Swiss TPH
Swiss Tropical and Public Health Institute

Integrated People-Centred Care: Finding Solutions to Chronic Conditions

White Paper from the Swiss TPH Symposium on 2 September 2025

Background

With the overall increase in life expectancy but rising burden of non-communicable diseases and associated disabilities, ever greater numbers of people spend a growing period of their lives living with chronic health conditions. Moreover, increasing global inequities have dramatically exposed the close interlinkage between health and a person's socio-economic and environmental situation. Many chronic patients have complex needs that require attention from multidisciplinary teams - spanning specialised and general health care, social welfare and benefits.

Setting the scene – what is integrated care?

People-centred care involves the delivery of integrated services to overcome fragmentation and reduce system inefficiencies. Integrated services are important for people with chronic and medically complex needs, for whom fragmentation has an adverse impact on their care experiences and outcomes. The term goes beyond managing medical problems and promotes wider health and wellbeing. At its heart lies a commitment to improving the quality and safety of care across the health and social sectors through ongoing and co-productive partnerships.

Swiss TPH brought together a diverse audience, working in Switzerland, Europe, including Eastern Europe and the Balkans, as well as further afield in Tanzania and Brazil. Jointly, on 2 September 2025, we examined the challenges that beset efforts to make care more people-centred, and shared learnings towards solutions. This included keynote inputs from the International Foundation of Integrated Care, World Health Organization, and Nuffield Trust, a patient-driven exchange, specific inputs on data-sharing and digital tools, innovative models, and research needs, finishing with a panel on policy and the systems perspective. The key results of the day are summarised in this white paper, and the agenda showing the full programme and all speakers is in the annex.

Common challenges to making care people-centred

Despite the differences in contexts, the following challenges and persistent pain points clearly emerged.

- Fragmentation is often driven by divisions of labour and funding across different line ministries which impedes coordination even when there is a strong will to collaborate.
- Services, especially inpatient services, are generally set up to suit the schedules and availabilities of care providers. This is not only incoherent and difficult to navigate for patients and their families but also gives the impression to patients that their time is less important than that of care providers. Today time is precious for everyone and ways to optimise and combine appointments would be a win-win.
- There is a lack of multidisciplinary patient assessments and case management that would help patients be linked to different providers in a holistic, coordinated manner.
- While concerns about data safety are fully recognised, patients with chronic conditions would be ready to give agreement for information from different providers to be shared with other professionals providing them with care.
- However, it is also recognised that sharing data would be helpful but not sufficient for overcoming gaps in understanding across different professional groups. Professionals with varying backgrounds would need common education and training, as well as safe interdisciplinary spaces to forge a common language and find complementary ways to work together as teams.

- Finally, the inputs from Ukraine reminded everyone that in times of conflict, fragmentation risks to increase while people's suffering is greatest and a holistic response would be most needed.

Finding solutions to fragmentation – through innovative models, policy influence, data, digital tools and research

When it comes to finding solutions, it is important to combine learnings and research across chronic conditions regardless of whether they are due to noncommunicable diseases, infectious diseases like HIV or tuberculosis, a combination of co-morbidities or rehabilitation. People with disabilities and their families are among those that suffer the most from fragmentation of care delivery.

- Health vs Care: it is critical to invest in health through prevention, health education, community interventions, promoting healthy behaviour *in tandem with* investing in social care interventions.
- Trust building is important to engage different actors across health and social care: multidisciplinary and intersectoral teams are best created from empowered community actors, non-governmental organisations, health and social workers.
- Community pilots of a continuum of care approach, giving attention to discharge planning, referral and follow up along a patient pathway, provide a starting point for effective models of integrated care. Such pilots allow stigma to be reduced right from the outset – in terms of mental health, trauma and physical impairment.
- In places where there is a lack of human resources, working across disciplines can make workloads more manageable. For example, in rural areas where there is a dearth of general practitioners, while many patients have co-morbidities combined with many socio-economic problems, community social workers and community nurses are both more available and better placed to carry out outreach and visit patients at home.
- There is still considerable scope to bring care closer to people through health care kiosks, hospital at home, community nursing, peer-to-peer learning (experienced patients as health ambassadors etc.), digital health options like social prescribing.
- Given the urgency, innovative mechanisms are needed to accelerate dissemination of successful models and influence policymaking.

Recommendations

Based on all the exchanges it became apparent that change is needed at all levels – from increased political will bringing bigger investments in care provisions, to patients having their time compensated to work as advocates for system change, and greater empathy and understanding among providers. Overall, as participants of the symposium we recommend and see the need to:

- Co-create the design of service delivery - patients and communities are key partners to identify and shape solutions.
- Move from individual care to population health by strengthening the public health perspectives in the provision of chronic care services, as well as developing multi-sectoral and inter-disciplinary responses.
- Continue the ongoing transition from single care interventions to integrated care pathways – identifying structured answers to the management of complex chronic diseases and conditions.
- Share data along care pathways - a key feature for patient safety and for continuous quality improvement of services.
- Bridge the gap between evidence and policy by creating clear, easy-to-understand messages for policymakers based on new evidence and actively seeking opportunities to use research findings to influence local and national policies.

