

**Lancet Global Health Commission  
on People-Centered Care  
for Universal Health Coverage**  
*Post-Convening Report*

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**Inaugural Convening**  
January 20-22, 2025

February 2025

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## Executive Summary

### Context and Purpose

From January 20-22, 2025, Harvard Medical School hosted the Lancet Global Health Commission on People-Centered Care for Universal Health Coverage, marking the first in-person gathering of the Commission and the official beginning of its work. This convening took place after a series of virtual Commissioner meetings in the fall of 2024, and it provided an opportunity for the Commissioners to build their relationships as colleagues while advancing the field of PCC. As governments worldwide struggle with widening health inequities, financing gaps, and evolving demographics and disease burdens, has emerged as a transformative paradigm—one that radically recenters individuals and communities at the heart of health system design, delivery, financing, and governance.

This inaugural meeting was an important step in the Commission’s work. By working to refine the Commission’s purpose and priorities, the intent was to move beyond conceptual discussions towards a structured research agenda. The objectives of the convening were as follows:



### Convening Objectives

- 1. Establish Strong Foundations for Collaboration:** Build relationships among Commissioners to ensure trust, understanding, and shared goals.
- 2. Achieve Conceptual Alignment on People-Centered Care:** Align on the philosophical underpinnings, definitions, and key principles of PCC.
- 3. Define Research Questions and Prioritize Aims:** Identify and prioritize the key research areas and questions for the Commission.
- 4. Organize into Functional Working Groups:** Form thematic working groups with purpose, collaboration plans and timelines

## **Key Outcomes**

During the inaugural convening, the Commission advanced its core objectives by accomplishing the following:

**Building Strong Foundations for Collaboration** – Commissioners fostered trust and forged deeper relationships through interactive activities such as a mini photo-based research exercise and other strategies for personal storytelling. By sharing diverse skills, personal experiences, and professional perspectives, participants created a solid bedrock for respectful critical discussion and inquiry.

**Moving Toward a Shared Understanding of PCC** – The group emphasized that PCC requires a broad, systems-level transformation rooted in concepts of personhood, dignity, and relational care, rather than only service delivery reform. Commissioners also explored the purpose and challenges associated with crafting a unifying definition, underscoring how it must be fit-for-purpose to shape broader policy and practice.

**Defining Research Areas and Questions** – Commissioners reflected on the findings of a broad literature scan and prior iterative discussions starting with themes from the previous virtual convenings to help shape the initial research agenda. Over the course of the two days, Commissioners began the process of developing a common foundational understanding regarding research principles and practices including participatory methodologies and community engagement which may be used in the ongoing work of the Commission.

**Organizing into Working Groups** – The Commissioners organized themselves into five working groups to advance the research agenda. These groups will ensure that a multiplicity of perspectives and approaches, spanning quantitative data, qualitative insights, and lived experience, guides the Commission's next phase of work.

## **Thematic Working Groups and Research Priorities**

The convening formalized five interdisciplinary working groups, each tasked with advancing key dimensions of PCC:

1. **Concepts, Definitions & Principles** – Establishing a shared framework for PCC, integrating personhood, human rights, and social medicine perspectives.
2. **Measurement and Outcomes** – Identifying existing evidence and gaps related to PCC and evaluating and developing measurement tools that capture both health system indicators and lived experience data to drive policy and accountability.

3. **Implementation Strategies** – Identifying evidenced-based and scalable PCC strategies and models and analyzing their enablers and barriers.
4. **Political, Social & Financial Enablers** – Evaluating policy levers, governance structures, social determinants, and financing mechanisms to enable PCC.
5. **Meaningful Engagement and Reflexivity** – Establishing best practices for embedding lived experience in health system design, delivery, governance, and improvement, ensuring that communities are co-creators of care models.

In addition, Commissioners discussed incorporation of an **individual-community-systems or micro-meso-macro organizational framework** across all working groups for both the report and Commission’s findings.

## **Next Steps**

Building on the momentum of the convening, the Commission outlined key next steps to advance the research agenda and operationalize the work:

**Clarifying Scope and Purpose** - The Secretariat will work alongside the Co-Chairs and Commissioners to narrow the scope of the research agenda of the Commission, to ensure it is highly impactful, feasible and purpose-driven. These guardrails will emerge from reflection on insights from the first convening and discussions with the Board of Advisors.

**Developing Research Frameworks** – Each working group will refine their research questions before conducting targeted literature reviews specific to their focus areas, using these findings to synthesize what is already known and identify whether/where new studies are needed. This evidence-driven approach will sharpen the focus and value add of the Commission and help support actionable, novel insights from each group.

**Second Global Convening in Bangkok, Thailand (August 2025)** – Hosted by the Thailand Ministry of Public Health’s Praboromarajchanok Institute (PBRI), this second in-person meeting will bring together preliminary findings from each working group, foster consensus on a unified research strategy and actionable plan and set the stage for strategic recommendations and advocacy.

## Overview of the Convening

### Participants

The convening brought together 32 of the total 34 Commissioners, a diverse, interdisciplinary group essential to advancing the PCC agenda.

1. **Luke Allen** – Co-Director, Global Primary Care, Oxford; Adjunct Associate Professor, UNSW
2. **Mark Barone** – Founder/GM, Intersectoral Forum of NCCs/NCDs in Brazil (ForumCCNTs)
3. **Lucía Feito Allonca** – Advisory Committee, Global Week for Action on NCDs; Registered Lawyer, Gijón Bar Association
4. **Stephen Bell** – Principal Research Fellow, Theme Lead: Social Science & Global Health, Burnet Institute
5. **David Duong** – Director, Global Primary Care at Harvard Medical School Center for Primary Care
6. **Sameh El-Saharty** – Senior Health Policy Advisor, World Bank
7. **Rushika Fernandopulle** – Co-Founder, Iora Health
8. **Tinashe Goronga** – Program Manager, EqualHealth Campaign Against Racism; Co-Founder, Centre for Health Equity Zimbabwe
9. **Kimberly Green** – Global Director, Primary Health Care, PATH
10. **Lisa Hirschhorn** – Professor, Feinberg School of Medicine, Northwestern University
11. **Beth Holt** – Associate Director of Health Systems, Global Primary Health Care, Harvard Medical School
12. **Nathan Hutting** – Associate Professor, Occupation & Health Research Group at HAN University of Applied Sciences
13. **Meena Isaac** – Assistant Professor, Community Medicine, Pushpagiri Medical College, Kerala
14. **Ruth Labode** – Director, Apple Pharmacy
15. **Xiaoyun Liu** – Deputy Director & Professor, China Centre for Health Development Studies, Peking University

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16. **Maureen Luba** – Senior Advisor, Global Policy, AVAC (**Virtual Attendee**)
17. **Maxo Luma** – Executive Director, Partners In Health, Liberia
18. **Adolfo Martinez Valle** – Head, Academic Unit, CIPPS at UNAM (Mexico)
19. **Brendan McCormack** – Head of School & Dean, The Susan Wakil School of Nursing & Midwifery, University of Sydney
20. **Sinit Mehtsun** – Executive Director, Health Systems Engagement, Gilead Sciences
21. **Stephen Mills** – Regional Director, Asia, EpiC Project, FHI 360
22. **Todd Pollack** – Director, Implementation Science, Global Primary Health Care, HMS
23. **Steve Reid** – Director & Chair, Primary Health Care, University of Cape Town
24. **Magda Robalo** – President & Co-Founder, IGHD, Guinea-Bissau
25. **Rosanne Rotondo** – Head, Global Health Access, Novartis Global Health
26. **Diah S. Saminarsih** – CEO & Founder, CISDI
27. **Glenda Sandy** – Advisor, Infectious Disease, Dept. of Public Health, Nunavik Regional Board of Health & Social Services
28. **Anthony Paulo Sunjaya** – Senior Lecturer, School of Population Health, UNSW Sydney; The George Institute for Global Health
29. **Carolyn Taylor** – Founder/Executive Director, Global Focus on Cancer
30. **Bach Xuan Tran** – Professor, Vice Head, Department of Health Economics, Hanoi Medical University
31. **Lavanya Vijayasingham** – Independent Global Health Research Professional
32. **Maxine Anne Whittaker** – Professor, James Cook University

**Absent:** Duc Anh Ha, Ibtihal Fadhil

Several members of the Board of Advisors, including Arthur Kleinman, Harold Nusser, Vichai Tienthavorn, and Cynthia Rayner participated in-person.

