MODELS OF INTEGRATED CARE
THE GLOBAL EXPERIENCE

DISCUSSION PAPER

APRIL 2023

Jacqueline Mallender
Arian Hatefi
Luke Allen
Zara Shubber
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Sameh El-Saharty
Ghassan Karem

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WORLD BANK GROUP
Health, Nutrition & Population

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Health, Nutrition, and Population (HNP) Discussion Paper

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Health, Nutrition, and Population (HNP) Discussion Paper

Models of Integrated Care

The Global Experience

Jacqueline Mallender,[a] Arian Hatefi,[b] Luke Allen,[c] Zara Shubber,[b] Mohini Kak,[b] Sameh El-Saharty,[b] Ghassan Karem[d]

[a] Economics by Design, London, United Kingdom
[b] Health, Nutrition, and Population Global Practice, the World Bank, Washington, DC United States
[c] London School of Hygiene and Tropical Medicine, University of Oxford, London, United Kingdom
[d] Primary Health Care Institute, Tripoli, Libya

This Discussion Paper was prepared for the Ministry of Health in Libya with support from the government of Japan through the World Bank Group–administered Policy and Human Resources Development Fund (PHRD)

Abstract:

This Global Experience Paper on Integrated Health Care was developed to provide the Primary Health Care Institute (PHCI) in Libya with insights as it designs and develops its plans to rebuild primary health care (PHC). The findings are informed by a review of recent international literature, and by insights provided by selected international experts. The paper uses the Framework on Integrated, People-Centered Health Services from the World Health Organization to structure the analysis of global experiences. Overall, there is no single model of integration that can or should be adopted in countries seeking to develop primary health care. There is, however, evidence of good practice in designing and developing local, context-specific solutions. Evidence to support effective strategies and policies relevant for conflict-affected situations is scarce. However, there are some common themes and issues relating to the need to rebuild trust in the quality and safety of services; to build from existing assets, including donor-funded programs; to adopt a multisectoral approach with a focus on infrastructure to support supply chain security, and the use of financial incentives to support workforce participation. The paper focuses on the pivotal role played by primary health care and identifies five high-impact strategies for the PHCI to rebuild PHC. These strategies are to accelerate the development of a multiprofessional primary health care workforce; develop primary health care provider networks; use primary health care to build linkages from existing community and donor assets; take a digital-first approach to integration; and use simple and transparent funding models.

Keywords: Integrated care systems, primary health care, Libya, fragile and conflict-affected situations, global health

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Correspondence Details: Jacqueline Mallender, Director, Economics By Design Ltd, 128 City Road, London, EC1V 2NX, United Kingdom, www.economicsbydesign.com, email: jacx@economicsbydesign.com

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FOREWORD

This is a report on global experiences of integrated care with particular focus on the role of primary care and the challenges facing fragile and conflict-affected situations. The report highlights the importance of developing a multiprofessional primary health care (PHC) workforce to strengthen capacity and capability, and to promote early adoption of population health and integrated disease management programs. It demonstrates the potential value of establishing networks of primary health care providers supporting local geographically defined populations with strong clinical links with secondary care providers. This is essential to accelerate quality and trust in services and support horizontal and vertical service integration. Value can be leveraged from the assets that already exist across local communities as well as from improved coordination with donor-funded vertical programs, across all sectors. The report also highlights the importance of digital health to support and empower patients, the health care workforce, and health care providers; benefits include improved patient engagement, more efficient and effective pathway management, and improved population health planning that results from high-quality data collection and information. Finally, the report highlights the importance of financial flows. There are clear benefits from working with other national agencies to encourage pooling of funds (where possible) and engaging in strategic purchasing, including the use of both simple payment models and incentives targeted directly to the health workforce.

After a decade of conflict there is a pressing need for Libya to address priorities in relation to the burden of illness and health inequalities, to restore basic services and service quality, and to improve geographical access to essential services. There is a real opportunity to build integrated care strategies into the reconstruction efforts from the outset. The planned health system reform, *Well and Healthy Libya: National Health Policy 2030*, already includes many of the system design features highlighted in this report as being essential for improving value in health systems. In this context, the Primary Health Care Institute has a pivotal role to play in enabling primary health care to lead local health promotion programs and to be the focus for high-quality, well-coordinated health care. The lessons highlighted in this report provide insights that can guide the Primary Health Care Institute as it develops the detailed road map for primary health care development.

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GLOSSARY

ACO	Accountable Care Organization
AHA	Active and Healthy Ageing
DALYs	Disability-Adjusted Life Years
EHRs	Electronic Health Records
EIP	European Innovation Partnership
EMR	Electronic Medical Record
EMRO	Regional Office for the Eastern Mediterranean
EPHS	Essential Primary Health Service
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICCNet	Integrated Cardiovascular Clinical Network
IFIC	International Foundation for Integrated Care
IHDNs	Integrated Health Service Delivery Networks
IHME	Institute for Health Metrics and Evaluation
IHO	Integrated Health Organization
IPCHS	Integrated, People-Centered Health Services
JLN	Joint Learning Network
KPIs	Key Performance Indicators
LMICs	Low- and Middle-Income Countries (as defined by the World Bank Group)
MDTs	Multidisciplinary Teams
NGOs	Nongovernmental Organizations
NOC	Network Of Care
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OECD	Organisation for Economic Co-operation and Development
PCNs	Primary Health Care Networks

PHC	Primary Health Care
PHCI	Primary Health Care Institute, Libya
PHCPI	Primary Health Care Performance Initiative
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations International Children's Emergency Fund
WBG	World Bank Group
WHO	World Health Organization
WONCA	World Organization of Family Doctors

PART I – EXECUTIVE SUMMARY

INTRODUCTION

This Global Experience Paper on Integrated Health Care has been developed to provide the Primary Health Care Institute (PHCI) in Libya with insights as it designs and develops its plans to rebuild primary health care (PHC). Integrated care is a key objective of the reform program *Well and Healthy Libya: National Health Policy 2030* (National Centre for Health System Reform n.d.). Delivering an integrated continuum of care will drive the reorientation of the health services delivery system. This review of the global experience in integrated health care is intended to inform strategies and interventions for inclusion in PHC reform for the PHCI.

For the purpose of this paper, the definition of integrated health services is taken from the Framework on Integrated, People-Centered Health Services (IPCHS) adopted at the 69th World Health Assembly in 2016 (Integrated, People-Centered Health Services n.d.[a]).

Integrated Health Services are "*health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course,*" (Integrated, People-Centered Health Services n.d.[a]).

The strategic priorities and policy actions contained in the IPCHS framework provide the starting point for analyzing international experiences relevant to Libya.

This paper is informed by a review of recent international literature, and by insights provided by selected international experts, beginning with a review of precurated literature from the International Foundation for Integrated Care (IFIC) Knowledge Tree (International Foundation for Integrated Care n.d.[a]), and complemented by citations, references, and lines of inquiry suggested by experts. It is not a systematic review that covers all literature on service integration.

THE LIBYAN CONTEXT

An oil-based economy, Libya is an upper-middle-income country with per capita GDP of $1,936, a Human Development Index of 0.724, and a global rank of 105 (Country Economy n.d.), but one that has experienced severe and damaging internal conflicts since 2011. The conflicts have had significant negative impacts on the economy, society, and health sector. In Libya, conflict and terror rank fourth in the top-10 causes of disability-adjusted life years (DALYs)—the number of years of potential life lost to premature mortality, added to the years of productive life lost because of disability—and stand out as major outliers in comparison with countries with similar socioeconomic profiles (IHME n.d.). Estimates in the World Health Organization's *Libya: Annual Report 2020* (WHO Country Office 2020) suggest that out of a total population of approximately 6.8 million, almost 900,000 required humanitarian assistance during the year, and up to 400,000 were displaced. The report concludes that the health system is severely compromised in access to functioning health facilities and to services, with

severe shortages of health workers and pharmaceuticals (medicines). These problems have been exacerbated by the COVID-19 pandemic. In March 2021, a new Government of National Unity was approved to maintain peace, commence work to rebuild the country, and progress toward national elections.

Libya is committed to reforming and investing in health, with primary health care (PHC) taking center stage in the development of integrated services (National Centre for Health System Reform n.d.). Led by the PHCI, the plan is to make PHC the center of integration of health service delivery. Family practice will be the key driver of prevention strategies and population health management. It will serve as a central point of coordination between tiers (referrals to and from secondary care) and across care pathways for every local catchment population. The 2020–2022 PHC Strategy (WHO 2016) identifies several detailed actions, which, if implemented, will provide an important foundation for the development of integrated care across the entire health system.

GLOBAL EXPERIENCES OF INTEGRATED CARE

As articulated in the Framework on Integrated, People-Centered Health Services adopted by the World Health Assembly in 2016, there is broad agreement on the strategic priorities for the development of integrated health systems and on the idea that these should be people-centered. The strategic priorities (WHO 2016) include the following:

- Empowering and engaging people and communities
- Strengthening governance and accountability
- Reorienting the model of care
- Coordinating services within and across sectors
- Creating an enabling environment consisting of leadership and management, quality improvement, information systems, systems research and knowledge management, workforce, regulatory frameworks, and funding and payment reforms

There is well-documented evidence to support the fundamental importance of these strategic priorities and their associated policy actions. The evidence, however, is complex and context-specific. There is no single model of integration that can be replicated at scale. Rather, there are many examples of good practice at local, regional, and national levels that can provide lessons for countries considering health system reform and associated policy actions.

There is also consensus that PHC has the potential to play a pivotal role. It provides a focus for implementing policies that empower and engage people and communities. In this way, citizens can take a greater role in managing their own health. Communities can also contribute to system performance by informing local needs assessment and priorities for improvement. PHC provides an opportunity for local participatory governance by citizens and for providers to be held accountable for quality and health system integration, as well as locality-based intersectoral collaboration. High-quality PHC is essential for the reorientation of health care systems. PHC provides consistent point-of-care coordination and case management for patients and their families, both horizontally (across a spectrum of needs) and vertically (referrals along a

care pathway). The development of high-quality, well-led PHC infrastructure (facilities, technology, and workforce) within an enabling regulatory framework, supported by the right financial incentives, is a vital catalyst to integrated care.

As might be expected, there is a paucity of evidence of good practice from countries implementing integrated care systems in postconflict situations. However, some important common themes are emerging. Strategies and policy actions that build trust in the quality and safety of services, particularly primary and community services, are vital if new care pathways are to be implemented by clinicians and used by service users. Horizontal and vertical programs should build from existing assets, including community resources, the private sector, donor-funded programs, and public sector infrastructure and resources. This approach should be multisectoral and cover the wider infrastructure required to make things work, including supply chains, transport systems, storage facilities, sharable physical facilities, and community spaces. Investment in reconstruction should initially be input-based, with funding sources pooled as much as possible. Providers should be paid using simple and reliable provider payment mechanisms, and workforce incentive payments should be used selectively for developing and rebuilding and engaging a high-quality health workforce.

Lessons for Countries Developing Primary Health Care

There are several strategic priorities that should be considered by countries like Libya seeking to reform their health system. These priorities reflect the learning from global best practice, while recognizing the challenges of implementing reform in the context of a fragile or postconflict setting.

All of them can be expected to have a positive impact on the triple aim of improving population health, enhancing the experience of service users, and raising the health system's value for money.

Countries can adopt strategies that support PHC providers to

- employ existing community assets, nongovernmental organizations (NGOs) and established community groups to develop a community-owned perspective on health priorities and population health needs for a locality;
- develop strong linkages with voluntary sector and private sector providers (including pharmacists, dentists, and so on) and with established, successful emergency relief and targeted donor-funded health programs;
- assist individuals and families to take ownership and control of their own health;
- enable the development of PHC networks by developing an operational framework;
- adopt a digital-first approach by enabling PHC and working with other agencies to support fast-track investment in digital platforms and informatics;
- pool financial resources by working with the Ministry of Health, Ministry of Finance, and international donor agencies and seek to distribute these through strategic purchasing;
- adopt simple provider payment models targeted at solving problems;

- review the legislative and policy framework, with a focus on reducing barriers to people-centered and integrated services that are safe, effective, and evidence-informed;
- enable subsidiary with accountability and build trust by strengthening local leadership, management, administration, and governance of local public sector bodies across sectors; and
- accelerate capacity and capability and promote population health and integrated disease management programs quickly by coordinating a national program to fast-track the recruitment and training of a multiprofessional PHC workforce.

Each of these strategies would have resource implications if adopted. They should all show a return on investment in terms of health system value. It will be important to develop more detailed logic models (or theories of change) that show the inputs, process, outputs, outcome, and associated costs and benefits as compared with alternative strategies. These could then be appraised from the perspective of their potential value to the system and the management effort needed to make them successful.

Because this is a long list, it may be prudent to try and identify priorities. An initial assessment of potential value and ease of implementation that has been undertaken suggests an initial short list of five priorities, shown in Table ES-1.1 below. These priorities will need to be revisited with the PHCI to take account of local opportunities and constraints.

Table ES-1.1: Five Priorty Strategies

Strategic priority	Summary description	Value-generation mechanisms
Accelerate development of a multiprofessional PHC workforce	Coordinate a national program to fast-track the recruitment and training of a multiprofessional PHC workforce to accelerate capacity and capability, and to promote population health and integrated disease management programs quickly.	Builds capacity and capability quickly Creates employment in local communities Promotes community engagement Provides PHC with a team to do more than just act as a gateway to secondary care
Develop PHC provider networks	Support PHC providers to form geographically based local networks that have strong clinical links with secondary care providers to accelerate quality and trust in services and accelerate horizontal and vertical service integration.	Develops capability and horizontal integration speedily Promotes vertical integration along with strong clinical governance, assurance, and efficient and safe integrated practice Builds trust in new service models (for patients and the health workforce)
Use PHC to build linkages from existing assets	Support these PHC networks to fast-track integrated service delivery linkages with existing services, community assets, and donor-funded vertical programs across all sectors.	Building links and integration rapidly Creates new integration alliances and partnerships quickly Builds trust across the system Encourages community participation
Take a digital-first approach to integration	Work with other national agencies to enable and empower PHC providers to take a digital-first approach as they develop new integrated care services to improve patient engagement and pathway management, and to support data collection and information.	Empowers patients to become involved in managing their own health Enables rapid adoption of new models of care by health care professionals Supports newly trained workforce to practice with confidence

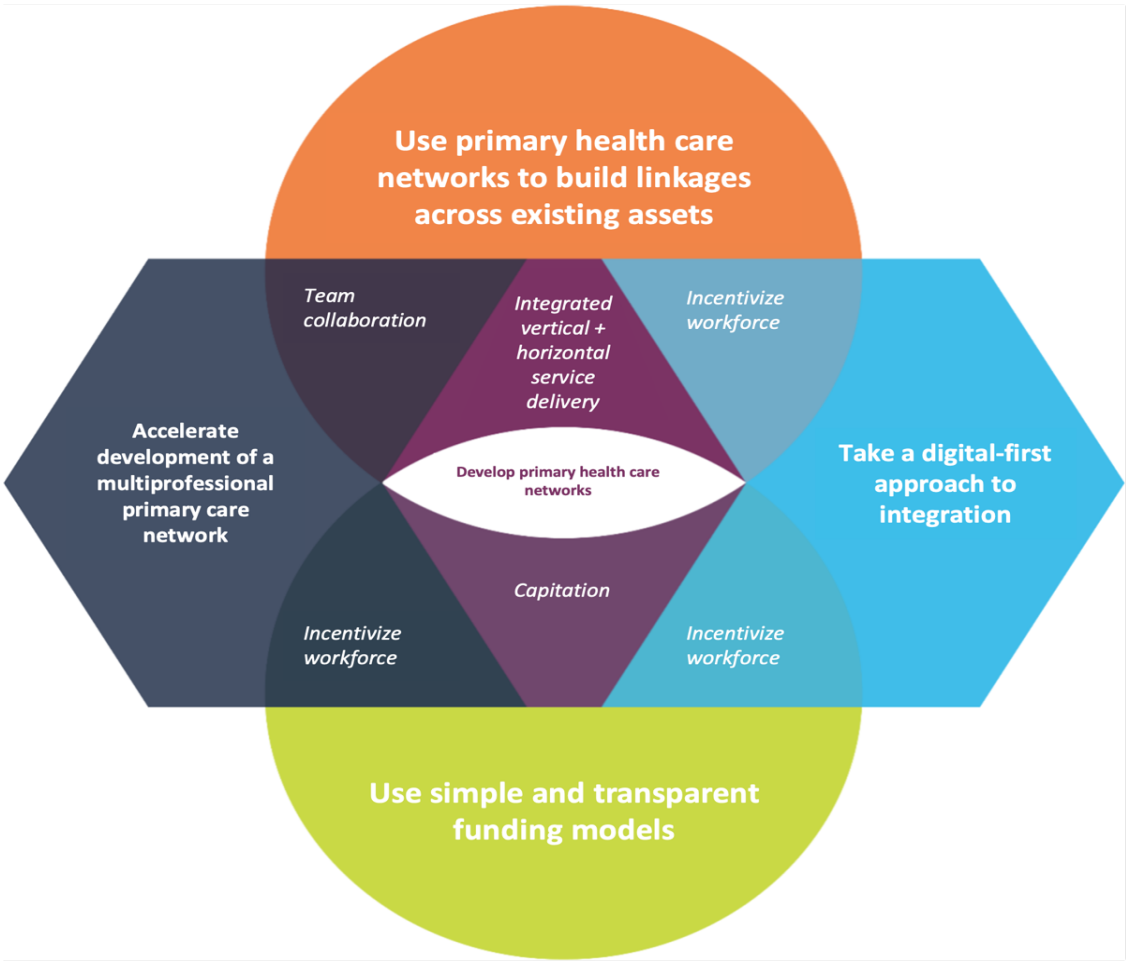
Use simple and transparent funding models	Work with other national agencies to encourage pooling of source funds (where possible) and strategic purchasing activities, including the use of both simple payment models and incentives targeted directly at the health workforce.	Improves resource allocation overall Provides financial security for providers Rewards workforce for participation and integration activities to improve performance

Source: Authors' Analysis

Note: PHC = Primary health care.

