

2 Designing policies to deliver people-centred health

This chapter evaluates what OECD countries have done to put in place people-centred policies in their health systems and considers the extent to which countries have promoted people-centredness in their policy making across the dimensions of the OECD Framework for People-Centred Health Systems. It finds that while policies have been adopted that contribute to moving towards a people-centred approach, they are oftentimes inadvertent – though positive – consequences of other policy priorities and goals. There remains a lack of a holistic understanding of how policies across sectors, actors, and levels of governance can build on each other to create a fully people-centred approach.

Results of the benchmarking exercise suggest that countries have not yet maximised putting people at the centre across their health systems. At the same time, growing attention to the importance of person-centredness has meant that there has been an increased focus on taking a people-centred lens to policy making. This chapter reviews the extent to which OECD countries have adopted and implemented policies that support a people-centred approach across the key dimensions of voice, choice, co-production, integration and respectfulness. It draws on the results of the OECD Policy Survey on People-Centred Health Systems to examine what countries have done to move towards a more people-centred approach. Twenty-three countries completed the survey, which was completed before the emergence of SARS-CoV-2 and thus reflects policies in place before the pandemic. Given the extraordinary nature of many of the measures adopted in the context of the COVID-19 pandemic, people's trust and confidence that health systems and governments act in their best interest and with them in mind has only become more relevant.

Voice: Strengthening patient voice in decision-making

Key findings

- While important steps have been taken to strengthen the role of patient voice in health systems decision-making, comparatively fewer countries consider patient voice in systems-level decision-making to be important or very important.
- Fewer than two-thirds of countries (14/22) reported that including patients in decisions about design of benefits packages and funding of health care services was important or very important, compared with more than 90% of countries (21/23) who consider it important or very important to include patients in decisions about their own treatment.
- While there is broad agreement that a people-centred health system is important, there has been more focus on how this can be applied at the micro (patient) level, with less attention to the systemic changes that are required to transform the apparatus of a health system.

Table 2.1. Examples of policies to improve voice in voice in health systems.

Type of policy	Country examples
Decision-making processes for health authorities	<p>Canada: The Patient and Family Advisory Council to advise Ontario's Minister of Health and Long-Term Care; Health Standards Organization includes patients and families on its technical committees to provide inputs for health and social service standards.</p> <p>Luxembourg: Patients are included on both the boards and working groups responsible for the development of disease-specific national plans.</p> <p>Austria, Germany: Patients are included in decision-making processes for insurance funds.</p> <p>Australia: The National Safety and Quality Health Service Standards requires health service organisations to partner with consumers through the planning, development, delivery and evaluation of health care services.</p>
Patient safety	<p>Ireland: Plans underway to launch strategic co-production groups, including the National Patient Forum and Patients for Patient Safety Ireland.</p> <p>Canada: Canadian Patient Safety Institute promotes the participation of patient voice in advancing patient safety; Canadian Foundation of Healthcare Improvement helps to facilitate patient involvement in the design, delivery and evaluation of health services.</p> <p>Germany: Opinions and proposals of the national patient safety advocacy group are heard in respective law making processes; integration of patients in working groups on health standards and public information.</p>
Healthcare research or funding for research	<p>Norway: Majority of funded projects through both the Research Council of Norway (RCN) and the Regional Health Hospital Authorities (RHA) included public involvement.</p> <p>Canada: Canadian Institutes of Health Research's Strategy for Patient-Oriented Research includes patients as active collaborators.</p>

The strong normative argument for involving patients more closely in health care decision-making is clear (Conklin, Morris and Nolte, 2015^[1]; Wait and Nolte, 2006^[2]). Some have stressed the intrinsic value of including patients in public involvement and decision-making, akin to the democratic process, and have emphasised that beyond the concrete outcomes achieved, involving patients in decision-making can help to influence priority-setting and health policy making over time, and that the benefits can accrue over time (Wait and Nolte, 2006^[2]; Thurston et al., 2005^[3]).

Beyond the normative argument for including patients in decision-making processes for health, however, there is evidence to suggest that involving patient voices in decision-making can help to improve the relevance and quality of certain aspects of health care. Involving patients and the public in decision-making around research, for example, can help to increase its applicability. In addition to the substantive value they bring through the personal knowledge and expertise from living with their conditions, some have argued that patients have a moral right to involvement, because the decisions taken will affect them, while others have suggested that involving patients helps to improve the success of research (Caron-Flinterman, Broerse and Bunders, 2005^[4]; Boote, Telford and Cooper, 2002^[5]; Schölvinc, Pittens and Broerse, 2020^[6]). Systematic reviews of the impact of patient involvement have found that while further research is needed, involving patients helps to improve the identification of relevant research topics, improves the relevance of the research, better analysed the results from the perspective of both researchers and health systems users, and improved the dissemination and implementation of outcomes (Brett et al., 2014^[7]). A review of research studies including patient and public involvement (PPI) in the United Kingdom found that PPI helped contribute to revisions in the design of studies, better recruitment, and improved dissemination of study results (Wilson et al., 2015^[8]). Nevertheless, patient involvement in decision-making around research, including priority setting and funding, has been found to lag behind initiatives taken to improve patient voice in health systems (Lloyd and White, 2011^[9]; Sacristán et al., 2016^[10]).

Including patients in decision-making helps health systems respond better to patient needs

Strengthening patient voice in the development and delivery of health care services can also increase the relevance of available services for users (Bombard et al., 2018^[11]). Across a range of health services, involving users in service delivery planning has been found to simplify and improve access to services, including through streamlining appointment processes, prolonging the opening hours of facilities, and better sensitizing services to the needs of people living with disabilities (Crawford et al., 2002^[12]). The inclusion of patients in planning processes has been credited with developing new relevant services for patients (Crawford et al., 2002^[12]). Staff attitudes towards patients have also been found to improve when service users are involved in health care design (Simpson and House, 2002^[13]).

Strengthening patient voice can also help health systems respond better to the need for better co-ordination and integration arising from a shifting burden of disease and demographic change. In a randomised controlled trial of including patients in identifying priorities for health care improvement in Canada, including patients in prioritisation both improved patient-professional agreement on what key priorities and reduced the likelihood that the prioritisation process focused on the management of individual diseases (Boivin et al., 2014^[14]).

Patient voice should be better incorporated into governance and systems-level decision-making

Though important steps have been taken in many health systems to strengthen the role of patient voice in health systems decision-making, comparatively fewer countries consider patient voice in systems-level decision-making to be important or very important, when compared with other dimensions of person-centred care. Fewer than two-thirds of countries (14/22) reported that including patients in decisions about design of benefits packages and funding of health care services was important or very important, compared

with more than 90% of countries (21/23) who consider it important or very important to include patients in decisions about their own treatment. This gap arguably reflects a key challenge in institutionalising person-centred care: while there is broad agreement that a people-centred health system is important, there has been more focus on how this can be applied at the micro (patient) level, with less attention to the systemic changes that are required to transform the apparatus of a health system.

Sixteen of 23 countries reported that policies are in place or are being discussed to promote the involvement of patients in the organisation, management, and delivery of health care services. Many OECD countries have taken important steps towards increasing the representation of patients in decision-making for health care in recent years. Patient representatives are included in decision-making processes for health authorities in a number of OECD countries, including Austria, Canada, Luxembourg and Germany. In Canada, the government of the province of Ontario has created a Patient and Family Advisory Council to advise the Minister of Health and Long-Term Care in identifying key priorities and issues affecting patient care, while the Health Standards Organization has also included patients and families on its technical committees to provide inputs when the Organization develops or revises health and social service standards. In Luxembourg, patients are included on both the boards and working groups responsible for the development of disease-specific national plans, including for cancer, rare diseases, and cardiovascular diseases. Patients have also been included in the governance of the National Cancer Institute, including in the executive office, on the board of directors, and as part of the scientific advisory board. In Australia, The National Safety and Quality Health Service Standards require health service organisations to partner with consumers in the planning, development, delivery and evaluation of health care services. The Partnering with Consumers Standard also requires health service organisations to partner with consumers in their own care, to the extent they choose.

In some countries, adequate resources have been identified as a barrier to the more systematic inclusion of patient voice. In both Austria and Germany, for example, patients are included in decision-making processes for insurance funds. In Austria, insured populations are primarily indirectly represented, through representatives from employer and worker organisations. Recognising that patient advocacy groups were less systematically included in consultations, social insurance funds, together with the Healthy Austria Fund and the former Ministry of Health and Women, has launched an initiative to strengthen the visibility and activities of patient groups, including to improve patient representation and participation at the federal level. The initiative includes funding to help improve the independence of groups and reduce their dependence on private donations.

