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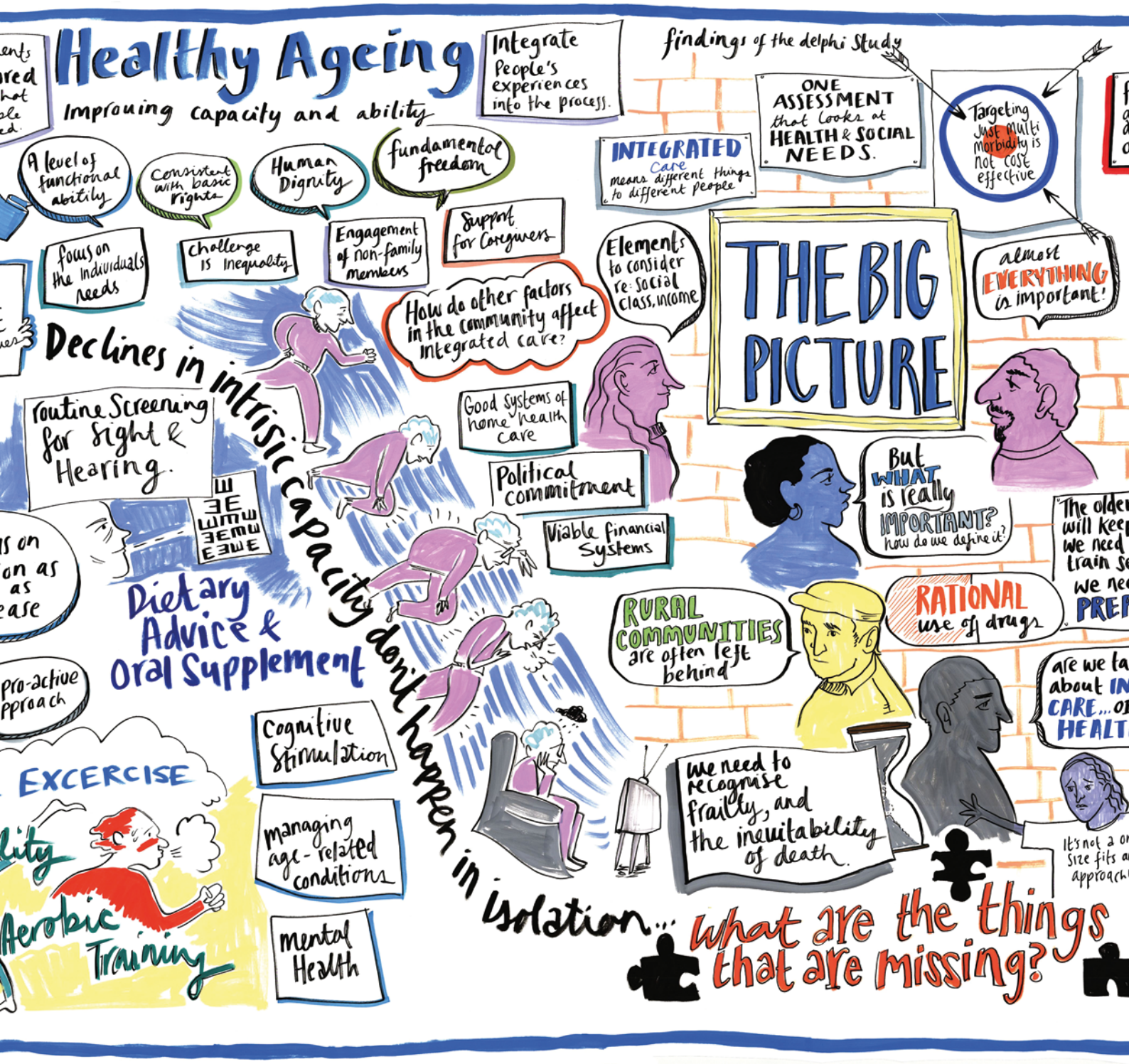

Global consultation on integrated care for older people (ICOPE) – the path to universal health coverage

Report of consultation meeting,
23–25 October 2017, Berlin, Germany

WHO/FWC/ALC/18.3

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Abbreviations

GMUSC	Global Alliance for Musculoskeletal Health
ICOPE	integrated care for older people
NGO	nongovernmental organization
SDG	Sustainable Development Goal
UHC	universal health coverage
WHO	World Health Organization

Acknowledgements

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Photographs: Inga Kjer/PHOTOTHEK.

Executive summary

The global consultation on integrated care for older people (ICOPE) – the path to universal health coverage (UHC) – took place in Berlin, Germany, 23–25 October 2017. Bringing together an international group of stakeholders and experts, it was designed to consult them on the implementation of the ICOPE approach of the World Health Organization (WHO).

The WHO *Global strategy and action plan on ageing and health* provides a policy framework to ensure that societal responses to population ageing are aligned with ambitious development agendas. The United Nations Sustainable Development Goals (SDGs) demonstrate a renewed global commitment to health systems, underpinned by the target for UHC. Without structural and social changes, however, many of the ambitions of the SDGs cannot be achieved.

Health systems will need to respond to the diverse needs of older people, including those who are experiencing high and stable levels of intrinsic capacity, those in whom capacity is declining, and those for whom capacity has fallen to the point where they need the care and support of others. On this regard, WHO commissioned a systematic review of evidence followed by a global Delphi study to identify which were the effective elements that would support the integration of care.

The Delphi study that has informed this consultation meeting has clarified different stakeholders' perspectives on implementing integrated care, yet further research is needed also to understand older people's perspectives better. The inputs from the meeting have been invaluable. Participants indicated that the elements identified as necessary for integrated care demand clearer descriptions, but without making them overly prescriptive and therefore difficult to interpret and implement in different settings. The consultation also identified missing elements that might be given consideration, including pain assessment and end-of-life care. In addition to the specific elements needed for ICOPE, the meeting proposed more general principles that should be followed in a set of broader goals and actions to support implementation.

The consultation meeting in Berlin was also a great opportunity for a rich diversity of global expertise – from various fields relevant to *Healthy Ageing* and including representatives of WHO Member States – to come together and share numerous lessons learnt in the implementation of ICOPE and to engage in rich discussions that would help to inform the development of the implementation framework for the WHO ICOPE approach.

The next steps resulting from the consultation meeting are to revise the Delphi study questionnaire and to clarify the key terms and concepts; to involve in the consultation organizations that work closely with older people; and to involve more participants from low- and middle-income countries in subsequent rounds of the Delphi study.

A follow-up regional consultation is also recommended for the development of country toolkits to implement the ICOPE approach.

Consultation materials online

A webpage at the WHO website is dedicated to the ICOPE consultation – see http://www.who.int/ageing/health-systems/icope/icope-consultation. Alongside this report, the meeting handbook, background papers and some of the key slides from presentations given during the meeting have also been published.

World Health Organization

The Ageing Population Presents new challenges

our goal is also to HEAR FROM YOU

A change in assessment- Promoting INDEPENDENCE & SELF RELIANCE

Healthcare systems need to be ADAPTED & STRENGTHENED

Scientists must rise to a new challenge

NO-ONE WILL BE LEFT BEHIND

• Ensure healthy life • Promote Wellbeing • Provide help & Support

WHO GLOBAL STRATEGY on Ageing & Health

Align health systems to the older populations they serve

Develop long term care systems

Improve measurement, monitoring and understanding.

Commitment action on ...althy Ageing

everyone ...d in ...

the Community

1 Introduction

Populations around the world are rapidly ageing and this demographic transition will impact almost all aspects of society. At the same time, the world has united around the 2030 Agenda for Sustainable Development, pledging that no one will be left behind and that every human being will have the opportunity to fulfil their potential in dignity and equality. The United Nations Sustainable Development Goals (SDGs) demonstrate a renewed global commitment to reinvigorate health systems. This is underpinned by target 3.8 for universal health coverage (UHC), whereby all people and communities have access to needed quality health services without the risk of financial hardship *(1)*. Unless structural and social adaptions are put in place, however, many of the ambitions outlined in the SDGs cannot be achieved.

The WHO *Global strategy and action plan on ageing and health* provides a policy framework to ensure that societal responses to population ageing are aligned with this ambitious development agenda *(2)*. It calls for action on aligning health systems with the needs of older populations and articulates that a transformation is needed in the way health systems are designed, to ensure affordable access to integrated services that are centred on the needs and rights of older people. These systems will need to respond to the diverse needs of older people, including those who are experiencing high and stable levels of intrinsic capacity, those in whom capacity is declining, and those whose capacity has fallen to the point where they need the care and support of others.

WHO proposed the integrated care for older people (ICOPE) approach to respond to this need. ICOPE is a community-based approach that will help to reorient health systems towards more person-centred and integrated care for older people, to better address the health and social care needs of older people and caregivers. It requires, however, a service delivery model that integrates health and social care, and ensures:

- community-level and home-based interventions;
- comprehensive assessments and care plans;
- shared decision-making and goal-setting;
- support for self-management;
- multidisciplinary care teams;
- unified information – or data-sharing systems;
- community engagement and caregiver support; and
- links with a long-term care system.

To enable the realignment of health systems towards the needs of older people, WHO needs to reach a global consensus on the key elements of an integrated care approach, and needs to create tools to support such care delivery at the country level. Concurrent work will include developing tools to support implementation, specifically:

- a service-level guide for health workers in community settings to implement the ICOPE recommendations in practice; and
- a country toolkit that includes guidance for countries to assess their health system and implement integrated care.

