

Integration of health service delivery networks in Honduras: a comparative assessment of theory and practice in five networks in the country*

Eduardo Benjamín Puertas,¹ Roney Alcides Martínez,² Gloria S. Figueroa,³ and Freddy E. Hidalgo³

Suggested citation (original manuscript)

Puertas EB, Martínez RA, Figueroa GS, Hidalgo FE. Integración de redes de servicios de salud en Honduras: valoración comparativa del planteamiento teórico y de la aplicación práctica en cinco redes del país. Rev Panam Salud Publica. 2018;42:e135. <https://doi.org/10.26633/RPSP.2018.135>

ABSTRACT

Objective. *There have been few evaluations of integrated health service delivery networks (IHSDNs) in the Region of the Americas. Honduras has made progress in the implementation of tools and strategies based on the essential attributes of IHSDNs. The objective of this study is to assess and compare the development of IHSDNs in theoretical and practical terms, by type of management, in five networks in Honduras.*

Methods. *The study was conducted in two stages: 1) a theoretical assessment based on a review and summary of six official documents on IHSDNs published between 2012 and 2017; and 2) a practical assessment in conjunction with the coordination teams of five networks, two of them with decentralized management and three of them with mixed management, using the IHSDN Assessment Tool of the Pan American Health Organization.*

Results. *The overall theoretical assessment yielded a development score of 55 points, compared with 42.8 for the practical assessment of the five networks. In the analysis by area, the model of care had the best results in both assessments, with higher scores in the theoretical assessment (62.5). The area with the lowest score (41.7) was governance and strategy. There were statistically significant differences between the theoretical and practical assessment in both the analysis by area and by attribute ($p = 0.007$ and $p < 0.001$, respectively). The networks with decentralized management had higher scores than those with mixed management ($p = 0.017$).*

Conclusions. *The gap between the theoretical and practical assessment suggests that implementation of the tools and strategies defined in the documents is incomplete. The provisional component remains the one that elicits the most interest and is considered the most important. Greater difficulties with integration were observed in the networks with mixed management, probably because of their dual governance. Continued evaluation of IHSDNs is necessary.*

Keywords

Health services; health care reform; decentralization; Honduras.

* Official English translation from the original Spanish manuscript made by the Pan American Health Organization. In case of discrepancy, the original version (Spanish) shall prevail.

¹ Pan American Health Organization, Tegucigalpa, Honduras. Send correspondence to Eduardo Benjamín Puertas, puertasb@paho.org

² Ministry of Health of Honduras, Tegucigalpa, Honduras.

³ Independent consultant. Tegucigalpa, Honduras.

An integrated health service delivery network (IHSDN) is defined as a network of organizations that provides, or makes arrangements to provide, equitable and comprehensive health services to a defined population and is willing to be held accountable for its results (1). The purpose of the IHSDN initiative is

to contribute to the development of health systems based on primary health care (PHC) and the delivery of more accessible, equitable, and efficient high-quality health services that better meet people's expectations.

The Pan American Health Organization (PAHO) considers IHSDNs one of

the main options for integrating PHC into the health services (first contact; comprehensive, integrated, continuous, and appropriate care; optimal organization and management; family and community approach; and intersectoral action), thus contributing to the achievement of universal coverage and access (1).

For good performance, IHSDNs should display the 14 essential attributes proposed by PAHO, which are divided into four groups: model of care; governance, and strategy; organization and management; and resource

allocation and incentives (Figure 1). Several studies suggest that IHSDNs could improve access, lower production costs, and increase the overall efficiency of the health system; reduce the fragmentation of care; prevent the duplication of infrastructure and services; and better respond to the needs and expectations of the population (2, 3). A study conducted in Colombia and Brazil found deficiencies in coordination between levels of care and limited implementation of mechanisms for coordinating care associated with the health system and the organization of the

service network (4). There is limited use of tools for evaluating networks and the evidence of their impact in Latin America (5-9).

