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INTEGRATED HEALTH SERVICES DELIVERY NETWORKS BASED ON PRIMARY HEALTH CARE

Introduction

1. This document proposes a regional policy for developing integrated health services delivery networks (IHSDN) to respond to the major challenges posed by health services fragmentation and to meet the commitments made in the Declaration of Montevideo, the Health Agenda for the Americas 2008-2017, and the Iquique Consensus. The policy notes that IHSDN contribute to the achievement of international development objectives such as those goals contained in the United Nations Millennium Declaration, and to the development of health systems based on primary health care (PHC), and hence, the delivery of more accessible and efficient health services of higher technical quality, in which the issues of gender equity and cultural competence are considerations and user perception of the quality of the services is more positive. Likewise, IHSDN help improve equity in access to health services without distinction of age, gender, race, language, place of residence, religion, politics, sexual orientation, education, or socioeconomic status. It recommends the drafting of national plans consistent with the situation in each country and based on the definition and essential features of IHSDN outlined in this document.

Background

2. Health systems in the Americas are characterized by high levels of segmentation[1]

[1] ***Segmentation*** is "the coexistence of subsystems with different modes of financing, membership, and delivery of health care services, each of them 'specializing' in different population segments, depending on their employment, income level, ability to pay, and social status. This kind of institutional arrangement consolidates and deepens inequity in access to health care between different population groups. In organizational terms, segmentation is the coexistence of one or more public entities (depending on the degree of decentralization or deconcentration), social security programs (represented

and fragmentation[2] (*1-3*). Fragmentation is a major cause of the poor performance of health systems and services. Fragmentation can by itself, or in conjunction with other factors, lead to difficulty accessing services, the delivery of services whose technical quality is deficient, irrational and inefficient use of the available resources, unnecessary increases in production costs, and low levels of user satisfaction with the services received (*4-6*).

3. From the standpoint of the demand for services, population aging and unhealthy lifestyles have led to an increase in chronic diseases and co-morbidity, and consequently, a growth in the demand for health care, mainly that provided in the home. These challenges require greater integration of service providers to ensure their proper management. Furthermore, users are demanding greater participation in health matters and that health services address their individual and group preferences. From the standpoint of service supply, advances in medicine and technology (for example, telehealth) suggest the need to adapt the models of care while facilitating greater collaboration between the different service providers.

4. The sectoral reforms of the 1980s and 1990s did not consider institutional development levels in the health sector of each country, but instead tended to adopt one-size-fits all models centered on financial and management changes, deregulation of the labor market, decentralization, and the promotion of competition among providers and insurers. The reforms also failed to promote essential coordination and synergy among system functions, ignoring their complex relationships and heightening the fragmentation of the health services (*7-8*).

5. Recent years have witnessed a tendency to abandon competition and introduce policies that encourage collaboration among health care providers as a way of increasing the efficiency of health systems and the continuity of care. The health authority plays a key role in fostering this trend through its functions of: (a) sectoral steering (for example, policy-making and system performance evaluation); (b) regulation; (c) the modulation of financing; (d) the monitoring of insurance; (e) performance of the essential public health functions (EPHF); and, (f) the harmonization of health service delivery (*9*). Annex A

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by one or more entities), different financers/insurers, and private suppliers of services (depending on the extent of market mechanisms and entrepreneurial management introduced during sector reform…"(Pan American Health Organization. Health in the Americas 2007 (Vol. I, pg. 319), Washington, D.C.: PAHO/WHO, 2007).

[2] ***Fragmentation*** in the service delivery system refers to "the coexistence of various units or facilities that are not integrated into the health network." (Pan American Health Organization. Health in the Americas 2007. Vol. I. pg. 319, Washington, D.C.: PAHO/WHO. 2007)/ Other definitions include (a) services that do not cover the full range of promotion, prevention, diagnostic and treatment, rehabilitation, and palliative care services; (b) services at the different levels of care that are not coordinated; (c) services that do not continue over time; and (d) services that do not meet people's needs.

outlines some of the health service integration initiatives that are currently under way in Latin American and Caribbean countries.

6. Notwithstanding these efforts, the mechanisms and incentives to promote the clinical integration and development of integrated networks are still inadequate and need to be considered in future sector development. This situation is evident in the commitments made by the countries of the Region in Article III of the Declaration of Montevideo, which says: "Health care models should …work for the establishment of health care networks and social coordination that ensures adequate continuity of care" (*10*). More recently, the Health Agenda for the Americas 2008-2017 (paragraph 49), recommended "strengthening referral and counter-referral systems and improving health information systems at the national and local levels to facilitate the delivery of services in a comprehensive and timely fashion," (*11*), and the Iquique Consensus, reached at the XVII Ibero-American Summit of Ministers of Health, indicates the need (paragraph 6) to "develop networks of health services based on primary care, public financing, and universal coverage, given their capacity to ameliorate the effects of segmentation and fragmentation, linking them with complex of social networks" (*12*).

7. From May to November 2008, PAHO held a series of consultations with the countries to consider the problem of health services fragmentation and strategies to address it. Ten national consultations were held during this period (Argentina, Belize, Brazil, Chile, Cuba, Ecuador, Mexico, Paraguay, Trinidad and Tobago and Uruguay), along with two subregional consultations (Central America, countries of the Eastern Caribbean, and Barbados) and a regional consultation in Brazil, in which more than 30 countries from the Region participated. The main achievement of the consultations was to confirm the need to address the issue of health services fragmentation and endorse the PAHO proposal for the creation of IHSDN in the Americas.

Situation Analysis

8. Health services fragmentation is manifested in many ways in the different levels of the health system. In people's experiences with the system, fragmentation is manifested as lack of access to the services, loss of continuity of care, and the failure of the services to meet users' needs. Specific examples include suppressed demand, waiting lists, delayed referrals, the need to visit multiple service venues to treat a single episode of illness, or the lack of a regular source of services. Other examples are unnecessary repetitions of history-taking and diagnostic tests or the prescription of interventions that do not take the cultural characteristics of certain population groups into account. Fragmentation in overall system performance is manifested as lack of coordination between the different levels of care and care locations, duplication of services and infrastructure, unutilized productive capacity, and health care provided at the least appropriate location, especially hospitals. Specific examples include low resolution

capacity at the first level of care; the use of emergency services to obtain specialized care, effectively bypassing outpatient visits; the hospitalization of patients whose illness could have been treated on an outpatient basis or the extension of hospital stays because of difficulties in discharging patients with social problems.

