Health Quality Alberta

Framework for an Integrated People-centred Health System

Providing a common language across roles, settings, and sectors to support system improvement

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We appreciate the generous contributions of all who participated and contributed their insights, expertise, and experiences.

ENVISIONING AN INTEGRATED PEOPLE-CENTRED HEALTH SYSTEM

Jurisdictions around the world are envisioning an integrated and people-centred health system that supports the health and well-being of people, communities, and the wider population. In such a system, collaboration thrives. Services are well coordinated, and people, organizations, communities, and governments co-create solutions.

This **Framework for an Integrated People-centred Health System** can help realize such a system for Alberta.

While integrated people-centred care offers a compelling direction for transformation, realizing it requires deliberate shifts in how health systems are organized, governed, and experienced. The need for change is evident because, despite widespread commitment to improvement, meaningful system-wide progress still eludes health systems around the world.

Integrated people-centred care is a catch-all term that refers to a type of health system, vision for health system transformation, improvement strategy, and a model of care delivery. It is described as a "fundamental design principle"[1] or "set of design principles"[2] because integrated people-centred care is understood as "so much more than the sum of a range of organizational processes acting at different levels".[1] In all forms, it is adopted for a similar reason: to shift thinking and practice in health system planning, decision-making, and care delivery – improving outcomes, quality, experience, and value. In doing so, it advances the Quintuple Aim: enhancing care experience, population health, and the work life of providers, while simultaneously reducing healthcare costs and advancing health equity.[3]

WHY AN INTEGRATED PEOPLE-CENTRED HEALTH SYSTEM

In many jurisdictions, health system decision-makers have rallied around the goals of integrated people-centred care to better meet the comprehensive needs of the people and communities they serve and to respond to mounting pressures. These pressures include aging populations, persistent health inequities, the rise in chronic diseases, healthcare worker shortages, and rapid advancements in digital technologies.

An integrated people-centred health system is one that:

- Adopts a broad understanding of health – and acts on the **determinants of health.**[i]
- Plans and sets priorities beyond a focus on medical treatment and improved clinical outcomes.
- Prioritizes the **wholistic** preferences, needs, and strengths of people and communities.
- Supports healthcare providers and recognizes the value of unpaid, informal caregivers.
- Sees people and communities as agents of change in achieving health and well-being and reducing health disparities.
- Sees social services as part of the health system to address more fully what matters to people and communities and thus builds partnerships among people, organizations, and communities within and across the health and social sectors.
- Designs for equitable access to health services and strives for equitable health outcomes.

How the WHO defines integrated people-centred care

The World Health Organization defines an integrated people-centred health system as: "An approach to care that consciously adopts individuals', carers', families', and communities' perspectives" and is "organized around the comprehensive needs of people rather than individual diseases" while ensuring "carers are able to attain maximal function within a supportive working environment" 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." [6]

[i] Some of the main determinants of health include income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, biology and genetics, gender, culture, race/ racism and colonization.[4] Other determinants include access to health services and social supports, working in partnership[5], positive coping skills, and healthy behaviours.

Applying a whole-system approach

Systems thinking sees a whole as made up of different, interrelated parts. It informs many approaches to quality improvement in a health system.

A situational improvement approach focuses on a micro-system or "multiple small units"[8] of care providers, administrators, and other staff involved in daily service delivery. This could be a team of professionals and staff who regularly work together to provide care to a defined group of people, such as a unit within a care setting, where the goal may be to develop and test an idea for change to bring about sustainable improvement.

A whole-system approach, however, acknowledges the expanded boundaries of a health system to bring into view a wider range of people, teams, professions, organizations, sectors, and policies for consideration. It urges improvement opportunities be uncovered and acted upon across the interrelationships, component parts, and practices that make up an integrated people-centred health system. The table below compares the focus of each of these two improvement approaches, both of which can support progress toward an integrated people-centred health system.

Table 1: Comparing situational and whole-system approaches

Comparator	Situational approach	Whole-system approach
The focus is…	located at or close to the point of care	the entire health system
The approach looks…	within a setting, profession, organization, sector, or defined population	beyond and across settings, professions, organizations, and sectors
Planning and action involves…	a small interdisciplinary group or network of people making up a team	teams across an array of contexts and groups
The goal is to…	scale or spread a quality improvement intervention to other microsystems	improve one or many attributes of an integrated people-centred health system

As health systems prioritize integrated people-centred care, they are also expanding their understanding of health quality. This emergent thinking is systems-focused, wholistic, continuously adaptive, and grounded in broader considerations of equity, culture, power, and lived experience.[ii]

A whole-system approach emphasizes the many enabling conditions and practices that need to be present to ensure a system is truly equipped to deliver integrated people-centred care.

A whole-system approach sees the improvement opportunities *within* sectors, situations, and care settings. And it also points to *the spaces between* them. That is, between government and healthcare service delivery, health and social sectors, provider roles and professional groups, providers and care receivers, and policy makers and communities.[7] It sees the spaces between all these system elements – and the accountabilities, roles, and relationships that shape and interconnect them – as rich, underdeveloped territory for collaboration and improvement.

[ii] Quality improvement used to focus mostly on checking for problems and fixing them through quality assurance. Over time, focus shifted to reflect that quality is also shaped by history, culture, and power structures, and that quality grows through strong relationships. This shift draws on ideas from Black feminist thought, critical race theory, disability studies, and anti-oppressive practice. Concepts such as cultural safety, cultural humility, and cultural responsiveness originated in Indigenous and Māori communities as responses to colonialism, power imbalances, and harm in healthcare. Together these ideas centre lived experience, highlight how power and structures affect care, and stress interpersonal responsibility in creating safe, equitable, people-centred care. This framework draws on this thinking to describe what quality means today.

WHY A FRAMEWORK

Development of this framework began with the question, 'How is quality defined today?'

With a mandate to promote and improve patient safety, person-centred care, and health service quality in Alberta, in 2025 Health Quality Alberta updated the widely used definition of quality first adopted in the Alberta Quality Matrix for Health in 2005.

Input was sought from system partners across Alberta, patient advisors, and communities. Jurisdictional reviews were carried out to examine health system frameworks at regional, national, and international levels and definitions of person-centred care, quality, and safety.

It was observed that definitions of quality are defined within the expectations of an integrated people-centred[iii] health system (see Definitions, pg. 10) and placed within a framework. This reflects a well-established understanding in health systems research that high-quality care is more than a clinical intervention. It is shaped by a complex, interconnected, and adaptive system of structures, practices, and contexts that influence people's experiences and outcomes.[9]

A comprehensive health system framework thus acts as a map. It provides a common language and foundation to guide policy, organizational strategy, measurement, and care delivery. This helps to ensure aligned and coordinated improvement efforts, rather than fragmented, isolated, or narrowly focused actions.