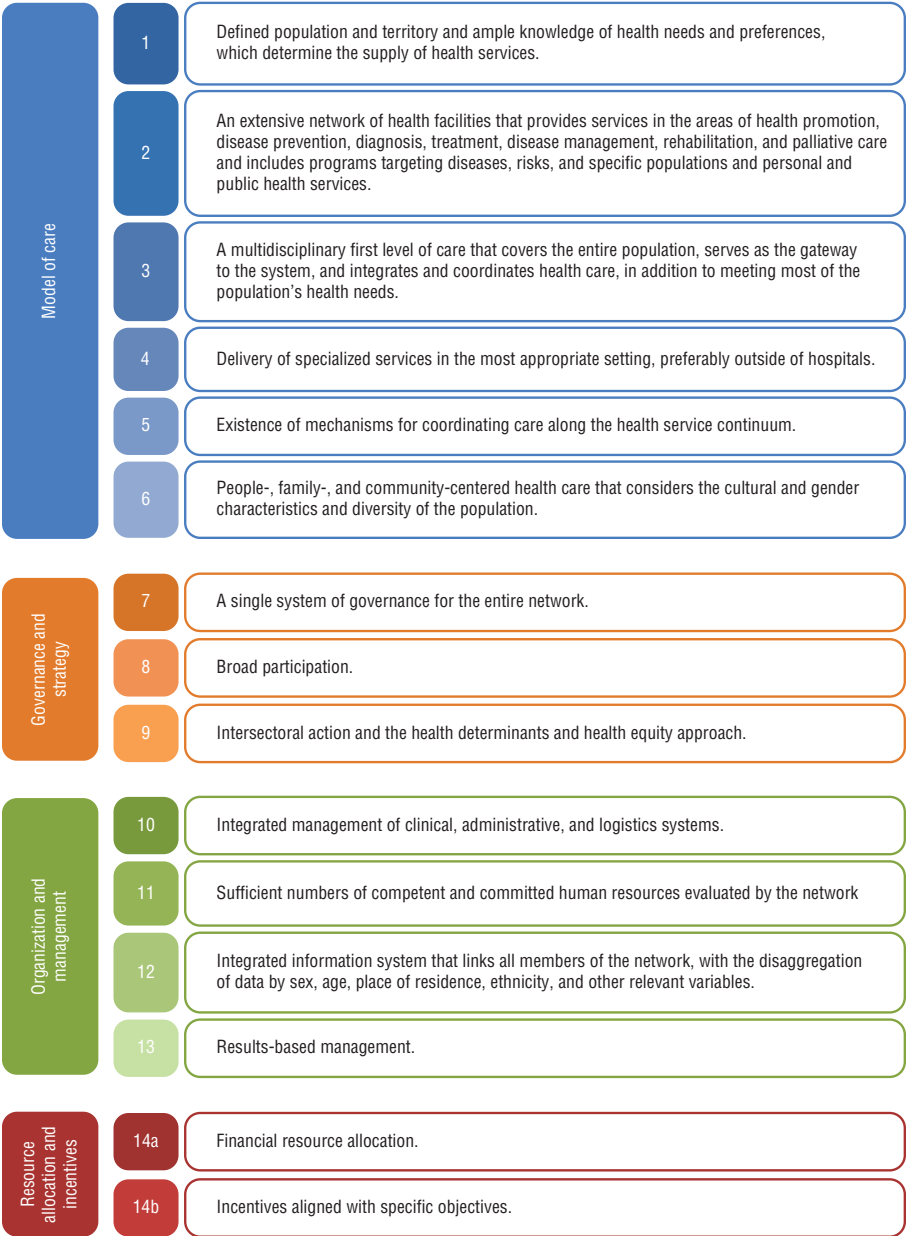
Honduras is confronted by the challenge of shifting from a highly fragmented and segmented health system to a system with integrated networks. This challenge is even greater when the decentralization of health services is accelerating in a context of the separation of functions, where the national health authority is facing challenges in connection with its governance role. The country has made great strides in developing and strengthening networks by embracing tools and strategies for the definition, creation, and strengthening of IHSDNs based on the essential attributes. The Ministry of Health (SESAL) has published its activities in this regard as official documents, as indicated further on. The types of service management include decentralized, nondecentralized, and mixed networks. The first of these is the responsibility of local governments and NGOs, the second is still the purview of the central level, and mixed networks are managed by a combination of authorities.

The purpose of this study is to assess and compare the development of IHSDNs from a theoretical-documentary perspective, in terms of their practical implementation, and by management type in five selected networks in Honduras.

MATERIALS AND METHODS

The study was conducted in two stages. In the first stage, the theoretical-documentary definition was examined through a review and analysis of six official documents related to IHSDNs and published between 2012 and 2017. Using the PAHO IHSDN Assessment Tool, which has been applied in several countries in the Region of the Americas, the explicit and implicit inclusion of every attribute in the official SESAL documents was assessed. In the second stage, practical implementation was assessed in five networks—two decentralized (El Jaral and San Juan) and three mixed (Siguatepeque, Santa Rita, and La Paz)—by network coordination teams consisting of a coordinator, supervisors, and members of family health teams, during a workshop held

FIGURE 1. Areas and attributes of integrated health service delivery networks



Source: Reference 1.

in November 2017 to evaluate implementation of the IHSDN strategy. In selecting the networks, consideration was given to the type of management (decentralized and mixed) and geographical criteria for national representativeness (networks with more than one municipality and high poverty rates). Moreover, these networks had complete, stable, and experienced coordination teams.

