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EXPANDING EQUITABLE ACCESS TO HEALTH SERVICES

*Recommendations for transforming health
systems toward universal health*

PAHO



Pan American
Health
Organization



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Organization
REGIONAL OFFICE FOR THE
AMERICAS

EXPANDING EQUITABLE ACCESS TO HEALTH SERVICES

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Expanding Equitable Access to Health Services: Recommendations for Transforming Health Systems toward Universal Health

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ACRONYMS AND ABBREVIATIONS

BPC	Basic package of care
CCM	Chronic care model
CHOICE	Choosing Interventions that are Cost-effective
CNCD/NCD	Chronic noncommunicable diseases/noncommunicable diseases
FONASA	National Health Fund (Chile)
GES	Explicit Health Guarantees (Chile)
HSSC	Health and Social Services Center (Canada)
IHSN	Integrated health service network
JUNASA	National Health Board (Uruguay)
MDGs	Millennium Development Goals
MhGAP	Mental Health Gap Action Program (World Health Organization)
NICE	National Institute for Health and Care Excellence (United Kingdom)
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
PEAS	Basic Health Insurance Plan (Peru)
PHC	Primary health care
PIAS	Comprehensive Health Care Plan (Uruguay)
PRONEC	Program for the Prevention and Control of Noncommunicable Diseases (Dominican Republic)
RENAME	National Essential Drug List (Brazil)
RENASES	National List of Health Actions and Services (Brazil)
SUS	Unified Health Service (Brazil)
WHO	World Health Organization
WONCA	World Organization of Family Doctors



Dr. Julio Siede

In memoriam

This publication is dedicated to the memory of Julio Siede, an outstanding family doctor, modern social communicator, enthusiastic professor, inexhaustible international consultant, wonderful colleague, and above all, a steadfast defender of the right to health.

Dr. Siede believed that all people should enjoy the right to health, especially people in situations of vulnerability, understanding that to accomplish this, effective policy strategies and technical instruments would be necessary. This publication is the fruit of that conviction, and of the need to support everyone who fights for the right to health, offering effective guidelines to help make that right a reality.

Through this publication, the Pan American Health Organization celebrates Dr. Siede's invaluable contribution to making universal health a reality in our Region.

CHAPTER 1



INTRODUCTION

Urgency of expanding equitable access to health services in the Americas

The Region of the Americas has made steady progress in tackling the determinants of health and improving the health of its populations (1). Great strides have been made in boosting the countries' economic and social development, strengthening their health systems, and increasing political commitment to meet the population's health needs. All this has led to clear improvements in human development indicators, such as the reduction of poverty and inequality, and progress toward universal primary education (1, 2). Positive trends in health indicators, such as reductions in infant and maternal mortality rates, deaths from HIV, and the prevalence rates of tuberculosis and other infectious diseases, have had a steady and positive impact on health.

This progress notwithstanding, the Region of the Americas remains one of the most inequitable regions in the world, where millions of people are without access to comprehensive health services (3). Poverty and inequality--the latter both among and within countries--remain serious problems in the Region. Almost 30% of the population in Latin America and the Caribbean (LAC) live below the poverty line, for example, and income inequalities are manifested in great disparities in countries' achievement of the Millennium Development Goals (MDGs) (4).

Reducing inequities in health has become more complicated due to shifting epidemiological and demographic patterns. The Region is witnessing a period of major demographic and epidemiological change. Chronic noncommunicable diseases (CNCDs) and their complications now account for a far greater proportion of needs and consume

a far greater proportion of health resources. These trends are exacerbated by an aging population. Between 2012 and 2020, the number of people in the Region over the age of 60 was expected to double from 100 to 200 million (4). Moreover, the simultaneous presence of communicable and noncommunicable diseases imposes a dual burden on health systems that, combined with social factors such as rapid urbanization and changing social values, creates new pressure to find the human and financial resources necessary for an adequate response to the additional demands.

Lack of universal access to health and appropriate universal health coverage has the greatest impact on people living in conditions of greater vulnerability. In places where access to services remains deficient, poor health can result in the loss of income and contribute to a cycle of poverty and disease among families and communities. Today, 30% of the Region's population cannot access health services for financial reasons, and 21% lacks access due to geographic barriers (3). These are serious constraints for universal access to health.

When health care organization and delivery are fragmented, the existing models of care obviously cannot meet the different health needs of individuals and communities, nor can they do so in an equitable, solidarity-based, efficient, and quality manner. In combination with other factors, fragmentation exacerbates health service access barriers (Box 1) and leads to health care that is lower in technical quality and less cost-effective. Consequently, the Pan American Health Organization (PAHO) has repeatedly called for the development of new models of care aimed at improving primary health care (PHC), response capacity at the first level of care (FLC), and the development of integrated health service networks (IHSNs) based on PHC (5, 6).

Many countries in the Region are also struggling to achieve the necessary response capacity to tailor health services to the new demands and needs of people with complex chronic diseases. Research shows that the vast majority of people with CNCs do not receive adequate care (7). Limited access to care and the existence of financial and other barriers are some of the main obstacles to adequate care (8). Furthermore, the prevailing model of care has not been very effective at tackling the social determinants of health in an intersectoral manner for promotion and prevention, or at expanding extramural social support through community outreach to meet the needs of older persons or mental health, community-based rehabilitation, or home care needs.

There are also great disparities in the availability, composition, and quality of human resources for health. For example, eleven countries in the Region have an absolute deficit of health workers (less than 25 doctors per 10,000 population) or significant disparities in the availability of those resources between urban and rural areas, creating even greater access problems (4). The WHO Global Strategy on Human Resources for Health recognizes the importance of health workers for achieving universal access to health and better health outcomes. It has likewise called attention to the growing imbalance between the demand for health care and workforce availability (9, 10). To improve access, a multisectoral effort will be needed that employs the PHC approach

through teams of health workers (including public health workers), primarily at the FLC and in the community.

Other problems that the Region faces in expanding equitable access to health services include the accessibility and rational use of medicines and health technologies. Progress in this regard will be greatly hindered by the lack of adequate financing and inefficient use of health resources. In 2011, public health expenditure in LAC averaged only 3.8% of gross domestic product (GDP), compared with 8.0% in the countries of the Organisation for Economic Co-operation and Development (OECD) (4, 11). Low health expenditure, combined with high out-of-pocket spending at the point of service, increases the risks of personal and household impoverishment and is an indicator of the inability of health services to guarantee universal access with quality, solidarity, equity, and efficiency.

Box 1. Summary of the main barriers to achieving universal access to health

- ◆ Excluded population groups, often the poorest, most disadvantaged communities
- ◆ Changing health needs, specifically those related to the growth of chronic diseases, violence, mental health problems, etc.
- ◆ Population aging
- ◆ Inefficient systems with limited access to the first level of care
- ◆ Segmentation of the health system
- ◆ Fragmentation in the organization and delivery of services
- ◆ Reduction in funding or limited funding to meet the population's health needs
- ◆ Weak governance and stewardship
- ◆ Insufficient social participation and community empowerment
- ◆ Lack of attention to intersectoral work

Although many countries in the Region have provisions in their constitution on the right to health for all and have made a commitment to universal access to health and universal health coverage (universal health), the latter could be expanded to tens of millions of people through a rights-, equality-, and solidarity-based approach and the consequent strengthening of health systems (12). However, the health authority stewardship and governance required to advance toward universal health are still inadequate. While some progress has been made (for example, in facilitating social participation in the development and implementation of health policies) increasingly holistic and sustained transformation of stewardship and governance is needed to comprehensively tackle structural problems such as health system segmentation and fragmentation.

Another challenge that the Region's health systems must face to achieve universal health is developing resilience—that is, the ability to absorb shocks, manage crises, and respond appropriately while keeping basic functions and essential services up and running (13).

Strategy for Universal Access to Health and Universal Health Coverage

In response to these challenges, in October 2014, the PAHO Governing Bodies approved the Strategy for Universal Access to Health and Universal Health Coverage through the adoption of Resolution CD53.R14 (4). This strategy recognizes the need to transform or strengthen health systems and services to combat the Region's health inequities and secure health and well-being for all. The strategy is grounded in the right to health, which is its core value, as well as equity and solidarity, in the spirit of Alma-Ata and PHC (14).



“Universal access to health and universal health coverage imply that all people and communities have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality health services determined at the national level according to needs, as well as access to safe, effective, and affordable quality medicines, while ensuring that the use of these services does not expose users to financial difficulties, especially groups in conditions of vulnerability. Universal access to health and universal health coverage require determining and implementing policies and actions with a multisectoral approach to address the social determinants of health and promote a society-wide commitment to fostering health and well-being” (4).

The two pillars of the universal health strategy (universal access to health and universal health coverage) imply that people and communities must be served without discrimination and receive the health care they need in comprehensive, affordable, quality health systems, without any type of barrier, through an intersectoral approach to address the social determinants of health. The right to health as well as equity and solidarity are key values to achieve this objective. Specifically, universal health coverage per se is not enough to ensure equity, health, and well-being. Action that addresses quality and access to health services is also fundamental to this task.

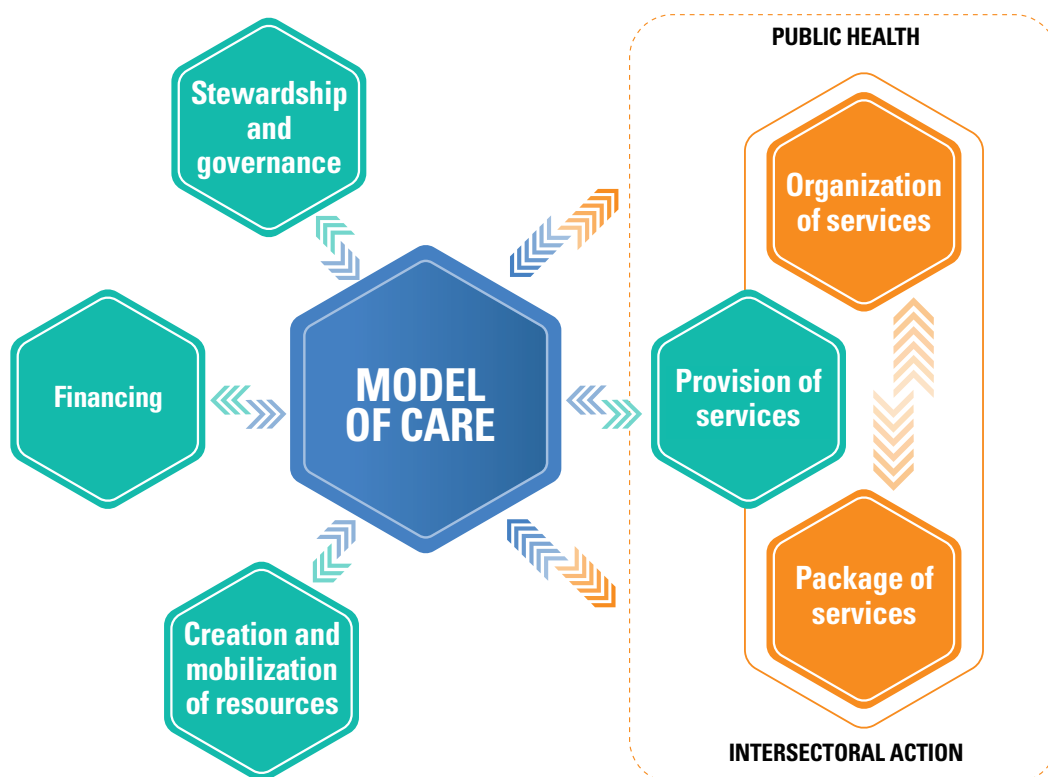
The Universal Health Strategy has four strategic lines:

1. Expanding equitable access to comprehensive, quality, people- and community-centered health services.
2. Strengthening stewardship and governance.
3. Increasing and improving financing, with equity and efficiency, and advancing toward the elimination of the direct payment that constitutes a barrier to access at the point of service.
4. Strengthening intersectoral coordination to address the social determinants of health in order to guarantee the sustainability of universal coverage.

The Strategy for Universal Access to Health and Universal Health Coverage expresses the need to “strengthen or transform the organization and management of health services through the development of health care models that focus on the needs of people and communities, increasing the response capacity of the primary level of care through integrated health services networks (IHSNs), based on the primary health care strategy” as key to expanding access to comprehensive quality services.

To deal with this complexity, it is important to recognize that the model of care defines the strategic rationale and general characteristics of the structure of health systems to provide comprehensive services based on the different physical, mental, social, and environmental needs of individuals, communities, and the general population, with a life course-, gender-, and ethnicity-centered approach to achieve health and well-being.

The model of care can be expressed in various dimensions: specification of the guaranteed services and benefits for health and well-being (the “what”); the way the services are structured and managed to provide that care (the “how” and “where”); and the role of intersectoral, social, and community actors (the “who”) and how resources are allocated to finance those services. Thus, the model of care links the four functions of the health system (Figure 1). Furthermore, given the population’s current health status and its determinants, models of care define institutional and health team competencies and capacity for intersectoral work.

Figure 1. Functions of the health system and model of care

Implementation needs

The Region urgently needs to reorganize health services to make them compatible with the people-, family-, and community-centered approach. The lessons learned show that access to equitable, comprehensive, quality health services cannot be increased as long as the care provided is predominantly curative and fails to include health promotion, disease prevention, rehabilitation, and the recovery of independence. Moreover, the evidence shows that introducing new people- and community-centered models of care is not enough, unless substantial changes are made in the content of the services (packages of services and comprehensive services) and the way they are delivered (organizational structure).

One of the main issues that health systems must tackle is the definition of the packages of services and benefits that must be guaranteed to ensure equitable access for people,

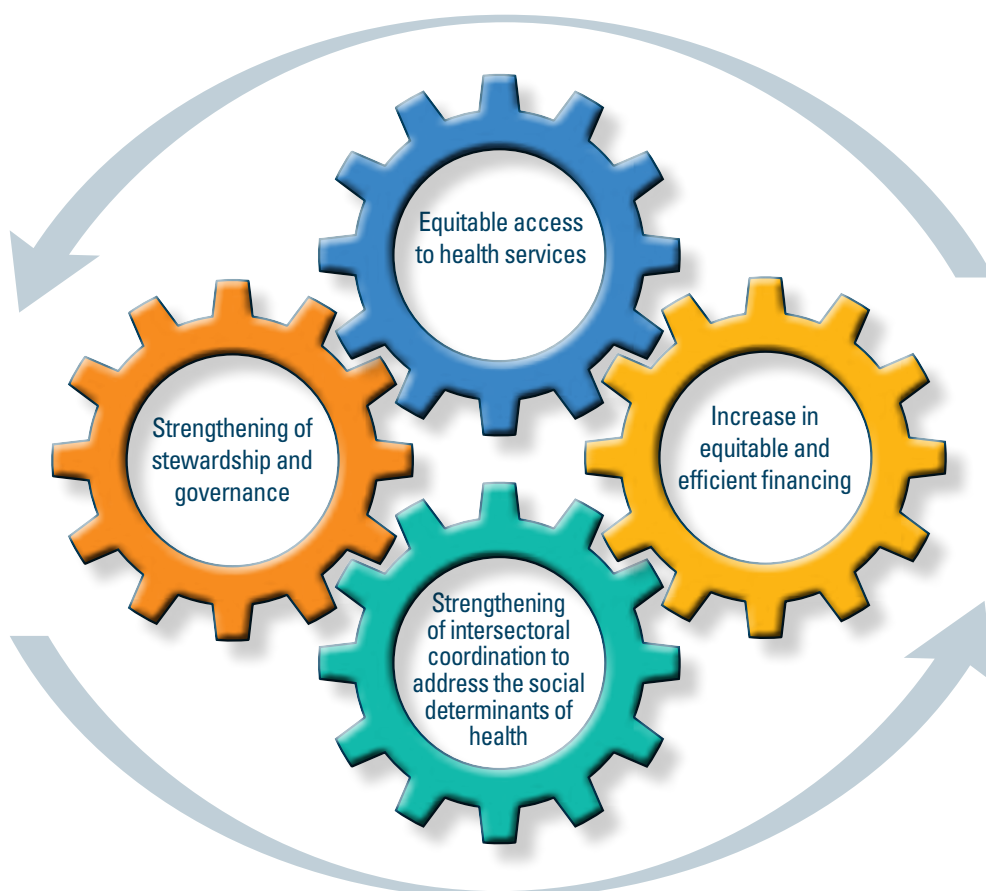
families, and communities, given the accelerated pace of health technology development and the limited financial resources (Box 2). A well-designed package of comprehensive services and benefits makes it possible to explicitly and transparently create universal guarantees, while developing progressive and dynamic public policy instruments that reflect and define the connections between the systems' financing function and efficient use of resources for quality health service delivery.

Box 2. Key questions for guaranteeing universal access to health and universal health coverage

- ◆ How can coverage be expanded to support universal access to comprehensive needs-based services?
- ◆ How can differentiated unmet needs and access barriers be identified in different contexts and settings, considering health determinants and the intersectoral approach?
- ◆ How can a lasting culture of health situation analysis and system responsiveness be developed, given the problems and their determinants?
- ◆ How can people and communities be empowered to become promoters and managers of their own health and care?
- ◆ How can responsiveness be increased so that resources are allocated to strengthen the FLC and IHSNs?
- ◆ How can current and future human resource needs be addressed, and new competencies developed to respond to the new challenges?
- ◆ How can health, information, and communication technologies, as well as pharmaceutical products, be integrated to secure better benefits for the population?
- ◆ How can health system governance and mobilization of the necessary financial resources be strengthened at each stage of progress toward universal health?

In the Region, packages of comprehensive services and benefits are based on lists of health benefits included in universal programs. They can also be created through the design of comprehensive and integrated universal packages of guaranteed health benefits. In the context of universal access to health and universal health coverage, these packages should be linked directly with health needs and be consistent with the model of care, human resources, supply systems, and financing capacity. These challenges can hinder the improvement of health outcomes for all if health system reforms are not introduced to reduce segmentation and fragmentation while improving health investment. Thus, it is necessary to work simultaneously on the Strategy and its four lines of action, given their interdependence (Figure 2).

Figure 2. The four simultaneous and interdependent strategic lines of the Strategy for Universal Access to Health and Universal Health Coverage



Scope and purpose of this report

The purpose of this report is to examine the basic aspects of the Strategy's implementation and offer a series of practical recommendations for the Member States' consideration in order to help national authorities plan and implement changes that can lead to measurable strengthening of the health services.

The report also reviews practical recommendations related to the first strategic line of the Strategy for Universal Access to Health and Universal Health Coverage and the following three interrelated lines of action:

1. Develop models of care centered on the needs of people and communities.
2. Strengthen the FLC.
3. Specify comprehensive, universal, quality services that can be expanded progressively.

The purpose of the Regional Forum was to formulate practical recommendations for the PAHO Member States that would advance work on these three lines of action through technical discussions and the sharing of country experiences. Its intent was not to offer new theories but to analyze good practices and lessons learned and select recommendations geared to action for effective change in the Region's health systems and services. This report, therefore, offers practical guidance for expanding access to quality services by strengthening first-level care provided by IHSNs, based on people-centered models.

It also indicates how to select the services and benefits that should be prioritized as part of the progressive expansion of health services to communities, as a means of improving individual and collective health (15). The report also considers issues connected with stewardship and the management of transformative change to guide and facilitate progress. Understanding how to approach implementation and stimulate investment in healthy lifestyles, well-being, and development is essential to achieving universal access to health and universal health coverage.

CHAPTER 2



TRANSFORMING MODELS OF CARE

“In the Region of the Americas, millions of people lack access to the comprehensive health services required to live a healthy life and to prevent disease, as well as to receive the health services they need when they are sick, including palliative care in the terminal phase of disease. This Region remains one of the most inequitable in the world. Ensuring that all people and communities have access to the comprehensive health services they need is a fundamental challenge for the Pan American Health Organization (PAHO) and is the purpose of this strategy” (4).



The need to transform the models of care

Despite progress and economic growth in the Region, poverty and inequity between and within countries remains a problem. The new models of care have not yet addressed the issues of access barriers, exclusion, and changing needs. Barriers include: 1) limited responsiveness and managerial capacity at the FLC; 2) fragmentation of health systems and services; 3) lack of financing, coupled with inefficiencies in health systems; 4) weak governance and stewardship, with limited social and intersectoral participation; 5) health outcomes below expectations; and 6) the rising cost of care, which threatens the sustainability of health systems.

Advances in health practice and health technology, coupled with demographic and epidemiological changes and rising social expectations, have added complexity to the way health care should be delivered. From a technical standpoint, the challenge consists of shifting from hospital-based care to health promotion, disease prevention, and health maintenance services that can be delivered adequately at the FLC (16). Accordingly, many countries in the Region are working to transform or rebalance their health services to make them effective and quality services delivered through IHSNs capable of solving health problems at the FLC and in the community.¹ Reorienting the model of care is a global strategic necessity for the simultaneous promotion of sustainability and quality improvement (17).

The Strategy for Universal Access to Health and Universal Health Coverage underscored the need to strengthen or transform the organization and management of health services (4). One of its basic components is developing new models of care that can better respond to the needs of individuals and communities through the PHC strategy (Table 1).

This approach includes many of the elements described in Chapter 4, such as investment in comprehensive care, with health promotion and disease prevention strategies that educate people about their health problems and promote their well-being. This requires new models of care that are capable of supporting the empowerment and participation of people and communities so that they can make better decisions about their health, with clear knowledge and decision-making power, and so that they are involved in promoting healthy spaces and intersectoral action.