These priorities are illustrated in Figure ES-1.1

Figure ES-1.1: Priority Strategies for Using Primary Health Care to Promote Integration



Source: Authors Analysis

CONCLUSIONS

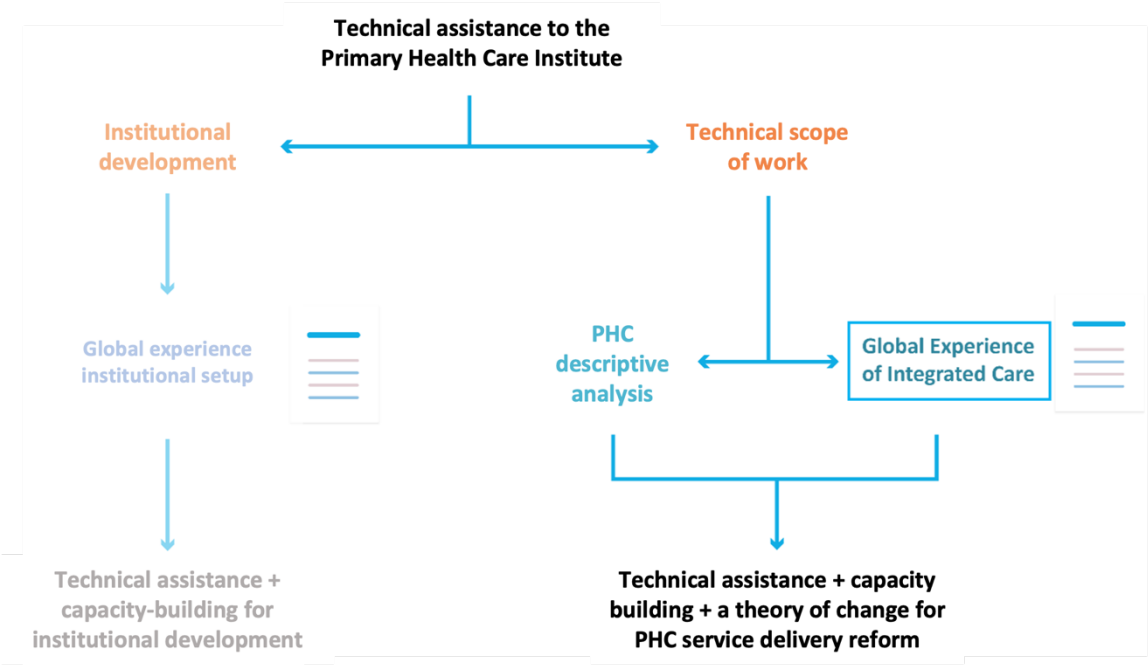
This is a report on global experiences of integrated care, with a particular focus on the role of primary care and the challenges facing fragile and conflict-affected situations. There is evidence that designing and implementing people-centered and integrated health care systems and services contribute to improved population health, patient outcomes, and health system efficiency. Although evidence of good practice in postconflict situations is scarce, there are some important common themes emerging, and the review has identified five high-impact strategies, which, if prioritized by countries considering primary health care reform, could accelerate health system performance improvement. In Libya, this work is expected to lend to ongoing World Bank technical assistance to the PHCI by supporting its contextualization to the Libyan context with the objective of contributing to the country's PHC reform agenda.

PART II – INTRODUCTION

This Global Experience Paper on Integrated Health Care aims at providing insights to the Primary Health Care Institute (PHCI) in Libya as it designs and develops its plans to rebuild primary health care (PHC) following a decade of internal conflict. The new Libyan government has inherited many health system challenges exacerbated by the post-2011 conflict and compounded by COVID-19. Integrated care is a key objective of the reform program, *Well and Healthy Libya: National Health Policy 2030* (National Centre for Health System Reform n.d.). Delivering an integrated continuum of care will drive the reorientation of the health services delivery system.This review of the global experience in integrated health care can inform the development of the road map for reform, accelerate implementation, and fast-track improvements in health outcomes.

This Global Experience Paper is part of a wider program of technical assistance that the World Bank is providing to the PHC Institute in Libya. This is summarized in Figure 2.1 below:

Figure 2.1: The World Bank's Technical Assistance to the Primary Health Care Institute



Source: Authors Analysis
Notes: PHC = Primary health care.

For this paper, the definitions of integrated and people-centered health services are taken from the Framework on Integrated, People-Centered Health Services

(IPCHS) adopted at the 69th World Health Assembly in 2016 (Integrated, People-Centered Health Services n.d.[a]).

These are shown below.

Integrated, People-Centered Health Services Definitions

Integrated Health Services
These are "health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course."

People-Centered Health Services
This is "an approach to care that consciously adopts individuals', carers', families', and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences. People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment. People-centred care is broader than patient and person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services."

The overall objective of the paper is to select international lessons that can be applied and implemented as part of Libya's health system reforms. The paper adopts the IPCHS Framework as a focus for analyzing international experience. IPCHS is being adopted across the world to enable health care systems to deliver on such key goals as the following:

- Improving health outcomes (population health, health inequalities, and clinical care)
- Improving the experience of care for patients, families, and carers
- Promoting health system efficiency and value for money
- Improving the experience of care delivery for health care professionals

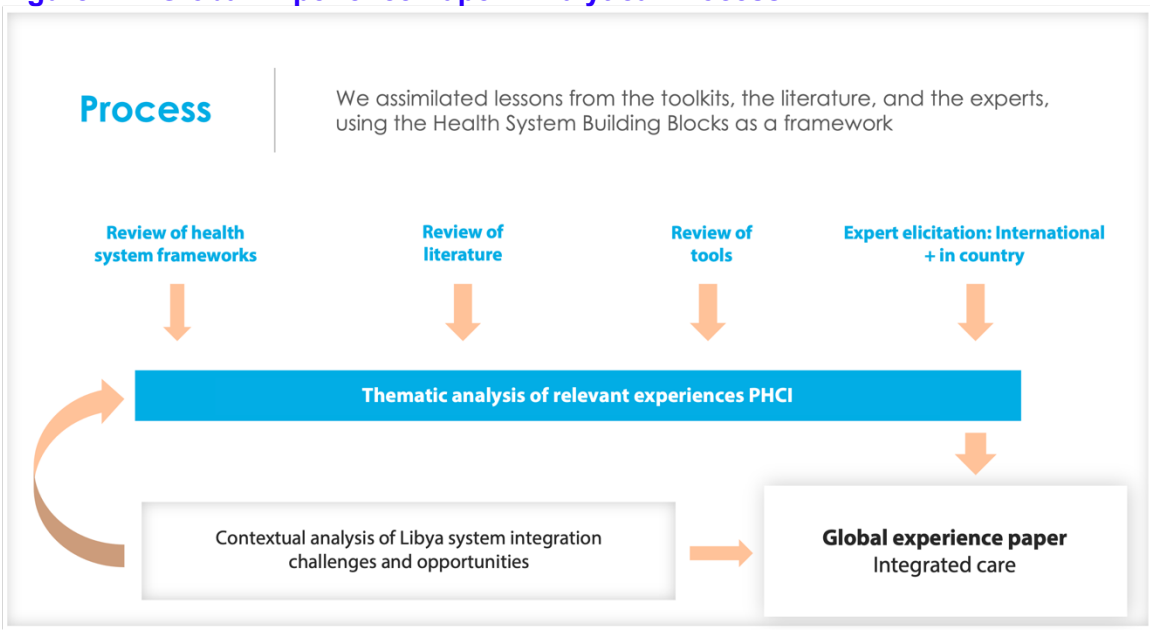
Integrated and person-centered care is being adopted at a local level, regional level, and national level by developed and low- and middle-income countries (LMICs) alike. There is a growing literature of evaluations and good practice assimilation, which provide important lessons for countries implementing IPCHS. These can help to accelerate the achievement of the benefits of integration. This report focuses on identifying those lessons that are of particular relevance to PHC and may be useful in meeting the unique challenges facing Libya.

A pragmatic approach has been adopted using evidence informed by an analysis of recent international literature, combined with insights provided by selected national and international experts. It was not possible within the timescales set for the development of this report to undertake a formal systematic review of the literature.

Moreover, the use of generic language to describe approaches and experiences presents challenges in the design of search terms. The search strategy adopted for this review was to instead focus on an analysis of key international reports and policy briefings, combined with a review of precurated literature from the International Foundation for Integrated Care (IFIC) Knowledge Tree, and complemented by citations, references, and lines of inquiry suggested by experts (International Foundation for Integrated Care n.d.[a]). It is not a review that systematically covers all literature on service integration. To supplement information on the current context in Libya and to identify additional international evidence and advice, interviews were held with a selection of international experts who have specific knowledge. These experts were also invited to review the report and comment on the findings and key messages.

A summary of the process is shown in Figure 2.2 below:

Figure 2.2: Global Experience Paper: Analytical Process



Source: Authors Analysis

The work was undertaken between March 2021 and June 2021.

A more detailed description of the process, including the literature review and list of experts consulted, is provided at Appendix A. A list of references is provided at the end of the report.

There are several strategic priorities that should be considered by countries like Libya seeking to reform their health system. These priorities reflect the learning from global best practice, whilst recognizing the challenges of implementing reform in the context of a fragile or postconflict setting. The report identifies key policy levers for integration, particularly relating to PHC, and points to examples of instances in which these best practice levers have been applied in fragile and conflict-affected situations. It identifies a number of integrated care strategies that might help Libya improve its health system performance. From this, a short list of priorities are identified. The report furthermore outlines a series of next steps and how they might be

integrated with the health system reform program and the development of a practical road map for delivery.

PART III – THE LIBYAN CONTEXT

CURRENT SITUATION

Libya is located in northern Africa and, although it is an upper-middle-income country with an oil-based economy, it has experienced severe and damaging internal conflicts since 2011. The Libyan economy is dependent on oil production and export. With per capita GDP of $1,936, it is a high middle-income country with a Human Development Index that ranks 105th globally (0.724) (Country Economy n.d.). Libya has experienced serious internal conflicts since 2011, which has had significant negative impacts on the economy and society. In March 2021, a new Government of National Unity was approved to maintain peace, commence work to rebuild the country, and progress toward national elections.

Healthy life expectancy at birth is currently 71.9 years and the maternal mortality ratio is 9 deaths per 100,000 live births. Table 3.1 below shows the top-10 causes of death and the top-10 causes of years lost from premature death and disability (IHME n.d.).

Table 3.1: Top-Ten Causes of Death and DALYs in Libya

Top-ten causes of death	Top-ten causes of DALYs
• Ischemic heart disease • Stroke • Road injuries • Chronic kidney disease • Hypertensive heart disease • Alzheimer's disease • Conflict and terror • Lung cancer • Diabetes • Lower respiratory tract infection	• Ischemic heart disease • Road injuries • Stroke • Conflict and terror • Diabetes • Depressive disorders • Low back pain • Headache disorders • Neonatal disorders • Gynecological disease

Source: IHME n.d.
Note: DALYs = Disability-adjusted life years.

Conflict and terror have made a major contribution to premature death and disability in Libya. As a category, **premature death and disability** ranks fourth in the top-10 causes of disability-adjusted life years (DALYs) and stands out as a major outlier in comparison with countries with similar socioeconomic profiles. But the conflict has also impacted other conditions, particularly mental health. Estimates presented in the WHO's *Libya: Annual Report 2020* (WHO Country Office 2020) suggest that almost 900,000 people required humanitarian assistance during the year, and up to 400,000 of the population was displaced.

The health service delivery system has been negatively affected by a decade of conflict and further exacerbated by the COVID-19 pandemic. The WHO's *Libya:*

Annual Report 2020 (WHO Country Office 2020) includes an assessment that the current health system is severely compromised in terms of access to functioning health facilities and to services, with severe shortages of health workers and pharmaceutical products. It was reported that even before the pandemic, more than half of PHC facilities had closed, with a further 50 percent closing in 2020. More than 250,000 children had missed vaccinations, and more than 66 percent of primary health centers were unable to provide any of the top-20 essential medicines. Access was particularly compromised in the south, with only 12 percent of facilities providing comprehensive essential services. Acute shortages of medical and nursing staff were also reported.

BARRIERS TO INTEGRATION

International evidence suggests that countries affected by conflict, or with high institutional and social fragility, face specific contextual challenges in relation to implementing integrated care (WHO 2015). These include specific health challenges such as the burden of disease and inequality for resident and displaced populations, a highly unstable supply of health care professionals, damaged and destroyed health facilities and supplies, a concentration of resources in donor-funded nongovernmental organizations (NGOs), disrupted communication and information systems, dysfunctional transport systems, interrupted supply chains, political and cultural instability, and pressure from the local population for visible urgent improvements to be made.

Left unaddressed, these issues will impact health outcomes and health system performance as Libya moves beyond conflict. An analysis of the challenges described in *Well and Healthy Libya: National Health Policy 2030* (National Centre for Health System Reform n.d.) is summarized in Table 3.2. This suggests that the Libyan health system is fraught with many of these barriers to integration. The prevailing culture—a hospital-based approach to health system supply, and autonomous silo-type work exacerbated by conflict—and an absence of an enabling legal framework, are among the challenges that need to be addressed as the country's health system moves toward a more integrated, people-centered approach. Evidence-informed disease management approaches and care pathways, combined with established referral systems, are not systematically used. Even where supplies are available, the management and optimization of medicines are not yet practiced systematically. This means that patients on multiple treatment pathways may not be complying with, or receiving, an effective integrated pharmacy solution.

Additionally, the health workforce is not currently trained or sufficiently rewarded to work within a multidisciplinary team structure, and PHC is nascent. There is a lack of public confidence in primary and community services to deliver services of the right quality consistently and safely. The relative absence of medical records has resulted in a dearth of information and information systems, which are both necessary for implementing an integrated approach. This puts enormous pressure on emergency and planned secondary and tertiary services, and late presentations by patients impact negatively on health outcomes. Finally, disrupted funding flows from government sources, combined with high levels of out-of-pocket expenditures, and catastrophic expenditures incurred by patients who use the private sector means that funds are not well targeted to building the new integrated services that are required to improve system performance on multiple fronts.

Table 3.2: Barriers to Integration in Libya's Health System

Governance of the health system	• A prevailing culture of autonomous health care institutions working in isolation from the wider system • Legacy barriers arising from the conflicts of the last decade and the absence of legal mandates for reform • Governance rooted in prerevolution vertical approaches to health system supply, which militates against efforts to move to a more integrated, person-centered approach
Health service delivery	• Conflict-affected areas where infrastructure and basic amenities have been significantly damaged, thus reducing the population's access to services • Poorly organized health care delivery systems for any given risk, disease, or condition, and their associated care pathways • Weak systems of patient referrals, and unclear care pathways across care settings as required to meet the health care needs of patients as a whole • Passive rather than proactive care management of patients • A lack of confidence in the quality of services, which itself discourages patients from accessing the services, and health professionals from referring patients • A system that is hospital-centric at the expense of primary and community services • A system that is insufficiently focused on prevention and population health management • Working practices across sectors that need to be established and operationalized to enable the implementation of health policies at the municipality level • A significant and separate private sector that accounts for out-of-pocket health care spending totaling about one-third of all health care spending
Health workforce	• A health workforce profile that is not well aligned to population needs • Health professionals who are not currently trained to, or motivated to, work in the multidisciplinary, multiprofessional teams that are needed to support new care pathways
Pharmaceuticals + other health technologies	• Weak or nonexistent systematic approaches to the management and optimization of medicines
Health Information System	• Barriers to the sharing of patient information across pathways required to optimize clinical decision making • Absence of systematic data analysis and reporting to support population health management and performance monitoring
Health system financing	• Health financing arrangements that result in high levels of out-of-pocket expenditure by patients and relatively high levels of catastrophic expenditure • Funding and financial resource flows that are designed around historical budget centers rather than directed to where they are most needed

Source: Based on authors analysis of *Well and Healthy Libya: National Health Policy 2030* (National Centre for Health System Reform n.d.).

PLANNED HEALTH SYSTEM REFORMS

The planned health system reforms provide a real opportunity for accelerated health system recovery and improvement of Libya's health system and delivery of Sustainable Development Goals (SDGs). Postconflict, Libya is committed to reforming and investing in health care and the Libyan Health System. Integration is a watermark throughout Libya's planned health system reform, as detailed in *Well and Healthy Libya: National Health Policy 2030* (National Centre for Health System Reform n.d.). The planned reforms align with the goals of Universal Health Coverage, Value-Based Care, and Integrated, People-Centered Health Services. The reforms center on providing an enabling environment to promote improved population health and health system efficiency. As indicated by the proposed financing arrangements in Section 4.6 of *Well and Healthy Libya: National Health Policy 2030* (National Centre for Health System Reform n.d.), the reforms include the following:

- A planned separation of the purchaser and provider functions
- The establishment of comprehensive health insurance and an essential benefits package
- Investment in a provider system incentivized to improve population health, PHC services, and coordination of treatment services across the system

The requirement now is to build a practical road map for implementation, informed by global experiences and focused on accelerating progress.

PHC will be central to the integration of health service delivery. The PHC Strategy for 2020–2022 (State of Libya, Ministry of Health, 2019) sets out a clear vision for the development of PHC, namely "*[a] strong, responsive and sustainable PHC system that improves health care for all Libyans, especially those who currently experience inequitable health outcomes, by keeping people healthy, preventing illness, reducing the need for hospital services and improving management of chronic conditions*." Led by the PHC Institute (PHCI), PHC is planned to be at the center of the integration of health service delivery, with the development of family practice as the key driver of prevention strategies and population health management. For every local catchment population, PHC will be a central point of coordination between tiers (referrals to and from secondary care) and across care pathways for health services delivery. The strategy identifies several detailed actions that, if implemented, will provide an important foundation for the development of IPCHS across the entire health system.