The theoretical and practical assessments were conducted using the 2017 version of the IHSDN Assessment Tool, which has an online component and an offline Excel component and permits the prioritization of opportunities for improvement through analysis of the results (10).

Assessing the 14 attributes of IHSDNs in the networks involved rating them according to the degree to which the criteria were met, based on a Likert scale of 1 to 4, where 4 represents the highest integration value (10). The team assessed each attribute using the criteria defined in the tool in order to minimize bias during the process and rated the attribute by consensus. Once each network assessment had been completed, the prioritization matrix was used to identify the criteria with the lowest score for each attribute so that the intervention proposals necessary for strengthening the IHSDN strategy could be drafted. Only the PAHO and SESAL administrators had access to the global results, while the individual networks had access only to their own data. Although the tool was not designed to assess networks based on the content of technical and regulatory documents, it was considered suitable, since both the theoretical and practical component were assessed by a multidisciplinary team, with no field work required. Furthermore, the goal was to compare the results of the theoretical and practical assessment to determine the degree to which the strategies included in the official documents had been implemented, in percentages, and bridge the existing gap.

During a workshop held in October 2017, several experts from PAHO trained a national team made up of staff from SESAL departments at the first and second level of care and delegates from selected health networks in the use of the tool.

A descriptive quantitative statistical analysis was performed with the numerical and categorical variables. The measures of central tendency (percentage and average) were calculated. The variables employed were: theory and practice, decentralized network, and mixed network. Fisher's F-test was performed, assuming equal network variances. If the p-value yielded by Fisher's F-test is below the threshold of significance, the null hypothesis of equality of variances is ruled out, and it is concluded that there is a difference among the variations in the networks. SPSS 24 software was used for the statistical analysis.

RESULTS

Theoretical and practical assessment by IHSDN area and attribute

The theoretical assessment based on the review of the official documentation of SESAL networks yielded a global development score of 55 for the IHSDN strategy. The analysis by area found that the assessment yielded the best results for the model of care (62.5), followed by resource allocation and incentives (45.8). Governance and strategy was the area with the lowest score (41.7), followed by organization and management (42.9) (Table 1).

The practical assessment of five selected networks (two decentralized and three mixed) revealed a lower development score (42.8) than the theoretical assessment, with a 12.2-point gap. On analyzing the four IHSDN areas, the difference between the theoretical and practical assessment was statistically significant ($p = 0.007$). From the area

standpoint, the model of care also had the best score, with a development score of 45.4, followed by governance and strategy, with 43.3 (Table 1).

The attributes with the highest scores in the five selected networks were the first level of care (58.3), people-centered health care, and social participation (55 each), and those with the lowest, information systems (30) and governance system and delivery of specialized services (35 each).

On analyzing the attributes of the IHSDNs, the difference between the theoretical and practical assessment was statistically significant ($p < 0.001$), with somewhat more than half of the 14 attributes (53.3) obtaining a higher score in the theoretical assessment than in the practical assessment.

Model of care

In the documentary assessment by attribute, it was people-, family-, and community-centered health care that had the highest development score (91.7 points). Most of the documents mentioned matters such as how to fully empower people to better manage their health and how to link and consolidate the approach centered on the rights and responsibilities of people. Furthermore, they provided information on some mechanisms active participation by the population and the levels of participation. The defined population and territory and first level of care attributes received the same score (75). This indicates the documents' inclusion of some basic conditions for achieving an ideal level of integration in an IHSDN—for example, the defined and sectorized territory, systems that contribute information useful for clinical decision-making and management, and consideration of the coverage of care and recognition of the population's demand for health services. The document review did not show an equitable distribution of health services that includes optimal territorial and population size or mechanisms to guarantee quality services through the use of new technologies. Moreover, the network of facilities attribute had a low development score (31). As to the delivery of specialized services attribute, the documents do not mention equitable geographical distribution of these centers; as to the coordination of care attribute, the documentation provided little

TABLE 1. Comparison of the results of the theoretical and practical assessments of IHSDNs by area of approach, Honduras, 2017

Area	Theoretical assessment %	Practical assessment %
Model of care	62.5	45.4
Governance and strategy	41.7	43.3
Organization and management	42.9	39.6
Resource allocation and incentives	45.8	42.9
Total IHSDN	55.0	42.8

information on a system to create a single database for the entire network (Figure 2).

