International Symposium on People-Centred Health Care: Reorienting Health Systems in the 21st Century

The Tokyo International Forum
Tokyo, Japan
25 November 2007
REPORT

INTERNATIONAL SYMPOSIUM ON PEOPLE-CENTRED HEALTH CARE:
REORIENTING HEALTH SYSTEMS IN THE 21ST CENTURY

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NOTE

The views expressed in this report are those of the participants in the International Symposium on People-Centred Health Care: Reorienting Health Systems in the 21st Century and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the International Symposium on People-Centred Health Care: Reorienting Health Systems in the 21st Century which was held in Tokyo, Japan on 25 November 2007.
SUMMARY

An International Symposium on People-Centred Health Care: Reorienting Health Systems in the 21st Century was held at the Tokyo International Forum, Tokyo, Japan on 25 November 2007. International participants included health experts, policy-makers, practitioners, academicians, researchers, advocates and other stakeholders from more than 17 countries and 40 health care organizations in the Region and around the world. They were joined by some 500 Japanese health professionals and other health workers who attended a three-day national conference of the Japanese Society for Quality and Safety in Healthcare (JSQSH). In addition, some 60 members of the diplomatic corps were present during the special address delivered by the Japanese Minister of Foreign Affairs.

The objectives of the symposium were:

(1) to provide an advocacy forum for reorienting health systems and health policies towards people-centred health care;

(2) to enable sharing and exchange of knowledge, experiences and best practices in providing good quality, safe, responsive, holistic and people-centred health care; and

(3) to disseminate the policy framework and launch an advocacy document to consolidate support towards translating policy into action.

Organized as part of the World Health Organization’s advocacy and social mobilization activities under the biregional People at the Centre of Care Initiative, the symposium featured key messages and presentations from internationally recognized health experts and policy-makers. Panel and group discussions and an open forum were also held. The symposium provided the venue for the launching of People at the centre of health care: harmonizing mind and body, people and systems. This is an advocacy publication for popular readership, to complement People-centred health care: a policy framework, which was endorsed by Member States at the fifty-eighth session of the Regional Committee for the Western Pacific held in the Republic of Korea in September 2007.

Group discussions during the breakout sessions afforded a thorough review of the draft Declaration on people-centred health care: health for all, by all. They also provided an exciting opportunity for participants to explore the way forward, particularly in identifying possible next steps. WHO will review the observations and suggestions and take them into consideration in planning follow-up activities to maintain the momentum for the paradigm shift towards people-centred health care.
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1. **INTRODUCTION**

Health improvements over the last century have been impressive, but health systems have reached an important turning point. Global and regional trends indicate that current health systems have become so disease-focused, technology-driven and doctor-dominated that they fail to respond to patient needs and expectations. The broader and more important aspects of cultural context, psychosocial factors, medical ethics and communication and interpersonal skills, among others, have been unduly neglected. Thus, there is a need to reorient health systems towards providing good quality, safe, responsive and people-centred health care.

A biregional effort of the WHO Regional Offices for the Western Pacific and South-East Asia has developed a policy framework and an advocacy document on people-centred health care. This was done through a consultation process involving a reference group and a series of stakeholder consultations in selected countries. The policy framework was endorsed by Member States at the fifty-eighth session of the Regional Committee for the Western Pacific held in Jeju, Republic of Korea from 10 to 14 September 2007.

WHO organized the International Symposium on People-Centred Health Care: Reorienting Health Systems in the 21st Century. It was held at the Tokyo International Forum in Japan as part of the advocacy and social mobilization activities to consolidate support for the paradigm shift. International participants included health experts, policy-makers, practitioners, academicians, researchers, advocates and other stakeholders from more than 17 countries and 40 health care organizations in the Region and around the world. They were joined by some 500 Japanese health professionals and other health workers who attended a three-day national conference of the Japanese Society for Quality and Safety in Healthcare (JSQSH). In addition, some 60 members of the diplomatic corps – composed of ambassadors to Japan, were present during the special address delivered by the Japanese Minister of Foreign Affairs.

The list of international participants is attached as ANNEX 1.

1.1 **Objectives**

(1) To provide an advocacy forum for reorienting health systems and health policies towards people-centred health care.

(2) To enable sharing and exchange of knowledge, experiences and best practices in providing good quality, safe, responsive, holistic and people-centred health care.

(3) To disseminate the policy framework and launch an advocacy document to consolidate support for translating policy into action.

1.2 **Opening remarks**

Dr Linda Milan, Director, Division of Building Healthy Communities and Populations, WHO Western Pacific Region, opened the International Symposium on People-Centred Health Care: Reorienting Health Systems in the 21st Century. She noted that the past century had witnessed dramatic changes in health care. She also noted that, amidst the technological advances, it was critical for health care systems to retain their fidelity to the public health core.
value of people at the centre of health care. The symposium presented an opportunity for meaningful dialogue and consensus to make progress in the right direction.

Dr Fumimaro Takaku, Board Chairperson, Japanese Society for Quality and Safety in Healthcare, stated that the symposium was an important event in respect of the improvement and quality of health care in Japan. Establishing quality and safe health care systems is one of the most important challenges in the 21st century. Health care and health care delivery systems differ from country to country and, as a result, the issues we face are sometimes different. Yet, high quality and safe health care is a desire of all countries. From this starting-point, he expressed the hope that there would be extensive discussions at the symposium.

1.3 Messages

Ms Jo Harkness, Chief Executive Officer, International Alliance of Patients' Organizations (IAPO), explained that her organization was a network of around 200 patient organizations representing 365 million patients worldwide. As is increasingly being recognized, health care systems in all regions are under pressure because of the burden of disease and increasing chronic conditions. Systems cannot cope if they do not focus on people. For IAPO, “the patient at the centre of health care” concept consists of a number of values and principles: respect for those involved in health care, choice and empowerment, advocacy, access and support. These values are also enshrined in international law and underpin many definitions of patient-centred care in various countries. IAPO welcomes WHO’s initiative on putting people at the centre of health care and looks forward to its further development.

Dr Yoshihito Karasawa, President, Japan Medical Association, noted that the provision of quality health care, as well as ensuring patient safety, had become an issue of concern. Medical care provision has always had inherent risks, and increasing sophistication creates new risks. It is imperative that those in the medical profession and members of the public share a common awareness of the risks involved. Two tasks need attention: the examination of the cost effectiveness of interventions and the diffusion of that information. It goes without saying that ensuring the safety of health care is important. In this regard, the establishment of advocacy and patient organizations is essential. It is hoped that this becomes a powerful force in supporting community health care.

The Honourable Mr Yoichi Masuzoe, Minister of Health, Labour and Welfare (MHLW), Government of Japan, expressed his appreciation for the role being played by Dr Shigeru Omi as WHO Regional Director for the Western Pacific. To ensure the improvement of quality and safety in health care, it is important to have the continued support of members of society. The Japanese government has been making efforts for the improvement of health care. Health care safety is one of the most important aspects of Japan’s overall health policy. Every year, the week of 25 November is designated as Health Care Safety Promotion Week. Accordingly, MHLW’s regional bureaus carry out programmes such as regional workshops during that week. In 2007, Health Care Safety Promotion Week started on the same day as the symposium. Thus, in the afternoon there was to be a joint public forum – National Action to Operationalize People-Centred Health Care, including Patient Safety.

The health care initiatives of MHLW include considering how to examine the causes of death and looking towards establishing a system in which a third-party organization will examine causes of death to ensure medical transparency. Also, the Ministry is considering the creation of a compensation system for medical errors, such as the establishment of a no-fault system. In addition to providing patients with compensation for injuries suffered in the course of receiving medical care, this will attempt to find the true causes of medical errors. In promoting people-centred health care, safe and high-quality health care is everyone’s objective. The symposium is
about actions to put people at the centre of this. Japan is also committed to providing a safe health care system from the perspective of the person. Globally, the United Nations Millennium Development Goals for 2015 were set in areas including poverty and health. Moreover, the Kyushu–Okinawa Summit emphasized actions to reduce the incidence of communicable disease. Since then, significant progress has been made, although continued efforts are needed. In addition, increased worldwide attention is being paid to maternal and child health. Health development has been the foundation for economic growth, and Japan would like to cooperate with WHO in making a contribution to international health cooperation. This in turn will promote global solidarity and economic development, constituting one of the best contributions that Japan can make.

In 2008, Japan will chair the G8, and health will be among the topics on the agenda. Minister Masuzoe asked for continued support. It had only been three months since he became the MHLW Minister and there were a number of problems to be addressed. What is needed is a long-term view and a focus on putting people at the centre of health care. The Minister was planning to establish a research and study committee to look into what kind of health care system Japan should have in the future, from a long-term perspective. He also expressed the hope that the fruits of the discussion during the symposium would be included in the MHLW vision.

1.4 Keynote speech

Dr Shigeru Omi, WHO Regional Director for the Western Pacific, stated that socioeconomic progress, coupled with advances in education and medical science, had resulted in unprecedented resources and opportunities for people to attain optimal health and well-being. People today, therefore, should be healthier in body and mind, and more content with the health care they receive. But this is not necessarily the case.

Globally, about 50% of patients remain dissatisfied with their health care experience. Concerns about patient safety are growing. Some 62% of patients in a recent study said that their doctors did not consider possible emotional factors when developing their diagnosis and treatment plan. Moreover, money does not seem to be helping. Global health expenditures have steadily increased, reaching US$4.1 trillion in 2004. Yet satisfaction does not seem directly related to the money that is being spent.

Dr Omi believes it is important to reflect on why this is happening. In his view, there are three main reasons. First, we have tackled health problems largely in isolation, even though there are many factors – social, economic, cultural and environmental – that impact on health. Second, modern health systems and services are mainly focused on the disease, rather than on the person as a whole. The third reason is the exclusive reliance on science and technology without due regard to human factors.

Dr Omi emphasized that health care had clearly reached a crucial turning point, and as we move further into the 21st century, we must re-examine our values and beliefs. Actions have to take place on two fronts. First, at the micro level, we have to harmonize mind and body. This means that health care must address not only the physical, but also the psychosocial and cultural dimensions of the individual. Second, at the macro level, we need to harmonize people and systems, both within the health sector and between health and other sectors.