9. In PAHO surveys, first-level and specialized care managers consider health services fragmentation a serious problem (*13-15*). For example, only 22% of first-level respondents and 35% of specialized care managers/providers believe that the systems for referral and counter-referral between levels of care are working properly. As to the location of care, respondents noted that almost 52% of hospitalized patients could have been treated outside a hospital environment. Finally, only 45% of first-level interviewees indicated that patients are examined by the same doctor/health team; that is, few have a regular source of care.

10. Although health services fragmentation is a common challenge in most of the countries of the Region, its order of magnitude and principal causes differ from country to country. Nevertheless, the literature review and country consultations pointed out the following as the leading causes of fragmentation: (a) institutional segmentation of the health system; (b) decentralization of health services that fragments the levels of care; (c) a predominance of programs focusing on diseases, risks, and specific populations (vertical programs) that are not part of the health system; (d) extreme separation of public health services from personal health services; (e) a model of care centered on disease, acute care, and hospital treatment; (f) weak health authority stewardship; (g) problems with the quantity, quality, and allocation of resources; (h) poor definition of roles and responsibilities, competency levels, recruitment and retention mechanisms, and disparities in the salaries of health workers; (i) the multiplicity of payer institutions and service payment mechanisms; (j) organizational models that hinder integration; (k) the cultural norms and behaviors of the population and service providers; (l) legal and administrative obstacles; and (m) the funding practices of certain international cooperation agencies/donors, which lead to fragmentation of the health services.

11. Concerning the funding practices of certain international cooperation agencies/donors, many of them are currently questioning the efficacy of cooperation centered exclusively on vertical programs and are reorienting their cooperation toward strengthening health systems with a more integrated approach. In December 2005, the Global Alliance for Vaccines and Immunization (GAVI) approved the use of its funds to strengthen health systems (*16*). More recently, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) also decided to support the strengthening of health systems insofar as they help fight these three diseases (*17*). The World Bank conducted an internal consultation on the integration of vertical programs in the health systems (*18*) and is supporting investment projects for health services networks in countries such as Brazil (*19*). The same can be said for the German Agency for Technical Cooperation

(GTZ), which in a recent report noted the need to reorganize the service delivery network, centered on primary care services, in order to set up a single, integrated, coordinated network of services. (*20*). Within this framework, WHO has launched the initiative Maximizing Positive Synergies between Health Systems and Global Health Initiatives to ensure that health systems and the selective interventions of global health initiatives are mutually reinforcing and can lead to greater achievements in global public health (*21*).

12. In addition, several activities showcasing best practices in the creation of IHSDN are under way in the Region, particularly in countries such as Brazil, Chile, Costa Rica, and Cuba, which have traditionally supported the development of IHSDN. More recently, other Latin American and Caribbean countries have been introducing similar practices in their health systems (see Annex A). Activities worthy of note are also under way in North America; for example, those of Kaiser Permanente and the Veterans Administration in the United States and that of the health services system in the Montérégie region of Quebec, Canada. In Europe, good practices have been found in the Autonomous Communities of Catalonia and Andalusia in Spain. In 2009, the Pan American Sanitary Bureau began 11 case studies on health services integration in the health systems of the Region. The lessons learned from these cases and others that will be identified in the future will be used in support of this initiative.

13. Finally, different interpretations of the concept of integrated health services, including networks, are partly to blame for the difficulties in understanding its meaning, drafting proposals for action, and evaluating progress in the integration of services (*22*). This document is expected to help surmount the conceptual problems in this area.

Proposal

14. The purpose of PAHO's IHSDN initiative is to contribute to the achievement of international development goals and those of the United Nations Millennium Declaration, as well as to the development of health systems based on PHC,[3] and thus, the delivery of more accessible and efficient services of higher technical quality, where gender and cultural competence are considerations and the public perception of the quality of the services is more positive. Furthermore, IHSDN help to increase equity in access to health services without distinction of age, gender, race, language, place of residence, religion, politics, sexual orientation, educational level, or socioeconomic status. PAHO regards

[3] PAHO defines **Health Systems based on Primary Health Care** as a broad approach to the organization and operation of health systems. Its main objective is to achieve the highest attainable level of health while maximizing the equity and solidarity of the system. Such a system is guided by the principles of PHC, which include responding to the health needs of the population; the pursuit of quality, government responsibility and accountability; social justice; sustainability; participation; and intersectoralism. Pan American Health Organization. *Renewing Primary Health Care in the Americas. Position Paper of the Pan American Health Organization/World Health Organization*, Washington, D.C.: PAHO; 2007.

IHSDN as one of the principal operational expressions of the PHC approach in health services, helping to guarantee several of its core elements, namely: universal coverage and access, first contact, comprehensive care, a family and community orientation, satisfaction of individual health needs, appropriate health care, optimal organization and management, and intersectoral action (*23*).

15. IHSDN can be defined as a network[4] of organizations that provides, or makes arrangements to provide, equitable[5] comprehensive health services[6] to a particular population and is willing to be held accountable for its clinical and economic outcomes and the health status of the population that it serves (Modified from: Shortell, SM; Anderson DA; Gillies, RR; Mitchell JB; Morgan KL. Building integrated systems: the holographic organization. Healthcare Forum Journal 1993 Mar-Apr;36(2):20-6).

16. As follows from the above definition, IHSDN do not require all of their member health services to be under sole ownership. On the contrary, some of their services can be provided through a variety of contractual arrangements or strategic partnerships in what has been called "virtual integration." This characteristic of IHSDN makes it possible to explore options for complementary services between organizations with a different legal status, either public or private. The nongovernmental sector plays a key role in health service delivery in several countries in the Region. Governments and others working to achieve global health goals are very interested in taking advantage of the opportunities

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[4] The concept of **network** has multiple meanings and applications. For example, from a sociological perspective, networks are a key mechanism of the social inclusion and integration of the contemporary individual, as well as a mode of organization especially adapted to the current operations of society, with major political potential due to their capacity to transform the situation (Bertolotto F, Mancheno M. Las redes: una estragegia para la reducción de la segmentación de los systemas de salud: contribución al seminario international GTZ/OPS/MSP/ASSE [unpublished; copy available on request] on integrated health services delivery networks and systems, Montevideo, 16-17 October 2008). Copy available on request. In the field of health services, the term ***network of services*** **(or *service network*)** basically refers to: (a) the functional coordination of provider units of a different nature; (b) hierarchical organization by level of complexity; (c) a common geographical referent; (d) command by a single operator; (e) operating standards, information systems, and other shared logistical resources; and (f) a common purpose. Copy available on request.