Consultation on the ICOPE approach

WHO has developed, and continues to refine, the ICOPE approach through evidence reviews and consultation. In July 2017, WHO launched a Delphi study to canvass expert opinion (80 experts) on the most important elements of an ICOPE approach at the service (meso)

and system (macro) levels. This initial consultation asked Delphi panellists to consider 31 discrete elements, informed by evidence and internal WHO literature, experience and emerging evidence. Following this initial exploratory round, during which an additional 15 elements were added by respondents, a global consultation meeting was held from 23–25 October 2017 in Berlin with experts and representatives from Member States to discuss the feedback on 43 ICOPE elements and the proposed framework.

Feedback received from the global consultation meeting and responses to the initial Delphi round were reviewed internally by WHO and a revised framework of ICOPE elements created, consisting of 18 elements (Figure 1). The process of distilling the 43 elements to 18 included:

- analysing feedback from the working groups that participated in an element review process at the global consultation meeting;
- identification of similar elements to reduce duplication and redundancy;
- internal review across WHO departments;
- grouping elements into logical domains that mapped to the WHO Framework on integrated people-centred health services *(3)* – see Figure 3; and
- internal WHO review and external peer-review of the revised framework of 18 elements.

Where does the current consultation fit and who is the target audience?

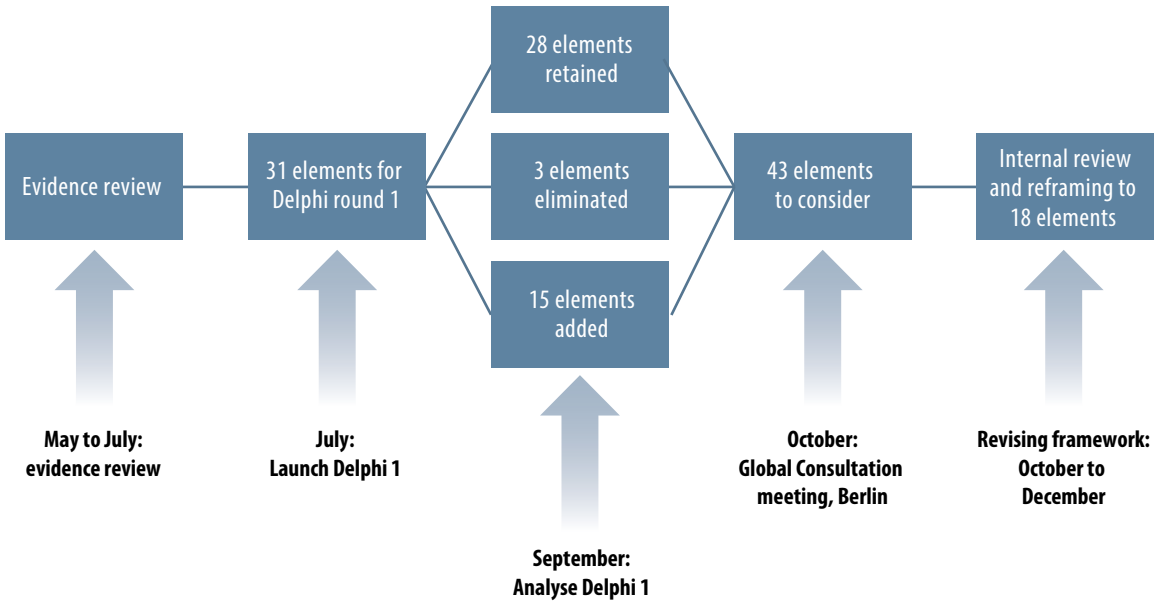
The purpose of the current consultation is to clarify and reach consensus on the critical elements needed for health and social care services to deliver the ICOPE approach at a community level. The focus is, therefore, on the health service/organizational (meso) level with some consideration of the system (macro) level, aligned with the existing WHO *Framework on integrated people-centred health services*.

The target audience for the outcomes of the consultation are:

- health and social care service officers and managers; and
- policy-makers.

The purpose of the global consultation is to seek feedback on the revised framework of elements that underpin the ICOPE approach at meso and macro levels. The 80 experts who participated in the first, exploratory, Delphi round were invited to participate, as was a broader network of stakeholders. The revised framework of elements reflects evidence from the literature and also feedback from consultation to date. The framework is not intended to be exhaustive at this stage, but rather to be a platform for canvassing feedback from stakeholders and to enable concepts to be further refined.

Figure 1. **Process of distilling the elements across the consultation phases in 2017**



2 Setting the stage

The following themes were central to the face-to-face activities of the Berlin consultation meeting. They also ran through the presentations and forums of a joint meeting held with the Global Alliance for Musculoskeletal Health (GMUSC) before the consultation began on day one. The main themes were:

- WHO *Healthy Ageing* framework;
- WHO's approach on integrated care for older people (ICOPE); and
- Universal health coverage (UHC).

The joint meeting with GMUSC was focused on integrated health and social care for older people to maintain physical and mental capacity.

It was therefore a highly relevant opportunity for participants of the ICOPE consultation meeting first to attend the joint meeting with GMUSC, provided thanks to collaboration between WHO, the German Federal Ministry of Health and the Japanese Ministry of Health, Labour and Social Welfare.

Having reinforced the concept of intrinsic capacity and how it can be maintained for older people when care is integrated, discussions followed about the full meaning of people-centred integrated services and UHC. Among some insights that were also shared was one presented by Anung Sugihantono, Director-General of Community Health, Ministry of Health, Republic of Indonesia, who gave an overview of the Indonesian experience of how care has started to be integrated. Among the other highlights, a presentation by GMUSC President Karsten Dreinhöfer focused on the value of exercise for *Healthy Ageing*.

WHO *Healthy Ageing* framework

In 2014, the World Health Assembly requested the director-general to develop a comprehensive *Global strategy and action plan on ageing and health*. After consideration by the Executive Board in January 2016 and by the 69th World Health Assembly, *Multisectoral action for a life course approach to healthy ageing: global strategy and plan of action on ageing and health* (Document A69/17) and a related resolution (WHA69.3) were adopted in May 2016.

The global strategy was guided by the *World report on ageing and health* that established a framework for public-health strategies that can target the full diversity of older people across robust, declining and significant loss of intrinsic capacities *(4)*. Figure 2 outlines how this framework provides opportunities for public-health action across the life course.

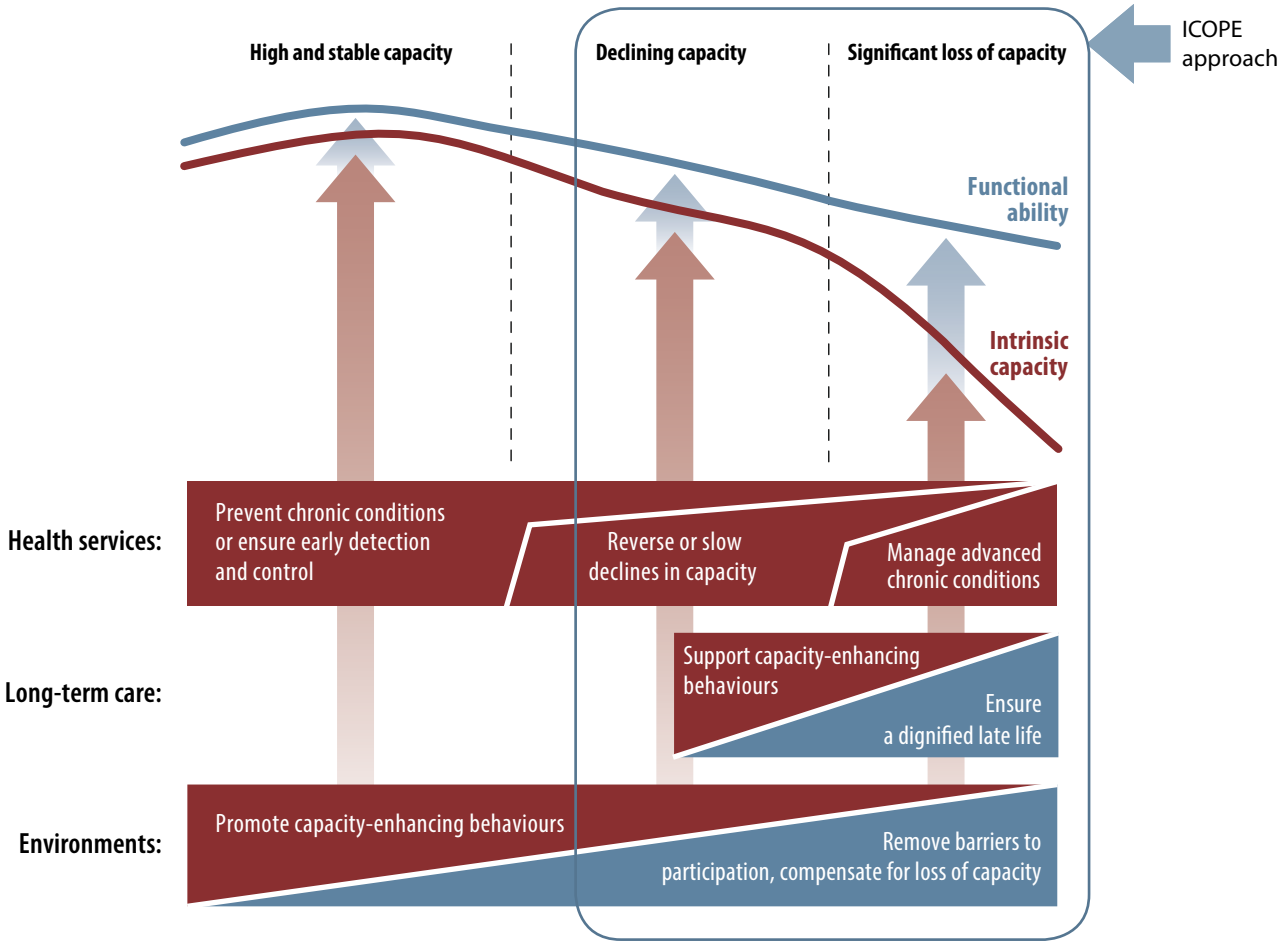
WHO defines *Healthy Ageing* "as the process of developing and maintaining the functional ability that enables well-being in older age". *Healthy Ageing* is about creating the environments and opportunities that enable people to be and do what they value throughout their lives. Everybody can experience *Healthy Ageing*. Being free of disease or infirmity is not a requirement for *Healthy Ageing* as many older adults have one or more health conditions that, when well controlled, have little influence on their well-being.