The new models of care also require capacity building, which will entail:

- ◆ Investing in first-level response capacity to achieve universal access to health (18).
- ◆ Prioritizing ambulatory care and outpatient consultations over hospitalization, whenever feasible, by developing effective, quality, and community-based PHC services, including home hospitalization.
- ◆ Guaranteeing access to essential medicines and health technologies, with the commitment to offering quality care that increases the availability and rational use of medicines (including vaccines).
- ◆ Regulating the delivery of care so that the use of health technologies and medicines is based on evidence that guarantees safe and effective quality care.
- ◆ Investing in the workforce by increasing employment opportunities with attractive working conditions and incentives, particularly in locations with limited health care, such as certain rural or remote areas.

1 In some countries, the first level of care is divided into two differentiated areas of care: 1. The entry point (or “deconcentrated” first level) 2. Care support (with concentrated diagnostic and therapeutic capacities)

- ◆ Promoting multidisciplinary work to boost the response capacity of local health services, create new job descriptions for personnel, and improve their combination of skills (19, 20).
- ◆ Creating new opportunities for intersectoral collaboration and work in the community to tackle the social determinants of health and make better use of limited resources; this would include investments in information systems for exchanging data and promoting shared learning.
- ◆ Coordinating care for people and communities in an integrated manner—for example, by merging programs for the vertical management of certain diseases (such as HIV/AIDS and tuberculosis) and promoting PHC-based IHSNs (6).

Table 1. Characteristics of conventional health care, disease control programs, and people-centered health care (the future)

Conventional ambulatory medical care in clinics or outpatient consultations	Disease control programs	Comprehensive people-centered health services
Focused on individual demand based on diseases and their cure	Focused on priority diseases	Focused on comprehensive care to improve the health and well-being of people, families, and communities, according to their needs
The relationship is limited to the consultation	The relationship is limited to program operations	Continuous care is provided for people, families, and communities throughout the life course, with a gender and intercultural approach
Episodic curative care	Disease control interventions defined by the program	Care is comprehensive, coordinated, and people- and community-centered (health promotion, disease prevention, treatment, rehabilitation, etc.)
Safe and effective technical advice to patients during consultations	Proactive management of patient risk factors to meet the objectives	The population shares responsibility for health vis-à-vis the health determinants through a systems approach and intersectoral collaboration
Users are consumers of the care they purchase	Population groups are the target of specific disease control interventions	Individuals and communities are empowered to become co-producers of care at the individual, organizational, and policy level

Source: Adapted from World Health Report 2008. Primary Care: Now More than Ever. Geneva: WHO; 2008. Available at: <http://www.who.int/whr/2008/en/>.

PAHO's strategy (4) for creating new models of care involves progressively expanding comprehensive and universal packages of services and benefits guaranteed by law, in keeping with health needs, system capacity, and national context. Consequently, understanding how and where to formulate and implement changes in different national contexts is key to redesigning models of care so that they are compatible with people-, family-, and community-centered services.

Strengthening the first level of care

Given the growing burden of chronic disease associated with lifestyles, unhealthy behaviors, social determinants, increasing life expectancy, and the consequent call for health promotion and disease prevention, it is widely recognized that countries must recalibrate their health systems and invest in effective, accessible, quality first-level and community health services and the intersectoral approach to health. Strengthening the FLC is essential for transition toward universal access to health, as is the availability of effective, quality services in first-level facilities, which have been associated with higher-quality health systems and greater capacity to achieve efficiency in both the Region of the Americas and globally (5, 21, 22). The FLC should be people centered, promote coordinated care, and help improve the management of care for people with complex health care needs through multidisciplinary and intersectoral commitments—strategies that are particularly effective in low- and middle-income countries (23).

The Strategy for Universal Access to Health and Universal Health Coverage recognized the need to strengthen and transform health service organization and management to improve first-level care in IHSNs, based on the PHC strategy.

In the majority of countries in the Region, health services and health investments have been concentrated in hospitals and highly specialized and expensive technologies. The Strategy underscores the need for strengthening the FLC to increase access, giving it a significant role in IHSNs. To achieve the necessary changes, the following is required:

- ◆ Increase investment in the FLC to strengthen services and increase access to them.
- ◆ Progressively expand service delivery at the FLC to meet unmet health needs, including the provision of essential medicines.
- ◆ Strengthen human resources at the FLC, especially in marginalized areas, through adequate incentive systems and social guarantees (decent work).
- ◆ Introduce new professional and technical functions for personnel to ensure sufficient capabilities, with the right combination of skills at the FLC.
- ◆ Consolidate the development of multidisciplinary health teams.
- ◆ Promote coordination between first-level and specialized care with other sectors to better address the social determinants of health.
- ◆ Guarantee the capacity to analyze health needs and provide adequate and timely response through the use of health information and new technologies (e.g., telehealth and mobile health).²
- ◆ Implement programs that empower people to take charge of their health and make informed decisions about their health and care options at the FLC.

² Mobile health refers to digital health interventions that use mobile technology to achieve health objectives.

Strengthening the FLC requires 1) active community participation in the planning, execution, monitoring, and evaluation of services; 2) integration of first-level individual and public health services, with emphasis on the social determinants of health and the needs of groups in conditions of vulnerability; 3) robust mechanisms for coordinating the different levels of care; 4) adequate resources, support policies, and relevant legislation to guarantee better health outcomes; 5) retraining of the workforce; and 6) reorienting care processes. The new approach to care will require transforming the curative model into a well-being model, backed by the political will necessary for change and the creation of supportive settings where people have the opportunity to make healthy life choices. Likewise, robust new governance systems in the integrated networks and intermediate and local government will be necessary, together with the inclusion of health in community social and economic development plans. It will also require reliable health data analysis systems. There are many good practices worldwide that can serve as models, along with opportunities for sharing experiences throughout the Region. The recommendations in this regard are:

- 1. Health care through coordinated, people- and community-centered services.**
- 2. Meeting population health needs through:**
 - a. A territorial and population-based approach that assesses the health needs of different social groups and the impact of specific interventions in terms of improved population health outcomes.
 - b. Use of the assessment's results to understand what will be needed to improve the FLC and boost its potential. Use of these assessments to justify new investments and the redirection of financial resources for health care.
- 3. Intersectoral and IHSN collaboration.**
 - a. Identify the role of service providers and partners in other sectors that can support local networks to strengthen the FLC (for example, social services, housing, schools, churches, volunteer groups).
 - b. Develop guidelines and instruments for ensuring the continuity of care in IHSNs.
- 4. Human resources and capacity and competency building.**
 - a. Evaluate existing capacities and identify gaps in order to prepare and implement plans for selecting and developing capacities.
 - b. Guarantee the development of strategies for hiring and training human resources to gradually improve skills and capacity at the FLC.
 - c. Create multidisciplinary first-level teams with access to specialists.
 - d. Invest in new functions, such as those of coordinators and managers, to enable people and families with long-term needs to receive care in their community.
 - e. Provide training for work in family and community health.
 - f. Invest in personnel with the capacity to oversee and manage networks and promote community participation.

5. Financing.

- a. Negotiate and ensure that a greater portion of the health budget is allocated to health promotion and primary care by protecting financing for the FLC in IHSNs through a specified proportion of dedicated funding.
- b. Ensure that financial incentives foster an increase in the number of professionals and service providers at the FLC, especially in the most disadvantaged areas.
- c. Gradually reduce out-of-pocket expenditure to eliminate the financial barriers that limit access to the FLC.
- d. Develop innovative financing and contracting instruments to promote intersectoral partnerships and collaboration.
- e. Develop plans for investing in human resources (education, equipment, facilities, and information technology).

Strengthening primary care is a priority for progress toward universal access to health. It requires a paradigm shift that promotes a community-based approach and emphasizes disease prevention and health promotion to reduce current reliance on the biomedical model based on health care institutions, which dictate its operations.

It is especially important for the FLC to be directly responsive to local health needs. Also, it should guarantee that the limited resources actually reach everyone and that needs are equitably met. In the Americas, it is necessary to invest in research to monitor the progress and results of the changes made, and to help guarantee improvements in quality. The construction of viability and sustainability is fundamental to capacity building at the FLC.

Creating integrated health service delivery networks

To achieve universal health, it will be necessary to integrate health service delivery in order to solve the problems created by health system fragmentation. Strengthening the FLC to support universal health and comprehensive people- and community-centered care is recognized as a basic principle (16). Since PAHO/WHO's publication of "Integrated Health Service Delivery Networks," the Region has been at the forefront of global efforts to promote more equitable, comprehensive, integrated, and continuous models of care (6).

The main task is to design approaches that guarantee health care and the well-being of the population. This requires strengthening the capacities that support the continuity and coordination of care for people, families, and communities throughout life. It also entails a shared responsibility on the part of health professionals and health care institutions to ensure that health determinants are addressed through intersectoral action. People and communities must receive support and be empowered to become co-producers of health care at the individual, group, organizational, and political level.

Another element that is key to success is the capacity to create governance, financing, and reporting entities, with a view to investing in new types of integrated health service delivery, implementing them, and measuring and monitoring their progress. It is also

important to introduce new, collaborative practices, which should be supported with professional education and training, capacity building, and the right combination of skills and organizational models to establish functional ties among the different areas of health care delivery.

SPECIFIC RECOMMENDATIONS

1. Coordinate people-centered care.

- a. Define a vision of a care policy based on the needs of caregivers, families, and communities.
- b. Educate patients to take charge of their own health, bringing peers and other community organizations into the process.
- c. Promote health with community-centered activities.

2. Community participation.

- a. Engage and empower the community, achieving community participation in planning activities around their needs.
- b. Educate people so that they understand their rights and responsibilities in health.
- c. Get community groups and civil society representatives involved in the planning of services and the political process.
- d. Raise awareness about public health problems that impact local communities and how to solve them.

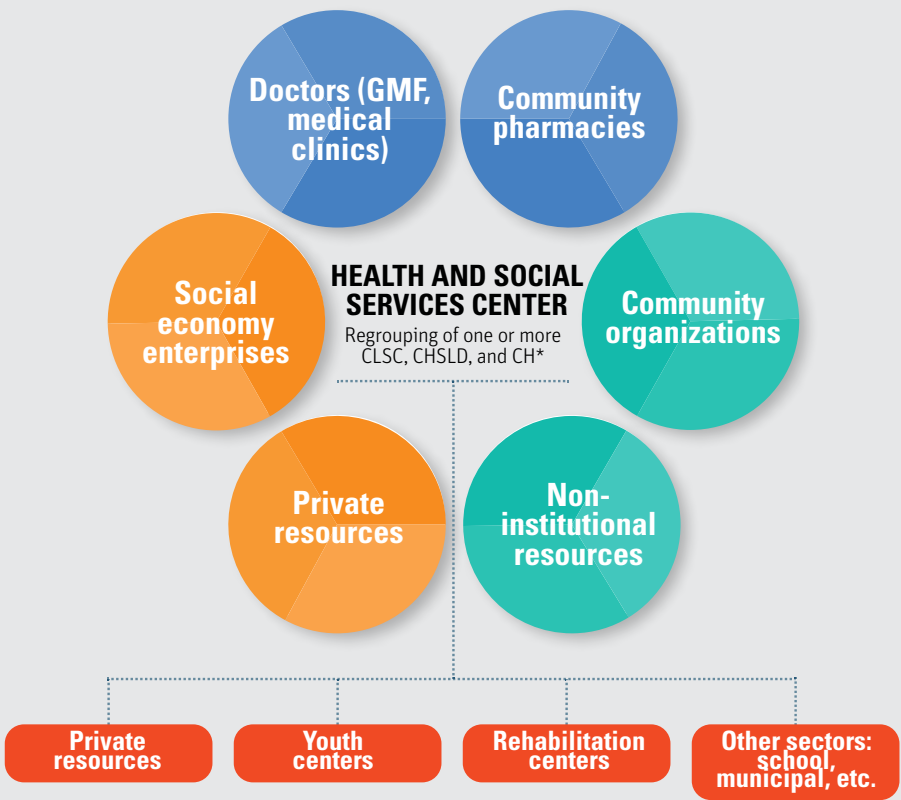
3. Building capacities for integration.

- a. Create a joint vision of the future of integrated services.
- b. Promote horizontal integration of the various partners devoted to health care in the community.
- c. Collaborate with community centers and other community-based organizations dedicated to the promotion of health and well-being and support for disease management.
- d. Establish functional connections between levels of care—for example, by defining provider roles and responsibilities in the continuity of care and intersectoral work.
- e. Create mechanisms to support coordinated care among the different providers and health centers—for example, through clinical guidelines and standards for health care and disease management.
- f. Create a list of the individuals who require care, with community participation, to identify the needs and priorities in which resources should be concentrated.
- g. Conduct research and share experiences through social networks to determine what works in local contexts.
- h. Educate and train human resources in their new roles so that they can perform them and create teams that contribute to the integration of care.
- i. Examine the role and performance of multidisciplinary teams in competency development and promote new professions and work opportunities.

Case study A. Integrated health and social services centers, Quebec (Canada)

The Province of Quebec introduced a long-term strategy to eliminate fragmentation in health care organization and delivery in its 17 administrative regions. The model employed involved the formal integration of financing and health care and social service delivery. Health system reforms in 2014 reoriented the model of care in 90 health and social services centers (HSSC) that tend to the needs of specific local populations. This approach integrates access and continuity of care with preventive and curative services for the most vulnerable (Figure 3).

Figure 3. Local health and social services network



* An HSSC may not include a hospital due to the absence of this type of facility in a territory, or to the complexity of the integration or regrouping of these services.

CH, hospital centers; CHSLD, residential and long-term care centers; CLSC, local community service centers; HSSC, health and social service centers; GMF, family medicine group.
Source: Adapted from the Ministry of Health and Services, Directorate of Communication. The Health and Social Services System in Québec. Québec: Government of Québec; 2016. Available at: <https://publications.msss.gouv.qc.ca/msss/fichiers/2017/17-731-01WA.pdf>

HSSC have introduced PHC-based health and social services provided through independent family medicine clinics. They have also promoted multidisciplinary work, expanding the role of nurses and public health workers and engaging community groups, including citizens' committees and committees for community representation. The basic interventions have been:

- ◆ Forging partnerships between community nurses and hospital emergency rooms to monitor and manage frequent users in community settings and thus reduce readmissions.
- ◆ Investing in comprehensive care education and training to support joint work and serve vulnerable groups in disadvantaged neighborhoods.
- ◆ Creating interdisciplinary teams comprised of health and municipal personnel to provide home support for older persons, with emphasis on independent living and adapted housing.

Some of the issues identified in Quebec are related to 1) an aging population with its attendant health problems; 2) growing inequality among social classes; 3) problems controlling financial expenditures; and 4) political issues related to the public financing of long-term health care. Integration turned out to be problematic because of the competing interests of professional groups and independent service providers. Lack of preventive services remains a weakness in health care delivery.

The lessons for the future of HSSC in Quebec include:

- ◆ The need to expand nurses' role in clinical and community services.
- ◆ The need for other health professionals to participate in health care delivery to support family doctors in clinical settings.
- ◆ The need to monitor the role and quality of private medical care, especially for the elderly.
- ◆ Low citizen participation in PHC management and organization, though it was better in planning-related tasks.
- ◆ The need for greater integration of curative and preventive services in family medical practice.

Source: Mattes H. The Quebec experience in consolidating primary health care and integrating health services. Presentation during the PAHO Regional Forum "Expanding Equitable Access to Health Services: Experiences and Key Interventions," Washington, D.C., 13 July 2015.

4. Stewardship and management.

- a. Set up programs to support integrated service management.
- b. Establish human resource policies to support implementation of the new service delivery models.
- c. Assign operational programming responsibilities to specific actors (integrated or coordinated service providers).
- d. Provide instruments that will help managers improve planning, coordination, and communication.
- e. Prepare and implement plans for building managerial capacity.
- f. Promote, lead, negotiate, agree on, and evaluate the integration of health in all policies to guarantee equity.
- g. Support the decentralization of health service management and delivery to meet the needs of local populations.

5. Shared governance and accountability.

- a. Ensure that integrated care is a right and obligation in health systems.
- b. Establish a coordinated, integrated/unified, and centralized system for regulating governance. Governance should be sectoral and intersectoral to promote changes and innovations in the way the health issues should be approached by different partners in health and other development sectors.
- c. Develop and maintain health information management systems that facilitate evidence-based management of the procedures and health outcomes of integrated networks.
- d. Establish common performance standards and specific work agreements for the different areas of care.
- e. Negotiate with professional associations to encourage their acceptance of the new ways of working.
- f. Amend the frameworks that regulate the work of multidisciplinary team members to facilitate cooperation.
- g. Focus governance on public health outcomes and development objectives instead of processes.

6. Finance.

- a. Increase resources for first-level and integrated care.
- b. Ensure that health service payment mechanisms and resources contribute to integration rather than fragmentation.
- c. Invest in integrated care and capacity building—for example, in health care coordination and case management.
- d. Increase investment in strengthening managerial capacity—for example, for managers of integrated health teams.
- e. Replace payments based on historical spending with payments adjusted for the population's risks.
- f. Use financial incentives to promote health coordination activities and packages of comprehensive health services and benefits.

Creating an enabling environment: organizing health service delivery

One of the elements underpinning the strategies for expanding equitable access to health services is the existence of organizational platforms that make it possible to introduce changes in the system. In fact, the World Health Organization (WHO) recognizes that its Member States must create enabling environments for such strategies, both nationally and regionally. This will require legislation, supporting regulations, and agreements on governance and organization that facilitate, rather than resist, health system transformation (24).

Concerning the promotion of universal access to health and universal coverage, numerous studies suggest that IHSNs have important benefits for health systems, including: 1) optimization of access; 2) integration of care; 3) continuity and life course approach; 4) rationalization of health production and technology use; 5) supplementation of the work of generalists with that of specialists; 6) greater involvement of civil society and other sectors; 7) improved access, 8) improvements in the overall efficiency of the system; and 9) promotion of services that are more responsive, more accessible, and meet the population's needs and expectations.

To support the transition, the participants in the Regional Forum recommended:

- ◆ Government policy in which IHSNs are an essential strategy for achieving more accessible, comprehensive, integrated, and continuous services
- ◆ A legal framework compatible with the development of IHSNs
- ◆ Public policy instruments for:
 - Geographic assignment of the population to be served.
 - Service planning based on the needs of the population.
 - Definition of comprehensive health services.
 - Standardization of the people-, family-, and community-centered approach.
 - Standardization of the gender and intercultural approaches in the services.
 - Sensitivity to the diversity of the population.
 - Development of the FLC as the point of entry to the health services and the coordinator of care.
 - Regulation of access to specialized care.
 - Manuals or clinical practice guidelines (activity protocols).
 - Human resources training and management, in keeping with the health needs of the population, and care through IHSNs.
 - Intersectoral collaboration to address the health determinants and equity in health.
 - Adoption of public petitioning and accountability processes with active social participation.
- ◆ Institutional clinical mechanisms
 - Multidisciplinary teams.
 - Staff rotation in all areas of care.
 - Single clinical files (electronic, insofar as possible).
 - Referral and back-referral guidelines and the monitoring and evaluation of adherence to them.
 - Case management.
 - Telemedicine and telehealth.
 - Self-care and home care duly supported and paid for.

- ◆ Non-clinical institutional mechanisms (including those that support clinical care)
 - Shared strategic planning, resource allocation, and performance evaluation.
 - Definition and functions of each network component as part of the continuity of care.
 - Information systems for health surveillance and the management of health service delivery networks.
 - Centralized appointment centers.
 - Shared clinical and logistical support systems.
 - Unique user ID.
 - Social service teams for intersectoral coordination.
- ◆ An efficient and sustainable increase in public health financing through appropriate resource allocation to improve equity, prioritizing the FLC to make it more responsive and improve its ability organize service networks
 - Progress toward the elimination of direct payments, which constitute an access barrier at the point of service.
- ◆ Regulation as an effective instrument for guaranteeing:
 - Better health service access and quality, especially at the FLC.
 - Quality and the use of technologies that benefit people and improve health care outcomes.
- ◆ Investment in research, evaluation, and monitoring:
 - Of the health system and its service outcomes to generate data that show the impact of the sectoral reforms on intersectoral work and on the health of people and communities.

Challenges in transforming the model of care

Transforming the model of care toward a people-centered, PHC-based model with a robust FLC that prioritizes community health and employs multisectoral strategies for action is a complex undertaking.

It will likely be necessary to surmount obstacles related to the different types of facilities—a process that requires steady transformative and far-reaching change, as well as programs with directors and managers that support such change (Chapter 5). Transforming a biomedical model into one that fosters the capacity to understand the needs of the whole person and employs multidisciplinary teams will threaten the independence of professional groups and specialists. It will also require the promotion of new care networks to allow for coordinated care among different providers and facilities.

This will call for the Member States to rethink and revise the model of care, which must be adapted to and implemented in different contexts (25). Governments will have to work with different health care providers and communities for coordinated and shared decision-making (see Chapter 4). They will also have to choose the design of the health services organization model, determining who will provide what services and to whom. In other words, the countries of the Region will have to tailor their health system transformation objectives to their own circumstances.

