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INTEGRATED HEALTH SERVICES - WHAT AND WHY?

Making health systems work

Main Messages

This Technical Brief is intended as a practical aid for people involved in discussions about "integrated health services". Integration is not a new topic – in the past it has been the subject of a rather polarized debate. It is once again topical, largely because of the rise of single-disease funding and in recognition of the fact that the health Millennium Development Goals (MDGs) will not be met without improving health *systems*.

Integrated health services means different things to different people, and it is important to be clear about how the term is being used. The brief proposes one working definition, the focus of which is providing the 'right care' in the 'right place'. Integrated service delivery is ***"the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."***

Many benefits are claimed for integrated health services. The evidence base is limited but there are five main messages from the literature:

- An "always good" versus "always bad" stance on integration is not helpful. On the ground, integration is about practical questions on how to deliver services to those that need them.
- Integration is best seen as a continuum rather than as two extremes of integrated/not integrated. It involves discussions about the organization of various tasks which need to be performed in order to provide a population with good quality health services. Integrated care can look different at different service levels. In reality, there are many possible permutations.
- Supporting integrated services does not mean that everything has to be integrated into one package. The aim is to provide services which are not disjointed for the user and which the user can easily navigate. For specialist care, the issue is how their activities are linked to other services.
- Managing change in the way services are delivered may require a mix of political, technical and administrative action. It may require action at several levels, including sustained commitment from the top. It is useful to look for good 'entry points' for enhancing integration and to consider what incentives there are for health workers and their managers to change their behaviour.
- Integration is not a cure for inadequate resources. It may provide some savings, but integrating new activities into an existing system cannot be continued indefinitely without the system as a whole being better resourced.

World Health Organization

Introduction

This Technical Brief is intended as a practical aid for people involved in discussions about "integrated health services". The term "integrated health services" has several usages and can be used to refer to a number of different health service issues. This Brief aims to demonstrate both the importance of clarity and the fact that "integration" is an important and topical issue.

The Brief outlines the various definitions of "integrated health services" and proposes one overall working definition. It then briefly describes key questions around integration – Is it a good thing? How is it achieved? In the past, discussions about integration have been rather polarized – this note aims to show that integration is best seen as a continuum and that it involves technical discussions about the organization of various tasks which need to be performed in order to provide a population with good quality health services.

The length of this Brief obviously means that it cannot describe the full complexities of the subject – references are provided for interested readers who want to explore the subject in more depth.

Context

> "We need a comprehensive, integrated approach to service delivery. We need to fight fragmentation."
> *WHO Director-General, 2007 (1)*

Why has the Director-General of WHO called so unequivocally for integrated health services? There are a number of reasons for the current interest in integrated services:

- Recent years have seen a dramatic rise in funding for single-disease or population-group-specific programmes, such as HIV/AIDS, immunizations, malaria and polio eradication. For example, funding for HIV/AIDS as a proportion of total health Official Development Assistance (ODA) has risen from less than 10% in the 1990s to around 30% currently *(2)*. There are concerns about potentially adverse effects on less well-funded health priorities.
- Health services face resource constraints. Of particular concern are human resource shortages in low-income countries. Available resources have to be used as efficiently as possible.
- The MDGs – with their simultaneous focus on child and maternal health, HIV/AIDS and malaria – have highlighted the fact that some constraints to effective scaled-up service delivery are common to several technical programmes. For example, all the health-related MDGs rely on the existence in a country of a well-functioning workforce of nurses and an efficient pharmaceutical distribution system – it thus makes no sense to tackle the three relevant goals separately *(3, 4)*.
- At the same time, talk of integration can arouse fears that specialist functions will be compromised. One example is technical supervision: efforts to introduce more integrated supervision, to reduce demands on local health workers' time and generate economies of scale with limited resources, raise fears about reduced quality of supervision. This fear should be baseless in a properly designed system, but must be addressed: such a system might well include specialist oversight of, for example, surveillance for a package of infectious diseases.

The idea of integrated health services is not new. Indeed it was the basis for the focus on primary health care in the 1980s. For some people this renewed interest is not surprising, as they regard integrated services as the most logical way to organize a health system today – indeed the only way that does not compromise universal access to a broad range of services. The current challenge is to be specific about what integrated services look like in different settings and how integration can contribute to the intended aim of people getting the care they need.