Building upon the updated definition of quality, the Framework for an Integrated People centred Health System provides an evidence-based model to move beyond disease-focused approaches toward systems and services organized around the full spectrum of people's and communities' needs.

[iii] People-centred and person-centred are distinct terms. People-centred care is based on collaboration and shared decision-making. It is grounded in a comprehensive understanding of the preferences, needs, and strengths of individuals, families, communities. See page 14 for the full definition.

HOW THE FRAMEWORK IS ORGANIZED

Frameworks for integrated people-centred health systems define essential parts similarly.[iv] They point to a range of system factors and practices that shape people's health outcomes and experiences.

This framework is organized according to three interrelated parts of an integrated people-centred system: quality dimensions, enablers, and shared responsibilities. Each part has its own role, but none works on its own. Their interdependence is what supports progress toward integrated people-centred care.

The **quality dimensions** describe what people should expect from an integrated people-centred health system. They define quality in this context and outline the types of care experiences, practices, relationships, and outcomes people should be able to count on. The seven interrelated dimensions are people-centred, accessible and timely, effective, efficient and sustainable, safe, equitable, and integrated.

How the quality dimensions have evolved

An environmental scan, interviews, and literature review showed the quality dimensions in the Alberta Quality Matrix for Health, while still relevant, were incomplete. Language has evolved over time, and new concepts in quality have been added. Equity and integration are now commonly included as standalone dimensions, and the definitions have deepened – such as what is meant today by safe.

Many quality frameworks now focus on person- or people-centred care. They connect this concept to equity, cultural safety and humility, health and wellness, the social determinants of health, integration across a patient's journey and across sectors and services, the needs of communities and populations, and partnerships. Each of these is embedded in a deeper understanding of quality. See next page for the former (left) and updated (right) quality dimensions.

[iv] Appendix I lists notable frameworks for integrated people-centred care that influenced this work.

Illustration 1: How the original quality dimensions (left) evolved (right)

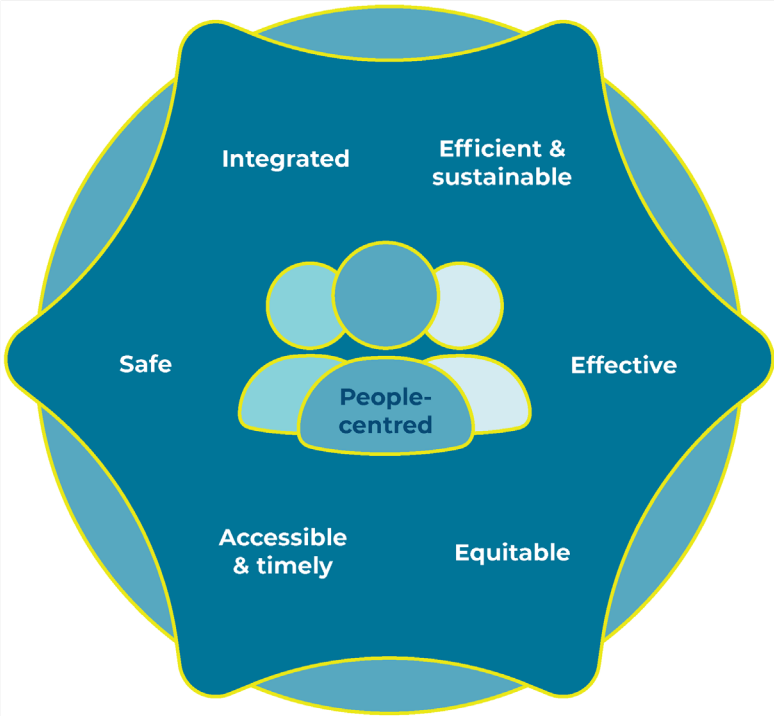

Illustration 2: The Alberta Quality Dimensions for Health

Like the framework parts, the quality dimensions are interconnecting concepts (see illustration, pg. 14). Because quality is a multidimensional concept, many factors contribute to improvement efforts. Context will always determine the interdependencies among the dimensions.

While the dimensions offer a lens through which people's experience in the health system can be viewed, the enablers and shared responsibilities create the conditions for these experiences to be realized.

Enablers are the structural, cultural, and operational conditions that support integration and allow improvement to be sustained over time. They shape the environment where care is delivered by influencing how priorities are set, how decisions are made, how resources flow, and how teams and organizations work together.

Enablers are the levers of change that allow integrated people-centred care to move from aspiration to practice. In this framework, they are collaborative governance, aligned funding, workforce capacity and capability, technology solutions, measurement and evaluation, cultural responsiveness, meaningful engagement, and people-centred organizational culture.

Shared responsibilities work within the enabling conditions of the system. They shape how people work, collaborate, learn, and respond across roles and organizations. They strengthen the social fabric of the system through everyday interactions, decision-making, and how people show up for one another over time.

These responsibilities — communicating transparently, cultivating relationships, demonstrating cultural humility, and evolving continuously — are behavioural commitments that help sustain integration and continuous improvement. When practised consistently, they knit together the human parts of the system — people, interactions, communities, and networks — into a more cohesive whole.