Transforming the model of care: evidence and examples of effective measures

There is substantial international evidence of the importance of reorienting models of care (25). The main strategies range from community-based capacity building at the FLC to promoting access to integrated networks with a variety of services available locally. A key element is building greater health planning and management capacity to effectively channel interventions to those who need them the most, making better use of human and financial resources.

The main strategies for transforming the model of care include (26): 1) investing in first-level centers; 2) establishing family and community medicine and health practice; 3) developing the first-level workforce; 4) creating multidisciplinary teams and community outreach services; 5) investing in differentiated care for older persons, including home care; 6) integrating mental health care into the FLC; and 7) promoting the use of new technologies for managing care in remote communities.

Reorienting models of care for chronic diseases

The need for measures to confront the growing problem of chronic noncommunicable diseases (CNCDs) has been recognized for many years. However, while these diseases are responsible for 70%-80% of deaths in the Region, only around half of the people who suffer from them receive a specific diagnosis and, in turn, only half of that group receive treatment. An even smaller proportion receive support in meeting their treatment objectives. In short, less than 10% of patients with a CNCD can properly manage their illness (25). NCDs are therefore one of the most important and urgent problems in the Region, since the growing burden of chronic disease poses a real threat to the health of the population and the future social and economic growth of countries.

In response to this situation, many countries have sought to promote integrated CNCD management for health promotion, address risk factors and the social determinants of health, and prevent these diseases.³ Different countries have attempted to adopt or adapt versions of the model of care for chronic diseases, and PAHO/WHO has played a key role by providing a framework for improving the health of people with these diseases (7, 26, 27). This framework focuses on strengthening the FLC and creating IHSNs to make these diseases the responsibility of the health system and improve the health status and clinical outcomes of people with CNCDs. Effective care for CNCDs includes (24):

- Reduction of direct expenditure by patients to alleviate the financial burden. People-centered care at the first level, with emphasis on prevention.
- Planned proactive care through health promotion activities.
- Quality care, including rehabilitation and palliative care.
- Health professionals trained and current with respect to CNCD management and prevention.

3 Also known as the chronic care model (CCM).

Concretely, effective care for health promotion and CNCD prevention requires new capacities and professional roles at the FLC to manage individual risk factors such as alcohol consumption, salt intake, tobacco use, diet, and physical activity.

A common vision, as well as multisectoral collaboration for the inclusion of health in all policies, is important for regulating tobacco use, alcohol consumption, and a diet rich in ultra-processed food, sugar, and salt. Urban planning that fosters physical activity and healthy settings, health promotion, and the prevention of social, family, and school violence is also important. The health-in-all-policies strategy also requires community and civil society participation to ensure that the entire population understands the causes of NCDs and makes a commitment to the same goals: healthier living, better self-care, promotion of change, and greater participation in decision-making.

PAHO's "Innovative Care for Chronic Conditions" report (7) offers a general overview of chronic care models in the Region. When designing these models, the Member States should include a series of essential components to make changes that could contribute to the achievement of the first line of the Strategy (Box 3).

Box 3. Recommendations for action: Innovative Care for Chronic Conditions

1. Implement the chronic care model in its entirety.
2. Ensure a people-centered approach.
3. Create (or review existing) multisectoral policies for CNDC management, including universal access to care, aligning payment systems to support best practices.
4. Create or improve existing clinical information systems, including monitoring, evaluation, and quality improvement strategies as integral parts of the health system.
5. Introduce systematic supported self-management for patients.
6. Orient care toward preventive and population care, reinforced by health promotion strategies and community participation.
7. Change (or maintain) health system structures to better support CNDC management and control.
8. Create PHC-led networks of care supporting continuity of care.
9. Reorient the health services, creating a chronic care culture including evidence-based proactive care and quality improvement strategies.
10. Reconfigure health workers into multidisciplinary teams ensuring continuous training in CNCD management.

Source: PAHO. Innovative Care for Chronic Conditions: Organizing and Delivering High Quality Care for Chronic Non-Communicable Diseases in the Americas. Pan American Health Organization, Washington, D.C. Available at: <https://www.paho.org/hq/dmdocuments/2013/PAHO-Innovate-Care-2013-Eng.pdf>.

Case study B. Chronic disease management in Alberta (Canada)

Alberta's health system has fully embraced the PHC approach in delivering services to patients with chronic diseases. To do so, it employs multidisciplinary health care and social service teams. The model emphasizes coordinated people-centered care throughout the care continuum. In order to achieve this, it has invested in health promotion and disease prevention, as well as the early detection of individuals at high risk, using data for risk stratification. One year after program launch, a comparison with the baseline showed a substantial reduction in the need for hospitalization among systematically monitored patients with certain chronic diseases: a 19% reduction in the number of hospitalizations of people with chronic obstructive pulmonary disease (COPD) and a 34% reduction in visits to emergency services.

Source: Delon S, Mackinnon B. Alberta's systems approach to chronic disease management and prevention utilizing the expanded chronic care model. *Health Q.* 2009;13:98-104.

Reorienting models of care for older persons

The acceleration of population aging throughout the Region has led to recognition of the need to intensify integrated management of the complex health needs of older persons and the requisite social services. Aging will heighten the demand for care due to the growing number of people with multiple chronic diseases, greater frailty, and dependency. Consequently, the new care and support models should be tailored to those new demands.

The recent World Report on Ageing and Health contains objectives, strategies, and activities that WHO regions and Member States should adopt. The report provides a global framework for action in public health. Its vision is a world in which all countries pledge to promote healthy aging, with plans of action to maximize the functionality of all. Four priority areas are defined (28):

1. Align health systems to the needs of older populations.
 - a. Develop and ensure access to services that provide older-person-centered care.
 - b. Reorient health systems around older-person-centered care.
 - c. Ensure a sustainable and appropriately trained workforce for hospital and outpatient care of older persons.
2. Develop systems for providing long-term care.
 - a. Establish the foundations necessary for developing a system of long-term care.
 - b. Build and maintain a sustainable and appropriately trained long-term-care workforce.
 - c. Ensure the quality of long-term care.

3. Creating age-friendly environments.
 - a. Combat ageism.
 - b. Enable autonomy.
 - c. Support healthy aging in all policies at all levels of government.
4. Improve measurement, monitoring, and understanding.
 - a. Agree on metrics, measures, and analytical approaches for healthy aging.
 - b. Improve understanding of the health status and needs of the older populations.
 - c. Increase understanding of healthy aging trajectories and what can be done to improve them.

According to the WHO report, the best way to optimize the functional capacity of older persons is to put them at the center of service delivery. In practice, this means coordinating care and services around the needs of older persons, which involves:

- ◆ Preparing complete descriptions of needs and care plans.
- ◆ Locating first-level services as near as possible to where people live.
- ◆ Creating multidisciplinary health care and social service teams to support management of care in the community.
- ◆ Contributing to older persons' self-management, providing peer support, training, information, and counseling (27).

The principles illustrated in Figure 4 are closely aligned with the lines of the regional Strategy for Universal Access to Health and Universal Health Coverage. They also examine the new capacities that health systems will require to meet the needs of the older population and promote healthy aging. People over 60 in the Americas often receive substandard care, meaning that they are less likely to receive appropriate treatment and more likely to be seen in hospital emergency services (7).

Providing continuity and improving the quality of care for older persons includes: 1) guaranteed access to first-level facilities; 2) lengthier consultations; 3) the availability of intermediate care (in both the hospital and rehabilitation and recovery services); 4) training for self-care and for the caregivers of older persons, who are sometimes family members or other older persons ("caregiver school"); 5) emergency health and social response teams; and 6) home services to support prevention, with a link to geriatric and community services and teams of specialists that provide end-of-life care for older persons and promote death with dignity. It is important to emphasize the link with geriatric services to permit geriatric assessment, identify risks to older persons, and set priorities for management at the FLC and in specialized services, if necessary.

Many countries in the Region are already addressing the issue of healthy aging. In Brazil, aging has been integrated into the national family health program to promote home visits by multidisciplinary teams made up of doctors, nurses, and social workers associated with first-level clinics. In Quebec, Canada, the objective of the Program of

Research to Integrate the Services for the Maintenance of Autonomy (PRISMA), which coordinates care for older persons, is to help patients maintain their independence. The services provided include hospitalization, emergency care, hospital outpatient care, the FLC, specialized geriatric care, rehabilitation, nursing homes, treatment, personal care, home care, home meals, adult day-care centers, pharmacy services, equipment, construction materials, and household help (29). PRISMA remains the only international model for coordinating care for older persons that has been extensively evaluated and has yielded improvements in the quality of care and the care experience at no additional cost to the health system (30).

Figure 4. Ten integrated services for people-centered care for the elderly



Source: Modified from Oliver D, Foot C, Humphries R. Making our health and care systems fit for an ageing population. The King's Fund, London. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf

Case study C. Integrating aging into the national family health strategy, Brazil

In 2006, Brazil's national health and aging policy made it possible to provide better care for older persons, taking advantage of the country's commitment to universal health coverage and its robust national family health program.

A basic feature of the family health program is the use of multidisciplinary teams consisting not only of doctors and nurses, but physical therapists, psychologists, physical education specialists, nutritionists, and occupational therapists, to name but a few. These teams work together in a family health support center that offers home visits and social, health, and community outreach services, as well as case-finding and home visits in a specific geographical area.

All health professionals learn to assess the functional status of older persons, including their frailty and psychosocial status. This general assessment has become a basic tool for integrating the care of different services and providers. This training is supplemented with new comprehensive PHC standards for older persons.

Considerations on aging were integrated into a variety of clinical care procedures, and new interventions specifically for older persons were introduced. Some of these latter are provided in older persons' communities by self-help groups and through healthy behavior classes, physical exercise, and dance classes. One of the program's strengths has been the community's commitment and participation. For example, older persons and volunteers are responsible for most of the social assistance provided.

Source: World Health Organization. World Report on Ageing and Health. Geneva: WHO; 2015. Available at: https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf

A review of the literature, including an in-depth analysis of seven case studies, found recurrent elements that contribute to health system strengthening to meet the needs of older populations (31, 32). They include: 1) a single point of entry to the FLC; 2) comprehensive audits of health needs; 3) care planning; 4) the coordination of care by designated case managers; and 5) an adequate integrated health service delivery network.

Integrating physical and mental health care

Mental health is a vital component of a person's general health and well-being. As WHO states, "without mental health there can be no true physical health" (33), because physical health and mental health are interdependent. Having a physical condition significantly heightens the risk of having a mental health problem and vice versa.

The prevalence of concomitant mental and physical health problems is high. A review of the literature suggests that around 45% of people with mental health problems also have a long-term physical health problem. Similarly, people with chronic cardiovascular or respiratory disease, diabetes, or chronic musculoskeletal disorders are two to three times more likely to have a mental health problem than the general population (34).

The evidence in the Americas suggests that:

- ◆ The association between depression and anxiety is three times more common among people with heart disease (in the population that has suffered a heart attack) than among those suffering from severe depression in general.
- ◆ Depression is an independent risk factor for stroke.
- ◆ The concomitance of diabetes and depression is high, as indicated by the fact that 60% of people with depression are at greater risk of developing type 2 diabetes.
- ◆ Mortality from mental health problems is low but is associated with more than 90% of suicides, some 65,000 per year in the Americas.
- ◆ Less than 50% of people with obvious symptoms of depression are likely to be diagnosed by a physician, and some 35%-50% of patients in need of treatment for serious mental health problems receive none whatsoever (33).

The interaction between mental and physical health significantly worsens with social deprivation. For example, among patients from lower socioeconomic strata who suffer from multiple physical disorders, the prevalence of mental illnesses is almost 50% (35). Symptoms that have no medical explanation are also very common and account for roughly 15%-30% of all consultations at the FLC (36).

People with concomitant mental health and physical disorders have poor physical health outcomes. Mortality among people with cardiovascular disease or diabetes, for example, is significantly higher for those who also suffer from depression (37, 38). Outcomes are especially poor among people with schizophrenia or other psychoses, whose excessive mortality is largely attributable to their fragile physical health, which shortens their life expectancy by 15 to 20 years compared with the general population (39).

Mental health problems also reduce access to care for physical health problems. A Canadian study showed that revascularization rates among people with ischemic heart disease were significantly lower among those who also suffered from dementia or psychosis (clinical need-adjusted rates) (40).

Approximately 15% of the Hemisphere's population suffers from concomitant physical and mental disorders. As a result, a person with serious mental health problems may live around 25 years less than the general population. This is a grave and urgent matter, for it not only shortens life expectancy but reduces the quality of life. Furthermore, it is associated with much higher costs for the health system due to lack of health promotion and disease prevention, the hospital-based approach to treating mental and psychiatric health, and the resulting complications of mismanaged chronic conditions (38).

The WHO/WONCA⁴ report “Integrating mental health into primary care: A global perspective” showed how improved access, health promotion, and respect for the rights of people receiving mental health care can lead to better care outcomes and timelier access (41). Mental health is better provided in first-level centers, rather than hospitals or asylums, to support rehabilitation. However, there is a constant lack of care and resources for mental health in comparison with other chronic diseases, as well as an ongoing lack of professional capacity, especially in FLC and community health settings.

To support comprehensive physical and mental health services in the Member States, in October 2010 the Director General of WHO launched the mhGAP Guide⁵ (42), aimed at expanding care for mental, neurological, and substance use disorders. The Guide describes how to set priorities by using selection criteria for interventions (e.g., high burden of disease, high costs) and how to select a group of priority disorders. It also provides a framework for addressing change and investment to improve care and treatment for people with mental health needs (Figure 5).

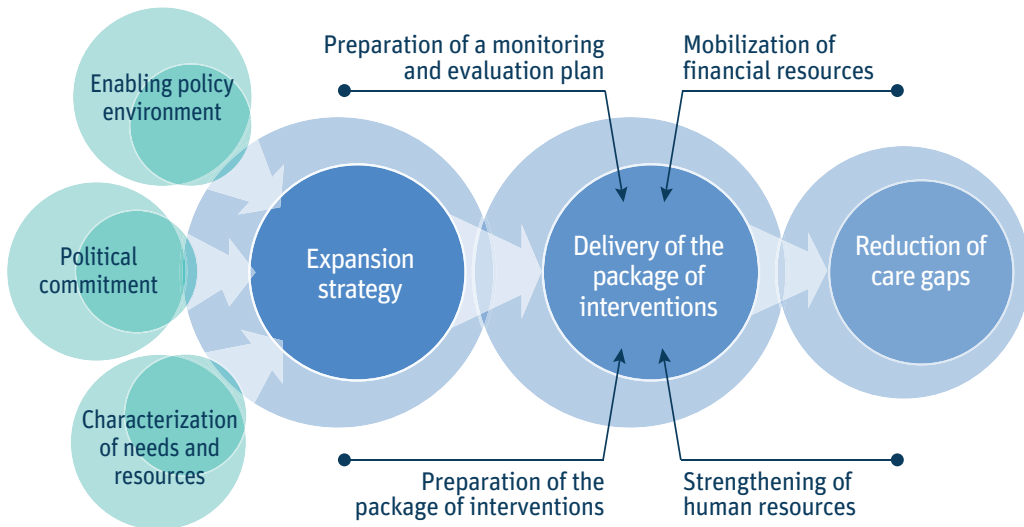
Case study D. Development of comprehensive physical and mental health services in The Bahamas

In The Bahamas, integrating physical and mental health services has had the support of a local health system that integrates FLC, family medicine, community health services, and hospital care. Using mhGAP, the mental health services have been integrated into first-level centers, expanding the range of available services and promoting access to mental health services for behavioral issues. These services have received support from educational and community programs and outreach services that promote healthy lifestyles. These elements are part of a broader strategy to shift services from hospitals to care in the community.

Source: The Bahamas. Presentation of William S. at the PAHO Regional Forum “Expanding Equitable Access to Health Services: Experiences and Key Interventions,” Washington, D.C., 13 July 2015.

⁴ World Organization of Family Doctors.

⁵ Mental Health GAP Program, World Health Organization.

Figure 5. Framework for mhGAP action

Source: Modified from World Health Organization. MhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings, Geneva: WHO; 2010. Available at: http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf.

The collaborative care model is the one with a better design for improving care and outcomes for people with physical and mental health problems (43) and has been widely tested in several countries. The basic components of collaborative care are:

- ◆ Proactive management of physical and mental disorders by non-physician case managers working in close collaboration with a family doctor and other primary care personnel.
- ◆ Periodic supervision meetings between the case manager, primary care personnel, and a mental health specialist to review new cases and the progress of existing patients.
- ◆ Case manager use of standardized treatment protocols.
- ◆ Active exploration by case managers of the link between well-being and physical and mental disorders.
- ◆ On some occasions, case managers may also be trained to offer brief psychological interventions.
- ◆ Concentration on education and the transfer of skills among the professionals involved in collaborative care (44).

The collaborative care model has often been used in the context of IHSNs. In the United States, organizations such as Intermountain Healthcare, the Veterans Health Administration, and Kaiser Permanente have made the principles of collaborative care (Case study E) (45) part of large-scale care programs that attempt to integrate mental health services into the FLC.

Case study E. Integration of mental health in Intermountain Healthcare, the United States of America

In the 2000s, the first-level physicians of Intermountain Healthcare, a not-for-profit health system operating in the states of Utah and Idaho, noted the need for a more effective way of assisting the large number of people with mental health problems who at the same time often suffer from a combination of physical illness, substance abuse, and difficult social circumstances. To address this situation, Intermountain developed a mental health integration program (MHI) that has now been deployed in most consultations at the FLC.

The program consists of first-level physicians who assume greater responsibility in mental health service delivery with the support of strengthened multidisciplinary teams. Basic elements of the model are:

- ◆ Care provided by teams with mental health professionals who are part of the primary care team, with the support of psychiatrists, psychologists, psychiatric nurses, and social workers.
- ◆ Cases managed by a nurse who coordinates medical, psychological, and social support.
- ◆ Significant investments in hands-on training for personnel (doctors, nurses, receptionists, and others) in order to raise awareness about mental health, teach empathetic communication skills, and share decision-making.
- ◆ Shared electronic medical records accessible to all members of the team.
- ◆ Proactive detection of mental health problems in high-risk groups.
- ◆ Supported self-management of physical and mental health.
- ◆ Use of community resources and peer support.
- ◆ Use of disease registries and evidence-based guidelines.
- ◆ Use of new technologies—i.e., telehealth and telecare.

As part of this program, mental health is provided as stepped care, with responsibilities balanced between first-level and specialized care, depending on the degree of complexity. Around 80% of the mental health care is not provided by specialists. Evaluations of the model have found significant improvements in physical and mental health outcomes, in self-management, and in the cost of care, which turns out to be lower.

Studies like the TEAMcare trial in the United States (46) have found that collaborative care interventions can improve recovery from depression among patients with diabetes or heart disease, or both, while at the same time improving self-management of their physical health. This was also the conclusion of a systematic review conducted by Huang et al. (47). Collaborative care also appears to be highly cost-effective and can lower costs (48, 49).

The Member States should adopt the integration of physical and mental health care as a core strategy for advancing universal access to health and universal health coverage. This is an important aspect of health care that has failed to arouse much interest but should be a priority for improving services and research in the Region's health systems.

Case study F. Brazil's Family Health Strategy

Over the years, Brazil has strengthened the FLC, centering it specifically on the family. This model is structured around decentralized units to promote equity and comprehensiveness with the support of the Family Health Strategy. Since 1994, health coverage for the Brazilian population has steadily improved, making it one of the most important and significant innovations in PHC worldwide.

By 2015, the Family Health Strategy had created some 38,478 health teams employing more than 260,000 workers in areas with vulnerable populations. Multidisciplinary teams assigned to specific geographic areas have become the first contact for health issues, and 62% of the population now has access to teams at the FLC in 5,430 municipalities, with coverage reaching some 120 million people.

Despite improved access and services at the FLC, there are obstacles to further improvement. These include structural and organizational problems, lack of professionals trained in family health (only 5% in 2009), and persistent differences in coverage and quality of care. Training to upgrade the skills of doctors and nurses is essential for family health services to expand to poorer communities and thus fulfill the aspiration of universal access to health.

Source: Facchini L. BRAZIL. The Family Health Strategy. Presentation at the PAHO Regional Forum "Expanding Equitable Access to Health Services: Experiences and Key Interventions," Washington, D.C., 13 July 2015.

Investing in the first level of care and family health

Investing in first-level response capacity is associated with a series of benefits, including greater access to care; the detection of health problems; greater immunization coverage; lower mortality rates; less use of hospitals; and more equitable and efficient health systems (23). Family health can also yield different benefits for the population, since it promotes closer ties between the first-level health team and other professionals (the first-level health or family health team) who work with the communities served. This promotes greater access and use of first-level services, in addition to offering greater opportunities for the implementation of participation and empowerment strategies. It also provides a platform to support the new types of services necessary for meeting the needs of older persons and people with complex physical and mental health needs—through the expansion of home care and community-based rehabilitation, for example.

Community-based multidisciplinary teams

Community-based multidisciplinary teams are essential for coordinating care for people, families, and communities in first-level or community care facilities, including people with multiple or complex chronic diseases. Several approaches have been adopted, some of them disease-specific and others for multiple disorders. Case management is often used, in which specific coordinated care is provided to support and manage patients' needs and facilitate their empowerment so that they can take charge of their own care.

These multidisciplinary teams need training for their professional staff, as well as support, since this is a new, collaborative way of working. Teamwork generally has many benefits. For example, it improves staff morale and workplace satisfaction, makes the user experience more satisfactory, promotes better clinical decision-making, and better outcomes (25).

