for emotional and psychosocial support. It mandates the restoration of connectedness in all health care interactions.
6. **People-centred care is efficient.** Health care occurs in a coordinated and timely manner. Waste should be minimized.
7. **People-centred care is ethical.** Grounded in a respect for human rights and recognition of the integral role of health for human development and happiness, the people-centred approach invokes transparency and accountability.



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What are the characteristics of people-centred health care?

People-centred health care represents a major shift in thinking. It has a long history in research, clinical practice and medical education, and in recent decades there have been concerted efforts to reorient health care services to make it a practical reality. Despite its long history and increasing popularity, people-centred health care has not been satisfactorily and collectively enunciated at the health system level to encapsulate the needs, wants and expectations of individuals, families and communities, and how health practitioners, health administrators and bureaucrats can respond.

The key characteristics of people-centred health care:

Individuals, families and communities

- Equitable access to health systems, effective treatments and psychosocial support
- Access to clear, concise and intelligible health information and education that increases health literacy and allows for informed decision-making
- Personal skills which allow control over health and engagement with health care systems—communication, mutual collaboration and respect, goal-setting, decision-making, problem solving and self-care
- Supported involvement in health care decision-making, including health policy, programme development, resource allocation and health financing.

Health practitioners

- Holistic approach to the delivery of health care
- Respect for patients and their decisions at the clinical level and respect for communities at the population health level
- Recognition of the needs of people seeking health care and communities seeking better health
- Professional skills to meet these needs—competence, communication, mutual collaboration and respect, empathy, health promotion, disease prevention, responsiveness and sensitivity
- Provision of individualized care at the clinical setting
- Access to professional development and debriefing opportunities
- Adherence to evidence-based guidelines and protocols

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- Commitment to quality, safety and ethical care
- Teamwork and collaboration across disciplines, providing coordinated care and ensuring continuity of care
- Involvement in health care governance and policy decision-making.

Health care organizations

- Accessible to all people needing health care
- Commitment to quality, safety and ethical care
- Safe and welcoming physical environment supportive of lifestyle, family, privacy and dignity
- Access to psychological and spiritual support during the care experience
- Acknowledgement of the importance of all staff—managerial, medical, allied health, ancillary—in the delivery of health care
- Employment and remuneration conditions that support teamwork towards people-centred health care
- Avenues for grievances and complaints to be addressed
- Organization of services that provide convenience and continuity of care to patients
- Service models that recognize psychosocial dimensions and support partnership between individuals, their families and health practitioners.

Health systems

- 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, 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
- Accountability.


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"You can't fix people in health care. You can fix things.
You can help a person be all they're capable of. Our goal is not
to fix people; it is to help people become all they're capable of."

Dr Vaughan Glover
Author, *Journey to Wellness: Designing a
People-Centred Health System for Canadians*

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WHAT IS CURRENTLY BEING DONE TO PROMOTE PEOPLE-CENTRED CARE?

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3

Recognition of the need for people-centredness in health care is mounting globally. In the Asia Pacific Region, many countries have called for greater attention and a unified response to this need. This chapter presents some of the ongoing initiatives that are attempting to realign current health care practices towards people-centredness. The examples reflect how change is happening within each of the four domains of people-centred care. While the majority of the interventions remain focused on the clinical setting, there are a number that are addressing people-centredness within the broader context of public health practice.

The evidence base for a people-centred approach is growing. Whenever possible, the evidence for specific interventions is indicated in this chapter. The examples highlighted below indicate that the move towards people-centredness leads to positive outcomes in both qualitative and quantitative indicators.

Initiating the journey towards people-centred health care requires change within four domains:

- Informed and empowered individuals, families and communities
- Competent and responsive health practitioners
- Efficient and benevolent health care organizations
- Supportive and humanitarian health care systems.

Achieving this change demands a shift in perspectives and attitudes about health care, whether at the level of individual care in the clinical setting or public health practice at the population level.

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DOMAIN 1: Informed and empowered individuals, families and communities



“The decisive role in health care and its reform cannot be made by the state, nor the health insurance companies, nor doctors, nor hospitals. The decisive role must be played by the citizen.”

Dr Milan Cabrnoch
Member
European Parliament

Achieving access to health care

Having access to health care is the first step towards better health. In most cases, access is determined by the broader sociopolitical and economic context of society, and interventions need to occur at the level of the health care system to ensure that people have equitable access to health care. However, the people-centred approach recognizes that people have both the right to and the responsibility for their own health care. Within this context, individuals, families and their communities have the responsibility to proactively seek access to health care. In turn, health practitioners and health organizations should encourage people to ask for help and to be advocates for their own health care. In addition, the health care system needs to put strategies in place to ensure that people have the means to obtain information and assistance in acquiring health care access.

One case demonstrates the importance of even just one critical piece of information that an individual needs to properly access health care in a timely manner. A man had been having difficulty walking for some time, but because his family thought he had no insurance for outpatient care, they did not bring him to a doctor until the day when he lost his balance, fell and broke his hip. If he had been seen in a clinic, and his walking difficulty resolved, the fracture and the hospital stay would have been avoided. His physician lamented: “The irony is that the patient actually qualified for full outpatient coverage under Medicare Part B. His family just never knew, and they didn’t think to ask any of the community social workers. It’s a shame, really. All they had to do was to ask.” (1)

Box 7. Providing help to individuals, families and communities to acquire health care access

A social worker by profession, Ana Ferro has worked for six years in the Municipality of Pedro Aguirre Cerda in Santiago, Chile. She is Director of the Community Centre for Mental Health.

For the past two-and-a-half years, Ana has also worked for the El Puente programme of FOSIS. In Ana's role as Apoyo Familiar, or Family Support Counsellor, for El Puente, she helps families living in extreme poverty become aware of the services and subsidies available to them.

Often these families do not know how to access tools to help them protect their health, get an education, have improved housing and find employment.

Ana says, "Poverty in Chile means being marginalized from everything. Everything. It's like being 'out of the system'. It is being excluded. Poverty, I believe, is what limits people from being able to achieve a better quality of life, and to have more opportunities.

People living in poverty have less access. Less access to services, to the market, and even the limited access that they have is disadvantageous.

El Puente works with families living in extreme poverty that have not had access to the services and subsidies meant for them. The idea is, once these families are identified, to get them benefiting from these tools at the institutional and community levels. This is done over a two-year period.

In general, when you ask a family how the programme helped them, they say 'to get more information'. The programme gives them a better understanding of the services available to them so that they can take charge of their own lives."

Interview with Ms Anna Ferro (2)

Access not only involves gaining entry to the health care system, but individuals, families and communities need to actively seek access to information that pertains to their health. In the clinical setting, this includes obtaining access to one's medical records and to information about one's clinical status, progress, prognosis and process of care. At the community level, it consists of the right to documents and information on policies, decisions, planned programme interventions, budgets and

other information regarding community health interventions. In this sense, access begins with asking questions and demanding a response from the health system. (See Box 6 on Malaysia's home-based health records system in Chapter 2, page 34)

Building capacity to make informed health decisions

The examples above call attention to the crucial role of promoting health literacy so that people can make informed decisions about all aspects of their health care. Health literacy incorporates the knowledge and skills that enable people to understand health information and apply it to their unique circumstances. It is integral to empowering people to assume responsibility for their health and is the foundation for healthy communities.

At the individual level, health literacy requires the ability to read, listen, understand and analyze information and to use these skills in making decisions about personal health issues. At the population level, health literacy includes the capacity to apply knowledge when working within the community setting to affect the social and economic determinants of health.

Evidence: Does health literacy work?

Poor health literacy is a serious liability for individuals and health systems. Individuals with low levels of health literacy are less likely to:

1. understand information provided by health practitioners;
2. consistently follow instructions about taking medication;
3. attend follow-up appointments; and
4. find their way around the health system. (3)

In some parts of the Asia Pacific Region, individual and family access to information, education and training that increases health literacy and enables people to participate in health care remains limited. The first requirement for building health literacy is access to quality health information that is accurate, reliable and easy to understand. People need good health information about:

- Health issues (diseases, treatments)
- Health promotion and disease prevention

- Types of health practitioners and health care organizations or services
- The roles and responsibilities of various health practitioners
- Health system navigation
- Interaction with health practitioners (communication, shared decision-making, problem-solving, negotiation, feedback, building trust, developing respect for all practitioners)
- Self-care and self-management.