Additional information about the context for health system reform in Libya can be found in Appendix B.

PART IV – GLOBAL EXPERIENCES OF INTEGRATED CARE

WHAT IS INTEGRATED CARE?

There is no single definition of integrated care. A recent review identified 175 different versions of integrated care (Armitage et al. 2009). There is a multiplicity of different models and examples, and it is extremely difficult to classify these using a consistent taxonomy. A recent exercise to develop a repository of European models found a diverse array of more than 548 different initiatives (European Commission n.d.).

As discussed earlier, for the purpose of this analysis we have adopted the definitions and strategic taxonomy used in the IPCHS Framework developed by the WHO.

INTEGRATED PEOPLE-CENTERED HEALTH SERVICES

There is a growing global consensus and an evidence base that integrated care and people-centered care have the combined potential to deliver significant benefits to individuals and their families, local communities, health care workers, and health systems (Bennett et al. 2015; WHO 2015). Evidence reviews for the IPCHS as well as more recent systematic reviews have shown a range of measurable benefits (Baxter et al. 2018a, 2018b; Mitchell et al. 2015; Rocks et al. 2020). In summary:

- Individuals and their families are expected to benefit from improvements in their experience of access and timeliness of care, and a sharper focus on shared decision making and on achieving health outcomes and goals that matter to them.

- Local communities are expected to benefit through improved engagement and trust, reductions in health inequalities, better management of noncommunicable diseases, and improved population health.

- Health care workers are expected to benefit from improvements in the experience of delivering care, management of workload, and stress reduction.

- Health systems are expected to benefit from increased operational efficiencies across the care pathway, and better value in terms of efficiency and effectiveness in the use of resources.

Examples of integrated care programs exist all over the world and cover a wide array of systems, models, and initiatives, with varied goals and outcomes. A recent review of integrated care models that compared their characteristics across high-, middle- and low-income countries demonstrated how important context is to their development. Many high-income countries have developed models targeted to addressing risks associated with aging, chronic disease across the life course, and

mental health. By contrast, low- and middle-income countries have focused more on communicable disease and programs to improve maternal health. Expectations also vary, with high-income countries focusing on improving health system quality, value for money, and experience of care, while low- and middle-income countries tend to be more concerned with increasing access and utilization and maximizing the efficient use of scarce resources (Mounier-Jack, Mayhews, and Mays 2017).

The evidence shows that the design and implementation of successful integrated care and people-centered care ought to be developed at the country, regional, and local levels to reflect the local geopolitical and socioeconomic context (WHO 2015). There is no single model of integration or citizen engagement that can be adopted globally to deliver the expected benefits. Rather than being a replicable care pathway or model of care, integration and people-centered approaches are features of health system design that can be facilitated and enabled through specific national, regional, and local strategies and policy actions.

Based on a review of the evidence and the potential benefits, in April 2016 the 69th World Health Assembly adopted the Framework on Integrated, People-Centered Health Services (IPCHS) (WHO 2016). This marked the culmination of a global collaboration among WHO member countries to explore why and how countries might progress with developing people-centered integrated health care, and to review the evidence base. The framework was intended to provide some consistency in definitions and an evidence-informed taxonomy of critical strategies and policy actions that should be applied as needed on a country-specific basis.

The framework proposes five evidence-informed strategies critical to the effective design and delivery of IPCHS. The five strategies are:

1. Empowering and engaging people and communities
2. Strengthening governance and accountability
3. Reorienting the model of care
4. Coordinating services within and across sectors
5. Creating an enabling environment

Source: WHO 2016

The Declaration of Astana (WHO 2018a) demonstrated the vital role of PHC within integrated care, at the level of the system, the health care organization, the health care worker, and the individual patient. Using the Valentijn model (Valentijn et al. 2013), the declaration included a conceptual framework that demonstrated the complementarity of actions to promote normative integration—targeted at values and cultures, and functional integration—focused on systems and mechanisms. The model showed how actions to meet the needs of individual patients were aligned with those needed to develop population health.

IPCHS is now considered a critical component of value-based health services and the achievement of Universal Health Coverage (UHC) (WHO 2021a). It is recognized that a healthier population drives economic growth (WHO 2018b). Because of the rising costs of health care, health system policy makers need to drive improvements to

population health and the efficiency of health care delivery. Together, health benefit package selection and strategic purchasing, combined with an IPCHS approach, are critically important to this agenda.

Empowering and Engaging People and Communities

The IPCHS Framework recommends strategies for empowering and engaging individuals and their families, communities, informal carers, and the underserved and marginalized. Policy actions center on education, health literacy, communication, shared decision making with consent, and engagement with expert patients (WHO 2021b), supported by community-based delivery models involving community health workers, use of human-centered design approaches to understand health-seeking behaviors and improve health system navigation, training and network support for informal carers, and outreach models to address health inequalities; these are all important elements of person-centered integrated health care.

Countries are increasingly adopting engagement strategies, and there are many examples of good practice with clear evidence of benefit, as well as comprehensive toolkits, and guidelines. The national good practice guidelines on community engagement, issued by the National Institute for Health and Care Excellence, to the whole of the National Health Service (NHS) in England, is a good example of policy development and adoption at the country level based on compelling evidence of initiatives that improve effectiveness and value for money (NICE 2016). An oft-cited example of a specific model is the "*ajents en salud*" model driven by the Alzira Centre for Public Health in Valencia, Spain, shown as Case Study 1 below. This model involves trained local community health agents championing the dissemination of positive health messages within the community, resulting in improved participation and outcomes (WHO 2020). Reviews of other evidence and studies are cited in the supporting material that accompanies the IPCHS itself (WHO 2015). Extensive repositories of practical guidelines and policy actions are available to inform the development of a country-specific strategy. Examples include Ferrer (2015) and, more recently, the WHO's guide to community engagement (WHO 2020) and the handbook on social participation for UHC (WHO 2021c).

Case Study 1	Community engagement	Project RIU Alzira Centre of Public Health (Valencia, Spain)
Purpose	**Activities**	**Outcomes**
To promote access and utilization of services in vulnerable settings	❖ A collaboration between PHC and social services ❖ Targeted at specific neighborhoods ❖ Identified and trained multicultural women to be community health agents (*agentes de salud*) to communicate and promote health and health services	❖ Increased access and utilization of health services ❖ Improved information about health, contraception, pregnancy, and the benefits and availability of health services

	❖ Technical and financial support and working spaces

Note: PHC = Primary health care.

Not many examples of community engagement approaches exist in postconflict situations, but there is potential to use these to promote citizen reengagement more widely. Recent community engagement initiatives in the conflict-affected Darfur Region of Sudan are being used to rebuild citizen engagement. Here, following 14 years of war, the World Health Organization (WHO) worked with the Ministry of Health and local health authorities to reestablish health services that had been destroyed during the conflict. In the areas affected, citizens had to travel long distances to health facilities and, in the absence of accessible services, were reliant on traditional services or went without support completely. Community networks, and participatory meetings and dialogues between citizens and local officials enabled the development of a shared understanding of local needs and how these might be addressed. Regular community dialogues are used to enable citizens to identify and prioritize their needs and to identify codesign solutions while at the same time holding the local health providers to account for delivery. These initiatives have been particularly valuable in the context of managing the risks of outbreaks of COVID-19 (Universal Health Coverage Partnership 2021).

Strengthening Governance and Accountability

The IPCHS Framework recommends strategies to strengthen governance and accountability specifically from the perspective of participatory governance and to enhance mutual accountability. Participatory governance is focused on developing a culture of stewardship and covers a broad range of policy actions—including citizen involvement in policy setting, system design, delivery oversight (priority setting models of care, quality, and safety), intersectoral collaboration, public-private partnerships, and quality, decentralized as appropriate. Accountability comes with actions to establish health rights and entitlements, provider empanelment, and, importantly, patient experience and outcome reporting.

Many good practice examples exist to support actions to promote patient and public engagement in governance (WHO 2015). Examples include the use of patient charters (Canada, Denmark, England, Ghana, New Zealand, and Norway), structured community consultations (the Philippines), and the use of patient experience data to drive improvement (Chile, Ghana, India, , Philippines, Uganda, Ukraine, the United States, and Uzbekistan).

The most progressive examples of participatory governance involve some form of community ownership and management. A widely cited best practice example of more comprehensive community involvement in PHC is the NUKA health system in Alaska. This is a community-owned system, which, since its establishment in 1997, has seen significant increases in participation, improved service access, a reorientation of care away from hospitals, reduced health inequalities, and improved outcomes (WHO 2015). Community-owned PHC networks in Mali are also cited as having rapidly accelerated coverage and service provision (WHO 2015). Here PHC networks include community-owned, community-operated primary care centers comprising small teams of doctors and nurses, supported by wider local government–funded health and municipality agencies. Between 1998 and 2007 they had grown from 466 to 826

covering just over 10 million people, all covered by locally negotiated plans. They are reported to be very popular and to have contributed to improvements in service utilization generally, and especially antenatal care and vaccination coverage. Another example are the Union Health Services, which are well-established examples of community-owned PHC facilities in New Zealand (Newtown Union Health Service n.d.).

There is insufficient evidence relating to conflict-affected situations, but there is a consensus that publishing health performance information can be a vital tool in developing local accountability (WHO 2016). Useful lessons might be drawn from the development of the Community Scorecard in Afghanistan. There, the Ministry of Public Health worked with community input to convert an established balanced scorecard into a community-designed scorecard to drive improvement in service quality and local provider accountability (Edward et al. 2013), as summarized in Case Study 2 below.

Case Study 2	Accountability	Community scorecard Afghanistan (Pilots)
Purpose	**Activities**	**Outcomes**
To improve services by strengthening local community engagement to monitor feedback and evaluate local services and improve accountability of the provider to the community	❖ Local adaptation of a national, balanced scorecard designed to assess and enhance the delivery of the basic package of health services ❖ Community Scorecard codesigned with community and provider input ❖ Development of agreed performance indicators and measures ❖ Trained facilitators to enable stakeholders to collaborate and agree on actions arising from reviewing performance indicator results ❖ Running cycles of review for improvement	❖ Improvements in service quality ❖ Valued by health facility providers and by participating community members

Reorienting the Model of Care

The IPCHS Framework recommends five strategies to help countries to reorient the model of care away from secondary care with more focus on prevention and PHC. These include prioritizing services on meeting health needs across the life course, increasing the value placed on prevention and public health promotion, developing strong PHC systems, shifting from hospital inpatient care toward ambulatory and outpatient care, and adopting new technologies (WHO 2016).

PHC plays a pivotal role in the model of care by providing communities, families, and individuals with a coordinating center of care. This enables access to a

comprehensive range of services. There is no single "off the shelf" turnkey model of PHC that can simply be adopted and deployed as is, without modification. However, together with United Nations Children's Fund (UNICEF), the WHO recently published its *Operational Framework for PHC: Transforming Vision into Action* (WHO 2021a). This provides extensive guidance, policy actions, and tools for countries seeking to design, build, and operate PHC. PHC models have proved an important component of resilient health systems as demonstrated during the COVID-19 pandemic (Haldane et al. 2021).

Models of good practice exist. This shows that rapid improvement can be achieved through the national development of PHC. One of the most high-profile examples can be seen from the nationally led PHC reforms in Turkey. A recent review of achievements by Hone et al. (2017) showed systematic improvements in PHC utilization and increased citizen preferences between 2002 and 2013, accompanied by a relative reduction in the use of secondary care. Much still needs to be done to develop an IPCHS in Turkey, but the PHC foundations have been established relatively quickly.

New models of clinical leadership in PHC are emerging, depending on the availability of health professionals and levels of trust in the system. Even for high-income countries that have systems with well-developed family physician-led PHC, the move to population health and to people-centered and integrated models is often accompanied by the development of multidisciplinary and multiprofessional teams, task shifting, and the development of networks of PHC providers. The NHS in England is a good example of this as its new Integrated Care Systems are now supported by the historically independent general practitioners working collaboratively as Primary Care Networks (PCNs) (NHS England 2021). The PCN can be led by a lead clinician from a nonmedical background. The whole team includes a range of community nursing staff, allied health professionals, and other health professional staff, increasingly with advanced practice credentials. Of critical importance is to build a high-quality PHC service that can be trusted by the community and the secondary care system.

New models of care are enabled through the development of multidisciplinary teams (MDTs) and care coordinators. A recent report from the World Bank (Kurpas 2020) highlighted the high prevalence of MDTs as enablers of models of people-centered integrated care. MDTs are generally nonhierarchical teams of peer professionals with different but complementary skills and professional backgrounds. By working together, they are better able to provide a comprehensive response to the needs of patients, and to provide a more collaborative care plan for patients living with multiple conditions or more complex needs. The report cites examples from across Europe and the United States, where MDTs have been used and where the composition and structure of the teams have been developed to best suit the local context. Some case studies have cited that the specific appointment of a case coordinator was an important additional feature and enabler of successful practice. This role might be provided by a family physician, a community nurse, or another health care professional, depending on the needs of the community being served.

Integration of physical and mental health should be included as a high priority for IPCHS, particularly in PHC. According to a recent review by the independent Kings Fund in the United Kingdom, the integration of physical and mental health services is vital. There is high prevalence of mental health issues among people living with long-term physical health problems and historic poor management of ill-defined persistent symptoms. This results in reduced life expectancy for people with mental health

problems who do not access services for physical health problems (Naylor et al. 2016). These factors have combined to increase costs and reduce quality. The review recommended actions in the area of prevention, PHC, noncommunicable disease management, secondary care, and community/social care. Good-practice case studies include Intermountain's Mental Health Integration Program (Intermountain Healthcare 2018) (Case Study 3), and several programs in the NHS in England.

Case Study 3	Integration of mental and physical health	Intermountain Mental Health Integration Program
Purpose	**Activities**	**Outcomes**
To improve support for people presenting with mental health conditions	▪ 185 PHC clinics ▪ PHC practitioners accepting more responsibility for providing mental health care ▪ Strong links with secondary care ▪ Stepped care approach from mild to moderate and high complexity ▪ Driven by consistent needs assessment ▪ Use of nonspecialists to deliver 80% of care ▪ Investment in practice staff training ▪ Strong leadership	▪ 48% reduction in per capita medical costs (during the first 12 months) ▪ 54% reduction in probability of patient attending secondary care in an emergency ▪ Reductions in use of secondary care for ambulatory care conditions ▪ Increase in diabetes control among diabetics with depression

Note: PHC = Primary health care.

Geographical communities are increasingly becoming a feature of integrated care delivery systems. This enables the integration of population health and prevention with service delivery for a "place" or a "neighborhood." A recent review by Goodwin and Ferrer (2018) highlighted these trends and examined three examples of good practice:

- The NUKA health system, Alaska
- The Gesundes Kinzigtal model in Germany
- The care system in Canterbury, New Zealand

All these examples show how population health can be integrated with service delivery when the right governance and accountability structures are in place and return on investment is considered over the medium to long term. The NHS in England has adopted the concept of "place" as a central design feature of the new Integrated Care Systems being rolled out across the NHS (NHS England 2021).

The experience of postconflict countries suggests that care is needed to ensure that PHC practitioners are supported with high-quality recognized training and credentialing, and are given status equal to their peers working in secondary care. A recent study of the Family Medicine Development Program—introduced in Bosnia and Herzegovina after the conflict in the former Socialist Federal Republic of Yugoslavia—showed considerable success from the development of the Queen's University Family Medicine Development Program (supported by Queen's University in Kingston, Canada). However, the study showed that despite huge success in the rapid development of PHC, the perception remains that family practice is of lower status than secondary care. This has clearly emerged as a barrier to its further development (Hodgetts et al. 2020).

Similar issues are reported for the development of PHC in Kosovo (Borgen Project 2020). Despite initial success, as far back as 2006, there were early signs of problems associated with underinvestment and a failure to change cultural perceptions about the quality and importance of PHC (Buwa and Vuori 2007). A 2005 World Bank study based on a selection of similar countries (Armenia, Bosnia and Herzegovina, Estonia, Kyrgyz Republic, and Moldavia) showed that family physician models had developed well but at this stage were largely system gatekeepers rather than centers for service delivery (World Bank 2005). A lack of incentives and poor salary levels were cited as core challenges to these systems. These issues are probably not unique to conflict-affected environments, but the challenges of reorienting the model of care are likely to be felt more acutely where the prior availability and quality of PHC is particularly damaged.

Reorienting services to adopt technological approaches to communication and case management has been turbocharged by COVID-19, with the rapid adoption of digital health technologies to reduce transmission risk, particularly in PHC (Peek, Sujan, and Scott 2020). A review of the potential impact of e-health on the US health system estimated that if health information technology (IT) were fully implemented in 30 percent of community physician offices, there would be significant reductions in demand (4–9 percent) and referrals to specialists (2–5 percent), and a significant increase in remote consultations (12 percent) (Weiner, Yeh, and Blumenthal 2013). A recent World Bank review of integrated care in central and eastern Europe demonstrated benefits from the introduction of unique patient identifiers and shared electronic health records (EHRs) to support care coordination across primary and secondary care (Kurpas 2020). Despite these benefits, there have been cultural and regulatory barriers to the adoption of telehealth, data sharing, and the use of artificial intelligence. Since the COVID-19 pandemic, these barriers have rapidly been dismantled in many countries. It is unlikely that there will be a full return to more traditional face-to-face models of care. With many technology solutions being developed using cloud-based storage, managed through APPs and Smart Phones, there are new opportunities for potentially low-cost digital-first approaches to PHC service delivery, population health management, value-based care, and Universal Health Coverage (Walcott and Akinola 2021).