In the practical assessment, the highest development score was obtained by the first level of care (58.3) and the people-, family-, and community-centered care attributes (55). The assessment was influenced by factors such as a first level of care staffed by health teams that act as gatekeepers for the system and can address some of the health demands. In addition, the model of care is transitioning toward a people-, family-, and community-centered model with user integration, participation, and education mechanisms in the services provided by the network. The lowest development scores

were seen in the network of facilities (36.2) and specialized services (35) attributes, due to the network's limited supply of primary care services, coupled with limited regulation of specialized care and a predominance of hospital care (Table 2).

Governance and strategy

In the theoretical assessment, the attribute of a single governance system for the entire network had the highest development score (75). The documents revealed the different types of governance, the membership composition of the governance body, and descriptions of the functions, management structure,

administration, and performance audit and reporting mechanisms (6). The assessment of the broad social participation and intersectoral action attributes yielded a score of 25, since the documents described no social participation mechanisms or programs or mechanisms to ensure the active participation of intersectoral entities.

In the practical assessment, the social participation attribute obtained the highest development score (55), even though there were few social participation entities. However, progress in actions and initiatives that promote community participation was reported. The system of governance attribute obtained a score of 35, since, despite the presence of multiple governance entities, the selected networks operated independently.

Organization and management

The integrated management attribute obtained a score of 56 in the theoretical assessment and stood out among the criteria describing health facility coordination for clinical and technical support. Furthermore, this attribute is connected with the results-based management system through fulfillment of the indicators of quality and user satisfaction and performance evaluation systems at all levels of complexity in the network. The documents did not describe several attributes in detail (sufficient numbers of competent human resources, integrated information system, and results-based management); thus, a score of just 25 was obtained.

The highest-scoring attribute in the five networks was results-based management (45), confirmed by the existence of an annual operating plan with measurable objectives spelled out in management agreements (in the decentralized networks). In this attribute, monitoring and accountability were evaluated. The information system attribute received a score of 30, since the networks do not have integrated financial, clinical, support, human resources, drug, and supplies subsystems (13). The development score for the human resources attribute (40) was not high, because procedures for analyzing the sufficiency of health workers remain limited.

Resource allocation and incentives

In the theoretical assessment, the two components of the adequate financing

FIGURE 2. Comparison of results (%) of the theoretical and practical assessments of IHSDNs in terms of the model of care, Honduras, 2017

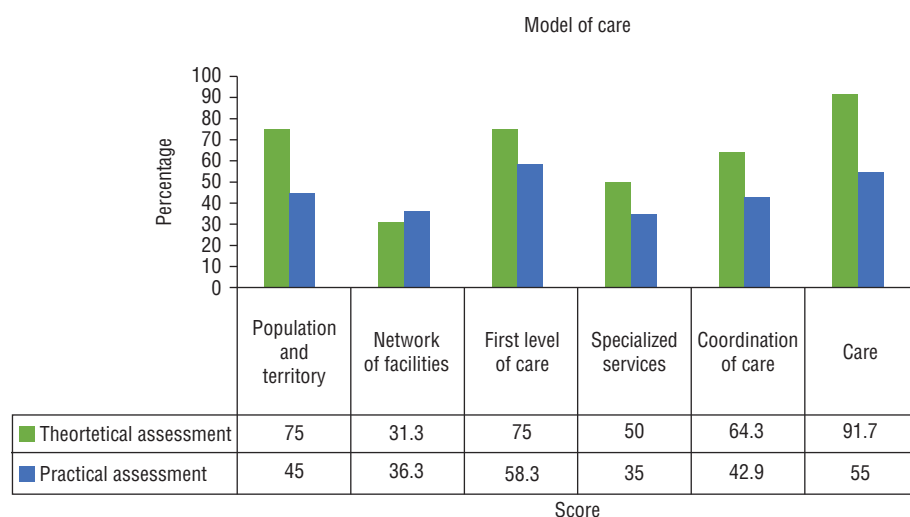


TABLE 2. Comparison of the development score obtained in the theoretical and practical assessment of IHSDNs by attribute, Honduras, 2017

Area	Attributes	Theoretical assessment (%)	Practical assessment (%)
Model of care	Population and territory	75.0	45.0
	Network of facilities	31.3	36.2
	First level of care	75.0	58.3
	Specialized services	50.0	35.0
	Coordination of care	64.3	42.9
	People-centered care	91.7	55.0
Governance and strategy	Governance system	75.0	35.0
	Social participation	25.0	55.0
	Intersectoral care	25.0	40.0
Organization and management	Integrated management	56.3	43.7
	Human resources	25.0	40.0
	Information system	25.0	30.0
	Results-based management	25.0	45.0
Resource allocation and incentives	(a) Financial resource allocation	66.7	43.3
	(b) Incentives	25.0	42.5
Total		55.0	48.8

Note: F: 35.642; $p < 0.001.91.7$

and incentives attribute were assessed. Financial resource allocation received a development score of 66.7, and the documents reveal to some extent how financial resources are allocated and negotiated based on production costs (11, 12). The incentives aligned with specific objectives attribute received a development score of 25, since the information on incentive allocation mechanisms is limited.

