STRENGTHENING HOSPITAL LEVEL INTEGRATED PEOPLE-CENTRED HEALTH SERVICES

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Introduction

Most of the healthcare systems are fragmented and constantly challenged by a growth in the ageing population affected by multiple chronic diseases, globalization, IT developments, economical restrictions and political regulation. For a long time, the healthcare sector has focused on disease-specific interventions. These specific, large-scale initiatives, however, have ignored the fundamental reality of the fragility of existing health care systems and issues in delivering timely and quality health care for the time and money invested.

The recent 2014 Ebola Virus disease outbreak in West Africa revealed the need for stronger link between the response and recovery of health systems outlined in National Health System Recovery Plans. The bottleneck that exists, due to health systems which are “too fragile and fragmented to deliver the volume and quality of services to those in need,” prevented many countries from achieving the health-related Millennium Development Goals of 2015. Health systems will continue to be challenged as countries aim to reach the Sustainable Development Goals (SDGs). The “double crisis” of devastating disease and overwhelmingly failing health systems in many low-income countries reveals the existing shortfalls in health workforce, lack of donor coordination, and weak health information systems (Phyllida Travis, 2004).

It is a global tendency that people are living to an older age which reflect with the growing of multiple-chronic conditions (MCC). The increasing global prevalence of multi-morbid chronic illness represent a challenge for the different health systems, in particular for the re-organization of the health service delivery. Hospitals and healthcare facilities has gone through reforms and re-adjustments to be able to face this challenge and to better respond to MCC (IHF, 2013)

With these evolution and crises in healthcare systems, the World Health Organization (WHO) Framework on integrated people-centred health services (IPCHS) strives for a fundamental model change of the management, delivery, and funding of health services. The Framework emphasizes the need for health services to adopt an integrated and people-centred approach.
The traditional silo approach in health care models, in which hospital management and health care delivery practices tend to adhere to, is often inefficient, fragmented, and costly for health care facilities. Developing inter-organizational networks “have the potential to improve outcomes by leveraging resources, lowering costs, and identifying solutions that are not achievable by any one agency”. The challenge of providing integrated health services, however, is facilitating new partnerships and the integration of systems because of the diverse needs of different local populations. The conservative tendency to work within a familiar silo is so widespread as it may be “less resource intensive, whereas working across boundaries increased opportunity costs and increases risk of failure”. However, the existing hospital-centered and disease-specific approach to treating disease weakens health systems in their ability to provide high quality, sustainable and universal care. The priorities of service providers can misalign from patient and population needs, and therefore leads to poor health outcomes for individuals of the community (Christine A. Bevc, 2015).

As stated in one of the ‘four key lessons’ of the paper “What is Integrated Care?” by Shaw et al. in 2001, while prioritizing people-centered and integrated health services is on the global agenda, there is no “one model” to satisfy the complex needs of different ageing populations around the world. The key issue in moving towards the coordination of health care services to meet the needs and preferences of individuals, families, and communities is the lack of intricate understanding of the existing, local needs of each health care facility and system. Without a complete understanding of how these facilities are managing, funding, and delivering health care, there is a risk of policy interventions failing to meet intended goals (Sara Shaw, 2011).
Systems are “dynamic architectures of interactions and synergies,” meaning that analyzing health care services from a systems approach can reveal the tightly connected and highly sensitive effects of intended changes and actionable improvements (Don de Savigny, 2009).

WHO has highlighted the need for health systems strengthening in health facilities and systems across the globe, as well as the “paramount importance of primary health care and universal health coverage”. At the core of health systems strengthening is the need for integrated health services, which are, according to WHO, “health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course” (WHO, 2015).

While health systems strengthening strategy remains contested by some global health actors as being too overarching, the international attention and debate around the issue has grown and developed since its emergence in the “2000 World Health Report”, which focused on health systems performance.