The convening was supported by members of the secretariat including Beth Holt, Todd Pollack, David Duong, Katie Cavender, Andrea Docanto, Erin Farren, Travis Songer, Lillian Zerihun and Shawna Novak, and Harvard students, including, Maria Kartika, Cinta Nurindah, Falguni Basnet, Saravanan Thangarajan, Aneesh Mazumder, Ernest Yip, Mariely Nunex, Natalie Sinjaradze, and Stella Zhang.

## Agenda Summary

Please see [Appendix A](#) for the full agenda.

### Day 1: Foundations and Conceptual Alignment

The first day of the Convening was devoted to forging relationships and a shared understanding of the Commission’s purpose, values, and key concepts related to PCC. This opening day combined storytelling, conceptual discussion and reflection, and engagement with preliminary literature findings to set the stage for deeper collaboration and action planning.



Commissioners gathered over breakfast to explore a Photo-based Research Exercise Gallery, where Commissioners shared personal images and narratives about themselves, their lived experiences and perspectives on PCC across diverse cultural contexts. Two commissioners, Carolyn Taylor and Lavanya Vijayasingham, then offered personal stories on how their respective journeys in global cancer advocacy and health systems research had shaped their views on empowering people with lived experience and communities. This opening session not only underscored how personal storytelling can illuminate systemic healthcare challenges but also reminded participants that PCC can be rooted in authentic human relationships.

After a brief logistical overview led by Todd Pollack, the conversation shifted to co-creating the Commissioners’ Group Agreement. Guided by Bethany Holt, Commissioners were provided with question prompts to spark dialogue on what norms and conditions foster an inclusive, respectful environment. Through small-group deliberation, participants outlined the conditions most important

#### **Our ‘living’ agreement to one another**

1. **Demonstrate respect** (“*every voice counts*”) - be present, active listening, no interruptions and be concise to allow space for everyone
2. **Communicate inclusively** (“*people process differently*”) - speak slowly, soft (inside) voices, allow verbal and written contribution and time for thinking/reflection, avoid jargon,
3. **Practice humility** (“*no right or wrong answers*”) - be self-aware and curious, assume good intent, identify common ground, remain open to new/different ideas and seek to understand each other
4. **Value authenticity** (“*we all have a story*”) - protect confidentiality, build trusting relationships, show empathy and kindness, acknowledge triggers and offer support, learn from lived experience, validate all perspectives
5. **Adopt growth mindset** (“*yes, AND*”) - ask for/provide clarification, embrace tension and diversity, productively challenge, give/receive feedback, offer actionable insights, be solution-oriented

<https://miro.com/app/board/uXjVL3HRYFM=/>



to them to be able to share their diverse perspectives and work effectively together, harnessing challenges as productive friction. These were consolidated into 5 commitments (see Figure 1).

The Personhood Panel, moderated by David Duong, provided deeper insight into the philosophical and cultural foundations of PCC. Board of Advisers member Arthur Kleinman, stressed the importance of comprehending people’s local worlds to ensure care remains person-centered, particularly for older adults with chronic illnesses shared through his lens as a caregiver to his late-wife with Alzhiemers. Drawing from her Indigenous heritage, nurse and educator Glenda Sandy described how colonial legacies influenced health outcomes and why cultural context is a source of strength. Reflecting on race and sexuality in Zimbabwe, physician-advocate Tinashe Goronga highlighted intersectional barriers to care. Physician and cancer survivor Meena Isaac shared how spirituality shaped her understanding of personhood in resource-constrained settings, and nursing scholar Brendan McCormack explored the tension between institutional “lofty claims” and lived realities, emphasizing authenticity and relational commitment. **Together, their deeply personal reflections underscored the need to balance the global scope of the Commission with an understanding of individual and local contexts that must shape our understanding of PCC.**

Following lunch, Steve Bell drew on his extensive experience in participatory research methods to illustrate key themes emerging from the Commissioners’ photo-based research exercise, in which they responded to the prompt: *‘Share 1-2 photos that tell us something about PCC in action (i.e. What is working? Where have experiences of care fallen short?); feel free to draw on your personal and/or professional experiences.* Themes that emerged from the qualitative analysis are captured in Table 1. **By showcasing Commissioners’ perspectives that highlighted both local innovations and systemic inequities, this session demonstrated the varied ways communities worldwide define and experience PCC.**

*Table 1: Themes from Photo-based Research Exercise, Part 2 (PCC)*

Theme	Examples/Details
Working with, alongside and in partnership with communities	<ul style="list-style-type: none"> <li>• Co-design, service/care delivery, evaluation, accountability</li> <li>• Shared decision making</li> <li>• Lived experience expertise</li> </ul>
Models of care provision	<ul style="list-style-type: none"> <li>• Care brought to communities</li> <li>• In clinics, communities and homes</li> <li>• By governments, NGOs and private sector organisations</li> </ul>

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Relational, social and emotional aspects	<ul style="list-style-type: none"> <li>• Service providers, families, parents, patients, children</li> <li>• Multiple forms of social support</li> <li>• *felt* by all</li> <li>• Beyond illness, disease, biomedical, to include stigma, abandonment, pressures (financial, parenting)</li> </ul>
Focus on the workforce	<ul style="list-style-type: none"> <li>• Need to be resourced</li> <li>• Interdisciplinary and responsive to needs of population</li> <li>• Comprise paid and voluntary people</li> <li>• Challenges of communities becoming staff</li> </ul>
Costs and resourcing	<ul style="list-style-type: none"> <li>• Enough trained staff / services / beds / food / basic comforts / equipment / supplies</li> <li>• Wasted money</li> </ul>
Efforts across multiple levels of society	<ul style="list-style-type: none"> <li>• Laws, policies, social norms, health systems, health services, health providers, communities, families, individuals</li> </ul>
Outcomes	<ul style="list-style-type: none"> <li>• Equity, dignity, connection, overcome health disparities, fairness, equality, privacy, comfort, engagement, trust, voice, valued</li> </ul>
Need for new / alternative ideas	N/A

Commissioners then turned to review the initial findings of a literature scan / bibliometric review, which was led by Secretariat Member, Dr. Lillian Zerihun with support from HMS students and trainees. This preliminary analysis, which drew from nearly 4,000 peer-reviewed articles published from 2014 to 2024, revealed a pronounced bias of published literature on PCC toward high-income countries, conditions related to the elderly and chronic diseases, and a dominance of qualitative and descriptive studies. Notably, there was a lack of research on financing PCC aspects, as well as on interventions targeting marginalized populations such as LGBTQ+ groups, Indigenous populations, individuals with disabilities, and pediatric cohorts. The analysis revealed that certain types of studies, conditions and settings were more likely to be explored in HIC contexts than LMIC contexts (see Figure 2). **The discussion that ensued recognized both the importance of localized case studies from underrepresented regions and the need to widen the scope of future searches to**

include the grey literature and non-English language sources. (See [Appendix B](#) for complete findings)