[5] **Equity** in health refers to the absence of unfair differences in health status, access to health care and healthy environments, and in the treatment received in the health system and other social services. Pan American Health Organization. *Renewing Primary Health Care in the Americas. Position Paper of the Pan American Health Organization/World Health Organization.* Washington, D.C.: PAHO; 2007.

[6] The term **comprehensive health services** refers to the management and delivery of health services such that the people receive a continuum of health promotion, disease prevention, diagnostic, treatment, and rehabilitation services through the different levels of the health system, in keeping with their needs throughout the lifecycle (Modified from WHO. Integrated Health Services–What and Why? Technical Brief No. 1, May 2008). Furthermore, the care **continuum** is the degree to which a series of discrete health care events are experienced by people as coherent and interconnected and consistent with their needs and preferences (Modified from Hagerty JL, Reid RJ, Freeman GK, Starfield B, Adair CE, Mc Kendry R. Continuity of Care: a Multidisciplinary Review. BMJ 2003; 327(7425):1219-1221).

offered by the large number of contacts between the populations targeted by interventions and the for-profit and nonprofit nongovernmental sector. The IHSDN initiative even provides a suitable framework for collaboration between countries through efforts such as the "shared services" of the small islands of the Caribbean and the complementation of services along common borders.

Essential Attributes of IHSDN

17. Given the wide range of contexts in the countries, it is impossible to prescribe a single organizational model for IHSDN; in fact, there are many potential models. The public policy objective, then, is to propose a design that meets the specific organizational needs of each system. Notwithstanding, the cumulative empirical evidence and consultations with the countries indicate that IHSDN must possess the following attributes, which are key to their satisfactory performance:

(1) covered population and territory defined and extensive knowledge of its health needs and preferences, which determine the supply of health services;

(2) an extensive network of health facilities that offers services in health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care, and integrates programs focused on diseases, risks, and specific populations and personal and public health services;[7]

(3) multidisciplinary first-level care that covers the entire population, acts as a gatekeeper to the system, and integrates and coordinates health care, in addition to meeting most of the population's health needs;

(4) delivery of specialized services in the most appropriate place, preferably in outpatient settings;

(5) existence of health care coordination mechanisms throughout the health service continuum;

(6) individual-, family-, and community-centered health care that takes cultural and gender characteristics and the degree of diversity of the population into account;

[7] **Public health** is an organized effort by society, primarily through its public institutions to improve, promote, protect and restore the health of the population through collective action, and includes services such as health status assessment, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster and emergency preparedness and response, and occupational health, among others (Pan American Health Organization. *Public Health in the Americas: Conceptual Renewal, Performance Assessment, and Bases for Action*. PAHO Scientific and Technical Publication No. 589, p. 46. Washington, DC:PAHO; 2002).

(7) a unified system of governance[8] for the entire network;

(8) broad social participation;

(9) integrated management of administrative, clinical, and logistical support systems;

(10) sufficient numbers of competent, committed human resources that are valued by the network;

(11) integrated information system that links all members of the network, with data disaggregated by sex, age, place of residence, ethnic origin, and other relevant variables;

(12) adequate funding and financial incentives aligned with network goals; and

(13) intersectoral action and addressing of health determinants and equity in health.

18. Table 1 contains a description of each basic attribute of the IHSDN described above.

[8] **Governance** is primarily "the process of creating an organizational vision and mission—what it will be and what it will do—in addition to defining the goals and objectives that should be met to achieve the vision and mission. Governance includes connecting the organization, its owners, and the policies that derive from these values – policies on the options that its members should have to achieve the desired outcomes. It also involves adopting the management necessary for achieving those results and an evaluation of the performance of managers and the organization as a whole. (Sinclair D, Rochon M, Leatt P. 2005. *Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission.* 1996-2000. The Institute for Research on Public Policy. Montreal 65-6).

Table 1. IHSDN - Basic Attributes

Attributes	Description
1. Definition of population and territory assigned and broad knowledge of their needs and preferences in health, which determine the supply of health services.	The main function of the IHSDN is to provide comprehensive health services to the population in an equitable manner in order to promote, preserve, or recover the health of individuals and the community in general. In order to achieve this, IHSDN must be capable of clearly identifying the populations and geographical areas for which they are responsible. Knowledge of the assigned population and territory makes it possible to develop profiles of the health status of the population, especially that of the most vulnerable groups, and of their environment. For data collection, the IHSDN coordinate information gathering with the community and other relevant public and private entities. The goal is to provide an updatable database on the community, thus facilitating current and future planning in the health services. It also implies the capacity to project needs, demands, and the future supply of health services—projections that include the number, composition, and distribution of health workers; material resources; and health programs necessary to meet the health needs of the population covered.
2. An extensive network of health facilities that provides health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care services, and that includes programs targeting diseases, risks, and specific populations, and personal and public health services.	In order to ensure comprehensive health services delivery, IHSDN have a wide range of health facilities that include first-level outpatient centers, centers that provide nursing services, orphanages, home care, specialized outpatient centers, rehabilitation centers, and hospitals. IHSDN provide all levels of care, elective and emergency services, and acute, long-term, and palliative care. Since their primary focus is keeping the population healthy, IHSDN emphasize the delivery of public health services and health promotion. IHSDN try to ensure equitable distribution of their operational units and their geographical proximity to the population served. IHSDN are also concerned about serving populations of an optimal size to facilitate access to the services provided; guarantee standards of quality in those specialized services, whose quality depends on the volume of services delivered (for example, heart or transplant surgery); and maximize economies of scale for network operations. Finally, IHSDN are concerned about integrating programs focused on disease, risks, and specific populations, personal services, and public health services.
3. A multidisciplinary first level of care that covers the entire population, serves as a gateway to the system and integrates and coordinates health care, in addition to meeting most of the population's health needs.	In an IHSDN, the first level of care plays a key role in the good operation of the network as a whole. The first level of care serves as the gateway to the system and guarantees equitable access by the entire population to essential services. This level provides comprehensive care capable of meeting most of the population's health care demand and health needs over time and throughout the lifecourse. It is the network component that develops the closest ties with individuals, families, the community, and the other social sectors, thus facilitating social participation and intersectoral action. The first level of care, moreover, plays a very important role in coordinating the continuum of services and the flow of information throughout the network of services, regardless of where the care is delivered. Is also the most critical level for achieving operational integration of the programs focused on diseases, risks, and specific populations, health services personal, and public health services. In IHSDN, the first level is not limited to delivering health service in health centers. Multidisciplinary health workers can move throughout the network of services and provide care at different locations, such as homes, schools, the workplace, and the community in general. In the same way, specialists in the different disciplines can provide health services at this level of care.