In conflict-affected countries, reorienting the service will need to include strategies to transition vertical (stand-alone) programs that have developed to address specific health needs (e.g., human immunodeficiency virus [HIV]) or to provide emergency relief to integrated services. Vertical stand-alone programs often funded by donors and/or run by NGOs have their place as a temporary measure where PHC is weak and there is a need for a timely, focused, and well-resourced intervention. However, as noted by Atun, Duran, and Bennett (2008), it is important to ensure that strategies are in place to transition, through linkages or other strategies, to a more

comprehensive approach. If not, these programs run the risk of increasing health inequalities and disrupting local markets for health workers and other essential resources.

Coordinating Services within and across Sectors

The IPCHS Framework recommends strategies for coordinating care for individuals, coordinating health programs and providers, and coordinating across sectors. Policy actions for coordinating care for individuals include the development of evidence-informed pathways, the use of health navigators, case management, and clear referral protocols along a continuum of care. Policy actions to coordinate health programs and providers include planning, strategic purchasing, and the development of clinical networks and connections, complemented by incentives to reward good practice. For intersectoral work, "Health in All" policies are a key feature, complemented by specific joint programs with education, social care, and social support. Of particular relevance in the context of the current COVID-19 pandemic is the requirement to coordinate for emergency preparedness and response.

There is strong evidence of the benefits of coordination in patient experience and health system efficiency, particularly in PHC. According to a 2018 WHO practice brief (WHO 2018c), evidence from the literature shows significant improvements in service user appreciation of PHC, and reductions in the use of hospital services and associated costs. A relevant example is the family health teams model in Brazil (Wadge et al. 2016) (see Case Study 4). The WHO practice brief working practices that should be given priority in developing coordinated care include designating a nominated PHC professional, coproduction, case management for patients with complex needs, single access points, transitional care, care pathways, enabling digital technology, and enabling workforce competencies (WHO 2018c).

Case Study 4	Continuity of care	Family Health Teams (Brazil)
Purpose	**Activities**	**Outcomes**
To provide a bridge between patients, families, and health care professionals	▪ Multidisciplinary family health care teams covering 4,000 people in a locality ▪ Each team comprises 6 community health workers, each with a caseload of 150 families ▪ Regular visits, screening, health education, clinical triage, basic services, health monitoring ▪ Reporting on a range of multisectoral indicators ▪ Induction and training of workforce ▪ Pay for performance	▪ Improved patient satisfaction ▪ Improved access to services ▪ Reductions in avoidable admissions ▪ Reduced infant mortality rates ▪ Reduced fertility rates

▪ Electronic medical records (in planning)	▪ Increased school enrollment

The adoption of clinical networks can play a vital role in improving the quality, safety, and effectiveness of services within and across providers. A recent systematic review by Brown et al. (2016) showed that despite a paucity of high-quality studies, the coordination provided by clinical networks can improve quality and outcomes across a range of different clinical areas (cancer, cardiovascular, preterm births, neonatal pain management, hemodialysis, diabetes). One example was for the Integrated Cardiovascular Clinical Network (ICCNet) adopted on a regional basis in Australia. It was designed to improve cardiovascular outcomes, particularly for patients who use rural hospitals without on-site access to specialist services. The study showed that the network improved outcomes (reduced mortality) for patients and improved the efficient use of resources in terms of specialist referrals and length of stay in hospital (Tideman et al. 2014).

The use of a formal Network of Care (NOC) framework could provide a useful operating model for coordination and collaboration (Chopra and Pate 2020). A Network of Care can be defined as "a group of public and/or private sector service delivery sites deliberately interconnected through an administrative and clinical management model which promotes a structure and culture that prioritizes client-centered, effective, efficient operation and collaborative learning, enabling providers across all levels of care, not excluding the community, to work in teams and share responsibility for outcomes" (Carmone et al. 2020). A scoping review of several successful case studies suggests that the operational characteristics of NOC include the following:

1. Agreement and Enabling Environment, including policy, financing, purposeful agreements, and buy-in and trusting relationships
2. Operational standards, including referrals, monitoring, supply and infrastructure, and workforce
3. Quality, Efficiency, and Responsibility, including coordination of care, clinical guidance documentation and review, and benchmarking (skills, measurement, and improvement)
4. Learning and Adaptation, including client-centeredness, flexibility, extending reach, evolution, and resilience (Carmone et al. 2020)

A recent review of the literature on PHC in conflict-affected settings suggests that program and intersectoral coordination is a key component of health reconstruction activities (Chaudhury et al. 2020). At the **program** level, coordination between donor-funded programs, NGO and community programs, and recovery and renewal development of PHC by Ministry of Health programs is an essential part of reconstruction and transition to integrated PHC services. **Intersectoral** coordination is also of vital importance, particularly rebuilding transport and communication links to enable and reestablish emergency referral pathways to operate effectively. Examples of this are emergency obstetrics, neonatal care, and other lifesaving pathways.

CREATING AN ENABLING ENVIRONMENT

The IPCHS highlights six strategic approaches to the creation of an enabling environment. These cover leadership and management, quality improvement, information systems, systems research and knowledge management, workforce, regulatory frameworks, and funding and payment reforms. The focus for leadership and management involves the development of transformational and distributed leadership and change management strategies. Information systems investment, commitment to and investment in systems research, and actions to promote knowledge management are key elements of strategies for strengthening information systems and knowledge. Workforce redesign and transformation is a high-priority strategic enabler, with the development of new skills and new ways of working. Enabling regulatory frameworks should reduce barriers and support IPCHS. Finally, but of equal priority, is the alignment of financing and payment models to ensure that the funding is available in the right place at the right time and provides the right incentives to support IPCHS.

The Importance of Leadership

Collaborative and distributed leadership approaches are of fundamental importance to the successful design, implementation, and continuous improvement of integrated health care. Research by Evans et al. (2016) and Miller and Stein (2020) highlights the leadership behaviors and skills of managers, and the new competencies they need, for effective implementation of integrated care. Key behaviors and skills include a good understanding of the current system, the proposed changes, and their rationale; a commitment to a collegial approach with shared leadership and power; a commitment to distribute tasks and accountabilities with collaborators; taking time to develop trust within and across organizations; and using deliberative and collaborative approaches to manage change. Of these, clear lines of subsidiarity and accountability are especially essential, supported by a “quality improvement” approach (Jones, Kwong, and Warburton 2021) to change management (Stein et al. 2021).

Leadership is also crucial to the development of improvements in quality and safety. This should include ensuring services are safe and effective and are a positive experience for patients and their families. Quality covers all aspects of IPCHS and should be seen as a cultural watermark, with a workplace culture that promotes openness and transparency, an evidence-informed approach to practice, and a focus on problem-solving for improvement. A recent guide developed as part of the USAID ASSIST Project on the role of leadership in quality improvement (Pavlickova 2020) highlights the importance of quality improvement approaches to improving safety and outcomes in health care, and how leadership is critical to ensuring that this is embedded within working practices. The guide provides insights on leadership characteristics and competency frameworks that might be valuable in developing relevant programs.

Leadership models for integrated care align well with the leadership requirements of reconstruction efforts in a postconflict environment. A recent UN article on leadership by Sukehiro Hasegawa, chair of the Hiroshima Peacebuilders Center Council (Hasegawa 2016) and author of the 2013 book *Primordial Leadership: Peacebuilding and National Ownership in Timor-Leste,* argues that “primordial leadership” is often required in postconflict reconstruction. More than simply passing regulations, issuing

rules, or creating institutional frameworks, primordial leadership focuses on bringing about a fundamental change of mindset by building a deep and widespread sense of ownership and accountability, and by appealing to the population's emotional ties to their country, their patriotism, and their sense of national identity and unity. This leadership style draws on passion and on the courage to embrace change and transformation to convince citizens that respect for the universal ideals of democratic governance strongly aligns with their own traditional community values and practices, and that the future of the country is worth fighting for. Primordial leadership includes a commitment to the national interest, integration of governance into local values and customs, communication that relates the required change to prevailing cultural and ethical norms, the ability to balance history with the future, and the ability to persuade or change traditional mindsets. These aspects of primordial leadership resonate strongly with the leadership skills needed for integrated care, and with the need for a shared vision; the development of accountability within the system; and the need to communicate, persuade, and collaborate with patients, the health workforce, and health administrators, who may be resistant to change.

Investment In Digital Infrastructure

Investment in digital information systems is a powerful accelerant of integrated care. This includes providing citizens and patients with information about their own health; disseminating clinical decisions in real time; and providing data and analyses for population risk management, quality monitoring, and improvement, and for system accountability. The core platform for all health information is the electronic health record. The first major challenge is to develop a system that is sufficiently flexible to connect to the array of data-capture tools (such as citizen and patient APPs, different health provider operating systems, cloud- and server-based databases), one that enables interoperability of data, and one that is not obsolete before it is installed. The second major challenge is to implement data governance practices that assure privacy, roles-based access, and cybersecurity. A third challenge is to provide a viable cloud-based infrastructure to enable reliable connectivity, adequate bandwidth, and required latency.

Many case studies from across the globe demonstrate the positive impact of patient identification and digital health records in improving the management, coordination, planning, and governance of integrated care (Boguslavsky, Gutierrez, and Holschneider 2019). There also appears to be evidence that the use of digital technology alongside empanelment, and the development of integrated care and population health management, can be mutually reinforcing strategies (Boguslavsky, Gutierrez, and Holschneider 2019).

A consensus appears to have emerged that a strategy that focuses on creating an enabling environment, consistent standards, transparent regulation, and sound principles of governance for the development of national health IT strategies is more sustainable than a strategy to promote the development of single, national, uniform system. A much-cited example of such a national system is the successful National Health Information System in Estonia (Barbazza et al. 2016). Estonia, a high-income country with high-technology capability, was able to build the system from scratch for a population of just 1.3 million people. However, a review of systems in Australia, England, and the United States (Morrison et al. 2011) suggests that a blended approach that balances local innovation and flexibility with a national policy of

standardization and governance provides a more cost-effective sustainable strategy than having a single national system. International collaboration is essential in developing an informed local strategy. A useful resource is the WHO's *Global Strategy on Digital Health 2020–2025* (WHO 2021d).

The IPCHS Framework encourages the development of policies for systems research and knowledge management, designed to facilitate and improve the IPCHS experience over time. There are examples of frameworks developed to assess the performance of integrated care. A recent study undertaken on behalf of the European Commission (Dates et al. 2018) involved an international review of the literature and the development of a European framework of indicators for measuring performance of integrated care systems. International forums for sharing good practices are also evolving. The most extensive is the International Foundation for Integrated Care (IFIC), which enables countries to showcase good practice at international forums and events and which publishes and links to studies of good practice through its IFIC Knowledge Tree (International Foundation for Integrated Care n.d.[a]). A more detailed description of the IFIC Knowledge Tree is provided in Appendix A.

Developing the Health Workforce

The health professional workforce is the most valuable asset of any health care system, and its development is a core strategy for successful IPCHS design and implementation. IPCHS policy actions here include ensuring sufficient and equitably distributed supply of staff with the right training, competencies, and levels of practice across a variety of disciplines; developing multiprofessional teams who are able to work across boundaries; ensuring adequate levels of remuneration and terms and conditions of employment; providing human resource support and management to promote well-being; and strengthening professional associations. A recent review identified the following health workforce competency requirements for integrated care: patient advocacy, effective communication, teamwork, people-centered care, and continuous learning (Langins and Borgermans 2015).

It is desirable and feasible to develop fast-track training programs for the development of the health professional workforce. A good example of how this has been done recently is the deployment of "The Role of PHC (PHC) in the context of the COVID-19 Pandemic," launched in September 2020 (WHO EMRO n.d.). This was a result of a collaboration of the WHO Regional Office for the Eastern Mediterranean (EMRO), World Organization of Family Doctors (WONCA), and UN partners such as the Joint United Nations Program on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations High Commissioner for Refugees (UNHCR), and the United Nations Children's Fund (UNICEF) as part of the regional workplan for implementation of the SDG-3 Global Action Plan for Healthy Lives and Wellbeing for All. The course "Primary Health Care (PHC) Practice in the Context of COVID-19" is online and integrated with country responses to COVID-19 within the WHO EMR0.

Development of the workforce will also include shifting tasks from doctors to nurses or other health professionals in PHC. An unpublished World Bank briefing note, authored by Gerard Bloom and Ellen Nolte (Bloom and Nolte n.d.), makes reference to the importance of upskilling the health workforce, including doctors (generalists and specialists), nurses, physiotherapists, pharmacists, other allied health professionals, and community health workers. This upskilling is to be accompanied by

task shifting—extension of the scope of practice by drawing on the wider health workforce to take on tasks previously the domain of medical professionals. In a recent study of task shifting in 39 countries (Maier and Aiken 2016), 11 countries demonstrated extensive task shifting (primarily through formal models), 16 were more limited, and 12 had no formal models. Those with formal models enabled this through regulation.

In a postconflict setting, there are many health workforce challenges that require high-priority attention at the level of the individual health professional and in terms of system infrastructure. Research from the Rebuild Consortium (Martineau et al. 2017) identified health workers as having experienced displacement, burnout, high workload, physical and professional isolation, poor access to training and continuing professional development, and/or outward migration. Qualified health workers are likely to have looked beyond their public sector salary for income and/or moved to higher-paid employment from donor-funded programs. There is also likely to have been an increase in the number of volunteer staff or potentially unqualified paid staff who are working beyond their competency as well as in staff working without formal contracts. Human resource infrastructure, including management policies, systems, data, performance oversight and governance, is also likely to be severely compromised.

The use of incentives-based packages for health workers in conflict-affected situations has the potential to help address geographical disparities in access to health workers and to promote the development of community-based workforce models. Research from the Rebuild Consortium (Martineau et al. 2017) recommends salary standardization at levels sufficient to prevent further migration from the public to private sector or overseas should be combined with targeted incentive packages to train and retain staff in hard-to-recruit roles and geographies. Investment in wider complementary initiatives to improve overall working conditions, the quality of physical working environments, and personal safety are also important factors.

Creating an Enabling Regulatory Environment

It is important to review and align the regulatory environment with a view to removing barriers to integrated care. Health system regulations and public administration regulations often evolve over many years, with an increasingly complex array of sometimes conflicting directives, policies, and protocols. Many of the regulations are focused on individual health professionals, health providers, health payers, health facilities, pharmaceutical manufacturers, and so on. What is needed are regulations that relate to systems and how they interact. One example of a standard of practice for IPCHS has been developed by the Health Standards Organization in Canada (HSO 2020). The HSO:76000 Integrated, People-Centered Health Services (IPCHS) is due to be released shortly and is expected to be focused on system standards to promote quality improvement. Reviewing existing structures and removing unnecessary rules that inadvertently hamper interdisciplinary cross-sector initiatives, prevent the health workforce from upskilling, and inhibit the upshifting of tasks from medical practitioners to other health professionals is important to support collaboration, innovation, and improvement at the front line of care. There is little evidence on good practice, but international efforts to collaborate for shared learning are emerging (Sullivan-Taylor 2019).

Funding and Payment Systems

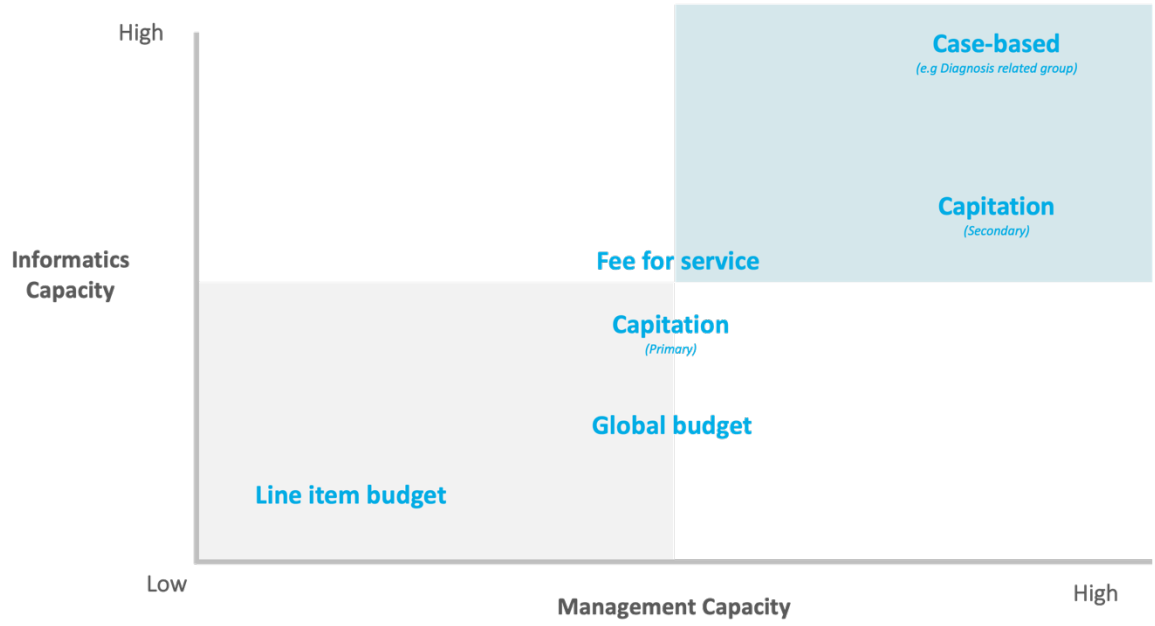
Well-designed funding and payment systems that promote IPHCS are essential to ensure that the right incentives are in place to meet needs, reward performance, and ensure that the money flows rapidly to where it is needed in the system to pay for staff, supplies, technology, and relevant infrastructure development. IPCHS strategies here center on assuring that there is sufficient health system funding to pay for what is needed, to allocate resources in a way that aligns with priorities and needs, and to use payment mechanisms between purchasers and providers of care flexibly to achieve goals.

Countries affected by conflict should prioritize policies to enable health system funding to be pooled in line with UHC goals. In practice this can be difficult to achieve as funds from external donors are often linked very explicitly to programs of care, or client recipients, by mandate or donor governance, and there is limited flexibility to include these funds as part of a general pool. Redirecting financial flows to address relative inequity in funding across programs or clients is equally problematic if this has a negative impact on financing overall. Nonetheless, a recent review of evidence (Jowett et al. 2020) emphasized the need to protect and pool prepayment and other domestic sources, and to include funds from external donors within the pool, or at least coordinate funding approaches. In this way, countries could reduce the risk of increasing disparities of access and shortages of funds for priority health interventions.