Functional ability is made up of the intrinsic capacity of the individual, relevant environmental characteristics and the interaction between them. Intrinsic capacity comprises all the mental and physical capacities that a person can draw on and includes their ability to walk, think, see, hear and remember. The level of intrinsic capacity is influenced by a number of factors such as the presence of diseases, injuries and age-related changes.

The WHO framework articulates intrinsic capacity and functional ability as new targets for health and long-term care systems. Current health systems are often better designed to deal with individual acute health conditions than with the more complex and chronic health needs that tend to arise with increasing age. There is an urgent need to develop and implement comprehensive and coordinated primary health care approaches that can prevent, slow or reverse declines in capacity, and, where these losses are unavoidable, help older people to compensate in ways that maximize their functional ability. These approaches should be designed around the needs of the older person rather than the provider, be community-based and efficiently coordinated with long-term care providers (both formal and informal).

Few countries have systems in place that adequately meet the long-term care needs of older people. Ongoing

Figure 2. **A public health framework for *Healthy Ageing*: opportunities for public health action across the life course *(4)***



demographic and social change means approaches that rely heavily on families to provide care, without the necessary training and support infrastructure, are unsustainable and often inequitable. In the 21st century, every country needs a long-term care system that can enable older people who experience significant declines in capacity to receive the care and support they need to live lives with dignity and respect.

Health and long-term care systems often operate independently from each other. This results in poor outcomes, inefficient use of health services and cost-shifting. It also fails to protect families from catastrophic care expenditures or to free informal caregivers – generally women – to have broader social roles. New models of connecting these systems are urgently required.

Realizing the value of older people and communities: the WHO ICOPE approach

The ICOPE approach provides guidance to health services and the health system in which they operate to respond optimally to the unique, varied and often complex needs of older people, with the ultimate aim of maximizing the functional ability of people. The ICOPE approach is principally focused on older people who are experiencing declines in intrinsic capacity and on those people who have experienced a significant loss in capacity and need care and support (Figure 2).

The ICOPE approach is grounded on the principle that functional ability can be maximized when health and social care for older people are integrated in a way that responds to their unique needs; that is, in a person-centred manner. Integration does not mean that structures must merge, but rather that a wide array of service providers should work together in a coordinated

way. Experience to date indicates that most successful programmes have taken a bottom-up approach to change, which has been supported by higher-level policy and mechanisms for shared financing and accountability within teams.

ICOPE is a community-based approach that will help to reorient health systems towards more person-centred integrated care for older people. It requires a service delivery model in which integrated health and social care can be provided to ensure:

- community-level and home-based interventions;
- a comprehensive assessment and integrated care plan;
- shared decision-making and goal-setting;
- support for self-management;
- multidisciplinary care teams;
- unified information or data-sharing systems;
- community engagement and caregiver support; and
- links with long-term care systems.

The ICOPE approach has been informed by a series of evidence reviews, which have been used to create the WHO *Guidelines on community level-interventions to manage declines in intrinsic capacity (5)* and identify elements of ICOPE approaches reported in the literature. A background paper has also been developed to summarize the rationale for the reorganization of health systems and the need for an integrated care approach *(6)*. The WHO guidelines and a summary brochure are available at http://www.who.int/ageing/publications/guidelines-icope.

What level of the health system?

The ICOPE approach recognizes that support for change is needed at multiple levels.

- At the individual (micro) level – guiding what health professionals provide and how users of care participate in care delivery and health.
- At the service/organizational (meso) level – guiding how services and service organizations design and implement care for older people.
- At the system (macro) level – guiding what systems need to accommodate and how they can support integrated care.

Key concepts of *Healthy Ageing*

- A person's functional ability is the combination and interaction of their intrinsic capacity with the environment they inhabit.
- Intrinsic capacity is the combination of an individual's physical and mental, including psychological, capacities.

The goal of the ICOPE approach at a service level is to promote one outcome, which is to maximize intrinsic capacity and functional ability in older people, through one comprehensive assessment and the development of one care plan. Key to the ICOPE approach is placing older people at the centre in a direction that stops seeing ageing as the burden of many isolated conditions, and starts prioritizing the wider, better-connected approaches that can support people's physical and mental capacities over the life course. Ageing will continue to present both preventable and inevitable challenges, yet older people make numerous crucial contributions to society. Optimizing their functional ability reduces burdens, and needs to be achieved, through both addressing older people's intrinsic capacities and providing policies and environments that are supportive to ageing populations.

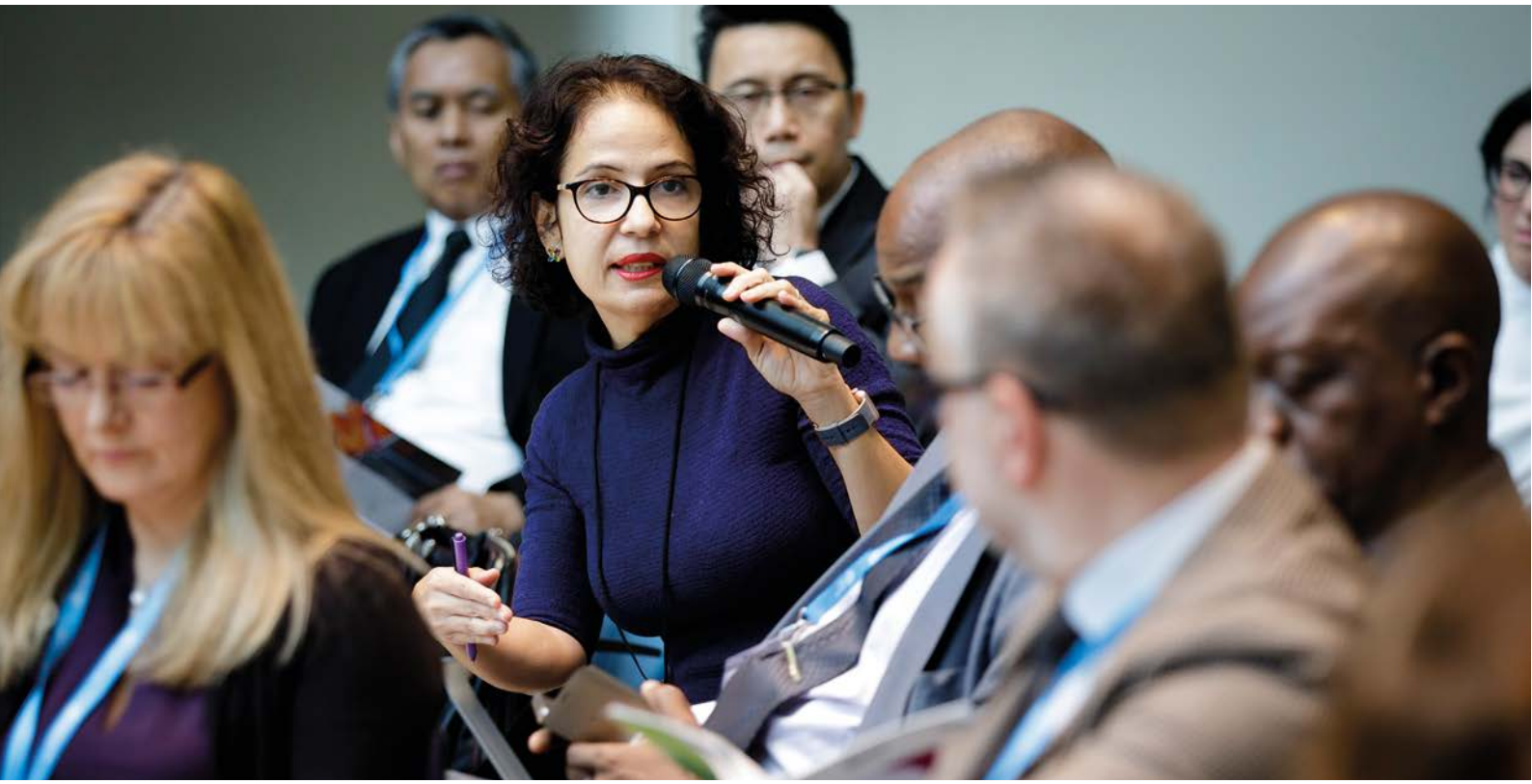
WHO's ICOPE approach spans all three levels of integrated health and social care for older people – macro, meso and micro – but places emphasis on the individual-care level. It centres this care on the older people themselves, seeing them as more than merely vessels of health status, but rather as individuals with unique experiences, needs and preferences whose daily lives include the context of their communities and the people close to them.

The ICOPE approach at a service level is underpinned by four guiding principles.