Multiple Meanings

"Integrated health services" means different things to different people. There are six main usages, but many nuances within these. Inevitably these overlap somewhat, particularly 1 and 2.

1. "Integrated" is frequently used to refer to **a package of preventive and curative health interventions for a particular population group** – often (but not always) this group is distinguished by its stage in the life cycle *(5).* Examples are the Integrated Management of Childhood Illness (IMCI), Integrated Management of Pregnancy and Childbirth (IMPAC), Integrated Management of Adolescent and Adult Illness (IMAI) and (not specifically related to life cycle) Integrated Management of Cardiovascular Risk. The aim of this form of integration is for individuals in the target group to receive *all* appropriate interventions, ideally from the client's perspective at a "one-stop shop". This can be very important - for example, TB services have to deal with the fact that many of their clients may be HIV positive, malnourished, smoke or have diabetes. Key questions under this definition are: Exactly what interventions should be packaged together? How are management support systems best organized to service these interventions? [1]

   Examples of efforts to deliver a package of interventions to a particular group[2]

   - *The creation of a 'one-stop shop' for people with both TB and HIV, from two previously separate clinics, in Khayelitsha, South Africa.*
   - *The creation of more adolescent friendly services within existing public health centres in India, to increase access by this age group to a package of counselling and clinical services.*

2. "Integrated health services" can refer to **multi-purpose service delivery points** – a range of services for a catchment population is provided at one location and under one overall manager. The specific 'shape' of integrated services at primary, secondary and tertiary levels of care will certainly look different because the different levels have different functions and staffing patterns. Examples are multi-purpose clinics, multi-purpose outreach visits and a hospital with the management of all its services consolidated under one Board and one Chief Executive. A feature of this form of integration from the user's perspective is the opportunity to receive coordinated care, rather than having separate visits for separate interventions. Again key issues are: Exactly what functions should be included in "multi-purpose"? How can management systems best support these service delivery points?

3. "Integrated services" to some means achieving continuity of care **over time**. This may be about lifelong care for chronic conditions such as HIV/AIDS, or a continuum of care between more specific stages in a person's life-cycle - for example, antenatal, postnatal, new born and child care.

4. Integration can also refer to the **vertical integration of different levels of service -** for example, district hospitals, health centres and health posts. In this form of integrated health services, an overall manager is in charge of a *network* of facilities and personal and non-personal health services - for example, a District or Provincial Medical Officer of Health, who in turn supervises the work of the managers of individual facilities. Ideally, s/he should be able to rise above day-to-day concerns and take a strategic overview of issues such as which services should be provided at which level(s) of the system. From the clients' perspective, a key feature of this type of integrated health service is well-functioning procedures for **referrals** up and down the levels of the system, and between public and private providers. Key issues are: what services should be provided where, and how to ensure that clients are efficiently referred. Realistically, to what extent can private and voluntary providers be integrated with the public system?

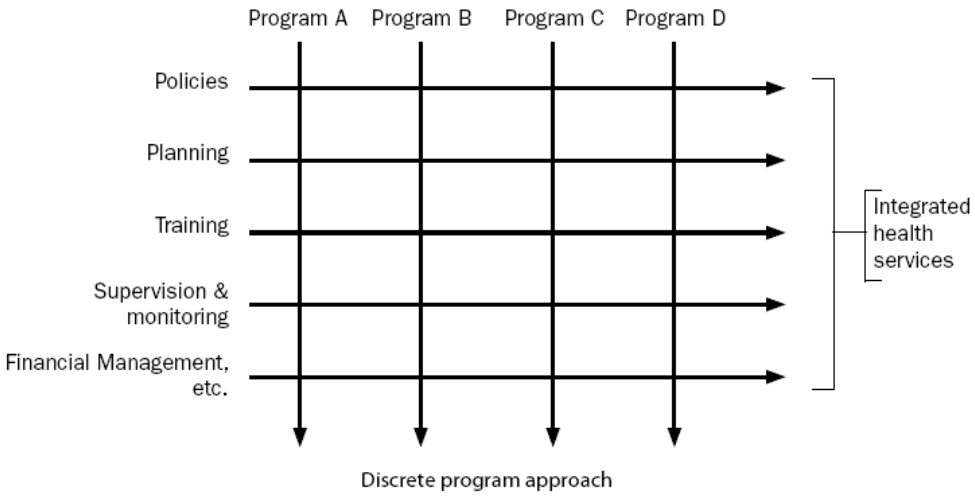
5. Integration can also refer to **integrated policy-making and management** which is organized to bring together decisions about different parts of the health service, at different levels. This definition is

[1] People speaking from a particular technical area also use this definition, but in a narrower sense to mean the combination of *some* services which were previously separate – for example the integration of HIV/AIDS and sexual/reproductive health activities; the syndromic management of respiratory symptoms (PAL), or the addition of Vitamin A or bed nets to immunization activities like National Immunization Days.

