	EUROPEAN COMMISSION RESEARCH AND INNOVATION DG	Final Report

Project No: 223123

Project Acronym: Equity-LA

Project Full Name: Impact on equity of access and efficiency of Integrated Health care Networks (IHN) in Colombia and Brazil

Final Report

Period covered: from 01/03/2009 **to** 31/08/2013

Start date of project: 01/03/2009

Project coordinator name:
Dr. Luisa Vazquez

Version: 1

Date of preparation: 01/10/2013

Date of submission (SESAM): 29/10/2013

Project coordinator organisation name:
CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA

Final Report

PROJECT FINAL REPORT

Grant Agreement number:	223123
Project acronym:	Equity-LA
Project title:	Impact on equity of access and efficiency of Integrated Health care Networks (IHN) in Colombia and Brazil
Funding Scheme:	FP7-CP-SICA
Project starting date:	01/03/2009
Project end date:	31/08/2013
Name of the scientific representative of the project's coordinator and organisation:	Dr. Luisa Vazquez CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA
Tel:	+34 932531820
Fax:	+34 932111428
E-mail:	mlvazquez@consorci.org
Project website address:	www.equity-la.eu

Final Report

Please note that the contents of the Final Report can be found in the attachment.

4.1 Final publishable summary report

Executive Summary

The inequities and inefficiencies of the Latin-American health systems have been known for decades and were accentuated by the economic crisis of the 1980s. By the end of the 1990s, the scenarios of the region were still discouraging, showing deteriorating access to and utilization of health care services, high public expenditure and decreasing health insurance coverage. To tackle health care inequity and inefficiency, governments of many Latin-America countries introduced integrated health care networks; also widely promoted by international organizations in spite of the lack of evidence on its impact. Integrated health care networks are defined as a network of organisations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served.

The aim of the project is to analyse the impact of different types of integrated health care networks regarding their performance, access, care coordination and continuity of care using the experiences of two Latin America countries: Colombia and Brazil. Results should inform the development of policies conducive to better quality health care and contribute to reducing inequities in access to health care by improving public healthcare organisations. To achieve the study aim, the project adopted an innovative multidisciplinary approach to health systems research combining qualitative with quantitative methods. The project is two-pronged: a) a country case study, based on a qualitative study and a cross-sectional study to analyse the actual performance of integrated health care networks with a particular focus set on women's health care; and b) a cross-country comparative analysis with multiple sources of evidence to determine factors and actors affecting the performance of integrated health care networks in each particular context.

Results from Equity-LA identified numerous failures in the policy implementation of Integrated Health Care networks (IHN) in Colombia and Brazil; indicating a poor performance of IHN in both countries in relation to intermediate outcomes (access, care coordination, continuity of care) and final outcomes (quality of care). The findings were corroborated by multiple sources of evidence (users, health services personnel, policy-makers, patient's records and policy documents) combining qualitative and quantitative research methods.

Regarding access to IHN, different barriers were identified related to 1) health policies: in Colombia due to fragmentation and limited coverage of the benefit insurance plan, and in Brazil due financing problems; 2) IHN organizers and coordinators: in Colombia, introduced managed care mechanisms by insurers that restrict access, and in Brazil, lack of coordination and control during the planning and financing of IHN; 3) structure and organization of health services within the networks: lack of available secondary care services in Colombia, and in Brazil also in the first care level and elevated waiting times; and 4) lack of individual's economic resources in both countries, difficulties in obtaining work permissions and family support for administrative work.

Care coordination is limited in both countries (except in the ambulatory care centres of the contributory networks in Colombia) due to poor information transfer across care levels; and in Brazil also due to lack of clinical coordination and coordination of patient access. Identified obstacles are related to 1) the health system characteristics: existence of economic incentives that favour competition instead of collaboration; which has been linked to introduced market mechanisms (managed competition in Colombia and internal markets between municipalities in Brazil) and 2) working conditions: partial and/or temporary labour contracts that elevate the rotation of personnel; leading to insufficient use of coordination mechanisms, physician's lack of motivation, etc.

The perception of continuity of care by users with breast cancer and diabetes are relatively high in Brazil when referring to relational continuity; but lower in Colombia due to fragmented purchase of

services by the insurer. In both countries, a loss of managerial continuity from diagnosis to treatment is observed due to long waiting times – exacerbated in Colombia by long insurers' authorization procedures and lack of geographical access – and the exclusion of necessary services for the management of diabetes care from the benefit packages. Finally, perceived informational continuity is low due to the lack of information transfer and collaboration between providers in all analysed IHN.

The overall performance assessment of IHN shows unsatisfactory results regarding access and quality of care: identified barriers of diabetes care were, for example, insufficiently done albuminuria and glycohemoglobine tests, irregular visits to nephrologists and ophthalmologist, limited access to specialists in Colombia for patients of the subsidised regime; identified barriers of breast cancer were, for example, long waiting times for specialist consultations and onset of treatment in Brazil and for patients belonging to the contributory regime in Colombia. Results suggest a poor performance of IHN in both countries, highlighting the need for implementing different types of interventions in order to improve quality of care as a final outcome.

Equity-LA filled part of the knowledge gap on integrated health care networks regarding: a) key actors' influence on potential access to integrated health care networks by means of individual interviews to healthcare users, health professionals, policy makers and managers; b) equity level in actual access to care by means of a cross-sectional survey; and c) performance of different types of integrated health care networks by means of case studies of patients with tracer conditions (diabetes mellitus, breast cancer). By generating new knowledge relevant to social and economic issues, this project is particularly relevant for the public health policy of the European Community, contributing to the European Policy Framework priorities in health for best returns into health outcomes and poverty reduction. Finally, the research brought together different interest groups concerned with health sector organisation (policy makers, civil society groups, health providers), enhanced research capacity of these groups and opened up the European research area to outside collaborators. These collaborative links will be strengthened and expanded in the follow-up project Equity-LA II, which will include new partner institutions in Argentina, Chile, Mexico and Uruguay.

Summary description of project context and objectives

The inequities and inefficiencies of the Latin-American health systems have been known for decades and were accentuated by the economic crisis of the 1980s. By the end of the 1990s, the scenarios of the region were still discouraging. Despite large inequalities, public expending as percentage of gross domestic product in health did not increase and private expenditure remained high; health insurance coverage decreased in almost every country, access to and utilization of health care deteriorated and a marked deterioration in public health facilities was observed. Although some regional health rates improved within time, inequalities in health status and different opportunities of access to and utilization of health services still remain. The large sub-population groups that are most seriously affected are highlighted when breaking down figures by socio-economic levels, geographical regions, gender, ethnicity and age. However, it is in the area of personal care services where the largest inequalities are found: the care for patients with chronic diseases is remarkably uneven and shows many inequalities in terms of outcome; as well as significant inequities in access to preventive and curative care.

In order to improve equity and efficiency, many countries in Latin America have carried out reforms to their financial and delivery structures during the last two decades; including calls for more efficient allocation of resources through market mechanisms, stronger institutional capacity of health systems through decentralised responsibility and management, and different ways of organising the sector. Prevailing neo-liberal ideas have influenced the health reform's agenda in these countries, claiming to be new paradigms for the reorganisation of health systems.

The Equity-LA project focuses on a major component of these health services reform policies in Latin America: the introduction of Integrated Health care Networks, also called integrated healthcare delivery systems. This type of health care organisations is defined as a network of organisations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served. Depending on the context where integrated healthcare networks develop, two basic types can be found: regional-based and enrolment-based integrated health care networks; each

of which poses distinct policy challenges. The former comes from the devolution of health care management to a lower tier of local government and its population is geographically defined. The latter appears in countries with competitive insurance markets (managed competition model) where consumers buy prepaid health care plans.

Both types of integrated health care networks have been widely promoted in Latin-American countries such as Colombia, Brazil, Chile, Argentina, Dominican Republic, Peru or El Salvador. The two studied countries–Colombia and Brazil–have different types of health systems but both have introduced policies promoting integrated health care networks as a way of organising the services in order to improve equity of access and efficiency. In Colombia, Laws 60 and 100 of 1993 created the framework for decentralization and competition in health care delivery. The reform core was to establish enrolment-based integrated health care networks in charge of the affiliation and organisation of service delivery, consisting of Health Promotion Entities (EPS) for the Contributory regime and Subsidized Regimen Administrators (ARS). Their function is to guarantee, by providing directly or contracting other health care providers, the delivery of a health package to the enrolled population. In Brazil, market forces led to the integration of different health care providers in networks with different types of agreements. In 2001, after the performance review of the decentralised Unified Health System (SUS), the Ministry of Health in Brazil issued a new norm to establish a strategy of health services regionalisation that involved the creation of regional health care networks coordinated by the municipalities and states. The municipalities grouped or individually assumed the function of providing or arranging to provide a coordinated continuum of services to a geographically-defined population. The process of regionalization of health services has gradually evolved over time and different types of integrated health care networks–initial, partial and semi-full–can be found depending on responsibilities shared by the state and local levels.

Integrated healthcare networks should develop more efficient and equitable health services and better quality of care through the improvement of care coordination, continuity of care and access to healthcare.

Care coordination is defined here as the harmonious connection of the different services needed to provide care to a patient throughout the care continuum in order to achieve a common objective without conflicts. Care integration is considered the highest degree of coordination. There are two interrelated types of care coordination: informational and managerial. Informational coordination or the transfer and use of the patient clinical information needed to coordinate activities between providers. Therefore, in order for effective coordination of patient clinical information to exist, its mere transfer is not enough, it also has to be analysed and used correctly. Informational coordination between levels would help to reduce the unnecessary duplication of medical supplies and services such as complementary tests, medicines, contraindicated drugs, etc. Managerial care coordination is the provision of care in a sequential and complementary way, within a healthcare plan which is shared by the different services and healthcare levels involved.

Continuity of care, on the other hand, is related to how patients' experience the coordination of services received; namely the result of coordination from the patient's viewpoint. Continuity can be defined as the degree to which patients experience care over time as coherent and linked. Therefore, continuity acquires its meaning within the context of different providers caring for one patient, within the framework of patients' expectations and priorities. Three types of continuity are defined: a) relational: the patients' perceptions of an ongoing, therapeutic relationship with one or more providers; b) informational: the patients' perceptions of the availability, use and interpretation of information on past events in order to provide care which is appropriate to their current circumstances; and c) managerial: the patients' perceptions that they are receiving the different services in a coordinated, complementary and unduplicated way.

Finally, quality of care is related to clinical outcomes or practices equal to or higher than accepted standards, minimum waste and costs within legal and policy requirements and a satisfied patient experience. This definition covers the three dimensions of quality: management, professional and patient. Management-quality refers to whether the service makes the best use of resources, without waste, and operates within higher-level requirements. Professional-quality refers to whether the service is provided according to current best professional practice and processes, and results in optimal clinical outcomes. Patient-quality refers to whether a service exceeds patient expectations,

provides a satisfactory experience and meets standards of humanity. Each dimensions of quality can be assessed individually, but the overall view of the three dimensions provides a more specific definition of quality of care. Poor quality care is understood as outcomes, costs or experiences below accepted standards and norms. Poor process quality refers to provider actions or omissions that are likely to result in poor outcomes or that diverge from accepted good practice.

Despite strong efforts to implement integrated health care networks in Latin America, the question of the repercussions of these reforms in equity of access and efficiency remains unresolved. Research conducted so far is inconclusive regarding the impact of these reforms on population affiliation. Furthermore, there is almost no evidence that establishes if being affiliated translates into a higher possibility of accessing the services. Particularly remarkable is the absence of empirical studies analysing the impact on equity of access of the organisational changes in the Latin American health systems, including Brazil and Colombia. Finally, research on factors influencing continuity of care is scarce and has not generally been preceded by enough qualitative studies to clarify research questions. Hence, the need persists to enhance research and to establish methodologies allowing for the implementation of equity-oriented policies in health systems. This research was designed to increase our understanding of the impact on equity of access, efficiency and continuity of care of the implementation of integrated health care networks in different Latin-American contexts from the stakeholders' perspective.

Research aim

To analyse the impact of different types of integrated health care networks to a) health care access and b) health care provision efficiency, with particular reference to women's health in two Latin American countries: Colombia and Brazil.

Specific objectives
a. To analyse how equity in access and health care provision efficiency are approached by sector policies
b. To establish key actors' influence and opinions (policy makers, managers, health personnel and potential users) in relation to potential access to integrated health care networks
c. To find out the extent of and equity level in peoples' actual access to care, particularly to women's health care, adequate to their health needs from integrated health care networks and factors that determine it
d. To analyse the performance of different types of integrated health care networks relating to their final aims of continuity of care and efficiency, particularly women's health care and determine contextual and internal factors influencing it
e. To provide evidence for the development of evidence-based policy-making to improve access to efficient healthcare across and beyond study countries

To reach the objectives, the project has adopted an innovative multidisciplinary approach to health systems research and which is two-pronged: 1) a country case study, based on a qualitative study and a cross-sectional study and 2) a cross-country comparative analysis with multiple sources of evidence. Phase 1 compared the actual performance of integrated health care networks relating to access to services, continuity of care and efficiency, in light of the policy framework, and from the users and potential users' viewpoint; with a particular focus set on women's health care (using diabetes mellitus types 2 and breast cancer as tracer conditions). In Phase 2 an across countries analysis was conducted to determine factors and actors affecting the performance of integrated health care networks in each particular context.