Across OECD countries, patient safety is a pressing health concern, with as many as one in ten patients harmed during a hospital admission and as much as 15% of hospital expenditure likely attributable to patient harm (Slawomirski, Auraen and Klazinga, 2017^[15]). Effective patient engagement has been identified as critical in helping to improving patient safety (Slawomirski, Auraen and Klazinga, 2017^[15]). Many OECD countries have taken steps to ensure patients are included in decision-making around patient safety and health service design. In Ireland, for example, plans are currently underway to launch strategic co-production groups, including the National Patient Forum and Patients for Patient Safety Ireland, who will work together with staff from the Health Service Executive on the design and evaluation of health services. In Canada, the Canadian Patient Safety Institute has similarly promoted the participation of patient voice in advancing patient safety, while the Canadian Foundation of Healthcare Improvement has helped to facilitate patient involvement in the design, delivery and evaluation of health services. In Germany the opinions and proposals of the national patient safety advocacy group are heard in respective law making processes and patients are integrated in working groups on health standards and public information. In Austria, the Ministry of Health has established an advisory board for patient safety, in addition to a patient safety association. In Ireland, the Open Disclosure Policy promotes a timely, transparent and compassionate response to promote communication following a patient safety incident.

Fewer countries have taken steps to more systematically include patients in decision-making around health care research or funding for research. An important exception is Norway, where the majority of funded

projects through both the Research Council of Norway (RCN) and the Regional Health Hospital Authorities (RHA) – the two major government funding avenues for health care research – included public involvement. All RCN decisions are required to have included public involvement, while the proportion of projects funded through RHA that included public involvement more than tripled between 2014 and 2018, from 20% to 68%. In Canada, the Canadian Institutes of Health Research’s Strategy for Patient-Oriented Research includes patients as active collaborators, with patient engagement an integral component of all its programs. Recognising the importance of including patient voice in research, Ireland’s Health Service Executive is in the process of setting up a *Patient and Public Involvement in Research Advisory Panel* as part of implementing its 2019-29 Action Plan for Health Research.

Choice: Expanding patient decision-making and improving affordability and access to care

Key findings

- Information about quality is especially important if patient choice is intended to improve access to high-quality care. However, even when information is available, patient decisions are not always necessarily made using quality and outcomes information. Access and affordability continue to constrain choice for many patients.
- Telemedicine can serve as a tool to help to expand patient choice and access to care. The COVID-19 pandemic has accelerated the scale-up of telemedicine in many OECD countries, with 45% of respondents in 22 OECD EU countries reporting that they had used telemedical consultation services during the pandemic.

Table 2.2. Examples of policies to improve choice in health systems

Type of policy	Country examples
Resources to improve access to information on quality	<p>Austria: Kliniksuche.at (“clinic search”) provides access to information about the quality of health services, through improving public access to quality metrics.</p> <p>Belgium: The VIP2 programme in Flanders (Flemish Indicators Project for Patients and Professionals) focuses on defining, developing, and implementing indicators to measure the quality of care.</p> <p>Israel, Norway: Online publication of national quality indicators to give patients the opportunity to use important clinical information when making health care-related decisions.</p> <p>Estonia: The Estonian Health Insurance Fund calculates and publishes online a selection of clinical care quality indicators for hospitals, as well as indicators related to quality and performance for family physicians.</p> <p>Costa Rica: The Costa Rican Social Security Fund publishes a selection of clinical care quality indicators for hospitals, as well as indicators related to quality and performance for physicians.</p> <p>United States: Medicare extensively collects quality indicators (including about patient experience, care processes, patient safety and outcomes), turning them into ratings that can be used by patients and caregivers to help inform their choice of health plans and providers.</p>
Resources to facilitate choice in health care providers and facilities	<p>United States: The CMS Innovation Center has focused on testing models to expand patient choices, including increasing services and providing additional incentives for providing services in the patient’s home or alternative sites of care.</p> <p>England: Reforms to promote patient choice and encourage competition.</p>
Resources to facilitate access to services	<p>Germany: The Law For Faster Appointments And Better Care expands appointment service points and increases consultation hours to improve access and reduce waiting times.</p>

In recent years, many health systems across the OECD have taken steps to increase the choices of goods and services available to individuals (Costa-Font and Zigante, 2016^[16]; Santos, Gravelle and Propper, 2017^[17]). These health systems reforms have for many countries been driven by factors beyond – though

in many cases including – a normative preference to expand patient’s decision-making power in their health systems. Many reforms that have expanded opportunities for patient choice have instead been driven by underlying goals of ensuring the sustainability of health systems by increasing competition and efficiency, particularly where public health systems operate in competition with parallel or supplemental private markets. Some researchers have linked the expansion of choice in health systems to the expectations and demands of the middle class in democratic systems, and have situated such reforms in the broader context of the responsiveness of public policy making more broadly to demands for expanded choice (Blomqvist, 2004^[18]; Costa-Font and Zigante, 2016^[16]).

Provider choice is widespread in OECD countries

Facilitating choice in health care providers and facilities is seen as an important component of people-centredness. Giving patients a choice in their provider and health facilities is considered to be important or very important in most OECD countries. Most responding countries (20/23) reported that they considered a patient’s choice of health care provider, including health care facilities and health care professionals, to be important or very important. In the United States, for example, the CMS Innovation Center has focused on testing models to expand patient choices, including increasing services and providing additional incentives for providing services in the patient’s home or alternative sites of care.

In a majority of OECD countries, patients have substantial flexibility in choosing their health care services across multiple levels of the health system, from primary to hospital care. The majority of reporting countries allow patients free choice in choosing their health care provider at the primary care level (18/31 OECD countries), outpatient specialist level (17/31 OECD countries), and hospital level (16/31 OECD countries). Even where free choice is available, roughly a quarter of countries report using financial incentives to guide patient behaviour, particularly at the specialist and hospital level.

Promoting patient choice can help to improve efficiency in some parts of the health system. A number of countries have introduced reforms promoting greater hospital choice for patients with the explicit goals of improving competition. In England, reforms to promote patient choice and encourage competition were found to have led to improvements in hospital efficiency, including on admissions per bed and doctor, as well as the proportion of day cases in hospital (Longo et al., 2019^[19]).

Information about quality is especially important if patient choice is intended to improve access to high-quality care. However, even when information is available, patient decisions are not always necessarily made using quality and outcomes information. While countries have increased the availability of quality and outcomes information available to patients, care-seeking behaviours are not always influenced by this information. Evidence from countries that have recently instituted patient choice policies suggests that patients are often influenced by more prosaic factors. In studies of hospital choice, patients in Germany and the Netherlands reported being influenced by factors including the distance from their home to hospital, the recommendation of their general practitioner, the input of family and friends, and online resources (Lako and Rosenau, 2009^[20]; De Cruppé and Geraedts, 2017^[21]). This may at least in part be attributable to difficulties for patients in readily identifying the information they feel is necessary to make informed choices (Victoor et al., 2016^[22]). In a study of choice in primary care in Finland, more than three-quarters of respondents felt choice to be important, but fewer than half felt they had real opportunities to make such choices, with just over one-third of respondents reporting that they were satisfied with the information they received for making choices (Aalto et al., 2018^[23]).

Improving access to quality information about the aspects of the *health systems* themselves is important to helping patients make informed decisions about their health and care. Countries have also taken steps to improve the transparency of health systems for patients and users. Eleven of 17 countries reported developing strategies or policies to inform patients about health care quality or costs of providers. Many countries have focused on improving access to information about the quality of health services, through improving public access to quality metrics, such as hospital performance indicators. Portals such as

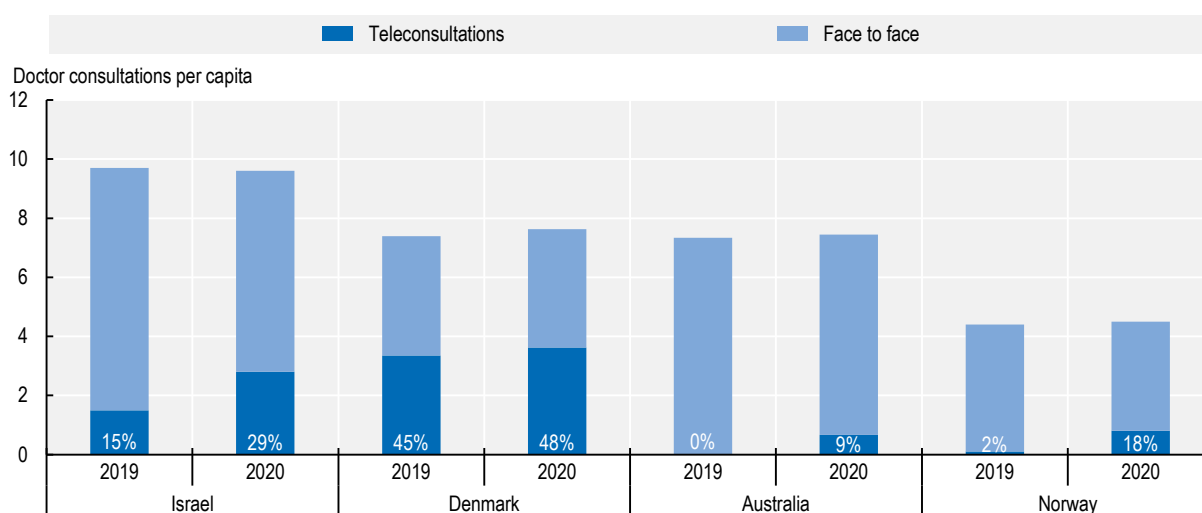
kliniksuche (“clinic search”) and *gesundheit.gv.at* in Austria and the VIP2 programme in Flanders (Belgium), as well as the publication online of national quality indicators, as in Israel and Norway, give patients at least the opportunity – whether or not it is taken – to use important clinical information when making health care-related decisions. In Estonia, for example, the Estonian Health Insurance Fund calculates and publishes online a selection of clinical care quality indicators for hospitals, as well as indicators related to quality and performance for family physicians.