Attributes	Description
4. Delivery of specialized services in the most appropriate location, preferably in environments other than hospitals.	Development of IHSDN will require constant adjustments in the supply of health services due to the changing the health needs of the population, the levels of sectoral resources, and advances in the health sciences and health technology. Appropriate care, then, means that the care provided conforms to the common needs of the entire population, while meeting the specific needs of specific population subgroups; that the care is effective and based in the best available scientific data; that the interventions are safe and that people will not be harmed or suffer injuries of any type; and that the priorities in terms of resource allocation and organization are based on equity and economic efficiency (cost-effectiveness, for example). In this context, it is preferable to provide specialized services in environments other than hospitals. As a result, IHSDN are promoting the reengineering of their hospitals, a task that, on the one hand, involves the adoption of outpatient surgery and day hospital systems, the development of home care services, and the creation of specialized outpatient centers, orphanages, and nursing homes, and on the other, the focusing of hospital care on the management of patients who require intensive acute care.
5. Existence of mechanisms for coordinating care throughout the health service continuum.	One of the greatest challenges facing IHSDN is managing many complex chronic diseases that span the continuum of services and require different treatment and rehabilitation sites. In this regard, there is no ideal combination of coordination mechanisms; rather, they will depend on each particular situation and, specifically, on the degree of uncertainty, specialization, and interdependence involved in the tasks. In general, situations that require greater coordination of care are seen in complex health problems marked by a high degree of uncertainty and interdependence and thus require co-delivery service models. The instruments or coordination mechanisms traditionally used by health organizations are based on the standardization of processes/results and mutual adaptation. Clinical practice guidelines and treatment protocols are examples of coordination instruments based on the standardization of processes. This type of mechanism can be used effectively when the interdependence among professionals is not high, the variability of the response to medical care among patients is minimal, and the programming of care is easy. Furthermore, mutual adaptation--that is, coordination of the work through organic coordination mechanisms that facilitate communication among professionals working in the same care process, is more effective for coordinating care for complex health problems with a high degree of uncertainty and interdependence. Examples of this type of coordination are interdisciplinary working groups, organizational matrices that combine structure by level of care, care processes and case management (Vázquez Navarrete ML, Vargas Lorenzo I (2007). *Organizaciones Sanitarias Integradas: Un estudio de casos.* Barcelona: Consorci Hospitalari de Catalunya).

Attributes	Description
6. Person-, family-, and community-centered care, taking culture, gender, and the diversity of the population into account.	IHSDN are characterized by health care delivery centered on the person, the family, and the community or territory. Care centered on the person means that it focuses on the "whole person;" that is, the care addresses the physical, mental, emotional, spiritual, and social dimensions of the person. It also means that health services adopt an intercultural and gender approach to health care. It implies that health workers have a certain degree of knowledge about the person; that the care meets the specific needs of the person; that there is empathy, respect, and trust; and that the patient and provider make clinical decisions together. Care centered on the person is also linked to a health care approach based on a person's or patient's rights (and sometimes responsibilities), which in some countries has come to be called the Patients' Bill of Rights. Furthermore, the family and community approach means that care is not provided exclusively from an individual or clinical perspective. On the contrary, it means that the care addresses the patient's problems in the context of his family circumstances, his social and cultural networks, and the circumstances in which he lives and works. The heart of the family and community health approach is a set of key individual, family, and community practices to promote growth, healthy development, inclusive care, disease prevention, home care for patients, and better practices in the search for care and in following the advice of health care providers. Finally, it means that families and communities are themselves, participatory receivers of health services, respecting cultural, ethnic, gender and other types of diversity that exist the community.
7. A single system of governance for the entire network.	The dimensions of governance are control, structure, composition, and operations. Control refers to the degree of government centralization, which can range from a single government agency (corporate government) to multiple decentralized agencies with different functions and different responsibilities. The members of the governing body determine the composition of the governance entity, which can include representatives from the communities and operational units of the network. The complexity of IHSDN governance will require highly dedicated members with a specific professional background. Responsibilities in governance include formulating the purposes of the organization--that is, the mission, vision, and strategic objectives of the network; coordinating the different governance bodies of the entities that comprise the network; ensuring that the vision, mission, objectives, and strategies are consistent throughout the network; ensuring that the network achieves optimal performance by monitoring and evaluating network results and processes; standardizing the network's clinical and administrative functions ; ensuring adequate funding for the network and the effectiveness of its own performance as a governance entity (Vázquez Navarrete ML, Vargas Lorenzo I (2007). *Organizaciones Sanitarias Integradas: un estudio de casos.* Barcelona: Consorci Hospitalari de Catalunya). Finally, in countries heavily dependent on external finding (from financial institutions and/or external donors, for example), the governance function must also include the capacity to manage and harmonize international cooperation, seeking the development of IHSDN as the preferred alternative for the organization, management, and delivery of health services and, the integration of programs focused on diseases, risks, and specific populations in the health system.

