1

Integrated Health Service Delivery Networks.
The Challenge for Hospitals

Extracts from a publication by the

PAN AMERICAN HEALTH ORGANIZATION

PREFACE TO THE ENGLISH EDITION

The Spanish edition of this publication was launched in September 2011. Over two thousand hard copies were distributed to PAHO Member States and an unknown number of digital copies have been downloaded from PAHO's websites or sent electronically. The interest it has generated has been overwhelming, and as the editors and authors had hoped, the book spurred a far-reaching debate about hospitals and their future in Latin America and the Caribbean. PAHO intends to systematically collect the recommendations and results of this debate as part of its ongoing initiative to develop a Regional Agenda for Hospitals in Integrated Health Service Delivery Networks.

Here we present the English version, and although the original translation of the title (*Integrated Health Service Delivery Networks: The Challenge for Hospitals*) was kept, it is important to point out that this English version is not a literal translation of the original publication.

The editing team worked arduously for many months on this version and faced several challenges. Translating the work of almost 50 authors on a complex subject such as hospitals from one language to another is by itself a demanding task. Moreover, there was the challenge of making different literary styles merge into a readable final product.

We confess that we have extensively edited, in some cases summarized, and in others--risking the authors' wrath--deleted a sentence here and there hoping to better adapt the text to the English literary style. We may not have been completely successful, but it is our hope that the English reader, particularly in PAHO's Caribbean Member States, will find this book interesting and, as has been achieved in Latin America, that it will challenge the thinking of hospital and health services managers, policy makers, academics, and others to engage in a constructive debate on the future of hospitals.

The Editors.

September, 2012

SPECIAL NOTE: This document contains only extracts of the publication to be launched in October 2012. The document was prepared for the sole use of participants attending the Experts' Meeting of Hospitals in Integrated Health Services Delivery Networks to be held in Bridgetown, Barbados on October 24 and 25, 2012. This document is NOT FOR GENERAL DISTRIBUTION.

INDEX

EXECUTIVE SUMMARY

1. Background

The socioeconomic context of the countries in Latin America and the Caribbean

(LAC) is characterized by inequity and social exclusion. Large population groups live in poverty and a marked increase in the urbanization of poverty persist, with an ever-growing concentration of wealth and with growing indicators of unemployment and increases in informal employment. There are still deficiencies in the supply of drinking water and in sanitation systems, with persisting vulnerability in the middle-income sectors. Health systems have been a reflection of social processes, with an origin and historical development characterized by the segmentation and fragmentation of the provision of health services and of the social security systems. This has been maintained in recent decades due to the influence of the political contexts of military dictatorships and neoliberal economic reforms, which have reduced the size and role of the State in many of our countries.

In practice, the models of care are not centered on the users of the systems and their demands. Instead, they focus on recovery from disease, from a perspective that is excessively medicalized and under pressures from the health industry to generate greater consumption of technology. In health services, the power resides within hospitals and health care processes are fragmented within the establishments themselves and are not integrated with other levels of care. This generates loss of continuity, poor quality and dis-economies of scale.

In that context, health systems in LAC must address health problems related to poverty and respond to new challenges resulting from the demographic transition and the change in the epidemiologic profile that manifests itself in the leading causes of death (cardiovascular, cancer, traumatisms). In turn, they should respond to the increased expectations and requirements related to quality of care on the part of the user population, the introduction of high-cost technology and procedures, and profound changes in political and economic aspects that have a strong impact on the sector.

Accordingly, hospitals are part of fragmented and segmented systems whose model of care is strongly directed at curative care and that has as its central focus activities related to the hospital bed. The latter is where economic expenditures, the communication focus of citizens and the worries of political actors are concentrated.

Without a doubt the key role of hospitals is to achieve effectiveness in care-related tasks since citizens expect and depend on a foundation of technical quality. This mission loses effectiveness in contributing to the health of populations when health services, are – among other aspects – poorly organized, insufficiently financed, and not structured from a first level of care with broad coverage

and high response capacity.

Given the deficit in coverage, the insufficient response capacity of the first level of care and the chronic shortage of resources, there is a perception of permanent "crisis" particularly with regard to the public hospital network. One significant challenge is expectations, between the population's growing demand and the sector's insufficient supply capacity, which is determined primarily by the already highlighted lack of coverage in basic first level services.

Despite the efforts of regional organizations and governments – from Alma Ata to date – to organize health systems in LAC on the basis of a Primary Health Care (PHC) strategy, these have only been implemented embryonically. Exceptions are countries with a strong tradition and consolidation of PHC, such as Chile, Cuba and Costa Rica, among others. These exceptions correspond to countries that have better health indicators.

The Pan American Health Organization (PAHO), in response to the consequences of strongly fragmented and segmented health systems, has been expressing the need to establish Integrated Health Services Delivery Networks (IHSDNs)[1] in the continent's health systems. Additionally, PAHO has proposed the essential attributes and domains that should be considered in the design and implementation of an IHSDN model centered on PHC. The overall objective is that service users perceive that their care is consistent with their needs and continuous over time, with no discontinuities in the logical chain of their requirements, independent of whether or not they receive services in different establishments or institutions. This concept of integrated health services has been present in the health discourse of countries in LAC for decades. However, discrepancies in the arena of implementing real measures for inter institutional coordination and cooperation have generated obstacles that until today have been difficult to reverse since they are based in a social, economic and political reality that does not contribute in the least to the sustainability of integrated systems.

In the majority of countries in LAC, the State – through Ministries of Health or different social security arrangements – is the principal or most important contributor of resources for hospitals. This means that the great majority of hospitals – even across the great diversity of countries in LAC – can be defined as "public function" hospitals. They are the property of Ministries, Social Security or private institutions that are for- or non-profit, that operate through some type of agreement with the previous institutions under different arrangements, they provide services to people who lack resources or to beneficiaries of social security, either through control of property or various types of agreements. As a result, the implementation of IHSDN in our countries is a task that the State should

[1] PAHO defines IHSDN [1] as "*a network of organizations that provides, or makes arrangements to provide, equitable, comprehensive health services to a defined population and that is willing to be held accountable for its clinical and economic outcomes and the health status of the population served*."

assume through institutions that have adequate steering role capacity.

This book deals with the development of health systems in LAC and the essential aspects for installing a hospital care model that is compatible with IHSDN: the model of hospital care and management, the approach to training its personnel, its form of government, financing mechanisms and use of technologies. This book describes how hospitals in some of the countries in LAC currently function and finally, proposes some reflections on a future agenda.

2. Hospitals in Integrated Health Services Delivery Networks

A hospital in the logic of IHSDNs implies a new care model and this should result in changes – that are not easy – in the way we think, act and live. The hospital in an IHSDN requires a model of organization and management that is different from that of an autonomous establishment that does not have shared commitments with other establishments for the purpose of jointly achieving certain goals and impacts on a given population. The essential attributes of the required model are shown in table 1.

Table 1. Essential attributes in a care and management model

Domains	At the network level	At the hospital level
Strategy	**Network-based planning:** Network definition of the service portfolio, referral and counter-referral systems, and feedback systems. Network control of management and financing.	Strategy aligned with the needs of the network's population.
Structure	**Population and Territory:** Hospitals are part of a service provider network. Services are structured around a defined population and territory. **Integrated Care:** Diverse types of establishments – with distinct types of ownership and dependence – provide promotion, prevention, diagnostic, treatment, disease management, rehabilitation and palliative care services that are organized, integrated and cooperative. They do this in a way that is harmonious with the public health activities carried out with the people and environment in the territory. **Based on First Level of Care:** The first level of care is multi-disciplinary and has universal coverage and a high response	The hospital has management autonomy, but the network defines the type of activities, level of complexity and specialties in inpatient and outpatient care, including urgent care. The structuring of care processes is based on the value-added for network users: clinical processes designed and executed in the network. Internal decentralization: clinical management. Focus on ambulatory care. Care according to users' care needs (progressive care).

	capacity. This level is used to modulate and coordinate integrated care processes, ensuring that actions are carried out in the appropriate places and with the necessary competencies.	
Competencies	To understand users' expectations and needs. To co-construct care protocols and co-define establishments' service portfolios and the work rules for care processes to be organized and cared out in an integrated, comprehensive manner. To train human resources "outside of the hospital" from the lens of IHSDN and in a way that is coherent with national and local policies aimed at strengthening areas such as health promotion and the anticipation of harm; the integration of processes centered on people as subjects with rights and based in the first level of care. To lead processes for bottom-up negotiation and harmonization to formally agree on goals and resources, information and feedback systems, and feedback and learning mechanisms.	To articulate care, logistic and maintenance processes in an integrated, cooperative manner (economies of scale). To generate competencies to support clinical management organized around processes and focused on performance. To agree on and implement health goals, efficiently organizing clinical and support processes. To adapt to the network's and users' requirements. To develop competencies for continuous improvement.

