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THE INTEGRATION OF HEALTH SERVICES. HEALTH NETWORKS

Doru BOTEZAT[1], Liviu OPREA[2] , Cristina GAVRILOVICI[3],

Abstract

This paper is based on a systematic and comprehensive review of the literature on the subject of systems' integration, trying to provide the most relevant definitions for the understanding of the concept of integration, processes and measures that can be used as instruments of planning, application and evaluation of the integration strategies that can be easily used by politics. Seen as a natural development of the society, not as a trend imposed by policymakers, integration is achieved in particular through an institutional and spatial dynamics, which usually results in network type configurations. The paper also presents an explanation related to the field of health. The first part represents a contextualization of the integration as phenomenon, followed by conceptual clarifications, and in the last part some coordinates of the mechanism of configuration of the networks in medical care systems are presented. From methodological standpoint this article resulted from the search, selection, evaluation and summaries of some papers focused on the economy and health policy systems in the field of health.

Keywords: integration; health system; networks.

Evolution towards Integration in a Changing Context

The limitations of resources and systemic crises of all sorts propose as debate topic the reconfigurations and redesigns of human organizations. Even the World Health Organisation (WHO) stipulates in its programmatic documents that '' from now on, due to limited resources, countries will be constrained to open to

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new solutions and new ways of thinking ‘’ (Kickbush, 2003, p. 383). For the health sector, these solutions may not be simple in the new social contexts. The challenges, however, differ from country to country and within countries depending on the specific needs of health. The countries that face crisis (including the economically advanced ones) are in a continuous struggle to find a balance between affordability, equity and efficiency on an extremely complex market, in which important interest groups dominate economy and politics. In these processes it is essential to find the explicit goals of the reforms and developments in order to monitor the compliance of these reforms with their goals.

The changes implemented by these reforms often generate incompatible effects in different segments of the health systems. This argument, in conjunction with the official certification of the need for change, resulted in a recommendation: to take into account an integrated health, or, in other words, to consider health system as a whole and not just as “care’’ or as an industry with suppliers and clients (Domergue, 2009). In this new paradigm of the 21 century the creation of networks that coordinate complex systems of health services appears to be the “universal solution” (Bailly, Bernhardt & Gabella, 2006, p. 58).From this perspective, the study of connections between the space dimension, the institutional dimension and the processes of integration of the activities is essential to the development of health networks. The basic principles of providing health care have evolved from *caring sick patients* to *organizing systems*, economics and the construction of *chains of services* because health is no longer seen as a result of medical care or as a state opposite to the disease. Whereas WHO has defined health as a “complete physical, mental state, and of social welfare” not only as *the absence of disease or infirmity* (Kickbush, 2003, 383), a holistic approach, as the vision of health, has become a common one. This new understanding led to considering caring from a wider perspective than a strictly medical one. For instance, if we take into consideration this new approach, it is not enough at a system level to provide primary, secondary and tertiary health care services, but also to create networks of health care providers organized around the whole spectrum of health services from health prevention and promotion to post-curative care.

In addition, because health care does not take place in a single location, such as a hospital, but it spreads on a whole community, the patient has to be correctly oriented to comply with the so-called *chain of health care* (Berlin, & Schatz, 2005). This chain has to be coherent, from the standpoint of successive interventions, persons who are involved, nature of care, and of connected services. This coherence implies to consider some needs of information and awareness of the system for which both individuals as beneficiaries, as well as the professionals involved in the system are responsible. Although, the implementation of health care networks aims to facilitate the functioning of the system, it has a certain degree of complexity that may prevent the expected benefits. At the same time, this restructure that leads to the establishment of the networks is seen as a means to generate value, theoretically attributable to the management through network. This is so, because networks generators of synergies that produce added value per se.