Case study G.**Promoting integrated people-centered care through the creation of decentralized multidisciplinary teams in Peru: integrated health service networks**

In Peru, there is a growing commitment to developing a more holistic vision of health service delivery and people-centered care to meet the needs of the population and alter the social determinants of health. This effort relies on intersectoral work and social participation. To a large extent, the vision has focused on the FLC and is family-oriented. The care structure has been decentralized to the regional and local sectors, supported by team managers, multidisciplinary teams, and the ambition of creating a unified health information system. Use of an IHSN has also helped to bridge the artificial gap between first-level and hospital care and to emphasize people-centered services.

Intersectoral work at the local level is possible when partnerships are forged between health services and local communities and when there is concerted emphasis on developing treatment protocols, infrastructure, and support systems. Greater personnel satisfaction and availability of basic health services have been confirmed. IHSN program priorities going forward include:

- ◆ Developing new strategies to promote disease prevention.
- ◆ Reducing hospitalizations and unnecessary interventions.
- ◆ Providing 24/7 coverage with continuous care available at the FLC.
- ◆ Improving care for current cases (over the long term).
- ◆ Improving the transfer of care between hospital and home and vice versa.
- ◆ Ensuring that care is shared by different health providers and sectors, the existence of a trusting relationship, and data and information sharing.
- ◆ Recognizing the importance of hospitals, as well as their limitations, and using them as specialized systems that should promote home and community care.

Source: Pan American Health Organization. Expanding equitable access to health services: experiences and key interventions. Peru, presentation by Fernando Carbonell. Washington, D.C., 13-17 July 2015.

Information and communication technologies

Rapid technology development is facilitating innovations in the way health care is planned and delivered. Significant progress has been made in the use of applications for remote monitoring of the treatment of diseases such as diabetes and COPD, thanks to the growth of mobile health applications. When properly used, these methods have facilitated self-care, support services, and symptom monitoring to facilitate early intervention.

These new technologies are not a substitute for the existing health services provided in the PHC and community context. Their cost and technical factors often limit their use, especially when the cultural context of different population groups is taken into account. Nevertheless, eHealth is now widely used across the Region as a means of supplementing access to services, especially in rural and remote locations, and facilitating the coordination of care among providers (50, 51).

Case study H. Strengthening the first level of care with new technologies, Panama

Panama has made strategic use of new technologies to strengthen the FLC, adopting the use of electronic medical records that support decision-making on diagnosis, symptom control, and patient monitoring as part of care planning and disease management. Standardization of health records has improved communication between health professionals and health service providers. Information systems and data-sharing facilitate clinical governance, assessment, and monitoring. They are also used to improve the allocation of scarce resources in locations with limited personnel and physical infrastructure.

Telemedicine has enabled remote patient management through the creation of virtual hospitals in communities, improved symptom control, and facilitated self-care. Obstacles to the program's progress include a lack of human and financial resources to support telemedicine, as well as the cost and availability of the technology infrastructure itself. Health professionals and users of the services have sometimes resisted these changes. New skills are needed and it may be necessary to introduce education and certification programs.

Source: Pan American Health Organization. Expanding equitable access to health services: experiences and key interventions. Panama, presentation by Reina Roa. Washington, D.C., 13-17 July 2015.

Summary and recommendations

This chapter has examined the need to strengthen and transform health system organization and management in the Member States to implement the first strategic line of the regional Strategy for Universal Access to Health and Universal Health Coverage. It has also described how the capacity to expand equitable access to health services requires capacity and skill building at the FLC and throughout the care continuum to create IHSNs. The challenges and requirements for this reorientation of service have profound effects on health systems and the way they approach this transformative change. The experiences described and cases examined in this chapter yield a number of strategic and practical recommendations in this regard. The key message is that,

while certain elements in the transformation of models of care are essential for meeting the demands of new generations in the Americas, it will be up to the Member States to tailor those principles to the particular characteristics of local health service delivery.

Concerning the development of new models of care, the evidence, case studies, and deliberations of the experts at the Regional Forum are a reminder of the unquestionable consensus and political agreement on the need for new forms of care coordinated by the first level and integrated health service delivery. Nonetheless, it appears that there are many avenues, with subtle variations, to achieving success, depending on what the work is centered on: people, to manage chronic diseases and conditions; older persons, to support active and healthy aging; and people with physical and mental health problems, for whom emotional and spiritual well-being is as important as access to health services with sufficient numbers of trained professionals and appropriate technologies and medicines. Another basic aspect of the new models of care is their heavy emphasis on the intersectoral approach, tackling the social determinants of health, and social participation and empowerment.

The evidence also points to the need for simultaneous strategies based on the object of the care, be it the patient, the family, a particular community, or the general population of a country. Likewise, organizing the services around new people- and community-centered models should effectively integrate care in the services and community through different networks of providers and organizations. It will therefore be necessary to introduce mechanisms in the services that effectively support the coordination of care among the new partners participating in the care or to create new multidisciplinary teams with improved skills. Accomplishing this will depend on the effectiveness of the health care organization model and how it is operated and managed. These capacities, in turn, are highly influenced by governance, reporting, regulatory, and financial considerations, which must be compatible to provide a platform conducive to transformation.

The complexity involved in transforming the model of care has led the Member States to request practical guidance on how to move the process forward. Throughout this chapter we have tried to describe the elements involved in carrying out this work. A critical message, however, is that in the final analysis, the Member States will have to embark on their own transformation process. While there is much to learn from the experiences and examples of other countries, issues related to the prioritization of services must be addressed to meet the specific needs of populations and communities. This also means that every health system will have to embrace a transformative process of change to accomplish this.

CHAPTER 3



PROGRESSIVE EXPANSION OF QUALITY HEALTH SERVICES

Prioritizing and selecting health services and benefits

This report has examined evidence and case studies to describe different ways of transforming health systems to expand equitable access to a broader, more comprehensive package of services for the population through investment in community-centered services at the FLC. However, for good strategic decision-making and investment, Member States must continually look at and assess the package of services and benefits offered and decide which should be universally available and at what level of the health system.

The Strategy for Universal Access to Health and Universal Health Coverage (4) calls for progressive expansion toward equitable access to comprehensive, quality people- and community-centered health services. A critical aspect of decision-making is selecting the services and benefits to be prioritized. The goal is to standardize a specific package of comprehensive services and benefits that will improve the health and well-being of people and communities (52).

When setting priorities for defining the progressive expansion of quality health services, a combination of methods should be used, bringing together the principal stakeholders (governments, regulators, providers, professionals, communities, and users) to make efficient decisions consistent with the health system's objectives. These methods may include economic models (such as cost effectiveness analysis), health technology assessment, equity analysis, epidemiological mapping, and evaluations of the quality of care and access, as well as civil society participation.

In the United Kingdom, these types of decisions are backed by institutions with the capacity to make objective decisions based on the best available evidence (in this case, the National Institute for Excellence in Health Care, or NICE). NICE and WHO-CHOICE⁶ are progressively offering greater access to tools for priority setting (53). Furthermore, the WHO strategy for rational use of medicines can offer countries guidance on policy-making, structures, information, education, and evidence-based clinical guidelines to support decision-making.

However, institutional capacity of this nature is not available in most countries in the Region. This raises the question of how best to advance priority setting and decision-making, and the main challenges and issues facing the Member States in successfully implementing them.

Foundations for the progressive expansion of health services

Participants at the Regional Forum made important points about the progressive expansion of equitable access to comprehensive, quality, people- and community-centered health services, debating conceptual and methodological elements to support the adoption of recommendations based on the cumulative experience in the Region.

The four main lines of action of the Strategy for Universal Access to Health and Universal Health Coverage (4) are interdependent strategies that support the objective of universal access to health and universal health coverage. To achieve this, it is essential to know what is implied by quality and the expansion of care required to achieve universal comprehensive health services consistent with the Member States' health needs and priorities and their operational and financial capacity. Because no health system can meet every need, it will be necessary to consider, examine, and prioritize what must be done and pursue a rational, objective, transparent, and evidence-based decision-making process.

The purpose of defining the approach (Box 4) is to specify how the progressive expansion of health services should be achieved. It is a series of continuous, evidence-based operations for selecting a package of comprehensive services and benefits that national health systems can guarantee to people, families, and communities, depending on their stage of development. Some health systems, including Brazil's, have already adopted comprehensive service delivery. Several countries in the Region have established specific guarantees that validate the right to health associated with service delivery. However, it is necessary to be more specific about what is actually guaranteed and how people can have universal access and demand these services.

6 WHO. Choosing cost-effective interventions (CHOICE) project.

Box 4. Defining the progressive expansion of health services (16)

The development of an orderly relationship in which a group of specific rights, explicitly defined in terms of services, technologies, or need, are included and described to produce the response that the health system will provide to a community to allow people fair access, regardless of their financial situation and employment status. The selected services can be enumerated in the universal integrated programs, expressed in terms of guaranteed services or integrated packages of benefits and services.

A package of services is characterized by two key features:

1. ***Social protection:*** to offer society certain guarantees with respect to people's right to health (for example, through guaranteed access).
2. ***Delivery of care:*** the care services and programs that will be available and how they will be provided (for example, through IHSNs).

Services should be comprehensive, continuous, and integrated into people's lives, meaning that they should include health promotion and disease prevention, diagnosis and treatment of disease, rehabilitation, and long-term care. Care should be available to all, according to needs, and should not be segmented or depend on a person's ability to pay. Consequently, any package of benefits and services must be universal, progressive, comprehensive, viable, sustainable, evidence-based, and socially acceptable.

The implications for the Region's health systems are far-reaching. These aspirations require firm political will and institutional and social policy negotiations and dialogue that lead to a fully developed package of comprehensive health benefits and services subject to regulation, monitoring, and evaluation. This will present a challenge in terms of the way in which political and social agreements are negotiated and care is financed: the definition of service delivery will have to include agreements on the appropriate and necessary financing of the services. This will also influence the way in which the new models of care are implemented—through expanded access to the FLC and improved coordination of care for people needing medium- and long-term services in the various health facilities, or in their home or other social and community institutions, with IHSN support. It also requires health systems to have the capacity to make decisions on technical specifications and priorities (e.g., investments, availability of detailed information and operational data, finances, and outcomes, health technology assessment, economic evaluation, epidemiological mapping, managerial development, legal assistance, and social participation).

In addition to laying the foundations for developing and selecting services and benefits, it is important that health care is planned so as to facilitate its progressive expansion, in order to achieve the goal of universal access to health and universal health coverage. This requires continued efforts to ensure that the population knows its rights and benefits, determine the cost of the interventions and services, update and expand the packages of benefits, and continuously evaluate service delivery in the context of ever changing needs and available resources.

Challenges in prioritizing services

How to prioritize the services to be included in the guaranteed packages of national health services has been a topic of considerable debate over the years in the Region of the Americas (54, 55). Historically, the discussion has centered around the strategic procurement of health services and the continuous search for the best interventions or packages of services. The degree to which health services and benefits are currently specified in the Region varies from country to country, as does recognition of the right to health. For example, while health systems in countries such as Brazil already have a list of the services and benefits provided by their universal health programs, others have restrictions or limitations (Table 2).

Prioritizing and selecting basic packages of services requires: 1) stewardship and governance, with the State and civil society negotiating with each other and setting health system objectives and priorities that are manifested in health policies that balance equity, efficiency, response capacity, and quality of choice; and 2) that the State must guarantee the negotiated health benefits, interventions, and services in order to meet the objectives of these policies. The entire process implies the creation of incentives and negotiations with the various stakeholders and health care providers, including civil society, to determine the packages of services and benefits to be offered (56).

Many low- and middle-income countries have been unable to provide timely and adequate health services to all the population, thus perpetuating and even exacerbating the wide gaps between urban and rural areas, and between rich and poor population groups. These circumstances make it even more necessary to strengthen the capacity for priority setting to ensure maximum health gains and universal access to care with limited resources. A policy on essential packages of care has been promoted in many countries as a means of addressing or reducing the burden of disease (57). The goal has basically been:

- ◆ To provide, at the very least, universal access to basic health services
- ◆ To expand service coverage to poor and marginalized population groups
- ◆ To ration the use of treatments and technologies that are expensive and not cost-effective

The World Bank (58) has promoted the essential clinical packages policy to channel resources toward interventions with a greater health impact. This approach, however, promotes vertical and fragmented disease-centered programs and does not necessarily further the basic objective of improving the health and well-being of all members of society.

Table 2. Health benefits and services packages in countries of the Americas

Country	Program	Year launched	Coverage (population %)	Legal underpinnings	Regulatory agency	Services included
Argentina	Compulsory Medical Program (PMO)	1995	52*	LN 23660 and 23661	Health Authority, Ministry of Health	All levels of care. Lengthy and explicit list. Some coverage criteria.
Brazil	National List of Health Actions and Services (RENASES)	2011	100	LN 8080 LN 8142 SUS	Ministry of Health, Health Councils (national, state, and municipal)	Services: <ul style="list-style-type: none"> • FLC • urgent and emergency care • psychosocial services • specialized care • public health monitoring
Chile	Explicit Health Guarantees (GES/AUGE)	2005	100	LN 19.966 LN 18.933	Health Authority, Ministry of Health	Free first-level services. Second- and third-level services for 80 health problems. Has coverage guidelines and a list of medicines.
Guyana	Package of Publicly Guaranteed Health Services	2008	100		Ministry of Health	All levels of care. Includes a list of medicines.
Peru	Essential Health Insurance Plan (PEAS)	2009	Workers covered by Social Security and public insurance	LN 29344 Universal Insurance	Health Authority, Ministry of Health	First, second, and third level, with care for 50 health problems selected according to the burden of disease.
Uruguay	Comprehensive Health Plan (PIAS)	2008	100	Decree 465/008 of October 2008	National Health Council (JUNASA), Ministry of Public Health (MPH)	Comprehensive health programs and catalogue of benefits: <ol style="list-style-type: none"> 1) types of medical care; 2) medical specialists, other professional and technical personnel for health monitoring and recovery; 3) diagnostic procedures; 4) therapy and rehabilitation; 5) oral health; 6) medicines and vaccines; 7) medical transportation.

*Only for workers covered by the Obras Sociales Nacionales and prepayment systems.

Source: Adapted from Leguiza Fandos J et al. Análisis comparativo de conjuntos de prestaciones que brindan los sistemas de salud en las Américas y el Caribe. PAHO-WHO. Unpublished. Washington, D.C., June 2012.

Whatever the definition of universal intervention packages that guarantee the right to health, the need to supplement them with new models of care is obvious. Intervention packages are an important feature of the new models focused on the search for responses to chronic conditions and diseases. These models address the social determinants of health and human behavior throughout the life course with methodologies that eschew the individual biomedical approach to disease and address new problems linked to aging, migration, climate change, social and health inequities, societal and domestic violence, mental health, harmful addictions, social and citizen security, traffic and workplace accidents, and citizen expectations.

It is essential to consider progressive investment in these new models of care, which improve universal health services and social support networks for the entire population. Each health system will follow its own path, based on historical, economic, political, and social realities and on the degree, peculiarities, and viability of national, regional, and local institutional pursuits.

Three national case studies

Case study I. Development of a comprehensive health plan, Uruguay

Uruguay's Comprehensive Health Plan establishes full guarantees under an integrated national health system. It has also sought to improve governance and the regulatory process. Launched in 2007, its main feature was the production of a catalogue with an exhaustive list of benefits, including 1,600 diagnostic procedures and almost 3,000 therapeutic and rehabilitation procedures, as well as oral health, vaccines, medicines, and transportation. In 2008, the catalogue was expanded to include a series of existing public health programs, such as self-care support.

Catalogue updates are based on scientific evidence and changes in epidemiological conditions, with technical input from a panel of experts. A rigorous analysis is performed that examines a series of impact criteria, evidence, and whether proposed improvements are justified in terms of patient recovery or better quality of life. In the final phase, the list is revised and disorders are organized by treatment efficacy and then prioritized.

The catalogue established rules for signing service contracts with public and private providers (a first round in 2008; a second round in 2012) that include penalties for noncompliance. The National Fund (financed by the income tax) negotiates rates and incentives to promote universal access and quality of care, along with professional incentives linked to changes in the model and quality of care. Payments are results-based, creating a source of technical and administrative autonomy, in addition to flexibility, for providers.

Uruguay's main challenge has been guaranteeing sustainable care, provided fairly and ethically. Its strategy for communicating with the public has been essential in raising awareness that the country has limited resources and in demonstrating transparency in the development of its system of guarantees. The main emphasis in system operations has been on transparency in decision-making, promotion and communication of results, management of public opinion and professional perceptions, and the promotion of social participation.

Source: Pan American Health Organization. Rodríguez A. PIAS and Fondo Nacional de Recursos. Presentation at the Regional Forum "Expanding Equitable Access to Health Services: Experiences and Key Interventions," Washington, D.C., 16 July 2015.

Case study J. **Universality and integration: creating national medicines and health services lists in Brazil**

Brazil has a complex national health system (Unified Health System, known as the SUS), grounded in the principles of universality, equity, and comprehensiveness. Given the country's large size, its health system is characterized by decentralization, regionalization, and social participation. The linchpin of the system is the development of PHC to promote widespread access to health care.

In 2011, Brazil introduced a new legal framework (Decree 7508) that restored the role of the SUS and the health planning process, resulting in the creation of the National List of Health Actions and Services (RENASES) and the National Essential Medicines List (RENAME). RENAME was a complete list of the services that the states and municipalities would provide, updated every two years, together with the quality standards and regulations governing access.

Six levels of action are involved in the regulation of service delivery:

1. Free user services without the need for ordinary mechanisms to control access (FLC centers).
2. Service for referrals to SUS services.
3. Service for access requiring prior authorization.
4. Services requiring care from a qualified specialist.
5. Services authorized in national clinical protocols or treatment guidelines—for example, for rare diseases.
6. Services that support the development of public health services (interventions for individuals or specific groups).

CONITEC, an organization similar to the United Kingdom's NICE, was created to evaluate medicines, health technologies, and policies and guidelines that support transparent decision-making, public consultations, and decisions on the content of the lists.

Due to Brazil's federal structure, the main challenge in the application of RENASES has been the negotiation of agreements and political commitments. The visionary position of RENASES has been tempered by realism, since the lists strongly reflect the current capacity of national health systems to meet the population's health needs. The lists have tended to freeze services and limit the potential for innovation or the approval of additional services. Universal access to health and universal coverage have improved but at different rates throughout the country, and with gaps in access, available human resources, and quality of care that have yet to be bridged.

Source: Leles F. Brazil: National drug listings and health services—facing universality and integration. Presentation at the Regional Forum “Expanding Equitable Access to Health Services: Experiences and Key Interventions,” Pan American Health Organization, Washington, D.C., 15 July 2015.

Case study K. Explicit Health Guarantee System/AUGE, Chile

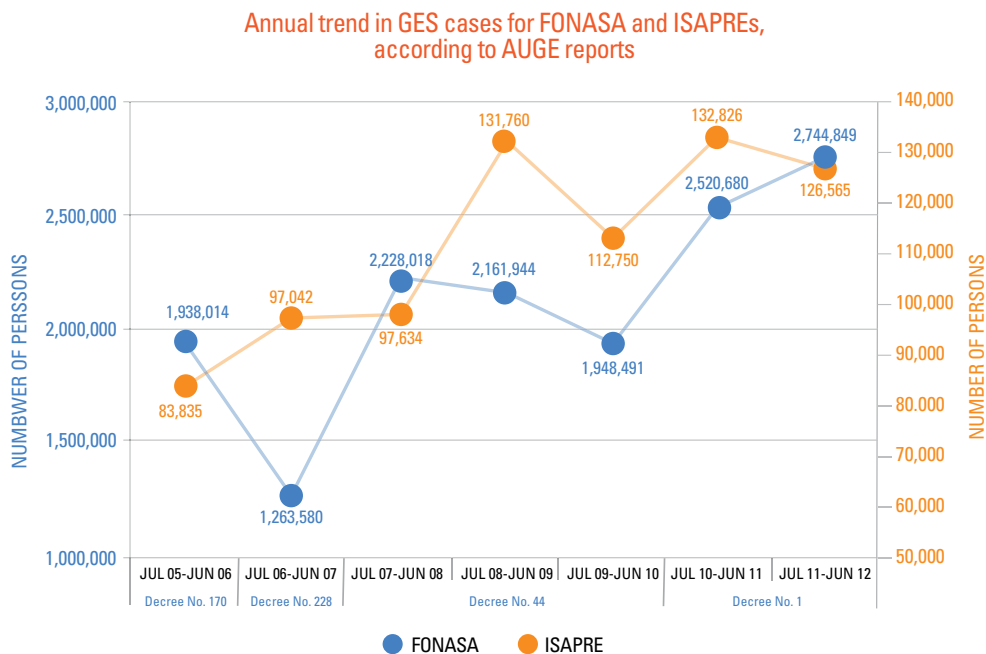
The Universal Access with Explicit Guarantees (AUGE) reforms in the Chilean health system have been aimed at supporting the creation of a more integrated health system and solving the problem of financing—in particular, the high levels of private financing and segmented service delivery. The reforms include new insurance programs for low-income people through the creation of the National Health Fund (FONASA), which covers 76% of the population, and the Health Insurance Institutions (ISAPRE), a private health system that provides coverage for higher-income groups.