There are many different mechanisms by which health providers are paid for health services. These range from direct payment of line items in a budget to payments for the delivery of a set of population-based health outcomes. A summary of payment models is provided by the Joint Learning Network in its 2015 overview (Cashin 2015). A useful overview of the use of different payment models for integrated care systems can be found in Nolte (2016). In practice, the models include payment for line items in a budget, block, or grant funding; case-based payments; bundled payments; capitation; performance-based payments; and combinations of these. They each have different strengths and weaknesses, and increasingly health systems are looking for blended approaches using a mix of methods determined by the need to build capacity, address inequalities, increase performance, improve outcomes, and encourage innovation.

It is important that payment models do not get out of step with the capabilities needed to make them work. As can be seen in Figure 4.1 below, some payment mechanisms require more management capacity and informatics capacity than others, and it is important to align the choice of payment mechanism accordingly (Mallender, Bassett, and Mallender 2020).

Figure 4.1: Payment Mechanisms: Management and Informatics Requirements



Source: Mallender, Bassett, and Mallender 2020

Mixed payment models can facilitate population health and integrated care, especially when combined with strategic purchasing and provider collaborations that promote integration. A recent review by the World Bank (Somanathan, Finkel, and Arur 2019) identified examples of a range of different payment models that have been used to promote IPCHS in the Organisation for Economic Co-operation and Development (OECD) countries, including the following:

- Add-on, performance-based models in Australia, Canada, Croatia, France, Germany, and Spain
- Bundled payments for the management of care for people with chronic conditions in the Netherlands, Portugal, Sweden, the United Kingdom, and the United States
- Population-based payments with shared savings in Belgium, Germany, and the United States, and Belgium

A common feature of these models is incentives for providers to reorientate the model of care and improve care coordination.

The accountable care model involves shifting some elements of financial risk from the purchaser to the provider, with payment conditional on the achievement of outcomes for a defined population. The accountable care movement originated in the United States as part of the 2009 Patient Protection and Affordable Care Act. The goal was to align payments for health care with actions that aim to improve patient outcomes, care quality, and system efficiency (Berwick, Nolan and Whittington 2008). The accountable care framework developed by Mark McClellan et al. (2014) was intended to guide countries seeking to align payment models with reforms. The authors defined an accountable care system, as follows:

> *One in which a group of providers are held jointly accountable for achieving a set of outcomes for a prospectively defined population over a period of time and for an agreed cost.*

The basic concept is to shift the emphasis from paying providers for activities and toward incentivizing providers to focus on outcomes and value. The authors originally proposed five components for characterizing and assessing accountable care, subsequently extended to seven in 2017 (Heeringa et al. 2020):

1. Governance and culture
2. Financial readiness
3. Health information technology
4. Patient risk assessment and stratification
5. Patient engagement
6. Quality and process improvement
7. Coordination, or integrated workflows to support continuity of care

At its most mature, an accountable care system would receive funding based solely on capitation payments for the population for which it is accountable, with associated goals for quality and outcomes. Population health management risk would essentially be passed from the payer or strategic commissioner to the accountable care system (possibly even with reinsurance arrangements to help pool risk across systems and over time).

There is some evidence of effectiveness of the Accountable Care Organization (ACO) model, and some good-practice case studies exist for PHC-focused or community-based accountable care reforms. A recent review of the literature by Wilson et al. (2020) unearthed evidence of effectiveness across the triple aims, both for the United States and international models (including both the public and the private sector), although the evidence of improved health outcomes was mixed. The case studies cited in McClellan et al. (2016) include “Healthspring” in Mumbai, India (see Case Study 5); “One Family Health” in Rwanda; and “Possible” in rural Nepal (see Case Study 6). These models each involve some element of payment being triggered by the achievement of performance metrics or service goals.

Case Study 5	PHC-focused accountable care reforms	Healthspring (India)
Purpose	**Activities**	**Outcomes**
To increase utilization of primary and community care and reorient the model of care	❖ Focused on 12 PHC practices, each serving a "member" population of 12,000 ❖ Use of net promoter score to measure patient satisfaction—same day feedback ❖ Use of teamwork scores to measure team performance ❖ Use of standardized clinical protocols ❖ Financial incentives based on 15% of provider salary ❖ Development of integrated EHR platform ❖ Deployment of telehealth services ❖ Training and deployment of multidisciplinary workforce	❖ 80% of patients avoided unnecessary hospitalization ❖ Diabetes targets achieved for 75% of patients ❖ 75% retention of members

Notes: PHC = Primary health care; EHR = Electronic health record.

Case Study 6	PHC-focused accountable care reforms	Possible (Nepal)
Purpose	**Activities**	**Outcomes**
To improve access and quality of care in a rural area in maternity and chronic diseases	❖ Public-private partnership ("Possible" is a nonprofit provider of PHC) ❖ Per capita payments for general district population ❖ 20% reward or penalty payments ❖ Network of PHC providers and community health workers (hub-and-spoke organizational structure) ❖ Care innovations ❖ Disease surveillance ❖ Use of cellphones to remotely monitor and track patient's health status	❖ Improved access to services, in particular antenatal care

Note: PHC = Primary health care.

Community-based examples of the accountable care model can be found in Goodwin and Ferrer (2018) and include NUKA, Alaska; Gesundes Kinzigtal, Germany; and Canterbury, New Zealand.

Models do exist where integration is developed from foundations in secondary care rather than PHC. In theory, with the right incentives in place and investment in the enabling strategies in terms of the health workforce, digital technologies, and the right leadership culture, it should not matter how integration is achieved. Where PHC is not well established, this approach can potentially bring advantages of corporate maturity, scale, access to data, clinical governance and a trusted reputation. However, it also carries risks of overly traditional cultures and models of care, which can dampen progress with IPCHS. In addition to many examples such as the ACO models in the United States, there are also models being developed in China such as the Luoho Hospital Group in Shenzhen (Liang et al. 2020), in the Basque Country (see Case Study 7) (Polanca et al. 2015), and in Saudi Arabia's Health Reform Vision 2030.

A review of a selection of Integrated Health Service Delivery Networks (IHDNs) in South America found these models wanting in relation to the development of primary health care (Pinto at al. 2020). A more recent review of the evidence on hospital-led, hub-and-spoke models (comparing ACOs, Medical Homes, Managed Care Organizations, Health Maintenance Organizations, Coordinated Care Organizations, and so on) in the United Kingdom and the United States suggests that there is no theoretical blueprint for the optimal model and that evidence of differential impact was mixed (Bhatia et al. 2019).

Case Study 7	**Primary and secondary care integrated system**	**Bidasoa Integrated Health Organization (Basque Country, Spain)**
Purpose	**Activities**	**Outcomes (5 years)**
To deliver structural, functional, and clinical integration policies for person-centered integrated care, particularly for those living with chronic conditions	❖ Country-wide strategy (2010) to develop integrated health organizations combining secondary and primary care ❖ Organizational integration of primary and secondary care under one structure from 2011 ❖ Bottom-up coordination of care processes between primary and secondary care ❖ New clinical pathways ❖ Continuity of Care Units to coordinate care across settings ❖ Patient education ❖ Shared medical records	❖ Improved collaboration between health care professionals ❖ Improved patient experience of care ❖ Reduced hospital utilization ❖ Per capita cost containment *(Integrated Health Organization (IHO) catchment ~400k population)*

- Transparent performance reporting

Countries affected by conflict situations are unlikely to have the data platforms or data systems to develop complex or risk-based provider payment mechanisms. They should start with a simple model of line item or block budgets that build to performance bonus systems as data and management capacity allows. A recent review of evidence (Jowett et al. 2020) highlighted the need to strengthen core systems as a priority to ensure that salaries can be paid and payments can be targeted at securing essential supplies. Although the IPCHS Framework looks to move systems away from input-based payment models, this should be seen as a journey that can be developed as the system matures. The possible exception would be the use of incentive payments to health workers to address specific shortages in roles or geographies and/or to achieve specific measurable targets in terms of increased utilization or take-up of priority services.

TOOLS TO SUPPORT THE DESIGN AND IMPLEMENTATION OF INTEGRATED CARE

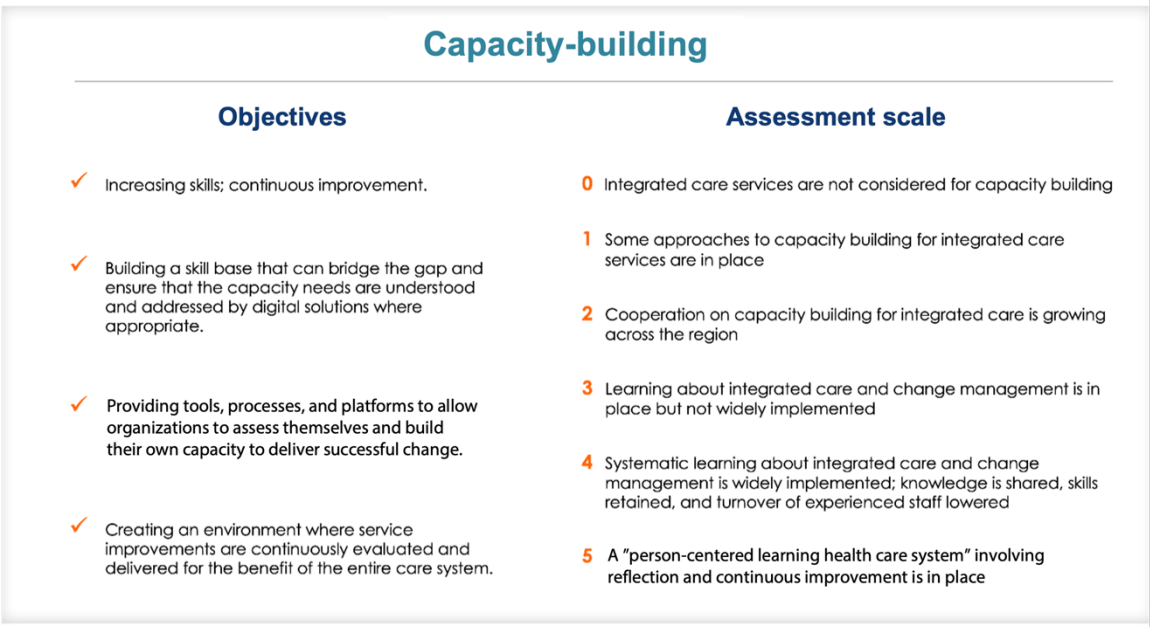
Tools do exist that can be adapted to a country context to allow systems to measure their current state and their progress to IPCHS.

The tool most closely aligned to the components of IPCHS, and which has been used and adapted across several countries and regions internationally, is the SCIROCCO tool (Scirocco Project n.d.[b]). This provides progression measures against 12 domains, each of which is considered essential to the successful design and implementation of integrated care. There 12 domains are, as follows:

1. Readiness to Change
2. Structure and Governance
3. eHealth Services
4. Standardization and Simplification
5. Funding
6. Removal of Inhibitors
7. Population Approach
8. Citizen Empowerment
9. Evaluation Methods
10. Breadth of Ambition
11. Innovation Management
12. Capacity-Building

For each domain, there is a description of the objectives of health systems and a maturity scale ranging from 0 to 5. Health systems can self-assess where they are against each domain and use the results to gain consensus on the current state of development and the priorities for moving forward. This in turn can be used to develop a system-specific road map. An example of one of the domains is given in Figure 4.2.

Figure 4.2: Scirocco Tool: Example Domain



Source: Adapted from Scirocco Project n.d.[b]

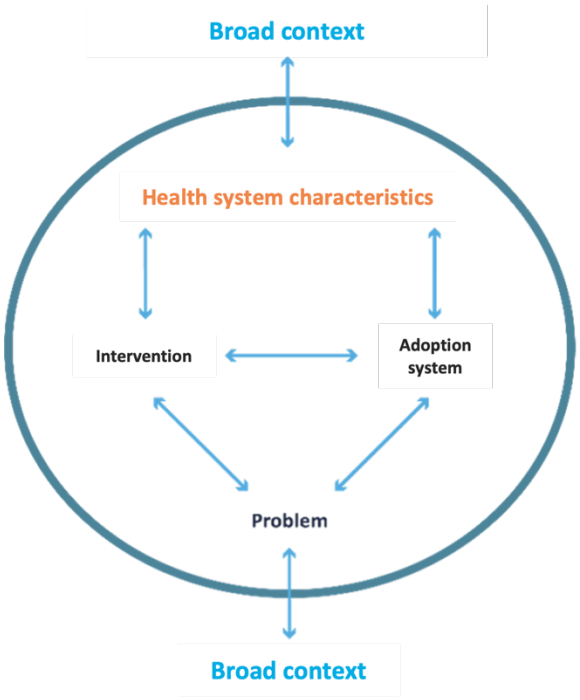
Funded until February 2022, the Scirocco Project team can support countries to adapt the tool to facilitate and stimulate local stakeholder engagement to undertake an assessment of the current situation, a current state assessment, and repeated self-assessments as the system is implemented.

Atun et al. (2010) have developed a useful conceptual framework for assessing priorities for integration requirements for specific conditions. This is a helpful method of assessing the need for integration based on levels of service complexity and stakeholder involvement. Summarized in Figure 4.3, the conceptual framework involves assessing complexity at the level of the intervention, the adoption system, and the health system characteristics. For example, a condition that typically involves multiple episodes and elements of care, involves many stakeholders over multiple levels of care, and requires high levels of user engagement in the patient's care management would be a high-priority condition for integration.

The Joint Learning Network for Universal Health Coverage has provided a useful tool—called the Vertical Integration Diagnostic and Readiness Tool (La Forgia et al. 2018)—to support integration between primary and secondary care. This includes three survey instruments to assess integration along a pathway of care covering primary, community, secondary, and tertiary care. The three instruments, which are targeted at policy makers, health care facilities, and practitioners, measure relationships, communications, and level of coordination between services. This is likely

to be a useful audit tool for countries that are developing policies, practices, and standards for integrated care and for monitoring progress.

Figure 4.3 Conceptual Framework For Assessing Priorities For Integration Requirements For Specific Conditions



Source: Adapted From Atun et al 2010

PART V – LESSONS FROM THE GLOBAL EXPERIENCE OF IPCHS

SUMMARY OF LESSONS FROM GLOBAL EXPERIENCE

As articulated in the Framework on Integrated, People-Centered Health Services Framework adopted by the World Health Assembly in 2016, there is broad agreement on the strategic priorities for the development of integrated health systems, and on the fact that these should be people-centered. However, the evidence supporting these strategies and associated policy actions is complex and context-specific. There is no single model of integration that can be replicated at scale. Rather, there are many examples of good practice at local, regional, and national levels that can provide lessons for countries considering health system reform and associated policy actions. Each country, nevertheless, will **need to design and implement its own unique approach to health care integration**. This will need to be designed to meet priority health challenges and to align with the country's foundational strengths, cultural heritage, socio-geographic characteristics, economic imperatives, and country vision.

There is also consensus that PHC has the potential to play a pivotal role because it provides the following:

- Focus for implementing policies that empower and engage people and communities to take a greater role in managing their own health, and for informing local needs assessments and priorities for improvement
- Opportunity for local participatory governance by citizens and for providers to be held accountable for quality and integration, and for locality-based intersectoral collaboration
- Consistent point-of-care coordination and case management for patients and their families both horizontally (across a spectrum of needs) and vertically (referrals and care delivery along a care pathway)

For these reasons, the development of high-quality, well-led PHC infrastructure (facilities, technology, and workforce) within an enabling regulatory framework, supported by the right financial incentives, is an important driver of integrated care.

As currently drafted, the 2020 PHC Strategy for Libya will provide an important foundation for PHC-led integrated care, in particular, the following:

- Improving the PHC infrastructure to ensure the availability of basic facilities, basic equipment, medical records (including sharing medical records across care teams and patients), and enrollment, and in encouraging collaboration across different PHC clinics
- Developing a skilled multidisciplinary PHC workforce, particularly in areas that are currently underserved
- The use of simple capitation funding to finance PHC to deliver the Essential Primary Health Service (EPHS) and the five priority health programs:
  - Reproductive health

- Child health
- Communicable disease
- Noncommunicable disease
- Emergency services

The use of pilots or vanguards to design, develop, and refine implementation action plans ready for spread and adoption will provide an important starting point for showcasing the benefits of reform.

As might be expected, there is a dearth of evidence of good practice from countries implementing integrated care systems in postconflict situations. However, there are some important common themes emerging. These include the following:

- The importance of using **community-engagement approaches** to reestablish trust in the quality, availability, and accountability of public health services
- The requirement for high-quality, well-trained **credentialed multidisciplinary PHC practitioners** whose skills and experienced are recognized and respected by their secondary care peers and by service users alike— without this, there is a risk that service users will continue to bypass PHC and seek treatment directly from hospitals
- The opportunity to quickly build on and **transition from stand-alone, vertical donor-funded programs** that are often relatively well-endowed in resources to develop more equitable horizontal services across a spectrum of needs
- The need to coordinate across the public, private, and voluntary sectors to ensure that **all available assets are used to rebuild and integrate services**
- The need to **coordinate with other public sector agencies outside health** to dismantle barriers and secure enabling infrastructure (e.g., emergency transport routes, multipurpose use of facilities and infrastructure, and so on)
- The importance of development and promotion of a **strong leadership and management culture** with a commitment to the national interest and a shared vision for health at local, regional, and national levels
- The need to use **incentive-based payment packages for health workers** to address geographical disparities in access and to promote new, integrated workforce and primary health care management models
- The potential to **pool internal sources of health financing** and combine these with funds from external donors (or strategies for aligning this finance) to ensure a more equitable distribution of resources across the system nationally, regionally, and locally
- The need to **keep provider payment models simple** until information systems and management capability are sufficiently well developed to allow a more sophisticated approach to value-based provider payment mechanisms

The incorporation of these lessons into Libya's health system reform program has the potential to improve long-term sustainability and reduce the risk of failure.