1. Older people have the right to the best possible health.
2. Older people should have an equal opportunity to the determinants of *Healthy Ageing* that does not reflect social or economic status or place of birth or residence or other social factors.
3. Care should be provided with equality and non-discrimination, particularly on gender and age.
4. Services are provided that respond to the unique health and social care needs and goals of the older person, which may vary over time.

Putting people at the heart of care

Putting people at the centre of service delivery is central to a commitment made in May 2016 by WHO Member States, when they adopted the WHO *Framework on integrated people-centred health services (3*). Among the goals adopted under this framework was the promise to make health care systems more responsive to people's needs, to promote collaboration with other sectors to address the broader social determinants of health, and to promote coordination within health sectors themselves.



People-centred care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring that care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside health and social care professionals to get the best outcome.

Nuria Toro, of the WHO Department of Services Organization and Clinical Interventions, presented the vision of this framework at the consultation meeting: "All people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care and are comprehensive, safe, effective, timely, efficient and acceptable; and all carers are motivated, skilled and operate in a supportive environment."

Integration of health services means: "Health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, 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."

WHO recommends five interwoven strategies that need to be implemented to achieve this vision (Figure 3). Health authorities are encouraged to select those policies and interventions that best fit their national, subnational or local needs and to customize them to match their priorities, capabilities and resources.

Finally, people-centred care is:

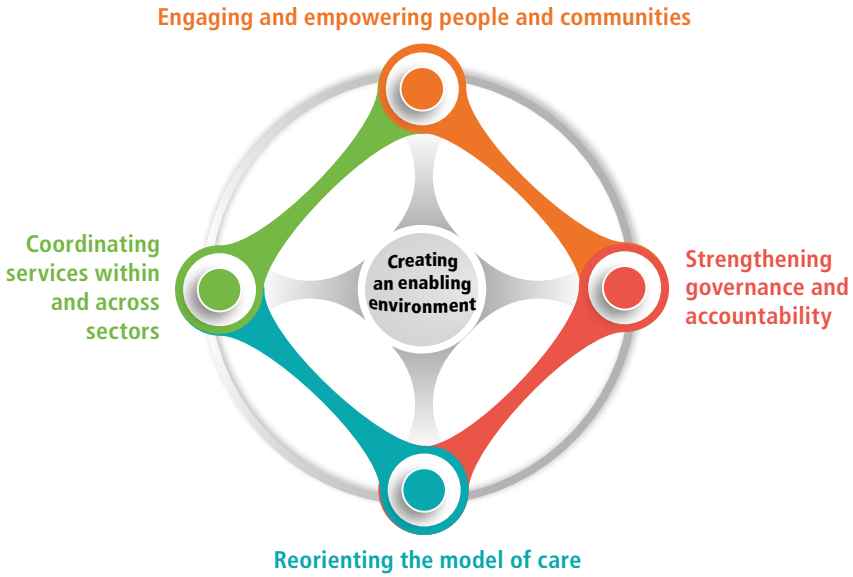
- an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases; and
- broader than patient- and person-centred care, encompassing not only clinical encounters, but also giving attention to the health of people in their communities and their crucial role in shaping health policy and services.

Such proactive, person-centred and integrated care is ingrained within the ICOPE service-delivery model. This approach views older people beyond the narrow view of their disease states. Presenters and participants alike in the consultation meeting in Berlin regularly returned to this guiding micro-level theme. An optimal approach to *Healthy Ageing* that includes integration of health and social care thus has a firm commitment, yet the need to develop an international consensus on the strategy remains – which is where this consultation plays its role.

Healthy Ageing for all at all ages

UHC is the foundation for achieving the health objectives of the SDGs: health and well-being for all

Figure 3. **WHO framework on integrated people-centred health services**



people at all ages. Across the world, older people aspire to receive quality, affordable health care. UHC – defined by WHO as ensuring that all people and communities receive the quality services they need, and are protected from health threats without financial hardship *(7)* – is one of a number of key actions within SDG 3 that are needed if all generations are to be included in sustainable development. But without considering the health and social care needs of the ever-increasing numbers of older people, this will be impossible to achieve.

Person-centred and integrated care in community settings have been repeatedly associated with better health outcomes, cost-effectiveness and higher user satisfaction. Thus, it is recognized that primary care organized at the community level can offer much more than a reduction of costs. A recent study on 102 low- and middle-income countries reported that broader coverage of primary care services was linked to longer life expectancy, suggesting that investment in primary care is a wise choice *(8)*. Increased accessibility even to deprived populations, provision of long-term person-centred care and emphasis on prevention and the reduction of unnecessary medical care are among the benefits that strong community-based care can offer, narrowing the gap between socially deprived and advantaged populations.

Moving to policy implementation

With the help of the ICOPE approach led by WHO, Member States and international stakeholders will be able to align health systems to the needs of older populations and see returns back into the vital yet ambitious SDGs. The aims of the ICOPE approach are well developed; now the consultation process, within which these Berlin meeting contributions are crucial, is stepping up to find an international consensus that will make a working reality of *Healthy Ageing* across various contexts, including those of low-, middle- and high-income countries.

The result of this consultation will be the identification of actions needed to assist countries to implement the ICOPE approach in health systems. The consultation will have considered which are the important elements of the approach and how these will be actioned.

Key messages

- *Healthy Ageing* for all is an indispensable need that must be integrated into an overall framework for organizing and delivering care in a person-centred, efficient, fair and cost-effective way.
- Reorganizing health services to be integrated and older-person-centred must be a core element of the strategic efforts to achieve UHC.
- Attaining the goals of WHO's public health framework for *Healthy Ageing* requires political commitment to integrated health and social care for older people, the development of coherent health systems policy, and normative guidance on the implementation and evaluation of integrated care both nationally and internationally.
- "To meet the needs of older people" is the overall commitment for health and social care systems that was made by WHO Member States in May 2016 when they agreed the *Global strategy and action plan on ageing and health*.
- An optimal approach to *Healthy Ageing* that includes integration of health and social care thus has a firm commitment, yet the need remains to develop an international consensus on the core implementation elements – which is where this consultation plays its role.

3 Global inspiration from case studies

With the opportunity to stimulate the contributions of a rich diversity of global expertise in attendance at the Berlin meeting, the consultation proceedings were designed to include inspiration from specific examples of integrated care for older people (ICOPE).

These "inspirational tours" were networking opportunities to share knowledge and engage in critical appraisal. Participants rotated through the examples shared and were encouraged to consider how the variety of components of integrated care had been employed in diverse contexts, learning:

- different approaches to organizing integrated health and social care;
- what worked or did not work across different health care settings; and
- lessons from research to inform evidence-based implementation.

A summary of some of the lessons learnt is given below.

This activity was structured to take place as delegates moved from presentations and panel discussions about ICOPE and onto providing their considered feedback on its elements via working groups. This gave participants time to build their relations with fellow delegates and to share some fresh thinking before embarking on the consensus-building tasks as part of the Delphi process.

The tours therefore stimulated ideas and examples. They also established a frame for the participants to give meaningful and critical evaluations when they came to give their feedback on the suggested elements of ICOPE implementation.

Not all the inspiring case studies presented over the two days are shared in detail here since the objective of this meeting report is to share the main results of the consensus-building exercise undertaken in the meeting. A diversity of contexts for the implementation of ICOPE is, however, one of the significant challenges being tackled by this consultation process, which is why certain case studies – the one from Uganda in particular – receive some coverage here. These experiences include an approach that has been adapted across low-, middle- and high-income settings. They are illustrative of how flexible the ICOPE principles and components might be to the variety of contexts for delivery.

Low-income setting: community engagement

The EasyCare approach is an example of providing standardized, holistic, personalized assessments and care plans for older people. Integrating responses to both their health and social needs, descriptions of three country cases using the approach are also found in a background paper to the consultation meeting *(9)*.

Adapted to local contexts, the core instrument developed by EasyCare takes the principles of the gold-standard comprehensive geriatric assessment – but also allows non-specialists to use a tool for assessing older people and providing integrated care.

In the low-resource context of Uganda, experience with this personalized assessment tool was outlined by the nongovernmental organization, Health Nest Uganda, with an "inspirational tour" during the meeting that highlighted the crucial need for, and success of, community engagement.

Dialogue after assessment

To facilitate assessment and care planning at the community level, the EasyCare tool was offered. But "a tool is not enough", Arthur Araali Namara said – "conversation is also needed": a unique dialogue opened up among older people, community members and health service providers, all asking, "What can we do as a community?"

This conversation was made possible by issues and concerns first being identified by assessments – with social, financial and health issues included – and then raising these at community meetings.

The model, which involves the training of district facilitators, was validated and piloted for feasibility and relevance before being adopted in 2012 by the Government of Uganda as a new approach to assessing the needs of older people.

Another of the "inspirational tours" shared at the meeting also gave the experience of a low-income setting:

- Azmeraw Abate, Tesfa Social and Development Association, Ethiopia: Community-level health and social care for older people in Ethiopia.

Middle-income settings

Erzhi Hu and Xue Zheng of Pinetree, China, presented "Working with the local needs: an EasyCare case study from China". As in many countries, people in China can now expect to live much longer than ever before. Recent health system reform initiatives have emphasized the need for a unified, robust method for assessing the needs of older people to plan person-centred health services.

To understand local needs, an integrated and personalized assessment was implemented. The outcome of this assessment was used to create a care plan, with a summary of identified problems, priorities, goals and actions. Knowing how some models in high-income countries could be replicated in China, it focused on less-resource-intensive and more efficient ways of care, known as the restorative care model.