Attributes	Description
8. Widespread social participation.	IHSDN promote activities that empower individuals to better manage their health (for example, through health education, self-care, and the self-management of disease), while improving the capacity of communities to become active partners in priority setting and the management, evaluation, and regulation of the network. There are different levels of social participation , which successively correspond to: (a) information sharing or, providing people with balanced information that will help them understand the problems, options, opportunities, and/or solutions; (b) consultation, or obtaining feedback from of affected communities on regard the analysis, options, and/or decisions; (c) involvement, or working directly with communities through a process that ensures that public concerns and aspirations are consistently understood and taken into account; (d) collaboration, or partnering with affected communities in every aspect of decision-making, including the development of options and identification of the preferred solution, and, finally, (e) empowerment, or ensuring that communities have full control over the key decisions that affect their well-being (Commission on Social Determinants of Health. Translating the Social Determinants Evidence into a Health Equity Agenda at the Country Level: A Progress Report on the Country Stream of Work in the CSDH. CSDH Country Work Report; October 2007).
9. Integrated management of administrative clinical, and logistical support systems.	Network management arrangements will depend on the size of the network (population and geographical area covered, workforce used, etc.) and the level of complexity (types of health facilities, existence of national or regional reference centers, existence of teaching or research functions, etc.). Large and highly complex IHSDN require more detailed organizational designs that facilitate the delegation of decision-making power and organizational coordination. Management changes include the transfer of management from individual departments to multidisciplinary teams charged with managing specific services for population groups throughout the care continuum , facilitating the creation of basic organizational structures and clinical service lines (Lega, F. Organisational design for integrated health delivery systems: theory and practice. Health Policy 81 (2007):258-279). IHSDN also develop systems for guaranteeing/continuously improving the quality of care for the network as a whole, since these systems help promote a systemwide culture of clinical excellence. Furthermore, IHSDN try to centralize clinical support operations (for example, laboratory, clinical, and radiology services) and the procurement, storage, and delivery of drugs and medical supplies to promote overall network efficiency , while at the same time setting up mechanisms for technology management and assessment to rationalize their use. Finally, IHSDN seek to share logistical support systems, such as the health transportation and centralized medical appointments systems.
10. Sufficient, competent, and committed human resources vetted by the network.	Human resources are an IHSDN's most important capital. The number and distribution of these human resources, combined with adequate competencies, translate directly into the ability to provide appropriate care and services to meet the needs of the population and territory. In this regard, defining the composition of the basic health teams for the geographical coverage assigned is essential and is the foundation for planning and guaranteeing the network's human resources. From the standpoint of personnel management, IHSDN examine the role of health personnel from the standpoint of public health and the clinical response as well as the organizational structure and management. IHSDN require a set of skills and lines of responsibility that differ from those required by traditional health services. New positions are needed (for example, directors of clinical integration, planning, and network development), in addition to new competencies (for example, the systems approach, negotiation, conflict resolution, change management, methodologies for continuous quality improvement, team building, and network management). In an IHSDN, the mix of competencies can be obtained by recruiting different types of professionals to work on a single task (multidisciplinary teams) or by assigning multiple tasks to a specific individual (multipurpose worker). IHSDN require an organizational development plan to achieve the desired change and systematic continuing education to upgrade the competencies of the work teams. In a broader sense, IHSDN require national training and human resource management policies compatible with network needs. Finally, the organizational culture is another basic factor that influences

Attributes	Description
	coordination in the organization. The culture helps make the coordination of care an element that fosters cohesion and identification among the staff working in the organization, especially if it promotes values and attitudes that promote collaboration, teamwork, and a results-based approach.
11. Integrated information system that links all the members of the network, with a breakdown of data by sex, age, place of residence, ethnic origin, and other pertinent variables.	The IHSDN information system should offer a wide range of data to meet the information needs of all network members. All member operational units of the network should be linked to the information system, although each operational unit uses different parts of the system's database. The design of the information system should be consistent with the network mission and the strategic plan and should provide information on the health status of the population served (including information on health determinants), the demand for and use of the services; operational information about patient progress regardless of where the care is received (admission, discharge, referral); clinical information; information on user satisfaction with the services; and economic information (billing, type of insurance coverage, costs, etc.). Furthermore, some of the basic elements that information systems should have are an integrated system of applications that links different network systems in; a common log-in and a unique ID for every person/patient; a common definition of terms and standards; and a database accessible to all members of the system that preserves the confidentiality of the information. An important matter in regard to the information systems is the need for IHSDN to conduct operations research for various purposes, such as improving the diagnosis of health status or contributing to evaluations of network performance and results. In order to accomplish this, IHSDN can develop their own capacities and/or contract the services of consulting companies, universities, or other entities specializing in research.
12. Adequate funding and financial incentives aligned with network goals.	IHSDN should set up an incentives and accountability system to promote integration of the network as a whole, the treatment of health problems at the most appropriate location in the care continuum, and the promotion and preservation of the health of people and the environment. To this end, the resource allocation system should permit each operational unit—hospitals, first-level care team, etc.—to take responsibility for both the direct expenses and the costs that they entail for the rest of the network. Integration and preparation of the budget base on global objectives, flexible mobility of economic and human resources within the network, and the transfer of purchasing power to the operational units are some of the most effective measures for achieving the overall efficiency of the network. Traditional payment systems that are independently applied in each facility and level of care (for example, fee for procedure, fee for service, or payment by budget) discourage coordination between the levels of care. In response to this situation, the IHSDN have been introducing resource allocation and financial incentives aimed at promoting coordination among service providers and addressing health problems in the most appropriate place within the continuum of care (for example, risk-adjusted per capita payments).
13. Intersectoral action and addressing the issue of health determinants and equity in health.	The IHSDN should create links with other sectors to address the more "distal" determinants of health and equity in health. Intersectoral action can include collaboration with the public sector, the private sector, and civil society organizations such as community, nongovernmental, and faith-based organizations. Intersectoral action can include collaboration with the education, labor, housing, food, environment, water, and sanitation, and social protection sectors. There are several levels of integration within intersectoral action that range , from a simple exchange of information to prevent programming that conflicts with that of other sectors, to coordination, to achieving the adoption of healthy public policies to achieve greater harmonization and synergy among the different sectors of the economy. Successful intersectoral collaboration requires growing levels of technical competence, management skills, and shared values among the sectors involved. Coordination with other services can occur through participation in advisory committees, standing committees, intersectoral working groups, etc.