Access challenges continue to pose important constraints on exercising choice

Material and geographic constraints can further impact the extent to which patients are able to exercise the choice available to them. More than one in five adults across 23 OECD countries reported postponing or forgoing care due to long waiting times or transportation issues, while one in six reported putting off or forgoing care because of cost (OECD, 2019^[24]). Delaying or forgoing care due to access and affordability concerns is particularly common among people of lower socio-economic status: those in the lowest income quintile were 28% more likely to report delaying or forgoing care due to accessibility (waiting time or transportation) issues, and three times more likely to delay or avoid care because of cost (OECD, 2019^[24]). In some cases, countries have introduced flexibilities into systems with otherwise limited choice to help overcome these access challenges. In some provincial health systems (Saskatchewan, Ontario) in Canada, for example, when waiting times are too long, patients are given a choice to seek care via a different specialist or hospital with shorter waiting times.

In recent years, there has been a growing interest in the use of telemedicine services – such as telephone and video consultations, and the remote monitoring of chronic conditions – to improve access to care and choice for patients. Patients who have used telemedicine services have reported very high levels of satisfaction with the care they receive, and telemedicine interventions have been found to improve treatment adherence and outcomes, as well as better self-management, for patients with chronic conditions. While patients have been enthusiastic about the possibilities of telemedicine, however, until recently telemedicine services were comparatively infrequent across OECD countries. Evidence from OECD countries suggests that in at least some countries, teleconsultations dramatically increased during the pandemic and were sometimes able to make up for drops in in-person consultations (Figure 2.1).

Figure 2.1. Doctor consultations per capita in 2019 and 2020 by mode of consultation



Source: OECD (2021^[25]), *Health at a Glance 2021: OECD Indicators*, <https://doi.org/10.1787/ae3016b9-en>.

In Austria, the national health service line 1450, established before the pandemic, offers telephone consultation and clearing in relation to treatment need seven days a week and 24 hours a day. While the system was not initially planned as an emergency/crisis hotline, it was further developed in the context of COVID-19 to enable residents to be triaged when they suspect a COVID-19 infection. A similar telephone triage service, the SNS24, exists in Portugal and was expanded to adapt to better address the pressures on the health system during the COVID-19 pandemic.

As the uptake of the COVID-19 vaccine has slowed in some countries, creative efforts to reduce access-related barriers have been developed to encourage vaccination and overcome vaccine hesitancy. In Austria, the health system has offered easy-access vaccines through the roll out of mobile vaccination services, which facilitate easier access to vaccination in rural areas and allow individuals to be vaccinated without needing to sign up online.

Box 2.1. How has the COVID-19 pandemic changed how countries use telemedicine?

Telehealth has many potential benefits in the context of COVID-19, both in the treatment of presumed cases of confirmed COVID-19 with mild symptoms, and for ensuring continuity of care, including for people with chronic conditions, in the context of confinement policies. Telehealth – the use of information and communication technologies to promote health at a distance, including non-clinical services and education – has been used in previous disease outbreaks like Ebola and Zika, and supplies a set of tools and applications to prevent spread. While the use of telemedicine in the OECD prior to the pandemic was still low, several countries have relaxed regulatory barriers and started to promote its use at scale in response to COVID-19. In just the first weeks and months of the pandemic, countries and regions that had no telemedicine legislation or reimbursement schedules introduced new services, new fees, new legislation, new guidelines and regulations, and have encouraged its adoption and use. The increase in the adoption and use of telemedicine/telehealth demonstrated the speed with which some barriers – including reimbursement/financing arrangements and provider resistance to virtual care – can be eliminated or mitigated. By February/March 2021, close to half (45%) of respondents in 22 European OECD countries reported that they had undergone a telemedical consultation during the pandemic.

In Australia, the government temporarily added telehealth services to the Medicare Benefits Scheme to mitigate COVID-19 transmission through health care visits. Temporary telehealth benefits were extended to both general practitioners and specialists, as well as nurses, dentists, and other health providers. The Australian Government has also accelerated the delivery of e-prescribing to help vulnerable populations avoid exposure to the virus. Doctors, including general practitioners, are able to electronically send a prescription to pharmacies, who can deliver the medicines directly to the home of the patient. Though Australia had already developed the regulatory structure for e-prescribing, the COVID-19 pandemic has fast-tracked its roll-out, with up to AUD 5 million channelled to rolling out the technological capacity in 80% of community pharmacies and general practices.

Canada has also expanded billing codes to support telemedicine and virtual care delivery during COVID-19. While telephone care remains the most widely employed form of virtual care, videoconferencing and secure messaging services are also available in all provinces and territories to enable communication between health care providers and patients. In May 2020, the Canadian Government announced investments of CAD 240.5 million to help develop, expand and launch virtual and mental health care tools in the context of the COVID-19 pandemic.

The promotion of telemedicine as a strategy to minimise virus transmission while maintaining access to health services has led to a rapid uptake in the proportion of consultations conducted remotely. In Norway, 37% of primary care consultations in March and April 2020 were teleconsultations, compared

with just 2% over the same period in 2019. In Portugal, remote medical consultations in primary health care units grew by 50% in the January-May 2020 period, compared to the previous year. The growth in teleconsultations helped to offset in-person declines in doctor visits in 2020 in Australia, Israel and Norway (OECD, 2021^[25]).

Co-production: Promoting patient engagement and empowerment

Key findings

- Patients are increasingly seeking health information to be in greater control of their own health and health care services. Providing curated health information is a way to ensure the quality of advice given to patients. Moreover, improving access to information about health systems gives patients the opportunity to be more engaged in their own care and can improve outcomes and satisfaction. Several countries maintain or support dedicated portals to help patients.
- Enabling people to access their health records and interact with their own medical information is a driver of co-production. While the majority of OECD countries (70%) say they are implementing ways for people to access their health data electronically, fewer than half (43%) include the ability for patients to interact with their own health records, and the data they do have access to is often just a subset of their full health record.
- Health literacy, including digital health literacy, is critical to ensure patients make positive decisions about their health. In 12 of 18 OECD countries with some form of health literacy data, more than half the adult population has low levels of health literacy. However, international comparability of the data is limited.

Table 2.3. Examples of policies to improve co-production in health systems.

Type of policy	Country examples
Provision of curated health-related information	<p>Austria, United Kingdom: <i>Gesundheit.gv.at</i> in Austria and <i>NHS Health A-Z</i> in the United Kingdom compile comprehensive, neutral information related to diseases and health conditions and topics and can serve as a trustworthy resource for individuals going online for information related to their health.</p> <p>Germany: Working towards developing government-affiliated websites to provide comprehensive health information to their populations.</p> <p>Costa Rica: The Costa Rican Social Security Fund has compiled online information on diseases and health conditions for health systems users to access through the Social Security Fund's website. The Ministry of Health has also developed accessible online platforms that offer tools for patients to learn about their rights and the services offered by the health system.</p>
Resources to help navigate the health system	<p>Canada: The Canadian Institute for Health Information maintains the dedicated online platform <i>Yourhealthsystem.cihi.ca</i> to inform both the population and policy analysts.</p> <p>Norway: <i>Helsenorge.no</i> is a guide for citizens wanting to take care of their health, as well as learn about public health care in Norway. Accessible platforms offer tools for patients to learn about their rights and the services offered by the health system.</p> <p>Israel: <i>Kol Briyut</i> call centre offers information to about the services available under the Health Basket.</p>
Patient's access to their own electronic health records	<p>Belgium: has expanded access to electronic records to patients since 2018, allowing patients to access both personal and general health information through the patient portal <i>masante.belgique.be</i> (<i>mijngezondheid.be</i>).</p> <p>United Kingdom: Patient Online is an NHS England programme designed to support GP Practices to offer and promote online services to patients, including access to coded information in records, appointment booking and ordering of repeat prescriptions.</p> <p>Estonia: Unified EHR enables residents to view all of their medical data in one place – including diagnoses, test results, medications. Residents can also interact with their data.</p> <p>Lithuania: A centralised 'one resident – one record' EHR system covers 95% of the population. It carries all relevant medical information in integrated electronic workflows covering appointments, referrals and e-prescribing. It also enables provider interaction and patients have secure access to their record through a patient portal.</p> <p>Costa Rica: All citizens have a unique digital health record, which is accessible through an online portal.</p>