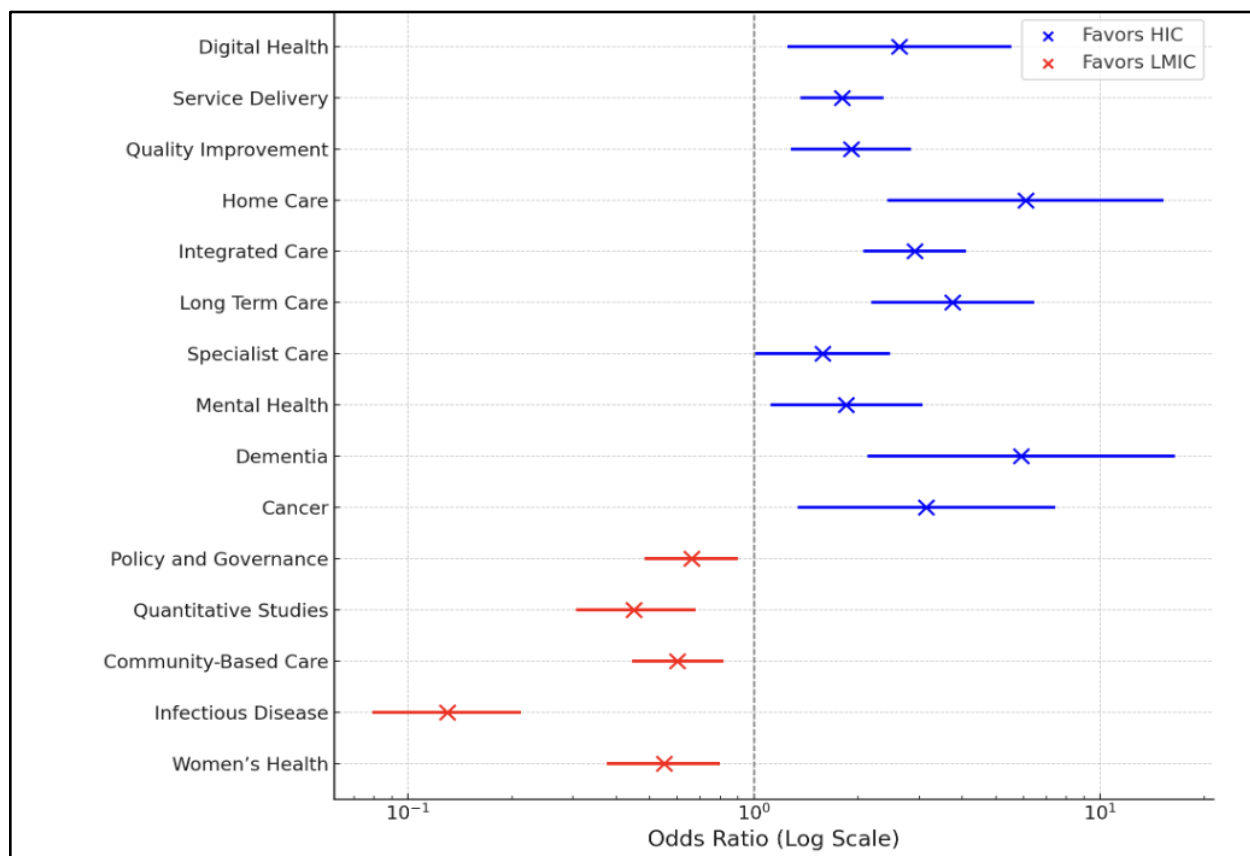


Figure 2, b) Odds of study on PCC (2014-2024) being conducted in high-income countries.

Building on these insights and prior discussions, David Duong facilitated an interactive brainstorming session on the major research domains to be tackled by the Commission. Six broad areas, synthesized from previous discussions in virtual meetings, were discussed: **conceptual alignment and definitions, evidence of outcomes, measurement and targets, implementation strategies, political, social, and economic enablers, and mechanisms to ensure meaningful engagement of people with lived experience.** By working in small groups, Commissioners surfaced critical questions for each domain, highlighting, for instance, the tension between aspirational definitions of PCC, existing definitions for PCC (i.e. the World Health Organization) and the everyday realities of frontline care systems.

The afternoon concluded with mini skills-building sessions offered by three Commissioners identified by the Secretariat to advance the work of the entire Commission: Luke Allen led discussions on foundational research methodologies, Maxine Whittaker introduced community-engaged research and monitoring approaches, and Steve Reid focused on community-oriented primary health care. **These sessions provided commissioners with theoretical and practical approaches to benefit the work of the Commission moving forward.**

The day ended with a collective reflection facilitated by Beth Holt. Participants shared their main takeaways, responding to a digital feedback form encouraging them to consider what perspectives or assumptions they carried into the discussions. Overall, the first day established a spirit of trust and collaboration and helped Commissioners immerse in the academic and social context for the Commission's subsequent work. By combining personal narratives, a conceptual exploration of personhood, empirical evidence from the literature scan and photo-based research exercise, discussion on preliminary research domains and skill-building exercises, **Day 1 laid a robust foundation for Commissioners to shift from building relationships and dialogue to generating concrete research aims and working group formation on Day 2.**

## **Day 2: Structuring and Operationalizing the Work**

The second day opened with a brief review and reflection on feedback gathered from Day 1. Many participants expressed the need for more frequent large-group discussions, clearer definitions of PCC and UHC, and short summaries after each session to reinforce shared understanding. This feedback shaped how Day 2's sessions were structured, building on the Commission's living agreement that emphasizes respect, inclusiveness, humility, authenticity, and a growth mindset.

To spark creativity and personal connection, Commissioners participated in an art reflection activity during which they browsed a gallery wall, chose a piece of art that resonated with a particular prompt, and shared their interpretations with peers. This exercise served as a warm-up to deeper group work, reminding participants that PCC is deeply intertwined with individual experiences and collective storytelling.

The morning continued with deeper discussion on six research areas, synthesizing and building on the previous day's brainstorm. Commissioners underwent a prioritization exercise in which they individually read through synthesized insights and questions within each of the six consolidated research areas (Concepts and definitions, Benefits and outcomes, Measurements and targets, Implementation strategies, Political, social and financial enablers, and Meaningful engagement). Todd Pollack facilitated feedback from all Commissioners in a large group on each of the six research areas individually to ensure that the key issues for each research area was captured and to

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obtain consensus on what was in-scope and what was out-of-scope for each research area. After consensus was reached on each research area, Bethany Holt then synthesized the live discussion for the large group. These considerations for each working group are included later in the report within each working group session.

Before lunch, Commissioners self-organized into the six working groups corresponding to these research areas. Each Commissioner was encouraged to join the group that best suited their expertise and interests, while also ensuring diversity of perspectives and regional representation. Over lunch, these newly formed groups introduced themselves more informally, laying the groundwork for collaboration.

After lunch, the working groups launched into a more structured action planning session. A methodology, “Claims, Concerns, and Issues” (CCI), was introduced by Brendan McCormack for the Working Groups to use to help further refine their research aims. In addition, working groups were asked to:

1. Draft a statement of intent articulating their core purpose.
2. Develop three to five preliminary research questions that aligned with the Commission’s broader mission
3. Nominate co-chairs responsible for guiding the group’s progress, ensuring coordination among groups, and maintaining close ties with the Secretariat.

By late afternoon, each working group presented its early outputs, highlighting draft research questions, identifying group leadership, and next steps. These updates were woven into a roadmap for the Commission’s next convening, scheduled for August 5-7, 2025 in Bangkok. Participants reaffirmed their commitment to present progress on research and recommendations at that meeting, maintaining momentum between in-person gatherings.