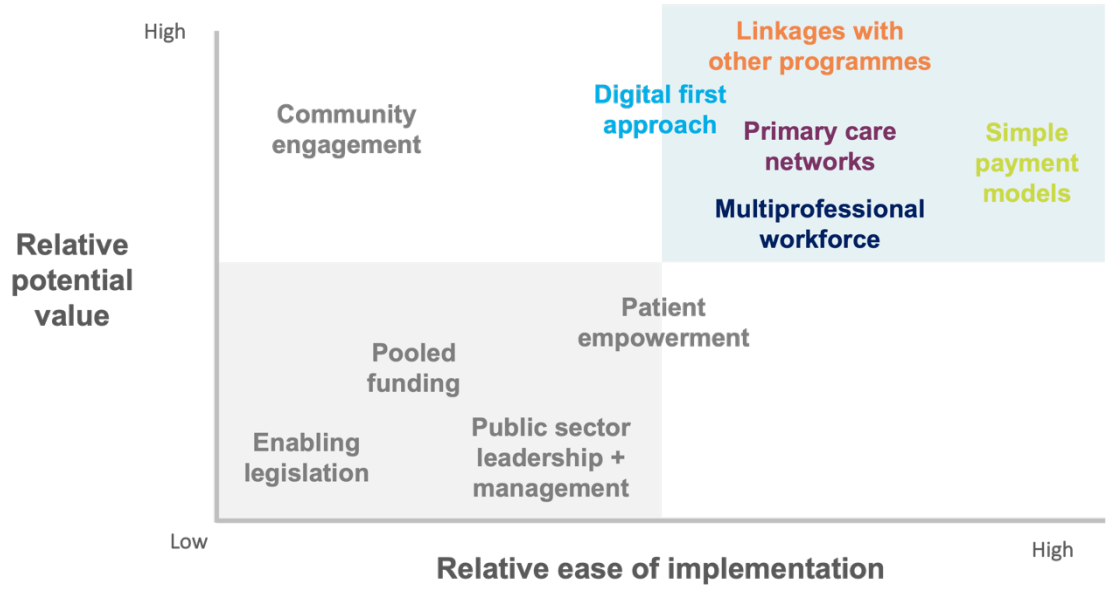
There are some important lessons from global experience that show the potential for primary care reform to accelerate improved health system performance and deliver benefits for patients. In summary, international experience suggests that integrated services will be accelerated if systems can do the following:

- ✓ Support PHC providers to **engage with existing community assets**, NGOs, and established community groups to develop a community-owned perspective on health priorities and population health needs for a locality
- ✓ Support PHC providers to **develop strong linkages** with voluntary sector and private sector providers (including pharmacies, dentists, and so on) and established and successful emergency relief and targeted donor-funded health programs
- ✓ Support PHC providers to **develop patient empowerment** by working with individuals and families to take ownership and control of their own health
- ✓ Enable the development of **PHC networks** by developing an operational framework
- ✓ Support fast-track investment in digital platforms and informatics and enable PHC to adopt a **digital-first approach** by working with other agencies
- ✓ **Develop pooled financial resources** and seek to distribute these through strategic purchasing by working with Ministries of Health and Finance and international donor agencies
- ✓ Adopt **simple provider payment models** targeted at solving problems
- ✓ Review the legislative and policy framework, with a focus on **reducing barriers** to people-centered and integrated services that are safe, effective, and evidence-informed
- ✓ Enable subsidiarity of accountability and responsibility, and build trust by **strengthening local leadership, management, administration, and governance** of local public sector bodies across sectors
- ✓ Fast-track, by coordinating a national program, the **recruitment and training of a multiprofessional PHC workforce** to accelerate capacity and capability and promote population health and integrated disease management programs quickly

Each of these strategies would have resource implications if adopted. They should all show a return on investment in terms of health system value. It will be important to develop more detailed logic models (or theories of change) that show the inputs, processes, outputs, outcomes, and associated costs and benefits compared with alternative strategies. These could then be appraised from the perspective of their potential value to the system and the management effort that would be needed to make them successful. This would allow priorities to be determined.

An initial assessment of relative potential value and the relative ease of implementation is included below as a starting point for discussion. This assessment is informed by the evidence gathered in the literature and views of experts but does not reflect the Libyan context and will need to be developed further in discussion with the PHCI. This mapping is shown in Figure 5.1.

Figure 5.1: Potential Value and Relative Ease of Implementation



Source: Authors analysis

As can be seen from this initial assessment, there are five strategies that fall in the top right-hand quadrant of the figure. These are likely to be of higher potential value and relatively more straightforward to implement. These are strategies that systems might consider prioritizing when embarking on primary health care reform. A description of each, together with some example activities and an assessment of relative value and ease of implementation, are provided in Table 5.1 below.

The remaining strategies also have a potentially important role to play in building value from an integrated care approach but may be more difficult to achieve or of lower potential value than the top-five strategies. These are strategies that systems might like to consider for later incorporation in a primary health care reform program. Table 5.2 below provides a description of each strategy, together with some example activities and a justification of why they have been assessed as being of lower relative value and more difficult to implement.

Table 5.1: Five High-Priority Strategies for Early Inclusion in Primary Health Care Reform

Intervention	Description	Example activities	Relative priority level		Description
Accelerate development of a multiprofessional PHC workforce	Coordinate a national program to fast-track the recruitment and training of a multiprofessional PHC workforce to accelerate capacity and capability and promote population health and integrated disease management programs quickly.	1. Map the current community and primary care workforce and associated vacancies for a local area by profession, role credential, length of tenure, and age. 2. Review international models for the wider PHC workforce, including, for example, the use of physician associates, pharmacists, dentists, therapists, community health workers, and so on. 3. Work collaboratively, possibly through a facilitated workshop process such as that used by Health Education England (HEE STAR), to identify solutions that will fill vacancies quickly on the basis of activities that either increase workforce supply, upskill the existing workforce, create new roles, or promote new ways of working (e.g., utilizing digital technology). 4. Explore international collaborations for fast-tracking the delivery of different solutions. 5. Design and implement projects to implement the solutions using national, regional, and local approaches, as needed.	**Potential value**	**High**	This will build capacity and capability quickly, creates employment in local communities, promotes community engagement, and provides PHC with a team to do more than just act as a gateway to secondary care.
			Ease of implementation	**Medium**	This will require the development and deployment of basic and enhanced professional roles and associated training programs. This can be fast-tracked by collaborating with international agencies and potentially other countries who are embarking on or have experience of similar national programs. COVID-19 has provided a model of how this can be done quickly.
Develop PHC provider networks	Support PHC providers to form local geographically based networks that have strong clinical links with secondary care providers to enhance quality and trust in services and accelerate horizontal and vertical service integration.	1. Review international models for PHC networks to learn from and incorporate best practices. This should include relationships across PHC providers but also models for developing strong relationships with secondary care providers (not just at the specialty level but at the system level). 2. Design the logic model and associated outcomes for PHC Network models compared with existing practice (e.g., improved PHC utilization and associated health system efficiency, and improvements to safety and clinical governance). 3. Work with stakeholders to design the key components of a "model" PHC Network for Libya, which could be used locally to design bespoke PNC Networks within localities. 4. Pilot the development of PHC Networks in demonstrator areas and support the pilots with formative and summative evaluations to inform spread and adoption at scale.	**Potential value**	**High**	This is vital for the development of good quality PHC services that the community and health care professionals can trust, as compared with hospital-based care.
			Ease of implementation	**Medium**	The development of the operational framework will be relatively easy. The difficulty will come with implementing the framework. Family physicians will have a vital role to play here: working collaboratively across a locality to develop cross-clinic referrals; collaboration on delivery initiatives; and sharing resources, rotas, and so on, and working to forge clinical peer-peer links with secondary care and associated care pathways where PHC is seen as more than just a gateway to hospital care.
Use PHC to build linkages from existing assets	Support these PHC networks to fast-track integrated service delivery linkages with existing services, community assets, and donor-funded vertical programs across all sectors.	1. Map existing programs for each locality. 2. Form local clinical networks across programs and PHC. 3. Use the clinical networks to review potential linkages and clinical or population-level health benefits from integration. 4. Establish service user representative groups to collaborate to identify potential benefits and priorities from the patient perspective. 5. Establish bilateral or cross-sectoral memorandums of understanding to support collaborative working.	**Potential value**	**High**	This will enable all resources to be leveraged to best effect by achieving economies of scale and scope in service integration.
			Ease of implementation	**Medium**	This will rely on the cooperation of third-sector and private sector providers and donor agencies and will be complex to navigate. Some alliances are likely to be easier to form than others.
Take a digital-first approach to integration	Work with other national agencies to enable and empower PHC providers to take a digital-first approach as they develop new integrated care services to improve patient engagement and pathway management, and to support data collection and information.	1. Review international models for PHC information systems that could be used to help administer PHC operations and to collect core data on the health status of an individual, and which could provide the starting point for PHC-led electronic health records (EHRs). 2. Undertake a review of digital tools already being used internationally for supporting the management of patients living with chronic conditions (e.g., diabetes and heart disease). 3. Undertake a current state assessment in terms of the digital readiness of PHC for primary care providers, workers, patients, and their families. 4. Work with national stakeholders to agree on the approach to the digital strategy (e.g., system procurement vs. enabling investment accompanied by standards and governance). 5. Subject to (4), develop programs to enable rapid implementation of established systems suitably adapted.	**Potential value**	**High**	This is an essential component of care coordination, care management, population health management, and overall performance improvement for an integrated health system. It is an important enabler of wellness management and workforce productivity.
			Ease of implementation	**Low**	This will be hard for primary health care systems to implement without this being part of a wider national strategy, starting with ensuring sufficient enabling telecommunications infrastructure. Key decisions will need to be taken as to whether to move forward with a single health information system for the public health system, or an enabling strategy allowing local solutions to be procured but governed by across-the-board standards and protocols.
	Work with other national agencies to encourage	1. Identify the baseline budget needed for PHC to deliver on the required benefits package and wider responsibility for population health and service integration.	**Potential value**	**High**	This will ensure that funds are available on a secure and sustainable basis and that performance rewards are developed and built as soon as management capability and information systems allow.

Use simple and transparent funding models	pooling of source funds (where possible), the use of simple payment models, and the direct targeting of incentives to the health workforce.	2. Determine a baseline formula for needs-based capitation for defined geographical units and, within these, PHC providers (formula might include weightings for age, population density, unavoidable differences in costs, and health needs indicators such as premature mortality). 3. Identify any additional investment requirements targeted at building physical and workforce capacity in particular geographies disproportionately affected by conflict. 4. Set PHC improvement goals for geographically defined areas and an associated, simple, limited set of KPIs (Key Performance Indicators) that can be measured accurately and that will drive the right workforce behaviors. 5. Identify an incentives fund for rewarding workers for KPI achievements. 6. Develop a simple governance and operating framework for transparent funding allocation and overseeing decisions relating to incentives payments. 7. Pilot arrangements with designated geographies and associated PHC providers.	**Ease of Implementation**	**High**	Primary health care systems should be able to select and implement the right payment system for PHC as needed. The only challenge might be to ensure that payments for secondary care do not cut across the need to promote out-of-hospital care. On their own, activity-based payments for secondary care will discourage the development of vertically integrated care pathways.

Source: Authors analysis
Notes: PHC = Primary health care;

Table 5.2 Five Lower-Priority Strategies for Later Inclusion in Primary Health Care Reform

Intervention	Description	Example activities	Relative priority level		Description
Patient empowerment	To work with individuals and families to take ownership and control of their own health using education, health literacy, and communication programs to promote prevention at the earliest opportunity, combined with a coproduction approach to care delivery. This should increase the adoption of healthy behaviors, treatment compliance, and community-based stewardship of health and health care.	1. Establish local stakeholder groups comprising health professionals and community representatives. 2. Review existing health literacy, education, and communication programs and assess their effectiveness. 3. Assess existing communication channels and how messages are received about the importance of healthy lifestyles. 4. Identify priorities for improvement and associated projects. 5. For each priority, cocreate programs for communications and coproduction of care delivery involving lay representatives, community champions, and effective communication channels, and build on accurate information. 6. Establish processes for continued involvement of stakeholders so that improvement can be continuous.	**Potential Value**	**Medium**	This is a vital component of prevention and wellness management and may need to be targeted initially at high-risk groups who see the potential benefits of behavioral change.
			Ease of Implementation	**Medium**	This will rely on the engagement of patients, families, and communities and requires behavioral change, which can be difficult to develop, particularly for those communities and populations that are disengaged.
Public sector leadership and management	This should include ensuring the deployment of modern working practices for public sector staff, procurement, management, and accountability, and will be especially important if districts and neighborhoods are to be charged with running PHC services and/or clinics (as opposed to the local ownership or ACO models discussed earlier).	1. Work with stakeholders (via workshops and other forms of dialogue) to specify the skills and competency requirements of local PHC leadership. 2. Identify a program of leadership development, including coaching and mentoring to build capacity quickly. 3. Work with stakeholders (via workshops and other forms of dialogue) to review administrative working practices and the extent to which they act as barriers to, or enablers of, integrated care and the identification of priorities for change. 4. Identify who controls the levers for change and whether these are national, regional, or local stakeholders. 5. Develop a strategy for influencing those in control.	**Potential Value**	**Medium**	Integrated care will be driven primarily by the activities of clinicians and the health care workforce working with one another and with patients, families, and communities. The public administration environment is an important enabler for this but does not directly promote integration.
			Ease of Implementation	**Low**	This will require cross-government and cross-country consensus, along with political support.
Enabling legislation	This should include a better review of professional workforce regulation, pharmaceutical regulation, health provider accreditation, competition regulation, data privacy and security, health financing, and so on. The focus should be on reducing barriers, promoting simplification, and facilitating a shift toward ethical practice, risk management, and openness and transparency-based risk assurance models rather than ones based on overly complex rules.	1. Work with stakeholders (via workshops and other forms of dialogue) to specify the skills and competency requirements of local PHC leadership. 2. Identify a program of leadership development, including coaching and mentoring to build capacity quickly. 3. Work with stakeholders (via workshops and other forms of dialogue) to review administrative working practices and the extent to which they act as barriers to, or enablers of, integrated care and the identification of priorities for change. 4. Identify who controls the levers for change and whether these are national, regional, or local stakeholders. 5. Develop a strategy for influencing those in control.	**Potential Value**	**Medium**	Unless there exists legislation that directly prevents integrated care, this activity will support other important activities (such as the development of new health professional roles) but will not impact directly of itself.
			Ease of Implementation	**Low**	This will require cross-government consensus and political support.
Community engagement	To use existing community assets, NGOs, and established community groups to develop a community-owned perspective on health priorities and population health needs for a locality. This will accelerate the building of local capacity, trust, leadership, and participatory governance.	1. Map existing assets for each locality. 2. Bring on board local community representatives and potential leaders and involve them in the development of PHC engagement approaches. 3. Use community workshops and other engagement activities to gain a shared understanding of priorities and a local vision centered on the needs of the population. This vision should be as comprehensive and holistic as possible, and include the wider social determinants of health, as well as physical and mental health. 4. Integrate these activities with wider postconflict reconciliation programs.	**Potential Value**	**High**	This will build engagement, trust, and local ownership quickly and help to fast-track PHC utilization and reduce pressure on the hospital sector.
			Ease of Implementation	**Low**	This is a practical measure that can be part of the development of PHC clinics in the localities and can be incorporated within the infrastructure and workforce development plans. However, it will need careful coordination with wider postconflict reconciliation programs, and will need sensitive implementation and to be done in a such a way as to avoid raising expectations beyond what can be achieved.
Pooled funding	It will be important to ensure that all funds coming into the health system—whether from government revenues, insurance contributions, or donor funds—are pooled or managed through risk equalization. This will ensure that resources can be managed across geographies of sufficient size to address priority needs and health inequalities. Strategic purchasing policies can then be adopted to buy required programs of care and emergency capacity from providers and provider networks.	1. Review internal sources of funds to identify the size of the health financing pool. 2. Review potential sources of donor funding to establish the size of the potential benefit from closer collaboration with external donors. 3. Map the geographical distribution of resources overall and by key component (prevention, PHC, secondary care) to identify variations and key driver (size of population, age profile, disease burden, unavoidable differences in costs, avoidable differences in inefficiency and health system performance). 4. Assess health financing availability against the essential benefits package for each care setting to identify the potential for pooled funds to increase the scope for redirecting resources toward national priorities for health improvement.	**Potential Value**	**Medium**	This will promote more equality of access to scarce resources and a more aligned approach to prioritizing resources where they are most needed.
			Ease of Implementation	**Low**	It will be hard for government ministries or agencies to implement this for external funders. They often have their own governance arrangements, which means that funds can be made available only if they are tied to specific programs or initiatives.

	5. Embark on negotiations with external donors to assess flexibility to align health financing to those priorities.		

Source: Authors analysis
Notes: PHC = Primary health care; ACO = Accountable Care Organization; NGOs = Nongovernmental organizations.

CONCLUSIONS

There is evidence that designing and implementing health care systems and services that are people-centered and integrated contribute to improved population health, patient outcomes, and health system efficiency. The evidence is complex and context-specific. However, as articulated in the Framework on Integrated, People-Centered Health Services adopted by the World Health Assembly in 2016, there is agreement on the strategic priorities that will deliver improved health system performance. These include community empowerment and engagement, participatory governance and accountability, reorientation of the model of care, coordination of services, and an enabling system design. **PHC plays a pivotal role**. It provides a focus for community engagement, local governance and intersectoral collaboration, care coordination, case management, and accountability for performance improvement for both population health and individual health.