This research contributes to FP7 SICA Health-3.5.2 by providing evidence on the implications of introducing integrated health care networks for equity in access and efficiency. In addition, the research develops and tests appropriate methods to assess the performance of health providers. Finally, results inform the development of policies conducive to better quality and more efficient health care provision and contribute to reducing inequities in access to health care by improving healthcare organisation in the publicly oriented health sector.

Description of main S & T results/foregrounds

This section includes the projects main results separated into seven chapters. First, the description of

Integrated Health care Networks (IHN) selected in each country, second the results on access to the continuum of care in IHN are presented, as well as their influential factors from the perspective of main actors. The third chapter summarizes the results on care coordination in IHN and factors influencing them, also from the perspective of main actors. The third and fourth chapter describes the results of a multiple case study of women with two tracer diseases: breast cancer (third chapter) or diabetes mellitus type 2 (fourth chapter) regarding continuity of care in IHN. The fifth chapter presents the comparative results of the performance assessment of IHN regarding access and quality of care in the tracer diseases. And finally, the seventh chapter summarizes the main results of the comparative analysis of the cross-sectional study regarding barriers in access to healthcare, determinants of health care utilization and the equity level of access to health care.

1. The Integrated Healthcare Networks (IHN) of the study

The study was carried out in two areas in Colombia; the district of Kennedy in Bogota and the municipality of Soacha; and in three municipalities in Brazil, in Recife, Caruaru and Paulista. In Colombia, four networks were selected; one contributory and one subsidized in each area. In Brazil, three networks were selected: the networks that provides care to the micro-region 3.3 of the Health District 3 in Recife, to the municipality of Paulista and of Caruaru.

Below, a description of the IHN analyzed is presented.

In Bogota and Soacha (Colombia):

IHN Case 1 (IHN 1-S) is made up of one insurer from the subsidized regime (EPS), a solidary health company, with a presence in 17 of the 32 departments in the country and organized in 3 regions-north, west and central-, and the network of health services contracted for Soacha. In the central region, which includes the departments of Cundinamarca, Boyaca, Tolima, Meta, Choco and Huila, there are 346,806 people affiliated, of which 10,163 are located in Soacha (Cundinamarca).

In Soacha, the EPS has only contracted the services of the first and second level of care (2 health providers (IPS), 1 municipal Social State Enterprise (SSE) and 1 departmental SSE). At the third level there are 8 IPS contracted (public and private) in Bogota; 4 in the area closest to Soacha. There are also diagnostic services contracted, the majority of which are in Bogota. All of the providers are external contractors.

IHN case 2 (IHN 2-S) is made up of a subsidized insurer of the subsidized regime, originally a family compensation fund that operated only in Bogota and in the surrounding municipalities of Cundinamarca, and the network of health services contracted for Kennedy. In 2010 there were 237,524 people affiliated, of whom 19,779 resided in Kennedy.

The public south-west network was contracted for Kennedy. Only those centers of the first level are found in the area, which consists of a district SSE. The centers of the second and third levels are outside of the area. For the second level, two IPS are contracted, and for the third, there is one hospital SSE specialized services with 3 third level (public) SSE, in other areas and 6 private IPS, 5 in the center of Bogota and one in a nearby area. Furthermore, there are other providers contracted for diagnostic services, in different areas of the city.

The IHN Case 3 (IHN 3-C) is made up of an insurer of the contributory regime (EPS), which was originally a family compensation fund that operated in Cundinamarca and more so in Bogota (98% (725,647) of those affiliated in 2011), and its network for Kennedy. In Kennedy there are 90,000 people affiliated.

In Kennedy, the insurer has its own ambulatory IPS for the first and second levels. Furthermore, there are 19 ambulatory IPS for the first and second levels outside of the area (8 of its own and 9 contracted). For the third and fourth levels, EPS has 8 private contracted IPS that are located outside of the area. Of these, just two are located in the south and center of the city. It also has contracted external providers for diagnostic and pharmaceutical support, located in Kennedy's ambulatory IPS and in the different areas of the city.

IHN Case 4 (IHN 4-C) is made up of an insurer from the contributory regime, originally a national insurance company, organized in four regions: Antioquia, Center, North and West, and the network in Soacha. In the center it is located in Bogota and some surrounding municipalities, such as Soacha, where there are 11,000 people affiliated.

In Soacha EPS contracts services for the first and for the second with a IPS. Urgent care and hospitalization services are contracted completely with IPS of the third and fourth levels located in Bogota (17 hospital IPS). EPS also contracts an external provider for diagnostic support and pharmaceutical providers that offer services equally in diverse parts of the city, one of which is located in Soacha.

In Pernambuco, Brazil:

IHN 1 is made up of micro-region 3.3 of Sanitary District III, located in the north-west part of Recife with 110,502 inhabitants (7% of the city) and made up of 8 neighborhoods. It offers first level services and those of second and third level.

In the area there are first level services available: 13 basic health units (BHU) with 27 Family Health Program (FHP) teams and 2 public basic traditional units (BTU) (68% of the population is covered by Family Health Teams (FHT) and 16% by Oral Health Teams (OHT) (8)). Second level care is offered in public services -2 multi-clinics, one ambulatory clinic specialized in women's health, of reference for DS III, and other centers of reference for Recife. These include one multi-clinic, maternity, 2 public hospitals (municipal/state) and 1 contracted hospital. Diagnostic support services are provided by contracted private providers for all of the municipality of Recife (9) (Annex 1). Third level care is offered in 10 state hospitals and 2 private, non-profit contracted hospitals.

IHN 2 corresponds to the municipality of Paulista, located 13 kilometers from Recife on the coast, with 300,466 inhabitants and with a geographic extension of 100 square kilometers. There are 24 neighborhoods, and there is the capacity to offer all of the services related to first and second level and a part of those of third level. In terms of first level, there are 34 family health units (46% of the population; 17% oral health). Second level care is offered at public municipal centers. There are two hospitals for third level of care (one is public and state owned and the other is contracted and private) (3). The rest are sent to other state hospitals.

IHN 3 is made up of the urban area of Caruaru, a municipality of the Pernambucan wild, 140 kilometers from Recife and distributed into 23 neighborhoods, with capacity for a complete service offering of first and second level of care and a portion of third level care services. First level has 27 FHT and 4 OHT. The services of second level are municipal services: 7 health centers, 2 multi-clinics, 4 specialized clinics, one maternity clinic, 3 hospitals and one emergency/care units (UPAS). For third level services there is one maternity clinic and one hospital, both state owned. Diagnostic support services are, for the most part, private and contracted.

2. Access to the continuum of care in the RISS and influential factors from the perspectives of the actors

This section presents the principal results of the comparative analysis of access to the continuum of care and the factors that influence the RISS of Colombia and Brazil, from the perspective of key actors: managers, health professionals, administrative personnel and health service users, both at the first level of care and specialized care.

Principal determinants of access were identified related to health policies, the intermediary role played by insurers in Colombia and in the case of Brazil, problems in the management of the networks. Finally, factors related to the health services were signaled out as well as those inherent to the characteristics of the population.

2.1. Factors related to health policies in Colombia and Brazil

In the discourses of the different interviewees, the way in which some of the policies adopted by the health systems of Colombia and Brazil determine access to both levels of care emerged with special

emphasis. While in Colombia the influence of insurance policies was highlighted, in the case of Brazil, the discourses were centered on the problems related to the financing of services.

2.1.1 Insurance policies in Colombia

Under the insurance model adopted in Colombia, in particular those elements that define coverage of the benefit plan, the establishment of copyaments and prorated fees (cuotas moderadoras) and the affiliation with the health insurance plan were considered to be factors that restrict access to health services with the most impact on the users of the subsidized networks.

In relation to the coverage of the obligatory health plan (POS), the existing differences in the benefit plans by type of regimen were described as problematic, as was the fragmentation of the POS by level of care and the exclusion of services, factors that-despite the intent to make the benefit plan equivalent- generate barriers to access to health services of the most vulnerable population affiliated with subsidized networks. Second, the existence of copayments and prorated fees was identified as another barrier to access to health services under the subsidized regime, in relation to non-POS-S events and consultation copayments for those with partial subsidies, and under the contributory regimen, the prorated fees that pay the working population that earns less income. However, it is recognized that the absence of prorated fees in the subsidized regime and exemption of copayments for people classified under Beneficiary Identification System (BISBEN) level 1 increase access for the most vulnerable population. Finally, in terms of the health insurance affiliation, the greatest impact was ascribed to the subsidized regime-in terms of restriction of resources to expand coverage. It was also ascribed to the existence of problems with identification of beneficiaries, the inexistence of a consolidated national database to properly track affiliates, and the transfers made by territorial entities between EPS, that took place without informing the population.

2.1.2. The Financing of health services in Brazil

In the discourses of the distinct informants of the three networks analyzed, the problem of financing emerges as a principal factor that impacts access to health services. In the case of the primary level of care, managers of the three networks attributed the problem of financing of health services to the insufficient transfer of resources by the federal and state governments. This leads to smaller municipalities or those further away not having the necessary resources to consolidate the actions of the Family Health Program (FHP), principally in terms of the contracting or sustaining family health teams over the long term. With respect to specialized care, users and managers, principally in Recife and Caruaru, signal that financial problems restrict the investment budget for public hospitals, which limits possibilities to improve infrastructure conditions and limits resources necessary for care of patients by more complex diagnostic teams.

2.2. Factors related to EPS intermediaries in Colombia

In Colombia, for the majority of informants of the IPS and users of the four networks analyzed, the mechanisms for control of the clinical practice and the supplier purchase models that have been established by the insurers suppose barriers that restrict access to health services.

Among the mechanisms for control of clinical practice, the informants signal the authorizations of clinical services and limits to the provision of services. Health professionals and managers of the IPS identify an excess in paperwork for the authorization of services that, when added to the lack of clarity in the law with respect to POS and non-POS provisions, translates into denial of services or into an increase bureaucratic procedures with the Scientific Technical Committees (CTS), territorial entities and service providers. This leads to increases in wait times and out of pocket costs, as well as the user’s loss of time, aspects that are disincentives to using the services. One problem identified exclusively by the informants of the subsidized networks is the existence of two entities responsible for guaranteeing care: the EPS for the POS-S services and the territorial entity for the non-POS. The user must submit paperwork with both entities to obtain authorizations, depending on the service required and the provider assigned. This leads to an increase in wait times for care. The second strategy for control of care in terms of the contributory networks, identified by health professionals of the external IPS and by users, is the existence of limits, both professional- by restricting the type and quantity of medication and diagnostic tests that can be prescribed- and numerical- in terms of

number of consultations per user within a given time period. These practices increase wait times and carry the risk of deterioration in the health of the patient. In terms of the purchase of services, the interviewees of the four networks signaled that insurers split the process of care into various sub-processes to be purchased from different hospitals, including within a single level of complexity (fragmented contracting). In the same way, they identify the frequent change of healthcare providers and the purchase of services outside of a geographic area as factors that restrict access to services by erecting obstacles to the provision of integral care to users, and by increasing paperwork and out of pocket costs for care.

2.3. Factors related to network management in Brazil

The principal problems related to the management of networks in Brazil as appointed by the informants are: the lack of coordination among municipal, state and federal governments in terms of the planning of network services, and the mistakes in the management and control of health service providers.

Related to the first problem, managers from Caruaru signaled the difficulties faced by the municipality, the state and federal government in the planning and financing of those services with greater levels of complexity (intensive care units, coronary care and some diagnostic support services) such that institutions can not rely on a well-defined budget. This restricts the possibility of providing services with the necessary resources. The second issue identified related to network management was the lack of management and control of the services offered by providers, both in the private and public sector. The informants of the three networks consider there to be noncompliance with the activities set forth in the contracts established with private providers, which privilege their economic interests. They also consider that there is prioritization of those users that belong to the health plans over those of the SUS. Finally, the informants of the three networks recognized the inexistence of an adequate process for control and management of professional contracts tied to the service networks, aspects that put into evidence the noncompliance with working hours that results from absenteeism, which leads in turn to the restriction of the hours of care for users.

2.4. Health factors related to health services characteristics

Both in Colombia and in Brazil, two types of factors were identified that were related to health services characteristics that influence the access to primary and specialized levels of care. On one hand, there are structural factors- among which the availability of resources for care and geographic accessibility -and on the other, organizational factors- which include mechanisms for scheduling appointments, wait times to obtain appointments, and the hours designated to healthcare. These two types of factors have the greatest impact on access to specialized care in the networks of the two countries.

2.4.1. Structural factors that influence access to the first level of care and specialized care

The supply of health services available at the first level of care in Colombia were positively described by the majority of informants, in contrast to Brazil, where they were signaled to be insufficient. In both countries, there was consensus in indentifying deficits in terms of infrastructure, human resources, and inputs necessary for care, especially in the urban slums in the study areas. In terms of specialized and hospital care, the discourses in Colombia and Brazil coincide in terms of the deficit in the offering of specialized care (medical attention, diagnostic tests, medications, hospitalization and emergency care) and human resources that impact the most vulnerable population in the three study areas. The lack of compliance with hours of service on the part of professionals at both the first level and specialized levels of care was particularly highlighted in the three networks in Brazil. This not only accentuates the deficit in professionals, it is a disincentive to health seeking and it results in congestion in emergency care services. In the contributory networks in Colombia, better availability of service offerings in the ambulatory IPS was signaled, and in terms of those in Brazil, some informants recognized that the existence of contracted services has improved the availability of specialized services and emergency care units in those areas where availability of services in the public networks is not sufficient.