Overcoming the traditional health professional-patient model is important to developing a co-productive relationship. This requires developing policies that target both actors. While many policies to improve patient engagement rightly focus on the role of health professionals in better communicating and facilitating a collaborative relationship with their patients, patients also bear ownership over the extent to which they embrace a co-productive approach. In Austria, the adoption of the National Strategy for Improving Healthcare Communication led to a multi-strategic implementation process that includes communication trainings for health professionals and improving the health literacy of health care organisations as well as measures to empower patients in communication (e.g. for asking questions), co-ordinated by the Austrian Health Literacy Alliance. In the context of the COVID-19 pandemic, stakeholder communication measures are being employed, based on an interdisciplinary assessment of needs, to encourage vaccine uptake and address vaccine hesitancy, particularly among underserved and vulnerable communities. These have included the roll-out of communication strategies targeting individuals whose first language is not German.

Interventions to promote better patient co-production have also been found to improve patient outcomes after hospital procedures (Trummer et al., 2006^[26]). In a study of patients undergoing heart surgery in Australia, patients in the intervention group – whose health professionals had undergone additional communications training and who received reorganised patient information services – had shorter lengths of stay in hospital, were released to less intensive care more quickly, and experienced significantly fewer post-surgery complications compared with patients who received traditional care (Trummer et al., 2006^[26]). Better communication between patients and health professionals – including more information, and the skills needed to interpret it – have been found to contribute both to higher patient satisfaction and improved patient safety (Slawomirski, Aaraaen and Klazinga, 2017^[15]). In Austria, an extensive literature review was commissioned on the improvement of communication between professionals and patients, which started the implementation of a National Strategy for Improving Healthcare Communication (adopted 2016).

One major driver of the role of co-production in influencing disease and treatment outcomes is its impact on patient empowerment. Higher levels of patient empowerment have been associated with better disease self-management, including treatment adherence and behavioural change, greater patient literacy, and improved clinical outcomes (Aujoulat, d'Hoore and Deccache, 2007^[27]). This is particularly important for health conditions that require active and ongoing patient participation and self-management for good outcomes, including non-communicable disease management and mental health conditions. Shared decision-making that promotes patient participation in making treatment decisions has been found to improve treatment adherence among patients with depression, while shared decision-making has been found to positively influence treatment-related empowerment among patients with psychosis (Loh et al., 2007^[28]; Stovell et al., 2016^[29]). In an intervention for diabetes patients experiencing disease-related difficulties, a patient-collaboration intervention focused on providing information and facilitating patient empowerment significantly improved clinical outcomes, including blood glucose levels, in addition to improvements in self-rated health and quality of life (Keers et al., 2004^[30]).

Digital technologies have expanded the tools of patient co-production – but the quality of information varies, and health literacy levels – including digital health literacy – are not always sufficient

In recent years, the digital transformation of society has led to rapid growth in the number of people using the internet and other digital tools to seek out health information. Between 2008 and 2017, online health-seeking behaviour nearly doubled among adults in 27 OECD countries (OECD, 2019^[31]). Patients now have the option to go directly to the source of clinical information, rather than relying on health professionals to interpret it for them.

While access to high-quality sources of information have proliferated, more general concerns about the quality of information available online raise questions about the ability – or in some cases, desire – of individuals to distinguish between established authorities and more dubious health information. While the

lack of a ‘filter’ between individuals and health-related information is positive for patient empowerment, without the sufficient ability to interpret the information presented to them, health outcomes can suffer.

With the proportion of the population seeking out health-related information online, health systems increasingly recognise the importance of ensuring responsible, accurate information is provided to individuals wishing to have a greater understanding of their health and input into decisions around care decisions related to them. Many countries have taken steps to provide access to high-quality information through official websites and health portals, with the explicit aim of providing public-facing quality information, while others have focused on improving health literacy to ensure patients have the proper tools to properly interpret what they find.

In many cases, these resources have been designed specifically to address demands for *health*-related information. Websites such as *gesundheit.gv.at* in Austria and *NHS Health A-Z* in the United Kingdom compile comprehensive, neutral information related to diseases and health conditions and topics and can serve as a trustworthy resource for individuals going online for information related to their health. Recognising the importance of ensuring people are directed towards quality resources when looking for health-related information, other countries, including Germany, are also working towards developing government-affiliated websites to provide comprehensive health information to their populations.

Health systems are complex, and understanding what services, care pathways, or rights patients have can be difficult to navigate even for the most informed. Ensuring patients have access to the tools and resources available to them is important to facilitating truly co-productive patient engagement. Interactive tools such as *Your Health System* in Canada, the *Kol Briyut* call centre in Israel, which offers information about the services available under the Health Basket, or the *helsenorge* public health website in Norway offer accessible platforms for patients to learn about their rights and the services offered by the health system.

In Australia, health officials have taken steps to increase health literacy around key information related to the COVID-19 pandemic. The broader population has quickly been forced to grasp new, often confusing concepts related to the virus, infection, immunity, and broader access to and use of the health care system and resources. Concepts such as ‘flattening the curve’ can be poorly understood. To ensure the population is able to best understand the flurry of health information related to the pandemic, authorities have undertaken activities to offer accurate – and localised – information, including developing specific websites, apps, and a dedicated telephone hotline.

Enabling people to access their health records and interact with their own medical information is a driver of high quality people-centred care. Digital technology provides the ideal platform to enable this access easily and efficiently. Belgium has expanded access to electronic records to patients since 2018, allowing patients to access both personal and general health information through the patient portal *masante.belgique.be* (*mijngezondheid.be*). Other examples of progress can be found (OECD, 2019^[31]). Estonia has a unified EHR, which enables residents to view all of their medical data in one place – including diagnoses, test results, medications. Residents can also interact with their data. For example, they can update their details, supplement existing information, and carry out administrative processes such as obtaining a medical certificate for a driver’s license without needing a specific appointment. Lithuania has implemented a centralised ‘one resident – one record’ EHR system that covers 95% of the population. It carries all relevant medical information in integrated electronic workflows covering appointments, referrals and e-prescribing. It also enables provider interaction and patients have secure access to their record through a patient portal. Australia’s My Health Record (MHR) system offers individuals a digital platform that includes records on health status, prescriptions, vaccinations, tests, hospital discharge, advance care planning, and other information. Ninety-nine percent of hospitals and pharmacies, and 97% of hospitals, are registered to use the system, which now includes more than 23 million individual MHR (Australian Digital Health Agency, 2021^[32]).

Adequate health literacy is essential for individuals to access, process and apply information relevant to their health and make decisions or adapt behaviours accordingly. Individuals with higher levels of health literacy have been found to have higher levels of self-management and self-care, contributing to better clinical outcomes for chronic conditions (Moreira, 2018^[33]). Higher health literacy is also associated with enhanced health information-seeking behaviour. Individuals with higher health literacy have been found to be more likely to access and actively use patient portals, compared with individuals with lower levels of health literacy (OECD, 2019^[31]). Poor health literacy has been associated with poorer overall health for older adults, including poorer medications adherence and a higher risk of mortality (Moreira, 2018^[33]). Misinterpreting health information due to poor health literacy, for example, can contribute to harmful health behaviours, including poor medications adherence or support for unproven or debunked medical claims, such as vaccine hesitancy (Khan and Socha-Dietrich, 2018^[34]; Moreira, 2018^[33]).

The majority of OECD countries reported that involving patients in decisions about their own care, and ensuring patients are treated respectfully and compassionately by the health system, are important or very important aspects of a people-centred health system. Ensuring patients have adequate health literacy to participate in decisions around their health and care is critical. Yet despite efforts across OECD countries to improve overall health literacy, a high proportion of the adult population in many countries continues to have difficulty accessing and interpreting health information. In 12 of 18 OECD countries with data, more than half the adult population demonstrated low levels of health literacy (Moreira, 2018^[33]). At least one-third of adults demonstrate low health literacy across most OECD countries (Moreira, 2018^[33]). Despite the interest in the topic of health literacy, progress towards its measurement at the system-level is still uneven across countries and availability of internationally comparable health literacy data is very limited.