In multicultural communities, this information should be delivered in culturally and linguistically appropriate formats.

Box 8. Cultural competence and health literacy

"I have been a breast cancer survivor for 13 years...The needs of Asian cancer patients are varied. Asian cultures are different. Every country has different ways of looking at things. There are issues with language, insurance, medications, not knowing who to talk to, and being denied [access to health care] because of your accent.

We need culturally and linguistically appropriate educational materials in different languages. We need interpreters and translation available. We also need information about financial assistance for cancer treatments as well as for the family. We need to know how to find a good doctor, where we can go for second opinions and other recommendations for treatment, and where to go for support. Patient navigation is very important."

Jina Peiris
Sri Lankan cancer survivor (4)

While information can support people to become involved in health care, it is insufficient in itself to empower people to take control of their health. Knowledge about health issues needs to be complemented with awareness of health services, and the development of skills to negotiate the health system and interact with health practitioners, self-care and self-management and decision-making about health care options. Effective strategies to enhance health literacy are participatory and clearly demonstrate how health information can be turned into action. (5)

At the clinical level, informed health care decision-making includes decisions about screening, diagnostic testing, treatment options and their attendant risks and benefits, self-care, and self-management. A range of social and organizational interventions have been developed and tested to inform, involve and educate people in order to provide them with decision-making skills and to support them through illness and treatment. Such interventions can improve patient knowledge and understanding, reduce indecision and decisional conflict, help people to have realistic expectations of treatment and/or screening outcomes, and shift the balance in clinical decision-making from being predominantly clinician-dominated to one that is shared or controlled by the patient. (6) In fact, there is evidence that educating and supporting patients, through motivational interviews, practical medication management skills and programmes directed to reduce risky social behaviours, have improved adherence to therapeutic regimens among HIV-infected persons. (7)

Chronic disease is the principal reason people seek health care in many parts of the world. A people-centred approach supports chronically ill patients to become adept at self-care: managing their condition, adhering to treatment regimens, making lifestyle changes, and coping with the emotional ramifications of their illness.

The Chronic Disease Self-Management Program, which is one of the most widely accepted self-management patient educational programmes worldwide, is designed to meet the needs of patients who have more than one chronic condition. It is taught by trained lay leaders. When, in 1996, chronic disease accounted for 81% of deaths and for a major portion of total health care costs in China, a local version of the programme was developed and implemented in Shanghai from 1999 to 2001. The programme improved participants' health behaviour, self-efficacy and health status, and reduced the number of hospitalizations among participants six months after completing the programme. (8, 9)

With the rising incidence of chronic diseases in the Asia Pacific Region, the relevance of self-care and self-management is increasing. Research shows that supporting self-care can improve health outcomes, increase patient satisfaction and help in making health care more cost-effective. For example, a review of 45 studies on the efficacy of asthma self-management education concluded that self-care improves asthma outcomes in children, and recommended that self-management education be incorporated into routine asthma care. (10) A secondary outcome of effective self-management is the reduced utilization of health care services. (11)

Participation at all levels of health care

The examples showcased in the previous section primarily involve participation at the level of individual care in the clinical setting. However, there are emerging examples of community participation at the population health level. It is important to identify and scale up these "best practice" examples so that the people-centred approach becomes normative in both clinical and public health practice.

For example, an agrarian reform project in the Philippines included a health component where community-based health financing models are developed, implemented and supervised by the community members themselves with technical assistance from the project. It is anchored on community participation and empowerment; sustainability in the area of health services and financing; capability-building; pre-paid community contributions with matching government and funding agency counterpart; and close collaboration and networking with other concerned government agencies. The project produced fully functional community-based social health insurance schemes, called “health cooperatives”, and has become the basis for developing a national health financing scheme for marginalized indigenous Filipinos. (12)

Box 9. Community participation in local health systems planning in Cambodia

The Cambodian Ministry of Health encourages community participation via Health Centre Co-Management Committees (HCCMC) and Feedback Committees. Each health centre is required to establish one of these committees before they can provide services and charge fees to those using the centre.

One nongovernmental organization in Kirivong District collaborated with volunteer monks from local Buddhist pagodas to develop their HCCMCs. In Cambodia, Buddhist monks are highly regarded, have wide social networks and are influential community members. Involving the monks increased the organization’s ability to disseminate health information widely in the community.

Initially, a Community Participation Advisory Committee was established, involving respected members of the local monastic community. The committee guided the development of HCCMCs and Feedback Committees for all district health centres. It also engaged the monks to participate in local community health planning and service monitoring. (13)

Developing leadership to advocate for people-centred health care

A truly people-centred approach to health care requires leadership from within. In some instances, personal experiences compel individuals to assume a leadership role. In other cases, individuals come together and form groups to take on this leadership role within their communities. However, systematic processes are needed to identify and engage community leaders who can build community ownership of people-centred health care. Leadership development programmes are also required to support these individuals and groups with the knowledge, skills, networks and resources to effectively advocate and guide progress in expanding the adoption of people-centred approaches.

For example, across all municipalities in Japan, a unique health promotion programme has been implemented since 1961. Community leaders—lay people identified and nominated by their community—are designated as health promotion leaders in their local neighbourhood and, once trained, they conduct health-enhancing activities such as disseminating information and running health festivals, sports events and cooking classes.

An evaluation of the programme looked at the level of health literacy and involvement in healthy behaviours among middle-aged female health promotion leaders. Findings suggested that, compared to members of the general population, the leaders were less likely to smoke, more likely to engage in physical activity and eat regular meals, and more interested in the relationship between food and health. The evaluation also found that these healthy lifestyle behaviours and attitudes were significantly associated with involvement in the health promotion leaders' programme.

The study suggests that the positive benefits of the programme on the health promotion leaders gave these women credibility in promoting health in their local neighbourhood. (14)

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DOMAIN 2: Competent and responsive health practitioners

“Treating and caring for a sick person is not just a matter of curing his or her disease. A patient has other needs as well. Being unwell can be a disorienting experience. Living with fear or anxiety is not easy. For some, just being in hospital is stressful, particularly if it means separation from loved ones.

In the past, doctors have failed to address these problems because they have been preoccupied with disease alone.

Therefore, we will be aiming for a more holistic approach to health care, where the whole person is treated, rather than just the clinical condition. This means dealing with people in the context of their human dignity, their rights, their families, their culture and their society.”

Dr Shigeru Omi

WHO Regional Director
for the Western Pacific

As the people tasked with providing health care services, health professionals have a tremendous responsibility. These professionals have to balance the requirement for competence at a time of rapidly expanding scientific knowledge and technological discoveries, with the need to be responsive to the needs and perspectives of individuals and communities.

Guaranteeing competency in health care service delivery

Competencies are the “skills, abilities, knowledge, behaviours and attitudes that are instrumental in the delivery of desired results, and consequently, of job performance”. (15) In promoting a people-centred approach, traditional health care training needs reform.

The traditional approach to medical education, following the biomedical model, has serious shortcomings, with little or no training in communication skills or the behavioural and social sciences. (16) Attempts to reform medical education and the practice of medicine are ongoing, through problem-based learning, increased emphasis on public health and disease prevention, consideration of psychosocial aspects of care, and ethical issues in service delivery and communication. (17)

The push for expanding family medicine in the Asia Pacific Region suggests that there is increasing recognition of the importance of holistic and humanistic approaches to health care. Yet, in much of the world, teaching is usually based on guidelines developed by specialists. The prevailing attitude among health care administrators, providers and recipients in the Region is that health care involves predominantly biomedical expertise and both assessment and treatment require intensive technical expertise. In line with this view, medical education emphasizes human anatomy and physiology, concentrating on body systems, diseases, symptoms and the interventions required to alleviate or minimize symptoms. There is little attention given to understanding the social determinants of health, acquiring the skills required for appropriate communication and counselling, maintaining effective interpersonal interactions, conducting health promotion and disease prevention, and applying humanism in health care.