19. Several studies suggest that IHSDN improve access to the system, reduce health care fragmentation; prevent the duplication of infrastructure and services, and improve system efficiency; lower production costs, and better meet the needs and expectations of people and their communities (*24, 25-30*). In any case, empirical evidence on the outcomes of integrated care models, including networks, is still limited, especially in low- and middle-income countries (*31-32*).

Policy Instruments and Institutional Mechanisms for the Creation of IHSDN

20. Policymakers, managers, and health service providers have a series of public policy instruments and institutional mechanisms that can assist them in creating IHSDN. *Policy instruments* represent the ways and means (strategies and resources) used by governments for meeting their goals and objectives, and they include legal instruments, capacity building, taxes and fees, expenditures and subsidies, advocacy and information. Examples of the application of some of these instruments specific to IHSDN include: (a) geographical designation of the population to be served; (b) planning of services based on the needs of the population; (c) definition of a comprehensive portfolio of health services; (d) standardization of individual-, family-, and community-centered model of care; (e) standardization of the intercultural and gender approach in the services, including the use of traditional medicine; (f) sensitivity to the diversity of the population (g) standardization of the system's gatekeeper ; (h) regulation of access to specialized care; (i) guidelines for clinical practice; (j) human resources education and management compatible with the IHSN; (k) risk-adjusted per capita payment; and l) integrated public policies covering the different sectors; and (m) intersectoral collaboration to address the issue of health determinants and equity in health

21. *Institutional mechanisms* are those that can be implemented in health service management/provider institutions and can be divided into clinical and nonclinical mechanisms. Clinical mechanisms are those related to health care as such and include, for example: (a) multidisciplinary teams; (b) rotation of staff among levels of care; (c) a single clinical record (electronic); (d) guidelines for referral and counter-referral; (e) case management; (f) telehealth; and, (g) self-care and duly supported and remunerated home care. Nonclinical mechanisms are those that support the care process and include: (a) a shared organizational mission and vision; (b) shared strategic planning, resource allocation, and performance evaluation; (c) definition of the functions and responsibilities of each component of the network as part of the service delivery continuum; (d) health worker and user participation in governance; (e) matrix organizational designs; (f) single centers for regulation of visits; (g) shared clinical and logistical support systems; (h) a single user ID code; and, (i) social service team for intersectoral coordination.

22. The relevance of these instruments and mechanisms (and others not mentioned in this document) will depend on the political, technical, economic, and social viability of each situation. In any case, whatever the instruments or mechanisms, they should always be backed by a state policy that promotes IHSDN as a key strategy for achieving more accessible, comprehensive health services. This policy framework, in turn, should rest on a coherent legal foundation consistent with the development of IHSDN in the areas of operations research and the best available scientific knowledge and evidence.

Monitoring and Evaluation of the IHSDN

23. The purpose of monitoring and evaluation is to improve the quality of decisions and the accountability of all actors involved in IHSDN—i.e., patients, providers, managers, government agencies, insurers and payers for services, decision- and policymakers, and citizens in general. IHSDN monitoring and performance evaluation poses serious technical challenges, such as the need for a systemic approach to evaluation, the methodological problems inherent to the systemic approach, and the limited availability and comparability of data. PAHO does not currently have methodologies for evaluating the IHSDN. The Bureau intends to develop them as part of the IHSDN initiative. Nevertheless, it believes that the monitoring and evaluation of IHSDN should include measurements that at the very least address the matter of resources and inputs, health processes, and health outcomes. Moreover, methodologies should be based on existing developments and in coordination with global efforts for the renewal of PHC, including the WHO initiative "Maximizing Positive Synergies between Health Systems and Global Health Initiatives," mentioned in paragraph 11 of this document. Thus, the IHSDN initiative will help improve evidence-based decision-making by strengthening the capacity of the countries to generate and make use of health information.

Technical Cooperation Priorities and Strategy

24. Past implementation of IHSDN has yielded valuable lessons that are helpful in formulating a successful implementation strategy. The most important of these lessons are that: (a) integration processes are difficult, complex and very long-term; (b) integration processes require extensive systemic changes, and specific interventions are not enough; (c) integration processes require a commitment by health workers, health service managers, and policymakers; and, (d) integrating the services does not mean that everything must be integrated into a single modality; multiple modalities and degrees of integration can exist within a single system (*33-35*).

25. The wide range of external contexts and internal realities of health systems make it difficult to issue rigid, very specific regional recommendations for the creation of IHSDN. Every country or local situation should formulate its own strategy for

implementing the IHSDN based on its political situation, financial resources, administrative capacity, and the historical development of the sector. Notwithstanding, the IHSN initiative needs a roadmap that, without ignoring the distinct realities of the countries, will make it possible to select some priority areas for action and establish a general timetable for implementation.

26. Concerning PAHO's technical cooperation priorities, the country consultations have yielded a consensus on the following cooperation priorities: (a) information systems (attribute 11), (b) governance (attribute 7), (c) management (attribute 9), (d) financing and incentives (attribute 12), (e) first level of care (attribute 3); (f) human resources (attribute 10); (g) care coordination mechanisms (attribute 5); and, (h) approach to health care (attribute 6). Incentives for operations research; ongoing evaluation of experiences and practices; and, the production, organization, and dissemination of scientific knowledge, empirical evidence, and lessons learned about the IHSDN, are also a basic component of technical cooperation. Concerning implementation, phase 1 of the initiative (2009-2010) will involve identification of the main problems of fragmentation in the health services and the preparation of national plans for the development of IHSDN. Phase 2 (to begin in 2010) will involve implementation of the national plans and their ongoing evaluation. For this purpose, PAHO will give priority to countries that have programmed the creation of IHSDN in their respective work plans for the bienniums 2008-2009 and 2010-2011.

27. The IHSN initiative falls under Strategic Objective No. 10 of the Strategic Plan 2008-2012 for the Pan American Sanitary Bureau, and more specifically, supports the achievement of Regionwide Expected Result 10.2, which says "Member States supported through technical cooperation to strengthen organizational and managerial practices in health services' institutions and networks, to improve performance and to achieve collaboration and synergy between public and private providers."

28. Regional progress of the initiative will be evaluated through indicator 10.2.2 of the Strategic Plan, which is*:* "Number of countries that have adopted PAHO/WHO policy recommendations to integrate the health services networks, including public and non-public providers." The 2007 baseline for this indicator was three countries, and the targets for 2009, 2011, and 2013 are 8, 10, and 13 countries, respectively (see Table 1). Moreover, progress at the country level will be evaluated through the progress indicators established in each national plan for each particular situation.