We are not describing a proposed development, but a transformation in progress. Many countries stated for more than a decade, the need for reform and are in a process of institutional design. The most common response was to shift the focus of care from specialized secondary and tertiary services to primary health care services. In addition, the role of primary care doctors changed from being primarily gate keepers to coordinators of care. For instance, in the NHS general practitioners became fund holders and now they coordinate the patients' care in the whole NHS. This process has been associated with a shift of health care resources from secondary to primary care. This was demonstrated as being cost-effective because primary care services are cheaper than secondary health care services and unquestionably, this sector solves the overwhelming majority of health issues. In addition, this change increases the effectiveness of secondary care because it decreases the waiting lists in secondary care by solving most medical conditions in primary care.

Even if the cost effectiveness justification of this shift is correct, it has not occurred due to an initially wrong design, but due to *an evolution of the social system that induced this need for transformation* in the 20th century the demographics of the population changed from a mostly young to an aging one. This ageing population pushed the system to shift the focus of the health care systems from the care of acute diseases to chronic diseases (Schneider, 1999). The progress of medicine emphasizes this balance by converting numerous disorders, from incurable into chronic diseases (Atun et al., 2010). Unlike acute conditions that require immediate action, the chronic ones can be cured neither immediately, nor totally, or in other words, they require "management" in the long run. This demographic change produced a shift from small local hospitals to regional hospitals. This was the period in which hospitals were consolidated as the main nodes of the health infrastructure. Centralization of medicine in such large facilities reflected, during this period, changes in the structure of society, in particular the transition from a rural to an urban preponderance (Suter et al., 2007). As the society has branched out into suburban areas, the paradigm shift has continued. For instance, the local hospitals in the small communities have served as feeders of regional hospitals. In the context of a system focused on the care of acute diseases the health system was beased ona *hierarchy between medical facilities* depending on the serviced area and the complexity and the operating capacity. The distribution of the medical care in units (facilities) of small size also reflects a social transformation. The health services develop on more and more individualized niches so that the 21st century is expected to produce different systems of health care, supported by different infrastructure.

On the other hand, the change of the *health care environment* pushed hospitals to consolidate in multi-institutional arrangements with other health care providers. This multi-institutional development has evolved due to financial constraints that pressured hospitals for an efficient management. The achievements in the industrial world have caused a fragmented system. Even the process of primary care has turned itself into multidisciplinary teams (including doctors, nurses, other clinicians, paramedics) that often work in different organizations. All of these changes in all of these institutions resulted in *a need for cooperation and*

coordination. The systems are not yet sufficiently adjusted despite some substantial improvements in health care quality. Their non-efficacy is caused by a lack of consistency between the various approaches and theories. Many programmes with qualitative effect have emerged only isolated and with limited purposes, leading to the imposition of quality analysis at the general level of the system.

From this perspective, Freidson (2001) proposes the breakdown of the system on three levels of the decision-making process: *the primary level* (individual or of the patients, as beneficiaries)-(the micro level), followed by *the level of the organizational context* (core) and finally, at *the level of funding and policies* (macro) or the level of administrative decision. Normally, these levels should be linked by the processes of decision – making that result in synergistic effects. In reality, this ideal is far from being achieved. The objectives of each level are ambiguous (if not contradictory), there are conflicting interests and the bureaucracy limits the information transfer, and thus, limits the optimal use, scientific advances. In the vision of Plochg and Klazinga (2002) putting together these levels can be done through an integrated *community* approach. Originally, this concept was a vision of how organizations within the health care system respond to the changing requirements of the society. But now it can function as a concrete strategy about how to put together in a synergic manner all efforts and qualitative improvements in the three levels of operation. The community, as entity is better outlined at the identity level than a population, so that it can more easily include and coordinate the three levels of decision-making process.

At the first (primary/individual level)it is described the decision-making process related to diagnosis and treatment of the patients. It uses the knowledge, roles and responsibilities and technologies required in this process. This is the first exchange of information between individuals - patients and health care professionals. at the level of health systems. This process has become a complex one. The explosion of scientific evidence for both patients and health professional involve the need for informational (infra) structure (storage, sorting, access) adapted to this volume of information that copes with scientific progress. For this purpose, tools such as “evidence based clinical guidelines” (Bodenheimer, 2000) have been formalized and sometimes embedded in the patient electronic medical records to assist the medical decision. This approach have simplified and made more complex the medical profession, at the same time. In turn, the epidemiological transition and technological advances have transformed medicine into a multidisciplinary activity.