WHO developed a set of new competencies meant to complement existing ones in order to equip health practitioners with the ability to address the growing problem of chronic diseases. Five new competencies were identified:

1. The ability to organize care around the patient—the “patient-centred” approach
2. The ability to communicate effectively to facilitate partnerships with patients, other providers and communities to improve health outcomes
3. The skills to ensure continuous improvements in the quality and safety of health care
4. The skills to monitor patients across time, using and sharing information through available technology
5. The ability to consider patient care and the provider’s role in the broadest perspective, taking into account the multiple levels of the health care system and the care continuum, to include population-based care. (15)

Integrating these competencies into the existing health care training models will require innovation and commitment to the concept of people-centredness. The aim is to provide trainees and health practitioners with the knowledge, attitudes and skills that will enable them to address the full spectrum of health needs of patients, their families and their communities. (18, 19) The people-centred approach requires the curriculum to extend beyond the physical aspects of health to incorporate its mental, emotional, social and spiritual dynamics. The focus needs to broaden beyond high-technology medicine to place a greater emphasis on primary care, mind-body and behavioural interventions, interaction with patients, cultural competency and humanities. (16, 20)

In some countries in the Asia Pacific Region, undergraduate education is provided in community settings where trainees have ongoing contact with patients with chronic conditions, allowing the trainees to develop people-centred communication skills and to gain an understanding of the psychosocial issues related to chronic illness. Other useful skills that could be included in education and training include problem-based learning, role modelling, and clinical training that encourages medical, nursing and allied health trainees to work in collaboration.

People-centred education and training for health practitioners needs to continue throughout the course of a career. Continuing professional development should incorporate the social and behavioural aspects of health care, early on in the training process. (16) Interactive or experiential workshops, either alone or in combination with other interventions, have been shown to improve professional practice. (21) Educational outreach visits are also a promising approach for improving professional practice. (22) These strategies can be utilized to promote the people-centred approach.

Box 10. A people-centred approach to medical education in Malaysia

Universiti Sains Malaysia (USM) offers a five-year medical degree based on the SPICES model (Student-centred, Problem-based, Integrated, Community-based, Effective, Scientific). Students are taught to assume a holistic approach with patients and to understand that clinical, psychosocial, economic, and cultural values contribute to effective health care delivery.

From the second to fourth years of studies, students participate in Community and Family Care Study. During the second and third years, pairs of students are allocated to a local community, where they undertake a health needs assessment in collaboration with the local health clinic. In the fourth year of study, each student adopts a patient with a chronic disease and complex sociocultural issues. Through home visits, students learn about the patient's disease experiences and provide education on adhering to treatment regimens. (23)

Transitioning to a holistic approach to health care

One of the key aspects of people-centred care is the conscious effort to understand the totality of the health experience, whether for an individual patient or for an entire community. In the clinical setting, a frequent cause of dissonance between a patient and his or her health practitioner lies in the underlying difference between a patient's subjective experience of illness and the clinician's objective approach to disease. In the public health setting, discord can arise when evidence-based population interventions are implemented with disregard for the sociocultural context of the community.

The biomedical focus of health care can lead health practitioners to consider the experience of illness as irrelevant—the pathophysiologic aspects of disease are divorced from the sociocultural and emotional realities that people experience—Descartes' mind-body dichotomy. Yet, for the majority of people, relief from their illness (the psychosocial components) is as important as relief from their disease (the pathophysiologic component). Unless health practitioners understand how people perceive their illness and discuss those beliefs with them, the effectiveness of any intervention may be compromised. A people-centred approach to health care would ensure that health practitioners are coached in the skills to see the total picture so that a consensus is reached between the person seeking care and the person providing care regarding aetiology, prognosis and treatment. (24) This holistic perspective allows health practitioners to provide the biomedical interventions for the disease plus the psychosocial interventions for the illness, in effect, maximizing the potential for a total cure by harmonizing mind and body.

Box 11. The LEARN technique

Clinicians at the Family Practice Residency Program at the San Jose Medical Center, San Jose, California, follow a set of guidelines to improve cross-cultural communication about health with a diverse patient population.

These guidelines form the mnemonic LEARN:

- Listen with sympathy and understanding to the patient's perception of the problem
- Explain your perceptions of the problem
- Acknowledge and discuss the differences and similarities
- Recommend treatment
- Negotiate treatment. (25)

The holistic approach requires health professionals to have the skills and willingness to communicate and listen to the people they serve. People-centred communication also requires a high degree of cultural competency and sensitivity to and respect for people's beliefs and needs. The diversity of cultural, spiritual and religious beliefs within the Asia Pacific Region mandates training to increase awareness and understanding of the role of sociocultural and spiritual factors in health. While it is unrealistic to expect complete mastery in this area, stereotyping individuals and communities should be avoided. Instead, health practitioners should make a systematic effort to learn about the cultural characteristics of the populations they serve, and use this knowledge appropriately. Involving non-medical professionals, like cultural anthropologists and social scientists, in health care education is one strategy. Another strategy is to actively incorporate knowledge about a person's sociocultural context into the health care plan. For example, recognizing the role of cultural and spiritual factors in health, practitioners might assess at an early stage whether patients and families rely on cultural and spiritual resources. (26)

Box 12. Spirituality and health in a hospital setting

The chaplain at Columbia Memorial Hospital in Ohio has developed a series of classes for interested hospital staff members, to help them become more aware of the impact that spirituality has on health and well-being. The three one-hour sessions include experiential exercises, discussions regarding the difference between spirituality and religion, and an overview of world religions. The purpose of the classes is to give staff members greater insight into their own spirituality so that they can be more attentive to the spiritual needs of patients. (27)

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Box 13. Culture and health

"I recently got involved with a Muslim women's association and their culture is very different. They are very slow in coming to the mainstream. I went to their meeting and talked about breast cancer. They listened and slowly have come to me after asking permission from their spouses to get screenings. However, they want to go only to female doctors, which would be OK with their spouses.

In the role of an advocate for cancer survivors, I have been asked to provide support to anyone Asian who calls the American Cancer Society. I am the only Asian volunteer, and they want to pair me up with any Asian patient. I told them that there are differences between many of the Asian communities and there needs to be a training, a conference or something about cultural competence for Asians."

Jina Peiris

Sri Lankan cancer survivor (4)

A holistic approach to health care also entails attention to the psychosocial needs of those seeking care. Providing emotional support is a critical function of people-centred health care. Support could include:

- Expressing positive affect, including the sense that the sick person is cared for, loved or esteemed
- Agreeing with or acknowledging the appropriateness of a patient's feelings, beliefs or interpretations
- Encouraging the patient to express feelings and beliefs openly
- Providing advice or information or access to new and diverse information
- Providing tangible support, such as shopping, home care or child care
- Giving the patient the sense of belonging to a network or support system of mutual obligation or reciprocal help. (28)

Because stress and anxiety often accompany illness, interventions to reduce these may have a treatment role for certain groups of people. There is evidence that psychological treatments, principally relaxation and cognitive behavioural therapy, are effective in reducing the severity and frequency of chronic headache in children and adolescents. (29) Therefore, health professionals would benefit from training in psychosocial interventions, like stress reduction and relaxation techniques, that can complement biomedical therapies.

Evidence: Emotional support and health outcomes

Addressing a patient's emotional needs can be cost-effective. Patients with support leave the hospital earlier, require less medication, resume walking more quickly, are more satisfied with care, comply more readily with treatment regimens and experience fewer side effects from drugs such as those administered during chemotherapy.