The basic principle of the system was to integrate public and private financing to create health services with explicit guarantees, comprehensive regulation, and sound stewardship that would promote models of care through integrated public and private networks. The emphasis was on strengthening the FLC to address the issues of chronic diseases and population aging. Under this system, access, equity, quality, and financial protection were guaranteed for 56 conditions. (Financial protection is important to prevent the package of benefits from becoming a regressive tax).

Creating the system was largely a political process. Nevertheless, there were consultations outside the Ministry of Health to reach agreement on the bases for the guarantees. Implementation would be progressive. The result was a substantial increase in financial coverage for people with insurance (Figure 6).

Source: Cid C. Chile: AUGE. Presentation at the Regional Forum “Expanding Access to Health Services: Experiences and Key Interventions,” Pan American Health Organization, Washington, D.C., 16 July 2015.

Figure 6. Number of annual cases seen in the Explicit Health Guarantee System (GES), through the National Health Fund (FONASA) and the Health Insurance Institutions (ISAPRE), in accordance with the Plan for Universal Access to Explicit Guarantees (AUGE Plan), Chile



Curiously, the AUGE Plan has been underutilized, since people have maintained dual coverage through FONASA and ISAPRE, with reduced prices. AUGE has shortened the time between diagnosis and treatment, but the plan has also been associated with greater bureaucracy. Some of the program's successes have been shorter waits for care and, partially, a change in the model of care to promote public health and tackle the issue of chronic diseases. The negative impact, which was unexpected, includes the behavior of providers, who have exploited current incentives in the payment systems. This needs to be addressed to change the payment of incentives throughout the disease cycle, perhaps through payments per package of services. The Chilean system still has problems in terms of segmentation and inequality but has made progress in promoting citizens' right to health.

Summary of critical aspects of implementation

The previous case studies illustrate different methods for selecting health services and benefits. Despite national differences, common elements have been observed among countries:

- ◆ Use of a national regulatory framework that defines and supports transformation processes;
- ◆ Communication and transparency in decision-making (for example, in the definition and design of the package of benefits);
- ◆ Consultation processes that include the participation of organized civil society (NGOs, trade associations, professional schools, academia, health advocacy groups, etc.);
- ◆ Emphasis on health promotion and access to services (instead of disease);
- ◆ Creation of financial mechanisms to support results-based management;
- ◆ Challenges in maintaining equity, given the potentially regressive nature of lists that limit coverage.

During the Regional Forum, the participants were asked to think about their countries' experience and to systematize and share it with others in order to develop ideas and recommendations on the adoption of practical strategies for prioritizing care and services. As part of this task, they were asked to develop and apply criteria and to consider what could be done to progressively expand benefits to people so that health systems could advance toward the strategic objective of equitable access to comprehensive people- and community-centered quality health services. Specifically, the participants were asked three questions:

1. How can services be prioritized to advance toward universal access and coverage in their national context?
2. How can guarantees be created within the framework of the right to health?
3. What are the barriers and facilitating factors for the selection and progressive expansion of quality health services?

From this discussion, a series of issues and challenges emerged about how to advance efforts in this area, including whether it was important to explicitly state what coverage would exclude rather than what would be included. There was some support for exclusions from the representatives of Costa Rica and Colombia, as it would mitigate the risk of judicializing access to health and rights, since all people would have the right to all types of care, barring specific exclusions. It was suggested that lists of included services could also limit the goals of service expansion and innovation. The opposing view, however, was that judicialization was necessary to safeguard the services and protect equity in access to care and coverage. Therefore, if health was a right, it would be necessary to accept the fact that people would resort to the courts when care was not provided or was inadequate.

Three necessary elements of this approach were reiterated: 1) specification of services to support the regulatory function; 2) specification of services to support the development of new models of care; and 3) specification of services to understand what financial resources are necessary and to promote financial sustainability.

In an ideal world, there would be no need to exclude any health problem from a list of available services or treatments. However, finding the best way to prioritize care requires community participation; priority setting therefore depends on the local or national context. Community participation in decision-making is an important principle. Thus, decisions will be guided by inclusive dialogue and effective communication, and agreement will be reached on potential benefits. However, there is a risk that certain population groups will control the dialogue—a situation that should be avoided, especially to protect groups that are less able to express their needs.

Summary and recommendations

In the debate about the different approaches and technical requirements for selecting and prioritizing health services and benefits, it is necessary to share experiences and knowledge about how to build models for the progressive expansion of access and coverage and what steps would be required. It has been suggested that the Member States would benefit from PAHO/WHO facilitation in this regard as part of technical cooperation at the country and regional level.

The following is a summary of the most important issues connected with the selection of health services, the progressive expansion of equitable access to comprehensive health services, and the delivery of quality people- and community-centered services:

Prioritization: When expanding access to health services and prioritizing investments to meet growing health needs based on the burden of disease, resources should be used for health promotion and disease prevention, which could reduce or halt the growth of demand. The concepts of health and well-being were underrepresented in the selection of health benefits.

Progress in this area requires looking for ways to tackle the social determinants of health and not simply provide services for the treatment of disease. Ideally, the continuum of care should be available at all levels and evolve from a treatment approach to an active effort to improve health.

Guarantees and exclusions: The provision of explicit guarantees of health coverage and packages of universal benefits should be a basic principle (as in the case of Chile's Explicit Health Guarantees); in certain cases, exclusions (that is, what the coverage does not include) could be beneficial for people's well-being and for reducing the tendency to provide treatment beyond what is medically necessary, bearing in mind ethical criteria and socially accepted rights.

Legislation: Outdated policies and legal frameworks can be barriers to developing new ways of working and may hinder certain activities. In the absence of specific regulatory frameworks, the limited availability of medicines and innovations in countries can give rise to challenges in the courts.

Human resources: To fulfill the aspirations inherent in the guarantees that are offered, it is vitally important to invest in human resources and the skills and competencies of professional, technical, and managerial personnel, as well as in decent working conditions.

Evaluation and testing: Health technology assessment to identify best practices in the definition of health care delivery is important for understanding and maximizing the quality of care and deciding where to invest. Applied research is needed to understand what the best approach is when seeking to adopt new care strategies and introduce new diagnostic and therapeutic technologies. Evidence-based guidelines and protocols could become important regulatory instruments for improving and maintaining the quality of care.

The community's role: The issue of family values and the role of family members and communities in supporting health, health promotion, and disease prevention is critical for meeting future demands. Policies should enable families and communities to play their role in health care, since it could improve outcomes for people with health and care needs and boost efficiency.

Social justice: Health systems must understand the needs of vulnerable groups and be responsive to them, since they lack the power to demand services due to social and political circumstances. Discussions about the definition of progressively expanding health services should mention and include these silent groups, who have neither a voice nor a vote.

Benefits and guarantees: The definition of benefits and guarantees is key to developing systems for universal access to health and is essential for expanding coverage and support for equitable access. In tackling the issue of progressive expansion, it is necessary to begin with the understanding that the enjoyment of good health is the right of all people. The delivery of services and support should go beyond the scope of what is or what is not included in health insurance. The selection of health services with the potential for progressive expansion should be linked to the values of empowered people and communities and should extend to intersectoral action. It should not be reduced simply to financial and technical concerns, or the biomedical paradigm.

The expansion of explicit guarantees should be based on a clear idea of society's values regarding health, the priorities related to the burden of disease in different contexts, and a reasoned discussion on how to address them with the available financial and human resources. In other words, not everything can be guaranteed. The important thing is dialogue, participation, and the forging of broad partnerships to reach agreement on the path to follow. One example could be to agree on priorities and translate them into changes or investments in care to strengthen the FLC in IHSNs.

There are five recommendations in this area:

1. Understand the importance of transparency and communication in decision-making on the availability of a comprehensive package of services and benefits.
2. Recognize that the status quo is not an option and that capacity (including technical skills and human resources), especially at the FLC, must be strengthened. PAHO's role would be to provide technical assistance for this purpose.

3. Greater financial resources are needed to support the transition. A closer working relationship between policymakers and technical experts will also be necessary. Both parties must make concessions and commitments.
4. Civil society needs support and must be better organized to become a partner in decision-making.
5. The selection of progressively expanding health services is not an end in itself, since the ultimate goal is to promote health and well-being. It should be considered an instrument for framing policies, finances, and current discussions, based on a knowledge of deficiencies in care, current and future priorities, and expected outcomes and benefits, giving preference to members of society who do not have a voice to guarantee equity.

The tasks involved in priority setting and decision-making about the nature and specific characteristics of health services and coverage in the Member States are important in themselves, since they represent a strategic intervention to break with the status quo and fulfill the aspirations of the Strategy for Universal Access to Health and Universal Health Coverage. Since the changes and reforms in the Member States' health systems could be far-reaching, a long-term commitment will be needed to address political and technical considerations and guarantee sustainability. PAHO has an important role to play in cooperation in this regard.

CHAPTER 4



EMPOWERING AND ENGAGING THE POPULATION

To enlist people's commitment, they must be given opportunities, skills, and resources to make them capable, self-confident users of health services (16). Offering incentives and mobilizing individual and community resources empowers people to make good decisions and choices about their own health and other people's. It also enables them to express themselves intelligently and become co-producers of health services. When the community can actively participate and work in concert with the health services and other entities and individuals, it can help create healthier settings and contribute to public policy-making.

For years, encouraging the active participation of individuals and communities has been a basic principle of successive WHO strategies, which always emphasize people-centered care. The Declaration of Alma-Ata, for example, recognizes community participation as a key ingredient in strengthening systems based on PHC (13). Since 2005, WHO has been at the forefront of efforts to enlist the commitment of families and patients through the Patients for Patient Safety Program, creating a patient defense network to ensure that patients' voices are heard in health care. More recently, WHO has sought to lay the foundation for patient and family participation to improve experiences and outcomes, and to lower the cost of care (59).

The need to engage and empower communities is a key element of the WHO Global Strategy on Integrated People-centered Health Services, which seeks to strengthen health services worldwide (17). The preliminary work for WHO's next global strategy on human resources for health also emphasizes the importance of community participation and empowerment, as follows: "Without efforts towards more appropriate demand

for and use of services, epidemiologic and demographic trends, coupled with rising health costs, will further stretch health systems already under strain. There needs to be a paradigm shift in terms of how services are configured to maximize healthy lives: human resources beyond the health sector need to be engaged and empowered to better manage health risks, share responsibility for service delivery, and increase community and individual self-reliance. Communities and families are essential components of care systems. Efforts to improve individual and family health need to include an understanding of health behaviors, appropriate housing design, and the environments in which people live, as well as whether and how they access health services (9).

People-centered care is a core component of the PAHO Strategy for Universal Access to Health and Universal Health Coverage (Box 5) (4). Thus, the majority of LAC countries give priority to boosting response capacity at the FLC as part of IHSNs to guarantee universal health.

Box 5. Empowering and engaging people: Strategy for Universal Access to Health and Universal Health Coverage (4)

Resolution, paragraph 2 (j) “To urge the Member States...to:

implement plans, programs, and projects to facilitate the empowerment of people and communities, through training, active participation, and access to information for community members, in order for them to know their rights and responsibilities, and for them to take an active role in policy-making, in actions to identify and address inequities in the social determinants of health, and in health promotion and protection.”

It was pointed out during the Regional Forum that improving health and well-being requires complementary work from health systems and services and intersectoral action, with the proactive social participation of individuals, caregivers, families, and communities in actively in managing and caring for their health.

This will require a cultural shift among health system professionals and managers, allowing them to see people as potential assets of health systems. Engaging people in shared decision making, including the selection of care and treatment options, teaches them to make informed decisions and makes them more likely to follow prescribed drug regimens and live independently and more able to work effectively with health professionals to meet their treatment or care needs.

There appear to be wide variations in understanding the importance of participation and empowerment strategies, despite the substantial evidence of their benefits (60, 61). As a result, approaches that seek to facilitate empowerment and achieve individual and community participation remain inadequate.

Approaches to facilitate people's empowerment and participation

The terms “empowerment” and “engagement” are often used synonymously to describe interventions and strategies in which individuals and communities participate (Table 3). However, they represent two different strategies that may overlap: empowerment seeks to enable people to take control of their health (for example, their health-related behaviors), while engagement seeks to involve people in the design, planning, and delivery of health services and in decision-making about care and treatment options (23).

Table 3. Strategies to achieve engagement and empowerment

For individuals and families	For communities
<ul style="list-style-type: none"> • Improvement of health education • Shared decision-making between users and health professionals • Supported self-management • Evaluation and personal planning of health care • People's access to their medical records • Peer support • Support for families and caregivers 	<ul style="list-style-type: none"> • Community engagement • Community awareness • Delivery of community health services • Patients' and users' groups • Addressing structural factors that marginalize at-risk communities • Petitioning and reporting to health service providers, managers, and local political and administrative authorities

Analysis of the evidence suggests the following strategies to engage individuals, families, and caregivers in care:

1. Self-management of health and health conditions. This includes support to acquire the knowledge, skills, and confidence for people to manage their own health (self-care) or a specific illness or condition and recover from an episode that has affected their health.
2. Shared decision-making in which support is provided to enable people to participate in decisions about their health, weigh their options (including taking no action), consider the risks and benefits, and decide whether the available options are consistent with their values, needs, and preferences.
3. Peer interventions to support patients, enabling them to offer assistance to and receive it from people in similar situations, based on mutual and shared understanding.
4. Support for families and caregivers to provide knowledge and develop skills and interventions so that people can take care of themselves and others (61).
5. Support for social organizations for the design, planning, execution, monitoring, and request for reports on municipal, departmental, and regional health plans, including intersectoral components.

Supported self-management

Self-management involves a series of tasks that people must perform to live well with their illness or condition. They often need active support to acquire knowledge, skills, and self confidence to manage their health. With proper guidance, people can work to change unhealthy behaviors and get past situations that keep them from pursuing healthy lifestyles (7, 62, 63, 64). The evidence invariably shows that supported self-management improves the health outcomes of people with CNCs (65, 66, 67). This approach can boost people's motivation and their confidence in their own abilities, reduce anxiety, improve physical function, and ultimately, reduce out-of-pocket spending by avoiding unnecessary hospitalizations and improving treatment adherence and management of the disease (68, 69).

The purpose of supported self-management is not only to help manage chronic conditions and specific chronic diseases, but to improve people's well-being and their ability to live well with their illness. For example, in the case of people with mental health problems, self management goes beyond the issue of drugs and addresses the needs of the whole person from a neurological, biochemical, psychological, social, and spiritual standpoint (67, 70).

Supported self-management uses motivational techniques and goals set jointly by providers and users. Proactive strategies, such as group education, face-to-face patient health counseling, and motivational interviews, have proven especially effective (63). These techniques are important because people who are more actively engaged in their own health care are significantly more likely to go for screenings and checkups, get immunized, and adopt positive health behaviors (e.g., behaviors related to diet and exercise, quitting smoking, and practicing safe sex). Studies that measure the degree of people's engagement to assess their ability to take charge of their health suggest that less active patients may cost health systems as much as 21% more than actively engaged people who report having taken better control of their health through proactive support activities, such as peer groups, health counseling, and health education (71).

Health system professionals and managers can use the 5 A's model (72, 73) to develop self-management and intervention plans with patients (Figure 7). This model is easy to understand, can be integrated into the daily activities of primary care professionals or peers, and is used to support collaboration and set health goals. In the United States, the Chronic Disease Self-Management Program proved a cost-effective way to increase the independence of patients and treatment efficacy and has been successfully replicated in other settings (74).

Figure 7. Five A's self-management model

Source: Modified from Whitlock et al., *Am J Prev Med.* 2002;22(4):267-284 and Glasgow et al., *Ann Behav Med.* 2002;24(2):8087.

Case study L.

Improving the quality of chronic care in the Caribbean (Anguilla, Antigua and Barbuda, Barbados, Belize, Grenada, Guyana, Jamaica, Saint Lucia, Suriname, and Trinidad and Tobago) (75)

Demonstration projects that make use of the chronic care model have been implemented in 142 health centers throughout the Caribbean, reaching 40,000 people. The objective has been to strengthen the capacities and competencies of local health teams to improve care for people with diabetes. These projects employ an approach in which patients, their families, and the community participate. They use PAHO's Passport to Healthy Lifestyles* to support education and self-management. The preliminary results show reductions in HbA1c levels, a substantial increase in the number of people receiving preventive services (e.g., nutrition counseling or vision exams), and better quality-of-care indicators.

* The Passport to Healthy Lifestyles helps people make healthy lifestyle decisions. Available at: http://www.paho.org/hq/index.php?option=com_content&view=article&id=6735%3A2012-chronic-care-passport&catid=4045%3Achronic-diseases-news&Itemid=40276&lang=en.

Periodic visits to FLC centers are ideal opportunities for building and improving self-management capacity. Nevertheless, it has been shown that this approach also works with remote technologies or in different community settings, such as the workplace, schools, and other community spaces (7). For example, a telephone hotline was used in a self-management program in Santiago, Chile, to promote counseling for people with type 2 diabetes, supplementing the customary care. The service achieved the active participation of people and their caregivers and family members and promoted continuous contact with local health teams. Patients improved their ability to control their blood glucose, were more willing to go for regular medical appointments, and were more satisfied with the care and treatment they received (76).

Shared decision-making

Shared decision-making is an interactive process in which individuals, their families, and their caregivers work with health professionals and health care providers to examine and choose the next stages of their health care. This requires an informed analysis of potential options and patient values and preferences (60). Shared decision-making approaches and instruments have traditionally been used in clinical consultations, where it is now customary to promote patient and family involvement in care and treatment decisions, especially in the case of people with complex, long-term conditions with different care and treatment options (77, 78). Recent innovations have included the involvement of specialized non-clinical personnel in decision-making, where duly trained professionals help guide people through the health care process (79).

There is convincing evidence of the benefits of shared decision-making and its association with:

- ◆ greater patient satisfaction with care;
- ◆ the development of more appropriate interventions better tailored to the patient's preferences and needs;
- ◆ fewer misdiagnoses and better-quality referral services; and
- ◆ a greater sense of independence in patients and a better understanding of their own illness (80, 81, 82, 83).

The use of materials to support decision making (e.g., pamphlets, videos, information at the point of care, patient access to medical records, and shared planning of care) has been shown to increase people's participation in their medical care, improve their knowledge, and facilitate options (23). However, shared decision-making appears to be effective only when people are willing to participate actively and when health professionals have the ability, training, and understanding to support the approach (82). In particular, professionals must have the ability to relate to patients to create an environment conducive to communication and interaction (e.g., the ability to listen and to encourage patients to participate during consultations). It is also necessary to be able to communicate risks and uncertainty regarding treatment outcomes, explore risks and benefits, and facilitate informed decision-making (60).

In the United States and Canada, various tools have been developed for this purpose, among them patient training, access to help in decision-making, information on options, medical records in the hands of patients, training and motivation of professionals, and policies to guarantee shared decision-making. These are then evaluated as a standard for quality of care. The evidence suggests that shared decision-making should be one of many components aimed at improving people's health behaviors and health outcomes (32).

Peer support

Peer support means offering help to people in similar situations (e.g., people with the same diseases or conditions) and receiving help from them in turn, based on mutual understanding, empowerment, and respect (84). The ability to share knowledge, discuss ideas, and offer advice will facilitate friendships or help people obtain access to services through volunteer groups, which have proven an important and effective strategy for supporting health needs. For example, peer support can boost the self-esteem of both peer counselor and patient, improve the ability to solve problems and self-care issues, foster a greater sense of well-being, reduce self-stigmatization or depression, and increase the likelihood of a person re-entering the workforce or resuming a role in the community (85, 86, 87, 88, 89). There is evidence, moreover, that these methods help reduce morbidity and mortality, increase life expectancy, improve people's perception of their health status, promote better adherence to drug regimens, and reduce the need for medical interventions (60).

Peer support is often an informal activity, but the evidence shows that a proactive approach involving peers from the community is important to facilitate engagement. People who provide peer support often have personal experience that they can share (e.g., with diabetes or mental health problems), enabling them to build a trusting and empathetic relationship with their peers and foster learning. The basic principles of peer support strategies are their mutual, reciprocal, and non-directive nature, which stresses people's recovery in a non-judgmental and safe setting (90). Peer support often works better in communities served by an IHSN, which takes advantage of the relationship between communities and first-level and specialized health teams. It is an important strategy for reaching groups in remote areas who might otherwise have no access to health promotion services or traditional clinics (91) and therefore contributes to the achievement of universal access to health and the promotion of equity.

Support for people, family members, and caregivers

More than 80% of health care for people who need long-term care (in addition to self-care) is provided by unpaid caregivers and family members (92). This burden reduces caregivers' quality of life, which is generally poorer than that of the rest of the society. It also decreases their ability to remain active in the labor market. This, in turn, reduces their income and social activity in the community, leads to greater

mental health problems, and shortens life expectancy due the stress associated with caring for a patient (93). This situation is the result of access barriers to the FLC and a lack of financial protection for health care (94). Consequently, growing reliance on the traditional family and caregiver generates risks for those who provide care for others, especially people with long-term illnesses and needs associated with old age. The support services available at the FLC are important for alleviating their burden. These include counseling and training to increase the resilience of caregivers so that they can cope with their responsibilities and continue to provide care.

Better knowledge about health

Improving education for health is a common strategy in the Region, involving a variety of practical methods ranging from media campaigns to specific educational support and lifestyle programs. The capacity to promote education for health can be strengthened by practical strategies for engaging and empowering people. There is evidence of the benefits of this approach, which increases people's ability to self-manage their care, control risk factors, and improve health-seeking behaviors, promoting better population health.