The day concluded with a reminder to complete a final survey, which would gather feedback on Day 2’s structure and content. By the end of Day 2, the Commission had coalesced around specific research domains, mapped clear responsibilities, and laid the foundation for a sustained, collaborative effort to execute the Commission’s mandate in 2025.

## Working Groups Discussions and Considerations

The next section of this report compiles working groups' preliminary statements of intent and research questions, summarizes their discussion points as well as the relevant considerations raised in the larger group discussions to take forward in each working group's work.

### Group 1- Concepts, Definitions & Principles

The **Concepts, Definitions & Principles**: Working Group will focus on ensuring that any PCC definition and frameworks adopted by the Commission remain adaptable across diverse cultural and health system contexts. This group seeks to clarify and interrogate existing definitions of PCC, and build on the Shared Understanding developed by the Commissioners in the previous virtual Convening (see Figure 2). It will also investigate the role of PCC and meaningful engagement of people with lived experience in enabling UHC.

### **Shared understanding of people-centered care**

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**Recognition of personhood:** People-centered care prioritizes the holistic needs, values, identities, and cultures of individuals and communities, recognizing and respecting their personhood—their intrinsic dignity, rights, and unique lived experiences—beyond their roles as patients.

**Holistic approach:** People-centered care integrates diverse perspectives, including caregivers and marginalized groups, and moves beyond clinical care to embrace broader concepts of health shaped by social, cultural, and economic factors.

**Empowerment and shared partnership:** People-centered care ensures individuals and communities' active and meaningful participation in their own healthcare, as well as in designing, delivering, and evaluating healthcare while emphasizing equity, respect, active participation, and shared governance to address power dynamics.

**Sustainable impact on health systems:** People-centered care fosters equitable, sustainable, inclusive, responsive health systems that aligning health and social policies and support Universal Health Coverage.

*Figure 3, Shared Understanding of PCC Co-developed by Commissioners prior to Convening*

**Members:** Brendan McCormack, Steve Reid (Co-Chairs), Glenda Sandy, Nathan Hutting, and Meena Isaac. Liaison from Group 6 will be Lucia Feito Allonca.

**Guidance provided by Commissioners to the Working Group as input for their work:**

- Define key terms: person(hood), care, caregivers, health, PCC, meaningful engagement of people with lived experience
  - Build on existing definitions (especially WHO's), but critically evaluate and acknowledge limitations, describing alignment (or not) with Commission's perspective
  - Define inclusion/exclusion for the purpose of the Commission/other Working Groups
- Consider whether PCC can be a globally relevant concept, or need local adaption; highlight differences across culture, context (public private, income levels), lifecourse
- Defining the relationship between PCC and UHC within the concepts and definitions
  - Should the link focus on coverage and equity, or more on financial hardship and sustainability?
- Consider whether we explicitly include human rights and the social determinants of health in the definition of PCC; if not, then acknowledge their importance

**Summary of Working Group Discussion:**

The discussion in Working Group 1 explored the central role of communities in achieving universal health coverage (UHC), emphasizing that community-led approaches may be more effective than traditional health systems. There was a strong call for conceptual clarity on PCC to guide both the commission and its Working Groups. The group discussed the need to expand the boundaries of what constitutes the health system, ensuring inclusivity and responsiveness to the needs of individuals and communities. PCC was highlighted as essential to achieving UHC, positioning people as the defining lens through which universality is understood. It was noted that PCC reintegrates individuals into the healthcare system and reintroduces communities into the conversation about care, reinforcing person-centeredness as a fundamental component of healthcare quality. Additionally, PCC was seen as a mechanism for addressing blind spots and breaking down barriers that limit access to care.



Concerns were raised regarding potential criticism of the framing and definition of PCC, particularly regarding its scope and measurability. Some participants worried that the concept could be too broad or abstract, making it difficult to implement in a meaningful way. There were concerns that PCC could be framed in isolation from broader wellness considerations, leading to an incomplete understanding of health. The ambiguity surrounding the definition also presented a challenge in terms of developing measurable indicators for evaluation. Participants cautioned that PCC could become an empty vessel if not framed effectively, potentially losing its core essence. There was also apprehension that the term “care” might be misinterpreted as referring primarily to biomedical management rather than a more holistic approach. Additionally, concerns were raised that outliers—particularly marginalized and underserved populations—might not be adequately included in the framing of PCC, leading to gaps in implementation.

Several critical issues were identified for further exploration. The group sought to articulate a clear pathway from person-centeredness to UHC, ensuring that PCC is not only conceptualized but also operationalized in a way that supports policy and systems change. A comparative analysis was suggested to examine healthcare systems with and without PCC principles, illustrating the impact of people-centered approaches on health outcomes. Participants also discussed the metaphor of PCC as a “vessel” and deliberated on the essential elements necessary for it to remain sustainable and impactful. Further questions were raised about how defining and framing PCC could contribute to long-term implementation, ensuring that it remains a viable and transformative approach. The challenge of developing an inclusive framework without being overly broad was also explored, as was the question of whether PCC should be framed as a rights-based approach, emphasizing health as a fundamental human right, or as a practical mechanism for improving health systems and achieving better outcomes.

#### **Draft Statement of Intent:**

We will frame the concept of people-centred care for universal healthcare coverage and provide a definitional lens through which the work of the Commission will be envisioned.

#### **Revised research questions (V3, February 25)\***

1. What definitions of person and people centredness in healthcare exist in the literature that will be helpful to our framing?
2. What are the essential practical components of people-centred healthcare?
3. How can a rights-based approach to UHC be enabled by people-centred healthcare?

*\*Please note these were updated post convening in order to provide timely feedback and guidance to the other groups.*



## **Group 2 and 3 - Measurement and Outcomes**

The Measurement & Outcomes group seeks to examine existing evidence in support of PCC, and evaluate and/or develop robust methodologies for capturing its holistic value to people, providers and health systems, beyond traditional biomedical measures of quality.

**Membership:** Anthony Sunjaya, Luke Allen (Co-Chairs), Adolfo Martinez Valle, Stephen Mills, Xiaoyun Liu, Lisa Hirschhorn, Sinit Mehtsun, Bach Tran and Bethany Holt. Liaison from Group 6 will be Steve Bell.

### **Guidance provided by Commissioners to the Working Group as input for their work:**

- Develop an interactive logframe/theory of impact for why PCC (and/or its specific or unique components) has benefits/value to health status and systems
  - Must follow from our agreed definition
  - Reflect on whether there are any downsides to developing a new theory of impact/change compared with adapting an existing one (e.g., UHC, SDoH)
- Critically evaluate current state of evidence that PCC is beneficial/valuable for different groups/levels
  - e.g., Care-seekers (patients), Care-providers, Communities, society and the environment, Health systems, UHC and financial sustainability
  - Consider wider scope of evidence including grey literature, non-english publications
- Describe and critically evaluate current tools, metrics and process for measuring PCC at different levels/ audiences / purposes
  - Include quantitative and qualitative measures
  - Consider implications for different cultures, contexts, sectors, income levels, fragile and conflict affected settings and how to adapt measures to reflect localization
- Refine, propose and test new tools and metrics



- Agree on “good enough” measures that are possible to measure, fit-for-purpose and can drive accountability and improvement
- Aim to move beyond proxies where feasible
- Consider ‘tracer’ indicators
- Include, elevate, lead on engaging people with lived experiences in developing and measuring PCC, using community-engaged methods
- With respect to feasibility, examine what can be used from existing large datasets and surveys, including possibility of adding new questions to existing surveys
- Consider the pros/cons and develop of a ‘maturity model’ or gradient for measuring PCC,
  - Acknowledge status is dynamic and should evolve over time
  - Consider how to use comparison within and between countries to drive improvement (e.g., use of scorecards)
- Address whether PCC is a means to an end, or an end/outcome itself
- Understand different research and measurement paradigms, and make it clear who is defining what is ‘valuable’
- Review lessons from implementation science about improving PCC
- Propose (aspirational) target(s) to generate action and accountability that are linked to proven/agreed benefits of PCC

**Draft Statement of Intent:**

Demonstrate the value of PCC and provide tools to measure it in order to improve the quality of care.