People who learn relaxation techniques handle the stress of surgery better than other patients. Even brief training in progressive muscle relaxation has alleviated nausea and vomiting in chemotherapy patients, decreased the need for pain medication in patients hospitalized for spinal surgery, and allowed the same patients to begin walking a full day earlier than patients treated in the typical post-operative fashion. (25)

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Reinforcing the capacity for compassionate care

Humanism may be defined in this context as the interest in and respect for patients and communities and their wants, needs and concerns. Humanism is integral to quality, safe and ethical health care. It is essential to the development of a trusting relationship between health practitioners and the individuals and communities that seek care. Health training programmes should aim to develop humanism and compassion in trainees, and these values should be reinforced through continuing professional development. Programmes can cultivate these values through communication skills training, providing support and debriefing for practitioners, and mentoring. Role modelling is also important; health educators who create a humanistic or learner-centred environment, respect student autonomy, and explicitly espouse humanism in health care can transfer these values to trainees through active modes of instruction.

Box 14. Integrating humanism into medical education in the Republic of Korea

Since 2001, the Young Schweitzer Program has worked to encourage ethical practices among young medical professionals in the Republic of Korea. The programme evolved from a public-private partnership between the Korean Doctor's Weekly, the Korean Society for Medical Ethical Education, and a pharmaceutical firm. The programme recognizes interns and medical students who demonstrate outstanding public service and scientific research through the Young Schweitzer Awards. Another programme component, the Young Schweitzer Academy, provides medical students with the opportunity to explore extracurricular education courses in medical ethics.

The Korean Medical Licensure Examination includes questions related to medical ethics and the psychosocial aspects of health care. One objective in including these questions is to spur greater attention to the humanistic and psychosocial dimensions of medical care. (30)

In a truly people-centred approach, individuals, families and communities who seek care can also provide valuable insights to health care professionals by participating in their education.

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Box 15. Patients and families as teachers

Since 1999, faculty from the University of Pennsylvania School of Medicine have partnered with patients and families who serve as teachers dedicated to shaping the practice of future physicians. This work evolved from the family-centred initiatives at the Children's Hospital of Philadelphia that began in 1992. Parents whose children are cared for at the Children's Hospital of Philadelphia are guest family faculty for a "Doctoring 101" course. The curriculum and format were created by the family faculty. The semester-long, required course explores topics such as delivering difficult news, critical conversations, living with illness and disability, and death and dying. In this powerful forum, medical students have a unique opportunity to understand illness from the perspective of patients and families. (31)

In the people-centred approach, compassion is not exclusively for individuals, families and communities that seek care. Health professionals also need to learn compassion for the other members of the health care team. Opportunities to foster positive attitudes towards teamwork and collaboration should begin early in the process of health care training.

Box 16. Inculcating the value of interdisciplinary teamwork

Along with learning the skills of their profession, students at the University of Minnesota's health professional programmes are learning how to work with one another. In the Transitional Care Unit (TCU) at nearby Walker Methodist Hospital, a care team that includes a geriatrician, a nurse and a pharmacist teaches students in each discipline through role-modelling inter-professional team practice.

"Team practice is...one of the things that is going to help us really improve care," says Marilyn Speedie, PhD, Dean of the College of Pharmacy at University of Minnesota. "But it's not easy to do. We are used to delivering parallel care, but to work together as a functioning team, we don't have very many examples of that." This programme is designed to change that.

Speedie says that studies of care on the TCU indicate the team approach is improving care, reducing patients' length of stay and saving money. "The average length of stay for patients with team-care is 20.4 days versus 27.0 days for other patients," she says. "That's a difference in cost of about US\$ 12 000 versus US\$ 14 300." A training programme of this nature requires an investment, both from the academic health centre and the hospital. "You have to make a conscious effort to move the quality of practice ahead," says Speedie. (32)

Developing leadership to advocate for people-centred care

“We [health care professionals] cannot wait for insurance companies, the government or other outside agencies to create this reality [of people-centred health care], anymore than patients can expect quick fixes for conditions better treated with lifestyle changes. The answers need to come from within.

We are health care, so we cannot expect someone else to transform the system for us. Every individual in health care can participate in providing the very best experience for patients, thus taking responsibility for being part of the transformation.”

**Randall Carter, Susan B. Frampton, Laura Gilpin,
Patrick A. Charmel**

Authors, *Transformation and the Future of Health Care
Putting Patients First: Designing and Practicing Patient-
Centred Care*

Moving towards people-centred health care requires people within health care to change: from old habits and behaviours to better ones, from one set of core values and beliefs and rituals, to a whole new culture of “putting people first”. And because improvement requires people to change, improvement requires leadership, which is often defined as “influencing people to make the changes needed to achieve results”. This is particularly true for health care professionals.

Encouraging and supporting leaders within the health care community requires a systematic leadership development process. Developing this process will be a specific challenge for the Asia Pacific Region.

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DOMAIN 3: Efficient and benevolent health care organizations

"Giving patients and families more direct involvement in their care challenges the traditional hierarchy and provokes questions about control.

But if we define success as doing what's right for the patient, then all our policies and practices should reflect that philosophy.

Staff members almost always find that working in partnership with families improves everyone's care experience."

Dr Glenn F. Billman

Director of Patient Safety

Children's Hospitals and Clinics of Minnesota

Establishing equitable, accessible and good quality health care services

The delivery of quality care is an ongoing challenge for all health care organizations. Quality includes both the technical and experiential dimensions of health care.

Safety is closely related to quality. Internationally, up to 45.8% of admissions result in disability from iatrogenic injuries or complications in the clinical setting. (33) Research in some countries of the WHO Western Pacific Region indicates that quality of care is compromised when health systems fail to take responsibility for unsafe care and adverse events in hospitals, and fail to implement effective quality assurance programmes. (34) Studies into adverse events in a number of Member States in the Region (35) have drawn attention to the critical role of the health system and its custodians in providing a safe environment using systems-improvement tools. (36)

People-centred health care requires a strong focus on safety and quality, and this in turn requires that health care organizations and practitioners be transparent about identifying poor performance and addressing problems. Hospitals in some countries in the Asia Pacific Region, however, are neither required to release data relating to safety and quality, nor to report to the public their overall rate of adverse events. Although community pressure is pushing towards the adoption of standards of open disclosure, the people who use health services in these countries have little real information on the quality of the services offered, and rely mainly on anecdotal accounts and subjective impressions to make their assessments. In poorer countries where health infrastructure is limited, people have no option but to use whatever health services are available.

The issues of quality, safety and responsiveness facing health care organizations are complex. Problems often have upstream determinants at the organizational or policy levels that are usually outside the control of those affected. Interventions are therefore needed at a number of levels to reorient health service delivery within these organizations towards a people-centred outlook. One strategy involves the recruitment of community representatives into organizational governing bodies in both the clinical and public health settings. These community representatives assure the inclusion of community perspectives and help to promote organizational accountability.

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Box 17. Pursuing perfection through patient and community involvement in quality

The Cincinnati Children's Hospital Medical Center is part of the Pursuing Perfection Project to implement the recommendations of the Institute of Medicine's *Crossing the Quality Chasm* report. The hospital's senior leadership is ensuring that there is support for patient and family-centred care at both the organizational and clinical levels. Quality improvement has been the driver of transformational change within this academic medical centre's inpatient and outpatient programmes. Partnering with families occurs on multiple levels: at the Family Advisory Committee, on quality improvement teams, on hospital-wide teams and unit-based committees and task forces. On many units, families are encouraged to be present for rounds and given choices on how they would like to participate. These patient- and family-centred rounds are linked with the patient's discharge goals.

The emerging quality improvement data indicate:

- Patients are being discharged sooner
- Medical order entry error rates have been reduced from 7%–9% to 1%
- Faculty report that patient and family-centred rounds are a more effective way to teach
- Families are involved in decision-making (31)

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Box 18 provides a public health example of how community empowerment and partnership resulted in improved nutrition among school-age children.

Box 18. A community health programme in Sao Paulo, Brazil

Since 1998, the Health for the Family Programme in Guarulhos, Sao Paulo, Brazil, has focused on health promotion activities for the families, many of whom are socioeconomically vulnerable. The programme has two essential components: a Basic Health Unit and Community Health Agents, who are from the community where the health unit operates and who are nominated, interviewed, and then elected by local community members.

The agents engage the community in health promotion activities and visit the families each month in their homes and identify real health needs—in terms of prevention and care—at the individual, household and community level. They also monitor and, where possible, initiate action on the socioeconomic determinants of population health.