Case study M.

Promoting health education and community participation in Tunja (Colombia)

In Colombia, 50% of families with young children are from the poorest sectors of society. Living in poverty leads to a negative cycle of disease, poorer mental health, limited education, and fewer opportunities for employment. Investing in early childhood development is therefore essential. However, traditional health care programs have tended to be paternalistic, foster dependency, inspire pity, and are ultimately unsustainable.

The city of Tunja, Colombia, has introduced a public health policy for children to create “a culture of care, treatment, and protection for children from gestation to age 5, by guaranteeing their rights and promoting their development to give them a better future.” Some elements of the program have been the promotion of community participation and engagement, health education, and a new approach to health care among city residents.

The program includes training for managers to support health education activities and counseling on nutrition, family life, the role of parents, and the promotion of community leadership. Focusing on families and family life has contributed to the development of work skills, continuous education, and prudent management of household finances. Approximately 355 “facilitating families” have been trained by 710 agents to work with 4,289 vulnerable families with young children. The program has made a real difference.

Between 2012 and 2014, it was observed that:

- ◆ The proportion of pregnant women with appropriate weight and health status increased from 33% to 86%;
- ◆ The proportion of children with a birthweight of 3,000 g or more increased from 60% to 65%;
- ◆ The proportion of children under 1 year with chronic malnutrition fell from 15% to 5%; and
- ◆ The proportion of fathers who attended the birth increased from 92% to 96%.

Source: Goodwin N. Expanding Equitable Access to Health Services: Experiences and Key Interventions. Proceedings of the Regional Forum. Washington, D.C., 13-17 July 2015. Unpublished report.

Community empowerment

At the FLC, community empowerment and engagement enable people to state their needs and to influence the way care is financed and provided to meet those needs. It is well known that many communities throughout the Region feel powerless in their relations with the health services. They tend to remain passive rather than attempting to improve their health by exerting influence in the surrounding community (23).

A necessary and important responsibility of health systems that aspire to advance toward universal health is to empower communities by giving them an opportunity to develop skills, self-confidence, and the ability to promote health and respond to crises (for example, during outbreaks of infectious disease). There is evidence that community projects can boost people's self-confidence and self-esteem and can be an important factor in promoting improvements in health, especially in low-income or marginalized communities (95). Community participation in decision-making also improves public health policy-making and social policies aimed at tackling the social determinants of health.

There is a recognized need to empower and engage communities, but the methods for doing so do not always lead to real participation or the inclusion of all groups; furthermore, there is evidence that impact is variable and depends on context (23). Community empowerment requires investments to raise awareness and build capacity so that people can put themselves in someone else's shoes and recognize collective needs (96). Effective strategies for meeting these objectives include local health committees, patient participation groups, open dialogue among the members of the community, and the availability of local health workers and facilitators (97).

Strategies for empowering and engaging communities include (60, 65):

- ◆ **Community participation** in planning and setting targets. This can help communities examine the factors that underlie health problems, raise community awareness, and lead to the use of community methods for solving problems. In Peru, for example, raising community awareness has been a strategy for promoting multisectoral collaboration and getting marginalized communities involved in decisions about their own care (98).
- ◆ **Raising community awareness** through education and community participation in learning events and activities, which can help build stronger social networks and generate more integration. This works well when focused on a specific health problem and when conversations and activities are culturally sensitive. The creation of local health networks in Quebec, Canada (99), is a good example (Case study N).
- ◆ **Care provided by the community** through volunteers or community health workers, who serve as partners in care. This can support the legitimacy of the services and build confidence in them. It can also strengthen the FLC, promote peer learning, and improve access to care and local support. For example, a program that encouraged consumer “ownership” of the health system in Nuka, Alaska, resulted in investments to promote universal access to health and community partnerships, which have had a profound and long-term impact, improving the health of the population (100) (Case study O).
- ◆ **Groups of people** who organize to address specific problems or needs, representing public opinion at the local or national level. This promotes democratic responsibility shared by health services and local communities, improves governance, and encourages advocacy. In Colombia, for example, the New Paradigm Project encouraged people with spinal cord injuries to meet regularly with health professionals to discuss their care issues. This intervention facilitated peer learning, improved self-management, and built trust (101).
- ◆ **Social oversight offices for health** (for example, FOROSALUD and CISALUD in El Salvador), which increase participatory democracy in health and help guarantee the sustainability of achievements by empowering social organizations and citizens to take charge of their health and improving the social determinants of health.

Case study N.

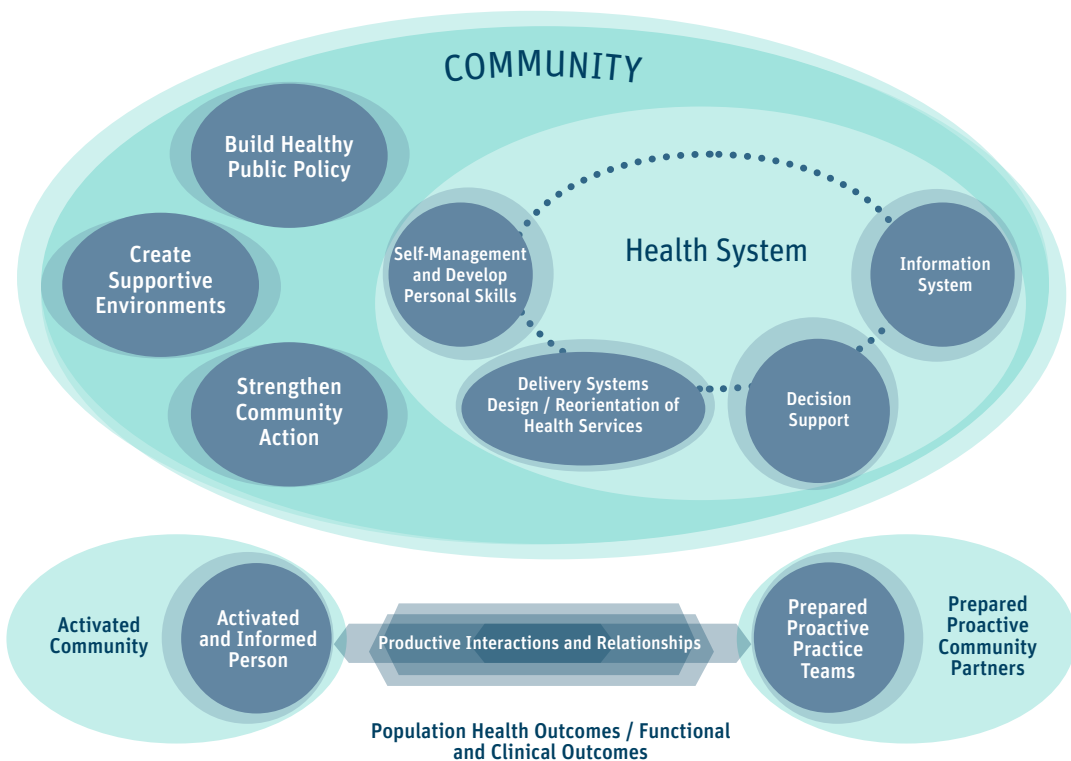
Raising community awareness in Abitibi-Témiscamingue, a remote region of Quebec (Canada)

Abitibi-Témiscamingue is a logging and mining community in Quebec, with a rural population of 148,000, scattered across 64 municipalities in an area 65,000 km². Living conditions in this industrial city are a cause of great concern among the local population. The situation has been associated

with social inequalities in health and an increase in the incidence of chronic diseases. Environmental pollution and an increase in diseases associated with mining are also troubling. These problems led the city of Rouyn-Noranda to become the first in the Americas to launch a healthy municipalities project (1987), which included the creation of a botanical garden and the reduction of children's exposure to the contaminants produced by foundries. The project was characterized by integrated health care management and delivery in which the municipality, schools, local hospital, health centers, and volunteer organizations participated.

In 2005, the city introduced the integrated management of chronic disease methodology in first-level health centers. This methodology emphasized disease prevention and health promotion and was based on the chronic care model and the identification of people at risk through case management (Figure 8). Care was decentralized for delivery in first-level clinics. At the same time, the city hired chronic care nursing staff and established multidisciplinary teams.

Figure 8. The expanded chronic care model: Integrating population health promotion



Source: Reiss-Brennan B, Briot PC, Savitz LA, Cannon W, Staheli R. Cost and quality impact of Intermountain's mental health integration program. *J Healthc Manag.* 2010;5(2):97-113.

Case study 0. Community participation in the NUKA health system, Alaska (United States)

In Alaska, the NUKA health system, which provides health care for the indigenous community, has significantly improved through the promotion of universal access to health and universal health coverage. The system has focused on strengthening the FLC and providing integrated, community-based health care solutions centered on people's needs.

In 1982, the Southcentral Foundation was established by the Native Leadership of Alaska as an opportunity to redesign health systems and better accommodate the needs, values, and priorities of the 60,000 people in the community. Based on the clear mission of working with the native community to achieve well-being through health and allied services, with the goal of improving people's physical, mental, and spiritual well-being, the project focused on creating shared responsibility for health outcomes between health service providers and the community, with a commitment to quality and family well-being.

In 1997, the Alaska Legislature passed a law enabling the state's native population to take over and manage its health system. As a result, the Southcentral Foundation created a series of first-level health centers with an interdisciplinary package of services that included primary care, dentistry, optometry, physical therapy, mental health, ambulatory services, and home treatment for adolescents and women. The emphasis has been on including the traditional and complementary medicine valued by the local population, together with home health care, education for health, and specific support programs for older persons and children. The local community's embrace of the Foundation and the adoption of the "walking with the community" strategy to achieve change have been key to its success.

The most significant results since 1997 have been:

- ◆ An increase in the population's registration in the FLC from 35% to 95%;
- ◆ Same-day access to routine appointments (the wait time was previously four weeks);
- ◆ Elimination of waiting lists for mental health consultations, thanks to the integration of physical and mental health services;
- ◆ Greater patient and personnel satisfaction and greater respect for native culture and traditions;
- ◆ A 75% reduction in staff turnover;
- ◆ A significant reduction in the use of unnecessary specialized care and treatment (36% in days of hospitalization, 42% in visits to emergency services, and 58% in treatment in specialized clinics); and
- ◆ The reduction of disparities and improvement of care outcomes for people with cancer, obesity, diabetes, and dental caries, coupled with lower rates of child abuse and abandonment, domestic violence, substance abuse, and suicide.

Community empowerment strategies protect people's right to health and promote shared responsibility between the population and health care providers. By creating clear, respectful, and responsible relationships between communities, providers, and decisionmakers, this approach enables people to assume greater responsibility for their health decisions and lifestyles and take action on the social determinants of health. Moreover, it helps them make informed decisions, improves their knowledge about health, promotes self-determination, and gets the population involved in decision-making to influence the issues that affect their lives and communities (61). Similarly, civil society and citizen empowerment in health is an indicator of the impact of social policies and their success and contributes to their medium- and long-term sustainability.

Summary and recommendations

Empowering the population and promoting its participation is a highly effective and efficient strategy for advancing universal access to health and universal health coverage in different contexts. However, it has not been actively promoted in most of the Americas and other regions of the world. Since it is not included in the packages of benefits and service necessary to support the expansion of equitable access to comprehensive, quality, community-centered health services, it is important that it be at the heart of the universal health strategies of the PHC team, the new models of care, and IHSN governance mechanisms at the local and intermediate levels.

The evidence in favor of community empowerment is strong, since it:

- ◆ Helps improve the health of patients and populations throughout the life course;
- ◆ Helps patients better manage their health problems, aging, disabilities, and mental disorders;
- ◆ Supports families and caregivers, enabling them to take better care of themselves and their dependents;
- ◆ Builds local capacity to influence social and personal health determinants and contribute to the creation of healthy spaces;
- ◆ Encourages communities and health services to join forces to co-produce health care services, thereby strengthening the FLC and improving the quality of services;
- ◆ Guarantees equitable access to health and health care decisions;
- ◆ Reduces dependence on institutional care and expensive medical treatments;
- ◆ Promotes community participation in decision-making and collaboration with the health system, local governments, and other economic and social development actors and sectors;
- ◆ Guarantees the impact and sustainability of public policies.

Strategic line 1 of the regional Strategy for Universal Access to Health and Universal Health Coverage stipulates the development of new models of care that meet the needs of people and communities. These should be included in regional planning and serve as basic components of the Member States' health strategies. Implementing

these strategies requires investment to build and develop new capacities, including those of the health personnel working at the FLC and in the community. Community participation and empowerment should be viewed as an opportunity to strengthen the FLC and develop new health service delivery models in that setting. Mechanisms should be created to promote individual and community participation and empowerment to progressively expand health service delivery. Strengthening health worker skills and competencies to support people's empowerment and participation will be central to new models of care for advancing toward universal health (102).

This means it will not only be necessary to develop IHSNs but to build capacity beyond the health sector. At the same time, it will be necessary to formulate multisectoral plans that include the development of community skills and competencies and to recognize the role of communities as co-producers of health. It will also be important to recognize and support the essential contribution of caregivers and other unpaid workers, often women who care for sick or elderly relatives. The workload of caregivers will probably increase as the Region's population ages. The risk of elder neglect and abuse may also increase. Thus, the multisectoral approach should attempt to assess and respond to such situations (103).

Finally, the evidence suggests that a limited approach to strengthening the population's participation and engagement and the reduction of that approach to the use of one or two basic strategies will not yield the necessary paradigm shifts. Capacity building and interventions with multiple components will be required, without limiting social participation to the use of unpaid, voluntary labor.

The common denominator of these strategies is their promotion of the capacity of people, caregivers, and members of the community to actively participate in their own care. Notwithstanding, individuals and caregivers may resist playing an active role for a number of reasons, ranging from their level of training and education to their beliefs, values, cultural norms, and expectations. There is evidence, however, that progress can be made in promoting participation and empowerment programs, especially in remote communities where access and participation are limited.

Case study P.

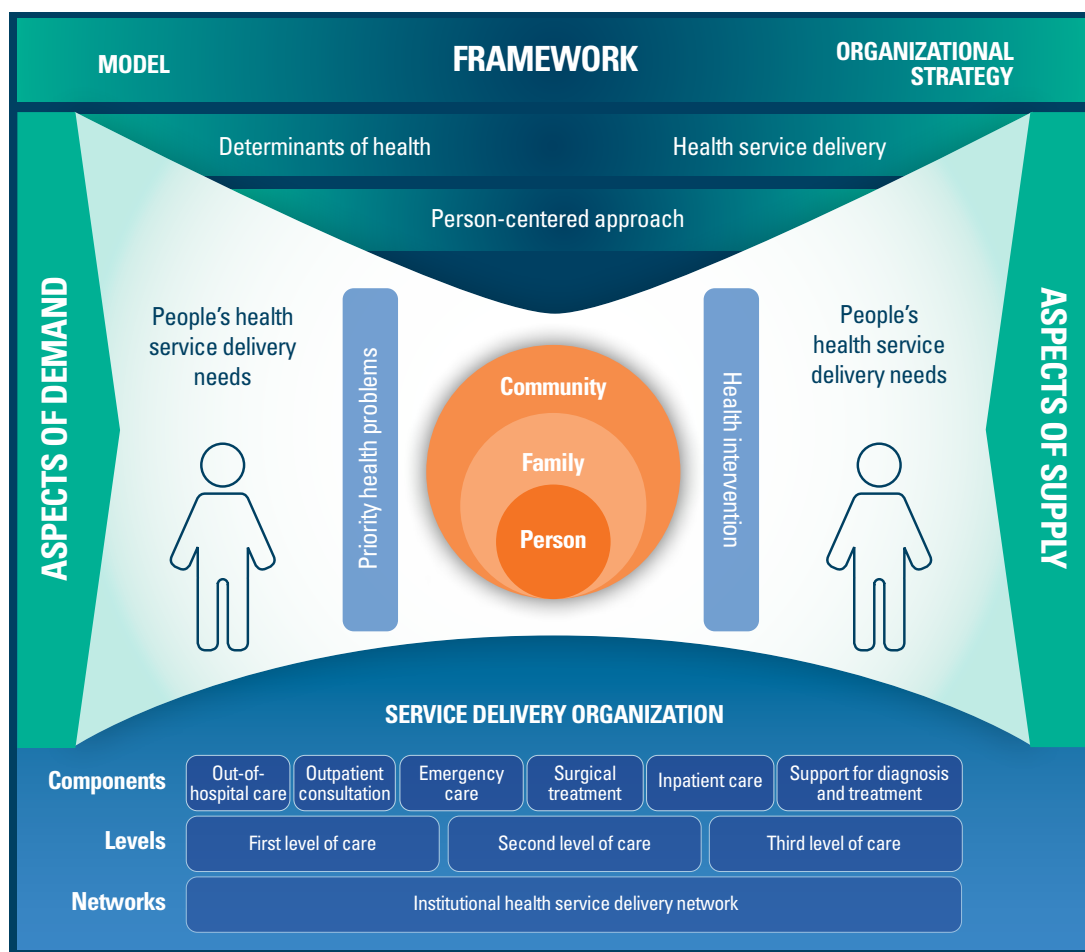
Vision of people-centered comprehensive care (Costa Rica)

Costa Rica is a country staunchly committed to universal health coverage but it has faced many challenges connected with the aging of its population and the increase in the number of people with chronic diseases. These developments have occurred in a fragmented health system with financial constraints that have affected the capacity to promote equity and meet the population's needs and expectations.

To address these problems, a people-centered model of care has been introduced to promote universal access to health and universal health coverage (Figure 9).

The approach is centered on promoting access to the FLC and the adoption of a series of integration instruments, including policies, standards, definitions of the levels of care, and the management of care to support the continuity of health service delivery and the creation of information and communication technology platforms for sharing electronic health records and promoting virtual and remote management of care (for example, a virtual campus).

Figure 9. People-centered model of care



Source: Pan American Health Organization. Integrated health service delivery networks: concepts, policy options and a road map for implementation in the Americas. Washington, D.C.: PAHO; 2011. Available at: http://www1.paho.org/hq/dmdocuments/2011/PHC_IHSD-2011Serie4.pdf.

CHAPTER 5



MANAGING CHANGE

Strategies that support leaders and managers in promoting and planning effective health system transformation

The participants at the Regional Forum agreed that transforming health systems and services toward universal access to health and universal coverage requires firm political will and strategies for managing change. They therefore recognized only partial success in strengthening health services given the numerous barriers to the creation of IHSNs and to more direct investment in the FLC (104). As a result, the strategy may be successful in particular locations but not health systems as a whole, due to the lack of national policies and strategies that involve systemic changes (structural and functional), limited development of managerial competencies for change, and the limited mobilization of the human, technological, and financial resources that make universal health feasible.

A good example is the establishment of IHSNs in Brazil. Some obstacles in this regard have been: 1) lack of policy agreement among the different areas of government; 2) problems creating adequate incentives for collaboration among municipalities; 3) inability to manage the complex task of integrating health practice; and 4) high political turnover, resulting in a lack of clear strategic direction and committed stewardship (105).

The capacity to reorient health services to make them more people-centered, to offer them at the FLC, and to make them more integrated has been described as a basically political achievement (11), since it requires turning the current medicalized model of care into one that empowers people and encourages their participation, transfers power and resources to first-level and community care, and introduces new types of

IHSNs that encourage professionals and organizations to work in new ways. These are long-term processes. For the reorientation of services to become the norm, there must be sustained political commitment that goes beyond isolated government action; and leaders and managers must have the skills to facilitate the process (106, 107).

Training leaders and leadership

PAHO's Strategy for Universal Access to Health and Universal Health Coverage is a transformative aspiration that requires new forms of collaborative leadership that foster the inclusion of different stakeholders in an effective policy dialogue. Thus, transformative leadership is needed, going beyond simply understanding how to unite people and organizations with potentially competing values and motivations. The new objectives and values must be communicated to unite stakeholders and motivate them to promote interdependence and joint participation in change (108, 109).

Exercising leadership also requires specific skills for working in networks, since it encompasses the entire system. Traditional command and control approaches are unlikely to work in circumstances where brokered agreements among different health care networks and facilities are needed. This calls for an investment in leaders and leadership in the health services to develop the necessary multidimensional skills for dealing with often complex situations (110, 111). Even more importantly perhaps, the evidence suggests the need for "collective leadership" among institutions and organizations, given the recognition that success depends on close cooperation and relationships (112).

Experience also shows the importance of shared leadership to ensure that clinical staff and others responsible for implementing the changes locally have the authority to act, innovate, and work toward greater decentralization of power and authority to communities.

During the Regional Forum, the lessons learned from the creation of new, integrated service organizations in Spain's Basque Country were presented. There, the ability to promote microsystems and allow innovation to flow from the bottom up was found to be useful. However, the leadership and impetus provided by local clinical leaders and other partners was key to redesigning the services (113, 114, 115).

A final lesson on leadership that has already been documented is the concept of transparency (112), i.e., the capacity of leaders to guarantee that all work related to transformative change is open to the participation of all stakeholders and to scrutiny, even by the public. This approach implies, moreover, that leaders must be accountable for the results of the changes for which they are responsible and communicate the effects (both positive and negative) clearly and inclusively. This builds trust and commitment, elements that will encourage health care partners to participate and pursue programs that promote transformation. This is important, because change is a highly disruptive exercise that challenges the status quo. Leaders must be courageous and fully prepared to deal with vested interests and to promote collaboration, in addition to committing themselves to a long-term change process.