In the practical assessment, there was little difference in the development of the two components of the attribute: financial resource allocation (43.3) and incentives (42.5). The results indicate that financial allocation in the networks is a combination of mechanisms for progressive strategic and negotiated allocation through management agreements (decentralized networks), with analysis of the resource gap in order to maintain the guaranteed portfolio of services for the population. The results also indicate that there is progress to be made in the incentive system and that, in some networks, incentives continue to be explicit and strategic, although aligned with the goals of the network (Table 2).

Practical assessment of networks. Comparison of decentralized and mixed networks

The networks with decentralized management (San Juan de Intibucá and Jaral de Copán) were those whose assessments yielded the highest development scores

(62.8 and 48.7, respectively). The La Paz network had the lowest score (26.9). Among the attributes, the highest development score in all the networks was received by social participation in Siguatepeque (100), followed by the first level of care and incentives in the Intibucá network (91.7 and 87.5, respectively). Several attributes received a low score (25) in at least three of the networks analyzed: information system, governance system, intersectoral care, integrated management, human resources, and results-based management and incentives (Table 3).

The five networks were reclassified as decentralized and mixed networks for subsequent analysis. The difference between the two types of networks was statistically significant ($p = 0.017$).

DISCUSSION

Based on a review of the official documentation of five networks in Honduras, the global theoretical assessment yielded a higher development score (55) than the practical assessment (42.8). By area, all the results of the theoretical assessment were higher—except governance and strategy, where the practical assessment yielded a somewhat higher score than the theoretical assessment. These differences were statistically significant ($p < 0.001$). The results make sense, because the documents tend to show the ideal situation aspired to, rather than what actually occurs in the implementation and day-to-day operations

of IHSDNs. The gap between the theoretical and practical assessment of progress in implementation of the IHSDN strategy (12.2) suggests that the country is not using all the tools and strategies indicated in the integrated network documents. In contrast, from an operational standpoint, the degree of network compliance with the stipulations of the official SESAL documents was 78, which implies real progress, although some aspects must still be implemented to achieve integration.

The model of care was the area with the highest development score in both assessments, indicating theoretical and practical consistency and demonstrating, furthermore, that the service supply component continues to be the one that generates the most interest and is considered the most important. The score of 45.4 obtained in the practical assessment of the model of care denotes moderate progress in the care component. The country has endeavored to develop a PHC-based health care system that provides accessible, equitable, efficient, and quality services (14-17). In this area, the health authorities are implementing several public policy instruments and institutional mechanisms, although to achieve integration of the networks and universal access and coverage, it will be necessary to strengthen the first level of care, improve coordination among levels of care, and control duplication, idle services, and saturation of the second level of care (18, 19).

TABLE 3. Results of the practical assessment of IHSDNs by attribute (%) in five decentralized (D) and mixed (M) networks in Honduras, 2017

Area	Attribute	Siguatepeque, Comayagua (M)	Santa Rita, Yoro (M)	El Jaral, Copán (D)	La Paz, Department of La Paz (M)	San Juan de Intibucá (D)	Average
Model of care	Population and territory	33.3	58.3	33.3	25.0	75.0	45.0
	Network of facilities	25.0	31.2	43.7	25.0	56.2	36.2
	First level of care	50.0	66.7	50.0	33.3	91.7	58.3
	Specialized services	31.2	31.2	31.2	25.0	56.2	35.0
	Coordination of care	46.4	32.1	50.0	32.1	53.6	42.9
	People-centered care	66.7	66.7	58.3	25.0	58.3	55.0
Governance and strategy	Governance system	25.0	25.0	75.0	25.0	25.0	35.0
	Social participation	100	50.0	25.0	25.0	75.0	55.0
	Intersectoral care	50.0	25.0	25.0	25.0	75.0	40.0
Organization and management	Integrated management	25.0	43.7	75.0	25.0	50.0	43.7
	Human resources	25.0	25.0	50.0	25.0	75.0	40.0
	Information system	25.0	25.0	25.0	25.0	50.0	30.0
	Results-based management	25.0	25.0	75.0	25.0	75.0	45.0
Assignment and incentives	Allocation of financial resources	25.0	50.0	50.0	25.0	66.7	43.3
	Incentives	25.0	25.0	50.0	25.0	87.5	42.5
Total		37.8	41.0	48.7	26.2	62.8	43.5