The most noticeable impacts of the Health for the Family Programme are the increased access of the population to basic health care and the link that develops between the local Basic Health Unit and the population, mostly as a result of Community Health Agents. This link makes it possible to recognize the true needs of the community and design strategies to address the socioeconomic determinants of health.

In the neighbourhoods where there is no link between the unit and the community (that is, no Community Health Agents), the unit tends to not feel as responsible for the community. Rather, unit staff members (often not from the community) only see the sick person who comes to the clinic. Thus, they prioritize disease and not health.

An actual example of the programme's impact on a community occurred in Pirapininga. Children less than 5 years old often played near the Basic Health Unit. Unit staff saw that these children were undernourished. The Community Health Agents spoke to the families of the children and discovered that the children stayed all day in a private school because both parents had to work. So, the Community Health Agents went to speak with the school administrators. They reviewed the amount and kind of food provided to these children. They discovered that it did not meet the daily requirements of children that age. It was not because the school neglected the children, but rather that they were lacking important information. A joint project between the Basic Health Unit and the school emerged as a result of this intervention, and now the children are no longer undernourished.

Interview with Ms Eneida Bernardo (2)

Providing healing and nurturing environments

Health care organizations need to move beyond quality initiatives focused mainly on improving technical organizational problems and also address the experiential aspects of health care quality. To paraphrase Dr Vaughan Glover of the Canadian Association for People-Centred Health, the health system must become people-centred rather than system-centred. (37) One concrete embodiment of people-centredness is the delivery of health care in healing and nurturing environments.

The design elements in a physical space can have a vital impact on the healing process. Thoughtful and people-centred facility design reconciles efficiency, functionality, cleanliness and orderliness with comfort and ease of use. Health care environments and areas that are well lit, well ventilated, cheerfully decorated and easy to find, help in reducing anxiety and promoting a positive outlook. Incorporating community input when planning and designing a facility ensures true adherence to the participatory principle of people-centredness.

Box 19. People-centred hospital design in New Zealand

Winner of the Green Ribbon Award for the first eco-hospital in New Zealand, Waitakere Hospital's new building aims to strengthen the connection between the physical environment and patient healing. Designing this environmentally friendly hospital involved collaboration between the local community, the Waitemata District Health Board, Waitakere City Council, and sustainable design consultants, providing a good example of local health care organizations working with the community to generate a people-friendly hospital. A community consultation on the hospital's design found that the local community wanted the hospital to emphasize wellness, connect with the natural environment and develop family-friendly spaces.

The hospital is energy-efficient, avoids waste, recycles, uses natural lighting as much as possible, utilizes sustainable and environmentally friendly materials, and conserves water. Other features include:

- an emphasis on people- and family-centredness
- respect for multicultural diversity and inclusion of people from all cultures
- no physical barriers to people with disabilities
- focus on art for healing
- gardens
- spirituality (the indigenous people of New Zealand, the Maoris, blessed the hospital on opening and Maori spiritual places are located inside and outside the hospital). (38)

Improving the physical design of a health facility is just one aspect of people-centred health care that health organizations can adopt. There are numerous current examples of creativity and innovation for the creation of people-centred health care environments. Planetree, a membership organization working with hospitals and health care centres to develop patient-centred care in a healing environment, believes that it is just as essential to create healing environments for the staff as it is for patients. Warm, home-like non-institutional designs which value humans, not just technology, are emphasized. Architectural barriers which inhibit patient control and privacy and interfere with family participation are removed. (39) Planetree-affiliated hospitals use visual arts, music and complementary interventions like therapeutic massage or aromatherapy to help promote comfort in health care facilities. A review of 31 studies showed that listening to music reduces pain intensity levels and the need for pain killers. (40)

Box 20. Navigating the hospital environment

“Wayfinding” is travelling from one point to another. In hospitals, wayfinding can be difficult for patients and visitors because the maze of corridors and numerous departments all look alike. This makes navigation of the hospital’s various service areas confusing and can add to the stress of seeking care.

The Wayfinding Project at the Waitakere Hospital in New Zealand aimed to identify the barriers to service navigation and develop wayfinding strategies suitable for patients and visitors.

Based on feedback from patients and staff, barriers to wayfinding included visual clutter, poorly coordinated signage, lack of a good site map, and inconsistency in department names. In developing its wayfinding strategy, the hospital sought community input again. The collaboratively developed strategy includes:

- Consistent language (only one name for each department)
- Consistent use of colour (one colour for clinical areas and one colour for non-clinical areas)
- Culturally relevant architectural detailing
- Visual landmarks used as guides or points of reference
- Graphic and signage clues (useful for all people irrespective of their level of literacy)
- Consistent visual clues (the same clues are used at each entrance).

Other wayfinding strategies include reducing the number of signs and using themes and icons as visual clues throughout the building. Wards are named after Auckland beaches, so ward signs feature beach icons, while bush and people are reflected in the interior colours.

The hospital reception areas are easy to locate. Each reception area has a bilingual department name (Maori and English), a beach icon as a visual clue, and a unique colour. Feedback from the community has been positive, with the wayfinding strategy identified as appealing, making it easy to move around the hospital. (41)

In the United States of America, Sharp Colorado Hospital and Healthcare Center has adopted its own employee-designated initiative that aims to make Sharp the best place to receive care. The initiative includes a Care Partner programme, patient information drives, music and art, volunteer baking, therapeutic massage, Healing Touch and clinical aromatherapy, which all contribute to a holistic healing experience. Marcia Hall, Sharp's Chief Executive Officer, declares: "I now have a path through the wilderness that will let me make a true difference, a difference to our patients and their families, yes. But also to our team members, doctors, volunteers, board members and neighbours... Because people are not numbers, diseases, insurance plans, armbands, organs, tests, procedures or room numbers. Because hospitals do not traditionally promote healing or health or wellness or comfort while they are fixing broken parts. Because it's right, it makes sense, it's easy and its time has come." (42)

The social environment of a health care facility can also be designed to facilitate healing. One method of achieving this is through support groups for people seeking health care. In the clinical setting, health care organizations can include support groups services in both inpatient and outpatient facilities. Inpatient support groups tend to have revolving membership, because of the short length of stay of most patients. These groups are useful for providing brief psychological support, disseminating information and screening individuals who might benefit from more intense counselling. Outpatient groups, on the other hand, can be regularly scheduled, involving group therapy sessions or a structured curriculum teaching useful health management skills with psychological support from other group members and trained facilitators. (25) When developing support groups services, managers in health organizations should be sensitive to the sociocultural issues, like linguistic capabilities, relevant to the populations they serve.

Box 21. What helped me was a support group

John Lin, a Chinese-American living in San Francisco, was diagnosed with prostate cancer in 2002. "What helped me was a support group. Each group was for a certain cancer. From there I got opinions about my [treatment] options. I couldn't find the same information in books because most are not up to date and they were very general. The members of the support groups were able to tell me the good and bad of different treatments. They told me a lot about chemotherapy and other therapies. They were good. They had a lot of people and resources and they were organized."

However, language was a barrier. "It would have been helpful to have a support group in Mandarin so I could ask more questions and understand more easily. I had to go through a lot to understand what was going on and what I was supposed to do."

John Lin

Chinese skin and prostate cancer survivor (4)

Support groups provide comfort and guidance not just to the individuals seeking care, but also to their families. Torise F. Saifoloi, a Samoan cervical cancer survivor, said, “We really need to reach out to those impacted and affected by cancer, the survivors, family members and caregivers and get them together. They are stressed.” (4)

Supporting coordination and continuity of care

Fragmented care not only inconveniences patients, but compromises the quality and effectiveness of care. Effective and efficient systems need to be in place to coordinate care and arrange services to meet patient needs. Collaboration and partnership across the various health care disciplines allows the functions of different practitioners to be developed in ways that complement each other, improves the overall quality of care, and reduces both gaps and overlaps between services. Collaboration also helps to ensure a smooth transition from one health practitioner to another.