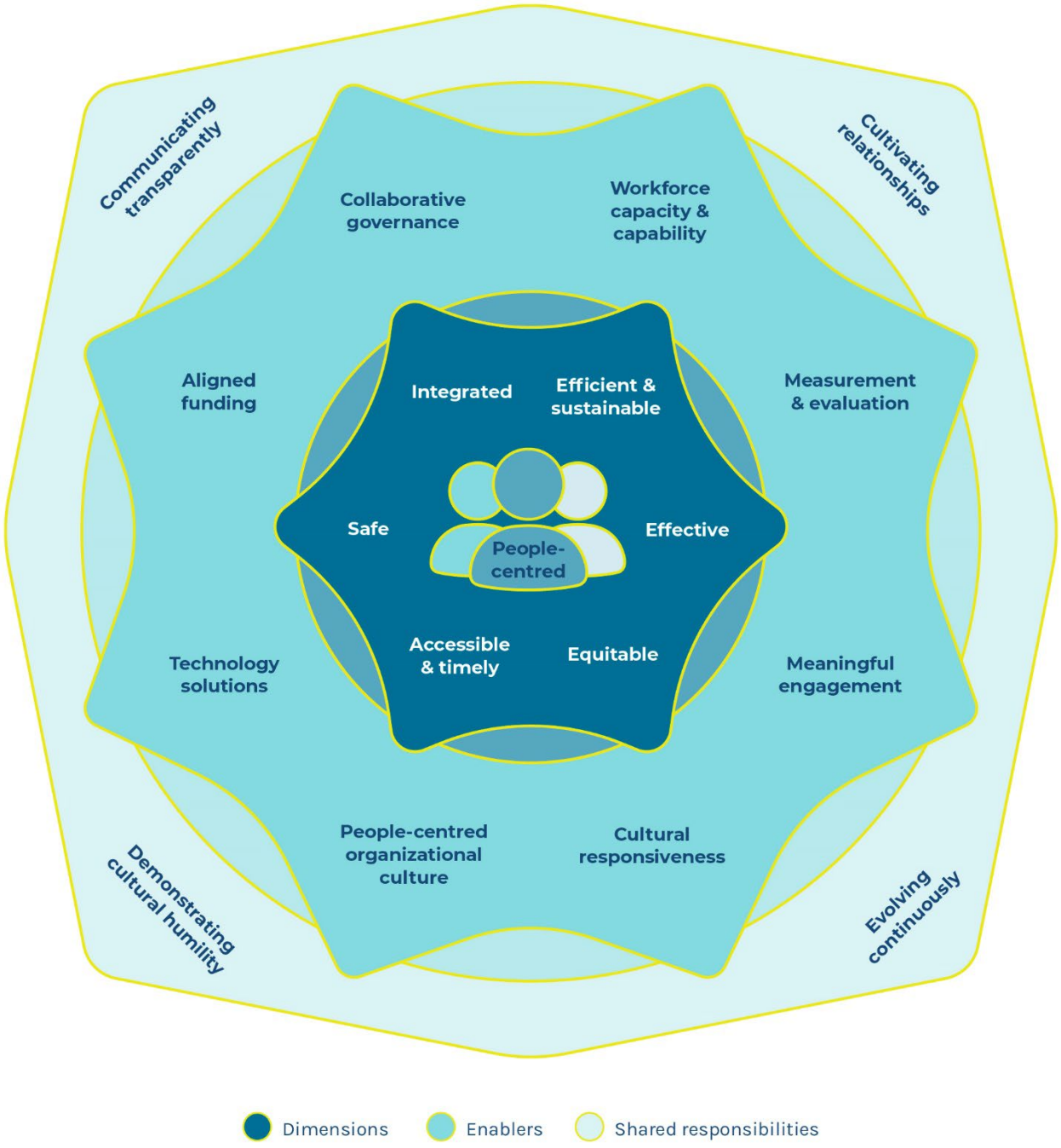

Illustration 3: The parts of an integrated people-centred health system and their interrelationships

APPLYING THE FRAMEWORK

This framework is intended to guide action. It can help people and organizations clarify their role and align their efforts in advancing an integrated people-centred health system.

It can be used to inform governance, policy development, strategic planning, standards, health service design and delivery, measurement and evaluation, and quality improvement. It offers a common language and resources to support coordinated effort across roles, settings, and sectors.

The framework is meant for those accountable for supporting the health and well-being of individuals, communities, and the population:

- Policy, governance, and oversight
- Healthcare services, programs, and teams
- Quality improvement specialists
- Community health and social services
- General health and well-being sectors (e.g., recreation)

Patient partner describes a person with lived experience with the health system who is in a formal role working collaboratively with the system.

This includes a variety of positions and roles: policymakers, leaders, administrators (e.g., physicians, nurses, allied health professionals, social workers, community support workers), educators, researchers, improvement facilitators, caregivers, and patient partners.

How this framework is applied will depend on context and role. Some parts of the framework will be more relevant in certain settings than others.

For all users, the starting point is the quality dimensions, with people-centredness at the core. These dimensions serve as the lens for assessing improvement opportunities, health outcomes, and people's experiences receiving and providing care. Enablers and shared responsibilities then guide how change is structured and enacted — shaping both the conditions that support improvement and the ways people work together to realize it.

When used collectively and applied consistently, the framework supports coordinated action towards a more integrated people-centred health system.

The interdependent concepts presented in this framework are defined in detail below. They are, by design, written to describe an ideal state. These definitions should be read as an answer to the question, 'What does each concept look like when fully realized?'

The definitions describe the destination a health system is moving towards as it strives to provide integrated people-centred care. Progress towards such a system is a journey. It includes learning, evaluation, growth, and the celebration of progress along the way.

QUALITY DIMENSIONS

Quality dimensions are interrelated concepts. For example, quality depends on integration, and integration requires a people-centred approach. Each dimension interconnects with others in this way. Taken together, they define what is meant by health quality and describe the care experiences, relationships with care providers, and health outcomes people should expect from an integrated people-centred system.

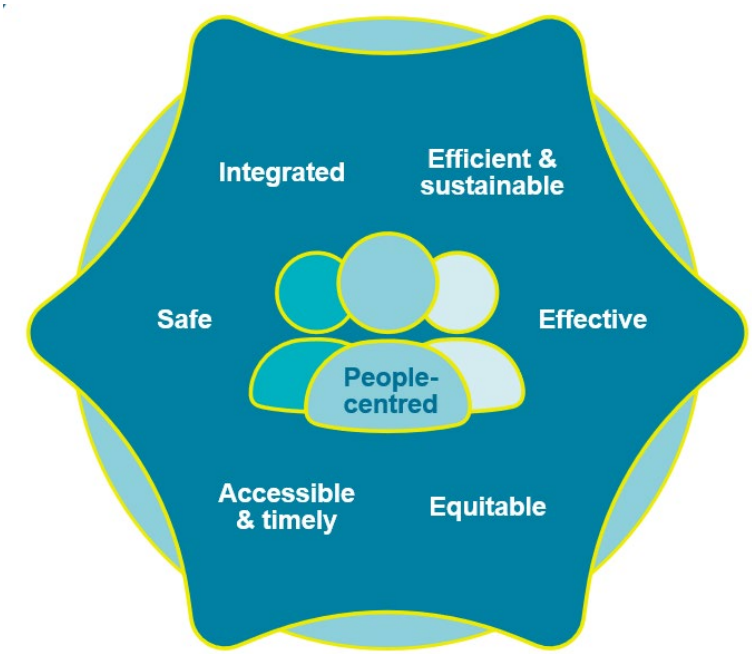

Illustration 4: The Alberta Quality Dimensions for Health

People-centred: The wholistic preferences, needs, and strengths of people and communities matter.

Care is **wholistic**, respectful, culturally responsive, and appropriate to the circumstances of individuals, families, communities, and the population, while also attending to healthcare providers' needs and circumstances. People-centred care involves caring for the wellness of the whole person. This includes physical, mental, emotional, spiritual, and socio-economic needs, **dimensions of identity,** and social and personal determinants of health.

People-centred care is based on collaboration and shared decision-making. This is supported by meaningful engagement, where individuals, families, communities, and providers are recognized as active partners in care and treated with dignity and respect. Collaboration is needed within and across health and social sectors at individual, organizational, governance, and policy levels. This

makes it possible to agree on health and well-being goals with individuals and communities, and for the population as a whole.

