



PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION



144th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 22-26 June 2009

Provisional Agenda Item 4.12

CE144/17 (Eng.)

11 May 2009

ORIGINAL: SPANISH

INTEGRATED HEALTH SERVICES DELIVERY NETWORKS BASED ON PRIMARY HEALTH CARE

Introduction

1. This document proposes a regional policy for developing integrated health services delivery networks (IHSDN) to respond to the major challenges posed by health services fragmentation and to meet the commitments made in the Declaration of Montevideo, the Health Agenda for the Americas 2008-2017, and the Iquique Consensus. The policy states that IHSDN contribute to the development of health systems based on primary health care (PHC), and hence, to the delivery of more accessible, equitable, and efficient health services of higher technical quality, in which gender equity and cultural competence are considerations and the public perception of the quality of the services is more favorable. It recommends the drafting of national plans consistent with the situation in each country and based on the definition and essential attributes of IHSDN outlined in this document.

Background

2. Health systems in the Americas are characterized by high levels of segmentation¹ and fragmentation² (1-3). Fragmentation is a major cause of the poor performance of

1 **Segmentation** is “the coexistence of subsystems with different modes of financing, membership, and delivery of health care services, each of them ‘specializing’ in different population segments, depending on their employment, income level, ability to pay, and social status. This kind of institutional arrangement consolidates and deepens inequity in access to health care between different population groups. In organizational terms, segmentation is the coexistence of one or more public entities (depending on the degree of decentralization or deconcentration), social security programs (represented by one or more entities), different financers/insurers, and private suppliers of services (depending on the extent of market mechanisms and entrepreneurial management introduced during sector reform...”(Pan American Health Organization. Health in the Americas 2007 (Vol. I, pg. 319), Washington, D.C.: PAHO/WHO, 2007).

health systems and services. Fragmentation can by itself, or in conjunction with other factors, lead to difficulty accessing services, the delivery of services whose technical quality is deficient, irrational and inefficient use of the available resources, unnecessary increases in production costs, and low levels of user satisfaction with the services received (4-6).

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

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

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

6. Notwithstanding these efforts, the mechanisms and incentives to promote the clinical integration and development of integrated networks are still inadequate and need

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

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

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

Situation Analysis

8. Health services fragmentation is manifested in many ways in the different levels of the health system. In people's experiences with the system, fragmentation is manifested as lack of access to the services, loss of continuity of care, and the failure of the services to meet users' needs. Specific examples include suppressed demand, waiting lists, delayed referrals, the need to visit multiple service venues to treat a single episode of illness, or the lack of a regular source of services. Other examples are unnecessary repetitions of history-taking and diagnostic tests or the prescription of interventions that do not take the cultural characteristics of certain population groups into account. Fragmentation in overall system performance is manifested as lack of coordination between the different levels of care and care locations, duplication of services and infrastructure, unutilized productive capacity, and health care provided at the least appropriate location, especially hospitals. Specific examples include low resolution capacity at the first level of care; the use of emergency services to obtain specialized care, effectively bypassing outpatient visits; the hospitalization of patients whose illness could have been treated on an outpatient basis or the extension of hospital stays because of difficulties in discharging patients with social problems.

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

10. Although health services fragmentation is a common challenge in most of the countries of the Region, its order of magnitude and principal causes differ from country to country. Nevertheless, the literature review and country consultations pointed out the following as the leading causes of fragmentation: (a) institutional segmentation of the health system; (b) decentralization of health services that fragments the levels of care; (c) a predominance of programs focusing on diseases, risks, and specific populations (vertical programs); (d) extreme separation of public health services from personal health services; (e) a model of care centered on disease, acute care, and hospital treatment; (f) weak health authority stewardship; (g) problems with the quantity, quality, and allocation of resources; (h) the multiplicity of payer institutions and service payment mechanisms; (i) organizational models that hinder integration; (j) the cultural norms and behaviors of the population and service providers; (k) legal and administrative obstacles; and (l) the funding practices of certain international cooperation agencies/donors (for example, the funding of vertical programs).