Furthermore, at this level patient empowerment programs have been implemented to promote patients’ self-efficacy, or in other words, patients’ perceptions that they have the ability to pursue their therapeutic responsibilities and to fulfil their personal, professional and social roles in the context of their chronic illnesses. In addition, self-management technologies such as peak-flow-meter, glucometers, and home blood pressure machines as well as self-management information technologies (e.g. websites to self-monitor chronic diseases) have been implemented to promote patients’ self-management management and to decrease the medical costs. Subsequently, the complexity of the management of the medical

care has increased because any decision initiates a series of processes involving and other non-medical professions or make reference to other organizations (an impetus for the adoption of an industrial-type of thinking by the health systems, states Janssen (2008).

The second level – the organizational context: Health involves professions (guilds) and institutions. Both have organizational forms and intrinsic logics: the allocation of tasks, responsibilities occurring from managerial reasons, specializations which are getting deeper (niches) which require a volume of knowledge, etc. As a result, it deepens its branches. In fact, specialization is the professional solution for the application of the new knowledge. The perverted effect, however, is fragmentation. Then, due to pressures and societal requirements, the branches within the health-care system need to be more responsible for the product they deliver. In this sense, there are new tools such as *peer reviews, audits, practical guidelines, workbooks and monitoring indicators* that lead to related activities. Health care delivery is no longer the monopoly of a single profession. In addition, *the public health system* involves a wide range of adjacent professional services (emergency, transportation, logistics, including military organization for emergency situations). On the other hand, the institutions have their own management division (besides the professional one), which makes them dependent on a mix of facilities, technologies, professions (and professional hierarchies) located in different areas, or involving services requiring moving from one space to another. At the same time, thanks to these technologies and facilities, even care itself may involve placing in various areas of the actors involved. Therefore, the institutions and caring are less dependent on a single space (as it was in the past the hospital or the clinic).

Hence, both specialization and institutionalization are contributors to the fragmentation. Through the interlocking of the two levels this fragmentation is even multiplied. Therefore, concepts like "clinical routes" "the case management" or "shared caring" were developed as innovations, but can evolve into a formalized organizational context: "*clinical governance*" or "*managed care*" (Bodenheimer, 2000).

The third-level – policy-making: Decision-making at the managerial level, funding and political regulation aim to allocate health resources. In this context there is a conflict between the free market approaches and public health that introduces new dimensions: competition, cost-effectiveness appraisals to allocate scarce resources and to control health care costs. But every link and every actor in these complex systems have significant interests and expectations to influence the system and, therefore, they create and develop strategies and tools to promote their vested interests.

All of these factors contribute to the fragmentation of health services that makes the health system hardly manageable. However, the resulted fragmentation can be reintegrated (not recentralized) leading to institutional aggregation at a community level that can fulfil most of the societal requirements and preferences. Ultimately this integration of public health institutions at a community level appears to be the unifying solution that promotes the coherence of public health,

medical care and social services at local and regional level. However, shifting the focus of quality improvement from the bedside to complex levels of system management, involving continuing planning and evaluation on issues that concern the quality requires the redesign and integration of the health organizations at the health care system. Next we discuss the conceptions of integration and networking.

Conceptions Integration & Networks

An integrated health system of supplying health services is a network of health caring suppliers and organizations that provides a coordination of the the services for a defined population and that is ready to assume clinical and fiscal responsibilities to improve the community health (Shortell, Gillies & Anderson, 1994).