Everyone – health stakeholders, duty bearers and claim holders – must change if we really are going to put people back at the centre of health care. This thinking led to the People at the centre of care initiative, which developed a policy framework, and building on the framework, a publication for general readership has been produced. Dr Omi was pleased to be able to launch
the publication during the symposium, which is a very important occasion. The title of the book is *People at the centre of health care: harmonizing mind and body, people and systems*.

In conclusion, Dr Omi called for a concerted effort to put the heart back into medical practice. He sincerely believes that 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. Therefore, physicians, public health officials and policy-makers need to aim for a more holistic approach to health care. This means dealing with people in the context of their human dignity, their rights, their families, their culture and their society.

Dr Omi hoped the symposium would mark a turning point in the effort to make health systems and health care more holistic and people-centred. With effective advocacy and leadership, he expressed confidence that we could get the job done together, accelerating the shift and realizing our vision.

2. PROCEEDINGS

2.1 Introduction

Dr Milan provided a brief background of the events that had paved the way for the *People at the centre of care* initiative. She sketched the process that had been used in developing the policy framework. She indicated the key features of the framework, particularly the four domains around which transformational policies and actions could be pursued. She also expressed confidence that the whole day’s programme (attached as ANNEX 2) would run smoothly and that everyone would contribute to and benefit from the interaction.

2.2 Thematic presentations

2.2.1 Informed and empowered individuals, families and communities

Dr Angela Coulter, Chief Executive, Picker Institute Europe, stated that people-centred health care was a radical reorientation of how we had traditionally thought about health systems. The hospital has traditionally been the focus of health policies. While primary care is recognized as being important, many health systems have ignored the role played by individuals, families and communities in promoting their care. Prevention is not capitalized on to the extent that it should be. We should instead turn the approach upside down and put the main focus on prevention and health promotion at the individual, family and community level.

There are many things that people do to look after their own health. These include understanding factors that influence health; self-diagnosis and treatment of minor illness; selecting treatment for acute conditions; and monitoring symptoms and treatment effects. They also include being aware of safety issues; managing symptoms of chronic disease; feeding back views on quality of services; and adopting healthy behaviours.

The Picker Institute carried out a large survey of the evidence base in the area of self-care, finding a large amount of evidence buried in the literature. Among the most salient points are: support in self-care; sharing treatment decisions; building health literacy; improving responsiveness; and promoting health. With respect to self-care, there are many initiatives that have worked well to support health care. One is self-management education. This can help
people with chronic conditions, helping them to feel more empowered and confident to deal with their condition. However, it is terribly important that education should be integrated into the health system. Evidence also suggests that self-care can be more effective when health professionals are involved. If we can integrate this into the health care system, we have the potential to create a really effective initiative.

Shared decision-making refers to engaging patients in the decision-making about their care. We know that patients want to understand their illness and to be aware of the treatment options. Yet with shared decision-making, clinicians must be willing to provide the information and the patient must be willing to discuss preferences in the context of his or her values. Other things that work are self-management guidelines, lay-led and professionally led self-management education. Computer-based interactive applications, telephone coaching and support, access to personal medical records, self-monitoring, self-treatment, and self-help and community support are also effective.

We must raise people’s health literacy. This is about the ability to make important decisions that affect patients as individuals. It involves advocacy and activism on behalf of patients and the ability of patients to get involved with decisions. Among the solutions that work are basic health knowledge, reading, comprehending and evaluating health information, and application of health prevention, health-promoting and self-care behaviours. Verbal communication with health professionals, health decision-making and health advocacy and activism are additional solutions.

The WHO world health report 2000 talked about respect for persons and client orientation. Among the things that can encourage responsiveness are patient participation groups, lay representation, public meetings, citizens’ juries, patient and population surveys, focus groups, patients’ panels and consensus conferences.

To make these things a reality, an entire system approach is needed. The key to success is thinking about ways in which this idea can be embedded within the health care system. At the macro level, we can develop a statement of patients’ rights or a patients’ charter, build the responsiveness of organizations and of the health professions, and invest in health information or websites. At the meso level, we can support patient participation groups, organize consultations, emphasize patients’ rights and make sure patients are aware of these rights, and embed public involvement at every stage of policy-making. At the micro level, we can make sure that health professionals have good training in the areas of communication skills, self-care education and support, aids to engagement, and community initiatives. This is the basis for a whole system approach, which is the most effective way to promote health for all.

The technical papers prepared by the resource persons for the four policy domains were distributed to the participants. Their presentations at the plenary sessions during the symposium are attached as ANNEX 3.

2.2.2 Competent and responsive health practitioners

Dr Alejandro Dizon, Physician-General Surgeon, Chief Quality Officer and Chair (Medical), Hospital Performance Improvement Council, St Luke’s Medical Center, Philippines, stated that an explosion of new knowledge and technology had brought health care to new heights. While this has created a better understanding of disease, it has also led to “defensive medicine” characterized by a high dependency on technology, lab results being treated instead of the patient, protection of the physician, preoccupation with responses to litigation, and expensive health care.
It is important not only to address the needs of the patient, but also to consider the values, expectations, preferences, capacity and overall well-being of the patient. This is in effect a patient-centred care system, but it goes further to encompass all people and stakeholders, aiming for a people-centred health care system. This requires comprehensive changes in four domains: individuals, families and communities; health practitioners; health care organizations; and health systems.

There are many types of health care practitioners – including physicians, nurses and paramedical clinical support staff – who play various parts as educators, role models and leaders. Physicians provide standardized care, for example, through following protocols and clinical practice guidelines (CPGs) and monitoring outcomes. They also work to ensure patient safety by proactively preventing harm, following the 3 Cs (communicate, coordinate and collaborate), learning from errors, providing continuity of care beyond the hospital, and providing health maintenance and disease prevention. In addition, physicians address nonmedical but equally important needs of the patient by taking into account his or her family and friends, traditions and customs, religion and beliefs, and cultural preferences. Supportive care occurs through spiritual visits and consultations, psychiatric support and referral to lay support groups.

Nurses spend the most time with patients, are on the front line in the care of patients and in their protection against harm, providing bedside and compassionate care. Providing good compassionate care is vital in providing patient-centred care. One problem though is that human resources will become more limited with the world’s rapidly ageing population and with the uneven distribution of health workers. In the Philippines, for example, this is a particular problem since 85% of all Filipino nurses are working outside the country. Clinical pharmacists provide complementary patient care to the nurses. They have a monitoring function and also collect and collate data on medication safety.

There are many new approaches to education and teaching. Rather than the traditional system, which tends to be disease-oriented, some follow the “Read one, see one, do one” model or take a “Blame and train” approach. New approaches address quality and safety, emphasize systems rather than human factors for errors, realize the nonmedical needs of the patient, and adopt models such as simulated or situational training and error training and prevention.

As for leaders, clinical heads need to ensure the competence of staff and the provision of timely care, monitor performance and outcomes, and celebrate and share successes and good outcomes with the whole organization.

In summing up the importance of patient-centred health care, Dr Dizon said it was useful to quote Dr Gerald Healy, the current President of the American College of Surgeons, who stated: “Patients do not care how much you know until they know how much you care!”

2.2.3 Effective and benevolent health care organizations

Dr Robin Youngson, Clinical Leader of Waitakere Hospital, and Founder and Chief Executive of the Clinical Leaders Association of New Zealand, emphasized that putting people at the centre of health care required a paradigm shift for health practitioners. They must move away from the biomedical, disease-oriented and technically driven model of care towards a more holistic approach that validates the cultural, psychosocial and environmental determinants of health and well-being. But no less a paradigm shift is required for the managers and leaders of health care organizations.

Just as we need a holistic approach to the health and well-being of people, we also need to treat health care organizations as living entities that have a mind, body and spirit. In the rush of
developing nations to adopt Western practices, we might also be mindful of our first nations’ cultures. In Maori health care, the four cornerstones are physical, mental, social/emotional and spiritual.

Some paradigm shifts are required in health care organizations. We are stuck in a machine-thinking, command and control model of health care. What our organizations need to understand instead is the complexity of human dynamics, focusing on meaning and relationships as much as structure. Technical problems are easy to define and to find solutions for. Organizations, though, need to lead adaptive change that requires a shift in values, beliefs and behaviours. There is a very profound difference between providing a service and being of service to individuals, families and communities. We all need to reflect on this.

We must move away from detachment and defensiveness to a person-centred approach and, regardless of our fears about what will happen, do the best we can to help victims of medical errors. In addition, we need to give consideration to models of accountability and move towards thinking about not just shareholder value but stakeholder value. We require a broader sense of stewardship to do the best for the people in the community, i.e. those whom the medical profession and health care organizations serve. Organizations need to shift from individual competence to organizational capability. They need to create systems in which medical and other health professionals are able to work together as a team. Finally, there is a need to move away from a “clinical facilities” orientation to a truly healing environment, where the little details are attended to. These details can include lower level windows, making the outside world visible to those in hospital beds – making a difference to the health of patients.

To meet the complexity of the challenge of putting people at the centre of health care, the management and leadership of health care organizations must evolve to become a prestigious health profession, requiring the highest qualifications and the most exacting ethical standards.

Perhaps the single most important attribute is that leadership training is provided in a cross-cultural setting. WHO might be in the ideal position to work with diverse nations to sponsor the development of international colleges of health leadership and management.

2.2.4 Supportive and humanitarian health care systems

Dr Chang-Yup Kim, President, Health Insurance Review and Assessment Service, and Associate Professor, Department of Health Policy and Management, School of Public Health, Seoul National University, stressed the importance of a supportive and humanitarian health system. He noted its role as a determinant of individual health and health care utilization, of providers’ behaviour, and as an interface with the nonhealth sector.

A health system constitutes all the activities whose primary purpose is to promote, restore or maintain health.1 A health system is basically a system to achieve health goals in a society. While some goals may differ, overall they are not so different. The three main goals are good health, responsiveness to the expectations of the population, and fairness of financial contributions. The three goals are to some extent interconnected and have different levels of attainment.

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Health care goals should be attained through health systems (1) delivering personal and non-personal services (delivering services), (2) raising, pooling and allocating revenues to purchase those services (financing), (3) investing in people, buildings and equipment (creating resources), and (4) acting as the overall steward of the resources, powers and expectations entrusted to them (stewardship).

The key elements of people-centred health care are access and equity, respect, information sharing, participation and coordination. Strategies for patient-centred health care include public reporting, pay for performance, shared decision-making, ensuring access and equity, standards for competence and accountability, community-based participation and values-based leadership.