For example, for First Nations, Métis, and Inuit Peoples, this calls for the use of an Indigenous-led, distinctions-based approach. Such an approach recognizes that groups and communities are distinct; each has its unique culture, territory, history, governance, and relationship with provincial and federal governments; each holds the solutions to best address persistently inequitable access to high-quality and culturally safe care.[5,6]

People-centred care builds on the concepts of patient- and person-centred care. With people-centred care, we broaden our appreciation of a person's wants and needs, recognize the role and capacity of communities in achieving health and well-being, and acknowledge the importance of seeing and caring for providers as people.

The complexity of identity is key to figuring out what matters to people. What matters to a person is shaped by many **dimensions of identity**. Age, gender identity or expression, nationality, sexual orientation, mental or physical ability, and race/ethnicity are often central to identity and personal experience. However, other external and social factors are also relevant. These include education, political beliefs, family, organizational role, language and communication skills, income, religion, appearance, work experience, and education.[7]

Table 2: Comparing patient-, person-, and people-centred care

Comparator		Patient-centred	Person-centred	People-centred
People, roles, and practices that are	*Who is the focus?*	The patient; the person sick with disease or experiencing a disorder of the mind or body	A person, even if they are still called a patient, and the suffering they experience because of disease or illness, the subjective or lived experience of being sick.	People and communities. 'People' is used inclusively to capture all the different persons and roles that are part of a health system. This includes people receiving care, people providing care (as professionals or family members), and communities. It sees communities as made up of leaders, organizations, and citizens with shared identities or values.
	What are the needs?	Drugs or diagnostics to help cure or treat a disease	An array of medical and non-medical needs (e.g., psychological, social, spiritual, financial, etc.).	Many needs matter and depend on the person or role and the community.

	Who are the experts or knowledge holders?	Clinicians	The person needing care, their family members, clinicians, and other professionals.	Everyone, particularly communities.
	Who has agency or responsibility?	Clinicians are expected to give advice that reflects and meets the clinical needs and values of patients.	Clinicians/other professionals and patients mutually participate in the relationship. Care receivers are seen as having knowledge and experience about the person's illness and life that is crucial to the interaction and decision-making.	Everyone. The goal is to equip people and communities to be involved in their care and health.
	What is the context for decision-making?	Decisions occur within a trusting clinician-patient relationship, often within a consultation or single medical encounter.	Decisions occur collaboratively in different situations and places. They unfold over time to meet a person's needs as they arise throughout life.	Planning and decision-making happens in collaboration with people and communities regardless of the context.

Accessible and timely: People can readily access services that meet their needs.

Health services are equitable, inclusive, appropriate, easy to find, get to and use, and available when needed, without physical, cognitive, geographic, or language barriers. Human resources are proactively matched to the needs of the population.

Intentional efforts are made to design and deliver services so that Indigenous and underserved groups can fully and equally participate and use services without experiencing barriers. This requires planning to ensure individuals and communities have access to a range of resources that improve health outcomes (e.g., food, housing, social support, financial aid).

Addressing differences in access involves more than just providing easy-to-reach services. It requires a commitment to providing meaningful and inclusive ways for people and communities to participate in planning and decision-making that affects their health. This ensures the services provided reflect people's cultural contexts and what matters to them.

Understanding culture more broadly

Culture refers to the values, beliefs, and experiences that shape a person's viewpoint, and which they bring to their work. This can include professional training, work experience, communities of belonging, social position, religion, gender identity, ethnicity or heritage, and more.

Effective: Decisions are based on current evidence and lived experience.

Health services achieve the best possible outcomes by drawing on current information and scientific evidence on clinical appropriateness, other knowledge systems (e.g., Indigenous ways of knowing and being)[11], and lived experience to meet individual, community, and population needs. This involves people – decision-makers, providers, care receivers, community leaders – considering and balancing different perspectives as part of coming to agreement on how to achieve optimal outcomes in a particular situation.

Why lived experience strengthens effectiveness

Recognizing lived experience acknowledges the strengths and capacity of people to make informed decisions about their health and healthcare and to co-produce health solutions. Care decisions are more effective when they reflect individual and community experiences and histories with illness, procedures, medications, and alongside established research and scientific evidence. Together, these perspectives support decisions that are clinically appropriate, responsive to context, and more likely to achieve intended outcomes.
This approach also supports equity in healthcare planning and delivery; inclusive, people-centred practices for measuring and understanding experience broaden the perspectives that inform decision-making.

Efficient and sustainable: Resource use balances individual, population, systemic, social, and environmental factors to benefit current and future generations.

The health system is sufficiently resourced with appropriate management and distribution of resources – including people, funding, time, and materials. Unnecessary waste is avoided while preserving any redundancies needed for safety. Coordination, trust, and role clarity exist across teams and services. This strengthens efficiency and sustainability by reducing duplication, misunderstanding, and avoidable harm.

Sustainability is supported by the ethical balancing of individual and population health outcomes alongside social, economic, and environmental factors to benefit current and future generations.

Efficient and sustainable for current and future generations

An integrated people-centred health system looks for opportunities to accommodate the needs and daily lives of people and communities. This perspective invites system decision-makers to consider what becomes possible when efficiency, equity, and people-centredness are considered together. Efficiencies can emerge when services are flexible and responsive to people's needs – for example, by offering appointments outside of traditional operating hours – while also improving access and experience.

Some jurisdictions also understand sustainability as including responsibility for planetary health, recognizing that the long-term health of people is inseparable from the health of the environment.

Environmental sustainability includes reducing ecological harm caused by healthcare delivery. This can arise, for example, from inappropriate prescribing practice and antimicrobial resistance,[12] and supply and drug waste. An integrated people-centred system anticipates the effects of environmental conditions such as wildfires, drought, and floods on the health and well-being of people and communities.[13]

Safe: Trust and feelings of security are fostered, and all forms of preventable harm are avoided.

People – including individuals, families, health and social service providers, and communities – experience care in ways that support trust, dignity, and a sense of security. An expanded understanding of harm includes not only medical harm, but psychological, emotional, cultural, moral, economic, data-related,[v] and societal harms, as well as harm arising from the absence or inaccessibility of care. Safe care is understood as multi-faceted and interpersonal, shaped by people's experiences and the context in which care is received and delivered. This includes attention to patients' physical safety, psychological safety, and cultural safety as distinct, but interconnected, aspects of safe care.