**Preliminary Research Questions:**

**Measurement:**

1. What metrics and tools have been used to measure PCC?
  - a. What are the learnings from measurement tools from related areas?
  - b. What are the right measures of outcomes?
  - c. What are the other measurement frameworks which are needed (ex. context)?

- d. What is missing? What components aren't being measured appropriately at the moment?
2. What are the potential data sources to measure PCC?
3. How do you measure meaningful engagement of people with lived experience?
  - a. What approaches are there to meaningfully involve people with lived experiences in the measurement of PCC?

**Outcomes:**

1. What outcomes have been reported for PCC and its associated components?
  - a. Measurement of outcomes?
  - b. What is the evidence that PCC can improve the outcomes?
  - c. What are the gaps? (scoping review)
2. Who are our decision makers and what evidence to they need to support the implementation of people centred care? outcomes and process? context?
3. Which gaps matter most to decision makers and how can we fill these gaps?

**Key Areas of Working Group Discussion:**

The discussion in Working Group 2 and 3 centered on establishing a clear framework for measuring PCC and understanding its impact across different levels of healthcare systems. Participants emphasized the importance of learning from existing community-based organizations, particularly those led by marginalized populations, citing strong evidence supporting their cost-effectiveness and contribution to better health outcomes (even if not cited in the academic literature). They highlighted that diverse measurement tools already exist, with shared themes across settings, though there are still areas needing improvement. Given the vast amount of data available, it was suggested that a careful review could help extract meaningful indicators of PCC processes and outcomes. Following a PCC approach was seen as essential to shaping broader health systems and improving population health, with the understanding that almost all health-related activities have some element of PCC within them. To fully capture its impact, participants advocated for the inclusion of non-traditional and non-academic measurement methods, such as visual storytelling and narratives, in addition to conventional qualitative and quantitative research. They proposed conducting scoping reviews to consolidate

existing knowledge, explore key themes, and develop a phased approach to guide the practical implementation of PCC measurement. The group also stressed the importance of incorporating multiple perspectives, including those of specialists, healthcare providers, and communities, to refine the understanding of PCC and ensure its applicability across different contexts.

Despite these promising discussions, several concerns were raised. One significant issue was the geographical disparity in PCC evidence, with limited research available in low-resource settings and among populations with minimal healthcare access. There was also apprehension about potential unintended consequences, such as whether PCC might inadvertently disadvantage lower-income groups. The lack of a universally agreed-upon definition of PCC was seen as a barrier to consistent measurement, with participants acknowledging the challenge of balancing specificity with broad applicability. They noted that policymakers might not prioritize process-based measures, and there was a risk that proxies could be used instead of metrics that truly reflect people's experiences and needs. Concerns were also raised about whether the scope of the discussion was too broad, making it difficult to develop a focused and actionable framework.

Additionally, the evolving nature of digital healthcare was discussed, with some participants questioning whether current PCC frameworks are responsive to emerging technologies. Some worried that the group might end up duplicating existing work rather than adding new insights, and there were concerns about epistemic tensions between different perspectives on what constitutes valid evidence. There was also an acknowledgment that key stakeholders, including organizations like WHO and other major players in global health, might not be fully engaged in these conversations, potentially limiting the influence of PCC-focused research.

The group concluded the discussion by reflecting on key questions that should guide future work. These included how PCC has been measured historically, what specific outcomes have been associated with it, and what gaps remain in the current evidence base. They debated what elements are essential to a successful PCC framework and how best to ensure that lived experiences inform measurement and implementation strategies. Additional questions were raised about how different stakeholders define success and what kind of data would be most compelling for policymakers and funders. There was also interest in exploring whether global PCC measures could be adapted to different country contexts and how they could be integrated into existing health data collection systems. The group discussed the potential contributions of implementation science in advancing PCC, particularly in

moving beyond proxies and ensuring that measurement tools reflect the priorities and preferences of communities. They concluded that future work should include a structured review of existing measurement tools, identify best practices from other health initiatives, and explore innovative ways to document and analyze PCC outcomes to drive meaningful change in healthcare systems.

## **Group 4 - Implementation Strategies**

The **Implementation Strategies** working group will examine how PCC practices and models of care—especially those led by communities—could be scaled and adapted across various health systems.

**Membership:** Kimberly Green, Rosanne Rotondo (Co-Chairs), Sameh El-Saharty, Rushika Fernandopulle, Todd Pollack, Maxo Luma, Ibtihal Fadhil. Liaisons from Group 6 will be Carolyn Taylor and Maureen Luba.



### **Guidance provided by Commissioners to the Working Group as input for their work:**

- Review evidence and provide examples of implementation strategies intended to advance PCC
  - Identify what works, and what doesn't; but be mindful of what is considered enough evidence to influence actions from key parties, that nothing is perfect
  - Explore HOW it works (implementation science informed)
  - Ideally present strategies on levels - personal/individual, community/institutional, health system (identified as a useful structure for the whole report)
- Examples strategies (not exhaustive):
  - Role of accompaniment
  - Advancing health literacy and community literacy
  - Social prescribing, spiritual care, and traditional practices
  - Caregiver capacity building and incentives, including upstream pre-service education and ongoing, implementation science-informed quality improvement
  - Role of technology, with consideration for digital literacy

- Discuss how to scale and replicate interventions from pilots/project to subnational, national, transnational levels
- Support, elevate and learn from community health workers - part of the care team - and ones with access, trust and knowledge of people (“not train it out of them”)
- Utilize case studies that others can learn from
- Examine how to develop approaches that are universal but reflect local worlds
- Consider how we can use community-led and co-created approaches to ensure sustainability and ownership
- Explore accountability mechanisms required to ensure progress
- Understand how traditional indigenous perspectives and practices can be integrated into PCC
- Examine can we learn from vertical programs; but ensure that PCC doesn’t become a discrete program / silo and rather an approach that strengthens the entire system
- Include the private sector and funders across spectrum of activities

**Draft Statement of Intent:**

Propose concrete implementation strategies that effectively deliver PCC at scale.

**Preliminary Research Questions:**

1. What are specific evidence-based PCC interventions (?strategies) - evidence-based PCC interventions and approaches?
2. What are specific evidence-based or promising PCC interventions and approaches (in peer reviewed and grey literature)?
3. What are barriers, enablers, and failures in the delivery of PCC ?
4. What are barriers, enablers, and failures of evidence-based and/or promising PCC intervention and approaches
5. What are the common and outlier learnings from selected PCC case studies that enabled scale? From service/site/country lens, and from different elements of health systems building blocks
6. What are effective strategies to enable social participation and meaningful people/community power and voice in PCC?

**Key Areas of Working Group Discussion:**

The discussion in Working Group 4 focused on the challenges and strategies for effectively implementing PCC at scale. Participants emphasized that while PCC is an aspirational model, most healthcare systems do not currently function in a truly people-centered way. There was a strong focus on understanding how to transition from theory to practice, identifying what it takes to scale PCC strategies and approaches. It was noted that much of the evidence for PCC exists at the service level rather than at the systemic level, which makes broader implementation more complex. Leadership was seen as a key factor, with examples such as Rwanda's health reforms demonstrating how governance and leadership can drive sustainable PCC models.