As might be expected, there is a relative lack of evidence of good practice in countries implementing integrated care systems in postconflict situations. Nonetheless, some important common themes are beginning to emerge. To begin with, strategies and policy actions that build trust in the quality and safety of services, particularly primary and community services, are vital if new care pathways are to be implemented by clinicians and utilized by service users. It is also becoming clear that horizontal and vertical programs should build from existing assets, including community resources, the private sector, donor-funded programs, and public sector infrastructure and resources. This approach should be multisectoral and cover the wider infrastructure required to make things work, including supply chains, transport systems, storage facilities, sharable physical facilities, and community spaces. Investment in reconstruction should initially be input-based, with funding sources pooled as far as possible. Providers should be paid using simple and reliable provider payment mechanisms, and workforce incentive payments need to be used selectively for developing and rebuilding and for engagement of a high-quality health workforce.

The review has identified five high-impact strategies that, if prioritized by countries considering primary health care reform, could accelerate health system performance improvement. The five strategies are, as follows:

Accelerate development of a multiprofessional PHC workforce	s the recruitment and training of a multiprofessional PHC workforce to accelerate capacity and capability, and to promote the early adoption of population health and integrated disease management programs.
Develop primary health care networks	Support PHC providers to form local, geographically based networks that have strong clinical links with secondary care providers to enhance quality and trust in services and accelerate horizontal and vertical service integration.
Use PHC networks to build linkages across existing assets	Support these PHC networks to fast-track integrated service delivery linkages with existing services, community assets, and donor-funded vertical programs, across all sectors.

Take a digital-first approach to integration	Work with other national agencies to enable and empower PHC providers to take a digital-first approach as they develop new integrated care services to improve patient engagement and pathway management, and to support data collection and information.
Use simple and transparent funding models	Work with other national agencies to encourage the pooling of source funds (where possible) and strategic purchasing activities, including the use of both simple payment models and incentives targeted directly at the health workforce.

These findings have potential relevance for countries such as Libya that are emerging from conflict. Deliberations to look for the transferability and validity of findings within the country context will help complete the knowledge transfer and adaptation of relevant measures. International maturity assessment tools for integrated care might also be useful to support the development and implementation of a road map for such countries. In Libya, this work is expected to lead to ongoing World Bank technical assistance to the PHCI by supporting its contextualization to the Libyan context, with the objective of contributing to the country's PHC reform agenda.

APPENDIXES

APPENDIX A: DATA SOURCES AND METHODS

Introduction

The analysis presented in this paper has been informed by several important global frameworks and good practice toolkits for the development of health systems and the journey to Universal Health Coverage, a complementary literature review, and advice from international experts.

This appendix provides an overview of these data sources and the methods used to identify relevant global experiences.

Global Frameworks and Good Practice Toolkits

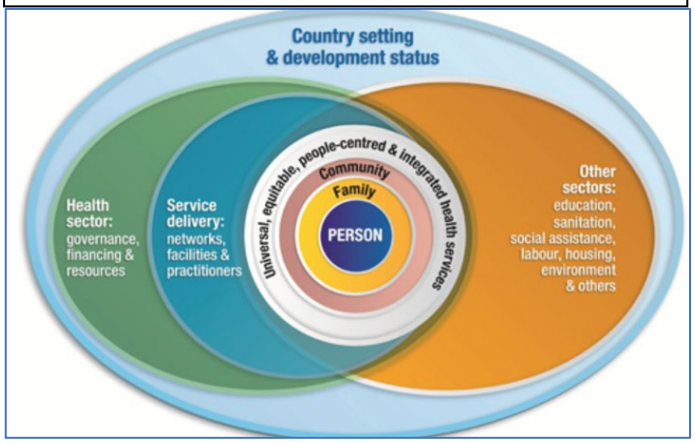
Several frameworks and good practice toolkits have been used to provide information and guide the analysis.

Integrated, People-Centered Health Services

The **Framework on Integrated, People-Centered Health Services** (Figure A.1), adopted at the 69th World Health Assembly in 2016 (WHO 2016), positioned an integrated, people-centered approach at the heart of the global journey to Universal Health Coverage and the achievement of the Sustainable Development Goals.

An integrated, people-centered approach is crucial to the development of health systems that can respond to emerging and varied health challenges, including urbanization, the global tendency toward unhealthy lifestyles, ageing populations, the dual disease burden of communicable and noncommunicable diseases, multi morbidities, rising health care costs, disease outbreaks and other health care crises.

Figure A.1: Framework on Integrated, People-Centered Health Services



The framework envisages a central role for individuals, families, and communities, with integration featuring across the health sector design (governance, financing, and resources) and service delivery modalities (network, facilities, and practitioners), combined with a multisectoral approach.

The framework does not recommend a single model of integrated, people-centered care; rather, it promotes five interdependent strategies:

1. Empowering and engaging people and communities
2. Strengthening governance and accountability
3. Reorienting the model of care
4. Coordinating services within and across sectors
5. Creating an enabling environment

The implementation approach needs to be developed in the context of the specific country and its local conditions. Key features of successful implementation are that it should be

- **A.** Country-led
- **B.** Equity-focused
- **C.** Participatory
- **D.** System strengthening
- **E.** Evidence-based
- **F.** Results-driven
- **G.** Ethically oriented
- **H.** Sustainable

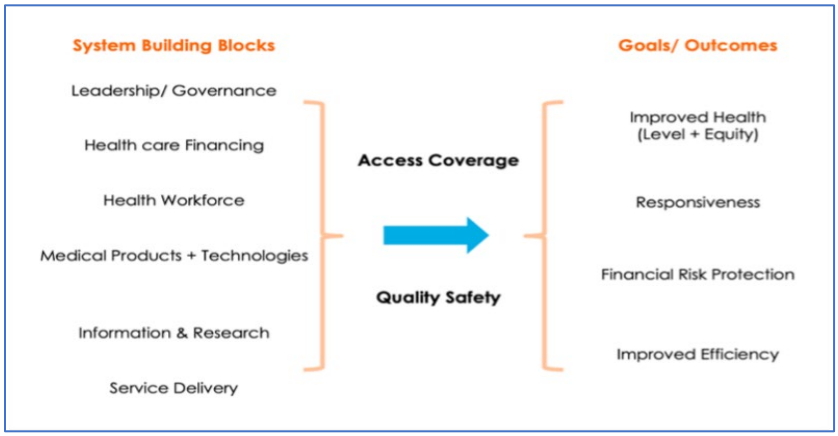
These principles have been used to inform the discussion of the findings of the global experience in relation to the health system reforms planned for Libya.

WHO Health System Building Blocks

Developed in 2010, the **WHO Health System Building Blocks Framework (Integrated, People-Centered Health Services n.d.[a])** organizes the development requirements for a health system around

Figure A.2: WHO Health System Building Blocks Framework

six core areas, as shown in Figure A.2 below:



Source: Adapted from WHO Health System Building Blocks Framework (Integrated, People-Centered Health Services n.d.[a]

The overall goals and outcomes are to improve access, coverage, quality and safety and, as a result, deliver improved health and health equity, improved system responsiveness, improved social and financial risk protection, and improved efficiency.

This framework provides a comprehensive set of indicators and measurement strategies designed to monitor progress in terms of health system strengthening. It has been used as the foundation framework for *Well and Healthy Libya* (National Centre for Health System Reform n.d.).

PHCPI Conceptual Framework

The **Primary Health Care Performance Initiative (PHCPI) Conceptual Framework** (Primary Health Care Performance Initiative n.d.) relates specifically to PHC and was developed by the PHC Performance Initiative—an international partnership among the Bill and Melinda Gates Foundation, the WHO, and the World Bank in collaboration with Ariadne Labs and Results for Development, and UNICEF.

The framework is built around a logic model that links inputs, delivery, outputs, and outcomes across the core components of a comprehensive PHC system. It was developed to inform initiatives to improve PHC and help with the measurement of progress. This work has since been developed further by Bitton, Veillard, and Basu (2018) for low- and middle-income countries. Their 5S-5M-5C framework identifies resources, processes, and functions required for high-quality primary health care.

International Foundation for Integrated Care: Nine Pillars of Integrated Care

The International Foundation for Integrated Care (IFIC) is a nonprofit whose purpose is to advocate for and promote integrated care around the world. Its roots lie in the *International Journal of Integrated Care*, first published in 2000. Since then, it has developed as a network, and then as an established foundation based in the United Kingdom and the Netherlands, with a collaborating center in Australia.

The **IFIC's Nine Pillars of Integrated Care** (Lewis and Ehrenberg 2020have been developed based on knowledge assimilated from a global network of more than 20,000 members and have been compiled to accelerate the adoption of integrated care as health and care systems recover and rebuild following COVID-19. The pillars are, as follows:

1. **Shared Values and Vision** ● emphasizing the need for population health and service integration to be seen as a system-wide responsibility, with all stakeholders committed to working together to achieve a shared vision.

2. **Population Health and Local Context** ● promoting the development of place-based initiatives designed around local needs, community assets, and multisectoral approaches.

3. **People as Partners in Care** ● building on from the concept of empowering patients, families, and carers in the development of population health.

4. **Resilient Communities and New Alliances** ● stressing the importance of community assets and social and community capital as a driver for effective, community-based, integrated care.

5. **Workforce Capacity and Capability** ● highlighting the need for core competencies and integrated working practices that are focused on patient advocacy, communication, interdisciplinary work, people-centered care, and continuous learning.

6. **System-Wide Governance and Leadership** ● based on network governance models that take into account the complexities and interdependencies of health systems, and emphasizing cooperation rather than competition.

7. **Digital Solutions** ● the cement that holds together the integration building blocks, from infrastructure through to shared care records and digital health technologies to improve the monitoring, management, and delivery of care.

8. **Aligned Payment Systems** ● tools that enable funds to flow where they need to go, driving rather than inhibiting integration or creating distortionary incentives.

9. **Transparency of Progress, Results, and Impact** ● sharing results in an open and transparent way to promote continuous learning and good practice because no single model of integrated care fits all systems

The nine pillars have been developed into the **IFIC Knowledge Tree** (International Foundation for Integrated Care n.d.[a]), which provides a repository of resources for countries, regions, and systems to share and engage in learning related to the development of integrated care.

The Scirocco Tool—Scaling Integrated Care in Context

The **Scirocco Tool—Scaling Integrated Care in Context** (Scirocco Project n.d.[b]) was developed from the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA)'s B3 Action Group on Integrated Care B3 Maturity Model. It is a self-assessment tool designed to help health regions to assess their readiness for integrated care. It has 12 domains of good practice, and it has mapped 5 scales of system maturity against each practice domain.

Although developed primarily for regions in Europe, it is based on an international synthesis of good practice in terms of both its features and its characteristics of integrated care and stages of maturity.

Literature Review

It was not possible within the timescales set for the development of this report to undertake a formal systematic review of the literature. Moreover, the use of generic language to describe approaches and experiences presents challenges in the design of search terms. The search strategy adopted for this review instead focuses on an analysis of key international reports and policy briefings, combined with a review of precurated literature from the IFIC Knowledge Tree, and complemented by citations, references, and lines of inquiry suggested by experts (International Foundation for Integrated Care n.d.[a]).

The starting point for identifying relevant literature has been the precurated databases included in the following:

- The IPCHS publications repository (Integrated, People-Centered Health Services n.d.[b])
- The IFIC Knowledge Tree (International Foundation for Integrated Care n.d.[a])

Each repository has been reviewed systematically, domain by domain, to identify potential sources of relevant literature. Where additional information was required to provide insights for the research question, additional literature was sourced based on citations and references. A complementary, targeted search was undertaken in selected specialist journals such as the *International Journal of Integrated Care*,[1] *Health Affairs*,[2] the *Integrated Care Journal*,[3] and *Clinics in Integrated Care*.[4] This complementary search was used wherever there appeared to be gaps in knowledge from the existing good practice databases and to identify additional material that might specifically relate to countries facing challenges and issues similar to those of Libya. Consulted experts also referenced additional selected literature for inclusion.

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[1] See https://www.ijic.org.

[2] See https://www.healthaffairs.org/journal/hlthaff.

[3] See https://ihj.bmj.com.

[4] See https://www.journals.elsevier.com/clinics-in-integrated-care.

Sourced literature was rated on a scale of 1–5 in terms of relevance to each research question, where 1 is not relevant and 5 is highly relevant. In total, 310 references were included in the relevance rating assessment.

The framework for assessing the relevance of the literature source is shown in Table A.1 below:

Table A.1: Framework For Assessing The Relevance Of The Literature Source

Reference	What levers are needed to drive integration in Libya?	What role can PHC play?	What models could deliver early benefits for Libya in high-priority areas of population health need—for example, mental health, cardiovascular disease, diabetes, and stroke?	Which of these could be led by PHC?	What tools could be adapted to help Libya to monitor and evaluate progress toward better integrated care?	Type of Document: A: Policy B: Good practice guide C: Peer-reviewed journal D: Case study E: Technical report F: Blog
Full name of document *(author, title, year)*	**Relevance rating 1–5**	**Relevance rating 1–5**	**Relevance rating 1–5**	**Relevance rating 1–5**	**Relevance rating 1–5**	**Type (A,B,C,D, E, F)**

Source: Authors analysis
Note: PHC = Primary health care.

From this, a total of 94 references were retained for inclusion in the analysis. Selected literature was also reviewed from the perspective of whether specific lessons might be drawn in relation to fragile and conflict-affected countries. Literature sourced for this review is included as a list of references at the end of the main report.

Expert Elicitation

The literature review was complemented by discussions with international experts identified from an analysis of authors and contributors to the frameworks and toolkits, and from authors of the literature that was rated most relevant to the research question. Questions posed to the international experts related to their knowledge of the topic, their ability to identify relevant literature and/or case studies that might otherwise have been missed, their awareness of literature that might specifically relate to fragile and conflict-affected countries, and their ability to make connections to other experts who might have specific insights of relevance to the Libyan context.

Our thanks are extended to the following:

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Helmut Hildebrant	Chief Executive	*Optemedis*
Niamh Lennox-Chhugani	Chief Executive	*International Foundation for Integrated Care*
Jerry La Forgia	Chief Executive	*Aceso Global*
Mark McClellan	Professor of Health Policy	*Duke-Margolis Centre for Health Policy, Duke University*
Ellen Nolte	Professor of Health Services and Systems Research	*London School of Hygiene and Tropical Medicine*
Andrea Pavlickova	Project Coordinator	*Scirocco Tool*

Thematic Analysis

Having compiled the relevant frameworks, toolkits, and relevant literature, lessons were extracted and mapped thematically against the IPCHS five priority strategies.

For each strategy, the literature was reviewed to find examples of initiatives and policy actions that had been implemented and where results had been observed or reported on. The analysis sought to draw out insights that either particularly related to the role of PHC and/or had been implemented in conflict-affected areas.

No attempt was made to rate the quality of the evidence because this was not intended to be a systematic review of impact.

The lessons for Libya were developed by combining insights relating to the current situation in Libya and the ambitions of the PHCI, with insights from international experts and the literature, and distilling those recommendations likely to have the greatest strategic impact on health system performance. These were then prioritized based on a subjective assessment of the relative impact they might have and their ease of implementation. This subjective assessment remains to be validated with local Libyan experts as part of the next phase of work.

APPENDIX B: THE LIBYAN CONTEXT

Introduction

This appendix provides an overview of the Libyan health system and current challenges to the planned health system reform and the role of PHC.

Libya Health System

Libya is a northern African country covering 1.7 million square kilometers located on the Mediterranean coast between Egypt and Tunisia. It shares borders with Sudan, Chad, Niger, and Algeria. More than 90 percent of its 6.8 million citizens live on the Mediterranean coast in and between Tripoli and Al Bayda. With a per capita GDP of $1,936, it is a upper-middle-income country with a Human Development Index of 0.724 and a global rank of 105 (Country Economy n.d.). The Libyan economy is dependent on oil production and export; but the economy and wider society have experienced significant negative impacts from serious internal conflicts since 2011.

Healthy life expectancy at birth is currently 71.9 years. Maternal mortality ratios need to be reduced by one-third, from 9 to 6 deaths per 100,000 live births by 2030, if Libya is to meet its Sustainable Development Goal.

Table B1 below shows the top-10 causes of death in Libya, along with the top-10 causes of years lost from premature death and disability (IHME n.d.):

Table B1: Top-10 Causes Of Death In Libya, Along With The Top-10 Causes Of Years Lost From Premature Death And Disability

Top-10 causes of death	Top-10 causes of DALYs
▪ Ischemic heart disease	▪ Ischemic heart disease
▪ Stroke	▪ Road injuries
▪ Road injuries	▪ Stroke
▪ Chronic kidney disease	▪ Conflict and terror
▪ Hypertensive heart disease	▪ Diabetes
▪ Alzheimer's disease	▪ Depressive disorders
▪ Conflict and terror	▪ Low back pain
▪ Lung cancer	▪ Headache disorders
▪ Diabetes	▪ Neonatal disorders
▪ Lower respiratory tract infection	▪ Gynecological disease

Source: IHME n.d.

In Libya, conflict and terror have contributed substantially to premature death and disability. As a category, conflict and terror ranks fourth in the top-10 causes of DALYs and stands out as a major outlier by comparison with countries with similar

socioeconomic profiles. However, the conflict has also impacted other conditions, particularly mental health.

The impact of the conflict on service delivery is also likely to have affected other health care outcomes. Service availability has been very seriously undermined across the country. The basic availability of 28 out of 29 health care services was below 50 percent, many being as low as 10 percent. Only diabetes exceeded 50 percent (53 percent) (National Centre for Health System Reform n.d.).

The health system has had three organizational layers dating back to 1969: national, district, and municipality. There are as many as 80 districts; they mirror the organizational structures at the national level. The districts oversee the hospital services (district and specialist). Within districts are municipalities that are responsible for the delivery of PHC. Tertiary care is provided through medical centers. All these bodies are autonomous, with their own devolved administrative and financial powers. The last decade of conflict has compromised the governance of the entire system and has led to greater levels of de facto autonomy for all organizations, yet with little system accountability, oversight, or adequate regulation (National Centre for Health System Reform n.d.). Table B.2 below provides a summary of health care facilities in Libya.