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

Another issue related to health care is the production of human resources, for example, how to produce the proper level of primary care providers, especially in market-oriented systems. Unfavourable conditions, their academic careers, lower income and status are factors that lead medical professionals to decide to become something other than general practitioners.

With respect to making health care organizations quality-sensitive, there is empirical evidence that accreditation and the use of report cards and practice guidelines are useful strategies for making health care organizations more supportive of patient-centred care. Accreditation refers to the official recognition and approval of a health care organization as fulfilling particular quality or performance standards. Accreditation programmes for health care organizations have had a huge impact on the performance of health care organizations in several developed countries.

Governments are attempting to improve the quality of care by structuring financial incentives and/or disincentives in payment schemes. A few countries (including the United States of America and the United Kingdom) are experimenting with new payment schemes based on “pay for performance” (P4P). One example is a web-based public information system for antibiotic prescription rates, which has resulted in a dramatic drop in the number of such prescriptions being written by doctors.

Developing information technologies should be utilized to strengthen decision-making. From the perspective of patient-centred care, a health information system and supportive information technology must exhibit certain characteristics. These are: shared decision-making, patient–provider communication, personal longitudinal health records, and integration of patient information across different areas of care.

There is no assurance that a market-oriented system will be better for patient care, but increasingly more countries are putting an emphasis on market approaches. We need to be very careful as there are many unfavourable conditions for patient-centred health care, such as medicalization, specialization and privatization. The above considerations indicate that patient-centred care should be approached using multidimensional strategies, from empowering individual patients to changing the entire health system. Among them, making the health system more favourable to patient-centred care should have the highest priority. This is because patients
and providers are becoming more tied to the system in terms of the determinants of behaviour, including economic incentives.

2.3 Panel discussion

Deputy Prime Minister and Health Minister Viliami Tangi of Tonga noted that he had learnt a lot from the presentations. While a clinical surgeon by training, he said that in his role as a politician, he was still looking at the way forward. What is the way forward? An immediate response would involve going back to the issue of training. Looking ahead, the system should be reorganized through training so that those coming out of school will think and practise in a wider and more holistic scope.

Professor Eng Kiong Yeoh, Director, Centre for Systems for Health, School of Public Health, Hong Kong (China) said that many of the problems we faced in health care came from the fact that we forgot humans had three parts to their brain: the intuitive, retaining and emotional parts. Second, individuals make up the system. When we look at a systems approach, we need to look at individuals. Third, problems arise in offering people-centred care because of time and resources. Good people-centred care is not just effective medically; it is cost-effective and saves money.

Representing the International Council of Nurses, Dr Junko Tashiro of St Luke's College of Nursing, Tokyo, stated that nurses everywhere supported people-centred health care. Nurses throughout the world care for people with diverse health needs and problems. They recognize the problems described, and the International Council of Nurses would especially welcome reform. Having people-centred health care as a common policy is like having a common language.

Dr Alberto Romualdez, former Secretary of Health of the Philippines and currently Director, Health and Human Values Programme, M-Tech Hospital, Philippines, noted that all the speakers touched on the issue of equity. In countries such as the Philippines, where equity in health is at a primitive level, he said that the people-centred approach might be used as an analytical tool. The four domains could represent a base to study equity issues. True patient- and people-centred care, however, can only happen if it imbues the mindset of all medical and other health professionals and the whole of society.

In response to the reactions, Dr Coulter said that the key to people-centred health care was a culture change. Health professionals need to stop thinking about doing things for people and start doing things with people. What people need is support from health professionals.

Dr Kim stressed that there was no single answer and that every approach needed to be comprehensive and well studied. He emphasized two additional points. First, the role of researchers and academics should be strengthened, as producing theory and empirical evidence is important in achieving change. Second, the leadership of nongovernmental organizations (NGOs) is important in changing health systems, including mindsets.

Dr Youngson emphasized that in providing health care, he had taken the approach that no patient had unreasonable demands. The only person who can heal him/herself is the patient. Doctors can prescribe treatment, but the key is the patient.

Dr Dizon agreed that a culture change was required. Besides training, we need to tackle the issue from a broader perspective that involves people even outside the health care system.
2.4 Draft declaration on people-centred health care

The draft Declaration on People-Centred Health Care was introduced by Professor Vivian Lin from La Trobe University, Australia, and Professor Naruo Uehara from Tohoku University, Japan. The draft declaration read as follows:

**HEALTH FOR ALL, BY ALL**

We reaffirm health in its fullest sense as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

We appreciate the significance of broader psychological, cultural and social determinants of health that impact health care outcomes and overall health and well-being.

We recognize the need for health care approaches and health systems that harmonize mind and body, as well as people and their environment.

We appreciate the relevance of a people-centred and rights-based approach to health care to all forms of health systems at all stages of their development.

We recognize the need to ensure that health policies lead to improvements in the quality of health care and that they take into account issues of human dignity, people’s rights and needs, and the role of family, culture and society.

We affirm that effective and sustainable health systems reform and reorientation require adequate and appropriate health care financing, as well as multisectoral participation and commitment by all constituencies and stakeholders at global, national and local levels.

We acknowledge that various international and regional covenants, declarations and agreements uphold and promote values and principles that underpin people-centred health care, including access, safety, quality in content and in process, affordability and satisfaction.

We agree on the following strategies for reorienting health systems towards people-centred health care:

- creating supportive environments for reorienting health care systems towards respecting, protecting and fulfilling the right to safe and quality health care;

- advocating the development of health policies and programmes that ensure the provision of effective, holistic and people-centred health care;

- reinforcing the culture of caring, communicating and healing in the context of broader psychological, cultural and social determinants of health; and

- enhancing the capacity of all health stakeholders to participate in pursuing the objective of attainment by all peoples of the highest possible level of health.

We envision the equitable, optimal, consistent and sustainable delivery of people-centred health care in the 21st century, driven by:

- informed and empowered individuals, families and communities;

- competent and responsive health practitioners;
• efficient and benevolent health care organizations; and
• supportive and humanitarian health systems.

We agree to work together to ensure that people are at the centre, as shapers and as partakers of people-centred health care, through meaningful participation in health systems design and development, and in health care policy and practice, in all settings and at all times.

The delegates were then asked to review the draft during the breakout sessions in the afternoon and prepare a revised version for consideration at the end of the day.

2.5 Special address

The Honourable Mr Masahiko Koumura, Minister of Foreign Affairs, Government of Japan, stated that in 2008, Japan would play host to two major international conferences: the Fourth Tokyo International Conference on African Development (TICAD IV) and the G8 Hokkaido Toyako Summit. At these forums, Japan will take up and call for a stronger engagement of the international community in global health – an issue that humanity cannot evade in its progress towards the future. He shared his views on what the international community should strive for in the field of global health and on the role of Japan’s diplomacy.

The year 2008 is the mid-point for the achievement of the Millennium Development Goals by the year 2015. At TICAD IV, Japan intends to take up the issue of health in Africa, and at the G8 Summit, the wider issue of global health. The objective will be to develop a common framework for action shared by the international community. Minister Koumura invited all key stakeholders, including national governments, international organizations, the business community, academia and civil society, to take part in developing this framework for action to respond to the issues that he would present in his address.

Where should the international community go from here? The notion of “human security” is particularly relevant to cooperation in the 21st century. That is to say, it is of vital importance that we should not only focus on the health and protection of individuals, but also strive to empower individuals and communities through health system strengthening.

Until now, international efforts in the health sector have largely centred on measures against infectious diseases as a pressing issue. From now on, it is essential to promote a comprehensive approach to strike at the root of the problem. This can be done through the promotion of research and development and strengthening of health systems via human resource development and retention. The importance of human resource development and retention on a considerable scale is self-evident. The “disease-specific approach” and the “comprehensive approach” complement each other. Striking a good balance between them will be at the core of an international framework for action to be developed and endorsed in Toyako.

The proposed framework for action cannot be formulated by health experts alone. We need experts from various fields to be involved in this process. Neither can it be promoted by the Japanese government alone. It is imperative that diverse stakeholders should collaborate further.

Developing countries, including those in Africa, must have ownership of the health agenda. The “Hideyo Noguchi Africa Prize” will be supporting various efforts in this regard in Africa, and will be presented for the first time at TICAD IV.

Major developed countries, including the G8 and international organizations, need to show clear political will to support the efforts of developing countries as their partners. In this respect,
Minister Koumura welcomed the health initiatives announced in 2007 by Germany, the United Kingdom, Norway and Canada. He also welcomed other countries who are emerging as new providers of aid through South–South cooperation to join our efforts. He said that it was equally important to mobilize NGOs carrying out grass-roots activities on the ground. Similarly, other stakeholders such as the business sector, private foundations and knowledgeable people should come on board with their diverse expertise and resources.

TICAD IV and the G8 Summit in 2008 will be excellent opportunities for the international community to strengthen their collaboration and build a framework based on a participatory approach suited to the 21st century. Japan, as G8 chair and host to TICAD IV, will aim to achieve this.

Minister Koumura also said that the theme of the symposium was perfectly in line with the concept of “human security” that he had spoken about. He concluded his speech by returning to the central premise that what matters most is “people”, not only in the field of health or development, but in all fields of international collaboration. The people are what we should focus our attention on.

2.6 Presentations: from slogan to action

In the afternoon, the international participants tackled key issues and priority actions needed at international level to promote people-centred health care. Dr Dean Shuey, Regional Adviser in Health Systems Development, WHO Western Pacific Region, and Dr Don Matheson, Director, International Relations, Director-General’s Office, Ministry of Health, New Zealand, moderated the session. Presentations that were made available are in ANNEX 4.

2.6.1 People-centred health care: a global perspective

In his opening presentation, Dr Benedetto Saraceno, Director, Department of Mental and Substance Abuse, WHO/HQ, stated that people-centred care was a difficult concept. It has a range of terms and definitions and there is no globally accepted specific meaning. People-centred care is different from typical health care. The responsibility lies with the patient. There are patient-determined goals, there is negotiated treatment, and the patient is an active decision-maker. It is more than just an emphatic interviewing of patients; it is about reorganizing health care systems.

In many countries, patients do not feel they are receiving patient-centred care. Yet in the larger scheme of things, is this lack of patient-centred care really important? Is it a nicety or a necessity? The answer is that it depends on the nature and duration of the condition for which a person is seeking care. In the case of a short-term health care need, patient-centred health care may be a nicety, since it will probably have little impact on the health outcome. Yet, in the case of a chronic condition, patient-centred health care can impact on the health outcome, and thus it should be considered a necessity.