Concerns were raised about the resistance that can emerge when shifting power toward patients and communities, particularly among institutions and policymakers who may fear losing control. There was a recognition that barriers to PCC implementation include financial constraints, regulatory frameworks, and entrenched hierarchies within healthcare systems. Participants underscored the importance of demonstrating to stakeholders that empowering people in their own care ultimately leads to positive health and system-level outcomes. They discussed the need for adaptable strategies that consider varying contexts and highlighted the importance of small, iterative improvements that can lead to significant systemic changes over time. The discussion also covered the importance of evaluating both the successes and failures of PCC implementation, ensuring that lessons learned from previous efforts inform future strategies.

A key theme in the discussion was the necessity of strong evidence-based approaches to PCC. Participants emphasized that before considering how to implement PCC, there must be a clear understanding of what is effective and why. The need to examine enabling factors, contextual influences, and policy durability across different health systems was highlighted, with examples from India and Colombia illustrating how similar policies can yield different results based on governance, corruption, and resource allocation. A scoping review was proposed to synthesize meaningful insights from interviews and existing data sources, drawing on perspectives from key organizations such as WHO and the World Bank. The group also recognized the value of case studies in understanding PCC at different scales, including national-level implementations that had varied outcomes depending on contextual factors.

The conversation also addressed broader health system enablers, particularly the role of primary care platforms and the community health workforce in supporting PCC. Participants stressed the need for systemic analysis to ensure that PCC principles are embedded within national health systems rather than being implemented in isolation. Flexibility and adaptability were highlighted as key approaches to ensure successful implementation. There was also discussion on the importance of identifying “outlier” countries that have successfully implemented PCC models and extracting lessons from their experiences. Examples such as Costa Rica, which prioritized healthcare funding over military spending, were cited as potential models for other nations to learn from. The need for deeper engagement with implementation science methodologies was raised, with a focus on ensuring internal and external validity while allowing for contextual flexibility.

When discussing key research questions, participants debated the need to ensure that PCC remains a comprehensive model rather than being narrowly disease-focused. While much of the existing literature on PCC is concentrated on HIV, there was a call to expand the research base to include other areas of healthcare. There were also concerns about the lack of legally binding commitments to PCC, with participants citing Ghana as an example where healthcare programs continued primarily due to external funding rather than government obligation. The discussion also touched on the political dimensions of PCC, emphasizing the role of public accountability in ensuring that governments prioritize people-centered policies (noting some potential overlap with Group 5). Examples from Liberia and Egypt illustrated the importance of political commitment and long-term partnerships in sustaining PCC reforms.

UHC was identified as an overarching goal, with participants debating whether PCC should be seen as a component of UHC or as a fundamental principle guiding its implementation. Some argued that UHC is an all-encompassing concept that integrates multiple elements, including PCC, while others highlighted the need to explicitly position PCC as central to achieving UHC. There was a strong consensus on the need to link PCC to established global health goals, recognizing that all country members have already committed to achieving UHC, which provides a powerful advocacy tool for embedding PCC principles into policy and practice.



## **Group 5- Political, Social & Financial Enablers**

The **Political, Social & Financial Enablers** group will explore the systemic enablers needed to support PCC in the long term, from the macro (health system/governmental) level.

**Membership:** Diah Saminarsih, Tinashe Goronga (Co-Chairs), Ruth Labode, Magda Robalo. Liaisons from Group 6 will be Mark Barone and Lavanya Vijayasingham.



### **Guidance provided by Commissioners to the Working Group as input for their work:**

- Describe the intersectoral, whole-of-society, macro-level enablers of PCC, utilizing existing enabler frameworks to capture wider context
  - For example: governance models, education, policies, economic development, gender equity, human rights, disability, social inclusiveness
  - Distinguish this from more downstream strategies (addressed by group 4)
- Evaluate whether our current health financing models are people-centered (or not); what do they incentivize/value
- Ask who should pay for UHC and how? Consider the proposal to structure a global alliance for PCC in a UHC fund?
- Explore alignment between PCC and SDGs with view of influencing the post-SDG agenda
- Acknowledge how historical and present-day (intersectionals), power dynamics have influenced PCC and UHC
  - Consider how economic imperialism comes into play as a barrier to PCC
  - Examine the impacts of the medical-industrial complex, political economy

- Consider impacts of environment and climate (One Health)?
- Develop approaches for top down and bottom up coalition building - both private sector and civil society - to generate solutions and hold accountability

**Statement of Intent:**

*In Development*

**Preliminary Research Questions:**

1. What factors contribute to the success of PCC interventions? What made it work? (i.e. political commitment, governance models and mechanisms, donor funding, accountability, and insurance schemes)
2. What are the barriers to achieving success? How can they be avoided/reduced/overcome? What made success not sustainable?
3. What are examples of successful models from countries that demonstrate effective strategies for scaling and sustaining?
4. How do social, economic, and other determinants as well as gender inequities disproportionately affect certain populations?
5. Where will the funding and technical resources for PCC come from? How could it be integrated into current practices of care and prevention?
6. How do we scale PCC?
7. An ecosystem consists of people and different sectors; how do you get people into/demanding PCC? How do we include diverse stakeholders and create incentives that align across sectors?

**Key Areas of Working Group Discussion:**

The discussion in Working Group 5 focused on the intricate relationship between political, social, and economic determinants of health and their impact on healthcare outcomes\*. Participants emphasized that every action in the health ecosystem has broader political, social, and economic consequences, making it critical to explore these intersections further. There was a strong recognition of how health

financing mechanisms intersect with human rights, particularly in low- and middle-income countries (LMICs), where access to sustainable health financing remains a major challenge. Africa, in particular, was highlighted as a region where financial sustainability is increasingly urgent, especially in the face of domestic challenges such as political instability and violence. The conversation acknowledged the role of structural power dynamics in shaping health policies, emphasizing the need to address male-dominated power structures and their influence on decision-making.

A key concern was the tension between global health governance and national political realities. While global governance requires coordination between international organizations, its effectiveness often diminishes at the national level due to political priorities, competing interests, and governance inefficiencies. Participants noted that national politics frequently undermine health governance, with healthcare funding often deprioritized in favour of other political and economic interests. The discussion also raised critical questions about where to draw the line between accountability and imperialism in global health governance, acknowledging the risk of top-down approaches that may not align with local priorities.

The group focused on the challenge of developing a robust framework for implementing PCC in a way that accounts for these complexities. Various methodologies were proposed to guide the development of such a framework, including scenario planning to map out different pathways for PCC success and failure, as well as behavioural mapping to explore the motivations, incentives, and behaviours of key stakeholders across sectors. Participants highlighted that understanding the incentives of different actors, including policymakers, donors, and healthcare providers, is essential to shaping effective PCC strategies. It was noted that success in this domain is often tied to behavioural shifts among policymakers, with incentives playing a crucial role in ensuring that evidence-based policies are adopted and sustained. Small-scale rewards, such as demonstrating improvements in individual health outcomes or showcasing cost savings, were identified as potential mechanisms to drive greater commitment to PCC implementation.

A major focus of the discussion was on how PCC can be effectively implemented in LMICs, where financial and institutional constraints are more pronounced. Participants underscored the need for strong community and social participation during the design phase to ensure that PCC frameworks are inclusive, contextually relevant, and responsive to local needs. Sustainability was another key concern, with questions raised about how to secure long-term funding for PCC initiatives. The

concept of "ideal PCC" was explored, acknowledging that its implementation will vary across different settings based on factors such as economic stability, governance structures, and health system capacity. The group also stressed the importance of linking PCC to Sustainable Development Goal (SDG) indicators, ensuring that PCC is integrated into broader global health and development frameworks.