Globally the health paradigm has shifted from acute infectious diseases to chronic diseases. This irreversible reality challenges the traditional patient and health professional relationship, as patients need to be empowered and educated to make daily choices in managing their chronic illnesses. Without proper management of prevalent chronic disease such as heart disease, diabetes, and obesity, these conditions could soon be life-threatening to a patient’s well-being. The health care costs in treating the burden of non-communicable diseases escalate rapidly, particularly among traditional self-contained silo curative care models. Across the world and especially in rural, low-income regions, people “still face significant problems of unequal geographical access to health services, shortages of health workers and weak supply chains” (WHO, 2015).

As chronic conditions are often multi-morbid and present until and through end-of-life care, the vital importance and need for urgency by health care leaders and facilities to work towards IPCHS are highlighted through Strategic Goals 3, 4 and 5 of WHO Framework. These goals are: “reorienting the model of care”, “coordinating services” and “creating an enabling environment” (WHO, 2015).

The International Hospital Federation (IHF) is committed to encouraging hospitals and health services to reach their highest potential for health according to the IPCHS framework, and recognizes and promotes the importance of having the patient at the forefront and center of reshaping the health care system.

The purpose of this white paper is to draw attention to the extremely diverse needs of responding to the health of populations across nations and regions. Furthermore, this paper explains why the shift towards people-centred and integrated care models is fundamental and vital towards building strong health care facility and system foundations. The possibilities
for health systems develop successfully are highlighted in this paper, in addition to the challenges of vertically integrating care among different organizations and communities. This paper also addresses potential roles for hospitals and health care facilities to consider within a health system, and both the possible successes and challenges involved with filling these specific roles in promoting and monitoring coordinated care.

Hospitals’ Role in Care Coordination

In WHO’s Technical Brief No.1, 2008, Integrated Service Delivery is defined as “the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system” (WHO, 2008).

Meanwhile, according to L. R. Burns and M. V. Pauly, in their paper entitled “Integrated Delivery Networks: a detour on the road to integrated health care?”, in the past two decades many hospitals have aimed for both vertical and horizontal integration (Lawton R. Burns, 2002).

**Horizontal integration**

- **Definition:** coordination of activities across operating units that are at the same stage in the process of delivering service
- **Example:** consolidations, mergers, and shared services within a single level of care.

**Vertical integration**

- **Definition:** coordination of services among operating units that are at different stages of the process of delivering service
- **Example:** linkages between hospitals and medical groups, outpatient surgery centers and homebased care agencies


According to Shaw et al., it is still essential to perceive the difference between these two integrations. If horizontal integration concentrates on “competing or collaborating organizations, networks or groups in the health economy and might involve, for instance, grouping outpatient clinics within a geographic network of providers,” the focuses of the vertical integration is on the “networks and groups at different stages of care within the health economy (what some commentators refer to as the supply chain or care pathway) and might involve, for instance, the drawing together of a hospital with local community services” (Sara Shaw, 2011).

“Initiatives to integrate care have tended to focus on either horizontal or vertical integration – rather than both – at any one point in time” (Sara Shaw, 2011).

Many of the studies on both types of hospital integration strategies showed initial financial losses and led to hospitals ending these new organizational methods before any benefits could be seen.
A survey on “Financial and Strategic Lessons from a Decade of Integration” in 2001, realized and conducted among thirty-seven large integrated networks, found that a higher up-front investment led to a greater deterioration in that network’s operating margins, return on assets, and debt position. This challenge shows that executives and hospital managers must thoroughly understand and assess specific changes to integrating care on a locally tailored level in order to minimize the potential losses.

Additionally, the difficulties in seeing a long-term gain from integrating systems should not be immediately reconciled with ending systems integration strategies. The careful position of hospitals within managed care is crucial in ensuring equitable health care access. Moreover, many of the challenges that health systems face is due to the lack of connectivity between patients and providers. By adopting a people-centred approach, this model could come “closest to being a consumer-oriented model of health care delivery” (Lawton R. Burns, 2002).