Geographic accessibility of the first levels in both countries was valued as positive, except in the marginal areas of Soacha and in the networks analyzed in Brazil due to the subpar road conditions and the distance to services. The informants of the subsidized network in Bogota highlighted the existence of strategies to facilitate transport of the health center users as a facilitator of access. In the networks in Brazil, the existence of geographic networks that comply with georeferencing criteria and the existence of home care actions of the PSF were highlighted. In terms of specialized and hospital care, although problems concerning the distances in both countries were shown, there are differences in their causes. In Colombia the barriers are attributed to the inexistence of second and third level centers in the subsidized networks that are in proximity to the residences of those affiliated, and to the fragmented purchase of services by insurers outside of the geographic area. This results in greater distances travelled and transport costs for users. In Brazil the principal barriers were the great distances to the hospitals of reference and the small number of public transportation routes available, referred to by the informants of Caruaru and the residents of the marginal zones of Recife. Some informants highlighted the adequate geographic accessibility of hospitals and multi-clinics.

2.4.2. Organizational determinant factors of access to the first level and specialized care

In both Colombia and Brazil, the principal organizational factors that influence access to services are the mechanisms for scheduling appointments, the wait times and hours of service.

In the networks of both Colombia and Brazil, having to request an appointment in person, long lines and hours were identified as barriers. In relation to the call-center appointment mechanism in Colombia, although physical travel and lines are avoided, there are other difficulties for establishing effective communication. Finally, for appointments made online, provided for only in the contributory Colombian networks, restrictions were found in terms of the number of users who were able to access this mechanism.

One of the barriers to access that emerges most intensively in the discourse of the majority of the informants in Colombia and Brazil is the elevated wait time for scheduling an appointment, which is more critical for specialized care. The shortage of specialized services emerges as a cause of this problem. In any case, in Colombia the existence of mechanisms for control of clinical practice designed by insurers was highlighted as one of the principal strategies for restricting access to specialized care.

In terms of the hours of service, the majority of the informants of the 4 networks in Colombia find them adequate in the first level of care, ambulatory care, and in specialized and hospital care. Only a few of the informants in the subsidized networks identified weaknesses in the hours of service of some centers of the first level during the night and on weekends, which affects the working population and those who reside in marginal zones of the municipality. In Brazil, the unfavorable opinions about the hours of service for care established by the institutions emerged for the first level in the networks of Recife and Caruaru.

2.3. Factors related to the population

The lack of economic resources was shown to be the principal barrier to access to services related to the population in both Colombia and in Brazil. In the contributory networks in Colombia the low level of income emerges with less intensity, other limitations appear in the discourses of the informants, such as the difficulty in obtaining work permissions, the lack of family support in carrying out administrative tasks and transfer to health services.

Second, the majority of the informants of the networks in both countries point the lack of knowledge of health rights and appropriate use of services as a barrier to access, except for some health professionals in the Brazilian networks who consider it adequate. In Colombia there are two different opinions: on one hand, managers and service providers attribute it to the low sociocultural level of the users, and on the other hand, the users that consider insufficient the information provided by the services, particularly in the case of Colombian insurers. In Brazil, there is greater recognition of the gaps in information provided by the services.

3. Care coordination in IHN and the actors' perspectives about factors that influence it

This section presents the principal results of the comparative analysis of care coordination among levels of care and the factors that influence IHN in Colombia and Brazil, from the point of view of key actors: managers, health professionals, and administrative personnel.

This section first presents general opinions about care coordination in the networks analyzed. Later, factors that influence coordination related to the characteristics of the health system, organization of services and training of health professionals are presented, and finally, opinions about the mechanisms of coordination among levels of care as developed in the networks analyzed are presented.

3.1. Opinions about coordination among levels of care in the networks

All of the groups interviewed coincide in signaling limited care coordination, except in the ambulatory care centers of the contributory networks in Colombia, where it is perceived as good. In the Colombian networks, opinions predominate about the lack of informational coordination, while in Brazil, although these opinions are present, deficiencies in the coordination of patient access and in clinical coordination are also highlighted.

3.2. Factors that influence care coordination

In the discourse of the informants, factors emerge that influence coordination among levels of care in two areas: first, health system characteristics, and second, factors related to the organization of services and the training of health professionals.

3.2.1. Factors related to health system characteristics

In Colombia there is generally reference to the existence of market disincentives to the integration of care, and in the subsidized networks, to the fragmentation of the benefit package (POS-S). The majority of informant groups pointed out that the search for economic profit in the managed competition model gives an incentive to insurers to establish short-term contracts and the fragmented purchase of services in order to get a cheaper price. There is also a disincentive to providers to compete amongst themselves instead of collaborating, in the search for individual profitability.

In the subsidized network, the fragmentation of the benefit package (POS-S) supposes the existence of parallel networks for the care of a single patient that are not coordinated amongst themselves: the insurer network (services POS-S) and those of the Secretariat of Health (no POS-S).

In Brazil, the characteristics of the health system also refer to the existence of economic disincentives to network configuration, in addition to the insufficient capacity of the municipalities to develop their competencies in network organization and political party interests.

Many of those interviewed believe there to be strong incentives, for both public providers and convened providers, to denial of care services agreed to during the network planning (Box 2). The inexistence of technical municipal teams that are qualified prevents carrying out the planning and organization of the network, contracting and evaluation of services with private contractors, and the implementation of coordination mechanisms among levels. Those interviewed are of the opinion that the interference of political party interests leads to, among other things, the disorganized planning of the networks, due to the competition produced among different levels of government. This competition results in investment in new services for electoral ends, without the guarantee of the quality of care, and in the development of parallel service networks that do not coordinate with each other.

3.2.2 Organizational factors that influence care coordination in the service networks

The organizational factors that emerge are related to the working conditions that facilitate coordination, the existence of instruments in the networks that facilitate coordination, the integration

of levels in the same physical space, and the proper training of health professionals.

Working conditions that facilitate coordination among levels of care

Two models of hiring are indicated, with contradictory outcomes: the indefinite 8 hour contract, and different forms of partial and/or temporary contracts which are more and more extensive. For those interviewed, temporary employment leads to doctors' lack of motivation and attention to quality of care, and it elevates the rotation of personnel, making it more difficult to use coordination mechanisms. Interviewees of all of the networks highlight the lack of time for use of the mechanisms of coordination, related to different factors by country. In Brazil, it is related to the excessive work load due to the insufficiency of human resources and accentuated by missed work days due to the tendency to hold multiple jobs. In Colombia it is related to the "pay for production" of the professionals that provides an incentive to reduce the time for medical consultation with the patient. Finally, the pay for service of the professionals is signaled in some of the subsidized networks in Colombia and Brazil and is considered to be an obstacle to clinical coordination in that it acts as a disincentive for specialists to return patients to the first level in order not to diminish their income.

Existence of mechanisms for coordination among levels of care in the network between care levels

The presence of coordination mechanisms as a factor that facilitates coordination is signaled primarily by the interviewees of the ambulatory centers of the contributory networks, which are those that have used a greater variety of clinical coordination mechanisms – shared clinical records, expert system and clinical practice guidelines. These favor the interchange of information and knowledge of professionals, and as such the willingness to coordinate, the response capacity of the first level and consensus in shared care.

Integration of the first level and specialized ambulatory care in a single center

The majority of those interviewed from the ambulatory centers of the contributory networks are of the opinion that the provision primary and secondary care in the same establishment favors coordination between those levels of care. The managers indicate that it facilitates the implementation of coordination mechanisms, and the professionals indicate that it favors informal communication, team work, and mutual understanding and ties.

Coordination skills of health professionals

Improper training emerges in both countries as a factor that makes clinical coordination more difficult. The interviewees point to university training of doctors at the first level as insufficient to carry out the function of coordinating patients in the network. This is aggravated- according to the informants of the Brazilian networks- and subsidized by the lack of continuing education in the networks, both through ongoing training programs and through support by specialists. Particularly in Brazil, it is aggravated by the presence of inadequate profiles in the first level of care. This provokes errors in the referral of patients to specialized care for diagnosis and control of common chronic diseases due to the insecurity of the professionals, as well as the lack of counter-referral of patients to the first level because the medical specialists do not trust the technical capacity of the general doctors.

3.3. Opinions about the use of existing coordination mechanisms in the networks

3.3.1. Clinical coordination mechanisms

The mechanisms for clinical information transfer are those most commonly referred to by the informants of all the networks. Those interviewed from the ambulatory providers of the contributory networks also specifically signal the existence of mechanisms of standardization of skills (expert system) and work processes (clinical practice guides), for the coordination of clinical management.

Mechanisms for information transfer

The format of referral and counter-referral is the most important mechanism of clinical information

coordination identified by those interviewed in all of the networks in both countries. This instrument is utilized to transfer information in the transition of the patient from the first level to specialized ambulatory care. In a lesser way, the interviewees refer to the hospital discharge report as an instrument for transferring information from the first level through the hospital discharge, and in the transfer of patients admitted in urgent care to other levels. Only the ambulatory providers of the contributory networks- along with a few specialists- signal the existence of a shared clinical history.

Although in the discourse of the informants of both countries numerous difficulties emerge in the use of the referral and counter-referral formats on behalf of the professionals, there are important differences. In the Brazilian networks, the interviewees coincide in indicating the lack of a registry of clinical information on the part of professionals, and in Colombia informants signal that there is a registry of clinical information, but that it is not sufficient. In relation to the use of the hospital discharge report, in both countries the majority of those interviewed from both levels of care signal that it works better than the counter-referral of information from specialized ambulatory care. They coincide in highlighting the regularity in the delivery of the discharge report to the user. In any case, the majority of those interviewed in the networks of Brazil are of the opinion that the registry of information on the discharge report is incomplete, although with exceptions. The majority of informants in Colombia consider it complete. In terms of the digital shared clinical history (CH) in the contributory networks, although the majority of the health professionals are of the opinion that this mechanism improves the transfer of information between the general doctor the specialist by permitting the permanent availability of the clinical information of the patient in both levels, they also signal negative aspects. These aspects include the fact that it does not contain the information about hospital care and about some specialties that are not connected to the CH, and that the registry of information by the specialists is insufficient.

In light of these difficulties, the majority of health professionals interviewed in both countries signal the necessity of frequently questioning the patient in order to obtain information about past medical care (motive of reference, test results, treatments prescribed).

Mechanisms of clinical management coordination

The interviewees of the contributory networks highlight two important mechanisms: the expert system and the clinical practice guides. The expert system is also found in one of the networks in Brazil, but according to informants, it is still in the initial phase of implementation. The clinical practice guides are found in the subsidized networks, but only for specific processes such as maternal perinatal care, and they are only shared among public providers of the network.

Expert system

The interviewees of the contributory networks highlight the existence of a group of specialists for support to general doctors- expert system- through the organization of monthly or weekly clinical sessions. These sessions are carried out for the review of cases or topics, joint visits of patients, and the permanent advice in person or by phone with the objective of improving the diagnostic capacity of the first level and the avoidance of unnecessary referrals and diagnostic tests.

These spaces were valued as positive by the health professionals and managers through recognition that they favor communication among professionals, improve the response capacity of the first level, and help define criteria for the proper referral of patients. However, some health professionals identify a principal barrier to their use: the fact that they are not shared with the external hospital network, such that certain specialties are excluded.

Clinical Practice Guidelines (CPG)

The majority of those interviewed from the ambulatory providers of the contributory and subsidized networks highlighted the importance of the CPG for the coordination among professionals that intervene in a clinical process to orient the clinical management of pathologies and define the criteria for the remission of patients through different services. However, many of the professionals signal difficulties in their use such as the insufficient time professionals have for their revision and consultation, and the fact that there is little knowledge of their existence.

3.3.2. Mechanisms of administrative coordination

The patient referral centers

In all of the networks analyzed, the informants signaled centers that act as links to coordinate access of patients to network services as a principal mechanism of administrative coordination among levels of care. In the Colombian networks the objective of this mechanism is the coordination of referral of urgent care patients, hospital admission patient and transfers, while in the Brazilian networks, the aim is the coordination of access to any level of care of the network.

In relation to the operation of the referral centers, there are differences of opinion among informants of Colombia and Brazil. In Colombia, it is perceived by most managers as a facilitator for coordinating access between levels, which reduces the average waiting time for urgent referrals, and facilitates the transfer of clinical information between levels. However, some professionals from one of the contributory networks highlighted high wait times for the authorization of the referral. This was related to the location insurer referral center in another city, with little knowledge of the existing service network in Bogota.

In networks of Brazil, although some informants believe that the existence of patients referral center facilitates coordination of patient access in some aspects- such as programming and testing prior to consultation or transfer of clinical information between levels in the transfer of urgent patients- most respondents noted significant performance problems. These include 1) the lack of coordination of access of a significant portion of the services and population covered by the network, 2) referring patients to inadequate facilities by existing referral centers, 3) high wait times in the referral of patients, 4) inadequate scheduling of outpatient services, and 5) lack of coordination among the many existing referral centers within the same network, which interrupts patient referral and counter-referral between different units.