[v] Both health data use and non-use, or loss of health data integrity (e.g., accuracy, completeness, reliability, relevance, and timeliness) can result in harm to individuals, populations, and the health system.[14] Data-related harm includes breach of personal health data, deliberate misuse of data to deceive or promote discrimination and/or inequities; and failure to optimize health system function and efficiency due to poor data design, misuse, non-use, or lack of data integrity.[14]

Table 3: Some of the main ways safe care is understood — as distinct but interconnected aspects

Aspect of safe	How it is understood	What it asks
Patient safety	Focuses on preventing physical and clinical harm arising from care delivery, including errors, adverse events (i.e., injury, infection, etc.), and system failures. It involves both reactive safety management (learning from incidents after they occur) and proactive safety management (anticipating risk and designing safer systems to prevent harm before it happens).[16, 17]	"How do we prevent clinical error and medical harm?"
Psychological safety	Refers to team environments where people feel safe to speak up, ask questions, raise concerns, and acknowledge mistakes without fear of blame, punishment, or humiliation.[18] It reduces interpersonal risk so that learning, improvement, and accountability can occur.	"Can people speak up without fear?"
Cultural safety	Focuses on the lived experiences of people who receive and provide care, especially those who have faced unfair treatment or harm in the past and continue to today.[15] It looks directly at issues like power imbalances, racism, discrimination, and the lasting effects of colonial systems in health systems. It is defined by the people experiencing care, not by providers or organizations. It asks health workers and systems to look honestly at their own practices and change anything that may cause harm. When cultural safety is present, people's identity, dignity, rights, and ability to make decisions about their own care are respected and protected.	"Is this environment set up in a way that notices and addresses power differences, protects people's dignity, and feels safe for both the people receiving care and the people providing it — especially for those who have experienced harm in the past or still do today?"

When something goes wrong, the response prioritizes compassion, openness, and fairness for all those affected. The focus is not on placing blame, but on understanding contributing factors, learning from experience, and strengthening systems and practices to prevent future harm. Individuals are treated fairly. The system learns and improves.

An integrated people-centred health system actively works to prevent harm that may occur during care delivery and harm that arises from the settings, structures, and processes through which care is provided.

It addresses system-level inequalities and gaps in care that undermine trust and contribute to harm, including those related to racism, discrimination, and exclusion. This helps people feel safe when delivering and receiving care or when asking for their needs to be met.[15]

Equitable: Services see and respond to the preferences and needs of communities to reduce and prevent unfair differences in experiences and outcomes.

Health services are inclusive and attentive to people's diverse circumstances, identities, and lived realities. An integrated people-centred health system recognizes that inequities in health outcomes and experiences are shaped by historical, social, and structural conditions. Equitable care addresses both existing and emerging differences in access, experiences, and outcomes. It acknowledges these differences are not random but reflect uneven distributions of resources, opportunity, and influence.

To respond to these inequities, a strengths- and needs-based approach is used. Individuals and communities facing persistent, avoidable, and unjust health inequalities can access and receive services appropriately. This approach occurs at the interpersonal and system level. The aim is not only to prevent inequities in the future but to address those that exist today, so everyone has the same chance to achieve their "full health potential."[19]

Equitable care addresses the historic and current factors that have created unequal access to care. It addresses differences in care experiences across communities. This includes how health system policies, practices, and decision-making can contribute to inequity. Cultural responsiveness is practiced as a key part of equity-oriented care.[20] Equitable care includes coordinated attention to the broader conditions across the health system that influence all of the other dimensions of quality.

An integrated people-centred health system also attends to inequities within the health workforce. It recognizes how organizational culture, professional structures (i.e., role design, compensation practices, etc.) and pathways into and through health professions can benefit some groups and constrain others. Addressing inequities within the workforce strengthens working conditions. It supports team functioning and organizational learning, and it contributes to the quality and equity of care experienced by people and communities.

Integrated: People, teams, sectors, organizations, and communities are interconnected.

Care is coordinated across many levels, processes, people, teams, and communities. This supports continuity and smooth transitions that contribute to better care experiences and improved outcomes. People across sectors and organizations, with different roles, expertise, accountabilities, and professional cultures, work together to create people-centred and well-organized models of care delivery.

Such models bridge policy, administrative, informational, and funding gaps to meet the needs of individuals, communities, and the population. Integration occurs across:

- Policy-making, management, and operations
- Types of care (e.g., health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, palliative care, and end-of-life) within a single visit and over time across different care experiences to support an individual's needs throughout their life
- Care settings, including hospitals, emergency and urgent care services, primary care, continuing care, people's homes, community, etc.
- Sectors, such as health and social services

Integrated care is supported through meaningful engagement with patient partners at all levels, teamwork and interprofessional collaboration, community engagement,[21] health literacy, and interoperability of data and information. Together, these conditions promote collaboration and collective action across sectors and organizations.

ENABLERS

Enablers are the structural, cultural, and operational levers of change. They are the conditions needed for realizing health quality and creating an integrated people-centred system.

Collaborative governance: Through distributed leadership, people and organizations share accountability and work together to achieve goals.

Governance in an integrated people-centred health system is collaborative.[27] It recognizes that accountability for the health and well-being of people and communities is shared, because needs are diverse across those communities and individuals. Governance structures and the ways in which people participate in decision-making are designed to support full collaboration.

Clearly defined and assigned roles and accountabilities exist at all levels – policy, program planning, point of care – and across organizations and sectors. Each role is clear about its accountability, which supports collaboration.[6] Clarity is upheld by mutually reinforcing strategies. These include a shared vision, mandates, standards, and other ways that specify and monitor accountabilities (e.g., terms of reference, performance measurement).

Governance models break down barriers between organizations and sectors and focus on cooperation not competition. Coalitions are built around a shared purpose. Multiple roles and perspectives, including patient partners and community, shape decisions across levels of government and health service delivery organizations.[28] People and organizations work together to navigate tensions between organizational mandates and the shared purpose.[29] Inclusive decision-making practices ensure diverse perspectives are considered. Conflict is resolved through constructive, respectful practices to maintain mutual trust and understanding.[vi]

Leadership is distributed, leveraging the effectiveness of people and groups working together.[30] It is a leadership approach that sees strength and influence from many different sources as necessary to creating change.[2]

An integrated people-centred health system owns its accountability to First Nations, Métis, and Inuit Peoples. It respects and upholds First Nations' Treaty Right to Health, Indigenous Peoples' own laws and protocols, the Truth and Reconciliation Commission of Canada Calls to Action, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), and the constitutional rights applicable to all Canadians.[11] This can be done when those in Indigenous, provincial, and federal governance roles collaborate and agree on Indigenous-led accountability mechanisms for improved healthcare.

[vi] Methods can include practices that are considered 'relational' and 'reflective', such as rapport-building and structured reflection in conversation.

Aligned funding: Sustainable, innovative funding models promote multi-sectoral integration and deliver better value.

Sustainable, ethical funding decisions consider rising healthcare costs, limited financial and human resources, and other demands on the public treasury. Innovative funding models align care delivery with what matters to people and communities. This is done to deliver better value and to promote coordination and continuous care over time for complex, chronic health needs. Funding mechanisms[vii] and accountabilities incent interdisciplinary team-based models and integrated care. Funding spans healthcare sectors, organizations, and providers, and crosses conventional bounds of health and social services.