Hospitals are in a unique position in which they can share the responsibility of preventative care, primary care, acute care, diagnosis, treatment, rehabilitation and palliative and end-of-life care. In the shared hopes of more reasonable health care costs, more efficient health care delivery systems, and universal, equitable access to care, hospitals should be considered as one link in a continuum of health services. This idea of care-coordination reduces the pressures on hospitals to provide for a generalized, all-encompassing care program with a limited number of staff and space. Health networks with coordinated mechanisms across social and health organizations can offer more specialized, quality care for specific patient needs, given that patients have the mobility and appropriate knowledge to navigate the different options and levels of care within a health system.

With this significant role of hospitals in the integration of people-centered health services, the functions of the people in it are also important. According to Suter et al., “roles and responsibilities of all team members are clearly identified to ensure smooth transitions of patients from one type of care to another. Shared protocols based on evidence, such as best practice guidelines, clinical care pathways and decision-making tools, are essential to the functioning of inter-professional teams and help to standardize care across services and sites, thus enhancing quality of care”.

“Physicians need to be effectively integrated at all levels of the system and play leadership roles in the design, implementation and operation of an integrated health system” (Esther Suter, 2009).

A paper made by Robinson in 1991 measured the role of managed care from 1985 to 1993 to show hospital expenditures grew 44% less rapidly in hospital systems in which had higher health maintenance organization (HMO) penetration. Systems with managed care were able to shift the acute care need in hospitals away from the center and towards the periphery of the health care system. This shift resulted in including the reduction of psychiatric hospitalization, and an increase substitution of outpatient for inpatient surgery. Similarly, the number of beds in hospitals across Europe has significantly reduced because of the rise in coordinated care, home nursing, and domiciliary hospital care systems. Furthermore, aligned with the IPCHS strategic goal 3.4, shifting towards more outpatient and ambulatory care, the
trends reflect how finding the right balance between primary care and specialized out-patient care and hospital inpatient care can foster an efficient system. Specifically, some policy intervention options include collaboration with home care, nursing, hospices, and outpatient surgery centers (James C. Robinson, 1991).

The recent development of polyclinics, such as those in Western Germany, has assisted in increasing the supply of medical professionals in non-traditional settings. In many parts of the world, primary-care physicians and specialist doctors are often independent from health systems, and thus leading to fragmentation in care, coordination, and efficient referrals.

In the case of United States (US) and United Kingdom (UK), about two thirds of ambulatory care providers work in solo or private practice. Additional alternate modes of care coordinating systems have emerged across the world, and have primarily been seen to offer an improved and higher quality of care for chronically ill patients. For example, in the United States, some large HMOs have proven to be successful in offering equitable access and quality treatment because of the provision of integrated care within a single organization. The health maintenance organization represents a prototype of managed care, where individuals are assigned to a primary care physician, who can then refer to specialists as needed.

The growing population of people with chronic disease has led to the growing interest in “self-management” of illness and pain, driven by the high costs of in-patient care. A study by Lorig et. al evaluated the effectiveness of a chronic disease self-management program. The participants enrolled in the program experienced statistically “significant improvements in health behaviors (exercise, cognitive symptom management, and communication with physicians), self-efficacy, and health status (fatigue, shortness of breath, pain, role function, depression, and health distress) and had fewer visits to the emergency department (ED) (0.4 visits in the 6 months prior to baseline, compared with 0.3 in the 6 months prior to follow-up; P = 0.05)”. The findings of this study align with the IPCHS strategic goal 1.1, empowering and engaging individuals and families, in order to achieve better clinical outcomes. The patient will spend “most time living and responding to their own health needs and will be the ones making choices” which impact their health. Patient programs that encourage health behaviors and self-help have supported the process of recovery and maintenance of chronic illnesses. Furthermore, programs, which combine patient education with stronger roles of non-doctor medical personnel, have a strong overall impact on health outcomes (Kate R. Lorig, 2001).
Barriers & Solutions to integrated care from a hospital perspective

Apart from having a shortage in health care professionals globally, one barrier in providing integrated health care services is that many hospitals and health systems are severely underfunded for this.