Capacity to collaborate

*“Collaboration, it turns out, is not a gift from the gods but a skill that requires effort and practice.” Douglas B. Reeves, *The Learning Leader*, 2014 (114).*

Effective adoption and implementation of the Strategy for Universal Access to Health and Universal Health Coverage will depend largely on the existence of a political environment receptive to change at the national, regional, and local level. Transformation can prove very problematic for many people and organizations, who may not appreciate the proposed changes or may feel threatened by their consequences. Furthermore, in many cases, working in partnership with different providers and professionals will be a new way of working that requires new skills.

The conditions that facilitate the management of change depend on three basic tasks:

1. Building a coalition of leaders and stakeholders to promote change from the top down.
2. Generating support for change from the bottom up within and among the professional groups and communities of practice where IHSNs are going to be set up. This is essential for success and includes the development of a shared set of standards, beliefs, values, and assumptions that will lead to change.
3. Developing local collaboration capacity that empowers and supports professional groups so that they can work together effectively or in multidisciplinary or multi-organizational teams (105).

Creating a guiding coalition

When formulating policies, government and regional agencies must cooperate with each other to support and implement strategies to develop new models of care, promote universal access to health, and progressively expand health services. This requires a multisectoral effort, both within the health sector (e.g., public health and primary, community, and hospital care) and between health and other sectors (e.g., long-term care for older persons and mental health care).

There is evidence of the importance of forming a coalition of high-level political partners to reach consensus on the collective objectives and mission of the system for health and well-being (108). Creating this type of team with key people and organizations is also very important at the local and regional level to defend the strengthening of the FLC and IHSNs to the general population, groups with specific needs, and professionals. This approach is effective and often makes a significant contribution as part of a change management strategy.

For this approach to be effective, actors with the position, power, credibility, and capacity to lead the process of change must be chosen. An inclusive multidisciplinary orientation team with the skills to manage the process must also be created. Meeting these basic commitments will require removing the obstacles to policy change and embracing the idea that creating an enabling environment for change requires both top-down and bottom-up initiatives (112).

Building support for change

There is evidence that enlisting support for change through networks of health care providers and other local stakeholders (e.g., groups representing people with particular health problems) is a complex adaptive task (112, 116). This is because each stakeholder (politicians, managers, clinicians, and patients) probably has different priorities and different degrees of understanding. Furthermore, attitudes toward change depend on behaviors driven by interpersonal relations and connections. Enlisting the support of key stakeholders is a sociocultural task similar to nation building, for which the concepts of community and citizenship must be developed.

The main problem in building support for change is actual control, since integrated care activists realize they have relatively little direct power (e.g., a high place in the hierarchy, financial capacity, knowledge) and they lack authority. Managers must therefore have competencies in mediation and interpersonal relations. They must also be able to stretch the limits to connect people and lift the constraints to working together (117, 118).

More locally, it has been shown that even when a guiding coalition has been built, there can be considerable resistance to change. This is not simply due to concerns related to different sources of funds and incentives or preexisting professional roles and responsibilities. It is a more deeply rooted concern stemming from a lack of understanding about the importance of reorienting care models to strengthen the FLC or promoting the coverage and access of marginalized populations. Thus, it is important to consider culture, norms, preexisting values, and how to explain and recognize them when introducing change at the local level.

Building support for change is an explicit component that requires an understanding of the problems that change creates, the promotion of inclusion, and a collaborative culture that enlists the commitment of local leaders, staff, managers, and the community. A culture of health where work is based on professional groups and specific organizations appears to be the greatest obstacle to change and calls for new ways of thinking and new competencies, among them systemic thinking, collaboration, and teamwork; quality management; and the improvement of scientific processes. In order to understand who and what to change, it must be recognized that individuals and teams are the key to lasting change. It is unlikely that the population will be supportive if it feels it is being forced to accept a program that lacks its agreement and consent.

Collaborative capacity

As noted in Chapter 4, people with complex long-term health issues have changing needs and will increasingly depend on a greater number of professionals and care facilities. These changes clearly pose a higher risk to users, due to the problems that can arise from fragmented care. Creating effective and reliable multidisciplinary teams and IHSNs is important, but the process is not always successful due to the limited capacity

for teamwork or the fact that teams lack the right combination of skills to effectively respond to the demand for care (119, 120).

Creating effective teams is a change management process in its own right, and it has been shown that the support provided for it will tear down isolated compartments and promote interprofessional education and learning (121). This work can be supported by a series of strategies, including multidisciplinary education and in-service training, which, in turn, can result in effective networks and teams. The success of strategies for change requires this type of investment to increase the capacity for collaboration and thereby ensure that the care delivered and organized at the local level fully meets the strategic objectives.

Change management plan

Given the diversity of stakeholders that have to participate in the effort to design and propose new approaches to care and service delivery, it is important to understand and employ change management strategies to facilitate the process. Although the participants at the Regional Forum agreed on the need for this kind of process, they noted that change management strategies had not been specifically implemented in most countries.

In essence, a change management strategy is a rational and deliberate series of tasks for health service managers, where new ways of working must be identified and explored and established practices challenged. Change management shows how things should be done by identifying different operational tasks that will allow it to happen. The approach calls for systems thinking, since managers must understand and take advantage of interrelationships instead of thinking in terms of cause and effect.

A series of instruments can help leaders and managers with this process. Most of them are related to validated theories of change, such as Kotter's 8-step Process for Leading Change (Figure 10) (122).

Furthermore, recent works have identified several integrated components necessary for reorienting health systems and turning them into people-centered work models (108). The basic management tasks required to support change include:

- ◆ An objective evaluation of the health system in order to understand the common reason for reforming the system and identify which aspects (needs, supplies, finances) will have to be addressed.
- ◆ Situation analysis to examine the suitability of the proposed changes to existing stakeholder roles and values, and to identify potential gaps and the investments needed to make them compatible.
- ◆ An explicit rationale for the need to change the way of working. Prepare vision and mission statements, which are necessary to develop a convincing narrative of what needs to be done and why. These should be addressed from the standpoint of improving care and outcomes for local communities and patients.
- ◆ The ability to establish mutual gains among partners and actors in care and to effectively manage and mediate the interests of the different partners and actors in terms of the broader collective objectives of universal access to health and universal health coverage.

- ◆ An effective communication strategy to convey clear systematic messages to all stakeholders and raise awareness.
- ◆ A clear co-produced statement of objectives and measures to evaluate performance and provide feedback.
- ◆ Quality improvement processes that create learning cycles over time.

It is not within the scope of this report to provide a detailed understanding of these matters related to change management. The purpose of this chapter is to highlight the complex and difficult leadership and management tasks that all decisionmakers in the Member States must perform when committing to the regional Strategy for Universal Access to Health and Universal Health Coverage. The pace and success of its adoption and the capacity to broaden the strategic lines will depend on how the process of change

Figure 10. Kotter's 8-step Process for Leading Change



Source: Modified from Kotter J. Leading change. Harvard Business School Press, 1996.

is directed and managed. A long-term ambition of the Region should be to establish a learning system that will enable individuals, groups, and organizations to acquire knowledge and skills.

Case study Q.**Change management program for the prevention and control of noncommunicable diseases
(Dominican Republic)**

In the Dominican Republic, along the border with Haiti, five marginalized provinces with a high prevalence of uncontrolled NCDs have been working to improve access and quality of care through the Noncommunicable Disease Prevention and Control Program (PRONEC).

PRONEC evaluated deficiencies in care for people with chronic diseases in national first-level health units. The program employs evidence-based models of care for chronic diseases to determine which models are best suited to the local context. Based on the results of the evaluation, an intervention plan was prepared in collaboration with health authorities, health care providers, and community members. Subsequent plans emphasized several aspects, from the training of multidisciplinary teams to the use of instruments that support self-care. Other measures were the preparation of manuals to support clinical decision-making; improvement of the quality of referral services between first-level and hospital care; and the promotion of integrated patient care in the transition between service providers. PRONEC's effectiveness is subject to constant monitoring and evaluation.

Source: World Health Organization. World Report on Ageing and Health. Geneva: WHO; 2015. Available at: https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf.

Summary and recommendations

The ability to effectively direct and manage change is essential for supporting the transformation of health services to strengthen the FLC and promote equitable, comprehensive access to quality people-centered health services. When adopting new strategies and models of care, the Member States will have to invest in the capacity for transformative leadership to support collaborative work throughout the system. To accomplish this, building trust among political authorities, service providers, professionals, and communities is essential. This occurs when decision-making is transparent and collective responsibility for progress and outcomes is promoted.

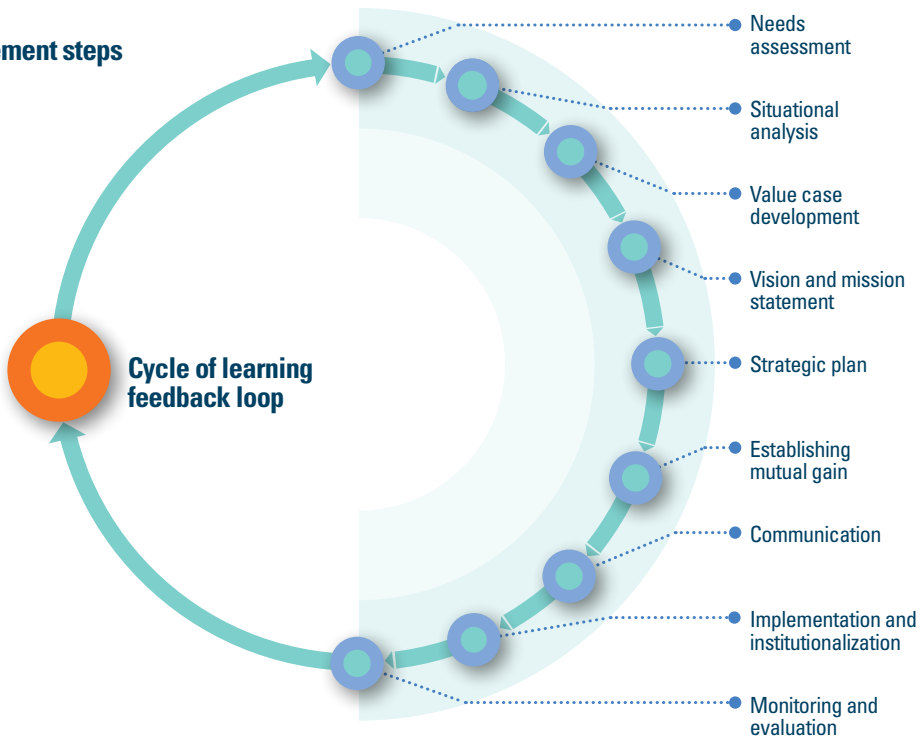
Health systems must program and create the conditions for change, which includes three basic processes: 1) creation of a guiding coalition comprised of leaders and stakeholders

that will drive the change; 2) support for bottom-up change among professional groups and between them and communities; and 3) development of local collaborative capacity that empowers and supports groups of professionals in joint multidisciplinary work or work involving several organizations, including local governments and civil society leaders. A key element for generating development sustainability and impact is the empowerment of communities and civil society organizations in the area of health.

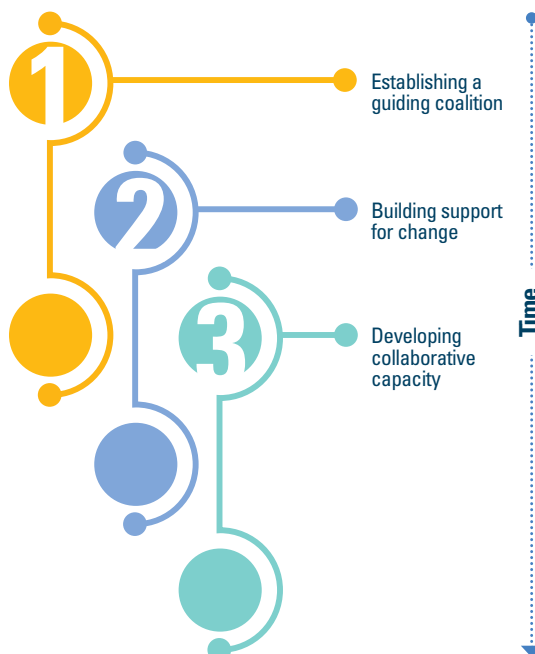
Finally, the Member States must recognize that facilitating change is a continuous process requiring advanced planning and adaptation as the situation changes. Effectively combining the basic steps for managing change and the activities necessary for building relationships can help Member States generate a virtuous circle that is more likely to achieve sustained transformative change (Figure 11). These activities require intelligent investment in technical and facilitation activities.

Figure 11. Transformative model of change centered on people and on integrated health services based on primary and community care

Change management steps



Relationship-building activities



Source: Adapted from: Goodwin N. Managing Change Towards Coordinated/ integrated Health Services Delivery. WHO: Regional Office for Europe.

CHAPTER 6



CONCLUSIONS AND FINAL RECOMMENDATIONS

This chapter summarizes the final session of the Regional Forum and the participants' main recommendations for the implementation of actions to expand equitable access to health services. It also presents the conclusions reached at the forum and during the drafting of this report.

Right to comprehensive and continuous health care

The participants described the need to provide comprehensive and coordinated care throughout the continuum of health needs. To accomplish this, it is necessary to strengthen the FLC in order to guarantee the comprehensive set of services that should be available at that level. All existing health service programs in the different Member States (for example, for specific diseases and groups of patients) should be recalibrated with that logic. In other words, care should be comprehensive and as complete as possible over time. Comprehensive care should be guaranteed as a right of all citizens.

It was recognized that the application of these principles is likely to be different in each country, depending on the national and regional context and reflecting the complexity of providing health care to a population with varying needs and aspirations. There were numerous questions about how to provide universal services; for example, how to reach the entire population, how to organize care, and how to finance it, in addition to the inevitable choice between seeking greater breadth or greater depth.

Underlying these concerns is the need to instill fundamental values and involve individuals and communities in learning about their own health and in decision-making. The participants agreed that Resolution CD53.R14 of the 53rd Directing Council of

PAHO, which adopted the Strategy for Universal Access to Health and Universal Health Coverage, constitutes a political mandate for progress toward universal health and for the corresponding work at the regional, national, and local levels.

Participation and training of people and communities

To support the aspirations of PAHO's Strategy for Universal Access to Health and Universal Health Coverage, it will be necessary to invest more time and effort in achieving the participation and empowerment of individuals, families, and communities. Several practical strategies were proposed during the forum, although it was noted that these are still incipient in many Member States. It was emphasized that rather than people being passive receptors of health care, there is a need to adopt approaches that make them active and committed participants in care and in the defense of the right to health, with equity and solidarity. This means making them active assets, partners of the health services, and political actors in the development of their own health and in the economic and social spheres. As promoters of well-being and quality of life, they would assume responsibility for self-care and promote individual and collective health. All this requires effective lobbying, social mobilization, community acceptance, and the empowerment of civil society, as well as social oversight of sectoral and intersectoral health agreements.

Capacity building and teamwork

Strengthening community-based teams should be a key strategy. Training will strengthen new service providers and health professionals and will promote teamwork and intersectoral coordination. It will be necessary to establish a strategy for human resources education and determine the combination of capacities needed in community-based teams working at the FLC. It will also be necessary to complement public health competencies (focusing on health promotion and the well-being of local communities) with competencies in individual care in first-level facilities. Significant components of team building include:

- ◆ The capacity of health systems to plan human, technological, and financial resources with a view to addressing current and future needs for new models of care.
- ◆ Adoption of adequate policies and strategies in the area of human resources for health, including the development of partnerships and alliances to make these resources politically, economically, and technically viable.
- ◆ Essential investments in and support for the training and education of professionals and technical personnel in universities and schools.
- ◆ Promotion of team-based professional and technical collaboration among colleagues aimed at the elimination of service delivery in "silos" (it may be necessary to adapt organizational structures).

- ◆ The need to ensure occupational satisfaction and safety, both in new PHC functions and in existing ones; these conditions are undervalued but are essential for workforce stability and for the objectives of the new care models.
- ◆ Human resources education for the FLC is a key priority for the future of these models.
- ◆ Management skills are of particular concern, especially for staff working at inter-institutional or network levels. In these cases, integrated network and community team managers, capable of managing public and individual health actions as well as intersectoral negotiation and agreements, may be necessary.

Developing intersectoral collaboration

Coordinated action with other sectors aimed at addressing the social determinants of health is essential in order to improve the health situation of the population with equity and with greater emphasis on groups in conditions of vulnerability and disadvantaged populations, and to achieve universal health. Particular attention should be paid to chronic conditions, migration, aging, emerging and reemerging diseases, climate change, disasters, access barriers to health services, and the social determinants of health. Intersectoral work should promote health, well-being, and social protection. Attention will also have to be paid to effective leadership and governance that can lead the development of universal health. This will require producing and mobilizing resources to strengthen the FLC and IHSNs, as well as joint action by health authorities at the national departmental, provincial, municipal, and other levels. It will also be necessary to reduce legislative barriers in some cases, and to create new legislation and regulations in others, in order to facilitate inter-institutional, intersectoral, and community work at the operational level.

Financing comprehensive care

Financing is a key element in the necessary transformation of health systems committed to expanding equitable access to quality health services through new models of health care. This is due to: 1) low historical investment in health services, especially in neglected, rural, and marginal urban areas; 2) financing of biomedical models that focus on hospitals and not on people and communities; 3) inefficient investment in health; and 4) segmentation of unpooled, unintegrated systems.

It is important to demand greater public financing and the elimination of out-of-pocket expenditure in order to close the existing gaps in health care, while addressing new needs and demands related to rapidly aging populations, rapid growth in the number of people with long-term chronic diseases, migration, mental health, accidents, addictions, technological and pharmaceutical development, and poor health due to social determinants, among other factors. The financing of universal health needs to expand beyond specific service delivery problems.

The complexity of these problems should not be reduced to insurance systems simply covering medical care. It is necessary to address long-term needs and to promote independence, autonomy, and home-based care. Health coverage and health insurance should also be expanded to cover long-term care for older adults.

These are important subjects, but the vision for universal health goes further. New sources of financing can certainly be developed; for example, direct contributions to workforce training, and new investments and incentives. It is necessary to locate sustainable resources and capital investments for long-term performance; and to conduct a methodological analysis based on the value of an investment with a view to expanding the benefits to people and communities and not simply considering costs and health outcomes.

Information, communication, and technology

Functional integration of the care and management of the population and patients requires having a unique user identification number. This helps manage the continuity of care, for example, when conducting risk stratification, offering guidance to people in need, and connecting people with services. This is an essential component of progress toward an electronic clinical record that can maximize the use of resources by reducing duplications. However, the capacity of information systems needs to be significantly improved in order to generate the information and data necessary for well-informed decisions, produce evaluations and measurements, govern complex systems, and understand the impact of changes made. With regard to health technology, it is necessary to develop the capacity to collect and interpret data that supports interventions. The use of telehealth and telemedicine could create opportunities to expand access to care.

Evaluation, production, and transfer of knowledge

When embarking on the construction and development of new health care systems, it is important to analyze and reflect strategically on what actually works. Governments should encourage academia to work with health services and systems and with local communities to produce knowledge and evidence to support changes. For example, academia could help find viable operational solutions, adapted to different national and local conditions, for people-centered health care as part of IHSNs. Regional-level knowledge exchange networks would allow countries to share empirical methodologies and experiences that are useful for changes.

For example, regional and subregional forums could be created in the Caribbean to share, adapt, and test different ideas and methods. For change management to be successfully implemented, it is crucial to share experiences in order to determine the best way of achieving this, both at the local and policy levels. It may also be appropriate to establish a worldwide association beyond the Region.

The participants in the forum insisted on the need for greater technical support for Member States on various issues. The most common challenges they mentioned include:

- ◆ Health technology assessments and mechanisms to assess clinical excellence, to identify and promote quality care, and as part of a methodology for defining health services.
- ◆ Self-evaluation tools to decide where to prioritize investments to improve the health of the population.
- ◆ Methods for engaging local communities in planning and evaluating care.
- ◆ Planning and provision of care based on the health and well-being needs of families and communities. Methods based exclusively on diseases should be discouraged and various issues should be addressed, such as violence against and abuse of the elderly, among others that are of increasing epidemiological and social importance. A holistic approach throughout the life course is therefore required.
- ◆ The principle of integrality is fundamental: care systems must not neglect any need but consider the person, families, and communities as integral entities rather than compartmentalized in health problems or diseases.
- ◆ Priority programs are important, but comprehensive care is imperative.
- ◆ A cultural shift is required among the population, professionals, and politicians to adopt new ways of thinking and working. A critical mass supporting change and a can-do attitude must be generated.
- ◆ In order to move forward with the activities over time, the Member States need to engage in transformative change. They will have to create spaces for learning, analysis, review, and consideration of different strategies and approaches.
- ◆ The progressive expansion of health services toward universal health is directly linked to financing, changes in models of care and organization, strengthening leadership and governance at each level of management, reducing segmentation and fragmentation, and addressing the social determinants of health. This means the Member States will have to make concerted efforts to prioritize health in all policies.
- ◆ It will probably be necessary at some point to include nontraditional methods in other sectors and communities, making it important for IHSN administrators and managers to establish very active networks and associations.

Change management

It is essential to develop the capacity to manage change processes. These are complex, long-term processes with opposed, parallel, and cross-cutting channels of two-way feedback that require robust change management processes.