The world is facing a rapid rise in chronic conditions, which now account for over half the global disease burden. Health patterns for treating chronic conditions need a fundamental shift on multiple levels, i.e. individual, family and community; health practitioners; health care organizations; and health systems and policies.

At the individual, family and community level, people must be informed and prepared to self-manage their conditions. Disease education is necessary but not sufficient. Communities are essential partners. At the health practitioner level, people must be informed, motivated and prepared. The transformation of health education is also essential. The health care organization
and delivery level is where the major change should take place. There is a need for an identified care coordinator with access to multidisciplinary practitioners; information systems and communication across providers, settings and time; self-management support for patients and their families; and access optimized for patients’ convenience. At the level of health systems and policies, we need to review and modernize systems and policies to support patient-centred care, include patient and consumer participation in policy development, pass legislation to protect patients’ rights, provide financing for self-management support, and provide health professional education.

Again, does patient-centred care result in better outcomes? Studies that have introduced some of the key components of patient-centred care have shown that patient-level interventions are essential – but not sufficient – to improve outcomes. Combined, multilevel interventions have more potential than single-level interventions; and there is no silver bullet – a systems approach is necessary.

Overall, despite a widespread recent uptake of the term, many health systems are not yet patient-centred. Patient-centred care is necessary for the effective management of chronic conditions. Again, there is no silver bullet: putting people at the centre of care requires change at multiple levels of the health system. Effective interventions exist for patient-centred care, and have resulted in improved quality of life, health status and health care efficiency. Trying harder within the same system of health care will not be efficient. Changing systems of care will.

2.6.2 Promoting patient-centred health care

Ms Jo Harkness, Chief Executive Officer, International Alliance of Patients’ Organizations, stated that the mission of IAPO was to build patient-centred health care through three strategic areas. These are: realizing active partnerships with patients’ organizations; international advocacy with a strong patients’ voice on relevant aspects of health care policy; and building cross-sectoral alliances and working collaboratively with like-minded medical and health professionals, policy-makers, academics, researchers and industry representatives.

While priorities may be different across countries, there are common principles. These include: respect and support for the individual patient, their wants, preferences, values, needs and rights; choice and empowerment; patient engagement in health policy; access and support; and accurate, relevant and comprehensive information. The essence of patient-centred health care is that the health care system is designed and delivered to provide an answer for the multidimensional needs of patients.

One of the main ways in which IAPO provides assistance to its member organizations is through capacity-building. Forms of support include the Global Patients Congress, online training materials and resources, and briefing papers/toolkits on health policy issues.

In IAPO’s work, it is important that members are represented effectively. This means ensuring that IAPO leaders know their members’ situations and consult with them to develop and agree on the overall IAPO policy positions. As regards patient-centred health care, IAPO is engaged in promotion and advocacy activities through avenues such as the United Nations (in March 2007) and members’ workshops, press conferences, conferences and projects. As for patient safety, one very successful initiative has been the Patients for Patient Safety Programme under the WHO World Alliance for Patient Safety. In this regard, actions are being taken to ensure patient involvement in patient safety initiatives through regional and national workshops, and toolkits for patient champions.
We need good partnerships and well-informed patients and health care providers. In this regard, it is important to note that patients’ organizations can participate and play an important role in the process.

Overall, the best way to achieve patient-centred health care is to have an approach based on the strong values of respect, partnership and equity, and to ensure that all relevant stakeholders are engaged and supported. This includes patients’ organizations and the general public.

2.6.3 Transformation of quality in people-centred health care

Dr James Killingsworth, Managing Director, International Relations, Joint Commission International, stated that a fairly clear distinction had been drawn between patient-centred health care and people-centred health care. There appears to be a trend towards greater awareness of the importance of the broad environment of care in determining outcomes. Yet these outcomes are still clinically centred.

With respect to the health system contribution to quality in patient-centred health care, national decision-maker strategies look “inward” through six dimensions of quality to ensure that health care is:

- **effective** – adheres to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- **efficient** – delivered in a manner maximizing resource use and avoiding waste;
- **accessible** – timely, geographically accessible, and provided in a setting with skills and resources appropriate to medical needs;
- **acceptable/patient-centred** – takes into account the preferences and aspirations of individuals and the cultures of their communities;
- **equitable** – does not vary in quality according to personal characteristics (gender, race, ethnicity, geographical location or socioeconomic status); and
- **safe** – minimizes risks and harm to service users.

There is a core set of values in people-centred health care that hinges on human dignity. In particular, this relates to respect for human rights and dignity, the central role of health in any process of development, an end to all forms of discrimination, and the importance of participation and inclusion of communities in health and development. Yet in this regard we have to rethink what we mean by quality.

With a transformation of quality through the values of people-centred health care, we need to add new values, a new scope for values in health care, and new “background” capabilities and abilities in health care practice.

Quality should be defined as the effective, accessible, acceptable, efficient, equitable and safe attainment of *valued outcomes* in health care. A quality assessment is needed to clarify the new meaning of quality. This requires a list of the characteristics of people-centred health care (reduce hybridization), clarifying outcomes for the characteristics of the list (priority), practical and functional versions of human dignity priorities on the list, and newly assessed quality (use the result).
Core values of people-centred health care mandate a new approach for quality. It will incorporate but not hybridize. Also, it will require careful analysis, reflection and study. Transformed “quality” assessment will prove essential to harmonization through people-centred health care. Finally, the process will pass through the emergence of a new background for quality in clinical practice and public health.

2.6.4 Patient safety

Sir Liam Donaldson, Chief Medical Officer, Department of Health, National Health Service, United Kingdom, and Chairperson, World Alliance for Patient Safety, introduced examples of medical errors. He stressed how such patient experiences could act as a conscience, catalyst, witness, compass and teacher for health care professionals. In contrast, the mirror image is the health care professionals’ reaction to these experiences. In that regard, they should take care to follow, reflect, listen, act and learn.

In the future, we want to move from awaiting risks to anticipating risks, from seeing incidents not as one-off events but from the perspective of a common cause. We want to move from punishment to re-skilling, from individualism to teamwork, from covering up mistakes to sharing experiences. We also want to move from defensiveness and withholding information to apologizing, seeking the truth and sharing it.

2.7 Open forum

Dr Youngson informed the group that in New Zealand he was advocating the addition of “the right to compassion” to the Code of Patients’ Rights.

Dr Killingsworth replied that it was often easier to recognize the exception than the norm. Yet he said that, whichever route was taken, there were legitimate concerns such as the need to have measures to be used for making comparisons. Performance pay is a very popular concept now, but it is extremely difficult to execute. If we as a group move ahead to encapsulate quality, we must recognize the limits of measurement.

Mr Hani Serag of the People's Health Movement said that if people were to be at the centre, then we had to define who was to be moved from the centre. We also need to know who is going to finance the paradigm shift. He stated that some issues had been missed, e.g. access to medical care, in making people at the centre of the health system. In addition, he stated that WHO now had three initiatives that were all interrelated. The fear is that they may dilute one another if care is not taken to ensure linkages. Finally, with performance pay, it is characteristic for the entire health system to be involved, and in many systems, doctors are being paid to disqualify patients’ claims for health insurance.

Ms Harkness stated that the shift in focus from technology and diseases to patients would not displace people. In moving from patient- to people-centred health care, we must be careful not to affect patients’ interests.

Dr Killingsworth commented that until we arrived at the basic meanings and worked out the definitions, we were going to have to press for people-centred health care. Later, we can look at this question from an economic perspective. Yet, if we put people at the centre, expenditures of time, human resources and costs would actually be lower. If we put people at the centre, we will have new issues, but possibly fewer costs.
Sir Liam pointed out that the three WHO programmes all had specific focuses. The important message is that all of the programmes are trying to achieve positive change and galvanize action at the international level.

Dr Saraceno agreed with Sir Liam. He added that each of the three programmes had its own *raison d'être* and there was no risk of any dilution between them.

Dr Joachim Sturmberg from Australia said that in talking about the health care system, we must really keep the focus on health.

On the issue of how we are going to know if we have made progress, Sir Liam stated that the question of measurement was very important and needed to be looked at in a fuller way than in the past. It is very difficult to construct system-level measures to assess change over a long period of time when they are disaggregated to the individual clinical team. There must be some mechanism to let teams know of their progress, but this is difficult at the national level. One thing that can be done is proxy measurement. There is also a deeper level of measurement that we need to explore.

Ms Harkness agreed that measurement was very important and said that IAPO, as a young organization, was making efforts in this regard.

Dr Milan agreed that measurements were very challenging. As regards the policy framework, WHO has been asked to work with experts on formulating measures and standards and providing guidance to Member States in planning, monitoring and evaluation. WHO does not lay claim to knowing all things; in fact, the reason for the conference was to attract good minds to discuss the topic. Dr Omi, she continued, had agreed to host a meeting on this very topic.

Dr Matheson stated that the question on measurement was symptomatic of global society having a rethink. This, however, presents an opportunity. What are the shared values across these rethinks? He did not think it was a bad thing that a lot of rethinking was going on.

### 2.8 Group discussions

The participants split into three groups to discuss specific, assigned topics.

Group A reviewed and suggested enhancements to the draft declaration. Group B tackled possible immediate actions to take the work forward, and Group C brainstormed on the opportunities for advancing the initiative in 2008–2009.

The composition of the breakout groups and the results of the discussions are attached as ANNEX 5.

### 2.9 Japanese session

A simultaneous afternoon session was conducted in the Japanese language, with more than 500 participants in attendance. The public forum was a collaborative undertaking between the Japanese Ministry of Health, Labour and Welfare and the Japanese Society for Quality and Safety in Healthcare (JSQSH).

In contrast to the English session that tackled international action to promote people-centred health care, the public forum in Japanese focused on national action to operationalize
people-centred health care. The discussion included patient safety, which is an important challenge faced by the health system in Japan.

Prior to the forum, JSQSH had organized an awards ceremony for outstanding patient-centred activities in three categories: patients, medical staff/settings and communities. Among 90 contenders, the following were declared winners: activities at the "Cancer Salon" in Shimane Prefecture; Patient Support Room at Shin-Katsushika Hospital in Tokyo; and NGO Community Care Link Tokyo. The experiences of the winners and of some finalists were highlighted in the presentations during the first part of the afternoon session in Japanese.