\*Recognizing the broad potential scope of this Working Group, it was agreed following the first Co-Chairs meeting to calibrate the political determinants to reflect current aid situations impacting global health, although not to make this an overly political document. However, we agreed that as our main audience, policy makers would want to see a clear language that reflects their perspective.

## **Group 6 - Meaningful Engagement and Reflexivity**

The **Meaningful Engagement and Reflexivity** group was tasked with ensuring that people with lived experience are actively embedded at every stage of healthcare decision-making—from research to policy to service delivery.



**Membership:** Maxine Whittaker, Lucia Feito (Co-Chairs), Steve Bell, Lavanya Vijayasingham, Mark Barone, Carolyn Taylor, Maureen Luba, and David Duong.

Each Member will also liaise with another 1-2 working groups to ensure that principles of meaningful engagement are embedded across the COMmission's work.

- Working Group 1 - Lucy
- Working Group 2/3 - Maxine and Steve
- Working Group 4 - Carolyn and Maureen
- Working Group 5 - Lavanya and Mark

**Guidance provided by Commissioners to the Working Group as input for their work:**

- Provide strategies and structures for meaningfully engaging people with lived experience in decision-making across different levels
  - Personal healthcare journey
  - Health program and system design and improvement
  - Health policy and system design
  - Private sector R&D
- Widen who is considered “people with lived experience”
  - Include care providers as stakeholders with lived experience and their tacit knowledge, not just technical knowledge
- Include people “living with, affected by or at risk of” - making it broader than just healthcare/illness experiences
- Explore capacity building and empowerment approaches for people with lived experience, e.g., Community-led monitoring, Participatory governance
- Ensure specific consideration for engaging marginalized and minority groups, asking whether/how to integrate diversity and/or adapt it universally?
- Place emphasis on ensuring community engagement from the beginning (planning phase) through to the end with decision-making power for community stakeholders
- Identify ways to tailor approach for language, literacy, abilities and cultural models
- Link work and recommendations to WHO key messages and resolutions related to meaningful engagement in order to maximize impact of the work
- Acknowledge how (shifting) positionality influences content and analysis, and make the reflexive process of the Commissioners clear
- Consider application of foresight methodologies

**Statement of Intent:**

Meaningful engagement of people and communities at primary care level (including community-based and home-care) to radically recentre health care to support people's wellbeing

**Preliminary Research Questions:**

1. What is the evidence (and how is it measured) of community engagement supporting recentred health care (including models of engagement)?
2. What is the evidence of where and how engaging people with lived experiences has successfully improved outcomes and impact of primary care services? How is this measured?
3. To what extent and how are the lived experiences of people living with, affected by or at risk of compromised health and wellbeing included in evidence for PCC?

**Key Areas of Working Group Discussion:**

The discussion in Working Group 6 centred on the meaningful engagement of people with lived experience in shaping and implementing PCC (nothing for us without us). A key theme was the necessity of adapting language to local contexts, ensuring that the terminology used is inclusive and resonates with the communities involved. While language adaptation was not a primary focus, participants acknowledged its importance in facilitating engagement. The discussion also highlighted the need to expand the scope of engagement beyond non-communicable diseases (NCDs), cancers and mental health to include broader health concerns, particularly infectious diseases, reproductive and sexual health care, and community-based healthcare interventions and the broader spectrum of care including prevention, rehabilitation and palliative care not just clinical services.

A central point of debate was the recognition of lived experience as a form of expertise and valuable "source of data". Participants emphasized that individuals with lived experience should be acknowledged not only as beneficiaries but also as valuable contributors to the healthcare system. They introduced the concept of compensating individuals for their expertise, underscoring the need to remunerate community health workers (CHWs) fairly rather than treating their work as voluntary. The group also discussed the necessity of distinguishing between different forms of lived experience (people living with, affected by and/or at risk of compromised health and well-being), particularly differentiating the perspectives of healthcare providers, caregivers, carers and people with health care needs/patients. Drawing lessons from the COVID-19 pandemic, there was a consensus that healthcare

workers' experiences should not be discounted, as they also navigate challenges in delivering PCC while managing their own well-being.

The conversation explored the broader structural issues related to engagement. Participants noted that meaningful engagement goes beyond mere participation and raised the question of who is engaging whom in the decision-making process. The importance of embedding people with lived experience into decision-making structures in a way that ensures their safety and mitigates power imbalances was emphasized. This required investments in sustainable platforms, capacity building, mentorship programs, health literacy initiatives, and financing mechanisms to support their meaningful participation. The group also stressed that while high-level policy discussions are critical, there is a pressing need to translate these ideas into community and service delivery levels to ensure tangible impact. PCC must be a multidirectional process where all people engage, listen to, educate and empower each other.

WHO's key themes on lived experience were examined, focusing on recognizing people's rights as leading experts in their own health journeys, addressing barriers to participation, and investing in long-term sustainability for engagement. Participants noted that while these themes align with their discussions, there is still a gap in how these principles are applied at the community level. They identified the need to map out best practices across different languages and regions, analyzing what has worked well and what has not. A strong emphasis was placed on ensuring that discussions of lived experience extend beyond disease contexts to include broader aspects of well-being and quality of life. Various innovative research methods may be needed such as photovoice, video voice were discussed.

The group also explored the nuances of social participation, acknowledging that while broad inclusion is ideal, it is not always feasible to engage every community member equally. A thematic analysis of existing case studies was proposed to identify successful frameworks and inform future efforts. Additionally, there was a call to redefine language around lived experience, shifting from a disease-focused perspective to one that centres on "user/potential user experience" to capture the diverse ways individuals interact with the healthcare system. The importance of meeting people where they are and recognizing that healthcare cannot be generalized across all populations was reinforced.

## Voices from the Convening: Key Takeaways and Reflections

Feedback surveys and candid discussions indicated that the convening made good progress on all of the objectives. The Commission now has established Working Groups, a foundation of trust and relationships, a sense of common purpose, and a roadmap to bridge to the next convening in Thailand. The discussions reinforced several essential insights, shaping the Commission's mandate to define and operationalize PCC as a critical driver for achieving UHC and the Secretariat is committed to integrating participant feedback into future virtual and in-person convenings in the spirit of continuous quality improvement.

### Reflections from Participants on Key Themes

A sample of Commissioners' reflections gathered through post-event feedback surveys and real-time discussions during the convening include:

- *"This convening was a reminder that PCC is not just about service delivery—it's about dignity, equity, and fundamentally rethinking how we approach healthcare."* – Commissioner
- *"One of the most valuable takeaways was seeing the commitment to including lived experience at every stage of policy and implementation. It was not just talked about—it was practiced."* – Commissioner
- *"The discussions reinforced the urgency of measuring PCC in meaningful ways. We need to capture the human experience, not just numbers."* – Commissioner
- *"We have to ensure that PCC is not just a pilot project or an isolated initiative—it must be embedded into national and global health strategies."* – Commissioner
- *"Hearing from different regional perspectives helped me understand that PCC can take many forms, but the goal remains the same: empowering people in their care."* – Commissioner
- *"The success of this convening will be measured by how well we carry these conversations forward into action."* – Commissioner
- *"This was a rare opportunity to build meaningful partnerships across sectors. We must continue fostering these collaborations."* – Commissioner
- *"We need to be bold in our advocacy for PCC. If we don't push for systemic change, who will?"* – Commissioner
- *"We need to ensure that meaningful engagement is not just performative"* – Commissioner.