- Apply scientific methodology to the modelling and evaluation of care pathways using real-life data, for example to show the expected effect measures of interventions in terms of outcomes and added values like patient-reported experience measures and patient-reported outcome measures.
- Bring health closer to the people: empower communities towards a healthy community approach, co-creation of care solutions, health information and education, early detection, etc.
- Develop sustainable health care financing solutions for chronic care (capitation, outcome-based, value-based, etc.)
- Facilitate the communication and dissemination of best practices!

Disclaimer

This white paper summarises discussions and insights from the Symposium on “Integrated People-Centred Care”, September 2nd, 2025. The views expressed are those of the joint discussions during the Symposium and have been summarised by the organising committee who take full responsibility for the content. The document is intended for information purposes only and does not constitute professional or policy advice.

Integrated People-Centred Care

Finding Solutions to Chronic Conditions

Kreuzstrasse 2, 4123 Allschwil, Switzerland

PROGRAMME
2 September 2025

08:45 On-site Registration *(09:10 virtual check-in)*

Welcome and Plenary

Moderator: Helen Prytherch, Swiss TPH

09:15 Welcome and Setting the Stage, *Helen Prytherch, Swiss TPH*
09:30 **International Integrated Care**, *Niamh Lennox-Chhugani, International Foundation for Integrated Care*
09:45 **Quality Innovations and IPCC**, *Joao Breda, World Health Organization*
10:00 **Translating Research into Policy: Influencing Integration and Social Care**, *Camille Oung, Nuffield Think Tank*
10:15 **Q&A with Discussion**
10:30 Coffee Break *(30 minutes)*

People's Perspective on Integration

Moderator: Jana Gerold, Swiss TPH

11:00 Patient and Service Provider Panel Discussion and Q&A

- **Patient Advocate**, *David-Zacharie Issom, European and Swiss Sickle Cell Federation*
- **Patient Advocate**, *Judith Safford, RheumaCura*
- **Patients' Association**, *Iryna Rachynska, Patients of Ukraine*
- **Interprofessional Education**, *Alessia Romer, SHAPED (Swiss Health Alliance for Interprofessional Education)*
- **Patient and Public Involvement,** *Annina Bauer, University Hospital Zürich*
- **Lancet Diabetes Endocrinology Commission**, *Jessica Hanae Zafra-Tanaka, University of Geneva*
- **CareRing**, *Ursula Becker, Hoffmann-La Roche*

12:15 Lunch Break and Exhibition *(75 minutes)*

Parallel Sessions

13:30	Data and Digital Management *Moderator: Fenella Beynon, Swiss TPH*	Coordination and Research *Mod.: Jari Kempers, European Health Economics*	Models and Policies *Moderator: Manfred Zahorka, OptiMedis*
13:30	**Two Giants, Five Lessons: What China and India Teach Us About People-Centered Digital Health**, *Alon Rasooly, University of Geneva*	**Kosovo Cohort Study**, *Ariana Bytyci Katanolli, National Institute of Public Health Kosovo, and Swiss TPH*	**Réseau de l'Arc in Switzerland**, *Alain Kenfak, Réseau de l'Arc SA*
13:50	**Digital Self-Management of Diabetic Patients in Kosovo**, *Talia Salzmann, Swiss TPH*	**INSPIRE - An Integrated Care Model for the Community**, *Suzanne Dhaini, Institute of Nursing Science, University of Basel*	**Modelling the Continuum of Hypertension Care for Policy Design,** *Pei Shan Loo, Swiss TPH*
14:10	**Social Prescribing**, *Stijn Coolbrandt, Health Endeavour Belgium*	**Chronic Disease Clinic**, *Maja Weisser, Ifakara Health Institute*	**Integrated Health and Social Care in Moldova**, *Ala Curteanu, Swiss TPH*
14:30	**Leveraging Crowdsensing and Explainable AI for Self-Care Management and Minority Stress Monitoring**, *David-Zacharie Issom, Haute Ecole Spécialisée de Suisse occidentale Genève*	**Patient-Centred Care at University Hospital Zurich**, *Katrina Obas, University Hospital Zurich*	**Integrated Care Models in Germany**, *Heidrun Sturm, OptiMedis* **From Practice to Impact: An Integrated Local Public Health Model in Ukraine,** *Alyona Gerasimova, Pact*

14:50 Coffee Break *(30 minutes)*
15:20 Bringing It All Together: Summarizing Key Messages from the Breakout Sessions

Health System Perspective on Integration

Moderator: Alexander Schulze, Swiss TPH

15:40 Panel Discussion and Q&A

- **International Cooperation**, *Erika Placella, Swiss Agency for Development and Cooperation*
- **International Foundation**, *Niamh Lennox-Chhugani, International Foundation for Integrated Care*
- **Swiss Forum on Integrated Care,** *Annamaria Müller, Schweizer Forum für Integrierte Versorgung*
- **Quality of Care and Patient Safety**, *Joao Breda, World Health Organization*
- **Hospital at Home in Basel County**, *Philipp Busche, Hospitales*
- **Researcher in Integrated Coordinated Care**, *Isabelle Peytremann Bridevaux, Université Lausanne*

16:50 Final Reflections and Closing Words, *Kaspar Wyss, Swiss TPH*
17:00 End of Event