3. Essential Domains for the Integration of Hospitals in a Network

3.1. Corporate Governance

Hospitals, and especially public hospitals, tend to have serious agency problems that result in a lack of alignment with health sector strategies and leads to fragmentation, loss of efficiency and poor quality. In light of these problems and seeking to prioritize the needs of users while making good use of resources, there has been growing interest in increasing organizations' competencies for good governance.

The adoption of corporate governance practices and structures improves management efficiency and user satisfaction in public sector hospitals, especially since it generates clear strategic mandates for the executives of the institutions that take into account all stakeholders and allow real and effective accountability.

In order for networks to function, there is need for network governance and clear differentiation of the leadership and management competencies. These competencies, when strongly established in

institutional arrangements, lead to strategic alignment and comprehensive, continuous care, even in the presence of a diversity of actors. The definition, planning and control of health objectives is the inevitable role of the network's governance body while their execution can be decentralized to hospital entities with growing capacities for autonomous management in a logic of networks. In this regard, it becomes necessary for networks and hospitals to implement governance councils whose efforts aim to align strategies in order to achieve shared health objectives. Table 3.1 (see Chapter 3) presents some of the governance functions that are consistent with an integrated system perspective.

Without a doubt, a priority task for the immediate future in public policies in health is the installation of corporate governance in our systems. Given the context of continuous change and the diversity of actors, the old paradigm of vertical integration and authoritarian hierarchical modes of the past is no longer acceptable.

3.2. Allocation and Incentives

It is crucial to recognize that even when hospitals serve only a small segment of the population, they consume the bulk of health systems' resources, converting them in practice into a serious obstacle to an approach centered on Primary Health Care, to the extent that this does not ensure a budgetary emphasis on first level of care actions. It is for this reason that new financing mechanisms should be developed (whose principles are described in Chapter 3, table 3.3), that together with providing sustainability for hospitals, collaborate effectively in an integrated system context.

3.3. Technologies

With respect to medical technologies in a model of IHSDNs, attention should be paid to their regulation, selection, adoption, diffusion and use, under a prism of cost-effectiveness, integration of services and continuity of care.

Information and communication technologies (ICTs) are powerful instruments for integration. Examples abound in the informatics solutions area, in the areas of data management, interoperability and communications: the electronic clinical history; on-line appointment scheduling systems; telemedicine; the use of mobile devices to maintain contact between health care centers and users; and a lengthy etcetera that changes day to day with the speed of innovations in current technology. All of these solutions can become true aids, to the extent that processes are effectively integrated starting from people, their work habits and their forms of organization. ICTs accelerate and facilitate well-designed processes; in addition, they amplify errors since clearly, they do not integrate magically. ICTs also imply high expenditures of energy in change management. When processes have not been improved ahead of time and when implementation-related efforts have not been foreseen, there tend to be failures. The construction of technological networks is a pragmatic challenge and the weaving of human networks is an epic and practical imperative.

In order to consolidate the innovation, efficiency, equity and added social value of technologies as guiding principles in LAC, we need independent agencies that advise on the regulation, adoption, use

and evaluation of technologies. Given countries' lack of resources, it may be more feasible to generate these agencies with in a sub-regional, cooperative way. (See Table 3.3 in Chapter 3)

4. Change Management

In order for the hospital to achieve value-added in the context of IHSDN, not only should it identify the needs of its users, but it should also identify the concerns of the service providers. The addition of value takes place in a relational space. Although sophisticated technological elements intervene, it is through person-person contact that greater or lesser value will be added, on the part of the citizenry and the hospitals and the health system's actions as a whole. The addition of value will be expressed and will become a reality depending on the degree to which each health worker has the ability to make adequate decisions and approach each user as a legitimate equal in the *multiverse* that health actions represent, like a chain that coordinates the actions between multiple points, nodes or integrated systems.

The foregoing explains the need to manage change processes, whose focus is on generating institutional conditions to: i) integrate care processes as a chain of interdependent and cooperative steps that involve conversations (through language) between people from different units of the organization and from outside of the organization; ii) increase the capacity to learn from the people who work in the network and in turn to produce a generative adaptive context that makes it possible to listen to the user and to produce continuous innovations that, on one hand, resolve the user's expectations and, on the other hand, permit the development of the potential of the organization's own workers; and iii) ensure that disputed matters of "network-based hospital governance" are incorporated to advance both the genuine expression of a hospital company's "owner" and the consolidation of adequate formulas for the genuine participation of users in the daily life of establishments. This will enable transparency regarding and resolution of power struggles within those entities and between those entities and the different institutions in the care network.

These change processes require strong investments in participatory leadership capable of generating an organizational context that shares basic declarations aimed at the co-construction of an identity, mission and vision that go beyond the walls of the hospital and that make it possible to add value to the citizen user through the integration of processes. This powerful vision should make "sense" for those who work in the hospital to the point of "becoming embodied" in their daily tasks and facilitating new conversations that make it possible to have a different organizational structure based on processes and outcomes that have the person as the center. It is also critical to understand that processes do not begin or end in the hospital and that results are the translation and consequence of bringing together the wishes of different actors. The foregoing requires the installation in daily practice of values and habits that, recognizing the need for interdependence, consolidate a culture of learning and cooperation so that network processes are fluid and high quality.

5. Country Experiences

The design and implementation of IHDSN in LAC countries represents a trend that is in its early implementation stage in the majority of countries. Table 4 presents a synthesis of some aspects, in the characteristic diversity of our countries.

6. Final Comments

In the process of developing this book, the authors confirmed that we are far from having experiences that can be presented as successful examples of hospitals working cooperatively in a network. Even the best experiences are still incipient and almost anecdotal, which implies a long road yet to travel.

At the same time, we propose that in response to epidemiological, demographic, technological and sociocultural changes, hospitals will have to redefine themselves and undertake major reforms in order to make the implementation of Integrated Health Services Delivery Networks viable. We understand this concept as essential for improving access to the system, for reducing the fragmentation of care, for improving overall efficiency, for avoiding the duplication of infrastructure and services, for diminishing production costs, and for better serving people's needs and expectations.

The implementation of IHSDNs will not emerge from replicating current structures and ways of doing things. *It cannot be achieved with more of the same.* We strongly believe that the problems that currently afflict hospitals will worsen if systemic modifications along the lines of the concepts upheld by the proposal for Integrated Health Services Delivery Networks based on Primary Health Care do not take place. Furthermore we have proposed that it will not be possible to implement truly integrated systems without generating changes in and from the way we design and carry out hospital care processes. In other words, we cannot envision IHSDNs without hospitals and hospitals will not be sustainable without IHSDNs.

We also propose that one of the main problems related to implementation of integrated systems in LAC is the difficulty that hospitals face in understanding and assuming new roles. Hospitals are not independent of the health system, nor are they alien to social and historical evolution.

Since the first level of care historically has had insufficient coverage and problem-solving capacity, population demands on hospitals is generally excessive, which in turn generates a kind of "chronic collapse." This "collapse" is at the base of an organizational culture characterized by a sense of resignation, negative responsiveness and a popular belief system that reacts by pressuring for more hospital services while also complaining about bad care, all of which strengthens a perverse cycle of categorizing the "hospital situation" as a synonym for countries' health problems.

Together with the insufficient coverage by the first level of care that has already been mentioned, there are also institutional weaknesses in essential State functions – for example, in the steering role – that are explained by the lack of people with the necessary competencies, added to the existence of weak public policy frameworks. The average duration of a Minister of Health in LAC barely reaches one year and it is common that when a minister changes – even within the same

administration – the new minister also changes people and policies. Additional factors are the lack of national agreements or State policies that make it possible to have long-term directives that can be translated into sustainable changes that generate impact on models of care and management. In this regard, the effort carried out in Peru to shape a "National Agreement" around health is laudable. This agreement has made it possible to generate legislation on a universal health plan and its gradual implementation through pilot projects.