This definition shows that the terms *integration* and *network* are interchangeable, but there some nuance differences. *Integration is the process that aims to create a relational dynamics. The network also implies a spatial dimension*, and from a technical standpoint, it results *as a particular form of integration* which can take other shapes (for example, integration through hierarchy). In this case, we have to make a separation between *network type integration* (which is accepted in the literature as "integrated system") and *the centralized system* that means a hierarchical or fractal integration type. Integrated system (network) each entity is a sub system in itself with its own identity and management (for example, an informatics' system in a hospital can have diagnosis departments, clinical services departments and administrative departments which have their own local and data systems, data accessing systems and information transaction systems, and the connexion between the sub systems is done through "hubs" separately managed which accumulate the data bases and manage the information according to needs and functions, those from the administrative department will not have access to clinical data, those from the clinical one will not have all the demographic data about the patient, and so on). The centralized system is cumulative, from each unit to the centre; it cannot be unpacked into sub- systems but only into their own hierarchical units (fractals) which, at most, can remake the central system at a small scale.

In the early 1980s, Aldrich and Whetten (quoted in Plochg and Klazinga, 2002) have reviewed the concept of network in the "Handbook of Organizational Design", being generally used as a metaphor. Nearly 20 years later, Milward and Provan (2000) two authors working in the field of social services, have made a similar remark. "Networks" tend to remain a vague notion, despite their long-lasting recognition as a distinctive form that offers a clear alternative of "modus operandi" both for markets and bureaucratic hierarchies. However, it remains unanimous the view that their importance is increasing in order to achieve the integration and efficiency of any system and the need for more detailed description, if their maximum potential is expected to be achieved.

For a more concrete illustration, costumed to the characteristics of the health system, integration can be defined as: *a process in which the activities of control, treatment and prevention are coordinated into a multi-functional delivery system* (Unger et al., 2003), a process that involves the creation and maintenance of a structure between the independent stake-holders in order to coordinate the interdependence of a collective aim/project (Contandriopoulus et al., 2003), attempt to connect the components of the health system (acute, primary, specialty, recovery, long-term care, education, housing, etc.) in order to improve the services and the outcome of the health care system (Leutz, 1999).

Several authors have conceptualized integration as a *continuum of inter-organizational relations, with increasing intensity of the interactions, the formalization of agreements concerning governance, sharing responsibilities and resources.* Integration is seen most of the times as a change or transformation, which can lead to a full merger of the organizations or to a formalized cooperation of the systems of governance, shared responsibility or delivery of complementary services, which involves joining the resources (Leutz, 1999, Kodner, 2009).

The literature reveals a wide range of similar concepts to the integration within the health systems (Axelsson, and Axelsson, 2006; Suter, 2007; Atun 2010; Nolte and McKee, 2008; Kodner, 2009, Shigayeva., 2010). Health systems have different governance arrangements, regulatory norms, and rules of management and financing flows, mix between skills and qualifications, political, institutional and professional, structures as well as cultural values. Furthermore, the concept of integration has been applied in many ways in the various health systems. There is a multitude of terms: integrated care, integrated services, horizontal diseases management programmes, case management, continuity of care, coordinated care, comprehensive care, to name just a few (Atun et al. 2010; Nolte and McKee, 2008; Kodner, 2009).

This lack of a common accepted definition and the variety of approaches to the analysis of integration has been referenced by Howarth and Haigh (2007) as an "academic swamp" and the recent empirical studies confirm the polymorphic nature of the concept. (Nolte and Mckee in 2008; Atun et al. 2010). Several disciplines and professions perceive the term differently. For example, in exploring the concept of *integrated assistance* in the industrialized countries, Leichsenring (2004), distinguishes between the discourses which have evolved from the perspectives of *"managed care" and "public health"* and those that have evolved from *the perspective of the social services*, which were focused on broader approaches of the whole system ("person-centered"). Moreover, the name *health networks*, replaced the former name *support networks* or *networks of care* just to allow inclusion of the non-medical or non-social-assisted components. Leichsenring (2004), in completing these perspectives also explores a certain *institutional discourse* that focuses on strategies of organizing to carry out the creation, integration and/or coordination of the services.