Further, to enable the involvement of caregivers from various backgrounds, an algorithm was developed to automatically produce the restorative care plan with inputs from a standardized needs assessment and the personal goals of the individual. Not only has Pinetree helped thousands of families to see improvements in their quality of life, but it has also managed to change the once heavy burden of caregiving into a more meaningful, uplifting career, effectively attracting talented young people into this field.

This was an example of how a needs-based integrated assessment can transform the lives of older people and the people around them. The approach has huge potential to promote personalized care for older people in China. It can also support the national policy of providing care for older people to remain in their own homes in an optimal state of health.

The other "inspirational tours" to share experiences of integrated care in middle-income settings were:

- Eduardo Augusto Duque Bezerra, Independent consultant, Brazil: Integral health care for older people in the Brazilian health system;
- Shintaro Nakamura, Japan International Cooperation Agency, Japan: Experiences of long-term care services in Thailand.

High-income settings

Finally, the following participants shared their experiences from high-income settings, including insights from leading academic and charitable organizations.

- Lisa Dolovich, McMaster University, Canada: Integrating care in the home with the primary health care and community links (see http://healthtapestry.ca).
- Lee Hampston, EasyCare Academy, United Kingdom: Person-centred assessment to integrate care for older people in the UK (see http://www.easycareacademy.com).
- Jo-Anna Holmes, Age UK, United Kingdom: Personalized integrated care in the UK (see http://www.ageuk.org.uk/our-impact/programmes/integrated-care).
- Michelle Nelson, University of Toronto, Canada: Inter-sectoral collaboration to meet peoples' needs post hospital discharge.
- Hans Winberg, Leading Health Care Foundation, Sweden: Designing sustainable care for older people in Sweden (see http://leadinghealthcare.se).

Panel discussion on case studies presented

After introducing the case studies on integrated care during the "inspirational tours", the presenters responded in a half-hour panel session to some discussion points raised from the floor by participants.

One of the discussions centred on the question of financial models and planning these properly for care integration, while another discussion saw some disagreement about the use of indicators to measure performance. The question of how pilot projects could be scaled up to make national policy a reality for some of the local successes was also raised. Finally, the presenters also responded to questions about the use of volunteers, and the nature of their role and how they could be given incentives.

Lessons learnt

1. Comprehensive assessment is an essential element that will enable providers to recognize the unmet health and social needs of older people. An integral part of such assessment is to develop a care plan, with a summary of identified problems, priorities, goals and actions that are person-centred.
2. Community engagement is a cornerstone for organizing people-centred services. Community engagement allows collaboration between different stakeholders, which improves the chances of selecting the right solutions and understanding and addressing the right problems. Although this has been identified as a critical strategy for organizing integrated care, there is minimal guidance on how best to engage communities and evaluate its effectiveness.
3. Although integrated care models are context-specific, all models of care have one critical element in common – an identified care coordinator responsible for ensuring the implementation of the comprehensive care plan.
4. Clinical guidelines are essential to avoid the overuse of ineffective medical services and to increase the coverage of cost-effective interventions and strategies.
5. Older people can be engaged as volunteers for organizing integrated long-term care services. Establishing networks of volunteers is essential to support care and to facilitate access to local services. As seen in Thailand, such a model of care is feasible if sufficient training is provided to volunteers.
6. Leveraging technology is key for improving the quality of integrated care services across different health and social care systems. Technology can be also used to supplement health care by providing both educational and motivational support for self-management (e.g. monitoring diet and physical exercise).
7. New models of shared and collaborative leadership are needed to address the challenges of integrated care. Evidence from 30 years of research suggests that powerful and significant transformations can be achieved through shared leadership, collaboration and collective initiative in organizing integrated care.

4 Global Delphi study – important elements for ICOPE implementation

The central aim of the consultation meeting in Berlin was for participants to discuss, ratify and begin crystallizing a consensus on the elements needed to implement integrated care for older people (ICOPE). This face-to-face feedback forms the middle part of a Delphi exercise that will help to resolve the current lack of international consensus on how health and social care should be integrated for *Healthy Ageing*.

Consultation discussion and feedback on ICOPE implementation

Working groups were convened in the second half of the consultation meeting to provide feedback on the results and framework used in the Delphi study.

Detailed feedback on the individual elements is provided in Annex 1. The following are the more general points that were made.

The elements, as written, lack clarity in their meaning

Delegates reported that the elements were generally unclear in their descriptions or labels. The descriptions could mean different things to different people. The elements needed to be given more explicit definitions to improve understanding by different stakeholders. An example of this was identified consistently across the consultation groups: element 21 ("new work cadres are developed").

Interpretation may be aided by grouping the elements

The meeting was also consistent in recognizing that better clarity would result if the elements were grouped into categories. Drawing the elements into intuitive themes would aid interpretation compared with each element appearing as a lone item. After reviewing all of the elements individually, one of the working groups in particular felt strongly that this was the case. These consultees then took on the task of moving the discrete elements around in different clusters until they had identified some underlying themes (these are proposed in Annex 1).

Some elements are too prescriptive: importance of local context

Participants also expressed the importance of a balance between improving clarity and avoiding overly prescriptive language. After the consultation discussions

had been fed back by participants, some reflected on the need for a careful balance to be struck. There was no doubt that the consultation had revealed a firm and consistent desire for greater clarity, but consultees equally showed their concern that different global contexts demanded flexibility in the implementation of ICOPE.

Some of the elements are written as general approaches to constructing a health system to support ICOPE, while others are highly prescriptive and may not be appropriate or feasible in some settings. This feedback will be used to inform the development of WHO products such as the ICOPE implementation country toolkit.

The need for a balanced level of clarity on the elements needed to implement ICOPE was also seen irrespective of local context. The comment against element 25 ("regular feedback of performance indicators is given to care providers") was that specifying "feedback of performance indicators" may be too prescriptive compared with simply saying "performance feedback". Yet the two versions of this element illustrate the tricky choice to be made for maximum clarity versus minimal restriction.

Returning to the question of local contexts, this was particularly relevant for element 18 ("traditional and complementary medicine is integrated within health services"). The consultation groups said this wording made the implementation element too prescriptive. Participants felt that this might explain why it reached an "uncertain" level of consensus in round one. With less prescriptiveness, the concept could be accommodated in health systems where it was socially and culturally appropriate.

The same observation about prescriptiveness might apply to the other two elements that achieved uncertain ratings in the quantitative round.

Missing concepts

Delegates identified a number of areas where elements were possibly missing. These omissions included clinical issues (e.g. assessment of pain, palliative care, end-of-life planning), as well as more general health system issues, including how health and social systems should accommodate the needs of people in rural and remote areas.

Other important general feedback from the appraisal of the elements

The language used across the elements was inconsistent and participants felt it should align with the preferred person-centred terminologies, such as referring to the "older person" rather than to the "patient".

Other strategies were suggested to ease the interpretation of the elements. In preparing for the next Delphi round and to maximize interpretability of the final set of elements, delegates recommended:

- the inclusion of a glossary of terms to support the clarified descriptions;
- guiding principles – ensuring the elements may be interpreted as principles or means to support the end goal, which is the promotion of functional ability in older people;
- explicitly canvassing the views of older people; and
- as reported above, categorizing elements into intuitive themes, rather than providing a long list of discrete elements.

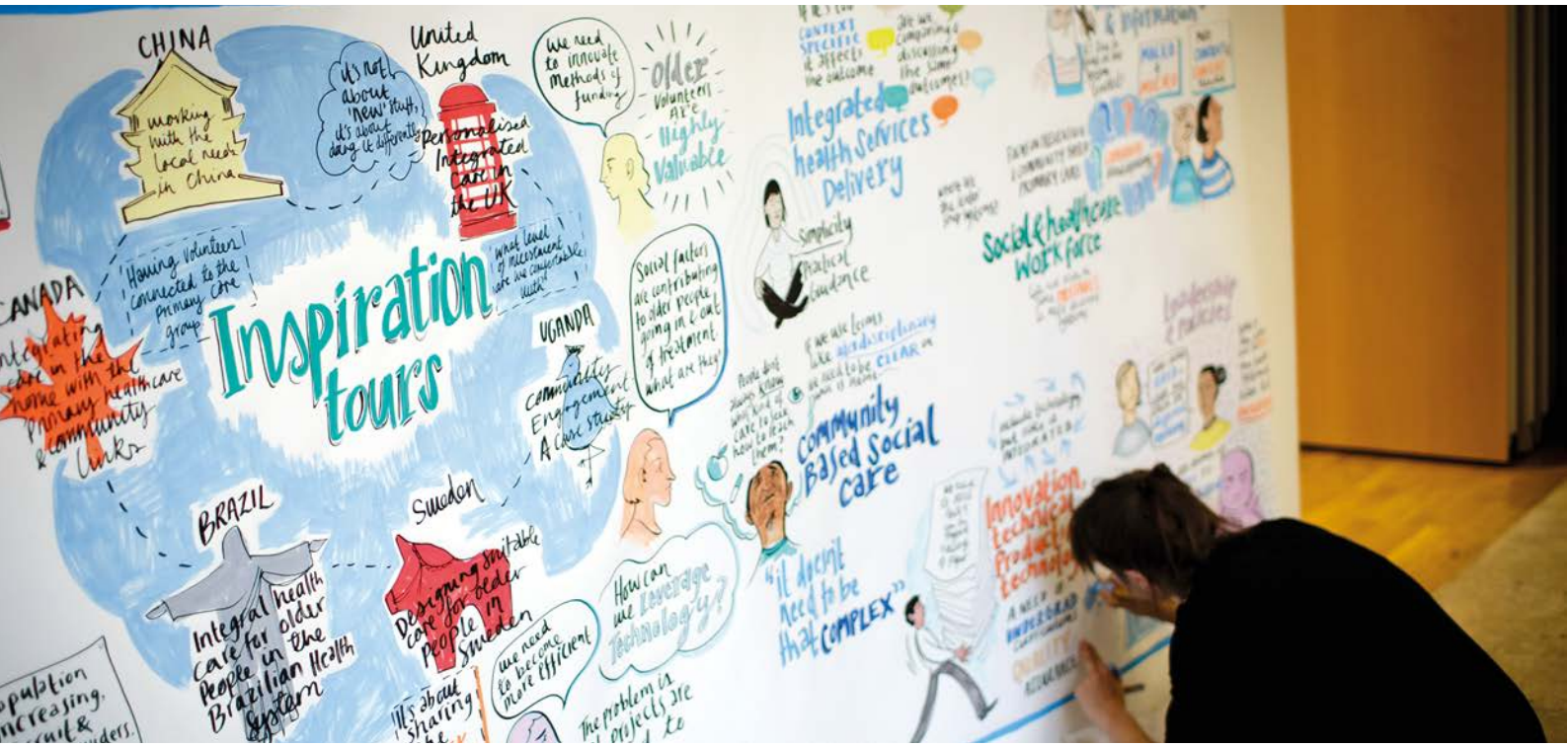
Feedback on goals and steps needed to implement elements