The speakers represented various stakeholders – policy-makers in government, academe, journalists and patient advocates, among others. The importance of stakeholder participation and involvement in ensuring patient safety and in sustaining health programmes and interventions was highlighted. For instance, the united action of self-help patient groups contributed to the enactment of the basic law on cancer in 2006. A community in which end-stage cancer patients can live with dignity can be built with collaboration and partnership of different groups in and outside the government sector. Also, the practice of patient advocates in the United States of America was cited as a good example from which Japan could learn. In Japan, communication between medical staff and patients is difficult and medical information is not readily available or understandable to patients. The occasion thus provided a venue for the recognition, dissemination and further adoption of "best practice" in making health care in Japan more holistic and responsive to the needs of the population.

A panel discussion on partnership for patient-centred care ensued. Panellists included key leaders in Japanese health care and other invited speakers who shared their rich experience and lessons learnt with their Japanese colleagues in the health field. Key ideas and lessons included the use of a multidisciplinary approach to assure quality and safety in health care, and open communication between patients and medical/health staff. They also included the establishment of patient and family advisory councils. One panellist appealed for positive change in people, because "when people change, health care changes”.

In addition, to lend an exciting backdrop to the symposium and utilize a powerful advocacy tool, JSQSH mounted an exhibition called "Striving for People-Centred Health Care". Sixty groups and organizations participated, including NGOs, civic groups and companies offering health-related products and services.

2.10 Closing session

Dr Milan stated that WHO was happy to have provided a forum for experts and health stakeholders to tackle the issue of people-centred health care. This is a paradigm shift that no one government or organization can achieve alone, but with all working together, change can happen. Finally, she explained that the draft declaration would continue to be refined to incorporate not only the input and comments of the participants, but also feedback and suggestions from other interested parties.

In his concluding remarks, Dr Omi noted that due to the strong efforts and progress of WHO Member States in the Region on “hard” health issues, “soft” issues such as patient safety and patient satisfaction could finally be tackled. The fact that a topic completely disregarded as a priority 20 years ago is now being pursued speaks highly of the job being done in health care provision in the Region. Dr Omi then expressed his appreciation to the delegates for attending this important forum. The next action, he concluded, would be to bring the respective countries’ wisdom together and make further progress on the people-centred approach to health care and on the desired paradigm shift in health systems.
3. CONCLUSIONS

Overall, the participants in the symposium indicated the following observations, conclusions and suggestions:

(1) The symposium was a welcome forum that enabled health stakeholder groups to share experiences and perspectives, to engage in meaningful dialogue and to understand and appreciate the need for reorienting health systems towards people-centred health care.

(2) Although there is much diversity across countries and cultures around the globe, health care that is accessible, safe, holistic, people-centred and of high quality is a shared goal, which is underpinned by universally recognized values and principles.

(3) The WHO definition of health in its fullest sense calls for greater focus on the broader psychosocial and cultural determinants of health, on harmonizing mind and body as well as people and systems within the health sector and between health and other sectors.

(4) It is important to emphasize a multi-stakeholder and intersectoral approach to the paradigm shift that spans the four policy domains in a culture change that must occur at all levels – a transformation in thinking and in doing among individuals, organizations and systems.

(5) Measurement is essential to track and ensure progress and to get successful initiatives going in sustainable ways. WHO needs to work with experts in developing indicators, standards and monitoring and evaluation tools, as well as in providing guidance and help to Member States.

(6) Further work is needed to hasten the adoption of the people-centred approach to health care. WHO needs to sustain the momentum and continue the dialogue and consultation with partners and stakeholders, taking advantage of various global and regional forums in the near future and achieving synergy with other similar initiatives.

(7) Priority actions to spread the movement for people-centred health care could include: convening a task force to ensure that the initiative will go in the intended direction, strengthening the knowledge and evidence base, working closely with countries and health-related organizations, and undertaking political and social mobilization.

WHO indicated that the participants' collective wisdom and input would be taken into consideration in planning follow-up actions and in collaborating closely with Member States and other partners and stakeholders in future work.
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ANNEX 2

The International Symposium on
PEOPLE-CENTRED HEALTH CARE:
REORIENTING HEALTH SYSTEMS IN THE 21ST CENTURY
The Tokyo International Forum
25 November 2007

PROGRAMME

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00</td>
<td>Registration</td>
</tr>
<tr>
<td>08:30</td>
<td>SESSION 1: OPENING CEREMONY (VENUE: B7)</td>
</tr>
</tbody>
</table>
| 08:30 | Welcome remarks: | Dr Linda Milan  
|       | Director, Building Healthy Communities and Populations, WHO Western Pacific Region |
|       | Dr Fumimaro Takaku  
|       | Board Chairperson, Japanese Society for Quality and Safety in Healthcare |
|       | Messages: | Ms Jo Harkness  
|       | Chief Executive Officer, International Alliance of Patients’ Organizations |
|       | Dr Yoshihito Karasawa  
|       | President, Japan Medical Association |
|       | Honourable Yoichi Masuzoe  
|       | Minister of Health, Labour and Welfare, Government of Japan |
| 09:05 | Keynote speech: | Dr Shigeru Omi  
|       | WHO Regional Director for the Western Pacific |
| 09:20 | SESSION 2: PLENARY SESSION (VENUE: B7) |
| 09:20 | Plenary presentations |
| 10:00 | TEA BREAK |
| 10:20 | Plenary presentations |
| 11:00 | Panel discussion |
| 11:30 | Declaration on People-centred Health Care |
| 12:00 | Special address: | Honourable Masahiko Koumura  
|       | Minister of Foreign Affairs, Government of Japan |
| 12:30 | LUNCH BREAK |
SESSION 3: FROM SLOGAN TO ACTION: THE WAY FORWARD

PUBLIC FORUM: NATIONAL ACTION TO OPERATIONALIZE PEOPLE-CENTRED HEALTH CARE, INCLUDING PATIENT SAFETY
VENUE: B7 (Language: Japanese)


13:50 Opening remarks
Ministry of Health, Labour and Welfare, Government of Japan
The President of the 2nd Annual Meeting of JQSQSH

14:00 Presentations

The Initiatives of patients, health care providers and communities for people-centred health care
Yasuyuki Sahara, Ministry of Health, Labour and Welfare, Government of Japan
Prof. Kazushige Maruki, International University of Health and Welfare Graduate School

The Initiatives of patients and patients' families
Mayumi Honda, Journalist, Yomiuri Shimbun Newspaper

The Initiatives of health care providers and health care organizations
Sawako Okamoto, Former Patient Advocate, Johns Hopkins Hospital

The Initiatives of communities and local governments
Akira Maemura, Journalist, Nikkei Newspaper

INTERNATIONAL ACTION TO PROMOTE PEOPLE-CENTRED HEALTH CARE
VENUE: B5 (Language: English)

Lead: World Health Organization, Western Pacific Region

Moderators:
Dr Dean Shuey
Regional Adviser, Health Systems Development, WHO Western Pacific Region
Dr Don Matheson
Director, International Relations, Director-General's Office, Ministry of Health, New Zealand

13:30 Introduction to the Session

Speakers:
Dr Benedetto Saraceno
Director, Department of Mental Health and Substance Abuse and Director of, Department of Chronic Diseases and Health Promotion, WHO/HQ

Ms Jo Harkness
Chief Executive Officer
International Alliance of Patients' Organizations

Dr James Killingsworth
Managing Director, International Relations
Joint Commission International

Sir Liam Donaldson
Chief Medical Officer, Department of Health, National Health Service, United Kingdom and Chairperson, World Alliance for Patient Safety

15:20 RRAK

15:30 Panel discussion: Partnership for patient-centred health care

Moderators:
Shigekoto Kaihara, Dean, International University of Health and Welfare Graduate School
Keiko Yamauchi, Partnership Program's Representative, JQSQSH

Panelists:
Deborah E. Hoffman, Center for Patients and Families, Dana-Farber Cancer Institute
Hiroshi Fujii, Head, Medical Consultation Department, Shimonoseki City
Masaharu Ito, President, All Japan Federation of Social Insurance Associations
Dr Haruko Akatsu Kuffner, Assistant Professor of Medicine, Division of Endocrinology and Metabolism, University of Pittsburgh
Katsumi Ohira, Director, Social Welfare Corporation Habataki Welfare Project

Awardees, Representatives

15:30 The Next Steps
(Break out sessions)

Facilitators:
Prof. Vivian Lin, School of Public Health, La Trobe University, Australia
Dr Susan Mercado, Programme Coordinator, Cities and Health Programme, WHO Centre for Health Development, Kobe, Japan

16:40 Plenary Session
(Summary of discussions)

17:00 CLOSING
THEMATIC POWERPOINT PRESENTATIONS

Informed and empowered individuals, families and communities
Angela Coulter

People-Centred Health Care: Competent and Responsive Health Practitioners
Alejandro Dizon

Effective and benevolent health care organizations
Robin Youngson

Patient-Centered Healthcare: Supportive Health Systems
Chang-yup Kim
Realigning health policy

Role of patients, families, communities in promoting health

- Understanding factors that influence health
- Self-diagnosis and treatment of minor illness
- Selecting treatment for acute conditions
- Monitoring symptoms and treatment effects
- Being aware of safety issues
- Managing symptoms of chronic disease
- Feeding back views on quality of services
- Adopting healthy behaviours

What works and what can be done?

- Supporting self-care
- Sharing treatment decisions
- Building health literacy
- Improving responsiveness
- Promoting health

Self care: what is it?

- “Self care is all that people do to maintain their health, prevent illness, seek treatment or support, manage symptoms of illness and side effects of treatment, accomplish recovery and rehabilitation and manage the impact of chronic illness and disability on their lives and independence.”

Alliance for Self Care Research
Self-care

- Health behaviours
- Interpreting symptoms
- Monitoring illness
- When to consult
- Self-medication
- Prescribed medicines
- Coping with long-term conditions

Self-care: what works?

- Self-management guidelines
- Lay-led self-management education
- Professionally-led self-management education
- Computer-based interactive applications
- Telephone coaching and support
- Access to personal medical records
- Self-monitoring, self-treatment
- Self-help and community support

Improving treatment decisions

- Review benefits, harms and uncertainties
- Explore role preference
- Clarify values
- Make a decision
- Plan next steps

Shared decision-making: what is it?