Despite this diversity of viewpoints and definitions, the literature suggests that, broadly, health care integration is viewed positively in relation to health systems. Common themes found in definitions are translations of the fact that

health integration reduces the fragmentation and duplication of health services, improves health care outcomes and results in greater public satisfaction with health services, improves performance health systems performance. Irrespective of the definition of health, the health care integration process remains important to specify that its purpose is to support access, and to assist, coordinate health care services and to assure their continuity, and multidisciplinary care. To achieve this goal, an integrated network have to share the best practices between its members. In addition, it should be multidisciplinary and patient centred and thus ensuring a care delivery adapted to patients' needs, including health education, prevention, diagnosis and care.

Identification of the networks

The *identification and the operationalization of the concept by defining its corollaries* (causes, goals, driving forces, determinant factors, etc.) is the most important issue. As mentioned above, the literature has described a variety of types of the integration of health systems (WHO 1996; Axelsson and Axelsson, 2006; Nolte and McKee, 2008; Kodner, 2009; Atun 2010, and Shigayeva, 2010). These types can be categorised following the answers they offer to some questions: *why is the integration desirable? What are the structures and/or functions at the level of the health system affected by integration? And how does integration influence the interactions between systems' components or between the stakeholders?* (Shigayeva, 2010).

The question "why" refers to the driving forces of integration. In essence, the integration is an answer to the fragmentation of the functions and services of the health care system, that cause inequalities, gaps, duplication, and create inefficiencies and raising costs. The question "what (do we integrate?)" includes matters related to structures resulted (integrated), networks or other forms between different levels starting with the system as a whole and the specific programmes and ending with the individuals and the stakeholders (Kodner, 2009; Atun et al. 2010). Topics about integration include, in addition to structures, processes, governance, financing, management and administration, clinical services, information system. Finally, the "what" of integration also includes the issue of cultural institutional convergence (and subcultures) of the rules, methods and approaches and of the symbolism, in the balance between stakeholders and the distribution of power (Fabbricotti, 2007).

The question "how to" integrate refers to the dynamics of the interactions between organizations, individual vendors, stakeholders, (Shigayeva et al., 2010). These interactions include the shared efforts of the participants: building alliances (strategic or under contract), regulations, organization and merging supplying activities, creating networks of care, the development of coordination mechanisms, etc. The connections between organizations may appear at different geographical levels: local, regional, national and international. Integration (networking) can be *horizontal* (between similar activities and services or provided at the same

level of complexity and vertical integration (network), related to the integration of the various levels of the services hierarchies (for example, between hospitals and primary assistance facilities) which allow for streams of patients from one level to another. (Atun et al. 2010, Kodner, 2009).

The causes that led to the integration can be identified from the alleged objectives of any conscious process of integration. Synthetically listed these goals would be: (1) To reduce administrative costs and scale savings; (2) Sharing of risks; (3) Removal of overloading some categories (cost-shifting); (4) Continuous improvement of quality and management; (5) Reducing the use of inappropriate and unnecessary resources; (6) Efficient use of capital and technology; (7) Continuum of care to the patients' level; (8) Focus on the health state of the beneficiaries, not on the provision of services; (9) Improving the health status of the community; (10) Addressing (orientation) towards prevention and social problems that affect the health of the community. Also, the objectives achieved become *strengths of an integrated system*. For example, *access to capital*. An economic advantage of the integrated supply arrangements is the increased ability and potential for success in accessing capital. This is due to a more solid amount of resources to some additional revenue, and last but not least, to the span acquired (the first two improve the organization's credit worthiness, the last one increases the number of contacts and the frequency of finding sources of capital on the market). The access to a more advantageous capital and economies of scale are reflected in the *reduction of operating costs* and *in the implicit lowering of the price of the services.* Also, multi-institutional connections can provide information for *a better strategic planning* at regional or community level: *the duplicity of facilities and services can be avoided, a better allocation of resources, reducing excessive capacity* and their use in other sectors, etc. Implicitly, *a better health condition reduces the need for care*. Paradoxically, at the same time with this reduction occurs staff's attracting and retention. To have a large motivated staff is seen once again as a symbol of strength. In the clinical field there must be covered a wide range of services and programmes, different levels of competence which require adequate staff and equipment. The availability of experts causes expansion of the referential networks of patients and other professionals, which leads to a widened access and to an increase in health within the entire system. Both WHO and the European Institutions involved in the management of health stipulate in their approaches some recommendations for all the organizations to follow the multi-sector health policies. Therefore, there is a concerted vision that health is influenced by both individuals and organizational movements from several areas (Kickbush, 2003).