Table 2. Summary of the characteristics of the health systems in some countries in LAC; integrating aspects and challenges

Country	Health System	Integrating Aspects	Challenges
Bolivia	National Health System with a centralized hospital-based focus, subsidized by the State, parallel to a private system targeted at specific groups.	Universal public insurance that has as one of its objectives the strengthening of IHSDNs.	To successfully implement the Health Model from an IHSDN perspective.
Brazil	Unified Health System – SUS – that is made up of the group of health actions and services, provided by federal, state and municipal public organisms and institutions, as well as by private organizations (usually not-for-profit) through agreements. Private services for the user population that is "not exclusive" to the SUS.	Decentralization in a context of an adequate steering role and a culture of social participation.	To decrease the segmentation of the SUS supply with regard to the supplemental system, improving public-private partnerships.
English-speaking Caribbean	National Health Systems inherited from their English	Systems with second and third levels of care that are	To generate institutional arrangements for

	history, which seek regional integration.	increasingly more regionalized.	shared services that strengthen the first level of care.
Costa Rica	Constituted by public and private health delivery institutions, as well as the Costa Rican Social Security Fund; the National Insurance Institute that administers the insurance of professional risks; private and public universities such as the University of Costa Rica and the National University, which oversee Human Resource training; the Costa Rican Water Supply and Sanitation Institute; municipalities; and private health services.	New Model of Comprehensive Health Care. Seeks to overcome basic schemes based on a predominantly curative approach and care based on free demand, which has generated high user and provider dissatisfaction with the country's health services. Instead, it focuses on a much more integrated model of care that operates according to levels of greater equity and solidarity.	To adapt the health supply to the new health challenges derived from epidemiological changes, including a deficit in coverage due to migratory movements. To improve the integration and coordination between the levels of care, overcoming hierarchical and bureaucratic barriers.
Chile	Health System based on an extension of the separation of functions, by creating two Health Under Secretaries that are dependent on the respective Ministry, and with a series of modifications in financing, insurance and the provision of care.	Law 19.937, the Health Authority and a new Management Model. This creates the Under Secretary for Care Networks and restructures Health Services toward "network management," through the formation of a Health Care Integration Council, a new location for the first level of care and a new administration	Given insufficient resources and the lack of incentives aligned with IHSDN, the goal is to improve the management of the relationship between the network's actors and the coordination of their actions, which represents a special task given the culture of our hospitals' health teams.

		design called hospital network-based self-management.	
Cuba	National Health System. Solid first level of care.	Vertical integration using a logic of command and control. Systemic culture with a highly-valued first level of care.	To strengthen the organizational umbrella that permits the coordination of the actions of all of the network's components. A stable first level of care in order to improve health workers' performance and their commitment to the health system. To improve the delivery of specialized services and the coordination between levels.
Colombia	National Health Service, with a focus on Primary Health Care. Organization of service networks according to levels of care and technological complexity and that has decentralized competencies and resources in the territorial entities.	Law 1438 in 2011, which aims to the refinancing of the sector; Primary Health Care; intersectoral work to affect health determinants; the establishment of an Institute for Technological Assessment; administrative and financial adjustments to the public hospitals network; and the requirement to form Integrated Health Services Delivery Networks	To overcome the difficulty of installing IHSDN in a context the privileges provider competition over complementarity, given the Colombian model of the internal market.

		(IHSDNs).	
Ecuador	Organized into three parallel sub-sectors: the public sector, dependent on the Ministry of Public Health and organized according to the country's political divisions; social security, with different jurisdictions and benefits provided on its own or through contracting; and the private sector, with a broad range of service offerings, from ambulatory medical offices to highly specialized units.	Constitutional framework that reaffirms the mandate to create a National Health System, explicitly prioritizes Primary Health Care, and orders the creation of a public health network. The integrated public health network will be part of the national health system and will be formed by the articulated group of state and social security establishments and other providers that are part of the State, with legal, operational and complementary ties.	To improve internal hospital management, to professionalize medical and clinical management, and to incorporate personnel from administrative and economic disciplines. This includes the adoption of innovative managerial practices that break the rigidity of public administration, when institutional convenience and the opportunity for care demand it.
Mexico	National Health System (SNS), Secretary of Health and the Mexican Social Security Institute (IMSS). State Workers' Social Security and Services Institute (ISSSTE). The three institutions above are the foundation on which Mexico's public health system was established.	Integrated Health Care Model (MIDAS). Defines as the strategy for the provision of integrated health services "the development of service networks and the interrelationship between units with different levels of equipment, as well as the functional integration of care-related resources and units in order to create virtual networks of health units and use public resources for health more efficiently."	Political will to implement IHSDN. To jointly plan health actions for the geo-populational spaces assigned to the network and in which all of the social actors involved participate. To evaluate the performance of the service networks.
Paraguay	Hospitals dependent on the Ministry of Health that are not	The Ministry promotes the construction of	To aim for cohesion and the management of differences in

	coordinated with social security hospitals. Private sector and Armed Forces hospitals in the context of a week steering role and limited coverage in Primary Care.	IHSDN based on Primary Health Care. It explicitly recognizes the need to have adequate response capacity at the first level of care, to ensure the adequate functioning of hospitals and to reorient, rationalize and improve care. A recent strong impulse toward the generation of supply at the first level of care.	approaches and methods on the part of the central health sector team that put the continuity of the important process being undertaken at risk.
Peru	Coordinated, Decentralized National Health System. Fragmented since there are Hospitals dependent on the Ministry of Health, Hospitals dependent on Social Security (EsSalud), and Armed Forces (FFAA) and private (EPS) hospitals. Decentralization with a weak steering role.	In April 2009, the Framework Law on Universal Health Insurance – Law No. 29344 – was approved. It seeks to encompass the group of Health Insurance Funds Institutional Managers (IAFAS) within an Essential Health Insurance Plan (PEAS).	To achieve articulation despite the fact that Social Security is dependent on the Ministry of Labor. To achieve the articulation of providers based on a Plan of obligatory services of a universal nature, through interinstitutional agreements. To achieve improvements in Primary Care (given that the focus has been excessively placed on hospitals). To achieve the avoidance of decentralization losing value due to a weak steering role and the effect of *caudillismo* and local

			patronage.

Furthermore, the need to have a critical mass of people with managerial competencies to lead hospitals in LAC has recently emerged in the regional debate, and includes the need for incentives towards acquiring such competencies and selection processes based on merit and not on political patronage. Examples of this are the advances in hospital management in Colombia, the High Level Civil Service system in Chile, the postgraduate training in health administration in Peru and the undergraduate training of professionals in the area of health administration in Brazil.

Hospitals, as high complexity institutions that serve small segments of the population, are responsible for the greatest proportion of health systems' expenditures and their activity generates a strong impact on countries' economies as well as high communication and political impact. As a result, reform of hospitals to incorporate them into integrated systems necessarily implies the realization of profound changes in our development models and social policies. In other words, setting up integrated systems is an undertaking that is difficult to generate and maintain in societies that are strongly stratified and marked by social exclusion. In addition, weaknesses in or a lack of coherent, persistent social policies that are universal and guarantee rights complicates the implementation of integrated health systems. Finally, a permanent obstacle will be the perspective that does not value the importance of generating changes from and with hospitals (cultural and organizational changes) that make the viability of integrated systems possible.

The vision of IHSDNs will be possible in all of our countries when policies and behaviors are developed simultaneously at the macro level (changes in our models of development and social policies); the meso level (structural modifications in governance, allocations and incentives and in human resource training); and the micro level (changes in organizational culture).

Thinking that all of this social construction that requires coherence and persistence at the level of a countrywide vision could be generated exclusively from the health sector is to condemn this vision to failure. In other words, to achieve hospitals in the logic of IHSDN forces us to generate the social and political conditions for these transformations to be reflected in our health systems. These conditions require us to have: the capacity to reach major national agreements in the health arena; the flexibility to integrate facilities with different ownership and dependency; the understanding that is needed to strengthen health institutions, particularly in their capacity to design, implement and regulate persistent public policies; the leadership and competencies to sustain complex change processes; alignment between objectives, financing and implementation tools; the ability to learn from what works; and finally, the generosity to share errors and good practices.

The foregoing obliges us to create an agenda for hospital change. This agenda should generate the questions, to be answered in a collective, participatory manner, with regard to how to connect three large forces to act simultaneously: government for integration, aligned financing and incentives, and

persistent efforts to change the organizational culture.

The authors put forward these questions based on the hypothesis that the Integrated Health Services Delivery (IHSDN) initiative will require changes in hospital identity and in the manner in which different health facilities relate when addressing the needs of the citizen user of health services, in order to move from discourse to effective action. For this to occur effectively, the authors propose the need to build an agenda for the hospital of the future starting from three assertions: 1) Without hospitals, there will be no IHSDNs; 2) With hospitals, there will not be IHSDNs if the *status quo* of the current hospital organizational culture persists; and 3) Without IHSDNs, the current problems and challenges of the hospital will not be solved. These propositions require a new pact between administrators, the health system, and society in which the hospital consciously adopts a new position and takes pride in it, not as a consequence of "being cornered" by the evolution of costs, the epidemiological profile, and technological innovation, but due to the understanding that this new identity "makes sense" for it. This is true even for hospital workers themselves since it is much better to resolve everything possible outside of the boundaries of the hospital since it is "healthier" for everyone: society, the health system, the hospital, etc.

This option of the hospital in IHSDNs – a strategic option where the hospital's own sustainability is at play – requires another crucial proposition: the inevitable need to include the people who work in hospitals in building integrated networks as a shared objective. If this does not happen, we will be condemning ourselves to maintaining the *status quo* and to making networks "an element of discourse, but not of action."