Skill gaps among health care workers can impede a co-productive relationship with patients

Health systems increasingly recognise the need to equip health care professionals with the skills needed to meet the changing – and increasingly complex – needs of the population. Countries have increasingly recognised the importance of fostering transversal skills, including better communication, analytical skills, and openness, and have worked to identify and rectify clear skills gaps among health care workers (OECD, 2018^[35]). Policymakers have identified the mismatch between the skills health care professionals have, and those they need, as one of the most pressing concerns for health systems today (OECD, 2016^[36]).

One approach to rectify this challenge has been to develop skills assessment instruments that work to identify skill needs and gaps among health care professionals and develop strategies to bridge these gaps. While many of these tools have identified skills that reflect clearly the needs of a more person-centred health system – including ensuring health professionals are equipped not only with clinical skills, but the social and communication skills to ensure patients are engaged and treated respectfully – few assessment instruments have been designed specifically with a person-centred approach in mind. This is to a large extent due to the fact that assessment tools have been developed by health care providers, often without input from patients and health systems users themselves (OECD, 2018^[35]).

Respectfulness: Ensuring people are valued in the health system

Key findings

- Across a subset of OECD countries, nearly nine in ten patients reported that they received easy-to-understand explanations related to their health, and more than four-fifths of surveyed patients reported that their doctor spent enough time at them during their consultation.
- Nearly all OECD countries (27/31) report that they have a formal definition of patient rights at the national level, and most countries have established ombudsmen who can help to mediate disagreements.
- Patient-oriented general skills of health professionals are necessary to deliver person-centred care. Policies to promote co-production from the health professional perspective are needed to improve communication skills and attitude towards a more active role for patients, but few countries report using them.
- Eleven of 18 OECD countries reported collecting some form of measures of patient experience and outcomes, but their use is far from being systemic in most countries, and international comparability of the measures is limited.
- The Patient-Reported International Survey (PaRIS) of patients with chronic conditions will allow for cross-country comparisons about people's experiences of care and how they assess the results of the services provided by their health systems. This will help policy makers identify best practices, fuel international learning, and foster a dialogue with patients and service providers about how to further improve the performance and people-centredness of health systems.

Table 2.4. Examples of policies to improve respectfulness in health systems.

Type of policy	Country examples
Official channel to report mistreatment or rights violations or Aggregation of data on patient complaints	<p>Austria: Hospitals are mandated to report number of patient complaints and how they were handled.</p> <p>Canada, the Czech Republic, Germany, Ireland, Norway, Turkey, United States: Ombudsmen who can help to mediate disagreements, either between health care institutions (such as hospitals) and patients, or across the health system more broadly at the national level. Ireland: Complaints Management System (CMS) standardises data for complaints throughout the organisation.</p> <p>Costa Rica: A complaints management system run through the Comptroller of Services of the Social Security Fund helps to mediate disagreements between health care institutions and patients, as well as across the health system more broadly.</p>
Skills for health professionals	<p>Austria, Mexico: National guidelines and strategies to improve the quality of communication by health care professionals, including to better address the needs of minority populations.</p> <p>Belgium: Patient Participation Culture Tool has been developed for health care workers to measure what factors from the health care professional's side impact patient participation and engagement, as well as information sharing.</p> <p>Japan: A "conciergerie" integrated care programme has promoted the participation of the patient as a member of their own care team.</p>
Institutionalising patient-reported experience measures	<p>Belgium: Patient-reported experience measures are collected at the hospital level, and have been included as an indicator in their Pay for Performance programme since 2018. Hospitals in Flanders are required to measure and public indicators of quality of care, including PREMs.</p> <p>Canada: Acute care patient-reported experience measures are regularly collected through the Canadian Institute for Health Information.</p> <p>Israel: Ministry of Health regularly undertakes PREMs with the explicit purpose of receiving feedback on the patient-centredness of health care professionals</p> <p>Japan: The Ministry of Health, Labour and Welfare regularly surveys people who sought hospital services, both as inpatients or outpatients.</p> <p>Lithuania: Collecting and reporting patient-reported measures are an accreditation requirement for personal health care institutions. Law on Healthcare Institutions includes patient satisfaction</p>

Type of policy	Country examples
	<p>Mexico: Patient satisfaction reporting in the Encuesta de Satisfacción, Trato Adecuado y Digno</p> <p>Norway: The Norwegian Institute of Public Health (NIPH) plans to include yearly PREMS for adult hospital patients between 2019-24.</p> <p>Spain: Patient-reported measures in the annual Health Barometer population survey.</p> <p>Sweden: Patient experiences measures from contact with the health system are included in an annual nation-wide assessment of patient experience.</p> <p>United Kingdom (Wales): Patient-reported health and social care experience measures are used to track performance.</p> <p>United States: Centers for Medicare and Medicaid (CMS) regularly survey a random percentage of beneficiaries to monitor patient experiences.</p>

Positive relationships with health care providers are important both for patient experience and outcomes of care

In recent years, health systems have put a growing focus on strengthening communication between health care professionals – and in particular, physicians – and their patients. Patients who feel empathy from their physicians report greater satisfaction with their care and have been found to be more likely to comply with medical regimes than patients who experienced a lack of empathy (Kim, Kaplowitz and Johnston, 2004^[37]). Higher satisfaction in a physician-patient relationship, including greater trust, has been associated with better clinical outcomes, including among patients with lower back pain, as well as with greater patient satisfaction and lower emotional distress for patients with cancer (Farin, Gramm and Schmidt, 2013^[38]; Zachariae et al., 2003^[39]).

The impact of a negative relationship between health care providers and patients has also been found to negatively affect health outcomes and quality of care. In particular, the effects of perceived discrimination by physicians on the outcomes of patients has been extensively documented, and found to be associated with an delaying or forgoing necessary medical care, including mental health services (Burgess et al., 2008^[40]; Lee, Ayers and Jacobs Kronenfeld, 2009^[41]). Among diabetes patients who had experienced perceived racial or ethnic discrimination, the probability of receiving key preventive tests, including a foot exam, blood pressure exam, or haemoglobin A1C test, was 50% lower than those who had not experienced perceived racial discrimination (Ryan, Gee and Griffith, 2008^[42]).

Patient-reported data from across OECD countries suggests that, overall, patients broadly report satisfaction with their care. Across a subset of OECD countries, nearly nine in ten reporting that they received easy-to-understand explanations related to their health, and more than four-fifths of surveyed patients reported that their doctor spent enough time at them during their consultation.

Patient rights and recourse for maltreatment are well defined most countries

An official channel to report mistreatment or rights violations can serve as an important measure of accountability for patients vis-à-vis the health system. Nearly all OECD countries (27/31) report that they have a formal definition of patient rights at the national level. Reporting mechanisms that offer patients the opportunity to complain about their treatment are commonplace in OECD countries. Most countries – including Canada, the Czech Republic, Germany, Ireland, Norway, Poland, Turkey and the United States – have established ombudsmen who can help to mediate disagreements, either between health care institutions (such as hospitals) and patients, or across the health system more broadly at the national level. While such recourse is important, these channels arguably function as measures of last resort. Many less extreme experiences with the health system, even where unpleasant or where a patient felt they were not treated with respect, will not rise to the level that a patient would feel the need to resort to official channels of complaint. Yet they can nonetheless have a deleterious impact on the patient’s experience with the health system, or impact the care that they receive. Ensuring patients have sufficient recourse to address difficulties with the health system is critical to providing an institutionalised measure of responsibility, even where behaviour is not so egregious as to warrant official complaint.

Aggregated data on patient complaints gathered through such channels can serve as an important tool for measuring how a health system is or is not meeting the needs of its patients. In Ireland, for example, a Complaints Management System (CMS) was developed in response to recommendations by the Health Service Executive Ombudsman's report, which called for the development of a standardised database for the capture and collation of complaints throughout the organisation in order to manage complaints and identify emerging trends. In Austria, for example, hospitals are mandated to report quality measures including the number of patient complaints and how they were handled. In Poland, the Patients' Rights Ombudsman annually presents a report on patient rights in Poland to the Council of Ministers and lower house of the Polish Parliament.