Capacity and social infrastructure are increased to support the voluntary sector and community-based organizations in health service planning and delivery at the local level.[30] In an integrated people-centred health system, programs are sufficiently funded to ensure equitable access to quality care does not depend on a person's ability to pay.

Workforce capacity and capability: Providers and staff can perform optimally.

An engaged and productive workforce is equipped to function in a complex and dynamic system. Workforce **capacity** is well matched to the needs of communities and the population, both in number of staff and in how they are assigned.

Workforce **capability** includes providers and staff with the skills needed to help them deliver integrated people-centred care. They are equipped to respond to complex circumstances like chronic multimorbidity and persistent health inequalities. An education curriculum trains professionals to think and act inter-professionally and cooperatively. This helps build strong and trusting relationships among providers, across sectors, and with community partners.

Team-based care, creativity, continuous learning, and role flexibility is the norm. This amplifies the collective strengths of the team, manages complexity, and drives change. Individuals and teams are skilled in technology, project management, cultural responsiveness, change management, and leadership for a complex and adaptive system.

Together, workforce capacity and capability help providers find meaning and "joy in work"[32,33,34] and perform at their best to deliver integrated people-centred and safe care.[35] The work environment and work schedule enables balance in people's lives. It builds interdisciplinary teams and fosters communication. Staff participate in planning and decision-making.

Technology solutions: Technologies enable new options for care delivery and facilitate the timely exchange of data across the system.

[vii] Some jurisdictions integrate health and social service budgets.

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When equitably implemented and supported, technology and digital solutions offer innovative models of care delivery, especially with limited workforce capacity and in large geographic areas. Technologies enable timely, secure access and communication between care receivers, providers, and teams, and across sectors, to deliver coordinated, team-based care. They help patients be more engaged in their care, a key aspect of people-centredness. The health system identifies and addresses disparities in access, digital literacy, and comfort with technology across individuals and populations.

Various technologies support diagnosis, treatment, monitoring, and the scaling of sustainable alternative models of care delivery. This includes virtual care, telemonitoring, electronic health records, web- or mobile-based applications, wearable devices, machine learning, and artificial intelligence. Predictive models of care that use data and analytics to process real-time and historical data are leveraged to forecast individual and population health outcomes.

Technology supports wholistic care. Data sources and algorithms are free of biases that reinforce inequity.[36] Thoughtfully designed and managed artificial intelligence tools ensure the fullness of patient stories is documented accurately. Thus, patients' needs and values, not physical symptoms alone, inform care.

Different information systems, devices, and applications can 'talk to each other.' They can "access, exchange, integrate," and use data seamlessly within and across organizations and jurisdictions.[19,37] People's preferences, needs, goals, and strengths are the starting point for design and implementation.[36] Development includes co-design and early-stage testing to ensure technology meets the needs, preferences, and contexts of users (patients, clinicians, pharmacists, etc.).

Industry collaborates with universities and government to foster innovation in development and procurement. They test and evaluate – with users – the effectiveness, technical integration, and impact. Planning for adoption and integration with existing systems is part of phase-one development to reduce the burden associated with change in the work environment. Learning about successful technology solutions from other jurisdictions and health systems is encouraged.[38]

Interoperability occurs when capacity is addressed in key ways. Interconnectivity is established for systems, devices, and applications to exchange data. Format and rules are defined for data exchange. Standardized definitions and coding vocabularies are created to ensure shared meaning for users. Data sovereignty is upheld, including Indigenous data governance principles, and data-related inequities are addressed. Governance, policy, legal, and organizational functions support shared consent, trust, and integrated end-user processes and workflows.[19,37] Cyberthreats, funding needs, and regulatory barriers are managed.

Measurement and evaluation: By design, information enables continuous improvement.

An inclusive approach monitors, measures, researches, and evaluates data and information to support continuous improvement. Information is available about people's care experiences, perceptions of health and well-being, health circumstances and outcomes (e.g., symptoms, treatment effects, function, etc.). The social determinants of people's health, such as education and income, are considered.

Healthcare performance indicators, patient-reported outcomes or experience measures, and population health measures are included. The latter provides information about the many factors that influence individual and collective health. All sources of data and information are used and assessed at individual, community, and population levels.

This is done to examine whether people are receiving integrated people-centred care, if care-delivery models have shifted towards integrated people-centred care, and if an enabling environment has been created.

Equitable, people-centred health measurement practices are used. Such practices avoid measurement bias that overlooks or misrepresents the experiences of equity-deserving groups and perpetuates health inequities.[39]

Context-based, people-centred approaches reflect the diversity of people and their experiences. Inclusive qualitive methods are adopted, such as conversations and interviews. These make it easier for people to share their diverse perspectives of their health and healthcare experiences. By closing gaps in data and information, health inequities in needs, experiences, and outcomes can be addressed.

Within a trusting relationship, participants in measurement activities understand why their experiences are being measured and how their information will be used to support change and improvement. Learnings are shared across organizations and sectors to build a wholistic picture of how a system is performing.

Progress towards integrated people-centred care is understood as a journey. When defining what success will look like, and when it can be expected, many perspectives are considered (e.g., care receiver, provider, community, etc.). Everyone understands some of the benefits will only be realized in the medium to long term.

Evaluation planning is proactive and embedded into program planning and implementation. Appropriate measures and tools are developed to evaluate the effectiveness of changes made. The quality of engagement is also measured to assess people's experience of being engaged, the impact of engagement, and how well engagement as an organizational responsibility is being carried out.[40]

Implementation science is used to explore how, why, and which types of interventions (e.g., policies, programs, specific practices) work in particular contexts.

This supports reaching targeted populations and the spread and scale of effective interventions.[41] Further, implementation science offers insights into how implementation is (or is not) happening, and ways to revise – from different perspectives – strategies to achieving quality.

Cultural responsiveness: Capacity-building responds to diverse communities and contexts.

The health system has the capacity to respond appropriately to the preferences, needs, strengths, experiences, and contexts of diverse communities. Services are respectful of, and relevant to, communities' health beliefs, health practices, languages, and histories.[42] Cultural responsiveness "is

what is needed to transform systems," inspiring action across individual, organizational, and system levels.[43]

At the individual level, cultural responsiveness shapes how providers act and internalize what they learn from education, training, and listening to others' experiences. It enables them to experience and demonstrate cultural humility. They are able to see the "differences in power and privilege and the historical and contemporary inequalities that emerge in and from social and therapeutic relationships."[43]

At system and organizational levels, the cultural and historical factors that have influenced health system development and organization are acknowledged.[43]

This awareness leads to reform of high-level strategic governance structures and policies, so that cultural responsiveness is established as the norm across the health system. These efforts are vital to delivering culturally safe care and addressing inequitable experiences and outcomes for Indigenous Peoples and other communities facing systemic barriers.[25,44]

Meaningful engagement: People and communities have the knowledge and agency to co-create health solutions.