Strategies to support and facilitate coordinated care include reminder notices via postcards, letters or telephone calls to patients for specific interventions (43); appropriate scheduling of appointments to suit patient needs and commitments; public announcements and signage in health-care organizations; patient-held health records; and protocols for discharge and referral.

Promoting multidisciplinary health care facilitates continuity of care and the implementation of clinical protocols, enhances communication between health practitioners, encourages knowledge sharing across disciplines, and promotes a sense of partnership. (44, 45)

Effective multidisciplinary teams have well-delineated roles and responsibilities and clear objectives for all health practitioners involved. They promote high-level participation by all members, encourage team problem-solving, and promote respect and communication even when opinions differ. Strategies such as team-building through workshops and meetings, training in collaboration and communication skills, establishment of smaller teams, detailed job descriptions for each profession, and communication protocols (46) all contribute towards creating successful multidisciplinary teams.

In Malaysia, a one-stop approach to accessing medical specialists in hospitals is utilized in government hospitals. On any given day, the hospitals schedule medical specialists from a range of disciplines to be available for consultation. Patients who need to see several specialists can do so in one visit, minimizing the time spent in the hospital outpatient facility. (23)

Box 22. Improving multidisciplinary relationships in New Zealand

In 2001, at the maternity services unit at New Zealand's Waitakere Hospital, inter-professional conflict developed between the midwives, who were fully independent practitioners, and doctors, primarily due to philosophical differences. The conflict escalated and hospital management became involved, but it reached a crisis point with a complete breakdown of inter-professional relationships. This situation had many effects: three neonatal deaths, suspension of an obstetrician, low staff morale, low staff levels and unit closures.

The interventions that defused the conflict began with a one-day interactive workshop led by an external facilitator. Attendance was compulsory, and there were 65 participants including health practitioners—midwives, obstetricians, anaesthetists and paediatricians—and consumer representatives. During the workshop, role play was used to generate discussion about the conflict. Participants were given opportunities to reverse role playing and thus learn about the viewpoints of other colleagues.

Following this successful workshop, a monthly multidisciplinary forum was established, consisting of midwives, representatives from the New Zealand College of Midwives, medical practitioners, midwife managers and educators, consumer representatives, and Maori and Pacific islander representatives. The purpose of the Waitakere Maternity Forum was to generate trust and mutual respect across the disciplines, create shared goals, and clarify roles and responsibilities of all health practitioners working in the maternity services unit. A midwife specialist was also employed to address quality issues.

Over time, these interventions built trust across the disciplines and totally transformed working relationships. The outcomes included reduced patient complaints about the maternity services unit, increased patient satisfaction, and improved clinical outcomes—a 30% reduction in Caesarean rates. (47)

Fostering values-based leadership

“Patient-centredness in a hospital is more than the sum of good practices or innovative programmes. It is, rather, a fundamental feature of institutional culture.”

Margaret Gerteis and Marc J. Roberts

Authors, Chapter 10 of *Through Patient's Eyes:*

Understanding and Promoting Patient-Centered Care

After reviewing the results of thousands of patient surveys, the authors at the Picker Institute made three observations:

1. The “patient-centredness” of a hospital is intrinsic to its overall culture, mission and system design.
2. Some environments are more conducive to patient-centred care than others.
3. Most importantly, management is critical to performance, regardless of environment. (25)

These observations underscore the value of institutional leadership in fostering the values of a people-centred approach. Health organizations that are successful in implementing people-centred health care go beyond formal mission and vision statements or official rhetoric; their leaders clearly articulate and model people-centredness, and motivate their staff to buy into the concept.

Leadership in health organizations for people-centred health care is essential. Improving the quality of health care across an organization requires leadership to create a health care environment characterized by good relationships between managers, administrators and health practitioners, where collaboration is the norm, and where all health practitioners and staff are respected and valued. To be truly people-centred, leaders should earn and maintain the respect of staff and colleagues, support caring practices, promote and foster multidisciplinary partnerships and teamwork, encourage open communication, and cultivate trusting relationships. They must be able to recruit and retain staff whose values are consistent with the overall mission. They need to oversee continuous improvement in the systems of health care service delivery. And they need to demonstrate people-centredness in all that they do. This includes extending the participatory approach to the individuals who comprise the health care staff, and allowing them to guide policy and programme development. Strengthening these leadership skills could be achieved through leadership development programmes, inter-professional leadership teams and continuing capacity-building.

Box 23. Culture change through leadership

Stamford Hospital in Connecticut in the United States of America chose to adopt a people-centred approach by partnering with Planetree, a non-profit organization that promotes patient-centred care in hospitals and health care facilities. The hospital's Chief Executive Officer recognized that shifting towards a people-centred model required culture change, and culture change required organization-wide buy-in.

One key strategy he promoted was making staff education and involvement a priority. As of 2005, over 2000 of the hospital's employees had participated in retreats on people-centred care. All new employees go through an orientation, where the entire first day is devoted to the hospital's people-centred philosophy and strategic plan. This helps to unite and engage the hospital staff in the hospital's mission.

Two years after implementing the people-centred approach, Stamford Hospital has documented an increase in employee satisfaction scores from the 33rd percentile in 2003 to the 60th percentile in 2005. Patient satisfaction scores rose from the 40th percentile to the 58th percentile in the same period. (42)

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DOMAIN 4: Supportive and humanitarian health care systems



“What is good for families and patients is often good for the health care system as well. Family-centred care is a winning proposition for all concerned.”

Beverley Johnson

President and Chief Executive Officer
Institute for Family-Centered Care

According to the World Health Report 2000, health systems include “all the activities whose primary purpose is to promote, restore or maintain health.” These include not just the delivery of health services, but encompass policies, legislation, financing mechanisms, resource allocation, education and information dissemination strategies, standards and competencies, and other activities that together constitute the governance of health care provision. Health systems have three fundamental objectives:

- improving the health of the population they serve
- responding to people’s expectations and treating them with dignity
- providing financial protection against the costs of ill-health. (54)

In most countries, governments are the stewards of their people’s health. Stewardship means establishing the best and fairest health system possible. In a people-centred health system, the health of the people must always be a national priority. As Dr Vaughan Glover of the Canadian Association for People-Centred Health puts it, “There is a tremendous difference between system-centred and patient-centred visions for health care. In a people-centred system...the non-negotiable base is the health needs of the individual.” (48) The exception is the greater need in special situations to safeguard public health, to protect the health and well-being of the greater majority of individuals in society.

Ensuring access and equity

A primary role for a people-centred health care system is to ensure equity and access to health care for all segments of the population. But it is not satisfactory to protect or improve the average health of the population, if at the same time inequality remains high because the gain accrues disproportionately to those already enjoying better health. The health system also has the responsibility to try to reduce inequalities by preferentially improving the health of people who are worse off, wherever these inequalities are caused by conditions amenable to intervention. (49)

Box 24. Gross national happiness policy framework in Bhutan

The term Gross National Happiness was first expressed by the King of Bhutan, His Majesty Jigme Singye Wangchuck. It is rooted in the Buddhist notion that the ultimate purpose of life is inner happiness. Bhutan being a Buddhist country, Bhutan's King felt the responsibility to define development in terms of happiness of people rather than in terms of an abstract economic measurement such as gross national product.

Minister Dasho Meghraj Gurung put the Bhutanese philosophy succinctly: "The ideology of gross national happiness connects Bhutan's development goals with the pursuit of happiness. This means that the ideology reflects Bhutan's vision on the purpose of human life, a vision that puts the individual's self-cultivation at the center of the nation's developmental goals, a primary priority for Bhutanese society as a whole as well as for the individual concerned."

Gross National Happiness, the principle of people at the centre of development, has been the underlying driving force behind service delivery in health and education. Bhutan's commitment to its people is reflected in the delivery of health care. The positive elements evident in Bhutan which facilitate the delivery of people-centred health care include the role of spirituality and religion in health for patients and health practitioners; integrated rehabilitation practice; integration of ethics, psychology and sociology in health practitioner education; a comprehensive school health programme; promotion of traditional medicine; high patient satisfaction with the delivery of care in the basic health units and hospitals; equitable distribution of human resources; and a high percentage of government expenditure afforded to the health system. (50)

At the health systems level, the first step to ensuring access and equity is to protect the population's right to health by articulating a national commitment to people-centred health care in legislation and policy.