11. Concerning the funding practices of certain international cooperation agencies/donors, many of them are currently questioning the efficacy of cooperation centered exclusively on vertical programs and are reorienting their cooperation toward strengthening health systems with a more integrated approach. In December 2005, the Global Alliance for Vaccines and Immunization (GAVI) approved the use of its funds to strengthen health systems (16). More recently, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) also decided to support the strengthening of health systems insofar as they help fight these three diseases (17). The World Bank conducted an internal consultation on the integration of vertical programs in the health systems (18) and is supporting investment projects for health services networks in countries such as Brazil (19). The same can be said for the German Agency for Technical Cooperation (GTZ), which in a recent report noted the need to reorganize the service delivery network, centered on primary care services, in order to set up a single, integrated, coordinated network of services. (20). Within this framework, WHO has launched the initiative Maximizing Positive Synergies between Health Systems and Global Health Initiatives to ensure that health systems and the selective interventions of global health initiatives are mutually reinforcing and can lead to greater achievements in global public health (21).

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

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

Proposal

14. The purpose of the PAHO IHSDN initiative is to contribute to the development of PHC-based health systems, and thus, to the delivery of more accessible, equitable, and efficient services of higher technical quality, where gender equity and cultural competence are considerations and the public perception of the quality of the services is more favorable. PAHO regards IHSDN as one of the principal operational expressions of the PHC approach in health services, helping to guarantee several of its core elements, namely: universal coverage and access, first contact, comprehensive care, a family and community orientation, appropriate health care, optimal organization and management, and intersectoral action (23).

15. IHSDN can be defined as a network³ of organizations that provides, or makes arrangements to provide, comprehensive health services⁴ to a particular population and is

³ The concept of *network* has multiple meanings and applications. For example, from a sociological perspective, networks are a key mechanism of the social inclusion and integration of the contemporary individual, as well as a mode of organization especially adapted to the current operations of society, with major political potential due to their capacity to transform the situation (Bertolotto F, Mancheno M. Las redes: una estrategia para la reducción de la segmentación de los sistemas de salud: contribución al seminario internacional GTZ/OPS/MSP/ASSE [unpublished; copy available on request] on integrated health services delivery networks and systems, Montevideo, 16-17 October 2008). Copy available on request. In the field of health services, the term *network of services* (or *service network*) basically refers to: (a) the functional coordination of provider units of a different nature; (b) hierarchical organization by level of complexity; (c) a common geographical referent; (d) command by a single operator; (e) operating standards, information systems, and other shared logistical resources; and (f) a common purpose. Copy available on request..

⁴ The term *comprehensive health services* refers to the management and delivery of health services such that the people receive a *continuum* of health promotion, disease prevention, diagnostic, treatment, and

willing to be held accountable for its clinical and economic outcomes and the health status of the population that it serves (Modified from: Shortell, SM; Anderson DA; Gillies, RR; Mitchell JB; Morgan KL. Building integrated systems: the holographic organization. *Healthcare Forum Journal* 1993 Mar-Apr;36(2):20-6).

16. As follows from the above definition, IHSDN do not require all of their member health services to be under sole ownership. On the contrary, some of their services can be provided through a variety of contractual arrangements or strategic partnerships in what has been called “virtual integration.” This characteristic of IHSDN makes it possible to explore options for complementary services between organizations with a different legal status, either public or private, and even between different countries (for example, the “shared services” initiative of the small islands of the Caribbean and the complementation of services on common borders).

Essential Attributes of IHSDN

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

- (1) covered population and territory defined and extensive knowledge of its health needs and preferences, which determine the supply of health services;
- (2) an extensive network of health facilities that offers services in health promotion, disease prevention, diagnosis, treatment, and rehabilitation and integrates both personal and public health services;⁵

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

⁵ **Public health** is an organized effort by society, primarily through its public institutions to improve, promote, protect and restore the health of the population through collective action, and includes services such as health status assessment, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster and emergency preparedness and response, and occupational health, among others (Pan American Health Organization. *Public Health in the Americas: Conceptual Renewal, Performance Assessment, and Bases for Action*. PAHO Scientific and Technical Publication No. 589, p. 46. Washington, DC:PAHO; 2002).

- (3) first-level care that covers the entire population, acts as a gatekeeper to the system, and integrates and coordinates health care, in addition to meeting most of the population's health needs;
- (4) delivery of specialized services in the most appropriate place, preferably in outpatient settings;
- (5) existence of health care coordination mechanisms throughout the health service continuum;
- (6) individual-, family-, and community-centered health care that takes cultural and gender characteristics into account;
- (7) a unified system of governance for the entire network;
- (8) broad social participation;
- (9) integrated management of administrative, clinical, and logistical support systems;
- (10) sufficient numbers of competent, committed human resources that are valued by the network;
- (11) integrated information system that links all members of the network, with data disaggregated by sex, age, place of residence, ethnic origin, and other relevant variables;
- (12) adequate funding and financial incentives aligned with network goals; and
- (13) intersectoral action.