Furthermore, a study named “A systematic approach to the planning, implementation, monitoring, and evaluation of integrated health services” by Reynolds, H.W. & Sutherland E.G. in 2013, found that problems were mostly related to poor guidelines and policies, underfunding, inadequate use of standards, weak supply chain systems, lack of skilled IT experts, and insufficiently trained personnel (Heidi W. Reynolds, 2013).

With this, the WHO Integrated People-Centred Health Services (IPCHS) strategy outlines the following five interdependent goals:

- **EMPOWERING AND ENGAGING PEOPLE**
- **STRENGTHENING GOVERNANCE AND ACCOUNTABILITY**
- **REORIENTING THE MODEL OF CARE**
- **COORDINATING SERVICES**
- **CREATING AN ENABLING ENVIRONMENT**

These goals are meant to be adaptable in order to fit local needs, and to have the focus of development be centered on people and their needs. It is often seen that shifting towards a vertically integrated system has the potential to generate significant benefits including improved access to health care, improved health outcomes, literacy, and self-care, increased patient satisfaction, society efficiency, and reduced overall costs.

Moreover, the emergence of e-health and m-health platforms, due to the recent advancements in technologies, holds great potential in achieving people-centred health care. According to the WHO, mHealth is the use of mobile and wireless technologies to support the achievement of health objectives and eHealth is the use of information and communication technologies (ICT) for health. Through these innovations, the care model can be redefined and shaped to allow new ways to share information and can especially assist in reaching health services to rural and geographically isolated communities.

In addition, integrating common practices in health care delivery with technology can be efficient for both patients and providers. This is seen with many health systems moving towards complete, electronic health record (EHR) systems. The study of a systematic review reports that the implementation of bedside electronic terminals and a central station desktop saved nurses up to 24% of their overall time spent on documentation during a shift. While EHR systems already exist in many hospitals, it is important that both privacy and routine
update practices are in order. As care coordination involves a range of strategies to enhance the patient experience, having infrastructure to share electronic medical records across systems can improve information flow when patients are transferred between different health care providers.

In moving forward in upholding commitments to providing integrated, people-centered care, it is important for specific countries and local facilities to develop their own strategies. These strategies should aim to be country-led, equity-focused, people empowering, systems strengthening, iterative learning and action cycles, and goal-oriented.

The IHF, having the role of helping international hospitals work towards improving the level of the services they deliver to the population, with the primary goal of improving the health of society, and taking a productive collaboration with WHO since 1947, is providing its full support and also looking forward to an advance progress with the WHO IPCHS strategy.

WHO IPCHS in Regions / Countries

According to WHO’s technical brief report, integrated health services have the following six main usages: “1) a package of preventive and curative health interventions for a particular population group, 2) multi-purpose service delivery points, 3) achieving continuity of care over time, 4) vertical integration of different levels of service, 5) integrated policy-making and management, and 6) working across sectors” (WHO, 2008).

Since the IHF supports the Framework on integrated people-centred health services developed by the World Health Organization, the IHF Secretariat has conducted a brief survey regarding this subject. This surveyed IHF Members worldwide from March-April 2016. 15 valid answers were collected from the following countries:

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>RESPONDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Association of Hospital Management Austria</td>
</tr>
<tr>
<td>Belgium</td>
<td>SANTHEA</td>
</tr>
<tr>
<td>Brazil</td>
<td>National Health Confederation</td>
</tr>
<tr>
<td>Canada</td>
<td>Healthcare CAN</td>
</tr>
<tr>
<td>Colombia</td>
<td>Fundación Santa Fe de Bogotá</td>
</tr>
<tr>
<td>Finland</td>
<td>Kuopio University Hospital</td>
</tr>
<tr>
<td>France</td>
<td>Arpajon Hospital</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Indonesian Hospital Association</td>
</tr>
<tr>
<td>Korea</td>
<td>Dae rim St. Mary’s Hospital</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Luxembourg Hospital Federation</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Lagos State Health Service Commission</td>
</tr>
<tr>
<td>Portugal</td>
<td>Portuguese Association for Hospital Development</td>
</tr>
<tr>
<td>Spain</td>
<td>Unio Catalana d’Hospitals</td>
</tr>
<tr>
<td>Switzerland</td>
<td>H+</td>
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<tr>
<td>USA</td>
<td>American Hospital Association</td>
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</table>
The chart below shows that the health care system in the respondents’ countries are mostly “some level of care coordination but variation among sectors and locations” and “independent, multi-stakeholders”, as both categories gained 33%.

From the comments provided by respondents, it can be noticed that in Indonesia, all hospitals are required to provide patient-centered care as mandated by the Indonesian Hospital Accreditation Commission (KARS). In Colombia, the health care system is extremely fragmented. Then, on the other hand, a decentralized healthcare system was described for Canada.

When it comes to responding to the needs of patient-centered care, considering the increasingly aging population with multiple chronic conditions, most of respondents (47%) underlined the need of a “stronger collaboration between stakeholders from primary care to referral services”.

In Colombia we assist to a Vertical integration of (mandatory) insurer networks, while, in Canada a multi-pronged approach within an overarching, integrated primary care policy framework is in place.
Considering the global challenge towards patient centered-care, an effective electronic system containing patients’ health records is crucial. In 2009, Suter et. al mentioned in their paper the importance of electronic health records. It was underlined that electronic health records are helpful in connecting "consumers, payers and providers across the continuum of care and provide relevant information to these stakeholder groups".

“It is essential that information can be accessed from anywhere in the health system, even in remote locations, to facilitate seamless communication between care providers. The information system should also enable system wide patient registration and scheduling coordination as well as management of clinical data” (Esther Suter, 2009).

It can be observed from the chart below that most countries have an electronic health records system but 47% only at a facility level. Only two countries have records shared at regional level.

![Chart showing distribution of electronic health records]

In Belgium, an electronic health records system exists but just for some medical data and it is not shared by all the stakeholders. In the US, the system is in development in different stages of interoperability.

In addition of having an effective electronic health records system, formal communication processes or tools helping patients to navigate the health care system are also needed.

WHO explained in its Technical Brief Report how absent or poor communication can affect even high levels of healthcare integration providers.

“Many permutations of integration from the users’ and providers’ perspectives are possible. In some models of care, despite high levels of provider integration, users may experience low levels of integration in their access to care - or vice versa. Imagine a primary care centre that has organized its professionals in a network, but where communication between them is poor. Though this centre may appear integrated from a provider perspective, for the user, navigating the system has not been made any easier. From his perspective, care is still fragmented” (WHO, 2008).
As shown below, more than half (53%) of the respondents stated that hospitals in their country have formal communication processes and tools to help patients navigate the health care system.

In Indonesia, the Commission on Hospital Accreditation (Komisi Akreditasi Rumah Sakit) requires the participation of patients and families in the decision making process (hospital care, procedures, services, etc.). Patients education programs are crucial to increase patients’ ability to navigate the health care system.

In Catalonia, Electronic Health Records are shared with all healthcare in a platform named HC3 (Història Clínica Compartida de Catalunya HCCC). In addition to this, each citizen has a folder called MyHealth (La meva Salut). This is a digital space that allows individuals to access personal health information, make inquiries and perform electronic transactions. My Health promote individuals’ participation and involvement. A similar platform is also available in Luxembourg, the Portail eSante.

In Nigeria, most Hospitals (from both the public and private sector) have websites for patients to access personal information.

In Austria a large Hospital Information System named MEDOCs is implemented. In Korea most of the hospitals have adopted Electronic Medical Records (EMRs) and picture archive and communication systems (PACSs).