Given the difficulties of the workings of the patient referral centers, informants point to the widespread use of informal networks (friends) by service professionals to learn about the appropriate network service for referral of a patient or get a more effective service (bed, consultation, diagnostic test, etc.). However, many interviewees believe that this type of strategy is inequitable, since the referral does not depend on the patient's needs and does not respect the existing waiting list.

4. Continuity of care in Integrated Health Care Networks (IHN): a user’s case study of women with breast cancer in Colombia and Brazil

In this section we present the results of the comparative analysis of the perceptions of women with breast cancer in terms of continuity of care in Integrated Health Services Networks (IHN). Results are separated by each type of continuity of care: management continuity – a patient’s view about the provision of different types of health care in terms of how they complement each other and whether they are connected in a coherent way for a smooth progression of the patient through the system; relational continuity – a patient’s opinion of an ongoing therapeutic relationship with one or more providers that connects care over time -; and informational continuity - a patient’s perception of the availability and use of information about past events and personal circumstances by the physician.

4.1. Management continuity

In both countries, the results show the loss of continuity of care from diagnosis to treatment of the disease for different reasons.

None of the patients in Brazil and Colombia received examinations foreseen by the national protocols (breast ultrasound and mammography) until symptoms appeared, even when they were medically treated for other conditions. For instance, one Colombian patient, who underwent consultation for possible cervical cancer, had to wait 11 months until the breast cancer diagnosis because her doctor underestimated her complaints.

All the Colombian patients complained about excessive delays between the appearance of symptoms and the first consultation. Most Colombian users underwent a 6 to 14 month delay, due to neglect of symptoms perceived by the patient and/or lack of disease knowledge on the part of the provider.

In general, the delays incurred in getting these exams were more criticized in Colombia than in Brazil. In Colombia, due to limited availability of equipment and/or of professionals, most users had to wait 2 to 3 months for a diagnostic procedure. One Colombian patient had to wait for a biopsy for 8 months, and in another case, the biopsy was delayed by an additional month as the medical history had been lost and had to be rebuilt using archives and the memory of those involved. In Caruaru (Brazil), several women complained of out-of-pocket expenditure – in opposition to the free care principle of a supposedly universal health system – because the lack of equipment availability drove them to seek services in the private sector. Only in Recife could Brazilian patients get biopsy results in less than 40 days as specified by national standards.

In their search for radiotherapy, chemotherapy and surgery, most Colombian patients complained of an excess of administrative and geographical obstacles, inconsistency of available doctors (due to permanent changes in physicians contracted by private insurers), out-of-pocket expenditure, and unavailability of drugs.

In Colombia, patients incurred delays for cancer extension examinations (bone scintigraphy, chest X-rays, abdomen ultrasound) while the private insurers (EPS) were authorizing the doctors' requests. Three of them had to submit the authorization for the procedure to a Technical Scientific Committee. By contrast, in Brazil, the lack of radiotherapy equipment appeared as an obstacle to care in municipality of Caruaru. Lengthy waiting lists were frequent in this country.

With regard to chemotherapy, the fragmentation in multiple healthcare providers of IHN, in addition to the lack of geographical access, obliged patients to make lengthy trips – unlike in Brazil. Specialists also changed more frequently in Colombia.

The unavailability of therapeutic inputs for chemotherapy treatments obliged a patient in Colombia to interrupt treatment during 2 months and postpone starting radiotherapy for 5 months. This user also expressed problems in the treatment of orthodontic complications resulting from chemotherapy as it was not a procedure covered by POS.

Both Brazilian and Colombian patients complained of the poor management of side-effects of chemotherapy in emergency services and of out-of-pocket expenditure to buy drugs to control them. In Colombia, most of the users affiliated to the contributory IHN perceived emergency department waiting times as lengthy, and they had to pay out of pocket for the prescribed drugs that were not available to the health care provider (IPS). In Brazil the majority of patients with nausea (as a consequence of chemotherapy) had to purchase medication.

Both Brazilian and Colombian patients positively assessed the treatment flexibility as an adaptation to interrelated problems. However, there were numerous complaints about weaknesses in communication, deficit in coordination and insufficient collaboration between care providers. In both countries, disagreements between specialists about diagnosis tests, alternative treatments and management of complications of the disease were frequent, and the opinion of family doctors / GPs was generally dismissed.

4.2. Relational continuity

Most of the Colombian and Brazilian patients expressed a lack of mutual trust / poor patient relationship with the oncologist. Specifically, they felt a lack of trust in asking questions and expressing doubts about the disease and the treatment, in contrast to what happened with the surgeon, who optimized the management of post-surgical complications. Just one user of the contributory IHN had the perception she belonged to a medical team made up of the breast surgeon, oncologist and gynecological oncologist.

Regarding consistency of personnel, in Colombia the interviewees mentioned the large number of

care givers, even within the same medical specialty, due to fragmented purchase of services by the insurer. In Brazil, they mainly described lack of staff stability in the first health care level. In contrast to international standards of care quality, in none of the countries were general practitioners involved in the care delivered at the specialty / hospital level.

The lack of stability of Colombian professionals appeared in the high number of care givers allocated to the same function within the same health care tier, which put a strain on the quality of care in the subsidized networks. In Brazil, both in Recife and Caruaru, the oncologists were the same across the 2 years of treatment, which is why the patients considered that their stability favored mutual trust with professionals.

4.3. Informational continuity

All the Brazilian patients, and only some of the Colombian patients referred to the fact that the specialists giving them care showed interest and concern for their cases and were familiar with their socioeconomic circumstances.

In none of the three Colombian networks studied were electronic clinical records nor the exchange of information between specialists deemed sufficient. In Brazil, the interviewees highlighted the absence of counter-reference information for first line doctors. According to the patients, this situation generated mistakes in the availability of clinical information at the time of the consultation, obliging them to reconstruct clinical information at each point of contact with new professionals.

In the contributory network analyzed in Colombia, shared clinical histories existed in the ambulatory IPS, but they were not used by all of the professionals in charge of specialized care. Therefore, there were differences in users' experiences: for those professionals who used the shared CH, there was no need for the transfer of documents by the users, there was greater knowledge of the case on the part of professionals and less risk of forgetting relevant clinical information.

In Colombia, many of the interviewees considered the information provided to patients by their oncologists to be deficient, and in Brazil such information was considered adequate. The interviewees referred to mistakes in the information given regarding disease characteristics, the indicated treatment and the care and management of cancer, in part due to the fact that they were attended to by different professionals, belonging to different institutions. This led to beginning treatment without knowledge of its scope, side effects or possible complications.

In Brazil, users received information on oncology concerning how and which services to go to in case of emergency, the nature and consequences of the treatments to be carried out, and how to readapt to their lives.

5. Continuity of care in Integrated Health Care Networks (IHN): a user's case study of women with diabetes mellitus in Colombia and Brazil

In this section we present the results of the comparative study of the integrated health services networks in Brazil and Colombia with respect to the continuity of care for women being treated for type 2 diabetes. The principal results of the study are grouped by the dimensions of continuity of care: management continuity, relational continuity and informational continuity.

5.1. Management continuity

The revision of the users' clinical records shows that for the majority, the diagnosis was made during the investigation of other diseases or during the emergency visit, as a result of metabolic decompensation. Despite the fact that some users had made a medical visit to the first level of care before the first symptoms, on these occasions the disease had not been detected. The majority of users signaled that the delay in the diagnosis and initiation of treatment had subjected them to a prolonged period of withstanding diabetic symptoms and the development of complications.

The clinical management of diabetes in the users of the Brazilian networks and the subsidized

networks in Colombia was carried out at the first level of care, while for those affiliated with the contributory regime, it was carried out in specialized care.

The users of both countries signaled different factors in terms of the time of programming of the visits for management of the disease and in continuing with the treatment prescribed by the professionals that resulted in the lack of continuity in the care for the disease.

In both countries and in both levels of care, women had difficulty in the management of medical appointments. The users of the Caruaru network and of the subsidized networks in Colombia perceived elevated wait times for a medical visit at the first level of disease management, although only the latter signaled that this was the consequence of the lack of continuity in care due to medical prescriptions no longer being valid. In terms of the tests related to disease management, the Brazilian patients indicated elevated wait times for obtaining results, which resulted in some users in Caruaru having to pay for the tests from private health services in order to accelerate the results and the return visit to the clinic.

For specialized care, all the users indicated elevated wait times for programming specialist visits. In some cases this caused them to abandon the search for care or to visit urgent care (emergency care units), when their health became worse. The Colombian interviewees indicated that the authorizations required by the insurers in order to receive care by a specialist had increased wait times even more.

With the exception of the users affiliated with the contributory regime that received care by providers contracted by the networks (external IPS), the majority of informants highlighted difficulties in the partial filling of medical prescriptions. In Brazil, this did not result in interruptions in treatment because the users could purchase the medications that they had not received, or because the services had notified them prior and reserved medications. In Colombia, some users could continue with their medications, either they could buy them individually or use family members' medication, but for others this resulted in the suspension of their treatment due to lack of funds to acquire medication.

In terms of the inputs for the control and management of the disease such as needles, strips, syringes or insulin, the users in Brazil and those of the contributory network indicated that they received these inputs, albeit with difficulty, while those affiliated with the subsidized networks mentioned that they were excluded from the Mandatory Health Plan (POS-S).

Finally, the majority of the users related difficulties related to geographic access – great distances and the lack of money to pay for transport to the services – which made it difficult or even impossible for patients to get to the centers. In the case of the Brazilian network users and those affiliated with the contributory regime, the centers of the first level of care, and the subsidized users of both levels, this barrier made it impossible to visit the doctor for follow-up care. It also resulted in the interruption of treatment and abandoning services of medium and high complexity, forcing the use of urgent care services when care was absolutely necessary.

Regarding to consistency of care, the majority of the women who received care in the Brazilian and Colombian networks identified the lack of shared planning between professionals at different levels for treatment and complications. They also considered insufficient the monitoring tests carried out every six months and indicated that some tests were repeated when they changed from one service to another.

In terms of the flexibility of care, some users of the networks in Brazil and those of the subsidized networks in Colombia suffered decompensation and a reduction in the effectiveness of the medical treatment received. Treatment was later adjusted or modified by the doctors doing the monitoring or by the urgent care services where they received care. In one case of some users of one of the subsidized networks in Colombia, alternative medication was not prescribed for meiformina intolerance.

5.2. Relational continuity

The Brazilian users identified the professionals at the first level of care as those responsible for the

management of their disease; the users of Colombian subsidized networks identified professionals from both levels, and those of the contributory networks identified the specialists who had provided them care.

In terms of the consistency of personnel, with the exception of the users of the contributory network, who indicated that they always received care by the same specialists, users signaled frequent changes in the teams; in Brazil, this was specifically related to specialists. The users perceived that the lack of stability of the teams made it difficult to establish a relationship with the professionals.

5.3.3. Informational continuity

Users of both the Brazilian networks as well as those of the subsidized networks indicated the use of informal mechanisms (phone calls, written notes) and formal mechanisms (reference letter) for the transfer of information among levels of care, predominantly among the first levels. However, they signaled that their use was not sufficiently adequate or systematic on behalf of those professionals. The informants indicated that the principal deficiency is to be found in the transfer of information from specialists of the first level of care, who give the responsibility for transfer of information to the patient. Only the users of the contributory network in Colombia signaled the existence of a shared clinical record among the professionals of the first level and of specialized care.

There were differences in the perceptions of women of both countries in terms of the cumulative knowledge of professionals of the first level regarding their personal contexts and values etc. In Brazil, users informed that the professionals showed interest in their cases, were familiar with contextual family factors and the expectations for treatment, while users of the Colombian networks signaled the lack of interest of the professionals including after suffering complications and hospitalizations. In relation to the specialists, in both countries users indicated that consultations of professionals took place exclusively in clinical care and were limited to prescription of medication. Only the users of the contracted provider of the contributory network (external IPS) related that the psychologists and social workers gained profound knowledge of their context and their expectations for treatment.

6. Performance of integrated health care networks in two tracer diseases, diabetes and breast cancer

This section presents the results of the performance assessment of integrated health care networks (IHN) regarding access and quality of care in two tracer diseases: diabetes mellitus type 2 and breast cancer.

6.1. Performance of IHN in diabetes

Indicators of quality of care were defined for diabetes patients: 1 sample of 50 patients in Recife, 3 samples of 50 in Bogotá, 1 from the subsidised regime (S) and two from the contributory (C) one. Diabetes patients in Brazil consult less and are seen by more different doctors, and virtually never by nurses. In Colombia, patients in the subsidised regime see more primary care physicians and fewer specialists, and only one contributory network involves nurses in care of these chronic patients. In both countries, the glycohemoglobine test, a key element for control of diabetes, is performed far too infrequently, especially in Recife and the subsidised regime in Colombia. Albuminuria is almost never controlled in Recife and the subsidised regime in Colombia and only in one third of patients in the contributory regime, and visits to ophthalmologists are rare. Another important indicator is counter-referral, which was extremely rare in all 4 samples. In the contributory regime in Colombia, electronic clinical records exist for part of the specialists and so a counter-referral may not be needed. In Brazil physicians claim they communicate with colleagues by cell phone; this claim could not be verified (see Table 1 in Annexe).

As regards indicators of result for quality of care, IHN 4-C shows half of patients with values of HbA1c below 7%; the other three networks had almost no patients with values below this threshold. For blood pressure, the research found about one third of patients with values below 130/80 mm Hg. For total cholesterol, values fluctuated between 30% and 70% of patients below the normal concentration of 200 mg/dl (HDL and LDL are more relevant indicators but were not tested in most

patients). Body Mass Index was uniformly too high, above 25 kg/m2, in most patients.