References

1 Pan American Health Organization. *Integrated Health Services Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas.* (Series: Renewing Primary Health Care in the Americas No.4

INTRODUCTION

Why a Book on Hospitals within the Framework of Integrated Health Service Delivery Networks (IHSDNs)?

The health systems of Latin America and the Caribbean (LAC) face common challenges, including untenable increases in the cost of health care services, inequitable access, poor technical efficiency, low service coverage, poor quality service delivery, problems with patient safety, poor management capacity, and the absence of mechanisms for performance evaluation and accountability. This is compounded by users' perceptions that services are of poor quality and, in some cases, not relevant to their needs and customs, translating into increasing public dissatisfaction.

In LAC, high levels of service fragmentation characterize the vast majority of health systems ([i] [ii] [iii]). Confronting the fragmentation of both health services and health care represents the greatest challenge facing health authorities at the regional and global levels. The traditional vision of hospitals as "autonomous" entities and the lack of coordination among hospital services and other institutions in the service network constitute important features of this fragmentation. This also imperils the development of new health service delivery models that are better adapted to new health and social needs, and that provide efficient, effective and equitable health services with continuous and appropriate care to preserve people's health and solve their illness-related problems throughout the course of their lives.

The Pan American Health Organization (PAHO) has raised attention to the fact that hospital services tend to be concentrated in urban areas, attributing excessive importance to highly specialized care and the use of expensive technologies, and in turn contributing to the widening of the gap between the demand for and supply of services. In addition, there is *"an imbalance in the distribution of patients between public and private sector hospitals based on financing schemes, whereby the public system usually cares for the more costly cases while private hospitals pre-select patients and limit access to more costly procedures ([iv])"*.

Furthermore, hospitals suffer from poor managerial capacity and a lack of systems for management and quality control for hospital procedures.

Throughout the world, hospitals constitute institutions that are highly valued by society and the professionals who work in them enjoy great respect, admiration and esteem. For many communities and cities, having a hospital is a guarantee of safety and a sign of development and prestige. This is even more significant if the hospital is an institution of recognized scientific and academic solvency.

Furthermore, hospitals are an important source of employment, commerce, and, depending on their prestige, attraction. Despite this high value, in many countries there is growing public dissatisfaction with the state of hospitals, the care they provide, and the quality of their services. Due to this situation of dissatisfaction and the pressures exerted by the changing health paradigm, there is an urgent need to review both the role of hospitals in the context of health services and their social function.

The current organization of health services, and the role that has been established for the hospital, facilitates a whole series of anomalies in care (utilization of acute care beds for patients that have stopped benefiting from intensive medical and nursing care, avoidable admissions of patients with problems that could be resolved on an ambulatory basis, excessive or unnecessary use of diagnostic resources, saturation of emergency services by patients with minor problems that do not require hospital management, etc.). These anomalies require the redesign of prevailing health service delivery models.

Reviews of the establishments that make up health services demonstrate that hospitals account for the highest percentage of public spending in health. Whether hospitals produce benefits that are consistent with the level of investment, in comparison with other health facilities, is questioned more and more. On the other hand, and given their importance and prestige for the population, they receive great political attention. In some troubling cases, this political attention leads to many of the decisions in the Region's countries regarding investments in new hospital infrastructure. These decisions often lack a basis in evidence, knowledge of the global development trends in hospital service, or the real needs of the populations they intend to serve.

Changes in the environment – and in particular the challenges generated by the demographic and epidemiological transitions, new and increasingly expensive technological innovations, financing problems, and lack of skilled human resources -, require us to make new considerations from the hospital and from the policy decision-making level. These considerations should clarify the strategic role of the hospital in the context of the changes being experienced by health services, should analyze how to achieve a balance between the hospital and the first level of care in order to attain more integrated services, and should define the strategic decisions necessary for its long-term sustainability.

Trends in Hospital Services

The transformations that are being generated at the global level and that press for changes in the role, function and organizational model of hospitals require us – as a region and in every country – to address the debate about the future of hospitals and about the *hospital of the future.* We should do so using the innovative and long-term lens provided by the conceptual framework of the Integrated Health Service Delivery Networks (IHSDNs) Initiative. All of this should occur in the context of the firm belief that the hospital has and will have for a long time relevance within the health system.

When we say hospital, what are we really referring to? Hospital institutions have changed during the 20th century as a consequence of many factors, including their integration into networks. We can no

longer speak of a single type of hospital and today a district hospital in a developing country has little to do with a large monolithic center in any great capital of the world. The definition may be the same, but, conceptually, the distance is enormous. Today the hospital has to be envisioned based on the function it carries out in the care network, which is conditioned by its population coverage and the service portfolio that it develops, based on available knowledge, technology and complexity.

In LAC, there are a vast number of institutions of diverse types and missions that are called "*hospitals*." The contrasts are numerous; for example, there are ambulatory care units with five or ten beds attended by a general practitioner and/or an obstetric nurse or midwife that receive the designation of "*first level hospitals*." In other cases, institutions called "*district hospitals*" are used to house older persons without family support who do not require medical or nursing care, but who are institutionalized for social reasons. These examples, which are few of many, point to the need for a consensus on a clearer categorization of what constitutes a hospital that will ensure adequate comparisons in operations research processes. Accordingly, there is a need to build, together and in consensus, this categorization as part of the debate that has emerged around *IHSDNs and the challenge for hospitals.*

The fundamental change in the current notion of the role and function of the hospital requires moving from a "focus on illness" that makes the hospital's key objective that of occupying (and maintaining occupied) hospital beds, to a "focus on care" aimed at supporting the continuum of integrated services (the network), and sharing the objective of maintaining the health status of people and the population. Thus, hospitals must begin transforming into an actor that is "*immersed in the group of care providers and not as the key center of care* ([v])" .

Moreover, new challenges necessitate the review of important aspects of hospital design and organization. Concern about patient safety and outcomes have become important drivers of change in medicine ([vi]). There is increasing evidence and concern about the dangers of inpatient care and adverse events associated with health care.[vii viii] There are not only a significant number of adverse incidents for patients while they are hospitalized, but the incidence of hospital infections (with multiple drug resistance to available antimicrobial drugs) is also growing ([ix]-[x]). The current reality requires hospitals to be designed architecturally and organizationally to increase the safety and satisfaction of patients and employees, and to improve care outcomes by reducing hospital infections, medication errors, and falls.

Additionally, hospitals have the obligation to become institutions that are more sustainable from the financial and environmental standpoint ([xi]). It is possible that there is an optimal size for hospitals to be highly effective and to achieve economies of scale [2,] ([xii]). However, it is increasingly critical that planning be determined by the technological and problem-solving capacity – and not by the number of beds – that is required to serve the population's needs.

[2] The majority of authors agree that this takes place between 200 and 650 beds.

The basic structure of the hospital has changed little in the past century, despite changes in the nature of diseases and possible responses. International trends aim at the organization of progressive care models that are more in line with people-centered care and in opposition to the traditional model of wards organized by specialty. It is troubling, then, that in our Region, we are still designing and establishing hospitals that adhere to traditional models, often without thinking about the changes that are occurring in health care or about the needs for the near future.

Furthermore, the pressure on hospitals to reduce costs, through initiatives such as the introduction of reimbursement systems based on case mix, the elimination of duplicated services, the reduction of fixed costs ([xiii]), and changes in employment regulations are already having an enormous impact on the service provision capacity of relatively small hospitals ([xiv]).

The hospital also requires changes with regard to its relationship to the rest of the network and to planning in order to serve the needs of the target populations. This obligates the hospital to seek out improved mechanisms for articulation with the other members of the network (primary care, other hospitals, etc.), and social services, as well as joint planning (as a network) of health objectives, resource allocation, and payment mechanisms.

In short, the transformation of hospitals in IHSDNs implies a challenging and complex readjustment of the current reality and of the *status quo.*

The Renewal of Primary Health Care and the IHSDNs Framework

The international conference on health held in Alma-Ata in 1978 marked an important milestone in the development of health systems at the global level by defining a new vision and strategy for strengthening society's capacity to reduce inequities in health and to promote the development of more effective health systems.

Three decades later, the values and principles enounced in Alma-Ata gather renewed strength with the growing recognition that health systems based on Primary Health Care (PHC) are more equitable and attain improved health outcomes. In this regard, The World Health Report 2008 *([xv])* proposes that PHC is "*Now more [necessary] than ever*" and calls for new reforms[3] to reorient health systems toward the ideal of health for all.

With regard to health services, the 2008 WHO report proposes the need for reforms "*to attain people-centered health systems.*" This implies the reorganization of health services based on people's needs in order to guarantee greater relevance and effectiveness, with a focus on values, principles and rights. This appeal generates new challenges and the need to find new forms of health services organization, financing, and management at the global level.

[3] a) Reforms that favor universal coverage, b) Reforms of service delivery, c) Reforms of leadership, and d) Reforms of public policies.