- *“Accountability mechanisms are crucial. If we’re going to advocate for PCC, we need clear benchmarks to track progress.”* – Commissioner.

## **Reflections from Participants on the Convening Process**

- *“The brainstorming and small-group work were the most productive sessions. We need more of that in future meetings.”*
- *“There were moments where power dynamics were evident, and we need to be mindful of creating inclusive spaces where all voices are truly valued.”*
- *“Thank you for an incredibly well-organized convening. The Secretariat team did a fantastic job.”*
- *“Some working groups may need additional support to ensure a balanced mix of scientific expertise and lived experience.”*
- *“For Thailand, let’s make sure the sound system works properly—technical issues should not be a distraction.”*
- *“The Photo-based research exercise session was particularly impactful—it reminded us why we do this work and who we’re accountable to.”* – Commissioner.

## **Moving Forward: Bridging to the Thailand Convening**

As one commissioner noted: *“We cannot afford for PCC to remain a well-intentioned aspiration. It must be measurable, financed, institutionalized, and led by the people it serves.”* Building on the commitments made at the Convening, the following steps will guide the Commission’s work ahead:

- **Follow-up Meetings:** The Secretariat and Working Groups will convene follow-up calls to align priorities and track progress. Each Working Group has been assigned a Program Scholar(s) for support and has access to a designated Google Drive folder for all documents. We recommend that the groups explore what additional resources each member can access at their home institution or workplace to support the working group’s efforts.
- **Research Development:** Each working group will receive additional tools and templates for mapping skills and experiences within and between groups. The goal is to refine and

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finalize working group research questions, aims, deliverables, and action plans by the end of March 2025.

- **Global Engagement:** The second in-person convening is scheduled for August 2025 in Bangkok, Thailand hosted by the team at PBRI. Further information will follow on the summer convening and other potential opportunities for engaging at the global level to further the Commission’s mandate.

*We extend our deepest gratitude to all commissioners, working group members, facilitators, and partners who contributed to this convening. Your insights, expertise, and commitment to advancing PCC have been invaluable. This convening was not just a discussion, it was a collective commitment to action, and we look forward to continuing this work together. For any further questions, comments, or contributions, please reach out to [LGH-PCC@hms.harvard.edu](mailto:LGH-PCC@hms.harvard.edu). Thank you for your dedication to transforming health systems through PCC.*

# Appendix

## **Appendix A: Agenda**

### *Inaugural Convening*

20-22 January 2025

*Harvard University  
Boston, Massachusetts  
USA*

### **Convening Objectives**

1. **Establish Strong Foundations for Collaboration:** Build relationships among Commissioners to ensure trust, understanding, and shared goals.
2. **Achieve Conceptual Alignment on People-Centered Care:** Align on the philosophical underpinnings, definitions, and key principles of PCC.
3. **Define Research Questions and Prioritize Aims:** Identify and prioritize the key research questions and objectives for the Commission.
4. **Organize into Functional Working Groups:** Form thematic working groups with clear objectives, collaboration plans and timelines

### **20 January - Welcome**

18:00 – 20:00 Welcome Reception at Commonwealth Hotel

### **21 January - Foundations and Conceptual Alignment**

08:30 – 17:00 Build a shared understanding of the Commission’s purpose, philosophical underpinnings, and key concepts of PCC.

- Welcome and grounding in the Commission’s goals and co-creation of norms for working together
- Personhood and the philosophical underpinnings of PCC.
- Review and discussion of literature scan insights and evidence gaps.
- Begin refining research questions and thematic priorities
- Mini Skills-building sessions – Learn from fellow Commissioners’ expertise

### **22 January - Structuring and Operationalizing the Work**

08:30 – 20:00 Define research questions, establish working groups, and develop preliminary plans for collaboration.

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- Build consensus on research questions and Commission aims.
- Form and meet in working groups to develop clear thematic focus, objectives, priorities and develop action plan through July 2025.

### **Detailed Agenda and Activities**

#### **20 January (Monday)**

Time	Activity
Commonwealth Hotel 500 Commonwealth Ave, Boston, MA 02215	
18:00 - 20:00	<i>Welcome Reception</i> Fenway Foyer (near Main Lobby)

#### **21 January (Tuesday)\*\***

Time	Activity
Harvard Medical School Countway Medical Library, 5 <sup>th</sup> Floor 695 Huntington Ave., Boston, MA 02115	
08:30 - 09:15	<i>Breakfast &amp; Viewing of Commissioner Photo-based Research Exercise Gallery</i>
09:15 - 09:45	Sharing our Stories—Two Commissioners sharing their lived experience
09:45 - 10:00	Welcome—Review objectives, logistics and orientation
10:00 - 10:45	Commission Building—Deepening introductions and establishing working norms and values
10:45 - 11:00	<i>Nourishment and Stretch Break</i>

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11:00 - 12:00	Personhood Panel–Exploring the values, philosophical and ethical underpinnings of personhood, across different historical and cultural contexts
12:00 - 13:00	<i>Lunch</i>
13:00 - 13:15	Team building / Energizer
13:15 - 13:30	Presentation on themes from Photo-based research exercise Part 2
13:30 - 14:15	Presentation on Literature Scan & Discussion
14:15 - 14:30	<i>Nourishment and Stretch Break</i>
14:30 - 15:45	Initial Brainstorming on Research Areas–Interactive brainstorm in small groups starting from the <b>6 domains</b> derived from virtual meetings, to establish <b>all possible areas for research question</b> development.
15:45 - 16:45	Mini-Skills Building Round Robin
16:45 - 17:00	Close & Reflections

**22 January (Wednesday)**

Time	Activity
08:30 - 09:00	<i>Breakfast</i>
09:00 - 09:20	Review and reflection
09:20 - 09:30	Team Building / Energizer

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09:30 - 12:00	<p>Presentation, discussion and consensus building on key Research Areas and translation to Key Research Questions and form preliminary Working Groups</p> <p><b>Part 1 (30min)</b> Secretariat team to present back the consolidated research areas in digital format based on brainstorm session from Day 1 and facilitate large group discussion on two questions:</p> <p><b>Part 2 (60min):</b> Prioritizing research areas</p> <p><i>Nourishment and stretch break (15min).</i></p> <p><b>Part 3 (45min):</b> Synthesize research areas and create working groups</p>
12:00 - 13:00	<i>Lunch in (Preliminary) Working Groups</i>
13:00 - 13:20	<i>Official Commission Picture</i>
13:20 - 15:30	<p>Working Group Action Planning:</p> <p><b>Part 1 (15 mins)</b> Large group recap</p> <p><b>Part 2 (100 mins + 15mins integrated break)</b> Working group sessions</p>
15:30 - 15:40	Team Building / Energizer activity together
15:40 - 17:00	<p>Working Group Presentation back to larger group</p> <ol style="list-style-type: none"> <li>1. Each working group presents back refined research questions and plan for comment and refinement (60mins)</li> <li>2. Outline next steps for operationalization working groups[1] - including non-Commissioner members, detailed action planning, meetings with Chairs/Secretariat (20mins)</li> </ol>

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17:00 - 17:20	Closing & Next Steps
17:30 - 18:00	<i>Transportation to Dinner</i>
18:00 - 20:00	<i>Dinner at Harvard Faculty Club 20 Quincy St, Cambridge, MA 02138</i>
20:00	<i>Transportation to Commonwealth Hotel 500 Commonwealth Ave, Boston, MA 02215</i>



## **Appendix B: Results of Global Literature Scan**

[View the slides from the Literature Scan presentation.](#)

## **Appendix C: Presentation slides from Day 1-2**

[View slides from day 1 of the Convening.](#)

[View slides from day 2 of the Convening.](#)