Due to lack of data, it was not possible to determine how many patients had complications at the time of the initial diagnosis, a potential indicator of access.

Three basic indicators for diabetes control are summarised (Figure 1 in Annex): glycohemoglobine, blood pressure and total cholesterol. The IHN in Recife and the subsidised IHN in Bogotá show markedly worse results, especially for glycohemoglobine, admittedly with a very small number of tests (11 and 6 HbA1c tests respectively, see Table 1).

6.2. Performance of IHN in breast cancer

Indirect indicators for analysing the performance of IHN in breast cancer comprised quality of care (e.g., patients with at least one mammography per year; patients with three or more visits by the same specialist) and more importantly access to IHN (e.g., delay between primary care visit and first specialist visit; delay between first specialist visit and biopsy request, etc.). There was one sample of 60 cases in Recife and two samples of 59 and 50 patients respectively in Bogotá (see Table 2 in Annexe)

As regards quality of care, there was good stability of personnel, in most cases the oncologist. Very few breast echographies were implemented in Colombia, many more in Brazil. The subsidised regime in Bogotá offered mammography to just 15% of patients, in sharp contrast with Recife and the contributory regime in Recife, both with more than 70%.

Stage of the breast cancer at initial diagnosis is a good measure of access to health services and coverage of preventive screening in the target female population. In both countries, but particularly in Brazil, a large number of clinical records did not register this indicator. For the patients with this data recorded, Recife did much better (over 75% detected in stages I or II), with the contributory regime in Colombia in second place and the subsidised regime in a distant third place, with no less than 63,2% of patients detected in stage III (Figure 2 and Table 2 in Annexe).

Access to specialist care and, within this secondary level of care, to different specialists and tests is measured by the time interval between first visit at primary care and specialist care, and between first specialist visit and onset of treatment. These delays had a non-Gaussian distribution and results are thus presented as medians. Here the findings (Figure 3 in Annexe) show problems in the SUS of Recife: the delay is long, 4 months between specialist visit and treatment. In the subsidised regime in Bogotá, the interval between primary care and treatment is a high median of 240 days. This data is not available for the Recife network. The exact number of days between each phase of the patient pathway and onset of treatment, including delay for request, implementation and registry of tumour biopsy is represented in Table 2 (Annexe).

Potential impact and main dissemination activities and exploitation results

1. Strategic impact

The project addressed the objectives of the FP7 Cooperation Work Programme: health for Specific International Cooperation Actions (SICA) of supporting research in order to provide a scientific base for International Partners Countries to improve their health services delivery, including aspects of accessibility, efficiency and quality of care.

1.1 Contributions towards FP7 Cooperation Work Programme: health for Specific International Cooperation Actions impact

The project focused on a SICA topic -Universal and equitable access to health care-, and aimed to contribute to the expected impacts by generating evidence on the links between different types of Integrated Health care Networks (IHN) policy and variables such as equity of access, continuity of care, coordination of care and quality of care in Brazil and Colombia, taking into account users and potential users viewpoints.

To address its objectives this multidisciplinary research focused on aspects relating to:

a) equity of access; access to continuum of care from social actor's viewpoint; health sector organisation; interfaces of different providers, including primary and secondary level;
b) performance evaluation;
c) women´s health (breast cancer) and chronic diseases (diabetes);
d) evidence-based policy decisions relating to accessibility, equity, and quality coverage in the health sector.

Calls for a better integration of health care delivery systems, as a means to address equity of access and efficiency have appeared worldwide. But there is not enough evidence on the impact of the introduction of IHNs. Indeed, an extensive literature search revealed an appalling lack of information on important aspects such as progress toward universal access through comparisons on accessibility in different subsystems (public, private not-for-profit and private for-profit) and analysis of equity of access and efficiency of the different types of IHNs that have arisen from the health reforms promoted by national governments in Latin America and multilateral institutions. The perspective of key social actors involved in the reform processes has not been taken into account in most previous research. This research aimed to help filling the evidence gap to support health policy making by providing
a) evidence on key actors´ and factors´ influence on potential access to IHN; equity level in people's actual access to care, adequate to their health needs from Integrated Health care Networks; performance of different types of IHN relating to their final aims of continuity of care and efficiency;
b) evidence-based policies to improve access to high performance healthcare.

Thus, this project had direct relevance of public health policy of the European Community by generating new knowledge relevant to social and economic issues. This project has contributed to European Policy Framework priorities in health for best returns into health outcomes and poverty reduction. In particular, it has contributed to the strengthening of health systems by analysing their quality, effectiveness or performance and equity of care, and the establishment of outcome based targets and an effective monitoring system.

1.2 Contributions towards achieving the Millennium Development Goals

The research contributed to the SICA support towards Millennium Development Goals (MDGs) –also reflected in the EC Policy Framework- goal 3 on gender equality and the empowerment of women, through the case study and medical records review for female breast cancer.

Achieving health-related Millennium Development Goals (MDGs) crucially depends on people having access to health care to meet their health needs. Thus, in Latin America and the Caribbean there is an urgent need to reduce the great inequities in health-care access and outcomes as a condition for achieving the MDGs. Although the Latin American countries differ in terms of health situation relating to Millennium Development Goals, they face common challenges to meet the commitments undertaken: a faster progress towards a substantial reduction in health inequalities, progress with respect to universal health-care coverage under social protection schemes and an improvement of the quality of resource allocation. With this aim, the PAHO highlights among the guiding principles for health policy: improving equity and extension of social protection in health; strengthening health systems capacity to respond to the needs of the population, among others, by building-up a network of services to make the universal right to health a reality, and ensuring continuity of care between different levels and subsystems of the health system.

The achievement of Millennium Development goals in any country is critically constrained by policy-makers ability to develop appropriate health policy. Often driven by the international agenda and wider contextual factors, the process of health policy-making is not always integrated, evidence-based or inclusive of key stakeholders. Greater understanding provides governments with stronger evidence and clearer criteria upon which to make decisions concerning both the process and content of policy to reduce inequities in health and promote more efficient Integrated Health care Networks.

The project facilitated promotion of evidence-based policies for the emergence of better quality and more efficient health care providers networks by developing and disseminating specific policy guidelines. These lessons, in turn, will benefit national efforts to reduce inequities in access to health

care by improving health care organisation in the publicly oriented health sector.

1.3 Contributions to national research agendas

The research addressed priority interests on the national research agenda of study countries Colombia and Brazil:

- In Colombia, the Ministry of Health and COLCIENCIAS has included research in public health as one of the action lines of the National Programme of Science and Technology, looking, amongst other issues, at evidence-based strategies to reduce maternal and infant mortality, to improve equity of access and develop integrated health care models. Research into and improvement of Integrated Health care Networks is a priority for the Health Secretariat of the Bogotá District.

- In the field of Health System and Policies, the Brazilian Ministry of Health defined research on health system organisation as a priority research area, with emphasis on integration of services, regionalisation, intersectorial coverage, access and continuity from user's perspectives.

The research addressed the important lack of knowledge on relevant aspects regarding the impact of the introduction of IHNs in the health systems, a widely promoted policy in Latin America. At the same time these aspects constituted priority research areas in the two countries of study.

1.4 Research capacity building and building networks

The project contributed to research capacity building and building networks.

a) Research capacity building
The development of research capacity in the partner countries formed an important project component. This enabled partner research institutions to identify priority issues on equity of access and IHN, carry out research in areas identified as priority research areas in health system development in their own countries, and develop their abilities in getting evidence into policy in practice, in order to build a basis for enhanced knowledge-development in their countries.

The project aimed at developing the research capacity at least in three domains: through EU-LA cooperation between paired institutions, amongst European research institutions and, amongst LA research institutions. This was mutually beneficial for European and Latin American countries.

In both countries, several junior researchers were long-term involved in the project, trained in theory and practice.

b) Building networks
The research brought together a diverse range of interest groups concerned with health sector organisation at local, national and international levels: policy makers, civil society groups, health providers. These collaborative links established in each country will continue after completion of the project, and will be strengthened and widened in the Equity-LA II project with new partner institutions in Argentina, Uruguay, Chile and Mexico.

These links together with capacity building activities have increased capacity for evidence-based policy making aiming at reducing inequities in health care, and improving efficiency and continuity of care in the involved countries. At the same time it has contributed to open up the European research area to outside collaborators.

1.5. European approach

Policy lessons were also relevant to EU countries. Improving access to, and efficiency of, health care provision by introducing different ways of organising the health sector, such as integrated delivery systems has attracted increasing interest worldwide. In many countries around the world, including Europe, there is a growing awareness of the need for integrated care. Countries are faced with an

increasing number of people suffering from complex health problems that require co-ordination of multiple agencies, professionals and financial streams. Co-operation between different levels of care providers is considered a remedy for fragmentation and discontinuity and it is also expected that integration will contribute to cost reduction and quality of care. Consequently different initiatives have evolved, also in Europe, such as the growth of networks of health care providers or the introduction of integrated care programs. In particular research results may be of importance for European countries: Spain, and especially Catalonia is implementing integrated delivery systems; France is going through a lengthy reform process trying to streamline health care with the " médecins traitants"; the UK would seem to have by far the most Integrated Health care Networks but is experimenting with contracting out to the private sector; and Belgium has some experience with comprehensive care delivered by family doctors and multi-disciplinary teams (maisons médicales), and is testing integrated local care systems.

1.6 Steps implemented to bring about the impacts

To bring about above described impacts, the research project undertook the following steps:

A) Production of evidence on different types of Integrated Health care Networks' impact on equity of access and efficiency

The project has produced new evidence about and research methodologies for Integrated Health care Networks, such as:

1. New knowledge on the impact of the introduction of IHN reforms on equity in access; the extent of people's actual access to care adequate to their health needs from IHN; how contextual factors influence access to and performance of Integrated Health care Networks; the performance of IHN relating to coordination of care and quality of care, particularly in the tracer diseases diabetes and breast cancer; the factors and actors that may hinder or enable the contribution of IHN to improving health care equity of access and efficiency; and a better understanding of the gender needs, but also gender barriers that are linked to social structures and health systems in order to contribute to reduce gender inequalities (specifically through the study of female breast cancer)

2. Evidence for policy makers to promote the emergence of better quality and more efficient health care providers that will benefit national efforts to reduce inequities in access to health care by improving health care organisation in the public health sector.

Policy recommendations have been put forth in the "guidelines for policy makers", produced both in Spanish and Portuguese:
• to strengthen policies that aim at improving equity of access and health care efficiency.
• in Brazil: solve the main problem of the SUS, which is long waiting lists, in primary care as well as for specialist consultations and diagnostic tests
• in Colombia: align incentives for care coordination between primary care and specialist care. This may require eliminate intermediaries, the insurance companies which do not seem to contribute anything positive to the health system
• in both Colombia and Brazil, to improve strategies for coordinating health care that take into account the identification, by all actors involved, of critical factors that influence continuity of care. This is intended to improve the performance of access mechanisms in place, or to generate new alternatives seeking consensual solutions.
• to develop better strategies to ensure that the views and experiences of users relating to continuity of care and access to health services are taken into account;
• to set up or improve training programmes directed at strengthening management skills to support integration in the health system.

3. Development of health services management know how and testing of research instruments to analyse and monitor factors and actors influencing health services performance.

To improve insurance and delivery system regulations and to make health services work better, policy makers and health providers must invest in efforts to measure systems' performance and to inform the public on it. Information about the performance of providers is essential to preserve the health care system and to protect the citizen's rights. The project has shown that monitoring of essential indicators of adequate control of diabetes is paramount. Equally important is monitoring of diagnosis-treatment interval in female breast cancer (and all other cancers).

This research project has significantly contributed to efforts for providing tested methods, tools and standards to evaluate the performance of IHN. The final aim was to assist governments (in their stewardship role) in their attempts to develop effective ways of not only measuring system performance, but also in using this knowledge to improve health systems' performance. A tested methodology, with tools, indicators and standards to monitor IHNs performance was delivered in the last phase of the project as a result of a literature review and research carried out at country and cross-country levels.

The performance evaluation framework and standards was derived from the following principles:
- establish measurable goals on universal and equitable access, continuity of care and performance in tracer diseases diabetes and breast cancer based on national targets.
- include measures of system operation based on process variable focus on sub-populations, including those at higher risk, with particular attention to women
- ensure data availability and quality
- ensure patients' perspective is included in the framework and measures
- provide reports that were comprehensible and meaningful to targeted audiences at different levels

Specific measures and strategies were suggested in the following areas: (1) access to adequate health care services, in both its potential and actual dimensions; (2) management, relational and informational continuity; (3) coordination of care, (4) and performance of IHNs in tracer diseases. For the latter, a combination of process and outcome indicators was used to measure coordination and quality of care.

The framework and measures developed provided tested tools for measuring health organisations' performance; to be used, for example, in purchasing agencies' information systems to support the evaluation of health care provision or in benchmarking initiatives to compare results among (competing, like in Colombia) providers and insurance companies.