In order to face these new challenges, and at times anticipating global initiatives, PAHO Member States have agreed on strategies to advance in that direction through processes aimed at the renewal of PHC. These processes are characterized by the transformation and consolidation of health systems based on PHC defined as "... *an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal while maximizing the equity and the solidarity of the system (*[xvi]*)*." These renewal strategies call on the region's countries to complete the implementation of PHC wherever this process has failed or is inconclusive, to strengthen PHC in order to face new challenges, and to incorporate PHC into a broader agenda of equity and human development.

As a result, the PAHO Directing Council adopted resolution CD49.R22 ([xvii]) on *Integrated Health Service Delivery Networks based on Primary Health Care* in 2009. The document, in addition to expressing the concern of Member States "*about the high degree of health services fragmentation and its adverse impact on the general performance of health systems …",* also states that "*integrated health service delivery networks are one of the principal operational expressions of the PHC approach at the level of health services delivery*."

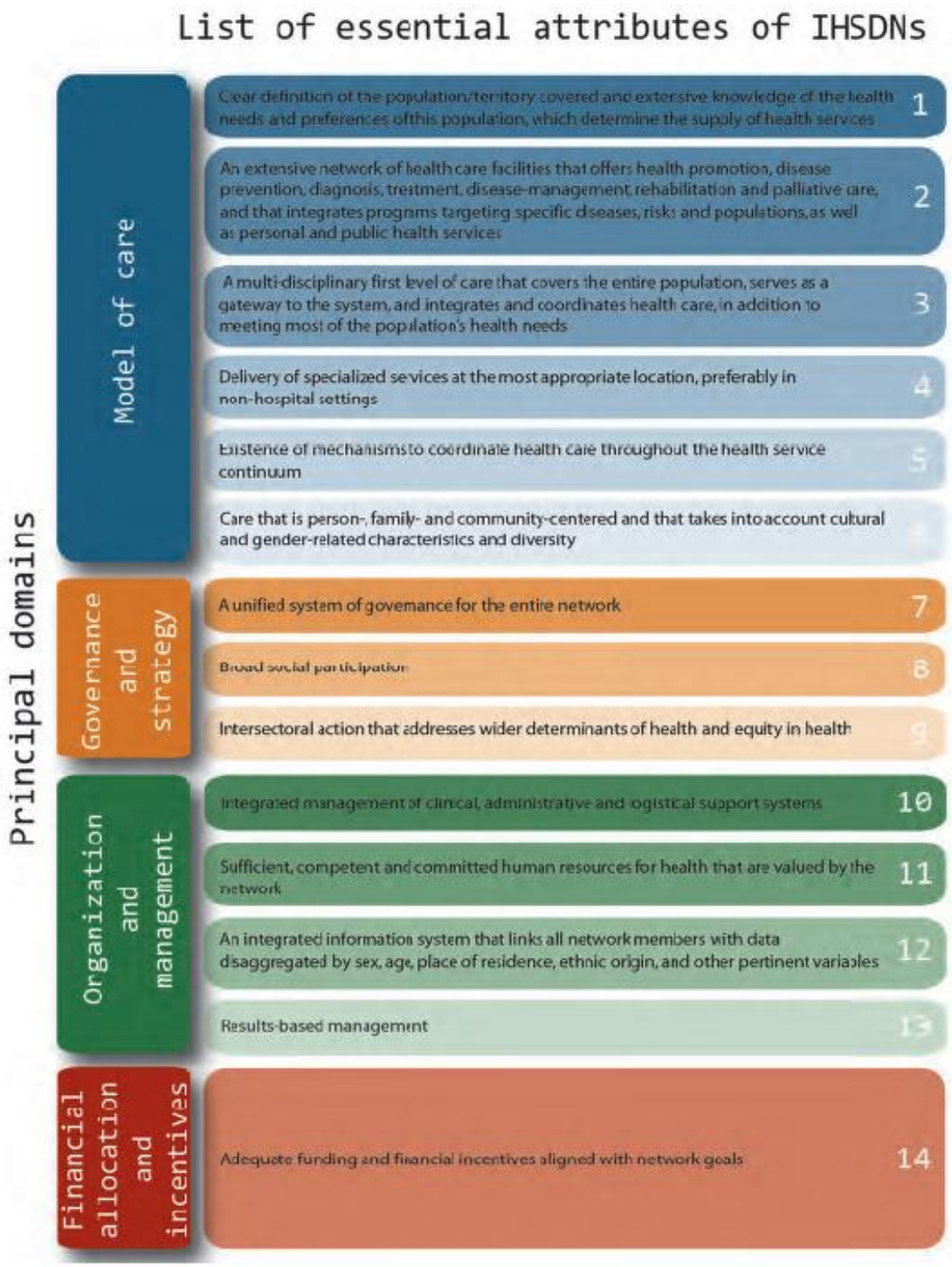
PAHO defines IHSDNs as "*a network of organizations that provides, or makes arrangements to provide, equitable, comprehensive, integrated, and continuous health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and the health status of the population served* ([xviii])". The IHSDN proposal introduces *essential attributes* framed within four *domains* that define an integrated network. (See Figure 1 on domains and essential attributes of IHSDNs).

These essential attributes are the product "of an extensive literature review and several consultations carried out as part of the PAHO initiative." Moreover, the PAHO document points out that "… given the wide range of health system contexts, it is not possible to prescribe a single organizational model for IHSDNs; in fact there are multiple possible models. The public policy objective is to achieve a design that meets each system's specific organizational needs ([1]*8*)".

Several studies suggest that IHSDNs could improve the accessibility of the system, reduce the fragmentation of care, improve overall system efficiency, prevent duplication of infrastructure and services, reduce production costs, and respond more effectively to people's needs and expectations ([xix]). Lower production costs would be obtained through improvements in the cost-effectiveness of services, decreases in unnecessary hospitalizations, reductions in the excessive utilization of services and diagnostic tests, reductions in the length of hospital stays, improvements in economies of scale and joint production, increases in production volumes, and increases in system productivity. Higher production volumes, in turn, are associated with enhanced quality of care. Furthermore, IHSDNs would tend to improve the synergies between the system's resources and the population's health needs through an improved balance between specialists and generalists. In financial terms, integrated networks perform better in terms of total operating margins, cash flows, and total net income. From the clinical standpoint, continuity of care is associated with improvements in the clinical effectiveness, response capacity and acceptability of services, and in the efficiency of the health system ([xx]).

The development of IHSDNs will require constant adjustments in the supply of health services due to continual changes in the population's health needs, the levels of sector resources, and advances in health-related scientific and technological knowledge.

Figure 1



Source: Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas. PAHO. Washington, D. C. 2011

Within integrated service networks, each unit has specific responsibilities and a defined capacity for problem-solving, so that the problems that cannot be resolved – since they are outside of the scope of their predetermined capacity – should be transferred to other nodes of the network that have the

necessary capacity. This means that these networks are step-wise systems of services with complementary complexity and clearly defined channels for communication, and patient referral and counter-referral. When proposed in this manner, the hospital becomes an important node – versus the central component – of the network. This means that it is necessary to generate new ways of organizing the hospital's functions so that it can contribute to the continuity of care in the network through planning that is centered on the population's needs and expectations, as designated and agreed upon by the network.

It is within this context that functionally different hospitals will be developed. Therefore, we should answer questions such as: *What should hospitals do in the future? What services will they provide? How will they be organized internally? How will they coordinate with other components of the system? How should they be constructed? What competencies will their human resources have?*

What Should Hospitals Do in the Future?

Evidence points out that there is a series of elements ([xxi]) that hospitals of any type should incorporate into their functions:

- A focus on population health.
- Systemic vision.
- A focus on service integration and coordination.
- The continuity of people-centered care.
- An adequate level of self-management and clinical management.
- The safety of patients and health workers.
- Results-based management and accountability.

These elements, among others, guide the type of hospitals for the future. These hospitals will be organized and equipped to provide safe care that responds to a population's health needs and on a territorial basis. In other words, they will be organized from the demand side, and coordinated and linked with other health and social services through a network.

Health financing and thus hospital financing will need to change its orientation radically in order to defray the cost of care plans provided through a network and on a territorial basis. The challenge will no longer be to continue marginally reducing patient hospital stays, but to avoid – insofar as possible – hospitalization by anticipating the management of patients and diseases ([xxii]) and thus avoiding sickness episodes and complications.

Finally, hospitals' outcomes – which will be measured in relation to their population-level and systemic performance – require the development of indicators that are able to measure the different dimensions of quality, efficiency, and effectiveness, together with contributions to health improvements that are of interest to society.

What Services Will Hospitals Provide?

Regardless of their research and teaching functions, hospitals have traditionally provided services through three modalities of care: ambulatory (outpatient), emergency, and inpatient. In recent years, and given costs, safety, and access, the trend is increasingly to carry out ambulatory care outside of the hospital, and to focus hospital care on serious emergencies and patients who require a significant amount of highly-complex medical or surgical care or treatments and have a need for constant intensive nursing care.