Table 2.5. Countries with formal definition for patient rights and institutions responsible for patient right violations

Country	Formal definition of patients' rights at the national level?	Institution(s) responsible for handling reported violations against the patients charter
Australia	Yes	Each state and territory has a mechanism (Commission for Health Complaints) for reporting health complaints.
Austria	Yes	courts and administrative authorities
Belgium	Yes	Inspection services at subnational levels
Canada	No	
Switzerland	No	
Chile	Yes	Superintendent of Health
Costa Rica	Yes	The national legislation states that all health services (public and private) must have a "Services Comptroller" which must give assistance and investigate any complaint of patients.
Czech Republic	Yes	Ministry of Health and Public Defender of Rights
Germany	Yes	Patients can report violations to the "Patientenbeauftragten"
Denmark	Yes	Danish Patient Safety Authority
Spain	Yes	National level: Ombudsman who manage the claims and suggestions regarding rights and obligations, included user of health system.
Estonia	No	
Finland	Yes	National Supervisory Authority for Welfare and Health, Regional State Administrative Agencies
France	Yes	
United Kingdom	Yes	Parliamentary and Health Service Ombudsman, Local Government Ombudsman, or the Courts
Greece	Yes	
Ireland	Yes	Health Service Executive; Office of the Ombudsman; Ombudsman for Children.
Iceland	Yes	The Ministry of Welfare; The Directorate of Health; The Ministry of Justice.
Israel	Yes	The Ministry of Health
Italy	Yes	Local Health Agencies
Japan	Yes	
Lithuania	Yes	State Healthcare Accreditation Agency under the Ministry of Health, The Commission on Evaluation of Damage Inflicted upon the Health of Patients under the Ministry of Health
Luxembourg	Yes	Ombudsman for children, Ombudsman for the health care sector
Latvia	Yes	Health Inspectorate of Latvia
Mexico	Yes	National Arbitration Medical Commission of the Ministry of Health.
Netherlands	Yes	Inspectorate
Norway	Yes	Fylkesmenn
Poland	Yes	Patients' Rights Ombudsman, Minister of Health, National Health Fund.
Portugal	Yes	Health Regulation Authority (Entidade Reguladora da Sade ERS)
Slovenia	Yes	Representatives of patients' rights, National Commission for Protection of patients' rights
Sweden	No	
Turkey	Yes	Patient Rights Boards
South Africa	Yes	Health Professions Council of South Africa (HPCSA)

Source: OECD (2016^[43]), Health Systems Characteristics Survey.

OECD countries are increasingly recognising the importance of developing cross-cutting, transversal skills that can help health professionals to institutionalise compassionate and respectful relationships with patients. Some countries, such as Austria and Mexico, have developed national guidelines and strategies to improve the quality of communication by health care professionals, including to better address the needs of minority populations. Health care professional-facing tools can also help to encourage health care workers to consider how their behaviour impacts the patient-practitioner relationship. In Belgium, the *Patient Participation Culture Tool* has been developed for health care workers to measure what factors from the health care professional's side impact patient participation and engagement, as well as information sharing.

Few countries have taken steps from the health care provider perspective to include patients as co-productive members of their own health care teams. This requires an approach that both encourages patients to engage more actively in their own care, and that works to overcome the resistance among many health care professionals to engage with patients co-productively (Palumbo, 2016^[44]). In Japan, a “conciierge” integrated care programme has promoted the participation of the patient as a member of their own care team, which has led to an improvement in the behaviour and attitudes of the health professionals involved in the programme (Taneda, 2016^[45]; OECD, 2018^[35]).

Countries have scaled up patient-reported measures, but collection is not always systematic

Over the last decade, OECD countries have markedly scaled up their use of patient-reported measures to inform health care policy making (Fujisawa and Klazinga, 2017^[46]). A number of countries have reported collecting measures of patient-reported experience measures (PREMs) or patient-reported outcome measures (PROMs) and developing channels of patient input to inform the performance and person-centredness of their health systems. Eleven of 18 OECD countries reported collecting measures of PREMs, which measure how patients experience health care and refers to practical aspects of care, such as accessibility, care co-ordination and provider-patient communication. A few countries also reported collection of data on PROMs. These indicators are an important component of ensuring the people-centredness of the health system as a whole. However, collection of PREMs and PROMs is far from being systematic in most countries, and international comparability of these measures is limited.

In Belgium, patient-reported experience measures are collected at the hospital level, and have been included as an indicator in their Pay for Performance programme since 2018. Hospitals in Flanders are required to measure and public indicators of quality of care, including PREMS, and plans are underway to develop reporting mechanisms at the federal level. Adult hospital patients also regularly report patient experiences in Norway, where the Norwegian Institute of Public Health (NIPH) plans to include yearly PREMS for adult hospital patients between 2019-24. Continuous monitoring is also planned for adult mental health patients, as well as patients who receive treatment for substance dependence. Collecting and reporting patient-reported measures are an accreditation requirement for personal health care institutions in Lithuania. The Israeli Ministry of Health regularly undertakes PREMS with the explicit purpose of receiving feedback on the patient-centredness of health care professionals, while in Japan, the Ministry of Health, Labour and Welfare regularly surveys people who sought hospital services, both as inpatients or outpatients. In the United States, the Centers for Medicare and Medicaid (CMS) regularly survey a random percentage of beneficiaries to monitor patient experiences. Also in the United States, the Consumer Assessment of Health Providers and Systems surveys, which measure patient and caregiver experiences with care, are included as part of the evaluation for all model tests run under the CMS Innovation Center.

The inclusion of patient-reported measures annual *Health Barometer* population survey in Spain, and patient satisfaction reporting in the *Encuesta de Satisfacción, Trato Adecuado y Digno (ESTAD)* in Mexico further examples of collection and reporting of some form of national PREMs. In Lithuania, the Law on

Healthcare Institutions was revised in 2018 to explicitly include patient satisfaction – including the number of complaints received annually and the proportion of complaints found to be valid. Alongside this legal revision, the government is in the process of implementing a quality monitoring system for health care institutions that includes patient-reported measures. In the United Kingdom (Wales), patient-reported health and social care experience measures are included to track progress, including the proportion of people who rate their care and support as good or excellent, as well as those who feel included and involved in decisions about their care and support.

In Canada, acute care patient-reported outcome measures are regularly collected through the Canadian Institute for Health Information and Cancer Care Ontario regularly collects patient-reported outcome measures for cancer, while in Sweden, patient experiences measures from contact with the health system are included in an annual nation-wide assessment of patient experience. While some of these measures align with the OECD Patient-Reported Indicators Survey (PaRIS), an important knowledge gap persists about the results of primary and ambulatory care in OECD countries in an international perspective. The *PaRIS International Survey of People Living with Chronic Conditions* will be a key tool to increase people-centredness of health systems in OECD countries.

Box 2.2. The Patient Reported Indicator Surveys (PaRIS).

The Patient Reported Indicator Surveys (PaRIS) support the creation and collection of state-of-the-art, internationally comparable patient-reported indicators to advance high performing, people-centred health systems. The PaRIS survey, currently under development, will be the first international survey of patient-reported health outcomes and experiences of people living with one or more chronic conditions who are treated in primary or ambulatory care.

Findings from the survey will fill an important knowledge gap about the results of primary and ambulatory care in OECD countries. It will allow for cross-country comparisons about people's experiences of care and how they assess the results of the services provided by their health systems. This will help policy makers identify best practices, fuel international learning, and foster a dialogue with patients and service providers about how to further improve the performance and people-centredness of health systems and primary care services. Developing the PaRIS survey on an international level will offer an unprecedented opportunity to benchmark the results of health systems and to promote international collaboration to greatly increase the evidence base on effective strategies to support people-centred care.

PaRIS will also collect information on other key aspects of people centredness, including Patient-Reported Outcome Measures (PROMs), which provide information on how patients assess the results of the care they receive, and integration and continuity of care.

Integration: Strengthening the role of primary care and digital tools to improve co-ordination of care

Key findings

- Thirteen out of eighteen responding countries reported that concrete policies to promote care co-ordination within the health system have been implemented, with five indicating that they are under discussion, including financing for integration or reporting integration-related indicators. Seven countries reported developing performance metrics that monitor progress towards better care integration and co-ordination.
- In many cases, integration measures have been developed for specific care pathways or diseases. However, countries are increasingly focusing on the role of primary health care in care co-ordination strategies, which is becoming a focal point for integration strategies.
- Strengthening primary care and multi-disciplinary teams could contribute to better co-ordination and integration across the health system. Nearly all countries have developed or are developing multi-disciplinary teams of health professionals to deliver more co-ordinated care to patients, and many of these are focused on the primary care level.
- Countries have put a major focus on the potential of digital tools to help solve integration challenges. The use of electronic health records has received substantial attention for its potential to improve integration across the health system. While there has been progress towards the uptake of electronic records, establishing linkages and integration between the use of electronic records has been slower. Primary care settings, in particular, have often been excluded from closer integration with other electronic health systems.
- Ten out of 19 responding countries reported implementing policies to strengthen co-ordination between the health and social care sectors, with most others reported that such policies are at least under discussion or have been announced (8/19).

Table 2.6. Examples of policies to improve integration in health systems.