B) Development of research partnerships with Latin American countries

In order to conduct this research, it was necessary to develop strong scientific partnerships between European and Latin American countries on basis of mutual interest, as considered in SICA's objectives, to generate and exchange knowledge needed to contribute to provide a scientific base for ICPC to improve their health systems. This has really been achieved by:

a. Research design. In the way it was designed, the research contributed to research ownership by Latin American countries, establishing links between them, and also with the European countries. The project contributed to sustainable development and to strong North-South collaborative links. Within both groups this collaboration should persist following the project's culmination, and is now assured through the on-going implementation of the Equity-LA II project.

b. Improving the research capabilities of universities and research institutions in the field of health systems research and health policy analysis in Colombia and Brazil. Not only by training and research experience, but also by establishing collaborative links within and among participating countries. There was a particular emphasis on improving capabilities to getting research results into policy and practice, and in the process many junior researchers were trained and actively involved in the research in its different phases.

c. Interacting through the research process, the project enhanced the collaboration between these research/training institutions, health service providers, policy makers, and civil society organisations involved in the project. Every research institution involved in this project has long-standing agreements with the Ministry of Health of its own country and with local health institutions. In

Colombia health services users organisations were members of the national scientific committee.

d. Involvement, from the very start, of policy makers, and other stakeholders, such as health providers and academics in the research process of diagnosis and identification of solutions of problems in IHNs facilitated the process of moving from diagnosis to action and getting research results into policy.

e. Fostering social ownership of the knowledge generated by the project. This has been achieved, in addition to involving key social actors, through the wide dissemination of results using materials and means appropriate to different audiences (including, meetings, workshops, round tables, short reports, scientific papers, conferences, etc.).

f. Contributing to further development of collaborating links between European and Latin American countries and within both groups, opening up avenues for future scientific and technological collaboration (see start of Equity-LA II August 2013). The involvement of PAHO (Pan American Health Organisation) and the coordination with other international agencies and networks guarantee dissemination of results beyond the two Latin American Countries

g. The participation of an international scientific committee, which contributed to the scientific excellence of the research process and at the same time to dissemination of results.

h. The gender mainstreaming strategy adopted by the Commission formed the basis for integrating the gender dimension in the project. Gender equality and the empowerment of women were addressed in two ways: in the process of research, encouraging gender balance in all committees as well as in researchers, data collectors and analysts, and in the substance of research, contributing to enhanced understanding of gender issues regarding management of and access to health care; female breast cancer was taken as study case and as a tracer disease foe measurement of performance of IHNs. Women were the immense majority of the researchers in the Equity-LA project, with the exception of the ITM team.

C) Utilization of the evidence produced by the research (Equity-LA) in policy-making: GRIPP, getting research into practice

In order to get an impact on health systems performance, special emphasis has been put on getting research results into practice. Thus, all Latin American research teams have long-standing collaboration links with the Ministry of Health of their country (Colombia) or their health secretary of state (Brazil). In addition, a strategy was developed from the very beginning of the project taking into account factors identified as enhancers of health research utilization in policy-making: the interactions across the interfaces between researchers and policy-makers, the role of policy-makers as “receptors”, and the need for careful priority setting. From the beginning, there have permanently been publications of research results through the Webpage.

Policy guidelines were produced in order to ensure that research results inform policy making. These guidelines included strategies on: policy advocacy, involvement of stakeholders, use of evidence.

Users of research results included European Commission (represented in the international scientific committee), Health Ministries and Public Health institutes of Members States, international and national policy makers and other stakeholders (e.g. WHO/PAHO) external funding agencies; local Integrated Health care Networks to improve their efficiency and access procedures for health care users; finally, the results can be used by scholars to enhance understanding of the relationship between efficient Integrated Health care Networks and access to health services, on the one hand, and health sector organisation and development in developing countries on the other. Most of the researchers in the project had and have academic teaching tasks and applied the generated knowledge in their training courses.

2 Dissemination of research results

Work package 5 was dedicated to knowledge management, with a strategy for dissemination of the results of the Equity-LA project. This included different mechanisms, involving all stakeholders,

in order to promote greater public engagement and dialogue.

2.1 Knowledge Management

In order to make sure that the maximum number of results became available for the benefit of society, the results of the project - research papers, peer-reviewed journals, policy recommendation guidelines, short reports, a book and other relevant publications- were made widely available by disseminating them in all relevant areas. Mechanisms for dissemination were:

a. Round tables in Colombia and Brazil to bring together researchers and a variety of local and national interest groups (policy makers, managers, and civil society organisations).
b. Meetings and workshops (with brief summary reports) of key findings and policy recommendations to local and national interest groups as a tool for improving integrated delivery systems' efficiency and access.
c. Participation in regional and/or international meetings concerned with health sector organisation and policy, to disseminate methods and findings for comparative research in other countries, relevant to donor agencies and other governments.
d. Short reports and research papers in peer-reviewed journals and other relevant publications for dissemination among the academic communities.

Five papers have been submitted to peer-reviewed journals:

- "Determinantes de utilización de servicios del SGSSS y SUS en municipios de Colombia y Brasil" (Determinants of the use of health care services of SGSSS and SUS in Colombian and Brazilian municipalities) has been submitted to the Pan American Journal of Public Health.

- "Barriers in access to healthcare in countries with different health systems: a study in municipalities of central Colombia and north-eastern Brazil" has been submitted to the journal Social Science & Medicine.

- "Regional-based Integrated Healthcare Network policy in Brazil: from formulation to practice" has been submitted to Health Policy and Planning.

- "Inequities in access to health care in different health systems: a study in municipalities of central Colombia and north-eastern Brazil" has been submitted to the International Journal for Equity in Health.

- "Integrated Healthcare Networks in Brazil and Colombia: their performance in two tracer diseases, diabetes and breast cancer" has been submitted to the International Journal of Integrated Care.

a. Building networks of key contacts among relevant organisations (academic, governmental, non-governmental, civil society, including users' organisations etc.) in Colombia and Brazil and other Latin American countries and international agencies, such as the PAHO, World Bank, WHO, EC etc. and coordinating with already established networks like ALAMES and IDESAL.
b. Shortly, publication in Colombia and Brazil of a book, with the main findings of country case studies as well as an analytical framework and tools to analyse health care organisations and access to health care. The draft of the book is ready, effective publication planned within 6 months.
c. Integrating research results into capacity building processes in research and training (in related areas) at the health services and training institution levels.
d. Policy guidelines have been produced in Spanish and Portuguese, to ensure that results inform policy making. These guidelines include findings and recommendations on access, coordination of care, continuity of care, and performance of IHNs.
e. The International Conference held in Bogotá, 15-16 August 2013. As informed in Delivery 5.2, this conference gathered about 200 participants from Latin America and Europe, a total of 9 countries from both countries. Final results of the research were presented and debated and commented by distinguished public health specialists.
f. Meetings with managers of insurance companies and health services providers, public and private, in Colombia: 29 of these meetings are planned in the coming months, to inform of the results of the

research in theses IHNs that were the object of the research
g. Meetings with authorities and health services managers in Recife and Caruaru, to give feedback to results of the research in these IHNs. Activity planned in the coming months, till April 2014: presentations of results to health professionals, students, academics, in meeting of FIO-CRUZ and Pernambuco University, to a total of about 600 persons in 10 different settings.

Address of project public website and relevant contact details

1. Project website

A specific project website has been set up: www. equity-la.eu. This website includes general information about the project such as research objectives, methods, working plan and beneficiaries, as well as past and ongoing dissemination activities (seminars, conferences, publications, etc.). Furthermore, the news section informs about upcoming events and recent publications. Its content is available in English, Spanish, Portuguese and Catalan.

2. Contact details

Consorci de Salut i Social de Catalunya (CSC)
Health Policy Research Unit
Av. Tibidabo, 21; 08022 Barcelona; Spain
www.consorci.org
Project coordinator and Principal Investigator: M. Luisa Vázquez (mlvazquez@consorci.org)

Prins Leopold Instituut voor Tropische Geneeskunde (ITM)
Nationalestraat 155; 2000 Antwerp; Belgium
www.itg.be
Principal Investigator: Jean-Pierre Unger (jpunger@itm.be)

Colegio Mayor de Nuestra Señora del Rosario (Urosario)
Escuela de Medicina y Ciencias de Salud
Carrera 24, No. 63 C – 69; 11001 Bogotá D.C.; Colombia
www.urosario.edu.co
Principal Investigator: Amparo Mogollón (amparo.mogollon@urosario.edu.co)

Fundação Universidade de Pernambuco (UPE) ; Centro de Pesquisas Aggeu Magalhães (FIOCRUZ); Instituto de Medicina Integral Prof. Fernando Figueira (IMIP)
Av. Professor Moraes Rego s/n. Campus da UFPE – Cidade Universitária
CEP: 50670-420; Recife/PE; Brasil
www.upe.br
Principal Investigator: María Rejane Ferreira da Silva (rejane@cpqam.fiocruz.br)

4.2 Use and dissemination of foreground

Section A (public)

Publications

LIST OF SCIENTIFIC PUBLICATIONS, STARTING WITH THE MOST IMPORTANT ONES											
No.	Title / DOI	Main author	Title of the periodical or the series	Number, date or frequency	Publisher	Place of publication	Date of publication	Relevant pages	Permanent identifiers (if applicable)	Is open access provided to this publication ?	Type
1	Determinantes de utilización de servicios del SGSSS y SUS en municipios de Colombia y Brasil	Garcia-Subirats I, Vargas I, Mogollón AS, De Paepe P, Ferreira da Silva MR, Unger JP, Vázquez ML	Revista Panamericana de Salud Publica/Pan American Journal of Public Health	submitted March 2013	Pan American Health Organization		27/03/2013	N.A.		Yes	Peer reviewed
2	Barriers in access to healthcare in countries with different health systems. A study in municipalities of central Colombia and north-eastern Brazil	Garcia-Subirats I, Vargas I, Mogollón AS, De Paepe P, Ferreira da Silva MR, Unger JP, Vázquez ML	Social Science and Medicine	submitted April 2013	Elsevier Limited		12/04/2013	N.A.		Yes	Peer reviewed
3	Regional-based Integrated Healthcare Network policy in Brazil: from formulation to practice	Vargas I, Mogollón AS, Unger JP, Ferreira da Silva MR, De Paepe P, Vázquez ML	Health Policy and Planning	submitted May 2013	Oxford University Press		22/05/2013	N.A.		Yes	Peer reviewed
4	Inequities in access to health care in different health systems. A study in municipal	Garcia-Subirats I, Vargas	International Journal for Equity in Health	submitted August	BioMed Central		02/08/2013	N.A.		Yes	Peer reviewed

	itie s of central Colombia and north-eastern Brazil	I, Mogollón AS, De Paepe P, Ferreira da Silva MR, Unger JP, Borrell C, Vázquez ML		2013							
5	Acompanhament o de mulheres com Câncer de mama no SUS: da suspeita diagnóstica ao tratamento	Pereira ICAL, Ferreira da Silva MR, Gusmão-Filho FAR, Vázquez ML, Vargas I, De Paepe P, Unger JP, Mogollon AS	Ciencia e Saude Coletiva	submitted August 2013	Associacao Brasileira de Pos - Graduacao em Saude Coletiva		15/08/2013	N.A.		Yes	Peer reviewed
6	Performance of Integrated Healthcare Networks in Brasil and Colombia: tracer diseases diabetes and breast cancer	De Paepe P, Vázquez ML, Vargas I, Mogollón AS, Ferreira da Silva MR, Riberiro de Gusmão-Filho AR, Unger JP	Journal of Integrated Care	submitted August 2013	Pier Professional Ltd		15/08/2013	N.A.		Yes	Peer reviewed
7	Barriers to care coordination in market-based and decentralise d healthcare systems: a qualitative study in Colombia and Brazil	Vargas I, Mogollón AS, Unger JP, Ferreira da Silva MR, De Paepe P, Vázquez ML	Social Science and Medicine	will be submitte d November 2013	Elsevier Limited		15/11/2013	N.A.		Yes	Peer reviewed
8	Acesso aos serviços de saúde em um município do interior de Pernambuco: o que pensam os usuários?	Albuquerque LC, Ferreira da Silva MR, Gouveia GC, Vazquez ML, Vargas I, De Paepe P, Unger JP; Mogollón AS	Ciencia e Saude Coletiva	will be submitte d December 2013	Associacao Brasileira de Pos - Graduacao em Saude Coletiva		15/12/2013	N.A.		Yes	Peer reviewed
9	Validity of the CCAENA questionnaire to	Garcia-Su b	BMC Health Services	will be su	BioMed Central		15/12/2013	N.A.		Yes	Peer revie

	assess continuity of care across care levels in different health systems: managed com petition and national health system. A s tudy in municipalities of central Colombia and north-eastern Brazil	irats I, Aller MB, Vargas I, Mogollón AS, De Paepe P, F erreira da Silv a MR, Unger JP, Vázquez ML	Research	bmitte d December 2013							wed
10	Patient perceptions' of continuity of care in different health systems: managed compe tition and national health system. A study in municipalitie s of central Colombia and north-easter n Brazil	Garcia-Su b irats I, Aller MB, Vargas I, Mogollón AS, De Paepe P, F erreira da Silv a MR, Unger JP, Vázquez ML	Medical Care	will be su bmitte d December 2013	Lippincott Williams and Wilkins		25/12/2013	N.A.		Yes	Peer revie wed
11	A comparative insight into systemic inte gration and care continuity in Brazil and Colombia: Perspective of women with br east cancer	Unger JP, De Paepe P, Sab ater J, Mo gollón AS, Vázquez ML, Vargas I, Fe rreira da Silva MR.	Social Science and Medici ne	will be su bmitte d December 2013	Elsevier Limited		15/12/2013	N.A.		Yes	Peer revie wed
12	El acceso a redes de servicios de salud en dos áreas geográficas de Colombia y Brasil : un estudio de casos	Mogollón A, García V, Var gas I, De Paepe P, F erreira da Silv a MR, Unger JP, Vázquez ML	International Journal of Health Services	will be su bmitte d February 2014	Baywood Publishing Co. Inc.		28/02/2014	N.A.		Yes	Peer revie wed
13	Barreras de acceso a redes de servicios de salud en Colombia: una mirada desde los actores involucrados	García V, Mogollón A, Vargas I, De Paepe P, F erreira da Silv a MR, Unger JP, Vázquez ML	Cadernos de Saude Publica	will be su bmitte d February 2014	Fundacao Oswaldo Cruz		28/02/2014	N.A.		Yes	Peer revie wed
14	Barreras en el uso de los mecanismos de coordinación asistencial en redes de ser vicios de salud en Colombia	León H, Mo gollón A, Vargas I, Ee	International Journal of Health Services	will be su bmitte d February	Baywood Publishing Co. Inc.		28/02/2014	N.A.		No	Peer revie wed