Note: $F = 5.977$; $p = 0.017$

In the governance and strategy area, the practical assessment of the networks yielded a slightly higher development score (43.3) than the theoretical assessment (41.7). However, in the practical assessment, the score for the single system of governance attribute (35) was less than half that obtained in the documentary assessment. This is likely due to the fact that implementing IHSDNs is a complex, long-term process, since adherence to all the guidelines set forth in the official documents of SESAL requires time, especially in terms of leadership and governance processes (20, 21). In other words, it is simpler to propose a system of network governance than to implement it; this is reflected in the low IHSDN development score for this attribute in the selected networks, which was barely 25, with the exception of El Jaral, for which it was 75.

One attribute with a higher development score in the practical assessment than in the theoretical one was broad social participation (55 compared to 25). Although progress in social participation is acknowledged, a stable process that involves the community in key decisions that affect the health of the population is lacking. Achieving active social participation remains a challenge for Honduras, since the foundations have not been laid for capacity building that enables people to be active, empowered partners who influence network governance.

The development score for organization and management was low in both assessments, although it was higher in the theoretical assessment than the practical assessment (42.9 compared to 39.6). However, the attributes received a higher development score in the practical assessment than the documentary assessment. One possible explanation is that SESAL is conducting technical and operational activities that are not described in the documents analyzed, as is the case for the results-based management attribute, since the networks are conducting activities that include monitoring, follow-up, and accountability, which are essential for developing the attribute. With respect to the human resources attribute, although the documents acknowledge the important role of the networks, they do not explicitly describe the management, training, and distribution of human resources or their functions by competency, incentives, and

rights. Nevertheless, this attribute received a higher score in the practical assessment, since some of its conditions were partially met.

The theoretical assessment of the resource allocation and incentives attribute yielded a somewhat higher score than in the practical assessment (45.8 compared to 42.9), which in some ways shows that the resource allocation situation depends on the country's political and economic viability, fiscal space for health, and advocacy capacity of health stakeholders. Neither the financing, incentive, reporting, and payment systems implemented in the networks or at the national level, nor the cost analyses, are detailed in the documents, even though these aspects are essential for linking levels of care under an economic and public health approach.

The assessment of the networks with mixed management found problems with integration and linkage, since with two types of governance (decentralized and nondecentralized) operating independently, the criteria for each attribute were not fully met. In these cases, integration efforts are confronted with existing organizational structures that can constitute a barrier to successful integration (20, 21). Based on these facts, the assessments of the networks with decentralized management yielded a higher score. Furthermore, when the networks were grouped by type of management, there were statistically significant differences between the results of the assessment of attributes by type of network.

As a limitation of the study, it should be mentioned that since the tool was not designed to assess networks through official IHSDN documents, it had to be adapted to the objectives of this study. Furthermore, the consensus method used in measurement may contain an information bias, since measurement can be manipulated for convenience and be directed to a specific need. Coverage bias may also have been introduced because the study did not examine nondecentralized networks, which could have furnished important elements for analysis and comparison.

In conclusion, SESAL exhibits progress in the implementation of the IHSDN strategy, which is clearly visible in the analysis and assessment of network areas and attributes. Progress toward network strengthening can be affected by

the development of the public health legal framework, accelerated decentralization, and the creation of new entities such as the health authority and health service administrators, which could further fragment the system. There is a significant gap between the description of the attributes in the IHSDN documents and their operational expression in the selected networks. This gap in the development of the attributes stipulated in the theoretical approach needs to be bridged, which implies commitment on the part of the authorities, training of human resources, and allocation of material and financial resources. The networks with decentralized management models had the highest development score, which is likely related to the greater availability of human, logistical, and financial resources. In the mixed networks, the problems with internal integration and linkage were greater, probably due to their dual governance. The attributes with the lowest development scores should be taken into account when formulating strategies for action to strengthen the network integration process; and this should be included and described in detail in future official documents. This study also reveals the need for the continued assessment of networks in the country to generate evidence that will facilitate appropriate and informed decision-making.

Acknowledgements. The authors would like to thank the Ministry of Health of Honduras and its national and regional authorities for their support. Our thanks also to Edgar Gallo and Reynaldo Holder, along with Francis Ramos and Gilberto Ramírez, the PAHO experts who trained the national team in the use of the IHSDN Assessment Tool, for their support in specific tasks that made it possible to advance this project. Finally, we would like to thank the teams in the assessed networks for their motivation and tenacity.

Financing. This study did not receive financing.