- A process in which patients are involved as active partners with the clinician in clarifying acceptable medical options and choosing a preferred course of action.

Sheridan et al 2004

Sharing decisions

- Review benefits, harms and uncertainties
- Explore role preference
- Clarify values
- Make a decision
- Plan next steps

Shared decision-making: what works?

- Communication skills training for professionals
- Coaching for patients
- Question prompts
- Diaries and topic lists
- Consultation summaries and recording
- Patient decision aids
Health literacy

- Basic health knowledge
- Reading, comprehending and evaluating health information
- Application of health preventing, promoting and self-care behaviours
- Verbal communication with health professionals
- Health decision-making
- Health advocacy and activism

Health literacy: what works?

- Written information
- Websites and portals
- Interactive digital television
- Mobile phone text messages
- Audio and video tape
- Targeted low literacy interventions
- Mass media campaigns

Responsiveness

- Respect for persons
  - Dignity
  - Confidentiality
  - Autonomy
- Client orientation
  - Prompt attention
  - High quality amenities
  - Access to social support
  - Choice of provider

WHO World Health Report 2000

Responsiveness: what is it?

Responsiveness: what works?

- Patient participation groups
- Lay representation
- Public meetings
- Citizen’s juries
- Patient and population surveys
- Focus groups
- Patients’ panels
- Consensus conferences
A whole system approach

Macro:
- Patients' rights and charters
- Organisational regulation
- Professional regulation
- Health information and websites

Meso:
- Patient participation groups
- Consultations, citizen's juries
- Patients' rights
- Public involvement

Micro:
- Communication skills training
- Self-care education and support
- Aids to engagement
- Community initiatives

Supporting self-care
Improving treatment decisions
Promoting health
Building health literacy
The International Symposium:

**People-Centred Health Care: Competent and Responsive Health Practitioners**

Alejandro C. Dizon, MD, FPCS, FACS

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**Trends in Health Care**

New knowledge / Research / Advanced Technology

- Disease - focused
- Physician - centered

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**“Defensive” Medicine:**
- Highly dependent on technology
- Lab results were treated and not the patient
- Protect the physician
- Response to litigation
- Over used and over-indicated
- Made health care expensive

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**Specialization:**
- Traditional system of perfection
- Errors and mistakes are unacceptable
- Complex care
- Fragmented care
- Patient was “lost” in the system

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**“To do no harm....”**

Institute of Medicine (1999):

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**Quality and Patient Safety**

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**Patient-centred Care**

- Disease-focused
- Patient-centred
- Culture of Safety

**Patient-centred care**

- Needs as a patient
- Needs as a person:
  - Values
  - Expectations
  - Preferences
  - Capacities
  - Over-all well-being

**AGENDA**

Key policies and action domain:
- Individuals, families & communities
- Health practitioners
- Health care organizations
- Health systems

**Health care practitioners**

- Physicians
- Nurses
- Paramedical clinical support - Medical/Radiation/technicians, clinical pharmacists/Staff
- Educators
- Leaders

**Physicians**

Competence:
- Verification of credentials from source
- Privileging
- Continuing Medical Education activities - outside or in house

**Physicians**

Standardization of care:
- Protocols and CPG's
- Monitor outcomes

Quality and Patient Safety:
- Prevent harm proactively
- 3 C's: communicate, coordinate, collaborate
- Surface and learn from errors
Physicians

- Continuity of care beyond the hospital
- Health maintenance and disease prevention

Wellness and Prevention:

- Address the non-medical but equally important needs of the patient:
  - Family and friends
  - Traditions and customs
  - Religion and beliefs
  - Cultural preferences

Music Therapy Program

Senior Arts & Music Wellness Program

Supportive Care:
- Spiritual visits & consultations
- Psychiatric support
- Referral to lay support groups
Nurses

• Spends the most time with the patient
• Front liner in care and defense against harm
• Provide bedside, compassionate care
• Quality of care delivery likewise affected by complex care

Manpower shortage:
• Global problem with aging population
• Philippines: Migration of Health Care Workers

85 percent of all Filipino nurses (estimate = 163,756 nurses) are working outside the Philippines in at least 46 countries. (Consega, et al 2003)

Of all data that were accounted for, at least 100,000 nurses left the country in the last 10 years – the highest volume in Philippine history. (POEA, 2004)

Migration:
• In urban centers: numbers and nurse:patient ratio maintained
• Expertise suffers
• Average = 2 years stay

Clinical Pharmacists

• One CP for every nursing floor for 2 shifts
• Provide complimentary patient care to the nurses
• Monitor: medication orders, ordering, dispensing, administration, prescription, reconciliation, interaction and education
• Collect and collate data on medication safety
• Unburdens the nurses for bedside nursing duties

Medication Safety Programs

• HAM (High Alert Medications): Medications that bear a heightened risk of causing significant patient harm when used in error
• SALAD (“Sound-Alike, Look-Alike Drugs”)
• BANDEM (“Banned Items”)
• PIH (Physician’s Illegible Handwriting)

You can prevent a fatal error… by doing the “write” thing
Philippine Medical Education - American System
- Medical School
- Postgraduate Internship
- Residency
- Fellowship

Traditional System:
- Disease - oriented
- “Read one - See one - Do one” model
- “Blame and Train” approach

New approaches to education & teaching:
- Addresses quality and safety
- Emphasizes systems rather than human factors for errors
- Realization of the non-medical needs of the patient
- Models:
  - Simulated or situational training
  - Error training and prevention
  - “Training on not only “how to do things but also how not to do things”

Quality of life of trainees:
- Reduced work hours
- Lessen fatigue factor
- More time for personal things

Clinical Head:
- Ensure competence of staff
- Timely care provided
- Monitor performance & outcomes
- Celebrate and share success and good outcomes with the organization

• Management courses
Leaders

Engage the patient:

St. Luke’s Medical Center

• Established in 1903
• 650-bed private, non-stock, non-profit medical center
• Tertiary hospital; Major referral center
• Academic - Teaching facility
• 1,700 physicians
• 2,600 associates

Doctor for the People

Summary

“Patients do not care how much you know until they know how much you care!”

Gerard Healy, MD, FACS
Incoming President
American College of Surgeons

People-centred care

Harmony of Mind and body, people and systems
Effective and benevolent health care organisations

Dr Robin Youngson
Auckland, New Zealand

A traditional Maori greeting from the first peoples of Aotearoa, New Zealand...
Acknowledging the land, the people, the spirits of the departed, us the survivors, the many leaders and important people gathered here today, and your heartfelt support for uplifting the philosophy and purpose of this symposium.

Health care organisations are a mirror.
The experience of people and their families seeking care is a reflection of how the organisation treats its own employees.

Putting People at the centre of health care requires a paradigm shift for health practitioners: away from the biomedical, disease oriented and technically driven model of care towards a more holistic approach that validates the cultural, psychosocial and environmental determinants of health and wellbeing.

No less a paradigm shift is required for us as the managers and leaders of health care organisations.

Execute
Implement
Strategic plan
Triage
Workforce
Manpower
Workload
Input
Output

• Bullet points!
Just as we need an holistic approach to the health and wellbeing of people we need also to treat health care organisations as living entities that have a mind, body and spirit.

"Te whare tapa wha" the four cornerstones of Maori health:
- "Taha tinana" (physical)
- "Taha hinengaro" (mental)
- "Taha whanau" (social/emotional)
- "Taha wairua" (spiritual)

Complexity of human dynamics, focus on meaning and relationships as much as structure

Machine thinking, command and control mechanisms

Leading ‘adaptive’ change that requires a shift in values, beliefs and behaviours

Technical problem solving and use of authority to direct resources

* "Leadership without easy answers" Ron Heifetz

Being of service to individuals, families and communities

Providing a service
Empathic support, apology and open disclosure

Detachment and defensiveness

Paradigm shift

Stewardship (stakeholder value)

Management (shareholder value)

Paradigm shift

Organisational capability

Individual competence

Paradigm shift

Healing environment

Clinical facilities

Paradigm shift

A story about putting the warmth of the human spirit into the cold walls of the hospital

As a hospital specialist, I hold the lives of patients in my hand. I trained for 14 years. I am held accountable for my competence and my professional behaviour.
As health care leaders and managers we hold the lives of whole populations in our hands.

How many years of training?
What qualifications?
What ethical standards?
How are we held accountable for our competence and professional behaviour?

To meet the complexity of the challenge of putting people at the centre of health care, the management and leadership of health care organisations must evolve to become a prestigious health profession, requiring the highest qualifications and the most exacting ethical standards.

Perhaps the single most important attribute is that leadership training is provided in a cross-cultural setting.

The WHO might be in the ideal position to work with diverse nations to sponsor the development of international colleges of health leadership and management. It starts here, today, with us.

He aha te mea nui o te Ao?
He tangata, he tangata, he tangata
(Maori proverb)

What is the greatest thing in the world? It’s the people, the people, the people
What Is a Health System

All the activities whose primary purpose is to promote, restore or maintain health

(WHO, 2000)

Goals of a Health System

- Good health
- Responsiveness to the expectations of the population
- Fairness of financial contribution

Health System Goals

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DISTRIBUTION</th>
<th>Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td></td>
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<tr>
<td>Responsiveness</td>
<td></td>
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<tr>
<td>Fairness in Financial Contribution</td>
<td></td>
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<tr>
<td>Quality</td>
<td>Equity</td>
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</tbody>
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Patient-Centered Healthcare: Supportive Health Systems

Chang-yup Kim, MD, PhD, MPH

Health Insurance Review & Assessment Service, Republic of Korea
Seoul National University School of Public Health

* The opinions expressed in this presentation are those of the author and not necessarily the views of the affiliated institutions.
Functions of a Health System

- Service provision
- Resource generation
- Financing
- Stewardship

Relationship between Functions and Objectives of a Health System

Structure and Functional Relationship of a National Health System

Major Components of a National Health System Infrastructure

Goals and Functions: Components of Responsiveness

- Respect for persons
  - Dignity
  - Confidentiality
  - Autonomy
  - Communication

- Client Orientation
  - Prompt attention
  - Access to social support networks
  - Quality of basic amenities
  - Choice of provider

Core Elements of People-Centered Healthcare

- Access and Equity
- Respect
- Information Sharing
- Participation
- Coordination
Strategies for Patient Centered Healthcare