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

Policy Instruments and Institutional Mechanisms for the Creation of IHSDN

19. Policymakers, managers, and health service providers have a series of public policy instruments and institutional mechanisms that can assist them in creating IHSDN. *Policy instruments* are the means for meeting public policy objectives and include legal instruments, capacity building, taxes and fees, expenditures and subsidies, advocacy and information. Examples of these instruments include: (a) geographical designation of the population to be served; (b) planning of services based on the needs of the population; (c) definition of a comprehensive portfolio of health services; (d) standardizing individual-, family-, and community-centered model of care; (e) standardizing

intercultural and gender approach in the services, including the use of traditional medicine; (f) standardizing the gatekeeper of the system; (g) regulation of access to specialized care; (h) guidelines for clinical practice; (i) human resources education and management compatible with the IHSN; (j) risk-adjusted per capita payment; and k) integrated public policies covering the different sectors.

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

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

Technical Cooperation Priorities and Strategy

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

23. The wide range of external contexts and internal realities of health systems make it difficult to issue rigid, very specific regional recommendations for the creation of IHSDN. Every country/local situation should formulate its own strategy for implementing the IHSDN based on its political situation, financial resources, administrative capacity, and the historical development of the sector. Notwithstanding,

the IHSN initiative needs a roadmap that, without ignoring the distinct realities of the countries, will make it possible to select some priority areas for action and establish a general timetable for implementation.

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

25. The IHSN initiative falls under Strategic Objective No. 10 of the Strategic Plan 2008-2012 for the Pan American Sanitary Bureau, and more specifically, supports the achievement of Regionwide Expected Result 10.3, which says "*Member States supported through technical cooperation for developing mechanisms and regulatory systems to ensure collaboration and synergies between public and non-public service delivery systems.*" Regional progress of the initiative will be evaluated through indicator 10.3.1 of the Strategic Plan, which is: "*Number of countries that have adopted PAHO's policy recommendations for integrating the health care delivery network, including public and nonpublic providers.*" The 2007 baseline for this indicator was three countries, and the targets for 2009 and 2013 are 12 and 22 countries, respectively. Moreover, progress at the country level will be evaluated through the progress indicators established in each national plan for each particular situation.

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

27. Finally, PAHO has managed to consolidate support for the initiative among other partners, including the Ministry of Health of Brazil, the German Agency for Technical Cooperation (GTZ), the Hospital Consortium of Catalonia (CHC), and the Hospital

Cooperative of Antioquia (COHAN). In any case, PAHO will attempt to increase the number of partners in 2009.

Action by the Executive Committee

28. The Executive Committee is invited to examine this document and approve the proposed resolution, attached (see Annex C).

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

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

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

Sources: (a) Ministry of Health (2008). Draft for debate: law creating the integrated federal health system: project for creation of the integrated federal health system: call for a broad and fruitful debate (Unpublished draft. Copy available on request); (b) Ministry of Health and Sports (2008). Regulations governing the National Municipal Intercultural Family and Community Health Network and Network of Services; (c) Ministério de Saúde (2008). Mais Saúde: Direito de todos 2008-2011. Ministry of Health (2001). (d) Ministry of health (2008). Institutional Mission of the Department of Care Networks <http://www.redsalud.gov.cl/conozcanos/subsecrudes.html>; (e) Secretary of State for Public Health and Social Welfare (2005). Model regional health services network: guidelines for the development of personal health care services (f) Ministry of health (2008). Regulations of the Law creating the National Health System. Executive Decree No. 82 Official Gazette http://www.mspas.gob.sv/pdf/documentos_SNS/Reglamento_ley_sistema_nacional_salud.pdf (g) Ministry of Public Health and Social Welfare. Experiences/lessons learned from the coordination/integration of health systems and services networks, Guatemala, June 2008. Unpublished presentation (copy available on request); (h) National Health Council (2008). Summary of contributions from the national consultation with Mexico on the proposal for the IHSDN. Mexico, DF, 3 November 2008. Unpublished report on the workshop (copy available on request); (i) Ministry of Health (2002). Guidelines for creating networks. Copy available on request; (j) PAHO Trinidad and Tobago. National Consultation on Integrated Delivery Systems, Kapok Hotel, 16-18 Cotton Hill, St. Clair. Unpublished report on the workshop (copy available on request); (k) Eastern Republic of Uruguay, Senate (2007). Integrated National Health: Creation. XLVI. Legislature. (l) Metropolitan District of Caracas, Ministry of Health, and Social Development (2005). Workshop: Definition of Health Services Networks of the Metropolitan District of Caracas.