Type of policy	Country examples
Incentives, financing, and tools for care co-ordination	<p>Belgium, the Czech Republic, Sweden: performance metrics that monitor progress towards better care integration and co-ordination, for specific care pathways or diseases</p> <p>Czech Republic: General Health Insurance Fund (VZP) launched new service codes and reimbursement mechanisms to better incentivise the development and use of patient pathways between oncological treatment centres and other health care providers to improve care integration for patients with cancer.</p> <p>Estonia: Care pathway pilot studies are underway in for stroke and cancer, with the goal to create a financing system that incentivise a co-ordinated, person-centred treatment pathway.</p> <p>Estonia: Quality bonus system to incentivise the performance of family doctors in chronic disease management, among other areas.</p> <p>Israel: Ministry of Health has taken steps to publicise the results of the Quality Indicators Report, which includes measures monitoring integration and co-ordination of care.</p> <p>Norway: Piloting primary health care teams that transition away from predominantly fee-for-service payments, towards payment methods for care over time or for bundled services, as well as towards targeted funding from local authorities for hiring additional categories of professionals into physician-owned practices or primary health care physician co-operatives.</p> <p>United States: Many Innovation Center models for primary care and episode-based payments incentivise co-ordinated or integrated care among providers.</p>

Type of policy	Country examples
Use of care co-ordinators	<p>Lithuania: Primary care institutions with at least 10 000 patients are required to employ a care co-ordinator, who is responsible for co-ordinating preventive screening and health services for patients living with chronic conditions.</p> <p>Norway: strengthen the links between primary care and specialist health services through appointing care co-ordinators to strengthen pathways of care.</p> <p>Sweden: Primary care clinics in are required to assign a care co-ordinator to a patient needing health or social care support following a hospital stay.</p>
Promotion of multidisciplinary teams and task-shifting	<p>Austria: multi-disciplinary teams are a requirement for innovative primary health care units where core teams of two to three general practitioners are complemented by nurses, administrative staff, and other health professionals, including paediatricians, therapists, or in some cases social workers.</p> <p>Belgium: Multi-disciplinary team meetings (multidisciplinaire oncologische consult, MOC) have been introduced in to improve care management for people with cancer to strengthen continuity of care and ensure patients receive more timely diagnosis and treatment.</p> <p>Canada: Primary Care Networks comprised of doctors, nurse practitioners, pharmacists, and community care centres offer access to co-ordinated health services in British Columbia, while in Manitoba, teams of providers including physicians, nurses, midwives, and community workers provide co-ordinated team-based care under the Service Co-ordination Framework for Primary Care. Use of multi-disciplinary health teams to promote integrated, community-based care has also been encouraged in the province of Ontario through the use of bundled payments.</p> <p>Costa Rica: Multi-disciplinary teams are a requirement for innovative primary care units, where core teams of a general practitioner are complemented by a nurse, administrative staff, and other health professionals. Primary Care Networks comprised of doctors, nurse practitioners, pharmacists and community care centres also offer access to co-ordinated health services. Multi-disciplinary teams are also required in palliative health care units and long-term care, including for at-home long-term and palliative care.</p> <p>Germany: The Federal Ministry of Health has launched a strategy process to promote multi-disciplinary teams, with the goal of strengthening the role of nurses and identifying the tasks and responsibilities nurses can take on in addition to their current competencies.</p> <p>Japan: Ministry has promoted task-shifting as an avenue to help reform the work style of medical doctors.</p> <p>Lithuania: Multi-disciplinary teams are active in general practice, outpatient dental care, and primary mental health services</p>
Use of e-health solutions and digital tools for integration	<p>Austria, Belgium, Canada, Israel, Lithuania, Luxembourg, and the United Kingdom (Wales): reported using e-health solutions and digital tools to improve integration and co-ordination within health systems.</p> <p>Austria: the electronic health records system Elektronische Gesundheitskarte (ELGA) was launched in hospitals in 2015, and expanded to pharmacies and physicians in private practice in 2018.</p> <p>Belgium: Financial incentives to encourage the scale-up of e-health services, including electronic prescribing. The Belgian health system performance report also includes performance metrics focused on the take-up of electronic health services as part of measuring progress towards better care integration and co-ordination, including the proportion of patients with a global medical record registered with a general practitioner.</p> <p>Canada has also focused on scaling up the use of electronic prescribing and other e-health initiatives and recently committed CAD 300 million over five years to expand e-prescribing, increase EHR use and improve linkages between EHR systems, and improve patient access to health records.</p> <p>Estonia: the government is harnessing its advanced digital capacity to improve the interoperability of registries and administrative datasets for individuals with needs for integrated care and vocational support.</p>
Integration of health care, long-term care and social services	<p>Japan: Since 2018, co-ordination at the municipal level between home medical care and long-term care so that older people who require support from both medical and long-term care can continue to live at home until the end of their lives.</p> <p>Norway: Anybody requiring long-term health and social care services is entitled to an individual care plan, if they would like one.</p>

People and health systems continue to bear the costs of poor integration

As demographic change transforms the burden of disease across OECD countries, people will increasingly need support from across different levels of the health care system, as well as assistance from both health- and social care. This is particularly true for people living with chronic conditions, as well as those who will ultimately require long-term care support. Better integrating health care – as well as better integrating health and social care – can facilitate health promotion, and poor integration has regularly been identified as key barrier to delivering better person-centred, community-based care.

Evidence from across OECD countries suggests the cost of poor integration and co-ordination is high. In the hospital sector, for example, delayed discharges and hospital readmissions contribute significantly to overall health spending. Caring for a patient in an acute hospital for whom care in other settings is

appropriate is expensive. Hospital spending accounts for a significant proportion of overall health spending in OECD countries, with overall hospital spending comprising 38% of health spending in OECD countries (OECD, 2019^[24]).

Estimates further suggest that delayed discharges and hospital readmissions contribute substantially to hospital costs. Studies have indicated that the additional bed days occupied by patients ready to be discharged from hospital could comprise between 11% and 31% of overall hospital costs (Landeiro, Leal and Gray, 2016^[47]). The costs of delayed discharge stem both from the additional days in hospital accrued by patients otherwise ready to leave, as well as the follow-on effect these additional days have on other hospital services. Occupied beds cannot be used for other patients who may require inpatient acute care, creating bed shortages and delaying transfers of care within hospitals, such as from the emergency ward. A cross-country systematic review of economic studies of delayed discharge estimated that the cost of delayed discharges averages between about GBP 200-565 (EUR 230-650) per patient per day (Rojas-García et al., 2017^[48]). While not all hospital readmissions are preventable, many are likely avoidable with better and more co-ordinated care in the community. In a study of a telephone intervention administered to patients following hospital discharge, for example, people who received a post-discharge follow-up call were 23% less likely to be readmitted to hospital within 30 days

Poor co-ordination between hospitals and community-based services has been recognised as a key contributor to delayed discharges and hospital readmissions for more than 30 years (Barker et al., 1985^[49]; Shepperd et al., 2013^[50]). Even with advancements in digital communication services, hospitals continue to implement discharge planning processes which are poorly co-ordinated with external services. In many cases, discharge planning begins at the end of a hospital stay, limiting the time that hospitals, patients and communities have to prepare for post-discharge support. Co-ordination remains fragmented in too many cases. In response, some countries have taken steps to change the governance of health and social care, in some cases merging all or parts of the two systems. In other cases, steps toward integration occur at a much more micro level, focusing on improving interdisciplinary responses.

All responding countries reported that that concrete policies to promote better care co-ordination within the health system have either been implemented (13/18) or are under discussion or were recently announced (5/18). Many countries (including Austria, Belgium, Canada, Israel, Lithuania, Luxembourg, and the United Kingdom – Wales) reported using e-health solutions and digital tools to improve integration and co-ordination within health systems. Other countries report working to strengthen primary care services and general practice (Austria, Japan, Lithuania), or to strengthen the links between primary care and specialist health services through appointing care co-ordinators to strengthen pathways of care (Lithuania, Norway). More than half of responding countries (10/19) also reported implementing policies to strengthen co-ordination between the health and social care sectors, with most others reporting that such policies are at least under discussion or have been announced (8/19).

Seven countries reported developing performance metrics that monitor progress towards better care integration and co-ordination. In many cases, these measures have been developed for specific care pathways or diseases, such as cancer (Belgium, the Czech Republic, Sweden). In Sweden, for example, standardised pathways for investigating and diagnosing cancer include time frames for significant steps along the pathway, as well as assessment measures for patient flow. Based on this cancer care pathway, Sweden has now begun a national project to develop standardised pathways of care across other diseases. In Israel, the Ministry of Health has taken steps to publicise the results of the Quality Indicators Report, which includes measures monitoring integration and co-ordination of care. In presenting the results of the exercise on a public-oriented online platform, health care providers are encouraged to incentivise – through public pressure – to improve their outcomes. In the Czech Republic, the General Health Insurance Fund (VZP) launched new service codes and reimbursement mechanisms to better incentivise the development and use of patient pathways between oncological treatment centres and other health care providers to improve care integration for patients with cancer. Care pathway pilot studies are underway in

Estonia for stroke and cancer, with the goal to create a financing system that incentivise a co-ordinated, person-centred treatment pathways for the conditions.