		Paepe P, Ferreira da Silva MR, Unger JP, Vázquez ML		2014							
15	Factores asociados a la continuidad asistencial en mujeres con diabetes mellitus tipo II en Colombia	Chávez J, Mogollón A, Vargas I, de Paepe P, Ferreira da Silva MR, Unger JP, Vázquez ML	Gaceta Sanitaria	will be submitted February 2014	Ediciones Doyma, S.L.		28/02/2014	N.A.		Yes	Peer reviewed
16	Desempeño de redes de servicios de salud frente a la atención del cáncer de mama en Bogotá-Colombia	Morales N, De Paepe P, Cardozo C, Mogollón AS, Vargas I, Ferreira da Silva MR, Unger JP, Vázquez ML	Revista Panamericana de Salud Publica/Pan American Journal of Public Health	will be submitted February 2014	Pan American Health Organization		28/02/2014	N.A.		Yes	Peer reviewed
17	Problemas de continuidad asistencial en el manejo del cáncer de mama en redes de servicios de salud en Colombia	Martínez M, Valencia S, Mogollón AS, Vargas I, De Paepe P, Ferreira da Silva MR, Unger JP, Vázquez ML	Revista Panamericana de Salud Publica/Pan American Journal of Public Health	will be submitted February 2014	Pan American Health Organization		28/02/2014	N.A.		Yes	Peer reviewed
18	Desempeño de RISS frente a la atención de la diabetes mellitus tipo dos en Bogotá y Soacha	Cardozo C, De Paepe P, Morales N, Mogollón AS, Vargas I, Ferreira da Silva MR, Unger JP, Vázquez ML	Cadernos de Saude Publica	will be submitted February 2014	Fundacao Oswaldo Cruz		28/02/2014	N.A.		Yes	Peer reviewed

LIST OF DISSEMINATION ACTIVITIES								
No.	Type of activities	Main Leader	Title	Date	Place	Type of audience	Size of audience	Countries addressed
1	Web sites/Applications	CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA	Equity-LA project in Spanish, English, Portugues and Catalan (http://www.equity-la.eu/)	01/01/2000	International	Scientific community (higher education, Research)		International
2	Flyers	CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA	Printed in Spanish, English, Portugues and Catalan disseminated in Europe and Latin America	01/01/2000	Conferences, presentations, etc.	Scientific community (higher education, Research) - Civil society - Policy makers - Medias	0	International
3	Web sites/Applications	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Dissemination of project activities through the Universidad del Rosario web site	01/01/2000	Colombia	Scientific community (higher education, Research)		Colombia
4	Organisation of Workshops	PRINS LEOPOLD INSTITUUT VOOR TROPISCHE GENEESKUNDE	Meetings IDESAL network (2009-13). Information about Equity-LA project and results	01/01/2000	Medellin, Quito and Bogotá	Scientific community (higher education, Research)	40	Mainly Latin American countries
5	Press releases	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Editorial: Participación en redes: propósito y motor de la internacionalización	01/04/2009	Periódico Nova et Vetera. No 5. Marzo 30 -Abril 12 2009 (Colombia)	Scientific community (higher education, Research)	5000	Colombia
6	Articles published in the popular press	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Equity-LA launching	01/05/2009	Periódico de la República, Bogotá	Civil society		Colombia
7	Presentations	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Presentation of Equity-LA project	26/05/2009	Bogota	Scientific community (higher education, Research) - Civil society - Policy makers - Medias		Colombia
8	Organisation of Workshops	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Project presentation-a las proveedoras!!!	31/05/2009	Bogota	Civil society		Colombia

9	Presentations	CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA	Presentation of Equity-LA project, attended by personnel of the Brazilian Consulate	24/07/2009	Barcelona	Scientific community (higher education, Research)		Brazil and Spain
10	Oral presentation to a scientific event	CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA	Casos d'èxit: Equity-LA. Programa de Salut del 7è PM convocatòria 2010.	08/09/2009	CCCB Barcelona	Scientific community (higher education, Research)		International
11	Presentations	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	Presentation of Equity-LA project	02/11/2009	Recife	Scientific community (higher education, Research) - Civil society - Policy makers		Brazil
12	Organisation of Workshops	PRINS LEOPOLD INSTITUUT VOOR TROPISCHE GENEESKUNDE	Presentation of the project Equity-LA	04/05/2010	Brussels	Scientific community (higher education, Research)		Belgium
13	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Barreras identificadas por distintos actores en torno a la afiliación al Régimen Subsidiado en Salud	12/08/2010	Congreso Nacional de la Salud. Universidad Industrial de Santander, Bucaramanga	Scientific community (higher education, Research)	150	Colombia
14	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Configuración y características de las redes de servicios de salud en Colombia	12/08/2010	Congreso Nacional en Ciencias de la Salud. Universidad Industrial de Santander, Bucaramanga	Scientific community (higher education, Research)	150	Colombia
15	Posters	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Factores que dificultan la coordinación asistencial: un estudio de caso en Colombia	12/08/2010	Congreso Nacional en Ciencias de la Salud. Universidad Industrial de Santander, Bucaramanga	Scientific community (higher education, Research)	150	Colombia
16	Posters	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Impacto del modelo de aseguramiento sobre el acceso a los servicios de salud	12/08/2010	Congreso Nacional en Ciencias de la Salud. Universidad Industrial de Santander, Bucaramanga	Scientific community (higher education, Research)	150	Colombia
17	Posters	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	La comunicación como instrumento de coordinación de la información: un	12/08/2010	Congreso Nacional en Ciencias de la Salud. Universidad Industrial de Santan	Scientific community (higher education, Research)	150	Colombia

			estudio de caso		der, Bucaramanga			
18	Oral presentation to a scientific event	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	O acceso à saúde nos diferentes níveis de atenção no Brasil: As barreiras ao acesso na perspectiva d	11/09/2010	IV Congresso Ibero-americano de pesquisa Qualitativa em saúde	Scientific community (higher education, Research)	60	Interntional
19	Oral presentation to a scientific event	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	Opinião dos Profissionais de Saúde sobre os Mecanismos de Coordenação Assistencial das RISS do Munic	11/09/2010	IV Congreso Ibero-americano de pesquisa Qualitativa em saúde	Scientific community (higher education, Research)	60	International
20	Oral presentation to a scientific event	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	Acesso aos Serviços de Saúde na ótica de usuários	11/09/2010	IV Congreso Ibero-americano de pesquisa Qualitativa em saúde	Scientific community (higher education, Research)	60	International
21	Presentations	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Presentation of preliminars results of the project	01/12/2010	ESE Hospital del Sur - Red 2-S, Bogota	Civil society	17	Colombia
22	Thesis	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Acceso y equidad de acceso a los servicios de salud en Kennedy y Soacha, Colombia	01/01/2011	Universidad Pompeu Fabra	Scientific community (higher education, Research) - Civil society		International
23	Thesis	CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA	Impacto en la equidad de acceso y la eficiencia de las RISS en Colombia y Brasil	01/01/2011	Brazil, Spain	Scientific community (higher education, Research)		International
24	Oral presentation to a scientific event	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	A coordenação do ciuidado à saúde no município de Recife: Opinião dos profissionais de saúde nos dif	20/04/2011	V Congresso Brasileiro de Ciências Socias e Humanas em Saúde	Scientific community (higher education, Research)	55	International
25	Oral presentation to a wider public	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	Acesso nos diferentes níveis de atenção à saúde: As barreiras ao acesso na perspectiva dos profissio	20/04/2011	V Congresso Brasileiro de Ciências Socias e Humanas em Saúde	Scientific community (higher education, Research)	55	International

26	Oral presentation to a scientific event	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	Formação de Redes Integradas em promoção de saúde	28/05/2011	I Seminário Internacional em Promoção de Saúde e cuidar em Enfermagem e VI Encontro Pedagógico da FE	Scientific community (higher education, Research)	120	International
27	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Factors affecting equitable access in all parts of the world	22/06/2011	XVI International Congress of the World Confederation for Physical Therapy, Amsterdam	Scientific community (higher education, Research)	2000	Netherlands
28	Organisation of Conference	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Conferencia Nacional "Desarrollo de sistemas de salud: el acceso y coordinación en redes de servicio	10/08/2011	Bogota	Scientific community (higher education, Research) - Civil society - Policy makers	165	Colombia
29	Articles published in the popular press	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Actualidad desde la Academia trabajando por una corbertura universal de salud	22/08/2011	Periódico Nova et Vetera. No.18, Bogota	Civil society	5000	Colombia
30	Oral presentation to a scientific event	PRINS LEOPOLD INSTITUUT VOOR TROPISCHE GENEESKUNDE	Efficiency evaluation instrument for Latin-American Integrated Health care Networks (IHN), analysis	01/09/2011	6th International Conference: Making Policy a Health Equity Building Process, Colombia	Scientific community (higher education, Research)		International
31	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Efficiency evaluation instrument for Latin-American Integrated Health care Networks, analysis of two	25/09/2011	International Congress on health Equity, Catagena	Scientific community (higher education, Research)	300	Colombia
32	Oral presentation to a scientific event	PRINS LEOPOLD INSTITUUT VOOR TROPISCHE GENEESKUNDE	Elaboração de Guia para Avaliação da Eficiência de Redes Integradas de Serviços de Saúde na América	01/10/2011	X Encontro Nacional de Economia da Saúde: Desenvolvimento, Economia e Saúde, Porto Alegre	Scientific community (higher education, Research)		International
33	Posters	CONSORCI DE SALUT I D'ATE	Equity of access to health care in the h	03/10/2011	7th European Congress on Tropical	Scientific community (higher educat		International

		NCIO SOCIAL DE CATALUNYA	ealth systems of Colombia and Brazil		Medicine and International Health, Barcelona	ion, Research)		
34	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	La continuidad asistencial en diabetes mellitus: un estudio de caso en Colombia	01/11/2011	Primer congreso internacional en sistemas de salud. Pontificia Universidad Javeriana, Bogotá	Scientific community (higher education, Research)	300	Colombia
35	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Factores que inciden en el acceso a los servicios de salud de la población vinculada de Bogotá y Soa	01/11/2011	Primer congreso internacional de sistemas de salud. Pontificia Universidad Javeriana, Bogotá	Scientific community (higher education, Research)	300	Colombia
36	Organisation of Workshops	PRINS LEOPOLD INSTITUUT VOOR TROPISCHE GENEESKUNDE	Recipe: the Equity-LA project. Efficiency of Integrated Healthcare Networks	01/02/2012	Institute of Tropical Medicine, Antwerp	Policy makers	40	Belgium
37	Thesis	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	Mater thesis: Acesso aos servicços de Saúde em Municipi do interior de Pernambuco: O que pensam os u	05/03/2012	Universidade de Pernambuco, Recife	Scientific community (higher education, Research)	20	Brazil
38	Articles published in the popular press	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Comisión Europea avala el proyecto Equity-LA en el que participa el Rosario	07/05/2012	Periódico Nova et Vetera. Año 7, Edición 13. Bogotá	Civil society	5000	Colombia
39	Organisation of Conference	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	"Desenvolvimento de sistemas de saúde: acesso e coordenação de redes de serviços de saúde"	15/05/2012	Universidade de Pernambuco, Recife	Scientific community (higher education, Research) - Civil society - Policy makers		International
40	Posters	CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA	Access barriers of healthcare in the health systems of Brazil and Colombia	21/06/2012	4th Conference on Migrant and Ethnic Minority Health in Europe, Milan	Scientific community (higher education, Research)		International
41	Organisation of Conference	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Experiencia en el desarrollo del proyecto Equity-LA	01/08/2012	Seminar: Colombian experiences on development in FP7 projects. Univers	Scientific community (higher education, Research)	50	Colombia

					idad del Rosario, Bogotá			
42	Thesis	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	Master thesis: Acompanhamento de Mulheres com Câncer de mama no SUS: da suspeita diagnóstica ao trat	24/08/2012	Universidade de Pernambuco, Recife	Scientific community (higher education, Research)	40	Brazil
43	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Problemas de la coordinación asistencial en redes integradass de servicios de salud en Colombia	04/10/2012	II Congreso Internacional de Sistemas de Salud. Pontificia Universidad Javeriana, Bogotá	Scientific community (higher education, Research)	300	Colombia
44	Oral presentation to a scientific event	PRINS LEOPOLD INSTITUUT VOOR TROPISCHE GENEESKUNDE	Performance of Integrated Healthcare Networks in Brazil and Colombia: tracer diseases	03/11/2012	ALAM congress; Montevideo, Uruguay	Scientific community (higher education, Research)	300	Participants from Latin American countries
45	Oral presentation to a wider public	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Acceso a la atención en las RISS en Colombia. Visión de los distintos actores	20/12/2012	Sesión Técnica del Consorci de Salut i Social de Catalunya, Barcelona	Scientific community (higher education, Research) - Civil society	20	Colombia, Brazil and Spain
46	Oral presentation to a wider public	FUNDACAO UNIVERSIDADE DE PERNAMBUCO	Acesso aos serviços de saúde no Brasil. Visão dos atores sociais	20/12/2012	Sesión Técnica del Consorci de Salut i Social de Catalunya, Barcelona	Scientific community (higher education, Research) - Civil society	20	Colombia, Brazil and Spain
47	Oral presentation to a wider public	CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA	Barreras en el acceso a la atención en las RISS de Colombia y Brasil. Resultados de la encuesta	20/12/2012	Sesión Técnica del Consorci de Salut i Social de Catalunya, Barcelona	Scientific community (higher education, Research) - Civil society	20	Colombia, Brazil and Spain
48	Thesis	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Master thesis: Desempeño de las RISS en la atención de usuarias con cáncer de mama	01/01/2013	Universidad Nacional del Rosario	Scientific community (higher education, Research) - Civil society		Colombia
49	Thesis	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Master thesis: El acceso al continuo de servicios entre niveles asistenciales en dos redes integrada	01/01/2013	Universidad Nacional de Colombia, Bogotá	Scientific community (higher education, Research) - Civil society		Colombia