The second task for the working groups was to identify some overarching goals for the principles of ICOPE implementation, while answering the question:

> What are the discrete implementation actions required within countries to implement integrated care in different health systems?

Any direction for implementation needs to be underpinned by general principles that should include the following:

- all implementation approaches are aligned to supporting functional ability in older people; and
- all approaches should be aligned with the guiding principles and flexible to local contexts.



Integrated health services

Overarching goal:

- Align health systems to support care that is personalized for older people, with services integrated across disciplines, settings and levels of the health system.

Implementation actions needed:

- Continuous assessment of population need based on functional ability and system capacity (facilities, workforce, services, infrastructure);
- Integration with existing capacities (programmes, infrastructure, workforce, facilities);
- Systems for shared information to promote shared accountability;
- Tools to support providers (e.g. guidelines), particularly those working in primary care settings;
- Cooperation between health and social care ministries;
- Systems to coordinate care across disciplines, sectors and settings;
- Financial incentives within a system to support right care, right time, right place, right team.

Community-based care

Overarching goal:

- Provide services in the communities to which older people belong and can participate in, and engage these communities in integrated, person-centred care for older people.

Implementation actions needed:

- Show clarity about what roles can be played by communities, and about who will be supported to take part, and how, in providing community-based and community-engaged care.

Health and social care workforce

Overarching goal:

- Build capacity in the current and emerging workforce to provide health and social care services oriented to the needs of older people.

Implementation actions needed:

- Care coordination roles;
- Develop capability in the workforce to undertake a comprehensive assessment of an older person's health and social care needs;

- Informal caregivers should be supported with training and financial means (e.g. tax credits);
- Evaluate capabilities in volunteer and retired workforce;
- Systems to ensure shared responsibility across providers (e.g. shared outcomes, shared information);
- Capacity-building initiatives for the workforce (e.g. interprofessional education that is scalable);
- Financing models to support interdisciplinary team activity;
- Training and regulatory frameworks to support workforce roles that complement existing roles (assistant roles, volunteer roles);
- Programmes to support workforce retention and satisfaction;
- Digital systems to support information exchange;
- Systems to monitor workforce performance;
- Workforce needs assessment and development of a local strategy.

Leadership

Overarching goal:

- Champion sustainable, integrated and person-centred health and social care to meet older people's needs.

Implementation actions needed:

- Systems to support cooperation with the non-health sector, especially social care, and strategies to involve community-level organizations and volunteers;
- Implementation of health and social interventions by nongovernmental organizations;
- Processes in place to involve communities meaningfully in policy planning and implementation;
- Workforce frameworks oriented towards competencies in fostering intrinsic capacity;
- Develop policies in each country that clearly articulate what integrated care means and why it is needed in that setting;
- Establish policies, informed by intersectoral steering group, to facilitate cooperation and joint funding between health and social care sectors;
- Launch public campaigns on the need to address *Healthy Ageing* and stating that health is a social issue as much as an individual one;
- Identify funding commitments to support ICOPE approach;
- Undertake a workforce-capacity review to inform policy development: volumes, distributions, competencies and possible new or extended roles;
- Appoint ministerial-level responsibility for *Healthy Ageing*;
- Undertake local evaluation of current policy landscape for health and social care;
- Develop operational plans to implement the ICOPE approach within local settings;
- Identify and support local champions;
- Establish partnership agreements between the state, service providers and nongovernmental organizations.

Research, innovation and technologies

Overarching goal:

- Benefit from existing and emerging person-centred technologies and systems.

Implementation actions needed:

- Systems that lever information and communications technology (ICT) to support self-management and caregiving (e.g. mobile health technologies, telemedicine);
- Assess the interoperability of any new ICT systems, particularly the seamless integration between health and social systems;
- Undertake an assessment of ICT requirements to support ICOPE and develop and appropriate public strategy to ensure services are based around needs;
- Evaluate ICT systems to ensure users' needs are being met;
- Integrate ICT systems into care pathways or models of care that support disease management;
- Evaluate population need for assistive products;
- Establish electronic health records;
- Develop policy that supports the use of appropriate technologies and assistive devices to promote functional ability.

Accountability and information

Overarching goal:

- Ensure information is available to inform care delivery that is aligned to the needs of the older person.

Implementation actions needed:

- Formulate policy or legislation that ensures multi-sectoral activities are shared and communicated;
- Systems are established to collect information about people's individual health and social care needs;
- Information systems are available that enable information exchange and that link to a personalized care plan and monitor providers' accountability to a single, comprehensive care plan;
- Systems are in place to translate care plans for specific issues into a comprehensive, shared and monitored care plan.

5 Concluding remarks and next steps

The WHO global Delphi study that informed the consultation meeting was a useful exercise to help understand different stakeholders' perspectives, although further research is needed to understand older people's perspectives better. The elements identified as necessary for integrated care will require clearer descriptions, and more clarity will also need to be brought to the definitions of key terms. In summary, this work to guide the implementation of integrated care for older people (ICOPE) will answer the following.

- There is a pressing need to frame integrated care as a necessary paradigm shift in promoting person-centred care in both high- and low-income countries.
- Current models of integrated care approaches are uniquely designed to fit specific health care systems, which limits the scope of generalizability to other contexts.
- Making the shift to integrated health and social care is critical for improving older people's intrinsic capacities and well-being.

Next steps

The consultation inputs have been invaluable and will now inform the next steps. The tasks ahead are to:

- revise the Delphi study questionnaire and clarify the key terms and concepts;
- involve in the consultation organizations that work closely with older people; and
- involve more participants from low- and middle-income countries in subsequent rounds of the Delphi study.

A follow-up regional consultation is also recommended for the development of country toolkits to implement the ICOPE approach.

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Annex 1: Details of feedback on individual elements of ICOPE implementation

What is the international consensus on the key elements needed to implement an integrated health and social care approach for older people? A summary of the feedback from participants in the global consultation meeting.

Notes:

- The three elements that had received an "uncertain" level consensus in round one (No. 12, No. 18 and No. 21) were given particular appraisal to understand possible reasons for the lack of consensus.
- A tick symbol ✓ denotes ratification of elements that had less need for clarification.
- Additional elements, in Roman numerals, are those suggested by experts in round one of the Delphi exercise and not in the original list identified by the evidence review. These were offered some consideration during the feedback discussions, although groups were focused primarily on interrogating the original list.
- "Survey explanation" is the information provided with the questionnaire in round one of the Delphi exercise.

Element	Feedback
Person-centredness	
Individualized interdisciplinary care plans are available for older people (element No. 1)	Clarity questioned Feasibility considerations suggested
Survey explanation: "Person-focused, interdisciplinary care plans that align with the older people's priorities, goals and preferences are created"	• Who should be included in a multidisciplinary team? What is the bare minimum for such a team? • Types of professional involved in organizing care may differ between countries of various income levels; regional differences could be clarified in the description • A representative for Kenya said, for example, that this team should be identified and given direction only after care needed is clarified
Patients are involved in care decisions and planning (element No. 11)	Clarity questioned
Survey explanation: "Patient involvement provides people with the sense that they can actively participate in their care and work collaboratively with care providers to address their problems through reflection and collective action"	• Description needs to be clear enough to understand that patients should be actively involved in the care decision and planning, not passively; an example might help • Clarity for this might be improved by establishing that older people should be given active participation in their care so that they may also be involved in decisions