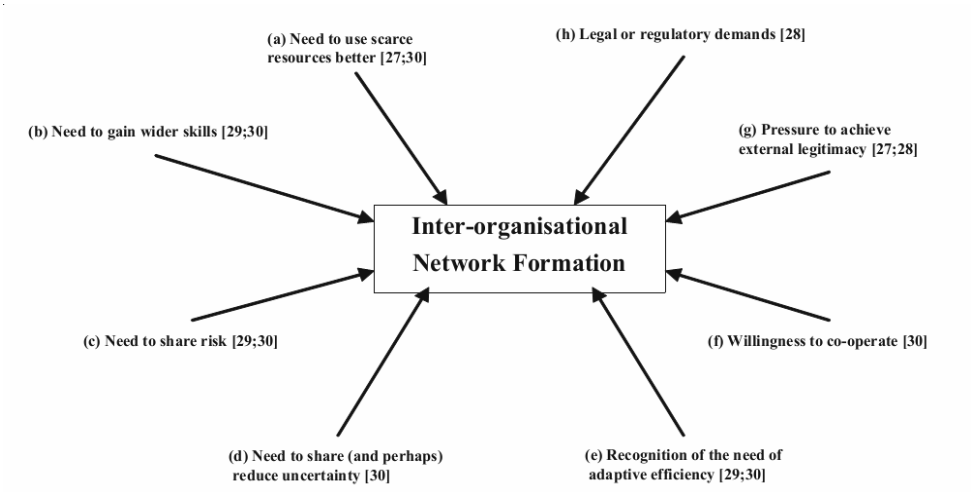
The driving forces may also be seen as accidental events (for example, a poorly managed accident causes a debate about change), a strong political leadership, new scientific evidence (for example, the need of collecting data from larger spaces) the presence of an agenda at a higher administrative level (for example, the presence on the EU's agenda) identification of common values, awareness of common problems at the society level, public/social pressure, etc. Also, the root of these proceedings may stay in the very nature of organizations that have experienced long periods of difficulty in achieving coordination of activities.

There is a literature which aims at this organizational nature of the networks, but of equal importance is to investigate local conditions favourable to the apparition of the networks that also brought research (Hannan, 2005). Grandori and Soda (1995) analyse the cases referring to the institutional contexts and to paradigmatic schemes which have been praised motivations of the various connections. Carroll (1984), in taking up this theme, uses the concept of *organizational ecology*, targeting towards the literature that counts on the prominence of the inter-organisational determination of the networks. Derived from this dispute and other literature reviews Warner and Gould, (2009) propose a composite scheme of the primary conditions for the formation of networks (Fig 1). The identified factors can be grouped under three conventional reference schemes:

1. *Resources (a and b)* (material, financial, abilities, legislative-regulatory) – Working in an isolated manner, the sectors and the organizations may be in a position to duplicate services and not to fund other services due to the limitations. Or, there may be circumstances in which some organisations lack sufficient expertise and need to collaborate with organizations that are experiencing financial deficit, but who have expertise. The networks are the way of meeting resources with experience, and hence efficiency.
2. *Contingencies (c to f)* (risks, uncertainty, regulations) – Organization of services in the society is likely to face multiple problems or with continuous changes in needs among the served population. In this context, the apparition of network type structures can reduce the risks and uncertainty through the fact that networks preserves the autonomy of entities, but can be more flexible through interconnections.
3. *Institutional resources (g and h)* (cooperation, political will, legitimacy) – on the same principle of the flexibility, networks are organizations with a higher degree of democracy in relation to hierarchical centralized structures. The actors or members of the networks are more entitled to appeal to legitimacy as long as they are "parts" of a group, and not levels in a hierarchy. In this regard, the regulatory factors which facilitate the network configurations (the legal climate that encourages partnerships) must be seen.