Primary health care as prescribed in the 1978 Alma-Ata Declaration is the cornerstone of people-centred health systems. A defining principle of primary health care is that people have the right and duty to participate individually and collectively in the planning and implementation of their health care. Another defining principle is that health is integral to socioeconomic development. These form the core values of people-centred health care.

Implemented well, primary health care can improve health equity and health outcomes. (51) There are growing calls to strengthen primary health care and family medicine globally. (52, 53) In the Asia Pacific Region, adopting a people-centred approach mandates health systems to re-examine the pivotal role of primary health care in improving access and equity.

Box 25. Strengthening primary health care in the Lao People's Democratic Republic

In the remote Xayaboury Province of the Lao People's Democratic Republic, a comprehensive district-managed primary health care programme has been in place since 1991. The programme was implemented in phases and key actions included strengthening local management skills, developing outreach initiatives, integrating primary healthcare facilities with other services, expanding primary care service delivery to outlying areas, providing equipment to district hospitals, improving drug dispensing, enhancing the skill base of health practitioners through job descriptions and supervision, involving village health volunteers and traditional birth attendants, and establishing evaluation mechanisms. Outcomes have included improved community access to primary health care and reduced infant, child and maternal mortality rates. (54)

Financial barriers are among the most critical in denying people access to timely health care. Establishing effective health care financing is a crucial task of health care systems. With increasing involvement in the global economy, much of health care in the Asia Pacific Region is becoming increasingly privatized. Yet the experience in a number of developed countries highlights the shortcomings of market-driven health care in ensuring equitable access. People-centred health systems should have a balanced policy on out-of-pocket payments for health to discourage unnecessary doctor and hospital visits as well as to reduce the regressive burden. There should be a proactive move to expand prepayment schemes, which spread financial risk and mitigate the impact of catastrophic health care expenditures. At the same time, governments should work to harness the energies of the private and voluntary sectors in achieving better levels of health systems performance, while offsetting the failures of private markets. (49)

Box 26. Economic reforms and health financing in China in the 1980s and 1990s

China's early health gains were associated with improved basic living conditions for the rural masses and establishment of a three-tiered health system, extending from the village, to the township and then to the county level. This health system emphasized prevention, often through community action, and accessible primary health care provided by "barefoot" or rural doctors. The existence of a cooperative medical system (CMS) ensured that financial barriers to health care were minimized. Almost all urban residents had work-related health insurance and 85% of rural people were covered by CMS. China's system of rural health care and achievements in improving health status have been internationally recognized.

However, structural economic changes such as the devolution of public sector finance to lower levels of government, decentralization of administrative responsibilities to individual cost centres, and the reform of state-owned enterprises have meant unintended consequences on health care. Between 1986 and 1993 the estimated share of government spending on health declined from 36% to 16%. In 1993 it was estimated that the average per capita health spending (public and private) was four times higher for urban areas than for rural areas. In addition, in rural areas the proportion of health expenditure from public funds is much less than in urban areas.

The Chinese Government has been progressively introducing health financing reforms since 2000 for rural health and urban primary health care to redress the situation. (55)

Box 27. People-centred health financing in Mongolia and Thailand

Mongolia introduced a social health insurance scheme in 1994. Within two years, 95% of the population was covered. The Government subsidized low-income and vulnerable groups. Employers are also expected to contribute to employee insurance premiums. Although the insurance scheme is no longer universal, 78% of the population is still covered. (56)

In Thailand, the 30 Baht Health Policy was introduced in 2001 and provides universal health insurance to all Thais. People pay only 30 baht for each visit to a health care organization. Government subsidizes the rest. The underlying principles are summarized as ESQUA (Equity, Social Responsibility, Quality, Universal Coverage, Accessibility). (57)

Establishing standards for competence and accountability in health

The health system's stewardship function involves exerting influence through regulation, standards setting, and collecting and using information. At the international level, stewardship means influencing global research and production to meet health goals. It also means providing an evidence base to guide the efforts of countries to move towards a people-centred model and improve the performance of their health systems.

Regulating professional standards through registration of all health practitioners and setting standards for education and health practice are important measures for ensuring public health and safety. Registration can influence clinical practice towards people-centredness by requiring health practitioners to adhere to a code of ethics promoting patient autonomy and respect for people's choices, and to conform to standards of good practice. The trend in both health registration requirements and legislation is towards protecting patient autonomy via informed consent, disclosure of risks and respect for patient decision-making. To ensure that health practitioners maintain and update their knowledge and skills, registration and renewal of licenses could require participation in continuing professional development activities.

Public reporting of health sector performance data can be an important tool in improving the accountability of national and local government units, health care organizations, health insurance companies, and specific services in health care organizations. In particular, the release of comparative data on health care may act as an incentive to improve the quality of service delivery. Public reporting is integral to health sector performance in several Western nations, where initiatives and organizations have been established to evaluate the performance of hospitals, health practitioners and health insurance plans. In the Asia Pacific Region, public accountability could be enhanced by mandatory public reporting of performance, tailoring reports to the needs of users, increasing the scope of data collected, adequate risk adjustment, reporting that focuses on health care organizations rather than individual practitioners, promoting public awareness of performance data, preparing the public for release of such data, and incentives to encourage improvements in quality.

As stewards of the public's health, health care systems have the responsibility to systematically evaluate new information and technologies in relation to their potential utility for health care. Health care systems also need to oversee the development of guidelines and recommendations based on their assessments.

Health technology is a growth industry. New developments emerge regularly and rapidly, and advances have brought about substantial improvements in public health. However, technological developments are also posing challenges in health care. Concerns have been raised about the focus on technology making it difficult to provide holistic care. The high cost of the development and utilization of technology, particularly over-utilization, is also problematic and has a major impact on the overall cost of health care.

Health technology assessment procedures intended to determine the effectiveness of new technologies have been developed to inform decision-making on health care spending. These assessments should consider not only cost-effectiveness but also potential contributions to quality health care and quality of life.

Medical and public health research into people-centred health care has taken place largely in developed or Western countries, and there is a pressing need to expand the evidence base in relation to people-centred health care in the Asia Pacific Region. In particular, interventions that have been developed and tested in Western contexts need to be piloted in the Region before broad implementation.

Funding is required for this research and for the development of guidelines that promote compassionate care and health equity and are appropriate to the cultural and social context. In particular, more research is needed on interventions that generate trust between patients and health practitioners, methods for consumer involvement in health system development, creative and innovative strategies for developing and teaching health practitioner curricula, mechanisms that ensure continuity of care, organizational incentives that improve quality of care, new models of care, integrated primary health care, appropriate health technology use, and health care financing methods.

Box 28. Health sector performance reporting in the United States of America and the United Kingdom

In the United States of America and the United Kingdom, reporting of health sector performance is an integral part of health system management. Public reporting of hospital performance data has been prominent in the United States of America since the 1980s, and it is justified along business lines—improved health care quality reduces costs. In addition to hospital performance, comparative data is also available on health insurance plans and individual doctors. Numerous initiatives and organizations have been established to evaluate health care quality and report on study findings, including the National Committee for Quality Assurance, Pacific Business Group on Health, National Quality Forum, Leapfrog Group, HealthGrades, Centers for Medicare & Medicaid Services, Consumer Assessment of Health Plans.

In the United Kingdom, public reporting of health sector performance has been in effect only since 1998, with the introduction of the Performance Assessment Framework (PAF). Before this, avenues for public reporting were limited. Furthermore, reporting itself initially was very low key, with information destined for managers rather than the community. Now, PAF is integral to the National Health Service. Other public reporting initiatives include rating of government hospitals, the Good Hospital Guide (private initiative), and National Health Service surveys.