Element	Feedback
Patients have the opportunity to report their experience (element No. 13)	✔ Ratified without need for clarification
Survey explanation: "Care recipient experience refers to any process observable by patients, including subjective experiences (e.g. pain was controlled), objective experiences (e.g. waited more than 15 minutes past appointment time), and observations of physician, nurse or staff behaviour (e.g. doctor provided all relevant information)"	
Patient-reported outcome measures are monitored (element No. 14)	✔ Ratified without need for clarification
Survey explanation: "A patient-reported outcome (PROM) is a health-related outcome (e.g. functional ability) directly reported by the patient who experienced it. Ideally PROMs should be co-developed by patients, the public and professionals to obtain maximum value and meaning"	
Care pathways	
Active case finding is undertaken (element No. 2)	Feasibility considerations suggested • High-income countries may have systems in place; low-income ones may not and would need systems to facilitate case finding • May be not relevant for some settings because of lack of additional human resources, funds and changes in public health care guidelines • Health literacy – on nutrition and exercise, for example – an important factor in reaching out to people who lack literacy for their involvement in finding care
Survey explanation: "Health and social care professionals visit homes and communities to identify older people in need of health or social care services or who are at risk of declines in their intrinsic capacity"	
Older people enter a common assessment and care pathway regardless of the entry point to the health system (element No. 3)	✔ Ratified without need for clarification
Survey explanation: "For community-dwelling older people requiring assessment, intervention and/or possible hospital admission, any point of entry to health and social care systems leads to a similar assessment and care pathway"	
Networks of health providers are established to facilitate referral pathways, including pathways for rapid access to acute care (element No. 29)	✔ Ratified without need for clarification • Tied to other elements?
Survey explanation: "Provider networks consist of a group of service providers who can readily communicate and on-refer to each other as required. Referral pathways are structured processes that enable efficient and accurate referral between health providers"	

Element	Feedback
Human resources	
Community-based health workers are available (element No. 4) Survey explanation: "Community health workers are integrated into primary care services to contribute to care organization and delivery for older people. "Definition: Community health workers provide health education, referral and follow-up, case management, basic preventive health care and home-visiting services to specific communities. They provide support and assistance to individuals and families in navigating the health and social services system"	No feedback was given on this element
Care is delivered by interdisciplinary teams (element No. 5) Survey explanation: "Depending on the national context, including workforce availability, different occupations with the required skill mix can communicate and work together as part of an integrated team for organizing and delivering health care for older people. "Definition: Interdisciplinary team refers to skilled health professionals, paramedical staff, various types of community-based health workers (e.g. social workers, carers, community health workers) communicating and working together to address the holistic care needs of older persons"	Tied to other elements? • Difficulty seeing difference between this element and element No. 1 on individualized interdisciplinary care plans (the first element listed at the start of this table). Does each define the other? • Members of an interdisciplinary/ multidisciplinary team should have equal value and work "synergistically in a non-hierarchical structure" with older people and those around them in a shared-care model
Training and support for formal and informal carers and community volunteers is available (element No. 8) Survey explanation: "Informal and formal carers and community volunteers are formally engaged in the care system and receive systematic support to improve the quality of the care administered for care-dependent older people"	✔ Ratified without need for clarification
Inter-professional education is routinely available (element No. 16) Survey explanation: "Health and social care workers require several key competencies to provide good-quality care for older people and support their family members (informal caregivers). Inter-professional education should be made available to health professionals and trainees that focuses on practical interdisciplinary care for older people. Multimodal education options should be considered to maximize reach, uptake and efficiency"	Clarity questioned • What is meant by inter-professional? • Without defining inter-professional education (IPE), it was suggested that this would have different levels – a national standard and accreditation, university credits for IPE, and IPE being available at clinical training sites with its outcomes assessed

Element	Feedback
New work cadres are developed (element No. 21) Survey explanation: "New career pathways – for example, care coordinators, self-management counsellors and advanced care practitioners – might be needed to implement integrated care for older people"	(Unclear consensus in round one for this element) Clarity heavily questioned • What type of new cadres? • Many of the working groups identified this element as unclear • The "uncertain" level of consensus reached for this element in round one of the Delphi study might be explained by its unclear nature • Existing staff could also be reassigned for organizing care for older people – so do new work cadres mean new roles, or existing roles being expanded or reassigned?
Human-resource management is aligned across services (element No. 23) Survey explanation: "Human resource management within and between health and social care is coordinated and designed around a common goal: developing and maintaining functional ability and intrinsic capacity in older people"	• An important element but difficult to implement, even in high-income countries
Community	
Community-based care services are available (element No. 6) Survey explanation: "Health services are organized and delivered, where feasible, at the community level. In practice, trained health and social care professionals provide self-management support, diet, exercise and psychosocial interventions delivered through structured consultations and regular follow-up, supported by ICT (information and communications technology) where possible"	Clarity questioned • Description of community-based care services unclear. Does it involve social care? If so, how is this element different from No. 15 for community-based home-care services (at the bottom of the next page)?
Civil society (NGOs) and patient groups are involved at the community level (element No. 7) Survey explanation: "In many countries, NGOs and patient groups are actively engaged in supporting health sectors in advocating, designing and implementing care programmes. The health sector can mobilize these community resources to promote early identification of needs and targeted interventions for older people"	✔ Ratified without need for clarification
Respite care is available (element No. 9) Survey explanation: "Respite care is available to support carers. Respite care (also known as short-term care) is a form of support for carers. By accommodating and caring for care-dependent older people, it gives carers the opportunity to participate in other activities for a period of time"	✔ Ratified without need for clarification

Element	Feedback
Communities are engaged in shaping care systems (element No. 10) Survey explanation: "Engagement of cross-sector stakeholders (e.g. municipality, patient organizations and health insurance companies) is important to ensure broad consultation and implementation support across the sector for strategies related to integrated care. Engagement may be achieved through various locally appropriate mechanisms, such as district-level multi-stakeholder health networks. "Definition: community involvement in health (sometimes called user involvement) may be defined as the process by which members of the community, either individually or collectively and with varying levels of commitment: a) develop the capacity to assume greater responsibility for assessing their health needs and problems; b) plan and then act to implement their solutions; c) create and maintain organizations in support of these efforts; and d) evaluate the effects and bring about necessary adjustments in goals and programmes on an ongoing basis"	✔ Ratified without need for clarification
Community-based home-care services are available (element No. 15) Survey explanation: "Community-based home care can be defined as non-clinical help and support for older people who are in need of care and who are living at home. They may live alone or with their family members"	Clarity questioned • What kind of home-care services are described by this element? Nursing care only? • Ties with another element? • How different is this from element No. 6 for community-based care services (the first element shown under Community on the previous page)?
New elements suggested in round one: ii. Home-hospital to avoid emergency admission iv. Older people in good health are engaged in the care of their peers	

Element	Feedback
Performance and feedback	
Provider report cards are used (element No. 12) Survey explanation: "Report cards are used to grade health care providers and compare them. Provider report cards generate information about the quality, efficiency and patient-centeredness of health care providers"	(Unclear consensus in round one for this element) Clarity heavily questioned • Reformulate what report card means • Are report cards related to provider performance and/or outcomes of care quality? • Would this mean league tables? Concern about the potential for unintended consequences, such as incentives that could skew priorities or even set care back, citing the experience of the quality and outcomes framework in the United Kingdom • Accountability should be aligned to the goals of older people and whether goals are reached • The word "loyalty" was used to describe how evaluation could help to ensure providers adhere to care plans • "Evidence" and "information" were also important considerations • The phrase "no decision about me, without me" was introduced in a general reflection on performance, and also to reiterate an overall theme, of person-centred care, that was consistently supported through the meeting
Performance-management practices are established for care providers (element No. 19) Survey explanation: "Performance management systems are established for care providers to evaluate and monitor capabilities in planning and delivery of integrated care for older people, and to identify professional development requirements"	✓ Ratified without need for clarification
Regular feedback on performance indicators is given to care providers (element No. 25) Survey explanation: "Regular feedback of performance indicators for professionals at the operational level is provided to enable them to improve their performance"	Clarity questioned • What information is shared? • Is specific connotation given by the use of the term "indicators"? The term could be removed from the phrase "feedback of performance indicators"

Element	Feedback
Policy and governance	
Inter-professional governance frameworks are in place (element No. 17) Survey explanation: "Inter-professional governance frameworks provide a common system across professionals that advocates and supports openness, integrity and accountability in practice between professionals at the operational/service level (e.g. joint accountability, appeal on pursued policies and responsibilities)"	Clarity questioned • What is meant by inter-professional? Evaluating relevance to ICOPE needs some definition for inter-professional/ interdisciplinary/multidisciplinary
Traditional and complementary medicine is integrated within health services (element No. 18) Survey explanation: "Traditional practices include medication therapy and procedure-based therapies such as herbal medicines, naturopathy, acupuncture and manual therapies such as chiropractic, osteopathy as well as other related techniques including qigong, t'ai chi, yoga, thermal medicine, and other physical, mental, spiritual and mind-body therapies. "Definitions: Traditional medicine is the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness"	(Unclear consensus in round one for this element) • Should be revisited in light of the cultural and legislative context. Means different things in different contexts • Integration of traditional medicine – or making it available at all – would require massive policy change in some countries • Considered too prescriptive. Frame instead as an option for health systems where socially and culturally appropriate
Physical infrastructure to support community-based health and social care (element No. 20) Survey explanation: "The physical infrastructure of health centres and hospitals should be designed in an age-friendly manner, including community-based long-term care infrastructure such as respite care and day centres"	✔ Ratified without need for clarification
Planning and delivery of health and social care are integrated (element No. 22) Survey explanation: "Health sector and social care services are viewed as a single, interdependent system. Services designed and delivered from this perspective need to take into account the whole spectrum of an individual's needs. Care delivered in response to these needs is holistic; it contributes positively to service users' short- and long-term health, well-being and quality of life"	• An overarching, defining principle for ICOPE that should be removed from here as an otherwise potentially optional item as part of a list of implementing elements