Countries are increasingly focusing on the role of primary care in care co-ordination strategies. In Estonia, for example, a quality bonus system has been developed to incentivise the performance of family doctors in chronic disease management, among other areas. To promote person-centred care co-ordination for people with complex needs, focused on the primary care level, a care co-ordinator role has been established to connect patients between their primary health care provider and other services offered in the social care system. Primary care clinics in Sweden are required to assign a care co-ordinator to a patient needing health or social care support following a hospital stay. Where the attending physician in hospital determines a patient requires a care plan following hospitalisation, the primary care clinic is also responsible for the plan. In Lithuania, primary care institutions with at least 10 000 patients are required to employ a care co-ordinator, who is responsible for co-ordinating preventive screening and health services for patients living with chronic conditions.

Nearly all countries have developed or are developing multi-disciplinary teams of health professionals to deliver more co-ordinated care to patients. Many of these are focused on the primary care level. In primary care, team- or network-based primary care models have been found to better serve the needs of a people-centred system by offering more services (often closer to home), while also delivering lower costs and economies of scale to the health system overall (OECD, 2020^[51]). People-centred primary care models have been developed or are in the process of being set up in at least 15 OECD countries (OECD, 2020^[51]).

Primary Care Networks comprised of doctors, nurse practitioners, pharmacists, and community care centres offer access to co-ordinated health services in British Columbia, Canada, while in Manitoba, teams of providers including physicians, nurses, midwives, and community workers provide co-ordinated team-based care under the Service Co-ordination Framework for Primary Care. These multi-disciplinary teams work together both in-person and virtually, depending on the needs of the local community. The use of multi-disciplinary health teams to promote integrated, community-based care has also been encouraged in the province of Ontario through the use of bundled payments. Norway is currently piloting primary health care teams, with the pilot transitioning away from predominantly fee-for-service payments, towards payment methods for care over time or for bundled services, as well as towards targeted funding from local authorities for hiring additional categories of professionals into physician-owned practices or primary health care physician co-operatives.

In Japan, the ministry has promoted task-shifting as an avenue to help reform the work style of medical doctors. Other countries have promoted a multi-disciplinary team approach in primary care. In Lithuania, for example, multi-disciplinary teams are active in general practice, outpatient dental care, and primary mental health services, while multi-disciplinary teams are a requirement for innovative primary health care units in Austria, where core teams of two to three general practitioners are complemented by nurses, administrative staff, and other health professionals, including paediatricians, therapists, or in some cases social workers. Multi-disciplinary team meetings (*multidisciplinaire oncologische consult, MOC*) have also been introduced in Belgium to improve care management for people with cancer to strengthen continuity of care and ensure patients receive more timely diagnosis and treatment. In Germany, the Federal Ministry of Health has launched a strategy process to promote multi-disciplinary teams, with the goal of strengthening the role of nurses and identifying the tasks and responsibilities nurses can take on in addition to their current competencies.

Health systems have increasingly turned to digital tools to strengthen co-ordination of care

Countries have put a major focus on the potential of digital tools to help solve co-ordination challenges in health care systems. In particular, the use of electronic health or medical records (EHR or EMR) has received substantial attention for its potential to improve integration across disparate parts of the health system. In recent years, OECD countries have made significant progress in moving towards the use of

electronic records. While there has been substantial progress made towards the uptake of electronic records, however, establishing linkages and integration between the use of electronic records has been slower, with just 64% of OECD countries reporting that data can be exchanged across a secure integrated network (Oderkirk, 2017^[52]; OECD, 2019^[31]). Primary care settings, in particular, have often been excluded from closer integration with other electronic health systems. This can mean that information recorded in primary care may not be transmitted to other patient settings, such as hospitals, or that information from a hospital visit is not necessarily shared with a patient's primary care provider, hampering effective, patient-centred co-ordination of care.

Many countries report policies to strengthen the use of electronic records in primary care are underway. In Austria, the electronic health records system *Elektronische Gesundheitskarte* (ELGA) was launched in hospitals in 2015, and expanded to pharmacies and physicians in private practice in 2018. Plans are underway to further expand the use of ELGA in laboratories and radiology, allowing ELGA to ultimately serve as the infrastructure for patient-facing eHealth applications, including electronic vaccination passports. In Belgium, the government has introduced financial incentives to encourage the scale-up of ehealth services, including electronic prescribing. A quarter of physicians and 37% of dentists currently issue electronic prescriptions. The Belgian health system performance report also includes performance metrics focused on the take-up of electronic health services as part of measuring progress towards better care integration and co-ordination, including the proportion of patients with a global medical record registered with a general practitioner. Canada has also focused on scaling up the use of electronic prescribing and other ehealth initiatives and recently committed CAD 300 million over five years to expand e-prescribing, increase EHR use and improve linkages between EHR systems, and improve patient access to health records. Through a project to support integrated service provision reform in Estonia, the government is harnessing its advanced digital capacity to improve the interoperability of registries and administrative datasets for individuals with needs for integrated care and vocational support. Efforts to improve the integration of digital tools have been accompanied by the introduction of performance-based financing to better incentivise integrated care.

Co-ordination between long-term care services delivered through social care, and health, poses an additional challenge to integration, particularly when health and social care are under the purview of different ministries. In Japan since 2018, co-ordination at the municipal level between home medical care and long-term care has been promoted through a programme funded by the long-term care insurance scheme, so that older people who require support from both medical and long-term care can continue to live at home until the end of their lives. In Norway, anybody requiring long-term health and social care services is entitled to an individual care plan, if they would like one. The patient and their family (next of kin) must be given the opportunity to be involved, if they wish to be.

Developing a holistic people-centred approach to health

Countries have in recent years scaled up a range of policies that promote or aim to strengthen people-centredness, across all five dimensions important to the health system. There is widespread recognition of both the importance of moving towards a people-centred approach, and an understanding of many of the barriers to doing so, including health systems fragmentation, skills mismatch, poor health literacy, and power imbalances that can detract from informed and active participation on the part of the patient. At the same time, many of the policies that have contributed to advancing the transition towards people-centredness have been developed primarily aimed at other goals – such as improving efficiency or quality – that are critical to achieving a high-performing health system, but not implemented in the interest of people-centredness per se. As such, many measures may not take into account their broader role in achieving people-centred health and systems. In other words, the development and delivery of many people-centred policies often remains fragmented.

There is a clear need to more deeply institutionalise the impact on people-centredness as a key parameter across health policy making, so that trade-offs can be made more apparent and a better balance can be achieved among policy objectives, such as efficiency, health security, or people-centredness. The OECD Framework and Scorecard for People-Centred Health Systems aims to contribute to the policy making process and to provide tools for countries to examine and evaluate such impacts. Far from being a definitive or all-encompassing framework for health policy, it is intended to shed more light on the policy issues surrounding health system from the perspective of the people.

The response to the global COVID-19 pandemic provides a good example of the application of the People-Centred Health Systems framework to a concrete and urgent policy need, underscoring the fragmented approach to people-centred policy making. In some ways, measures taken to contain the pandemic have furthered long-held goals of people-centred health systems, such as the adoption of digital tools and teleconsultations that have facilitated patient choice, or the promotion of multidisciplinary teams and expansion of responsibilities taken by certain primary care practitioners, including community pharmacists. At the same time, the speed of the response meant that patient voices were not included as systematically as a person-centred response would warrant, and many of the measures adopted – most notably infection control policies adopted in hospitals and long-term care facilities – went against the expressed wishes of patients and their families.

A lack of thorough measurement across the five dimensions of people-centred health systems underscores the reality that countries have further to go to delivering systematically people-centred policies, across sectors, services, and levels of the health system. Benchmarking across the five dimensions of the OECD Framework has highlighted that while certain countries appear to perform relatively strongly across the different dimensions of people-centredness, very few countries perform uniformly well across voice, choice, co-production, integration and respectfulness in orienting their health systems to be people centred. Moreover, data availability across all measures and dimensions by country remains inconsistent. The lack of available data to measure progress across all five dimensions underscores how far many countries have to go to better embedding people-centredness as a key actionable principle throughout their health systems. All countries have room to improve the people-centredness of their health systems.

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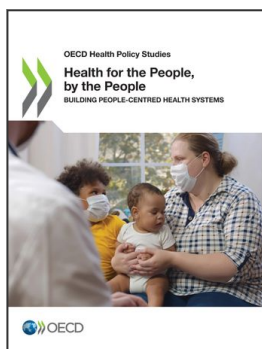
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