Conflicts of interest. None declared.

Disclaimer. Authors hold sole responsibility for the views expressed in the manuscript, which may not necessarily reflect the opinion or policy of the RPSP/PAJPH or the Pan American Health Organization.

REFERENCES

- Organización Panamericana de la Salud. Redes integradas de servicios de salud: conceptos, opciones de política y hoja de ruta para su implementación en las Américas. Serie: La renovación de la atención primaria de salud en las Américas No. 4. Washington, DC: OPS; 2010.
- Wan T, Lin B, Ma A. Integration mechanisms and hospital efficiency in integrated health care delivery systems. *J Med Systems*. 2002;26(2):127-43.
- Lee S, Alexander J, Bazzoli J. Whom do they serve? Community responsiveness among hospitals affiliated with systems and networks. *Med Care*. 2003;41(1):165-74.
- Vargas I, Mogollón-Pérez AS, De Paepe P, Ferreira da Silva MR, Unger JP, Vázquez ML. Barriers to healthcare coordination in market-based and decentralized public health systems: A qualitative study in healthcare networks of Colombia and Brazil. *Health Pol Plann*. 2016;31(6):736-48.
- Herrera Vázquez MM, Rodríguez AN, Nebot AC, Montenegro H. A network to promote health systems based on primary health care in the Region of the Americas. *Rev Panam Salud Publica*. 2007;21(5):261-73.
- Vilaça Mendes E. Health Care Networks. Brasília DF: Organização Pan-Americana de Saúde, Conselho Nacional de Secretarios de Saúde; 2011.
- Ramagem C, Urrutia S, Griffith T, Cruz M, Fabrega M, Holder R, et al. Combating health care fragmentation through integrated health service delivery networks in the Americas: lessons learned. *Int J Integr Care*. 2011;1(Suppl):5-16.
- López P, Alonso C, García A, Fernández I. Presencia de los atributos para la integración de las redes de servicios de salud. *Rev Cubana Med Gen Integr*. 2009; 25(4):86-97.
- López P, Alonso C, García A, Segredo A, Ruales J, Alfaro G. Herramienta multidimensional para la medición de la integración en redes de servicios de salud del primer nivel de atención. *Rev Cubana Salud Publica*. 2015;41(3):510-31.
- Organización Panamericana de la Salud. Redes integradas de servicios de salud: herramienta de valoración del proceso de integración de redes de servicios. Washington, DC: OPS; 2016.
- Secretaría de Salud. Serie de guías técnicas para la implementación del MNS: Guía para la configuración y delimitación de redes integradas de servicios de salud. Tegucigalpa: SESAL; 2015.
- Secretaría de Salud. Gobernanza de las redes integradas de servicios de salud: Lineamientos para su organización y funcionamiento. Tegucigalpa: SESAL; 2017.
- Secretaría de Salud. Sistema Nacional de Referencia y Respuesta (SINARR): Lineamientos para su organización y funcionamiento en las Redes Integradas de Servicios de Salud. Tegucigalpa: SESAL; 2016.
- Organización Panamericana de la Salud. Universidad Nacional Autónoma de Honduras, Facultad de Ciencias Médicas. Diplomado de Atención Primaria en Salud dirigido a Equipos de Salud Familiar. Tegucigalpa: OPS, UNAH, FCM; 2017.
- Secretaría de Salud. Diplomado de Planificación de Recursos Humanos para la Salud Universal 2016: Propuesta de Intervención: Censo de Recursos Humanos del Sistema Nacional de Salud. Tegucigalpa: SESAL; 2017.
- Secretaría de Salud. Modelo Nacional de Salud: Por una Honduras Saludable. Tegucigalpa: SESAL; 2013.
- Carmenate L, Herrera A, Ramos D. Situación del Sistema de Salud en Honduras y el nuevo modelo de salud propuesto. *Arch Med*. 2016;12(4):1-10.
- Mejía I, Orozco M. Situación organizacional de la atención de salud en la red de servicios, Municipio de Lamani, Comayagua, Honduras, 2010. [Tesis de Máster en Salud Pública.] Managua: Universidad Nacional Autónoma de Nicaragua, Centro de Investigaciones y Estudios de la Salud; 2011.
- Martínez E, Orozco M. Reordenamiento hospitalario en la gestión de 4 hospitales regionales de la Secretaría de Salud de Honduras en el primer semestre del 2011. [Tesis de Máster en Salud Pública.] Managua: Universidad Nacional Autónoma de Nicaragua, Centro de Investigaciones y Estudios de la Salud; 2011.
- Vásquez ML, Vargas L. Redes integradas de servicios de salud: ¿Solución o problema? *Rev Ciencias Salud*. 2006;4(1):5-9.
- Pinillos M, Antoñanzas F. La atención primaria de salud: descentralización y eficiencia. *Gac Sanit*. 2002;16(5):401-7.