The emphasis will be primarily on acute care. This includes the following: an adequate supply of beds and equipment for resolving acute cases and providing intensive care; services organized for progressive care and that also prioritize the increasing focus on the provision of ambulatory care; enhanced development of day surgery and day-hospital services; and programs for managing hospital discharges that accelerate the process of discharging and transitioning patients to their homes, the first level of care or other extramural services.

With regard to emergency care, well-designed alternative models of care can be more effective and have higher patient acceptance.[xxiii] These models can include agreements for greater access beyond normal scheduled hours to the first level of care, in smaller units that are more accessible to patients and through virtual links to hospitals in a way that allows for increased diversity of services while maintaining high-quality care. Rapid evaluation, which depends on the diagnostic media, the return time for results, and a limited number of systematic protocols, can limit admission to patients that really need it.

Such decentralization implies a significant change in the activity level of hospital emergency services and requires a closer relationship between community- and hospital-based services ([xxiv]), improved access to diagnostic equipment for primary care physicians, and coordination mechanisms to ensure that patients are referred to the adequate level of care.

In the area of diagnostic media, reduced costs and miniaturization are already permitting the decentralization of activities that were previously concentrated in a central department ([xxv]). New types of equipment are allowing for the training of personnel to carry out a broad range of basic imaging and laboratory tests. Images can now be transmitted throughout the world, allowing access to expertise independent of location. Clinical networks sustained by information technology offer the opportunity to integrate hospital care more closely with primary care ([xxvi]- [xxvii]).

In high-technology cases, hospital planning and management should guarantee economies of scale that permit both efficiency of the most expensive resources and a high degree of equity that allows access to these technologies for all who need them.

Which Human Resources Will Hospitals Work With?

The changing nature of the workforce is perhaps the greatest challenge faced by many health systems. An explosion in the number of super specialists and the emergence of teams of multi-specialists and

multi-professionals both occur frequently, in contrast to the shortage of professionals that provide services at the first level of care. These developments have possible benefits for patients with rare diseases but they represent a challenge when organizing the large volume of a hospital's general tasks. Present-day medicine demands that specialists have extensive knowledge of a variety of conditions since many patients (in particular the elderly and those with chronic diseases) have multiple disorders. The idea of the generalist, whose expertise resides in the diagnosis and treatment of a variety of common disorders, seems to be recurring. In the United States, these physicians – called "*hospitalists*" – frequently organize and coordinate the increasingly complex processes of care.

Changes in employment-related regulations, as is the case in countries with restrictions on professionals' working hours, force institutions to develop new methods to cover hospitals during night shifts and weekends and to ensure that high-quality medical care is available at all times.

Furthermore, changes in non-physician professional staff's attitude toward employment drive hospitals to have to redefine professional functions and, in particular, expand the role of nurses. However, expanded nursing responsibilities will substantially change the nature and state of the profession and many nurses will no longer be willing to accept the lower pay and lesser positions in the clinical hierarchy that they currently tolerate. These developments are further accentuated by the growing shortage of nurses in many parts of the world, which places additional pressure on health services to generate imaginative strategies for utilizing personnel ([xxviii]). In general, the principal challenge regarding human resource policies for hospital planners will be how to tear down the traditional barriers between different medical specialties, and between physicians and other disciplines. These barriers are often due more to history than to logic and they frequently lead to the fragmentation of patient care.

Objectives and Premises of this Book

The launch of the PAHO position paper on IHSDNs immediately generated a series of strategic questions: *How should the hospital insert itself in the logic of IHSDNs?, What type of hospital?, How should the culture, processes, and structure of that new hospital be defined?, How should the hospital be financed and how should its governance system, its information systems, and the formation of human resources and other key issues be determined?, How should "change engineering" that makes the proposed vision viable be envisioned?, How can different countries' histories, processes, constructions, and experiences regarding hospitals and IHSDNs be reflected, with the greatest possible number of perspectives with respect to errors, obstacles, successes, local experiences, narratives …?*

Motivated by the publication and with these questions in mind, a group of hospital managers in Chile took the initiative to publish a book on the role of hospitals in integrated health service delivery networks. This initiative brought together a sizable number of health services managers, academics and researchers from different countries who collectively developed the ideas that are presented here with the support and technical assistance of the PAHO.

This is not another book on hospital management. It is an ambitious project with a difficult approach that tries to challenge current thinking and dogmas on the role of hospitals in health systems and to expand the necessary debate on that role in the transformation toward integrated health service delivery networks.

Framed within the vision of contributing to the development of health systems that are modeled with human beings as the central focus, this book aims to make a provocative contribution to addressing the debate on *what hospital?* is needed in order to develop integrated health service delivery networks, and as a response to the challenge faced by countries in the Region of the Americas as they decide to advance toward the organization of IHSDNs as a means to solving the important problems of health services fragmentation.

The IHSDN strategy proposes a complete remodeling of services, a remodeling that forces institutions to place singular attention on hospitals. Until today, hospitals hold a high degree of power in the region's health systems. Therefore, hospitals could become real obstacles in the construction of a model based on IHSDNs. An understanding of such resistance and mechanisms to generate a change in hospitals is essential for the effective installation of integrated networks.

In order for the concept and initiative of Integrated Health Service Delivery Networks – IHSDNs – to move from discourse to effective action, it is necessary to generate changes in the identity of the hospital and in the way in which different institutions face the needs of the citizen user of health services. In order for this to take place in an effective manner, the authors propose the need to move forward from three important premises: 1) Without hospitals there will be no IHSDNs; 2) With hospitals there will be no IHSDNs if the *status quo* of the current hospital organizational culture persists; and 3) Without IHSDNs the hospital's current problems and challenges will not be resolved. These three premises require a new pact between managers, the health system, and society, in which the hospital consciously assumes a new position and takes pride in this change. This transition should not be viewed as a consequence of being cornered by the evolution of costs, the epidemiological profile, and technological innovation. Instead, it should be approached with the understanding that it is much better to resolve as much as possible outside of the boundaries of hospitals because it is "healthier" for everyone: society, the health system, the hospital.

This option of the hospital in order to make IHSDNs possible – a strategic option that takes advantage of its own sustainability – requires another crucial proposition: the inevitable need to include hospital workers in the transformation to integrated networks as a shared objective. If this does not take place, we will be condemning ourselves to supporting the *status quo,* and to making networks "an element of discourse, but not of action."

Through this book, the authors have attempted to collect the perspectives and experiences in LAC and at the global level regarding the vision and development of a hospital reality that is consistent with IHSDNs. They plan to contribute to the transformation – starting from social processes – of health

systems that place special importance on the person in his or her entirety, as a subject with rights and as a protagonist of his or her history and life in society.

This proposal aims toward a hospital that works in a network that tends increasingly toward ambulatory care; the comprehensive nature of health care based on care processes that are structured in networks; the co-accountability and participation of people and communities; and an understanding of the importance of social determinants.

This publication is not an attempt to set doctrine or be prescriptive. It seeks, above all else, to offer a new approach to the subject of hospital organization and management with a view toward expanding the regional and, why not, the global debate. It hopes to do so in such a way that will allow for continued efforts to define with greater clarity the future of hospitals and their role in integrated networks as an alternative to the fragmentation of health services in the transformation to health systems based on PHC.

Brief Description of the Book's Chapters

The first chapter addresses the history of the hospital, and synthesizes current challenges from a vision of the hospital as a social agent. Chapter two frames the challenges that are unique to the hospital as an actor of utmost importance in the broader context of health services, in light of the challenge of the transformation of integrated networks based on the PAHO proposed framework.

Having clarified those challenges, chapter three proposes options for change and strategies for the hospital using the logic of IHSDNs domains and analyzes the hospital's actions within the scope of IHSDNs essential attributes.

Chapter four uses a proactive tone to present decision-makers at the public policy and managerial levels with ideas and mechanisms for participatory and strategic management of the transition toward hospitals in IHSDNs.

Chapter five presents cases of what works and what does not work from the experience of some of the region's countries. The final chapter, chapter six, more than conclusions tries to present an ideal future vision of the type of hospital that is appropriate for IHSDNs.

In addition, on the back cover of the publication, the reader will find a compact disk that includes several contributions exploring some of the issues in greater depth, and expanded versions of case studies from countries in the Region of the Americas that could contribute to the enrichment of strategies for change and management.

In a publication of this kind, it is important for both the authors and readers to generate consensus on the definitions and concepts that provide the best foundation for achieving improved coherence and understanding of what is proposed. In order to support this effort, key terms have been included in the

Glossary to improve understanding of the text and to clarify, in particular, our definition for cases in which a single term has multiple uses and meanings (i.e. Primary Health Care).