- Public reporting
- Pay for performance
- Shared-decision making
- Support for care coordination function
- Diffusion of IT with patient engagement

(Davis, 2006)

Strategies for Patient Centered Healthcare

- Ensuring access and equity
- Standards for competence and accountability
- Community-based participation
- Values-based leadership

(WHO, 2007)

Supportive Financing and Resources

- Access and equity
- Basis for primary (health) care

Policy as Determinant of Equitable Health

Access to Healthcare

Why Not General Practice

Perceived barrier in healthcare utilization

Unfavorable conditions
- For Academic career
- Lower income and status
- Others

(Korean Trainee Survey, 1999)
Quality-Sensitive Providers

- Standards and Guideline
- Accreditation/Certification
- Payment
- Report card

Mean Scores for Clinical Quality

Report Card: Web-based Public Information System for Antibiotics Prescription Rates

Supportive Information System

- Shared decision making
- Patient-provider communication
- Personal health records
- Borderless integration of patient information
**Initiatives of Sundhed.dk**

- Infrastructure
  - Standardization
  - Health Data Network
  - Security
- Electronic Patient Records
- Telemedicine
- Cross-sectorial communication
- Shared care

**Concluding Remarks**

- Unfavorable conditions
  - Medicalization
  - Specialization
  - Privatization
- Multi-dimensional strategies
- People-centered health system
PRESENTATIONS

(Afternoon Session in the English Language)

Person-centred care: a global perspective
Benedetto Saraceno

Promoting patient-centred healthcare
Jo Harkness

Transformation of Quality in People-Centred Health Care
James Killingsworth
Person-centred care: a global perspective
Dr Benedetto Saraceno
Director Department of Mental Health and Substance Abuse

Person-centred care defined
- Range of terms and definitions
  - “Biopsychosocial care”
  - “Culture of communication”
  - “Care that is responsive to patients’ needs, wants, preferences”
  - “Patient provider partnership”
  - “Shared decision-making and responsibility”
  - “Patient empowerment”
- No globally-accepted specific meaning

Typical vs. person-centred care

Typical care
- Responsibility FOR patients
- Provider-determined goals
- Provider-determined treatment
- Patient is passive recipient

Person-centred care
- Responsibility TO patients
- Patient-determined goals
- Negotiated treatment
- Patient is active decision-maker

“Patient-centred care is more than just empathic interviewing of patients, it is about re-organising healthcare systems ...”
Baumann AE et al., MJA 2003: 179:253-256

Health systems are not person-centred

Across five countries and almost 4,000 patients:
- “My regular doctor or health professional DOES NOT ...”
- make clear specific treatment goals (20-38%)
- help me understand what needs to be done for my health (12-29%)
- ask for my ideas or opinions about treatment (47-87%)
- keep me motivated (28-42%)
- provide advice on weight, nutrition, exercise, smoking, drinking (33-49%)
- discuss the emotional burden of the condition (81-68%)

Nicety or Necessity?

It depends ...

Person-centred care requires multi-level change
- Individual/family/community
- Health practitioners
- Health care organizations
- Health systems and policies
**Individuals/families/communities**
- Informed, motivated and prepared
- Disease education necessary but not sufficient
- Communities are essential partners

**Health practitioners**
- Must also be informed, motivated, and prepared
- Transformation of health education transformation is essential

**Health care organization and delivery**
- Identified care coordinator with access to multidisciplinary practitioners
- Information systems and communication across providers, settings, time
- Self management support for patients/families
- Access optimized for patients’ convenience

**Health systems and policies**
- Review and modernization of health systems and policies to support patient-centred care
- Patient/consumer participation in policy development
- Legislation to protect patients’ rights
- Financing for self-management support
- Health professional education

**Nicety or Necessity?**
Does patient-centred care result in better outcomes?

**What does the evidence say?**
- Patient-level interventions essential – but not sufficient – to improve outcomes
- Combined, multi-level interventions more potent than single-level interventions
- No silver bullet → systems approach is necessary
Summary

- Despite widespread recent uptake of the term, many health systems are not yet patient-centred.
- Patient-centred care is necessary for effective management of chronic conditions.
- There is no silver bullet: putting people at the centre of care requires change at multiple levels of the health system.
- Effective interventions exist for patient-centred care, and have resulted in improved quality of life, health status, and health care efficiency.

“Trying harder will not work. Changing systems of care will.”

Crossing the Quality Chasm, Institute of Medicine, 2001
Promoting patient-centred healthcare around the world

Jo Harkness, Chief Executive Officer, IAPO

25 November 2007
Tokyo, Japan

Content of Presentation

• IAPO’s approach to promoting patient-centred healthcare
• Principles of patient-centred healthcare
• Activities to promote patient-centred healthcare

IAPO’s helps build patient-centred healthcare worldwide by:

1. Realizing active partnerships with patients’ organizations, maximizing their impact through capacity building
2. Advocating internationally with a strong patients’ voice on relevant aspects of healthcare policy
3. Building cross-sector alliances and working collaboratively with like-minded medical and health professionals, policy makers, academics, researchers and industry representatives

IAPO’s Membership

• 200 member organizations
• Membership spans 40 countries and all world regions
• Representing an estimating 365 million patients

Global issues for patients’ organizations:
Cross border and cross disease issues

• The massive issues of access to treatment and care
• Lack of meaningful patient involvement in health policy decision-making
• The need for an international concerted effort to address patient safety
• The need for quality health information and communication

Patient-Centred Healthcare Principles

• Respect and support for the individual patient, their wants, preferences, values, needs and rights
• Choice and empowerment
• Patient engagement in health policy
(See www.patientsorganizations.org/involvement)
• Access and support
• Information that is accurate, relevant and comprehensive
(See www.patientsorganizations.org/healthliteracy)

The essence of patient-centred healthcare is that the healthcare system is designed and delivered so that it can answer the needs of patients
IAPO provides a range of capacity building support to its members including:

- Online training materials and resources
- Briefing papers/toolkits on health policy issues

Promoting patient-centred healthcare around the world

**Policy and Advocacy**

- **Patient-Centred Healthcare**
  - Promotion of Patient-Centred Healthcare
  - Meeting at the United Nations, March 2007
  - Member workshops, press conferences, conferences, projects etc
- **Patient Safety – WHO World Alliance for Patient Safety**
  - Ensuring patient involvement in patient safety initiatives
  - Regional and National Workshops
  - Toolkits for Patient Champions

**Cross-Sector Alliances**

- Cross-sector alliances are crucial to improving healthcare for patients. IAPO works to build relationships with committed like-minded stakeholders.
  - No patient-centred care without cooperation
- Improved communication needs well-informed patients, health care professionals and other health care partners.

**Conclusion**

The best way to achieve patient-centred healthcare is to have an approach based on strong values of respect, partnership and equity and to ensure that all relevant stakeholders are engaged and supported including patients and patients’ organizations and the general public.

**Contact us**

Please visit our website to find out more: [www.patientsorganizations.org](http://www.patientsorganizations.org)

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Transformation of Quality in People-Centered Health Care

World Health Organization International Symposium on People-Centered Health Care
Tokyo, Japan
November 25, 2007

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Managing Director, International Relations
Joint Commission International

Quality orientation in standards for patient-centered medicine: some examples

- Outward look in patient care management, Kaiser Permanente (1947)
- JCI Hospital Standards, 3rd edition, (July, 2007)

Quality orientation in standards for patient-centered medicine: some examples

Selected Standards Area
- Outward "Look"
- Environmental and Patient Safety Goals
- Infection and Sexual Health Promotion
- Prevention and Control of Infections
- Supportive Services: Health and Community Resources
- Tobacco Substances and Smoking Prevention

Core Measure Set Definition

- A unique grouping of performance measures carefully selected to provide, when viewed together, a robust picture of the care provided.

Current Joint Commission Core Measure Requirements

- Standardized core measure sets
  - Acute myocardial infarction (9 measures)
  - Heart failure (4 measures)
  - Pneumonia (7 measures)
  - Surgical Care Improvement Project (5 measures)
  - Pregnancy and related conditions (3)
  - Children’s asthma care (3)
- Data collection required on 3 full measure sets
  - Some exceptions for small and specialty hospitals
- More than 3,800 hospitals collecting data
  - Monthly data transmitted quarterly to the Joint Commission
Core Measure Set
(Includes 4-10 Well-Tested, Evidence-Based Measures)

A = Initial set
B = Initial set
C = Initial set
D = Initial set
E = Initial set
F = Future measure
G = Future measure

Health System contribution to Quality in patient-centered health care
National decision-maker strategies (a look “inward”) through six dimensions of quality to ensure that health care is:

- Effective—adheres to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- Efficient—delivered in a manner maximizing resource use/avoids waste;
- Accessible—timely, geographically reasonable, and provided in a setting with skills and resources appropriate to medical needs;
- Acceptable/patient centered—takes into account preferences and aspirations of individuals and the cultures of their communities;
- Equitable—does not vary in quality due to personal characteristics (gender, race, ethnicity, geographical location, or socioeconomic status);
- Safe—minimizes risks and harm to service users.