50	Organisation of Conference	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Acceso y coordinación en redes de servicios de salud en los sistemas de salud en Colombia y Brasil	15/08/2013	Universidad del Rosario, Bogotá	Scientific community (higher education, Research) - Civil society - Policy makers	185	International
51	Posters	CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA	Determinantes del uso de servicios por nivel asistencial en el SGSSS en el municipio de Colombia y B	04/09/2013	Congreso Ibero-Americano Epidemiología y Salud Pública, Granada	Scientific community (higher education, Research)		International
52	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	La continuidad asistencial en RISS en Colombia. Un estudio de caso de ususarias con diabetes mellitu	01/10/2013	IV Encuentro de investigación de la Universidad del Rosario	Scientific community (higher education, Research)	300	Colombia
53	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Desempeño de 3 RISS frente a la atención de la diabetes mellitus tipo 2	01/10/2013	IV Encuentro de investigación de la Universidad del Rosario	Scientific community (higher education, Research)	300	Colombia
54	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Desempeño de las RISS en relación al acceso a la atención de ususarias con cáncer de mama en la cuid	01/10/2013	IV Encuentro de investigación de la Universidad del Rosario	Scientific community (higher education, Research)	300	Colombia
55	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Problemas de la coordinación asistencial en redes integradas de servicios de salud	01/10/2013	IV Encuentro de investigación de la Universidad del Rosario	Scientific community (higher education, Research)	300	Colombia
56	Oral presentation to a scientific event	CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA	Equity in access to healthcare in two different health systems: a study in municipalities of central	13/11/2013	6th European Public Health Conference, Brussels	Scientific community (higher education, Research)		International
57	Oral presentation to a scientific event	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	El acceso al continuo de servicios entre niveles asistenciales: un estudio de casos de mujeres con c	01/10/2013	IV Encuentro de investigación de la Universidad del Rosario	Scientific community (higher education, Research)	300	Colombia

58	Organisation of Workshops	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Dissemination of results of the case studies	01/12/2013	Universidad del Rosario, Bogotá	Civil society	20	Colombia
59	Organisation of Workshops	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Dissemination of results of the case studies	01/01/2014	Universidad del Rosario, Bogotá	Civil society	200	Colombia
60	Articles published in the popular press	COLEGIO MAYOR DE NUESTRA SENORA DEL ROSARIO	Project dissemination of results.	01/04/2014	Periódico el Tiempo	Scientific community (higher education, Research) - Civil society	100000	Colombia

Section B (Confidential or public: confidential information marked clearly)

LIST OF APPLICATIONS FOR PATENTS, TRADEMARKS, REGISTERED DESIGNS,UTILITY MODELS, ETC.					
Type of IP Rights	Confidential	Foreseen embargo date dd/mm/yyyy	Application reference(s) (e.g. EP123456)	Subject or title of application	Applicant(s) (as on the application)

OVERVIEW TABLE WITH EXPLOITABLE FOREGROUND								
Type of Exploitable Foreground	Description of Exploitable Foreground	Confidential	Foreseen embargo date dd/mm/yyyy	Exploitable product(s) or measure(s)	Sector(s) of application	Timetable for commercial use or any other use	Patents or other IPR exploitation (licences)	Owner and Other Beneficiary(s) involved

ADDITIONAL TEMPLATE B2: OVERVIEW TABLE WITH EXPLOITABLE FOREGROUND	
Description of Exploitable Foreground	Explain of the Exploitable Foreground

4.3 Report on societal implications

B. Ethics

1. Did your project undergo an Ethics Review (and/or Screening)?	Yes
If Yes: have you described the progress of compliance with the relevant Ethics Review/Screening Requirements in the frame of the periodic/final reports?	Yes

2. Please indicate whether your project involved any of the following issues :

RESEARCH ON HUMANS

Did the project involve children?	No
Did the project involve patients?	Yes
Did the project involve persons not able to consent?	No
Did the project involve adult healthy volunteers?	No
Did the project involve Human genetic material?	No
Did the project involve Human biological samples?	No
Did the project involve Human data collection?	Yes

RESEARCH ON HUMAN EMBRYO/FOETUS

Did the project involve Human Embryos?	No
Did the project involve Human Foetal Tissue / Cells?	No
Did the project involve Human Embryonic Stem Cells (hESCs)?	No
Did the project on human Embryonic Stem Cells involve cells in culture?	No
Did the project on human Embryonic Stem Cells involve the derivation of cells from Embryos?	No

PRIVACY

Did the project involve processing of genetic information or personal data (eg. health, sexual lifestyle, ethnicity, political opinion, religious or philosophical conviction)?	Yes
Did the project involve tracking the location or observation of people?	Yes

RESEARCH ON ANIMALS

Did the project involve research on animals?	No
Were those animals transgenic small laboratory animals?	No
Were those animals transgenic farm animals?	No
Were those animals cloned farm animals?	No
Were those animals non-human primates?	No

RESEARCH INVOLVING DEVELOPING COUNTRIES

Did the project involve the use of local resources (genetic, animal, plant etc)?	No
Was the project of benefit to local community (capacity building, access to healthcare, education etc)?	Yes

DUAL USE

Research having direct military use	No
Research having potential for terrorist abuse	No

C. Workforce Statistics

3. Workforce statistics for the project: Please indicate in the table below the number of people who worked on the project (on a headcount basis).

Type of Position	Number of Women	Number of Men
Scientific Coordinator	1	0
Work package leaders	3	1
Experienced researchers (i.e. PhD holders)	7	5
PhD student	2	0
Other	14	8

4. How many additional researchers (in companies and universities) were recruited specifically for this project?	0
Of which, indicate the number of men:	0

D. Gender Aspects

5. Did you carry out specific Gender Equality Actions under the project ?	No

6. Which of the following actions did you carry out and how effective were they?	
Design and implement an equal opportunity policy	Not Applicable
Set targets to achieve a gender balance in the workforce	Not Applicable
Organise conferences and workshops on gender	Not Applicable
Actions to improve work-life balance	Not Applicable
Other:	

7. Was there a gender dimension associated with the research content - i.e. wherever people were the focus of the research as, for example, consumers, users, patients or in trials, was the issue of gender considered and addressed?	Yes
If yes, please specify:	Tracer conditions were breast cancer and diabetes mellitus type II in women only

E. Synergies with Science Education

8. Did your project involve working with students and/or school pupils (e.g. open days, participation in science festivals and events, prizes/competitions or joint projects)?	Yes
If yes, please specify:	Capacity building of students who are elaborating their Master's and doctoral thesis within the project

9. Did the project generate any science education material (e.g. kits, websites, explanatory booklets, DVDs)?	No

F. Interdisciplinarity

10. Which disciplines (see list below) are involved in your project?	
Main discipline:	3.3 Health sciences (public health services, social medicine, hygiene, nursing, epidemiology)
Associated discipline:	5.4 Other social sciences [anthropology (social and cultural) and ethnology, demography, geography (human, economic and social), town and country planning, management, law, linguistics, political sciences, sociology, organisation and methods, miscellaneous social sciences and interdisciplinary , methodological

	and historical S1T activities relating to subjects in this group. Physical anthropology, physical geography and psychophysiology should normally be classified with the natural sciences].
Associated discipline:	

G. Engaging with Civil society and policy makers

11a. Did your project engage with societal actors beyond the research community? (if 'No', go to Question 14)	Yes
11b. If yes, did you engage with citizens (citizens' panels / juries) or organised civil society (NGOs, patients' groups etc.)?	Yes, in communicating /disseminating / using the results of the project
11c. In doing so, did your project involve actors whose role is mainly to organise the dialogue with citizens and organised civil society (e.g. professional mediator; communication company, science museums)?	No
12. Did you engage with government / public bodies or policy makers (including international organisations)	Yes, in communicating /disseminating / using the results of the project
13a. Will the project generate outputs (expertise or scientific advice) which could be used by policy makers?	Yes - as a primary objective (please indicate areas below multiple answers possible)
13b. If Yes, in which fields?	
Agriculture	No
Audiovisual and Media	No
Budget	No
Competition	No
Consumers	No
Culture	No
Customs	No
Development Economic and Monetary Affairs	No
Education, Training, Youth	No
Employment and Social Affairs	No
Energy	No
Enlargement	No
Enterprise	No
Environment	No
External Relations	No
External Trade	No

Fisheries and Maritime Affairs	No
Food Safety	No
Foreign and Security Policy	No
Fraud	No
Humanitarian aid	No
Human rightsd	No
Information Society	No
Institutional affairs	No
Internal Market	No
Justice, freedom and security	No
Public Health	Yes
Regional Policy	No
Research and Innovation	No
Space	No
Taxation	No
Transport	No
13c. If Yes, at which level?	National level

H. Use and dissemination

14. How many Articles were published/accepted for publication in peer-reviewed journals?	18
To how many of these is open access provided?	17
How many of these are published in open access journals?	15
How many of these are published in open repositories?	0
To how many of these is open access not provided?	1
Please check all applicable reasons for not providing open access:	
publisher's licensing agreement would not permit publishing in a repository	No
no suitable repository available	No
no suitable open access journal available	No
no funds available to publish in an open access journal	No
lack of time and resources	No
lack of information on open access	No
If other - please specify	Journal does not permit open access

15. How many new patent applications ('priority filings') have been made? (''Technologically unique'': multiple applications for the same invention in different jurisdictions should be counted as just one application of grant).	0

16. Indicate how many of the following Intellectual Property Rights were applied for (give number in each box).	
Trademark	0
Registered design	0
Other	0

17. How many spin-off companies were created / are planned as a direct result of the project?	0
Indicate the approximate number of additional jobs in these companies:	0

18. Please indicate whether your project has a potential impact on employment, in comparison with the situation before your project:	Difficult to estimate / not possible to quantify, None of the above / not relevant to the project

19. For your project partnership please estimate the employment effect resulting directly from your participation in Full Time Equivalent (FTE = one person working fulltime for a year) jobs:	0Difficult to estimate / not possible to quantify

I. Media and Communication to the general public

20. As part of the project, were any of the beneficiaries professionals in communication or media relations?	No

21. As part of the project, have any beneficiaries received professional media / communication training / advice to improve communication with the general public?	No

22. Which of the following have been used to communicate information about your project to the general public, or have resulted from your project?	
Press Release	Yes
Media briefing	Yes
TV coverage / report	Yes
Radio coverage / report	Yes
Brochures /posters / flyers	Yes
DVD /Film /Multimedia	No
Coverage in specialist press	Yes

Coverage in general (non-specialist) press	Yes
Coverage in national press	No
Coverage in international press	No
Website for the general public / internet	Yes
Event targeting general public (festival, conference, exhibition, science café)	Yes

23. In which languages are the information products for the general public produced?	
Language of the coordinator	Yes
Other language(s)	Yes
English	Yes

Attachments	List of partner Equity-LA (2).pdf, Annexes_Equity-LA.pdf
Grant Agreement number:	223123
Project acronym:	Equity-LA
Project title:	Impact on equity of access and efficiency of Integrated Health care Networks (IHN) in Colombia and Brazil
Funding Scheme:	FP7-CP-SICA
Project starting date:	01/03/2009
Project end date:	31/08/2013
Name of the scientific representative of the project's coordinator and organisation:	Dr. Luisa Vazquez CONSORCI DE SALUT I D'ATENCIO SOCIAL DE CATALUNYA
Name	
Date	29/10/2013

This declaration was visaed electronically by Sina WAIBEL (ECAS user name nwaibesi) on 29/10/2013