Change management should involve political and technical authorities at the national, intermediate, and local levels in the health sector, the economic and social fields, civil society, national and subnational governments, the private sector, and NGOs, among others.

The best way to ensure the sustainability of these complex changes is to ensure that they are based on democratic political processes that are consensus-based and built on

citizen participation, with mechanisms for accountability. Each context will determine the characteristics, possible dimensions, and viable trajectories of change management processes.

Final observations

The participants in the Regional Forum achieved consensus and political commitment to the goals of universal access to health and universal health coverage and, specifically, to the rights of all people to health and well-being. There was also broad agreement on the need to take steps now, especially to strengthen the first level of health care. For Member States, the challenge going forward will be to decide on approaches to expanding equitable access to health services in order to have real impact at the national and regional levels. This report contains recommendations and actions that represent a variety of potential options that should be actively considered. Nevertheless, how this is implemented, and how care should be provided and organized will necessarily vary according to the specific context.

The Regional Forum showed the value of sharing experiences and learning about the advances made in other countries. Also, certain key areas in which PAHO could collaborate were raised, including the facilitation of future exchanges for learning and cooperation. The PAHO secretariat indicated that it would prepare recommendations on the options for organizing technical cooperation to guide advances through the coming years. For example, support could be provided for more structured projects aimed at understanding how to involve users and communities and how to train them to participate in health initiatives. PAHO has a function in this regard, since it can call on Member States to share information and promote joint efforts, as well as providing the necessary technical assistance when required.

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GLOSSARY

Intersectoral approach (*also intersectoral action, focus, work*): coordinated intervention of more than one social sector in actions aimed at improving the health and well-being of the population, involving policies, programs, and projects carried out by two or more ministries or agencies of the government. This includes both purely horizontal action between ministries and agencies, and actions across different levels of government. Traditionally, the health sector has taken a lead in actions across sectors for health and health equity; for example, through the “health in all policies” approach and the “whole-of-government” approach.

(World Health Organization. *First draft of the Framework for Country Action Across Sectors for Health and Health Equity, Second WHO Discussion Paper, 2015*. Available at: <http://www.who.int/nmh/events/WHO-discussion-paper2.pdf?ua=1&ua=1>).

Universal access to health: the absence of geographical, economic, sociocultural, organizational, or gender barriers that prevent all people from having equitable use of comprehensive health services, and from having a healthy life that enables their human development and well-being.

(Pan American Health Organization. *Strategy for Universal Access to Health and Universal Health Coverage. 53rd Directing Council of PAHO, 66th Regional Committee of the World Health Organization for the Americas. Washington, D.C.: PAHO; 2014*.

Health needs assessment: systematic review method of population health problems that leads to consensus on priorities and the allocation of resources to improve health and reduce inequities.

(Cavanagh S, Chadwick K. *Health needs assessment: A practical guide. UK National Institute for Health and Clinical Excellence; 2005*. Available at: https://www.webarchive.org.uk/wayback/archive/20140616160834mp_/http://nice.org.uk/nicemedia/documents/Health_Needs_Assessment_A_Practical_Guide.pdf).

Self-care: also called self-management or personal care, it is what people do for themselves to establish and maintain health and prevent and deal with illness. This is a broad concept encompassing hygiene (personal and general), nutrition (type and quality of food eaten), lifestyle (sporting activities, leisure, etc.), environmental factors (living conditions, social habits, etc.), socioeconomic factors (income level, cultural beliefs, etc.), and self-medication. (World Health Organization. *Report of the 4th WHO Consultative Group on the Role of the Pharmacist. The Hague, Netherlands: WHO; 1998*).

Quality of the health services: the degree to which health services for individuals and populations (1) increase the likelihood of desired health outcomes and (2) are consistent with current professional knowledge. To this definition should be added the subjective component of quality, which is users’ perception of quality.

(Pan American Health Organization. *Regional Policy and Strategy for Ensuring Quality of Health Care, Including Patient Safety, CSP 27/16; 2007*).

Response capacity: in this context, the capacity of health services to provide comprehensive care capable of meeting most of the population’s health needs and demands over time and throughout the life course.

(Pan American Health Organization. *Adapted from Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas*. Washington, D.C.: PAHO; 2010. [Series: *Renewing Primary Health Care in the Americas* No. 4]).

Universal health coverage: the existence of organizational mechanisms and health system financing sufficient to cover the entire population.

(Resolution CD53.R14, 53rd Directing Council of PAHO, 2014).

Continuity of care: corresponds to the degree in which a series of discreet health care events is experienced as coherent and connected, and consistent with the patient's medical needs and personal context.

(From Hagerty JL, Reid RJ, Freeman GK, Starfield B, Adair CE, McKendry R. *Continuity of care: a multidisciplinary review*. BMJ 2003; 327(7425):1219-1221). In: Pan American Health Organization. *Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas*. Washington, D.C.: PAHO; 2010. [Series: *Renewing Primary Health Care in the Americas* No. 4]).

International conventions on human rights: human rights are basic standards necessary for human life, without which people cannot survive or develop with dignity. They are inherent to human beings, inalienable, and universal. The United Nations established a series of common standards on human rights when it approved the Universal Declaration of Human Rights in 1948. Since then, the UN has approved numerous binding international instruments on human rights: treaties that serve as a framework for discussing and implementing these rights. The principles and rights defined in these instruments have become legal obligations for the States that decide to adopt them. The international human rights framework consists of the Universal Declaration of Human Rights and six fundamental human rights treaties: 1) the International Covenant on Civil and Political Rights; 2) the International Covenant on Economic, Social, and Cultural Rights; 3) the Convention on the Rights of the Child; 4) the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; 5) the International Convention on the Elimination of All Forms of Racial Discrimination; and 6) the Convention on the Elimination of All Forms of Discrimination against Women. Other relevant instruments for this document are the Inter-American Convention on Protecting the Human Rights of Older Persons and the Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities. Every country in the world has ratified at least one of these treaties and many have ratified the majority of them. These important documents hold governments accountable for respecting, protecting, and giving expression to the rights of individuals in their countries.

(Adapted from UNICEF. "The Human Rights Framework." Available at: <https://www.unicef.org/child-rights-convention/children-human-rights-explained>).

Long-term treatment or care: refers to the range of health, personal care, and social services offered to individuals with different degrees of physical or intellectual disability who are not able to live independently. The duration of these services is variable. They may be offered in the home, community, or appropriate facilities to people with relatively stable medical conditions, whose level of functioning is unlikely to improve with medical treatment.

(Adapted from World Health Organization. *A Glossary of Terms for Community Health Care and Services for Older Persons, Japan, 2004*. Available at: <https://apps.who.int/iris/handle/10665/68896>).

Life course: an approach based on a model that suggests that health outcomes for people and communities depend on the interaction of multiple protective and risk factors throughout people's lives. Accordingly, each life stage influences the following one. These factors involve environmental, biological, behavioral, and psychological features, as well as access to health services. This approach provides a more comprehensive vision of health and its determinants, urging the development of health services more centered on the needs of users at each stage of life.

(From Pan American Health Organization. *Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas*. Washington, D.C.: PAHO, 2010. [Series: *Renewing Primary Health Care in the Americas* No. 4]). In: Lu M, Halfon N. *Racial and ethnic disparities in birth outcomes: a life-course perspective*. *Matern Child Health J*. 2003;7(1):13-30).

Efficiency: in this context, refers to optimal utilization of resources to achieve specific social objectives.

(Resolution CD53.R14, 53rd Directing Council of PAHO, 2014).

Family and community health approach: means care that addresses problems in the context of an individual's family circumstances and social and cultural networks, and the circumstances in which people live and work. It also means that families and communities both receive and sometimes provide health services (e.g., care in the home), respecting all types of diversity (i.e., gender, cultural, ethnic, and any other diversity in the community).

(Pan American Health Organization. *Adapted from Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas*. Washington, D.C.: PAHO; 2010. [Series: *Renewing Primary Health Care in the Americas* No. 4]).

Health equity: the absence of unfair differences in health status, in 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: A Position Paper of the Pan American Health Organization/World Health Organization*. Washington, D.C.: PAHO; 2007).

Multidisciplinary team (first level of care): may include any of the following professionals and community agents (the first three categories usually constitute the minimum core team): general practitioners, nurses, professional midwives or obstetricians, physical therapists, occupational therapists, social workers, psychologists, nutritionists, pharmacists, dentists, first-line managers and administrators, community health agents, nurse auxiliaries, medical assistants, and medical technologists.

(Pan American Health Organization. *Handbook for Measurement and Monitoring. Indicators of the Regional Goals for Human Resources for Health. A Shared Commitment*. Washington, D.C.: PAHO; 2013. Available at: https://www.paho.org/hq/index.php?option=com_content&view=article&id=5696:2011-manual-medicion-monitoreo-indicadores-metas-regionales-recursos-humanos&Itemid=42273&lang=en).

Fragmentation (of health services): coexistence of several unintegrated units or facilities within the health care network. Other definitions include: 1) services that do not cover the entire range of promotion, prevention, diagnosis, treatment, rehabilitation, and palliative care; 2) services at different levels of care that are not mutually coordinated; 3) services that do not continue over time; and 4) services that are not adjusted to people's needs.

(Pan American Health Organization. *Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas*. Washington, D.C.: PAHO; 2010. [Series: *Renewing Primary Health Care in the Americas* No. 4]). In: Pan American Health Organization. *Health in the Americas 2007*. Vol. I, p. 319. Washington, D.C.: PAHO; 2007).

Case management: continuous delivery of care throughout different services that coordinate and integrate needs and resources around the patient. It basically differs from disease management in that it more focuses on individual patients and families than on the population of patients with a particular disease. It is aimed at people with a high level of risk who require very expensive care, are very vulnerable, or have complex health and social needs. Case managers coordinate patient care throughout the continuum of care.

(Smith JE. *Case management: a literature review*. *Can J Nurs Adm*. 1998; 11(2):93-109).

Network manager: professional administrator or team that, without having direct hierarchical authority over all health facilities in a network, performs functions that enhance the coordinated operation of the network as a whole. The main functions involve management and allocation of resources and incentives. This is one of the possible arrangements that emerges as part of governance building during the implementation and operation of IHSNs.

(Pan American Health Organization. *Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas*. Washington, D.C.: PAHO; 2010. [Series: *Renewing Primary Health Care in the Americas* No. 4]).

Governance: joint action that organizes interactions among actors, the dynamics of processes, and the (informal and formal) rules by which a society determines its behaviors, makes decisions, and implements them.

(Hufty M, Báscolo E, Bazzani R. *Gobernanza en salud: un aporte conceptual y analítico para la investigación*. *Cad Saude Publica*. 2006;22:S35-S45).

Clinical practice guides: systematic recommendations, based on the best available scientific knowledge, to help professionals and patients decide on the most appropriate and efficient health interventions to address a specific health-related problem in specific circumstances.

(Grifell E, Carbonell JM, Infesta F. *Mejorando la gestión clínica: desarrollo e implantación de guías de práctica clínica*. Barcelona: CHC Consultoría y Gestión; 2002. In: Pan American Health Organization. *Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas*. Washington, D.C.: PAHO; 2010. [Series: *Renewing Primary Health Care in the Americas* No.4]).

Hospitals: health facilities with medical personnel and other organized professionals, that admit patients and offer medical, nursing, and other related services 24 hours a day, 7 days a week. Hospitals offer a great diversity of services for acute care, convalescence, and palliative care, with the necessary diagnostic and therapeutic capacity to respond to acute and chronic manifestations of disease, as well as injuries and genetic anomalies.

(World Health Organization. *Health Topics*. Available at: <https://www.who.int/hospitals/en/>).

Unmet health needs: “the difference between the services judged necessary to deal appropriately with health problems and the services actually received.” These are the result of access barriers related to accessibility, availability, and acceptability.

(Pappa E, Kontodimopoulos N, Papadopoulos A, Tountas Y, Niakas D. *Investigating unmet health needs in primary health care services in a representative sample of the Greek population*. *Int J Environ Res Public Health*. 2013;10(5):2017-2027. Available at: <http://doi.org/10.3390/ijerph10052017>).

Direct out-of-pocket payments (or direct payments): fees or charges often collected for medical consultations, procedures, or investigation in order to pay for drugs and other supplies, and for clinical analyses. Depending on the country, these are collected by government agencies, religious health centers, or private facilities. Some are official charges and others are not (e.g., “under the table” payments). Even users covered by insurance are required to share these costs (normally in the form of co-insurance, copayments, or deductibles) and to pay out-of-pocket at the point of service for the part not covered by the insurance plan.

(World Health Organization. *Adapted from: World Health Report. Health systems financing: the path to universal coverage*. Geneva: WHO; 2010).

National plan of action: a broad intersectoral master plan for attaining national health goals through implementation of a strategy. It indicates what has to be done, who has to do it, during what time-frame, and with what resources. It is a framework leading to more detailed programming, budgeting, implementation, and evaluation. It specifies, in operational terms, the steps to be taken in accordance with the strategy, keeping in mind the various objectives and targets to be attained and the programs for attaining them.

(World Health Organization. *A Glossary of Terms for Community Health Care and Services for Older Persons*. Japan: WHO; 2004. Available at: <https://apps.who.int/iris/handle/10665/68896>).

National health policy: a formal statement or procedure within an institution (notably government) which defines goals, priorities, and the parameters for action in response to health needs, within the context of available resources.

(World Health Organization. *A Glossary of Terms for Community Health Care and Services for Older Persons*. Japan: WHO; 2004. Available at: <https://apps.who.int/iris/handle/10665/68896>).

First level of care (FLC): in this document, the term “FLC” has been used instead of “primary care” in order to avoid confusion regarding the concept of primary health care (PHC), which, for PAHO, represents a broad approach to the organization and operation of the health system as a whole, and not only the delivery of health services at the FLC. In any case, both “FLC” and “primary health care” are defined here as the delivery of integrated and accessible services by health workers, aimed at resolving most of people’s health needs, developing an ongoing relationship with people in the context of the family and the community.

(Institute of Medicine. Primary care: America’s health in a new era. Washington, D.C.: National Academy Press; 1996. In: Pan American Health Organization. Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas. Washington, D.C.: PAHO; 2010. [Series: Renewing Primary Health Care in the Americas No. 4]).

Stewardship: the exercise of substantive responsibilities and competencies in public policy on health, in the context of the new framework for relations between government and society in countries today. It is a function typically under the purview of government, exercised by the national health authority. Its purpose is to implement public decision-making and initiatives to meet and guarantee the health needs and legitimate aspirations of groups of social actors, within the framework of each national development model.

(Levcovitz E. Estructura, Organización y Políticas del Sector. In Lineamientos Metodológicos: Análisis del Sector Salud (Washington, D.C.: PAHO/WHO; forthcoming).

Human resources for health: to facilitate international comparisons, given the disparity of available data for many professions, we will use the WHO definition, which adds physicians, nurses, and midwives to represent the total human resources for health in a country. However, countries are still encouraged to collect information on all of the health professions that are relevant to the health care team.

(Pan American Health Organization. Handbook for Measurement and Monitoring. Indicators of the Regional Goals for Human Resources for Health. A Shared Commitment. Washington, D.C.: PAHO; 2013. Available at: https://www.paho.org/hq/index.php?option=com_content&view=article&id=5696:2011-manual-medicin-monitoreo-indicadores-metas-regionales-recursos-humanos&Itemid=42273&lang=en).

Integrated health services delivery networks: a network of organizations that provides, or makes arrangements to provide, equitable, comprehensive, integrated, and continuous health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and the health status of the population served.

(Pan American Health Organization. Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas. Washington, D.C.: PAHO; 2010. [Series: Renewing Primary Health Care in the Americas No. 4]).

Permanent or long-term relationship between system users and the first level of care (FLC): in the context of this document, this refers to an established, sustained relationship between the FLC and the health system user throughout the life course.

Response capacity at the first level of care (FLC): capacity of a first-level facility to correctly diagnose and effectively treat users' health problems, having an appropriate level of human resources and materials available for primary care. This capacity is measured by evaluating selected health problems as indicators, and based on the performance of clinicians, according to the definitions established in clinical practice guidelines.

(Adapted from: Peñaloza B, Leisewitz T, Bastías G, Zárate V, Depaux R, Villarroel L, et al. Metodología para la evaluación de la relación costo-efectividad en centros de atención primaria de Chile. Rev Panam Salud Publica. 2010;28(5):376-387).

Health in all policies: an approach aimed at improving health and well-being. It involves an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity.

(World Health Organization. Adapted from: Health in All Policies Framework for Country Action. Washington, D.C.: PAHO; 2013. Available at: <https://www.who.int/healthpromotion/frameworkforcountryaction/en/>).

Segmentation (of health systems): health systems characterized by the coexistence of subsystems with different modalities of financing, affiliation, and service delivery, each of them "specialized" in different strata of the population, according to labor status, income level, ability to pay, and social position. This type of institutional organization consolidates and deepens inequities in access to health services between different population groups. In organizational terms, this means the coexistence of one or more public entities (depending on the degree of decentralization or deconcentration) and social security systems (represented by one or more entities), as well as various financing/insurance schemes and private service providers (depending on the degree to which market mechanisms and business management practices have been introduced during sectoral reforms).

(Pan American Health Organization. Health in the Americas 2007. Vol. I, p. 319. Washington, D.C.: PAHO; 2007. In: PAHO. Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas. Washington, D.C.: PAHO; 2010. [Series: Renewing Primary Health Care in the Americas No. 4]).

People- and community-centered health services: the focus is on “the person as a whole”; i.e., care that considers a person’s physical, mental, emotional, and social dimensions throughout the life course. This also means that health services incorporate intercultural and gender approaches and focus on vulnerable populations. It implies that health workers have a degree of knowledge about each person; that care is adapted to the person’s specific needs; that there is empathy, respect, and trust; and that clinical decision-making is shared by the provider and the person. It means empowering people to manage their health better, through strategies such as health education, self-care, and self-management of their illness. People-centered care is also linked to approaches focused on the rights (and sometimes the responsibilities) of people or patients with respect to health care. In some countries, this has been expressed in “patient charters.”

(Pan American Health Organization. Adapted from: Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas. Washington, D.C.: PAHO; 2010. [Series: Renewing Primary Health Care in the Americas No. 4]).

First-level care services: often including, but not limited to, disease prevention and treatment, first-line emergency services include stabilization of the patient and referral to another center, continuity of treatment and coordination with other types and levels of care (such as hospitals and specialists), mental health care, palliative and late-stage care, health promotion, growth and development of healthy children, maternal care, rehabilitation services, and other services that correspond to the model of care in each country or the level of health system development.

Comprehensive health services: management and delivery of health services so that people receive a continuum of promotion, prevention, diagnosis, treatment, disease management, rehabilitation, and care palliative services at different levels and locations in the health system, according to their needs throughout the life course.

(World Health Organization. Adapted from: Integrated health services – what and why? Technical Brief no. 1, May 2008. In: Pan American Health Organization. Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas. Washington, D.C.: PAHO; 2010. [Series: Renewing Primary Health Care in the Americas No. 4]).

Health system: group of organizations, individuals, and actions focused fundamentally on promoting, recovering, and/or improving health.

(World Health Organization. The World Health Report 2000: health systems: improving performance. Geneva: WHO; 2000).

Telehealth or telemedicine: use of communication technologies to assist in the diagnosis, treatment, care, and management of health conditions in remote areas.

(World Health Organization. A Glossary of Terms for Community Health Care and Services for Older Persons. Japan: WHO; 2004. Available at: <https://apps.who.int/iris/handle/10665/68896>).

Community health workers: offer education, referral, follow-up, case management, and home visiting services to vulnerable groups, most often women at highest risk for poor birth outcomes, particularly low birth weight and infant mortality. Services are generally provided by paraprofessionals who live in or are familiar with the community. They are trained to provide basic health education and referrals to families and communities for a wide range of services and to provide support and assistance in navigating health and community service systems.

(Pan American Health Organization. Handbook for Measurement and Monitoring. Indicators of the Regional Goals for Human Resources for Health. A Shared Commitment. Washington, D.C.: PAHO; 2013. Available at: https://www.paho.org/hq/index.php?option=com_content&view=article&id=5696:2011-manual-medicion-monitoreo-indicadores-metas-regionales-recursos-humanos&Itemid=42273&lang=en).

The Region of the Americas has made considerable progress in improving the health of its population, but it remains one of the most inequitable regions in the world. The challenges are enormous and varied: millions of people lack access to comprehensive health services, health systems provide fragmented care, and there are major disparities in human resources for health.

In response to these challenges, PAHO adopted the Strategy for Universal Access to Health and Universal Health Coverage in 2014, recognizing the need to transform or strengthen health systems and services to combat health inequities and secure health and well-being for all people in the Region.

This report addresses the basic aspects of implementing the Strategy, offering Member States a series of practical recommendations to help them plan and implement changes that will lead to the strengthening of their health services. It reviews the practical recommendations related to the first strategic line of the Strategy and the three interrelated lines of action. It also explains how to select the services and benefits that should be prioritized as part of the progressive expansion of health services to communities. Finally, it considers issues related to stewardship and the management of transformative change.

Understanding how to address change and stimulate investment in health, well-being, and development is essential to achieving universal access to health and universal health coverage.

PAHO



Pan American
Health
Organization



World Health
Organization
REGIONAL OFFICE FOR THE Americas

525 Twenty-third Street, NW
Washington, D.C., 20037
United States of America
Tel.: +1 (202) 974-3000
www.paho.org