The book attempts to examine IHSDNs from the perspective of the hospital's function and to present the experiences of different countries in the region regarding the role of their hospitals in the configuration of integrated health service delivery networks. Given this, we have attempted to organize the book in such a way that it can be read from different perspectives by different readers since it adapts to each person's needs.

In the *Executive Summary,* the most relevant ideas discussed in this book are condensed for the reader who has limited time and cannot read almost 300 pages. For those who are interested in detailed reading, this book attempts to follow a coherent order that moves from the history of hospitals in LAC to the presentation of provocative conclusions. Other readers will prefer to learn about the subject by reading specific chapters without following the established order and we hope that such an approach is also easy and useful. Finally, but not any less important, we would like to highlight that we consider that this publication may be useful for the academy and in the education of new human resources. In so doing, we have endeavored to the utmost to maintain didactic clarity and an approach that is flexible and oriented to the future.

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CHAPTER 6:

Reflections for an Agenda for Hospitals in IHSDNs

In response to epidemiological, demographic, technological, and socio-cultural changes, hospitals will have to redefine themselves and undertake major reforms to deliver cost-effective, high-quality, and sustainable services. To achieve this, it will be necessary to make the implementation of Integrated Health Service Delivery Networks (IHSDNs) viable. IHSDNs are essential to improve the accessibility of the system, reduce fragmentation of care, improve overall efficiency, avoid duplication of infrastructure and services, decrease production costs, and better respond to people's needs and expectations.

The implementation of IHSDNs will not arise out of replicating current structures and ways of doing things. ***This cannot be achieved with more of the same*.** The problems that currently afflict hospitals will worsen if system-wide changes along the lines of the proposal for IHSDNs based on Primary Health Care (PHC) do not take place. Furthermore, it will not be possible to implement effective networks without generating changes in the way hospital care processes are designed and carried out. In other words, IHSDNs cannot be envisioned without hospitals, and hospitals will not be sustainable without IHSDNs.

When constructing an agenda that manages to transform itself into public policies within the governments in LAC, the role of PAHO will be key in making relevant issues visible and generating a vision of the future for the region's health systems which, once shared by the different actors, will make the required changes possible. In the construction of such an agenda, there are crucial topics in the debate for the coming years.

One issue will be how to bring to the fore of the public agenda the awareness that the current fragmentation and segmentation of health systems in the region is one of the principal obstacles that threaten the provision of equitable, efficient and effective health services that are valued by citizens. At the diagnostic level, systems face problems with low technical efficiency, coverage and quality of services, patient safety, management capacity, performance evaluation and accountability, together with untenable increases in the costs of health care services and in users' perceptions that existing services are of poor quality. It is difficult to specify how to inform the various actors, particularly those who participate in key decision-making, that continuing to invest limited resources in the same way that has been done in the past will not contribute to solving today's problems or those of the near future. These concerns are not foreign to more global debates related to development, social policies, the role of the state, markets, and citizenship in a country's vision where social inclusion, quality of life, and sustainable human development are relevant topics that bring inclusion and health equity within reach. In other words, the agenda for a new hospital cannot ignore more global subjects, since it can be difficult to think about hospitals in networks based on PHC in societies modelled around exclusion and on each socioeconomic segment having a different type of service, according to ability to pay or capacity to influence the dominant elites. The foregoing implies the construction of social and political consensus that permits long-term countrywide agendas in the area of health systems and that achieve policies that persist beyond changes of ministers and governments.

Since hospitals occupy the center of healthcare organization both for citizens and decision makers, as well as the highest percentage of public spending in health, the concern arises about how to generate a

new perspective not only on behalf of decision makers, but also on behalf of public opinion. The latter forces us to think about strategies directed toward the mass media as a relevant part of the agenda for hospital reform.

When talking about "hospitals", this definition ranges from unspecialized medical establishments with fewer than one hundred beds to highly sophisticated facilities in terms of technology, with many hundreds of beds and thousands of employees. Regardless of size and level of specialization, most "hospitals" in LAC unfortunately share a limited vision of integrated networks. This situation demonstrates the need for new definitions of what is understood by "hospitals" and how these fit into the concept of IHSDNs.

PAHO undertakes the challenge of making hospitals part of a service provider system structured around a defined population and territory; with competencies to identify users' needs and expectations; with various types of establishments that provide organized, integrated, and complementary services for health promotion, prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care, in a manner that is harmonious and integrated with public health actions for people and the environment in the territory. Furthermore, PAHO proposes that these policies and arrangements should start from a first level of care that is multidisciplinary, has universal coverage and has high response capacity. The first level should also be the level from which integrated care processes can be modulated and coordinated, ensuring that actions are carried out in the correct places and provided with the necessary competencies. The questions that arise in this regard relate to how to generate political will so that public policies are designed to generate the conditions for all of this to take place.

The hospital in an IHSDN will require an organizational and management model different from that of an autonomous establishment that does not have shared commitments with other establishments, for the purpose of jointly achieving certain goals and a certain impact on a given population. This implies that hospitals will have to participate in a strategic thinking process together with the network; it is during this process that the structure and culture of the establishment and hence its care practices will be determined. Integrated processes with a systemic, cooperative approach to health outcomes centered on people as subjects with rights and based on the PHC strategy will require competencies for organizing support, logistics, and information processes, as well as adequate human resources in terms of quantity, competencies, and distribution. The question that emerges relates to the debate necessary for installing the policies and values that guide these models in societies and organizations.

The role of hospitals in IHSDNs will be to contribute to the resolution of problems as required by the care network, on the basis of the type of activities, level of complexity and specialties that the network itself defines, in both in- and outpatient care and including emergency care. This new role requires simultaneous action among the different establishments of the network, together with the active participation of different social actors, with health objectives as the uniting force. This co-construction should employ a network perspective, planning tools, and the management and evaluation of the responses jointly generated by the different members. This will imply not only that the network defines

the establishments' service portfolios in a participatory manner and generates the conditions for care processes to be organized and carried out in an integrated and comprehensive manner, but also that the hospital itself reflects on its own identity. The challenge is how to achieve this last goal without generating resistance, but on the contrary, valuing this new condition as an opportunity to be useful, prestigious, and recognized.

The key questions revolve around how to make hospitals – and accordingly, the people who work in hospitals – "allies" in the goal to organize around networks, considering that power is concentrated in hospitals and their lack of "will" to integrate can derail the IHSDNs strategy. Perhaps the key response to achieving this is to find a way for hospital workers to understand that the majority of the "problems" that overwhelm and "collapse" hospital services are due precisely to the non-existence of IHSDNs. They need to understand that a first level of care with strong response capacity and broad coverage, together with a second level of care with specialized ambulatory services, is the best guarantee that hospital emergency services will not be crowded by users that consult for banal problems or for complications that could have been foreseen. The difficulty in undertaking elective surgical interventions due to pressures of emergency services has a similar explanation; as does the parallel phenomenon with bed-days that, when prolonged, prevents the hospital from receiving acute users due to deficiencies in the network's long-term stay and in-home hospitalization establishments or inadequate health-related social support. These are only some examples that support the hypothesis that a hospital's "problems" are definitely a consequence of poorly organized, fragmented systems. The question is what can be done so that this issue is perceived and understood by the different actors.

This new hospital model for networks requires putting on the agenda the debates and questions of how to achieve three large requirements simultaneously - government support for integration, aligned financing and incentives, and persistent efforts for a change in organizational culture.

When discussing the implementation of an agenda for confronting the challenges of a hospital under the logic of IHSDNs, in addition to the role of PAHO and the Ministries of Health, the role of universities and institutions such as the National and International Federations and Associations of Hospitals Administrators/Managers is also relevant. It is critical for these organizations to join forces to support propitious spaces for the appropriation of the concept of IHSDNs among different local and regional actors.

In order for networks to function, network governance and clear separation of the competencies for management and execution need to exist, both at the level of networks and of hospital establishments. These competencies, when strongly established through institutional arrangements, permit strategic alignment and integrated, continuous care even when there is a diversity of actors. The definition, mandate, and control of health-related responsibilities is unavoidably the role of the network's governing body and their execution – and how to achieve this – can be decentralized in hospital entities with growing management autonomy and capacity under the logic of the network. In this regard, it becomes necessary for networks and hospitals to implement directing councils aimed at aligning actions

to achieve shared health objectives. The question relates to how – given such diversity – can effective instruments for network corporate governance that take into account the diverse realities of LAC be designed.