In Portugal, the health data platform (Plataforma de Dados da Saúde) is a web platform that provides a central system for recording and sharing clinical information in accordance with the requirements of the National Commission on Data Protection. The platform can be accessed by individuals and health professionals.

Improving communication methods for patients and families is also a challenge for health care providers. For 33% of respondents the IT infrastructure to assist patient navigation represents a major concern to increase the effectiveness of communication methods.

At the same time, four countries put forward that it is a priority to work on breaking down silo approaches, which requires a change of mentality.
Respondents also indicated some additional potential elements that need to be improved to increase the effectiveness of communication tools. These are: hospital enforcement, willingness of insurers and providers and, in particular, health care literacy and education.

A study by Lê et. al in 2016 entitled “Can Service Integration Work for Universal Health Coverage? Evidence from Around the Globe” mentioned in one types of integration referenced to empirical outcomes that a better and developed communication processes and tools in a healthcare system leads to an “improved timeliness and efficiency of care.” This demonstrates how fundamental an effective communication in an integrated people-centred health services is (Gillian Lê, 2016).

In the case on how frequently hospitals in a region/country interact with the following services, it can be observed in the graph below that there is a growing tendency to regularly interact with elderly living facilities and home care. Social services are fully integrated in Portugal, in Spain community based organization are fully integrated and in Luxembourg, both elderly living facilities and home care are fully integrated. The service with whom hospitals seems to have limited interaction is the one of the alternative medicine.
Integrated people-centred health services is one of the priorities among others for most of the countries and, for both Belgium and Finland, this is a top priority.

As it can be noticed from the chart below, most of the respondents indicated having limited assessment tools to evaluate the level of integration of care. For more than 30% of respondents the assessment is not in place. However, in both Austria and USA there is a large number of assessment tools. Finally, for both Colombia and Indonesia, the assessment is done by the Ministry of Health.

Respondents were asked to indicate the type of mechanisms in place to support integrated people-centred health services. As it can be noticed, 3 out of 15 respondents indicated that there are no mechanisms in place.
When mechanisms are in place, the most frequent is guidelines and framework, followed by community of practices, training and formal regulation.

In Spain, there are guidelines, protocols, health and social administration program to promote integrated care.
Conclusion

With all the shortages of healthcare professionals globally, the amount of hospitals and health systems that are severely unfunded, and the continuously rapid growth of an aging population with chronic diseases, the hunger for solutions heightens. The development and strengthening of the WHO’s Integrated People-Centred Health Services in Hospital Levels, as a solution for all of these, is a big challenge for all the healthcare providers.

The literature reviews showed that the challenge of delivering integrated health services is “facilitating new partnerships and integration of systems because of the diverse needs of different local populations”. The frequently unproductive, disintegrated, and pricey traditional silo approach in health care models, in which hospital management and health care delivery practices are mostly inclined to, are some of the barriers in achieving the goal of integrated care. Without a comprehensive understanding on the present “hospital-centred and disease-specific approach”, there is a threat of strategy interventions failing to fulfill projected goals (Christine A. Bevc, 2015).

The result of this study conveyed that countries are starting to implement integrated people-centred health services. However, the implementation still needs vast improvement in order to attain effective outcomes.

In addition, based on the results of the research, it can be concluded that the following are essential elements for a strong and effective integrated people-centred health services:

- prioritization of integrated care;
- Electronic Health Records System;
- effective and formal communication processes and tools;
- formal mechanisms to support the integration of care

Strengthening the integrated people-centred health services still needs further development. However, taking into account the strategies adopted by health care providers in different countries, it can be assumed that people-centered services will be effectively implemented at the wide-range.

This study has presented relevant information about strengthening integrated people-centred health services in hospital level. Next steps will involve investigating and reviewing the outcomes of strategies made and applied to reinforce integrated care, as well as the improvements still needed to be used.
References