The experiences of the two countries demonstrate that:

- Public reporting of health sector performance is important in improving accountability
- In the United States of America, consumers use data to guide health care decision-making, and interactive websites are used to make public reporting consumer friendly
- Both countries offer provider incentives to act on quality report cards; however, in the United Kingdom these incentives include greater autonomy while in the United States of America the incentives are economic. (58)

Cultivating community-based participation in systems development

Participatory approaches to health care systems development are mentioned repeatedly as an essential element in people-centred care, but real-world examples at the national level are infrequently encountered. Malaysia, however, provides a good example (see Box 29). Also, a recent white paper published by the National Health Service of the United Kingdom highlighted the fundamental importance of involving communities in health system reform at the national level.

Box 29. Providing channels for community participation in health care system development in Malaysia

The Malaysian health care system has well-established channels for community feedback through Patient Satisfaction Surveys, complaints boxes, media (e-mail, telephone and verbal) to the Minister of Health and Director General of Health and to the Bureau of Public Complaints in the Prime Minister's Department.

There are clear guidelines on the response and investigation of complaints based on the severity of the complaint such as formation of an independent or internal inquiry board, whether it should be at hospital or department level, or be referred to the courts.

Boards of Visitors for all Ministry of Health hospitals and Advisory Panels for health centres are composed of community members, thereby providing an opportunity for community participation and oversight of the health facilities run by the health system. (23)

Promoting values-based leadership at the highest levels in health care

“In preventing and controlling such suffering, we must think beyond the practice of reducing everything to component parts, and this is where, I believe, modern medicine needs to accommodate a more integrated and holistic approach.

Centuries ago, Plato said, ‘The cure of the part should not be attempted without treatment of the whole.’

Centuries later, the World Health Organization recognized this principle in its 1948 constitution...when it defined health as a ‘complete state of physical, mental and social wellbeing’.

Today, therefore, is our chance to redefine our health systems so that they provide the balance and connectedness that the 21st century so desperately needs.”

His Royal Highness the Prince of Wales

Ultimately, leadership for people-centred care at the highest levels of the health system will determine how quickly a health care transformation can occur. Perhaps the best existing example at the national level is the National Health Service of the United Kingdom (see Box 30). Its move towards people-centred care is driven by simultaneous top-down and bottom-up forces. The momentum of the transformative process is being pushed by the support of the highest-ranking leaders in the country. But the direction of health system change is being guided by the grass roots through nationwide consultations and the formation of citizen advisory councils. This embodies the true essence of people-centredness and the vital importance of having champions at all levels to promote the values of people-centred care.

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Box 30. Community voices guide national health system reform in the United Kingdom

In a landmark 2006 publication, the Department of Health of the United Kingdom reported the results of a nationwide consultation on health care reform.

Public consultations in 2005 and 2006 attracted more than 140 000 people, culminating in a 1000-person Citizen Summit in late 2006. In addition, a 10-person Citizens Advisory Panel worked with the department through the entire public engagement process. The outcome is the white paper *Our Health, Our Care, Our Say*, which lays out the blueprint for a system-wide transformation towards people-centred care.

The United Kingdom's Health Secretary, Patricia Hewitt, enumerated the outcomes expected from the changes outlined in the paper:

- People will be helped in their goal to remain healthy and independent
- People will have real choices and greater access in both health and social care
- Far more services will be delivered—safely and effectively—in the community or at home
- Services will be integrated, built round the needs of individuals and not service providers, promoting independence and choice
- Long-standing inequalities in access and care will be tackled. (59)

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“Ultimately, there is nothing as important as informed public discussion and the participation of the people in pressing for changes that can protect our lives and liberties.

The public has to see itself not merely as a patient, but also as an agent of change.”

Professor Amartya Sen
Nobel Laureate in Economics



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4



Of the three women whose stories opened the first chapter of this book, only two are alive today. Silei, the Pacific Islander woman whose diagnosis and treatment were delayed, succumbed to metastatic breast cancer earlier this year. Her experience testifies to the persistence of health disparities in a world of growing global affluence.

Helen and Le survived their battle with cancer. Both women were transformed by their health care experience, but in opposite ways. Helen's journey through breast cancer diagnosis and treatment gave her life a mission and meaning. She is now an active community advocate for breast cancer, promoting mammograms and breast self-examination and assisting other women to navigate the difficult course of breast cancer work-up and management. Le, on the other hand, experienced a transformation into depression and dysfunction. Bewildered and overwhelmed by her disease, with no one to turn to for support, she emerged from the health care setting with a cure, but without healing.

Silei, Helen and Le are real women from this Region whose stories highlight the inadequacies that exist in our current system of health care, despite development, globalization and the remarkable advances in medical knowledge and biotechnology. The challenge for the Asia Pacific Region, then, is how to systematically redress health care so that health outcomes are better managed and less discrepant, and people in the Region are supported to attain the best possible health. This book argues that the way to achieve this is through a reorientation of health care towards a people-centred focus.

Already, as some of the examples in this book describe, health institutions, communities and even some countries have begun implementing people-centred approaches, although most of these are happening in piecemeal fashion. To date, only a few countries have clearly articulated a national vision and strategy for people-centred care. Still, the clamor for people-centred health care is growing among WHO Member States in the Asia Pacific Region. In response to interest expressed in official meetings, WHO has developed the People at the Centre of Care Initiative and formulated a policy framework for people-centred health care. (1, 2)

Changing the culture of health care is a formidable challenge, but it is an inescapable task in the face of persistent health disparities. This requires more than reform; it requires transformation. Reform implies changing an existing system, but what is needed is not to discard the old methods and perspectives but rather to expand and build on them and introduce new approaches that provide appropriate responses to the changing landscape of health care. Transformation means taking health care to the next level.

Transforming the health care system into a people-centred one is both a goal and a process; it is simultaneously the destination and the journey towards better health. What is needed now is, firstly, to disseminate the common vision and framework for policy and action to all the relevant stakeholders in the Region. Secondly, the four key players—people’s representatives, health professionals, health organizations and ministries of health—must advocate for extensive commitment to the transformation process within the Region. Next, we must broaden the consultation process and, in the spirit of true people-centredness, bring in community voices across the Asia Pacific Region to help design the details of the road map towards people-centredness. The United Kingdom’s experience can help guide this effort. Fourthly, we must implement the strategies in the road map and transition from intentions to action at all levels, whether in individualized clinical settings or for population-based public health. This includes applying the people-centred approach in our own organizations and programmes. Finally, we must monitor progress carefully and apply the lessons learnt from early mistakes to revise and refine the transformation towards better care.

By harmonizing mind and body, people and systems, we can restore the balance in health care. By putting people at the centre of care, we can fulfill our vision of “health for all, by all”.

Let us begin the journey today. Each individual, institution, organization and nation must decide how they will take this initiative forward. As presented in previous chapters, the principles are clear, even if the actions to take those principles forward will vary in different settings. It is not possible, or desirable, to have a prescription that applies to every situation. But, the principles must be applied appropriately in every situation in our health systems.

Working together with our shared vision of people at the centre of health care, we can, in the words of Mahatma Gandhi: “Be the change we want to see in the world.”

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AUTHORS

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CONTRIBUTORS

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REVIEWERS

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EDITORIAL AND PUBLICATION TEAM

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Gains in socioeconomic status and public health in the Asia Pacific Region have made it possible to go beyond the normal work of preventing and fighting diseases and begin focusing on enhancing the quality of health care.

People at the Centre of Health Care: Harmonizing mind and body, people and systems calls for a bold transformation of health care and health systems in the 21st century.

Quality of care has become an increasingly important issue for the World Health Organization's South-East Asia and Western Pacific Regions, and a policy framework for people-centred health care was endorsed by Member States in September 2007.

Specific policy reforms and interventions necessary to transform health care to a more holistic, people-centred approach will need to be determined by leaders and policy-makers at local and national levels in consultation with their constituencies and all interested stakeholders. This book, which is designed to bring members of the public into that debate, is a first step in encouraging dialogue.

This book was conceived by Dr Shigeru Omi, WHO Regional Director for the Western Pacific, who believes that people must be at the centre of health care. In visits to Member States and in consultations with health officials and experts, Dr Omi was encouraged to find that many colleagues share his vision. In a milestone statement in September 2003, he declared that the time has come to aim for a more holistic approach to health care and "to put the heart back into medical practice".

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