Table B.2: Organisation Of Health Care Facilities In Libya

Organization Of Health Care Facilities			
Health care level	**Type Of facility**	**Number**	**Capacity**
PHC	PHC units	728	Provide basic curative, preventive, and promotive services to 5,000 to 10,000 citizens.
	PHC centers	571	Provide basic curative, preventive, and promotive services to 10,000 to 26,000 citizens—general practice, maternal child health services, immunization, laboratory services, pharmacy, dental services, and other clinics such as diabetes, hypertension, and dermatology.
	Polyclinics	56	Staffed by physicians, polyclinics each provide laboratory, radiology, and pharmacy services to 50,000 to 60,000 citizens.
	Centers for Disease Control (CDCs)	29	Designed to provide tuberculosis diagnosis and treatment, the CDCs were later assigned to cater for all communicable diseases and, subsequently, noncommunicable diseases as well.
Secondary care	Rural hospitals	27	40–60 beds.

	General hospitals	48	More than 100 beds.
Tertiary care	Specialized hospitals	17 in all: neurosurgery (1) Plastic surgery and burns (1) Ophthalmology (2) Gynecology and obstetrics (2) Tuberculosis and chest diseases (5) Oncology (4)	These specialized hospitals have varying bed capacity.
	Medical centers	4 (one each in Tripoli, Benghazi, Sabha, and Tabrouk)	1,000–2,000 beds and all have specialties.

Source: National Centre for Health System Reform n.d.
Note: PHC = Primary health care.

There are also private sector health facilities. As of the time of writing, they comprised 415 outpatient and 103 inpatient clinics, with a total bed capacity of 2,088; 297 dental clinics, 311 medical laboratories, and 1,934 pharmacies, plus several unregulated clinics practicing herbal and traditional medicine.

Health care infrastructure has been impacted by a decade of conflict. There are large geographical variations in the availability of services, with significant levels of closures; even in those facilities that are open, services may not be operational. One report suggests that only 39 percent of inpatient beds were functional. The additional demands brought by COVID-19 have resulted in up to 90 percent closure of PHC centers and hospital services—especially in some of the worst-affected areas (National Centre for Health System Reform n.d.).

From a workforce perspective, Libya has relatively high levels of health workers, with a core health workforce density of 76 per 10,000 population, compared to the WHO standard of 23. However, this masks relative shortages of midwives, nurses, and general practitioners; significant shortages in PHC maternity and child health services; and geographical disparities that negatively affect Sirt and Benghazi and areas away from the major centers. Staff themselves are highly underutilized, with more than 14,500 staff at 302 PHC facilities providing no service at all. The lack of timely and complete staff salary disbursements is also a major factor in areas of conflict. Additionally, in 59 percent of hospitals and 90 percent of PHC, there is a serious shortage of medicines.

The public health system is free, but the combined effect of disrupted supply, inadequate facilities, and unpaid or irregularly paid staff has inevitably eroded trust in the system. The result is that many Libyans have turned to the private sector for service. Even before the conflict, out-of-pocket expenditure in Libya was estimated in 2009 at 34 percent of total health spending (Harvard University and NATO 2013).

Finally, the funding flows within the health sector reflect historic, and essentially out-of-date, budget management. For example, for PHC, the health sector budget is fragmented into four components: staff salaries are handled centrally by the municipalities; recurrent costs of equipment and supplies are managed at the facility level; capital expenditure is managed at the Ministry of Planning; and medical supplies are funded from the Medical Supply Organization, which is again centralized. It is particularly challenging to align funding to ensure that resource distribution is optimized to meet the needs of patients in the most efficient way.

Clearly, the priority must be to develop and build service delivery capacity, but if Libya is to build a better system, there are many barriers to integration, besides service delivery capacity, that will also need to be addressed. These are summarized in Table B.3.

Table B.3: Barriers to Integration

Governance in health system	▪ A prevailing culture of autonomous health care institutions working in isolation from the wider system ▪ Legacy barriers arising from the conflicts of the previous decade and from the absence of legal mandates for reform ▪ Governance rooted in prerevolution vertical approaches to health system supply, which militates against efforts to move to a more integrated, person-centered approach
Health service delivery	▪ Conflict-affected areas where infrastructure and basic amenities have been significantly damaged, thus reducing the population's access to services ▪ Poorly organized health care delivery systems for any given risk, disease, condition(s), and the associated care pathways ▪ Weak systems of patient referrals and unclear care pathways across care settings as required to meet patients' health care needs as a whole ▪ Passive rather than proactive care management of patients ▪ A lack of confidence in the quality of services, which itself inhibits patients from accessing services, and health professionals from referring patients across the system ▪ A system that is hospital-centric at the expense of primary and community services ▪ A system that is insufficiently focused on prevention and population health management ▪ Working practices across sectors that need to be established and operationalized to enable the implementation of health policies at the municipality level ▪ A significant and separate private sector that accounts for out-of-pocket health care spending totaling about one-third of all health care spending

Health workforce	▪ A health workforce profile that is not well aligned to population needs ▪ Health professionals who are not currently trained to, or motivated to, work in the multidisciplinary, multiprofessional teams that are needed to support new care pathways
Pharmaceuticals and other health technologies	▪ Weak or nonexistent systematic approaches to the management and optimization of medicines
Health information system	▪ Barriers to the sharing of patient information across pathways required to optimize clinical decision making ▪ Absence of systematic data analysis and reporting to support population health management and performance monitoring
Health system financing	▪ Health financing arrangements that result in high levels of out-of-pocket expenditure by patients and relatively high levels of catastrophic expenditure ▪ Funding and financial resource flows that are designed around historical budget centers rather than directed to where they are most needed

Source: Authors Analysis

Health System Reform in Libya

Post conflict, Libya is committed to reforming and investing in health care and the Libyan Health System. Integration is a watermark throughout Libya's planned health system reform as set out in *Well and Healthy Libya: National Health Policy 2030* (National Centre for Health System Reform n.d.):

> *Well and healthy people, whose health needs, especially of the underserved and vulnerable, are effectively addressed.*

The mission is to

> *reform and thereby build a health system that is responsive and ensures access by all to the needed health services without anyone facing financial hardship.*

Specific 2030 goals for health system reform are focused on the achievement of SDG3 targets and increasing healthy life expectancy at birth from 71.9 years to 74.9 years (both genders) by 2030, and reducing maternal mortality ratios by one-third—from 9 to 6 deaths per 100,000 live births—by 2030.

The underlying policy aim is to ensure Universal Health Coverage and the achievement of the Sustainable Development Goals. A multisectoral approach has been taken to ensure alignment between actions that impact the wider social determinants of health and to promote a health-in-all-policies approach to public policy across the government.

Well and Healthy Libya includes policy statements aligned with each of the WHO Health System Building Blocks (Framework on Integrated, People-Centered Health Services n.d.[a]). Specific national policy goals are set out for each area:

1. **Governance in health system**: “Within the health policy framework, which covers public and private (for-profit and not-for-profit) health sectors, introduce reforms in the health system for ensuring effective oversight, regulation, accountability, and coalition building or partnership for health.”

2. **Health service delivery:** “Develop and organize service delivery based on PHC, which assures universal access, as a fundamental human right, to a health services package (defined by MOH [Ministry of Health]), including emergency services at all levels of health care.”

3. **Health workforce:** “Health workforce in adequate numbers and with an appropriate skill mix with required qualifications and competencies are distributed equitably across all levels of the health care delivery system and geographical regions.”

4. **Pharmaceuticals and other health technologies**: “Population across all regions has equitable and sustainable access to affordable, good-quality, essential medicines, vaccines, blood and blood products and medical devices.”

5. **Health information system**: “A health information system with high-quality, timely, and reliable data, which are systematically gathered, synthesized, analyzed, interpreted and presented, reflecting the health system situation and trends, and made available for population health literacy and decisions and management decision making.”

6. **Health system financing**: “Ensure that the health system’s financing is adequate, sustainable, efficient, and equitable, and that it protects people, especially the underserved and vulnerable, from financial risk.”

Taken together, the reform initiatives are designed around the need to increase resources, build capacity, and develop an effective and resilient health care delivery system. *Well and Healthy Libya* envisages

> ***reorienting the health services delivery system*** *from a reactive “passive” system to one in which individuals, families, and communities are active participants in health, as well as being beneficiaries of the service.*

The plan of the reform policy is to institutionalize family practice as a core part of the wider health system that collectively provides a platform for integrated care. Specifically, the policy recognizes that the reformed system needs to provide a platform for integration across the continuum of care (promotive, preventive, diagnostic and curative, rehabilitative, palliative, and terminal care).

PHC Reform

PHC is planned to be at the center of the integration of health service delivery, with the development of family practice as the key driver of prevention strategies and population health management, and as the gatekeeper to health services delivery for every local catchment population.

It is in this context that the Ministry of Health (MOH) has developed its PHC Strategy for 2020–2022 (State of Libya, Ministry of Health 2019). The strategy sets out a clear vision for the development of PHC:

> *A strong, responsive and sustainable PHC system that improves health care for all Libyans, especially those who currently experience inequitable health outcomes, by keeping people healthy, preventing illness, reducing the need for hospital services, and improving management of chronic conditions.*

The strategy identifies several detailed actions designed to enhance prevention, advance population health management, increase access, raise quality, strengthen partnerships, improve information and informed decision making, and upskill the PHC workforce. The plans focus on developing infrastructure, a skilled workforce, and simple financing and performance management arrangements. If implemented, these plans will provide an important foundation for the development of IPCHS across the entire health system.

APPENDIX C: THE IPCHS FRAMEWORK POLICY ACTIONS

The IPCHS Framework presents five key strategies for designing and implementing person-centered integrated care:

1. **Empower and engage people and communities** ● "*providing the opportunity, skills, and resources that people need to be articulate and empowered users of health services and advocates for a reformed health system."*

2. **Strengthen governance and accountability** ● "*requires a participatory approach to policy formulation, decision making and performance evaluation at all levels of the health system, from policy making to the clinical intervention level.*"

3. **Reorient the model of care** ● "*ensuring that efficient and effective health care services are designed, purchased, and provided through innovative models of care that prioritize primary and community care services and the coproduction of health."*

4. **Coordinate services within and across sectors** ● "*requires integration of health care providers within and across health care settings, development of referral systems and networks among levels of care, and the creation of linkages between health and other sectors."*

5. **Create an enabling environment** ● *"a diverse set of processes to bring about the necessary changes in leadership and management, information systems, methods to improve quality, reorientation of the workforce, legislative frameworks, financial arrangements, and incentives."*

The following paragraphs provide a synopsis of each strategy, along with recommended policy actions.

Empower and Engage People and Communities

The IPCHS Framework identifies four strategic approaches to empowering and engaging people and communities. For each, a number of policy actions and interventions that should be considered are summarized in Table C.1:

Table C.1: Strategic Approaches to Empowering and Engaging People

1.1 Empower and engage individuals and their families	1.2 Empower and engage communities	1.3 Empower and engage informal carers	1.4 Reach the underserved and the marginalized
• Health education • Informed consent • Shared clinical decision making among individual families, carers, and providers	• Community-delivered care • Community health workers • Development of civil society • Strengthened social	• Training of informal carers • Informal carer networks • Peer support and expert	• Integration of health equity goals into health sector objectives • Provision of outreach services for the underserved, including mobile units, transport systems, and telemedicine infrastructure

• Self-management, including personal care assessments and treatment plans • Knowledge of health system navigation	participation in health	patient groups • Caring for the carers • Respite care	• Outreach programs for disadvantaged or marginalized populations, who may not receive effective coverage owing to barriers linked to factors that include income, education, residence, gender, ethnicity, working conditions, and migrant status • Contracting out of services when warranted • Expansion of PHC-based systems

Source:WHO 2016
Note: PHC = Primary health care.

Strengthen Governance and Accountability

Two strategic approaches are recommended by the IPCHS Framework, together with policy actions and interventions, to strengthen governance and accountability. These are shown in Table C.2.

Table C.2: Strategic Approaches to Strengthen Governance and Accountability

2.1 Bolster participatory governance	2.2 Enhance mutual accountability
• Community participation in policy formulation and evaluation • Community representation on the boards of health care facilities • National health policies, strategies, and plans promoting integrated, people-centered health services • Strengthened health services governance and management at the subnational, district, and local levels • Harmonization and alignment of donor programs with national policies, strategies, and plans • Decentralization and devolution to local levels, where appropriate • Comprehensive planning across the public and private sectors • Strengthened stewardship role of the Health Ministry with respect to nonstate actors • Clinical governance *Source: WHO 2016*	• Health rights and entitlement • Provider report cards • Patient satisfaction surveys • Patient-reported outcomes and balanced scorecard • Performance-based financing and contracting • Population registration with accountable care provider(s)

Reorient the Model of Care

The IPCHS Framework identifies five strategic approaches and policy actions (Table C.3), as well as interventions for the strategic approaches to reorient the model of care. The first two are focused on reassessing priorities and prioritizing health promotion, illness prevention, and public health needs.

Table C.3: Strategic Approaches to Reorient the Models of Care

3.1 Define service priorities based on life course needs	3.2 Revalue and pursue promotion, prevention, and public health
• Local health needs assessment based on existing patterns of communicable and noncommunicable diseases • Comprehensive packaging of services for all population groups defined through a participatory and transparent process • Strategic purchasing • Gender-, culture-, and age-sensitive services • Health technology assessment	• Monitoring population health status • Population risk stratification • Surveillance, research, and control of risks and threats to public health • Improved financial and human resources allocated to health promotion and disease prevention • Public health regulation and enforcement

Source: WHO 2016

Reorienting the model of care also includes strategies to build strong PHC-based systems and to shift services toward more outpatient and ambulatory care. Policies and interventions included in the IPCHS Framework are shown in Table C.4 below.

Table C.4: Strategic Approaches to Build Strong PHC-Based Systems

3.3 Build strong PHC-based systems	3.4 Shift toward more outpatient and ambulatory care
• PHC services with a family-based and community-based approach • Multidisciplinary PHC teams • Family medicine • Gatekeeping to access other specialized services • Greater proportion of health expenditure allocated to PHC	• Home care, nursing homes, and hospices • Repurposing secondary and tertiary hospitals for acute complex care only • Outpatient surgery • Day hospitals • Progressive patient care

Source: WHO 2016
Note: PHC = Primary health care.

Finally, reorienting the health system includes the deployment and adoption of digital health technologies (Table C.5).

Table C.5: Digital Health Technologies

3.5 Innovate and Incorporate New Technologies
• Shared electronic medical record • Telemedicine • mHealth

Source: WHO 2016

Coordinating Services within and across Sectors

The fourth strategy included in the IPCHS Framework relates to coordination. Policy actions and interventions are identified for three strategic areas (Table C.6).

Table C.6: Strategic Approaches to Coordinate Services across Sectors

4.1 Coordinate care for individuals	4.2 Coordinate health programs and providers	4.3 Coordinate across sectors
• Care pathways • Referral and counterreferral systems • Health navigators • Case management • Improved care transition • Team-based care	• Regional or district-based health service delivery networks • Purchasing integrated services • Integrating vertical programs into national health systems • Incentives for care coordination	• Health-in-all policies • Intersectoral partnerships • Merging of the health sector with social services • Working with education sector to align professional curriculum toward the new skills needed • Integrating traditional and complementary medicine with modern health systems • Coordinating preparedness and response to health crises

Source: WHO 2016

Create an Enabling Environment

Finally, the IPCHS Framework presents six strategic approaches to the creation of an enabling environment.

The first of these involves **strengthening leadership and management for change** achieved through

- transformational and distributed leadership
- change in management strategies

The second involves the need to **strengthen information systems and knowledge,** achieved through

- the development of information systems
- systems research

- knowledge management

The third enabling strategy is to strive for **quality improvement and safety** through

- quality assurance
- creating a culture of safety
- continuous quality improvement

Reorienting the health workforce is also a key component of an enabling strategy for integrated care. Policy actions and interventions here include the following:

- Tackling health workforce shortages and maldistribution
- Health workforce training
- Multiprofessional teams working across organizational boundaries
- Improving working conditions and compensation mechanisms
- Creating provider support groups
- Strengthening professional associations

The fifth enabling strategy is to **align regulatory frameworks**.

Finally, the sixth enabling strategy is to **improve funding and reform payment systems** through

- assuring sufficient health system financing and aligning resource allocation with reform priorities
- mixed payment models based on capitation and bundled payments

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This Global Experience Paper on Integrated Health Care was developed to provide the Primary Health Care Institute (PHCI) in Libya with insights as it designs and develops its plans to rebuild primary health care (PHC). The findings are informed by a review of recent international literature, and by insights provided by selected international experts. The paper uses the Framework on Integrated, People-Centered Health Services from the World Health Organization to structure the analysis of global experiences. Overall, there is no single model of integration that can or should be adopted in countries seeking to develop primary health care. There is, however, evidence of good practice in designing and developing local, context-specific solutions. Evidence to support effective strategies and policies relevant for conflict-affected situations is scarce. However, there are some common themes and issues relating to the need to rebuild trust in the quality and safety of services; to build from existing assets, including donor-funded programs; to adopt a multisectoral approach with a focus on infrastructure to support supply chain security, and the use of financial incentives to support workforce participation. The paper focuses on the pivotal role played by primary health care and identifies five high-impact strategies for the PHCI to rebuild PHC. These strategies are to accelerate the development of a multiprofessional primary health care workforce; develop primary health care provider networks; use primary health care to build linkages from existing community and donor assets; take a digital-first approach to integration; and use simple and transparent funding models.

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1818 H Street, NW
Washington, DC USA 20433

Telephone: 202 473 1000
Facsimile: 202 477 6391
Internet: www.worldbank.org
E-mail: feedback@worldbank.org