In regards to financing, although hospitals serve a small segment of the population, they consume the bulk of health systems' resources, becoming a serious obstacle for a PHC-based approach. It is for this reason that it is important to develop new financing mechanisms that provide sustainability for hospitals while allowing them to collaborate effectively in the context of an integrated system. Therefore, the challenge of a financing model is that alignment with a country's health objectives should translate into growing proportions of public spending being allocated to the first level of care, and allocations and incentives that favour networking and transfer risk in a balanced manner. This model should include incentives for hospitals to provide the care that the network demands according to the prioritized needs of the population, with the best possible quality, and without having to reduce cost-effective treatments and diagnostic procedures as a result of insufficient resource allocation. Thus, as part of the agenda, we should discuss how resources should be allocated not only to provide financial stability to a hospital and cover the costs of care, but also and fundamentally, to encourage the hospital to continuously rethink and reinvent itself "in a network," while also being responsible and efficient in the use of assigned resources.

As part of an agenda for change, at the macro level we should discuss how to make financing more focused on health results (impact) than on the quantity of services. Similarly, they should be based more on the population's prioritized demand and the most cost-effective actions to meet these demands than on how to finance the supply side. At the micro level, we should discuss how to translate desired objectives into clinical management agreements that are integrated in the network, generating incentives for productivity within the goals assigned by the network, as a way of achieving clear alignment of the clinical teams and especially physicians, given the leadership they exercise within these teams.

The concept of IHSDNs will induce complex processes of change in the organizational culture of hospitals. The history of hospitals in LAC countries, together with the paradigm of the beneficence agency relationship, is strongly marked by self-sufficiency and isolation. What is important for the current hospital culture is what happens within its walls. This perspective is replicated for each unit that is part of the establishment, with each one behaving as a singular entity. This result in limited capacity to adapt to users' needs and explains why care processes "begin and end" not only within the establishment, but within a single unit or system.

The IHSDN concept requires a new hospital culture focusing on *innovating* to integrate care processes that are person-centered, as a chain of interdependent and cooperative steps that take place in conversations between people from different units of the organization and from outside of the organization. This generates a context of adaptive learning that makes it possible to meet users' expectations, and develop the capacity of the organization's workers. It also allows the balanced

incorporation of the explicit management of the "owner" of a public sector company into the hospital practice in the following way: with regard to *what to do*, together with formulas for real participation of workers and users; and in the *how to do it* in the everyday life of establishments, generating transparency and regulating power conflicts both within and between establishments in the care network. The question that arises is how to achieve this new culture.

The hospital is a socially constructed organization and even though policies and objectives (and funding aligned with them) may be defined from the outside; hospitals "are NOT manageable from the outside." Given this, it will be essential to discuss the role of Ministries and financing entities, so that they promote the clear, coherent, and sustainable stewardship of the various instruments that generate the conditions (governance, allocations, and incentives) that facilitate the contexts in which complex processes of change and daily life take place "on the inside" within hospitals and, most importantly, that make IHSDNs possible. The question is how to generate a powerful vision that makes sense to those who work in hospitals in order to modify their way of looking at reality, leaving behind deficits and "problems" so that they can look at what works and rethink hospitals' responsibilities. We should seek new strategies that will not endorse the classical resignation and desperation that is the basis of what we feel culturally: "we already tried that, nothing works here." These new strategies will require leadership, which is why we should ask ourselves how to generate conditions for professional directives, with the competencies and incentives needed to face these processes.

For this new type of hospital, the place in which human resources education is carried out should not be neutral. If the hospital continues to be the privileged place for undergraduate- and graduate-level training, we will continue to perpetuate a model that we intend to change. How to influence training centers regarding this new paradigm is a relevant topic for a hospital agenda. In turn, information and communication technologies can be a great integration motor, and an unquestionable support for network strategic thinking and well-structured and cost-effective processes in terms of the logic of cooperation. The subject for the agenda is how to achieve network-wide strategic thinking and communities of learning where information and communication technologies are effective tools.

IHSDNs as a future strategy require three linked lines of action: network-based governance, financing, and the implementation of daily network practices. As a product of these efforts we can visualize tomorrow's hospitals:

We envision hospitals in which the sense of belonging to the network of services in which they participate and with which they share responsibility for the health of a given population generates their identity. Hospitals that work with the network to study and get to know the needs of this population, identify its health problems, define priorities in a participatory manner, and structure its portfolio of services based on the network's need. Hospitals that present themselves to society as part of a coordinated group of providers and units starting from the first level of care and organize themselves internally based on the organization of the network. Hospitals that focus services from this perspective and contribute their response capacity to a strong, integrated overall network.

We envision a hospital that behaves like a partner. That tries to maximize its interests in education, research, knowledge building, prestige, etc., together and through the interests of the group. That contributes as just another member in the governance of the network by sharing its strengths. That offers its operating rooms, laboratories, imaging services, and intensive care services to the network, without intending to control it. Whose executive or hospital management team works in a participatory manner to translate the guidelines created by the establishment's governing entity, in permanent dialogue with the network's management team, in order to share and reach consensus, in resolving problems and implementing solutions in both care and management. That participates in population-level strategies without limiting itself to serving individuals only within hospital walls, providing an integrated dimension to the network's interventions. That shares and interacts with other social and community actors as a member of a whole and not as an isolated, self-centered and vain entity. That participates in spaces for community consensus-building and management as part of the network.

We envision a hospital that favours a *non-hospital-centered model of care* and supports extramural care of the population. The hospital as a flexible entity capable of responding appropriately to the reality of its population without intending to adapt the demand to its interests and traditional services. The hospital that constructively adapts to change, not to accumulate power, but to serve its community. A hospital that reduces its beds and intramural services to what is strictly necessary, yields to ambulatory care and in-home care when appropriate, and concentrates its human and technological energies on patients who need acute care, continuous observation, specialized care or rapid response in the case of complications.

We envision hospitals that do not understand their work devoid of working daily with units from the first level of care, to which they contribute their specialized capacities and from which they receive their general knowledge. They work with these units to coordinate interpretations of the health situation and health interventions. That guarantees continuous, integrated health care. That work together with colleagues from the first level of care to develop and incorporate protocols and guidelines for care, shared health records, referral and counter-referral mechanisms, and other tools for management and care. That creates and shares joint spaces for training and implement technical discussions about public health and clinical cases with the first level of care. That investigate and generate knowledge that is shared in the network.

Rather than being the center of the system, we envision a companion hospital that collaborates and works on equal terms with the rest of the network's units. More than the center of a universe that produces services; the hospital should be the hands that join in an integrated "*multiverse"* and contributes to the generation of solutions for the quality of life of people and populations. A hospital is not valuable due to the amount of beds and technology it can offer, but due to the value it adds to the network through the quality and relevance of its services for caring for acute illnesses of different origins.

Finally, we envision a new hospital that understands that power and value reside in collaboration and not in isolation, in being part of a whole and not in individuality, in constructive movement and not in static defence of the past, in having the technology related to the role that it performs and not in having the most recent fashion in the medical industry, in achieving collective health results more than in making headlines, in serving, in sharing prominence. The hospital should feel proud of its new role and be recognized as an indispensable member by all of its colleagues in the network, by the health system, and by society.

From the start, we did not intend to write another book on hospital management. We were motivated by the desire to contribute, starting from the pragmatic and moving toward the construction of health systems that are modelled on having the patient as the center. Therefore, we intend – without dogmas – to make a contribution by generating questions on what type of hospitals are needed to construct IHSDNs in Latin America and the Caribbean. This represents our response to the challenge faced by the countries of the Region of the Americas when they make the decision to advance toward the organization of IHSDNs as a means to solve important problems related to health services fragmentation.

During the preparation of this book, we learned that we are far from having experiences that can be presented as successful examples of hospitals that function in networks in a unified manner. The best experiences are still incipient and almost anecdotal. This means that we have a long road to walk. We hope that this book contributes to the journey.

We reaffirm our hypothesis that the IHSDN Initiative will require changes in hospital identity and in the manner in which different establishments view the needs of the citizen user of health services in order to move from discourse to effective action. For this to take place in daily practice, the authors propose the construction of an agenda for the hospital of tomorrow based on three premises: 1) Without hospitals, there will be no IHSDNs; 2) With hospitals, there will not be IHSDNs if the *status quo* of the current hospital organizational culture persists; and 3) Without IHSDNs, current hospital problems and challenges will not be solved. These three premises require a new pact between managers, the health system and society, in which the hospital consciously assumes a new position and takes pride in it, not as a consequence of being cornered by the evolution of costs, the epidemiological profile, and technological innovation, but due to the understanding that this new identity "makes sense." For hospital workers themselves it will become clear that resolving everything possible outside of hospital walls is "healthier" for all: society, health system, hospital, etc.

This vision of a hospital that will enable IHSDNs– a strategic option where the hospital's own sustainability is at play – requires another crucial proposition: the inevitable need to include the people who work in hospitals in the construction of integrated networks as a shared objective. If this does not happen, we will be condemning ourselves to maintaining the *status quo,* and making networks "an element of discourse, but not of action."

Using the proposed aspects as a foundation, the authors would like to highlight their willingness to collaborate with PAHO in implementing this agenda so that the hospital we dream about can become a reality.