Core Values of People-Centered Health Care—Human Dignity in Health

1) Respect for human rights and dignity
2) Central role of health in any process of development,
3) End to all forms of discrimination
4) Importance of participation and inclusion of communities in health and development

Transformation of Quality by the Values of People-Centered Health Care
- Additional/new values
- New scope for values in health care
- New “background” capabilities and abilities in health care practice

Quality transformation

Quality—“The effective, accessible, acceptable, efficient, equitable, and safe attainment of valued outcomes in health care”

Human dignity: rights, development, discrimination and community

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

Quality assessment—clarifying the new meaning of “quality”

- List characteristics of people-centered health care—reduce hybridization.
- Clarify “outcomes” for the characteristics of the list—priority
- Practical and functional versions of human dignity priorities on the list
- Newly assess quality—use the result
Transformation of “Quality”

- Infection control example:
  - Human rights
  - Human dignity
  - Participation of communities
  - Demonstration of non-discriminatory features
  - Contributions to health and development

Transformation of “Quality”

- Additional quality metrics:
  - Not re-named quality performance from patient-centered health care
  - Suited to inclusive scope (communities)
  - New profiles—contributions to development, removal of discriminatory practices

Heart Failure: Rate-Based/Proportion Measures

- Assessment of LV function
- ACE inhibitor for LV dysfunction
- Smoking-cessation counseling
- Discharge Instructions

Heart Failure Measure Set

Distribution of 2004 Hospital Summary Rates

Conclusions

- Core values of People-Centered Health Care mandate a new approach for quality
- It will incorporate but not hybridize
- It will require careful analysis, reflection and study
- Transformed “quality” assessment will prove essential to harmonization through People-Centered Health Care
- The road will pass through emergence of a new “background” for quality in clinical practice and public health
BREAKOUT GROUPS

AND

OUTPUTS OF THE GROUP DISCUSSIONS
**International Symposium on People-Centred Health Care:**  
**Reorienting health systems in the 21st century**  
25 November 2007  
Tokyo, Japan

**Breakout groups**

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DECLARATION ON PEOPLE-CENTRED HEALTH CARE

HEALTH FOR ALL, BY ALL

We reaffirm health in its fullest sense as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”;

We appreciate the significance of social determinants of health - psychosocial, spiritual, cultural, political, and economic - that impact health care outcomes, health status and overall well-being;

We acknowledge the need for health care approaches and health systems that harmonize mind and body, as well as people and their environment;

We recognize that achieving this harmony entails genuine transformation of current health care systems and the culture of health care towards a people-centred focus;

We value the relevance of a people-centred and rights-based approach to health and health care, for health systems at all stages of development;

We uphold the need to ensure that health policies lead to improvements in the quality of health care and that they take into account issues of human dignity, people’s rights and needs, and the role of family, culture and society;

We affirm that transforming health systems effectively and sustainably necessitates adequate and equitable health care financing, as well as multisectoral participation and commitment by relevant constituencies and stakeholders, especially patients, families and communities, at global, national and local levels;

We believe that partnering with individuals, families and communities served by the health system is essential to creating transformational change in health care
organizations, the education of health professionals and the design of research, evaluation and systems of measurement;

We acknowledge that various international and regional covenants, declarations and agreements uphold and promote values and principles that underpin people-centred health care, including access, safety, quality in content and in process, affordability and satisfaction.

We concur on the following strategies for reorienting health systems towards people-centred health care:

- Creating supportive environments for reorienting health care systems towards respecting, protecting and fulfilling the right to safe and quality health care;

- Advocating the development of health policies and programmes that ensure the provision of effective, holistic/comprehensive (?), equitable (?) and people-centred health care;

- Reinforcing the culture of caring, communicating and healing in the context of broader psychological, cultural and social determinants of health; and

- Engaging, empowering and enhancing the capacity of all health stakeholders to pursue the attainment by all peoples of the highest possible level of health;

We envision the equitable, optimal, consistent and sustainable delivery of people-centred health care in the 21st century, driven by:

- Informed and empowered individuals, families and communities;

- Competent and responsive health practitioners;

- Efficient and benevolent/just (?) health care organizations; and

- Supportive and humanitarian health systems.

We commit to work together to ensure that people are at the centre, as shapers and as partakers of people-centred health care, through meaningful participation in designing and developing health systems, and in creating and implementing health care policies and practices, in all settings and at every opportunity.

November 25, 2007
Tokyo International Forum
International Symposium on People-Centred Health Care:
Reorienting health systems in the 21st century
25 November 2007
Tokyo, Japan

Output of Group B

Facilitator: Vivian Lin
Rapporteur: Kathy Fritsch

Things to do the following week to move things forward:

- Association of Medical Education in the Western Pacific – provide relevant feedback and update in forthcoming meeting
- Thailand – Health Systems Research Institute will advocate and disseminate by e-mail the draft declaration to relevant institutions; report to council meetings of the Medical Association about the movement and encourage the association to be actively involved; advocate strengthening of medical and health ethics teaching in the final year of medical education
- Bhutan – further address people-centred health care issues, including medical errors, by sharing information from the symposium; try to put the topic on the agenda of the annual medical conference, including possible development of a similar policy framework that is relevant to the country
- Malaysia – will prepare briefing/feedback to senior officials and share information and ideas with key stakeholders, including health-related associations
- Singapore – sharing the draft declaration with the Ministry of Health; as a WHO Collaborating Centre, chart own course on how to put people at the centre of health care and also work with others in the Region; empower individuals, families and communities by providing and mobilizing appropriate resources
- IAPO – sharing the draft declaration on the IAPO website; people-centred health care will be a topic in upcoming February conference; undertake awareness raising and consider how to build linkages with partners in the Region
- China – prepare a report and share information; meet with local people through the local health bureau as part of the local health management programme, especially on people-centred health care and quality improvement; advocate with the Chinese Doctors Association to translate key documents to Mandarin
- Philippines – share information with key people; prepare and distribute summaries; include in educational updates of the College of Medicine training programmes and in meetings with professional organizations
- WHO/HQ – start role of champion of the initiative and declaration on behalf of the Western Pacific Regional Office and the South-East Asia Regional Office towards a global movement
- New Zealand – start ongoing discussions and exchange on how to be an effective leader and manager in people-centred health care at given environment or setting; work on going global
- Australia – take the work forward through the College of General Practitioners, cross fertilizing with WHO.
Advocacy through:

- Briefing notes
- Web sites
- Agenda setting by WHO Country Representatives
- Media, including strategies to get media support for the movement
- Newsletter
- Sharing the declaration
- Agenda setting in professional associations' conferences and meetings
- Communication and advocacy within bureaus of health
- Champions, e.g., capturing symposium speakers on video to place on web sites to communicate passion and to carry the message forward
- Creating/enlisting "support" or "action" groups to help in moving the agenda forward and sharing lists of persons to talk with

Programme development and capacity building:

- NCDs and mental health, for starters
- International curricular development (leadership, using online discussion forum, other modes of communication; health professionals curriculum more generally)
- Capacity-building activities from micro (individual) all the way to macro (national/system) levels (e.g., methods to empower individuals through decision aids and other mechanisms)
- FAQs/key statistics (e.g., presence of language barriers within and across staff and people being served)/include both thematic and tactical content
- Creating a trusting and learning environment, thinking about appropriate measures to determine what is happening in various, specific settings (e.g., policy checklist – for example, a policy about how to talk to patients)

Systems development:

- Glossary – interpretation/meaning of terms associated with people-centred health care systems (how to make sense of illness experience, psychosocial aspects, explanatory models of mind and body, etc)
- Partnership development with different stakeholders
- Medical error reporting
- Internships
- Accreditation
- Database of organizations interested or helpful in promoting people-centred health care
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Tokyo, Japan

Output of Group C

Facilitator: Susan Mercado  
Rapporteur: Dean Shuey

Guide questions for Set A:

1. What needs to happen to sustain momentum on people-centred health care?  
2. Who are the key actors?

Work in countries: Stimulate, encourage and support localized actions on the paradigm of 'people-centred health care' in countries through the following:

- Health planning at the macro (national) level but ensure that this is reflected as well in meso (regional/organizational) and micro (individual) levels;
- Systems redesigning, health sector reform (e.g., with particular reference to financing and decentralization) and reengineering;
- Community-based programmes and actions;
- Patient safety initiatives;
- Capacity-building, pre- and in-service training of health workers and professionals; and
- Clinical and public health practice models and standards.

Convene a task force on people-centred health care: A technical task force to further dissect and uncover the pivotal meanings and issues for WPRO to ensure that the initiative will go in the direction intended; the Regional Director to set the criteria and the composition of the group

Strengthen the knowledge and evidence-base on the initiative: Develop a system of generating, evaluating and sharing evidence among practitioners and researchers through the following:

- “Learning groups” composed of stakeholders (providers, professionals, consumers, researchers, governments) that can immediately link knowledge and evidence to action to influence more widespread practice; linked to capacity building for leaders;
- Studies on comparative national policies;
• Conduct research on what are the ‘barriers’ and ‘facilitators’ of successful outcomes; and

• Ensure that specific strategies, plans and actions can be evaluated.

**Build capacity of leaders:** Invest on training of leaders and consider the following:

• Government leaders’ workshops, using a ‘cluster model’;
• Teams that involve “converted” health professionals and patient advocates and;
• Strengthen leadership skills in relation to people, values and systems

**Communicate, advocate, publicize and market the effort:** Use social and strategic communication; disseminate knowledge through seminars and publications and target the following actors:

• Community-at-large
• Media
• Health care professionals
• Local governments
• Patient advocates
• “Converted” health professionals
• Academics
• Ministries of public health
• Medical schools
• Medical students
• Nurses, paramedical workers, community health workers
• Business
• Media

**Undertake political and social mobilization:** Develop a strategy to broaden support for the initiative through:

• Stakeholder analysis
• Social mobilization
• Consensus-building

**Guide question for Set B:**

1. **What are the opportunities for taking the work forward in 2008-09?**

   **Develop a strategy in 2007 to guide advocacy in 2008-09**
   • Conduct a situational analysis for the initiative to understand where we are in countries and as a region, and;
   • Undertake stakeholder mapping to see who the key actors are at the regional level.
Advocate at and through the World Health Assembly and Executive Board

- Disseminate advocacy materials at the WHA 2008
- Organize a working session during WHA 2008
- Present a resolution at the EB 2009
- Call for a World Health Assembly Resolution in 2009

Link to the global development agenda

- Include this in the mid-term evaluation of the MDGs in countries
- Take up offer of MOFA, Japan to include this in the agenda of G8 (Can governments of other countries write letters of support? What is the mechanism for doing this?)
- Include in the RFPs for projects with development banks

Advocate at scheduled meetings and events

- “International Conference on Health Promotion and Quality in Health Services” 19-21 November 2008, Bangkok, Thailand
- Annual Asian Health Systems Reform Network (DRAGONET), Singapore
- Meeting on Comparative Policy Reforms (December 2007, Hong Kong)
- Evidence-based Policy for Health Governance, 2008, Singapore
- APEC, 2008
- 12th World Congress on Public Health, 27- April-1 May 2009, Istanbul “Making a Difference in Global Public Health Research Practice”;
- Relevant East Asian meetings and forums

Explore thematic and synergistic linkages

- Include this in the re-launch of Primary Health Care in 2008
- Incorporate in the work of the WHO Committee on Social Determinants of Health
- Focus on urban primary community care events and demonstration projects
- Link to the global debate on climate change and global warming
- Link to the issue of longevity, quality of life and demographic change

National events

- Include this in national health days
- Conduct national workshops and meetings
- Integrate in new planning cycles of the MOH