Element	Feedback
Electronic data-sharing platforms are in place (element No. 24) Survey explanation: "Electronic health records and shared data platforms are available to capture, organize and share information about individuals and clinical populations. This information may help identify older people's needs, plan care over time, monitor responses to treatment and assess health outcomes. Information systems can also facilitate collaboration between different health care workers and between health and social care teams and their patients, who may be located in a range of settings or geographical locations"	Feasibility considerations suggested • This is a useful component, but an electronic data-sharing platform is not feasible in all countries • Rights and ethical concerns of people whose data is shared should be considered in establishing any platform • What information is shared? Could specific purposes serve ICOPE, such as sharing data on polypharmacy?
Joint funding mechanisms for health and social care are in place (element No. 26) Survey explanation: "Joint funding across health and social care sectors may help ensure coordination and efficiency and is particularly important for ageing populations. At district or sub-national levels, funds for health and social care could be pooled together for organizing efficient integrated health and social care"	✔ Ratified without need for clarification
The capacity of health and social care systems to deliver integrated care is regularly assessed (element No. 27) Survey explanation: "Capacity assessments of the health and social care systems can serve as a baseline snapshot of the current status of priority health and social care needs and capacity of available services to respond to them, identify gaps and opportunities to improve"	✔ Ratified without need for clarification
Incentives are in place for coordination (element No. 30) Survey explanation: "Incentives encourage health care professionals to work together and ensure that their clients' health and social needs are being met and that the right care is being delivered in the right place, at the right time and by the right team or person. There are four main categories of incentives targeting health care professionals, including: financial incentives, professional ethics including intrinsic motivations, organizational cultures, for example informal behavioural codes, and policies and governance"	Clarity questioned • What types of care coordination would be given incentives and who would receive them? • Is coordination in reference to referral, follow-up, organizing care or implementing care plans?
A regulatory framework is in place (element No. 31) Survey explanation: "Regulation plays a key role in establishing the guidelines within which professionals and organizations must operate to adopt more person-centred and integrated health systems. For example, setting new quality standards and/or paying against performance targets"	✔ Ratified without need for clarification

Element	Feedback
New elements suggested in round one: iii. Integrated medicine prescription systems vi. Boundary-spanning reimbursement models (where different actors are jointly responsible for results) vii. Special administrative and legal frameworks to protect older people from abuse x. Evidence-based clinical guidelines (to protect against therapies that are not evidence-based) xi. Protocol for engagement with the private sector xiv. Dedicated long-term care insurance system	No feedback was given on this element
Technology	
Assistive products (devices/technologies) are available (element No. 28)	✔ Ratified without need for clarification
Survey explanation: "Assistive products are those whose primary purpose is to maintain or improve an individual's functioning and independence to facilitate participation and to enhance overall well-being (for example: walking aids, spectacles, hearing aids and pill organizers)"	
New elements suggested in round one: i. Telemedicine is supported viii. Technology is available for self-monitoring of health	No feedback was given on this element
The following new elements suggested in round one were not supported as essential to ICOPE delivery, with feedback centred on relevance, feasibility or clarity	
v. Specialized services (e.g. geriatric medicine departments) in hospitals	Relevance or feasibility questioned for many contexts
ix. Formal and sensitive mechanism for direct feedback from service providers	Clarity questioned on what the feedback is and who receives it
xii. On diagnosis and referral planning, a supervisor position and timely support processes for front-line health workers	Feasibility questioned
xiii. Cash benefits for care provision	Feasibility questioned, especially without more clarity
xv. Age-friendly infrastructure	No feedback was given on this element

Annex 2: Participants

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Annex 3: Working groups

Working group one

International experts

Azmeraw Abate
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Leocadio Rodriguez Manas
Pim Valentijn

Member State representatives

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Carmen García-Peña
Alain Mouanga
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International experts

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Arthur Araali Namara
Michelle Nelson
Kabir Sheikh

Member State representatives

Stanley Bubikire
Muthoni Gichu

Working group three

International experts

Jane Barratt
Howard Catton
Fumie Griego
Leo (Erzhi) Hu
Deborah Kopansky-Giles
Ksenia Tugay

Member State representatives

Xu Chong
T.B. Ananda Jayalal
Pannet Pangputhipong
Ekachai Piensriwatchara

Working group four

International experts

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Lisa Dolovich
Lee Hampston
Catherine McMahon
David Price
Loong-Mun Wong

Member State representatives

Luong Quang Dang
Gloria Ramirez Donoso

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Gro Berntsen
Maggie Keeble
Alfonso Lara Montero
Dimity Pond
Hans Winberg

Member State representatives

Rizki Ekananda
Melody Ennis
Toru Kajiyama
Anung Sugihantono

Working group six

International experts

Eduardo Bezerra
Michael Kidd
Finbarr Martin
Shintaro Nakamura
Ornella Punzo
Elina Suzuki
Anthony Woolf

Member State representatives

Mohammad Eslami
Nabil Kronfol
Yohei Takahashi

Annex 4: Agenda

23–25 October 2017, GIZ-Haus, Reichpietschufer 20, 10785 Berlin, Germany

Day one

Activity	Person/party responsible
Introduction: universal health coverage (UHC) and integrated health and social care for older people	**Chairs:** **Federal Ministry of Health, Federal Republic of Germany** **Anung Sugihantono, Indonesia**
Welcome	John Beard, World Health Organization (WHO) Toru Kajiwara, Japan
Objectives of the meeting and participant introductions	Islene Araujo de Carvalho, WHO
UHC and population ageing	John Beard, WHO
UHC and long-term care in Japan	Toru Kajiwara, Japan
WHO framework on integrated people-centred health services	Nuria Toro, WHO
Panel: Integrated health and social care for older people	**Chairs:** **Sofi Bergkvist, ACCESS Health, USA** **Xu Chong, China**
Key elements of care integration and coordination at clinical level	Islene Araujo de Carvalho, WHO
Five decades of community and residential services in Singapore	Loong-Mun Wong, Agency of Integrated Care, Singapore
Healthy Ageing and the need for long-term care systems	Anne-Margriet Pot, WHO
Questions and answers	
Ten-minute critical reflections on patient-oriented outcomes and key elements for integrating care for older people	Elina Suzuki, Organisation for Economic Co-operation and Development (OECD) Yohei Takahashi, Japan Ekachai Piensriwatchara, Thailand

Day two

Panel: Delphi study findings	**Chairs:** **Karsten Dreinhöfer, Global Alliance for Musculoskeletal Health (GMUSC)** **Manfred Huber, WHO**
Delphi findings: key elements at service organization and system level (two presentations followed by questions and answers)	Jotheeswaran Amuthavalli Thiyagarajan, WHO Andrew Briggs, WHO

Day two (continued)

Activity	Person/party responsible
Five-minute critical reflections from Member States	Nabil Kronfol, Lebanon Anne Priscilla Muhoni Gichu, Kenya TB Jayalal, Sri Lanka Mohammad Eslami, Islamic Republic of Iran Mouanga Alain, Congo
Inspirational tour	**Chairs:** **Fumio Griego, International Federation of Pharmaceutical Manufacturers & Associations** **Rachel Albone, Help Age International**
Station 1: Integrating care in the home with the primary health care and community links	Lisa Dolovich, McMaster University, Canada
Station 2: Working with the local needs in China	Erzhi Hu, Pinetree Care Group, China
Station 3: Personalized integrated care in the UK	Jo-Anna Holmes, Age UK, United Kingdom
Station 4: Community engagement: a case study from Uganda	Arthur Araali Namara, Health Nest, Uganda
Station 5: Integral health care for older people in the Brazilian health system	Eduardo Augusto Duque Bezerra, independent consultant, Brazil
Station 6: Designing sustainable care for older people in Sweden	Hans Winberg, Leading Health Care Foundation, Sweden
Feedback from the tours	
Working groups (parallel sessions)	**Chairs:** **Anthony Woolf, Fragility Fracture Network** **Shintaro Nakamura, JICA**
Introduction to the working groups	Andrew Briggs, WHO
Questions and answers from working groups	Islene Araujo de Carvalho, WHO
Group 1: Integrated health services delivery	Andrew Briggs, WHO Islene Araujo de Carvalho, WHO
Group 2: Community-based social care	Anne Margriet Pot, WHO Jotheeswaran Amuthavalli, WHO
Group 3: Social and health care workforce	Manfred Huber, WHO Katherine Silburn, WHO
Group 4: Innovation, technical products and technologies	John Beard, WHO Shelly Chadha, WHO
Group 5: UHC, accountability and information	Nuria Toro, WHO Paul Ong, WHO
Group 6: Leadership and policies	Enrique Vega Garcia, WHO Taiwo Adedamola Oyelade, WHO Yuka Sumi, WHO

Activity	Person/party responsible

Day three

Working group presentations and feedback	**Chairs:** **Jane Barratt, International Federation on Ageing (IFA)** **John Beard, WHO**
Inspirational tours	
Community-level health and social care for older people in Ethiopia	Azmeraw Abate, Tesfa Social and Development Association, Ethiopia
Person-centred assessment to integrate care for older people in the UK	Lee Hampston, EasyCare Academy, United Kingdom
Inter-sectoral collaboration to meet peoples' needs post hospital discharge	Michelle Nelson, University of Toronto, Canada
Experiences of long-term care services in Thailand	Shintaro Nakamura, JICA, Japan
Face-to-face consensus on the critical elements (voting if needed)	Islene Araujo de Carvalho, WHO
The way forward and closure of the meeting	**Chairs:** **John Beard, WHO** **Federal Ministry of Health of Germany**

Federal Ministry of Health

World Health Organization

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