The strengths and capacity of people to make informed decisions about their health and healthcare is recognized and supported. Communities are engaged in creating and sustaining their own health and well-being, with the goal to "unlock community and individual resources for action on health."[6] People find it easy to get clear and relevant information from providers to self-manage their health needs and participate in care decisions.

Communities and individuals co-produce health services and healthy environments. They contribute to health policy by partnering meaningfully across sectors and roles. Deliberate efforts are made to include people and communities who have been excluded or underrepresented in decision-making. Supportive environments help people feel safe to contribute and share experiences, fostering mutual trust and belonging.

The health system mobilizes community resources using asset-based, community development approaches to build models of care delivery based on local strengths and goals. These efforts are foundational to an integrated people-centred health system; they bring forward lived experience, context, and strengths, leading to responsive and equitable policies, strategies, programs, and care decisions.

People-centred organizational culture: Interpersonal relationships thrive, and respect for people's potential is threaded throughout the organization.

Organizational culture reflects the values, beliefs, attitudes, and behaviours embedded in care settings and workplaces that shape how people and teams interact and how work is done. In essence, it is 'how things are typically done.'

People-centred organizational culture recognizes the potential of people individually and collectively. It sees and cares for providers (and all staff) as people, so the focus is *doing with* people rather than *doing to*.[45] Everyone, including unofficial leaders, contributes through their influence and strengths to act on the things they can change.

Ethical practice is expected and supported. Healthy interpersonal relationships are reinforced through mutual trust and open communication. Individuals recognize and respect the expertise of colleagues. They demonstrate compassion, curiosity, inclusivity, creativity, and flexibility in how they work with others. Learning is prioritized over judgment.

These conditions enable an environment where change can happen, and new ways of working can emerge. Monitoring and strengthening organizational culture supports progress across all dimensions of quality by highlighting how people can interact, collaborate, and improve care together.

As a people-centred organizational culture is sustained, shared beliefs, attitudes, and behaviours may spread beyond individual workplaces. This can influence how people work across organizational boundaries to lead change between services, professional groups, and organizations. Ultimately, such a culture is "about relationships and how mutual understanding of (the) needs and aspirations of people across all levels builds trust, commitment, and capacity to make things better for all."[46]

SHARED RESPONSIBILITIES

Shared responsibilities describe how people show up with and for one another across an integrated people-centred health system. They determine how the quality dimensions and enablers are lived in everyday practice. From policy to leadership and care delivery, collective commitment and action to these responsibilities strengthen connection, reinforce shared purpose, and support integrated people-centred care.[viii]

Communicating transparently: Information is shared clearly and accessibly to strengthen trust and accountability.

Transparent communication strengthens mutual trust and reinforces shared accountability. This occurs across care relationships, teams, organizations, sectors, and levels of the system.[48] It ensures information and decision-making is clear and accessible. People know how and why actions were taken. Information is complete, and communication is timely.

Across different roles and organizations, people have the information and opportunity to participate in decisions, and they feel safe in doing so. They can see how their input affects decisions and outcomes, reinforcing confidence in the process.

In an integrated people-centred health system, timely, transparent communication supports clarity, trust, and credibility among colleagues and in care relationships. People and communities are actively engaged in decisions that affect their health and well-being.

In practice, communicating transparently includes:

- Sharing information clearly, honestly, and in plain language people can understand and act on
- Disclosing uncertainty, limitations, risks, and trade-offs
- Clarifying decisions and processes and providing context
- Inviting questions, feedback, and input in an ongoing, two-way communication loop
- Owning mistakes, repairing gaps, and communicating about next steps

Cultivating relationships: Work is centred on mutual respect, shared knowledge, and co-created goals.

In an integrated people-centred health system, people understand care depends on relationships. They rely on one another across teams, professions, organizations, sectors, and communities. They work together to support people and improve care. Attention is paid to how systems, structures,

[viii] This framing is consistent with learning health system literature, which emphasizes that sustained improvement requires the shared commitment and coordinated action of individuals and organizations across governance, leadership, and care delivery roles.[47]

and everyday interactions affect people's experiences receiving, delivering, coordinating, and planning care — especially across differences in role, identity, and power.

Instead of short, task-focused exchanges, people build longer-term connections based on mutual respect, shared knowledge, common goals, and collaboration.[49] Everyone is part of a wider network of relationships stretching across time, setting, and context.

In an integrated people-centred system, the quality of these relationships is foundational to quality itself. Strong relationships help people coordinate their efforts, work through tension constructively, and build the collective capacity to manage complexity together.

In practice, cultivating relationships includes:

- Recognizing that care depends on relationships and is shaped by interactions
- Listening actively and valuing lived experience
- Being mindful of how actions, words, and decisions affect others, especially across differences in role, identity, and power
- Fostering mutual trust through respectful and ongoing interactions, not just one-off conversations
- Strengthening collaboration across roles, professions, teams, organizations, sectors, and communities

Demonstrating cultural humility: Practice is shaped by ongoing reflection on identity and context.

People show an ongoing openness to learning how identity and lived experience, as well as history, institutions, culture, and power, affect experiences for people and communities. They apply this learning in their practice.

Cultural humility understands culture broadly. It refers to the values, beliefs, and experiences that shape a person's viewpoint, and which they bring to their work. This can include professional training, work experience, communities of belonging, social position, religion, gender identity, ethnicity or heritage, and more.

People demonstrate cultural humility by accepting the limits of their own perspective and expertise and by approaching others with curiosity and respect, not assumption. This includes seeing oneself as a learner when it comes to the experiences of others. They think about which positions and perspectives have influence within care spaces and in health system planning, decision-making, and coordination. Efforts are made to shift these dynamics so that more perspectives and experiences are considered and practices are changed.

In an integrated people-centred health system, demonstrating cultural humility supports equity, deepens trust, and contributes to a culturally safe and inclusive health system.

In practice, demonstrating cultural humility includes:

- Examining one's own assumptions, biases, and social background
- Acknowledging power imbalances and historical and ongoing inequities
- Seeking and being guided by the experiences of people and communities and how they define 'safe'
- Embracing (un)learning and changing practice in response to feedback and lived experience
- Changing actions, communication, and decisions when experiences reveal harm.

Evolving continuously: Actions evolve collaboratively in response to feedback and change.

Across the health system, organizations, individuals, and teams stay open to learning and adjusting in complex and changing environments. People accept that uncertainty, new information, and unexpected outcomes are a normal part of a health system. Rather than reacting defensively or sticking rigidly to old ways of doing things, people and organizations remain alert to emerging evidence, lived experience, and changing community needs. Sustained efforts are supported by shared purpose.