Table 1. Progress Indicators - IHSDN Initiative

Indicator	Year						
	2007	2008	2009	2010	2011	2012	2013
Member States							
• Countries that have adopted PAHO's policy recommendations on integrating health services delivery networks (number of countries)	3	5	8	9	10	12	13
• Preparation and implementation of national plans for development of IHSDN (number of countries)			3	1	1	2	1
• Assessment of the impact of national plans (number of countries)							7
Pan American Sanitary Bureau							
• Formation of a network of technical entities that collaborate in matters related to IHSDN			√	√			
• Completion of the PAHO position paper on IHSDN				√			
• Development of IHSDN support methodologies and instruments				√	√		
• Case studies on the integration of services							
• Regional and subregional meetings for sharing experiences and good practices			√	√			
• Direct technical assistance and field visits				√	√	√	√
• Monitoring of the initiative and coordination with global initiatives to strengthen health systems and the integration of services		√	√	√	√	√	√
		√	√	√	√	√	√

29. In support of this initiative, the Pan American Sanitary Bureau has a total operating budget of US$ 1.3 million for the bienniums 2008-2009 and 2010-2011; this figure includes regular funds, other sources, regional contributions, and the contributions of the Representative Offices. The Bureau has programmed resources equivalent to the work of one full-time Regional Advisor, and the support of health systems and services consultants from the participating countries. In addition, work in the Bureau on the IHSN initiative will be interprogrammatic, within the framework of the Organization's realignment with the PHC strategy.

30. Finally, PAHO has managed to consolidate support for the initiative among other partners, including the Ministry of Health of Brazil, the German Agency for Technical Cooperation (GTZ), the Hospital Consortium of Catalonia (CHC), and the Hospital Cooperative of Antioquia (COHAN), the U.S. Agency for International Development (USAID), and the Spanish Agency for International Cooperation for Development (AECID), through the Spanish Fund-PAHO. In any case, PAHO will attempt to increase the number of partners in 2009.

Action by the Directing Council

31. The Directing Council is requested to review the information in this document and explore the possibility of adopting the resolution recommended by the 144th Session of the Executive Committee, found in Annex C.

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Annexes

Version 200309

Selected Initiatives from Health Services Integration Efforts in Latin American and Caribbean Countries

Country	Initiative	Objective
Argentina (a)	Law creating the Integrated Federal Health System	Achieve harmonious, adequately coordinated integration of parts of the health system in a network that follows a national plan and responds rationally and effectively to the needs of the population; measurements based on the preparation of a health map.
Bolivia (b)	Municipal Intercultural Family and Community Health Network and Network of Services	Establish networks of first-, second-, and third-level health facilities, which may belong to one or more municipios, coordinating and complementing them with traditional medicine, within the framework of interculturalism and the social structure in health management.
Brazil (c)	Better Health: The Right of All 2008-2011	Integrate promotion, prevention, and care activities into a broad perspective of health care, reviving the Federal Manager's role as a catalyst, to coordinate the organization of health networks with a development-model perspective geared to equity in its personal and territorial dimension.
Chile (d)	Health care networks based on primary care	Develop health networks by designing policies for their coordination and linkage that permit the health needs of the user population to be met with equity and respect for the rights and dignity of people, within the framework of the health objectives.
Dominican Republic (e)	Model of regional health services network	Create organizational and operational forms of the care model aimed at providing services in a more rational, comprehensive manner, taking the family and its relation to social processes as the starting point.
El Salvador (f)	Law creating the national health system	Establish a model for organizing the health facilities of system members into functional networks for equitable delivery of quality health services to the population with continuity of care.
Guatemala (g)	Coordinated health care model	Implement a comprehensive care model involving the Ministry of Public Health and Social Welfare and the Guatemalan Social Security Institute for delivery of the Package of Basic Services in Escuintla and Sacatepéquez Departments. This activity lasted only until 2003.
Mexico (h)	Functional integration of the health system	Facilitate health service convergence and the portability of health insurance between different sector institutions such as the Ministry of Health, the Mexican Social Security Institute, Petróleos Mexicanos, and the Safety and Social Services Institute for State Workers.
Peru (i)	Guidelines for network	Promote the formation of multiple networks of providers from renewed public and private entities with accredited, categorized services, promoting competition, effectiveness, efficiency, and quality of care for the entire population, without exclusion.

Country	Initiative	Objective
Trinidad and Tobago (j)	Experience of the Eastern Regional Health Authority	Create an integrated network of health services between primary care facilities (polyclinics and health centers) and the *Hospital Sangre Grande*.
Uruguay (k)	Integrated National Health System	Implement a comprehensive model of care based on a common health strategy, coordinated health policies, comprehensive programs, and activities in the areas of promotion, protection, early diagnosis, timely treatment, recovery, and rehabilitation of users' health, including palliative care.
Venezuela (l)	Health network of the Metropolitan District of Caracas	Reorient the model of care to address the quality-of-life and health needs of the population, gearing it to the construction of integrated health networks that provide regular, adequate, timely, and equitable responses to these needs, with a guarantee of universality and equity.

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PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL AREAS

1. Agenda item: 4.12. Integrated Health Services Delivery Networks based on Primary Health Care.

2. Responsible unit: HSS/SP

3. Preparing officer: Hernán Montenegro, HSS/SP

4. List of collaborating centers and national institutions linked to this Agenda item

- Collaborating Center: Hospital Cooperative of Antioquia (COHAN).
- Other associated institutions: Ministry of Health of Brazil, German Agency for Technical Cooperation, (GTZ), the Hospital Consortium of Catalonia (CHC), the U.S. Agency for International Development (USAID), and the Spanish Agency for International Cooperation for Development (AECID) through the Spanish Fund-PAHO.

5. Link between Agenda item and Health Agenda for the Americas 2008-2017

Paragraph 49 of the Health Agenda for the Americas, which notes the need for "strengthening referral and counter–referral systems and improving health information systems at the national and local levels to facilitate the delivery of services in a comprehensive and timely fashion."