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 Annex B

ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL AREAS

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

2. Responsible unit: HSS/SP

3. Preparing officer: Hernán Montenegro, HSS/SP

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

- Collaborating Center: Hospital Cooperative of Antioquia (COHAN).
- Other associated institutions: Ministry of Health of Brazil, German Agency for Technical Cooperation, (GTZ), the Hospital Consortium of Catalonia (CHC).

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

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

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

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

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

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

8. Financial implications of this Agenda item:

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



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144th SESSION OF THE EXECUTIVE COMMITTEE

Washington, D.C., USA, 22-26 June 2009

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Annex C

ORIGINAL: SPANISH

PROPOSED RESOLUTION

INTEGRATED HEALTH SERVICES DELIVERY NETWORKS BASED ON PRIMARY HEALTH CARE

THE 144th SESSION OF THE EXECUTIVE COMMITTEE,

Having reviewed the report submitted by the Director on *Integrated Health Services Delivery Networks based on Primary Health Care* (document CE144/17), which summarizes the problem of health services fragmentation and proposes the creation of integrated health services delivery networks to address it;

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

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

RESOLVES:

To recommend that the Directing Council adopt a resolution written as follows:

**INTEGRATED HEALTH SERVICES DELIVERY NETWORKS
BASED ON PRIMARY HEALTH CARE**

THE 49th DIRECTING COUNCIL,

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

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

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

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

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

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

RESOLVES:

1. To urge Member States to:
 - (a) take note of the problem of health services fragmentation in the health system, and when applicable, in the subsystems that comprise it;
 - (b) facilitate dialogue with all relevant stakeholders, particularly health service providers and home and community caregivers about the problem of service fragmentation and the strategies to address it;
 - (c) prepare a national plan of action promoting the creation of integrated health services delivery networks as the preferred modality for health services delivery in the country;
 - (d) promote human resources education and management compatible with the creation of integrated health services delivery networks; and
 - (e) implement and periodically evaluate the national plan of action for the creation of integrated health service networks.
2. To request the Director to:
 - (a) support the countries of the Region in the preparation of their national plans of action for the creation of integrated health services delivery networks;
 - (b) promote the creation of integrated health services delivery networks along common borders, including, when applicable, plans for cooperation and/or compensation for services between countries (or “shared services” in the case of the Caribbean);
 - (c) develop conceptual and analytical frameworks, tools, methodologies, and guidelines that facilitate the creation of integrated health services delivery networks;
 - (d) support human resources training and health management compatible with the creation of integrated health services delivery networks, including unpaid individuals who provide health care in the home and community;
 - (e) mobilize resources to support the creation of integrated health services delivery networks in the Region, which includes the documentation of good practices and the sharing of information on successful experiences among countries;

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



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Annex D

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

<p>1. Agenda item: 4.12. Integrated Health Services Delivery Networks based on Primary Health Care.</p>
<p>2. Linkage to program budget:</p> <ul style="list-style-type: none">a) Area of work: HSS, Strategic Objective 10b) Expected result: The CD will adopt the resolution on IHSDN
<p>3. Financial implications</p> <ul style="list-style-type: none">a) Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US\$ 10,000, including staff and activities): The total expenditure of the Pan American Sanitary Bureau (regional office and Representative offices) for the period 2008-2011 will be equivalent to US\$1.3 million. Country expenditure will be calculated once the countries have drafted their national plans for the creation of IHSDN.b) Estimated cost for the biennium 2008-2009 (estimated to the nearest US\$ 10,000, including staff and activities): Bureau expenditure for the biennium 2008-2009 will be equivalent to US\$ 553,000.c) Of the estimated cost noted in section b), what can be subsumed under existing programmed activities? The total expenditure.
<p>4. Administrative implications</p> <ul style="list-style-type: none">a) Indicate the levels of the Organization at which the work will be undertaken): The equivalent of one full-time Regional Adviser is needed for this item. At least four Regional Advisers are currently working part-time on this item.b) Additional staffing requirement (indicate additional required staff full-time equivalents, noting necessary skills profile): Not required.c) Time frames (indicate broad time frames for implementation and evaluation): Implementation can begin in 2009, and evaluation of the results, in 2011.