Manuscript received (original in Spanish) on 28 December 2017. Revised version accepted for publication on 2 August 2018.

Integración de redes de servicios de salud en Honduras: valoración comparativa del planteamiento teórico y de la aplicación práctica en cinco redes del país

RESUMEN

Objetivo. En la Región de las Américas se han realizado pocas evaluaciones de redes integradas de servicios de salud (RISS). Honduras ha avanzado en la implementación de herramientas y estrategias basadas en los atributos esenciales de las RISS. Este estudio tiene como objetivo valorar y comparar el desarrollo de RISS en su planteamiento teórico-documental y en su aplicación práctica, por tipo de gestión, en cinco redes de Honduras.

Métodos. El estudio se realizó en dos etapas: 1) valoración teórico-documental, mediante la revisión y síntesis de seis documentos oficiales de RISS publicados entre 2012 y 2017, y 2) valoración práctica con los equipos de coordinación de cinco redes, dos descentralizadas y tres mixtas, usando la Herramienta de Valoración de RISS de la Organización Panamericana de la Salud.

Resultados. La valoración teórica global alcanzó 55 puntos de desarrollo comparada con la valoración práctica de las cinco redes, que alcanzó 42,8. Según el análisis por ámbitos, el Modelo asistencial obtuvo mejores resultados en ambas valoraciones, mayor en la valoración teórica (62,5). Gobernanza y estrategia fue el ámbito que recibió la valoración más baja (41,7). Entre la valoración teórica y la práctica las diferencias en el análisis de ámbitos y de atributos fueron estadísticamente significativas ($p = 0,007$ y $p < 0,001$, respectivamente). Las redes con gestión descentralizada alcanzaron mejores valoraciones que las mixtas ($p = 0,017$).

Conclusiones. Existe una brecha entre la valoración teórica y la práctica que sugiere que la aplicación de las herramientas y las estrategias definidas en los documentos son incompletas. El componente provisional sigue siendo el que genera mayor interés e importancia. En las redes mixtas se observó mayor dificultad de integración, probablemente debido a la doble gobernanza. Es necesario seguir evaluando las RISS.

Palabras clave

Servicios de salud; reforma de la atención de salud; descentralización; Honduras.

Integração Das Redes De Serviços De Saúde Em Honduras: Avaliação Comparativa Entre O Planejamento Teórico E A Aplicação Prática Em Cinco Redes Do País

RESUMO

Objetivo. As redes integradas de serviços de saúde (RISS) têm sido pouco avaliadas na Região das Américas. Honduras fez avanços com a implementação de ferramentas e estratégias baseadas nos componentes básicos das RISS. O objetivo do presente estudo foi avaliar e comparar o desenvolvimento das RISS segundo o planejamento teórico-documental e a aplicação prática, por tipo de gestão, em cinco redes de Honduras.

Métodos. O estudo foi realizado em duas etapas. Na primeira etapa foi feita uma avaliação teórico-documental, com a revisão e o resumo de seis documentos oficiais das RISS publicados entre 2012 e 2017. E, na segunda etapa, foi feita uma avaliação prática com as equipes de coordenação de cinco redes (duas descentralizadas e três mistas) com o uso da ferramenta de avaliação das RISS da Organização Pan-Americana da Saúde (OPAS).

Resultados. A avaliação teórica atingiu 55 pontos de desenvolvimento geral comparados a 42,8 na avaliação prática das cinco redes. A análise por âmbitos demonstrou que o modelo assistencial obteve melhores resultados em ambas as avaliações, com uma pontuação maior na avaliação teórica (62,5). Governança e estratégia foi o âmbito que teve a menor pontuação (41,7). Entre as avaliações teórica e prática, as diferenças na análise dos âmbitos e atributos foram estatisticamente significativas ($p = 0,007$ e $p < 0,001$, respectivamente). As redes com gestão descentralizada comparada à mista obtiveram uma pontuação maior nas avaliações ($p = 0,017$).

Conclusões. Existe uma defasagem entre a avaliação teórica e a prática que aponta para a aplicação incompleta das ferramentas e estratégias definidas nos documentos. O componente de prestação de serviços continua sendo o de maior interesse e importância. Observou-se uma maior dificuldade de integração nas redes mistas, possivelmente devido à dupla governança. É preciso continuar avaliando as RISS.

Palavras-chave

Serviços de saúde; reforma dos serviços de saúde; descentralização; Honduras.