6. Link between Agenda item and Strategic Plan 2008-2012:

The framework for the IHSN initiative is Strategic Objective No. 10 of the Strategic Plan 2008-2012, which seeks "to improve the organization, management and delivery of health services." More specifically, the IHSN initiative will support the achievement of Regionwide Expected Result 10.3, which states "Member states supported through technical cooperation for developing mechanisms and regulatory systems to ensure collaboration and synergy between public and non-public service delivery systems".

7. Best practices in this area and examples of countries within the Region of the Americas:

Several activities showcasing best practices in the creation of IHSDN are under way in the Region, particularly in countries such as Brazil, Chile, Costa Rica, and Cuba, which have traditionally supported the development of IHSDN. More recently, other Latin American and Caribbean countries have been adopting similar methods in their health systems (see Annex A). Noteworthy activities are also under way in North America; for example, those of Kaiser Permanente and the Veterans Administration in the United States and that of the health services system in the Montérégie region of Quebec, Canada. In Europe, good practices have been found in the Autonomous Communities of Catalonia and Andalusia in Spain. The lessons learned from these cases and others that will be identified in the future will be used in support of this initiative.

8. Financial implications of this Agenda item:

In support of this initiative, PAHO has a total operating budget of US$ 1.3 million (contribution from the regional level and Representative Offices) for the bienniums 2008-2009 and 2010-2011. Furthermore, HSS/SP has programmed resources equivalent to the work of one Regional Advisor devoted full-time to this activity, in addition to support from health systems and services country consultants.

PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

49th DIRECTING COUNCIL

61st SESSION OF THE REGIONAL COMMITTEE

Washington, D.C., USA, 28 September-2 October 2009

CD49/16 (Eng.)
Annex C
ORIGINAL: SPANISH

PROPOSED RESOLUTION

INTEGRATED HEALTH SERVICES DELIVERY NETWORKS BASED ON PRIMARY HEALTH CARE

THE 49th DIRECTING COUNCIL,

Having reviewed the report of the Director *Integrated Health Services Delivery Networks Based on Primary Health Care* (Document CD49/16) which summarizes the problem of health services fragmentation and proposes the creation of integrated health services delivery networks to address it;

Concerned about the high degree of health services fragmentation and its adverse impact on the general performance of health systems, manifested in difficulty accessing the services, the delivery of services low in technical quality, irrational and inefficient use of the available resources, an unnecessary increase in production costs and low levels of user satisfaction with the services received;

Aware of the need for strengthening health systems based on primary health care (PHC) as an essential strategy for meeting national and international health targets, among them those stipulated in the Millennium Development Goals;

Recognizing that integrated health services delivery networks are one of the principal operational expressions of the PHC approach in health service delivery, helping to make several of its essential elements a reality, namely universal coverage and access; the first contact; comprehensive care; appropriate health care; optimal organization and management; and intersectoral action, etc.;

Aware that integrated health services delivery networks increase access to the system, reduce inappropriate care and the fragmentation of care, prevent the duplication of infrastructure and services, lower production costs, and better meet the needs and expectations of individuals, families, and communities; and

Recognizing the commitments made in Article III of the Declaration of Montevideo on the renewal of primary health care, paragraph 49 of the Health Agenda for the Americas 2008-2017; and paragraph 6 of the Iquique Consensus of the XVII Ibero-American Summit of Ministers of Health, which underscore the need to develop more comprehensive models of care that include health services networks,

RESOLVES:

1. To urge Member States to:

(a) take note of the problem of health services fragmentation in the health system and, when applicable, in the subsystems that comprise it;

(b) facilitate dialogue with all relevant stakeholders, particularly health service providers and home and community caregivers about the problem of service fragmentation and the strategies to address it;

(c) prepare a national plan of action promoting the creation of integrated health services delivery networks with a family and community health approach as the preferred modality for health services delivery in the country;

(d) promote human resources education and management compatible with the creation of integrated health services delivery networks; and

(e) implement and periodically evaluate the national plan of action for the creation of integrated health service networks.

2. To request the Director to:

(a) support the countries of the Region in the preparation of their national plans of action for the creation of integrated health services delivery networks;

(b) promote the creation of integrated health services delivery networks along common borders, including, when applicable, plans for cooperation and/or compensation for services between countries (or “shared services” in the case of the Caribbean);

(c) develop conceptual and analytical frameworks, tools, methodologies, and guidelines that facilitate the creation of integrated health services delivery networks;

(d) support human resources training and health management compatible with the creation of integrated health services delivery networks, including unpaid individuals who provide health care in the home and community;

(e) mobilize resources to support the creation of integrated health services delivery networks in the Region, which includes the documentation of good practices and the sharing of information on successful experiences among countries;

(f) monitor and evaluate the progress of integrated health services delivery networks in the countries of the Region; and

(g) promote dialogue with the international cooperation/donor community to raise awareness about the problem of health services fragmentation and seek its support for the creation of integrated health services delivery networks in the Region.

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

Financial and Administrative Implications for the Secretariat of the Resolution Proposed for Adoption

1. Agenda item: 4.12. Integrated Health Services Delivery Networks based on Primary Health Care.

2. Linkage to program budget:

a) Area of work: HSS, Strategic Objective 10

b) Expected result: The CD will adopt the resolution on IHSDN

3. Financial implications

a) Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US$ 10,000, including staff and activities): The total expenditure of the Pan American Sanitary Bureau (regional office and Representative offices) for the period 2008-2011 will be equivalent to $1.3 million.

Country expenditure will be calculated once the countries have drafted their national plans for the creation of IHSDN.

b) Estimated cost for the biennium 2008-2009 (estimated to the nearest US$ 10,000, including staff and activities): Bureau expenditure for the biennium 2008-2009 will be equivalent to $553,000.

c) Of the estimated cost noted in section *b)*, what can be subsumed under existing programmed activities? The total expenditure.

4. Administrative implications

a) Indicate the levels of the Organization at which the work will be undertaken): The equivalent of one full-time Regional Adviser is needed for this item. At least four Regional Advisers are currently working part-time on this item.

b) Additional staffing requirement (indicate additional required staff full-time equivalents, noting necessary skills profile): Not required.

c) Time frames (indicate broad time frames for implementation and evaluation): Implementation can begin in 2009, and evaluation of the results, in 2011.

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