At the same time, in the absence of any will to cooperate, all other factors cannot guarantee the formation of networks. Also, the organizational advantages of the network cannot be enabled effortless in order to remove structural inertias or other potential which cause failures. References to the will for cooperation and effort are correlated for the general idea that the network is formed in a *context* and requires a management as stand-alone professional activity (Kickbush, 2003).

Figure 1. *Factors influencing network formation (Warner and Gould, 2009).*



From this perspective, it appears that these factors are not separate and autonomous pillars in organizational support, but are acting in aggregate. In fact, the network must insert these defining features into a so- called "macro culture" (Sheaff et al., 2010). Once lost control over individuals and organizations by dissolving the centralized systems (Milward and Provan, 2000), the networks (or any other configuration of integration) serve as surrogate structures for the Government.

The health networks usually include individuals beyond organizations (e.g., patients, doctors, informal caretakers). Jones, Hesterly, and Borgatti (1997) state that network type collaboration is made through *open contracts*, *default, for undetermined period* which coordinate and secure *mandatory* social exchanges. Otherwise the terms "exchange" and "contract" "spread" beyond their meaning to include in their semantic structure relations as these: "act of charity" or "human solidarity" (for example, blood donation, or donations for transplantation), relations that health as a system includes beyond a classic economical mechanism (Titmuss, 1997). Otherwise, it should be noted that the network has as a binding element, beyond the technique factors listed above which aim at the "need for network", interpersonal relationships based on trust, reciprocity and the community of interests.

But cooperation based on such relationships require, as pointed out, the explicit preset of a framework for legitimating members (Sheaff et al., 2010). The network also requires stable rules to interact (not necessarily formal) as basis for trust and reciprocity (Thomson and Perry, 2006). These are the elements of "soft" infrastructure or *logic infrastructure* that articulates *network macro-culture*. To these are also added *shared goals* and *common values* represented by artefacts, language and symbolism. Furthermore, macro-culture interacts once with micro-culture, as attribute of a member within the network (individual or institution) and then with

a general *macro-culture* or *social culture* of the whole community (the nation) in which the network is built. Inevitably, such interference creates *a dynamics of the network*. When networks emerge from negotiation, macro-culture is formed from the merger of micro-cultures which at the same time, mutually, reciprocally legitimate (Ehlinger, Perret and Chabaud, 2007). Other cases reported by the literature are mixtures or mosaics in which different cultures coexist separately (Chao and Moon, 2005).

The macro-culture of the network contributes to the coordination and governance of the network in the same way in which the micro-culture of an organization is a contributor to the management of that organization involving *artefacts* (collective products and services of the network, technologies and inputs to produce them, as well as the symbolic artefacts such as logos, publications, etc.) and *values* (negotiated, resulting from the emerged or negotiated problems such as *moral codes or ethical systems*, etc.) (Granovetter, 1995).

Conclusions

In conclusion, the integration processes cannot be put in question for systems which serve health care in the society, the concepts of *integration* and *network* (partly interchangeable) include a vast and dense explanatory spectrum at the same time requiring for the political decision makers a systematic evaluation and analysis for the best conditions of implementation. Within the varied typology of the health networks there can be included: *professional networks* ("expertise"), *network of references* ("care") *project networks, programme connection networks, such as the World Health Organization*, which coordinate systems and create standards, *networks of users and service providers*; *political networks* (including the "communities" of politics); *learning and educational networks*, as well as *networks of interest* promoting the interest of certain political or interest groups (Southon, Perkinsand and Galler 2005). System reforms in many countries have made the principles of the market as efficiency targets, thus appearing the issue of the impact of these measures on the structures of Government and the health care system. Also, for health managers emerge other questions regarding the way in which these networks can be managed, keeping unaltered the principles of equity in the access to it and serving of a large number of recipients with the best results in the general health plan.

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