A responsive approach relies on open reflection, shared problem-solving, and a commitment to learning together.[50] These practices help teams balance consistency with flexibility, sustain progress over time, and strengthen trust. They also build capacity across roles, teams, and organizations to handle complexity with integrity and confidence.

In practice, evolving continuously includes:

- Accepting feedback and changing an approach as the needs of individuals, communities, and contexts change
- Reflecting on and learning from experience, evidence, and outcomes over time
- Approaching concerns or unintended outcomes with curiosity and openness rather than defensiveness or blame
- Balancing consistency with flexibility when working in complex or uncertain situations

WHAT HAPPENS NEXT

Transforming a health system is a multi-stage, large-scale undertaking. This framework calls for a significant shift in thinking and practice across Alberta's health system.

It asks individuals and teams to understand people-centred care and to recognize that improvement in one dimension of quality requires attention to the others. It also emphasizes the importance of the enabling conditions of an integrated people-centred health system because these conditions shape *how* care is delivered, not just *what* care is delivered.

While the concepts shared here may feel ambitious, they respond to the lived realities of many people and communities. Change can begin right away through actions people take in their roles across the health system – how they communicate transparently, cultivate relationships, demonstrate cultural humility, and evolve continuously. At the point of care, this means asking: 'Who is this person, and how can we best work together on what matters to them?'

Decision-makers and leaders play a critical role in creating the conditions that allow this work to take root and flourish. This requires looking beyond organizational and professional boundaries and aligning policies, resources, and system priorities with the enabling conditions of an integrated people-centred health system.

As a starting point, this framework identifies areas where focused action is essential: strengthen collaborative governance, align funding to support integration and value, build workforce capacity and capability, cultivate a people-centred organizational culture, advance technology solutions that enable integration, embed measurement and evaluation for learning, promote cultural responsiveness, and enable meaningful engagement.

At the point of leadership and decision-making, this means asking: 'What matters to the people and communities we serve, and how can the conditions of the system support that?'

By stewarding these enabling conditions, decision-makers play a pivotal role in shaping a health system where integrated people-centred care is not the exception but the norm. Ultimately, these behaviours and conditions should translate into the experiences people have when interacting with the health system.

Across the health system, this means asking: "How can care be experienced as equitable, safe, accessible and timely, efficient and sustainable, effective, and integrated – in a way that is people-centred?"

Together, the shared responsibilities, enabling conditions, and quality dimensions described in this framework support a health system where people, communities, and those who provide care experience quality that reflects what matters most for health and well-being.

GLOSSARY

Communities: Groups of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or other settings.

Cultural humility: An ongoing practice of self-reflection and learning that recognizes how identity, experiences, history, culture, and power shape interactions with others. It involves approaching others with curiosity and respect, being open to learning from their experiences, and changing practice in response.

Cultural safety: An experience in which people feel respected, safe, and free from racism, discrimination, and other forms of harm. It requires ongoing attention to power imbalances, inequities, and practices that may cause harm and is ultimately defined by those experiencing care.

Determinants of health: The various biological, social, economic, and environmental factors that influence the health of individuals and populations.

Dimensions of identity: The many characteristics, attributes, and social factors that define a person's sense of self and shape their experience and perspective on the world.

Enablers: The structural, cultural, and operational conditions that support integration and allow improvement to be sustained over time. They shape the environment where care is delivered by influencing how priorities are set, how decisions are made, how resources flow, and how teams and organizations work together.

Integrated people-centred care: A catch-all term that refers to a type of health system, vision for health system transformation, improvement strategy, and a model of care delivery. It is described as a "fundamental design principle"[1] or "set of design principles"[2] because integrated people-centred care is understood as "so much more than the sum of a range of organizational processes acting at different levels".[1] In all forms, it is adopted for a similar reason: to shift thinking and practice in health system planning, decision-making, and care delivery – improving outcomes, quality, experience, and value.

Integrated people-centred health system: A health system organized around the wholistic preferences, needs, and strengths of people and communities, where people, providers, organizations, sectors, and governments work together to improve health and well-being. It is characterized by the quality dimensions and supported by the enablers and shared responsibilities described in this framework.

Lived experience: The knowledge, insights, and perspectives gained through direct personal experience of health, illness, caregiving, or interacting with the health system. Within this framework, lived experience is recognized alongside research evidence, professional expertise, and other knowledge systems to inform planning, decision-making, and improvement.

Patient partner: A person with lived experience with the health system who is in a formal role working collaboratively with the system.

Patient safety: The discipline of avoiding, preventing, and mitigating preventable harm or adverse events. It is an organized framework of activities designed to make medical harm arising from care delivery less likely and to reduce the impact of any harm that does occur.

People-centred: People-centredness builds on the concepts of patient- and person-centred. People-centred care more broadly considers a person's wants and needs, recognizes the role and capacity of communities in achieving health and well-being, and acknowledges the importance of seeing and caring for providers as people. People-centredness is based on collaboration and shared decision-making with the people and communities a health system serves.

Quality dimensions: Describe what people should expect from an integrated people-centred health system. They outline the types of care experiences, practices, relationships, and outcomes people should be able to count on.

Shared responsibilities: Practices that work within the enabling conditions of the system. They shape how people work, collaborate, learn, and respond across roles and organizations. As behavioural commitments, they strengthen the social fabric of the system through everyday interactions, decision-making, and how people show up for one another over time.

Wholistic: An approach that recognizes the whole person in the full context of their life, acknowledging the interconnected physical, mental, emotional, spiritual, socio-economic, and contextual factors that influence health and well-being.

Workforce capability: The qualifications, skills, and experience of a workforce, suited to a given workplace and supported by ongoing education and training, and the ability of individuals to build trusting relationships and work collectively and effectively across roles.

Workforce capacity: The productiveness of a workforce and its ability to function optimally, as influenced by how well it is matched to the needs of the environment, both in number of staff and how they are assigned.

APPENDIX I: Integrated People-Centred Care Frameworks

Organization	Title
World Health Organization	*People-centred health care: A policy framework* *WHO global strategy on people-centred and integrated health services: interim report* Framework on integrated, people-centred health services
Scaling Integrated Care in Context (Scirocco)	*SCIROCCO Maturity Model for Integrated Care*
Transnational Forum on Integrated Community Care	*Integrated Community Care 4 ALL Seven Principles for Care Strategy Paper to Move ICC Forward*
Healthcare Excellence Canada	*The Canadian Quality & Patient Safety Framework for Health Services*
Health Standards Organization	Integrated People-Centred Health Systems standard
International Foundation for Integrated Care	*9 Pillars of Integrated Care*
OECD (2021)	*Health for the People, by the People Building People-Centred Health Systems*

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