[2] Sources: a) *Trop Med Int Health. 2004; 9:A1 1-5 b) presentation by Bruce Dick WHO/CAH*

illustrated in Figure 1. For example, a ***provincial*** management team in an integrated system may have overall responsibility for the health status of a given population and may be able to simultaneously contract services from the public, voluntary and private sectors. An integrated ***district*** service would conduct integrated supervision – supervisory visits to health centres, for example, would encompass *all* aspects of the centre's work, ideally using a standardized checklist. As an example, Uganda introduced integrated support supervision to districts by multi-disciplinary 'Area Teams' in 2003. Countries with many development partners have worked to promote convergence in ***national*** policy and operations, through instruments such as jointly agreed health sector strategies and joint health sector performance reviews, which are at the heart of Sector-wide Approaches (SWAps). More integrated financial management or information systems have been slower to develop. Key issues include how best to provide an all-round good service for clients and how to solve problems such as a lack of coordination or gaps in the service. Structural changes to management support systems may be needed if more integrated policy and management functions are to be achieved.

Figure 1 – Integrated Policy and Management



6. Integration can mean **working across sectors.** It occurs when there are institutionalized mechanisms to enable cross-sectoral funding, regulation or service delivery. In industrialized countries, this concept is frequently applied to the coordination of health and social services, such as for long-term care for the elderly. It may refer to work with education services to develop effective school health promotion campaigns. The key issue here is to identify the most appropriate sector(s) to deal with a particular health issue and establish linkages between them.

In addition, there is a seventh, less common, usage, applied in countries dominated by health insurance. In this context, integration can mean that **the insurance function and health care provision are provided by the same organization**. According to this definition, Health Maintenance Organizations are an example of integration *(6)*.

Of the different usages, definitions 1-5 are best seen as continuums, rather than in terms of "integrated" or "not integrated"[3]. For example, a fully integrated service has one set of management support systems (financial and human resource management, logistics and supplies, etc.) supporting the service as a whole. In reality, various arrangements can exist under any of these definitions. In practice, separate management support systems often exist when a particular area is (or has been) supported financially by an external development

[3] The notion of 'adaptive verticality' recently suggested by Battacharya is similarly a more constructive approach to the equally ideological vertical versus horizontal debate *(7)*.

partner. This means that there are many hybrid versions of "integrated health services". One variant sometimes seen is, for example, district TB or family planning staff who report to the District Medical Officer and participate fully in district health team activities, but who receive supplies through separate supply systems or send surveillance data through stand-alone information systems.

One working definition

The most common use of "integration" – and the meaning implied in the WHO quotation above – is a combination of definitions 1-4.[4] This can be summarized as:

"The organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money."

This reinforces the fact that integration is a **means to an end**, not an end in itself. There are clearly many issues going on "behind" this general definition and it is useful to look at "integration" from various perspectives, or 'levels': the household or individual user; health care provider; health sector policy and strategy level, and inter-sectoral policy *(8)*.

For the ***user***, integration means health care that is seamless, smooth and easy to navigate.[5] Users want a co-ordinated service which minimizes both the number of stages in an appointment and the number of separate visits required to a health facility. They want health workers to be aware of their health as a whole (not just one clinical aspect) and for health workers from different levels of a system to communicate well. In short, clients want continuity of care.

For ***providers***, integration means that separate technical services, and their management support systems, are provided, managed, financed and evaluated either together, or in a closely coordinated way. The way services and support systems are organized will differ at primary care facilities (such as a dispensary or health centre), compared with secondary or tertiary level hospitals. At primary level in many low-income countries, there is often only one health worker to deliver care. Here, discussions about more integrated delivery are theoretical - though the health workers' job may be made easier or harder depending on how their management support systems are organized. At a district hospital, there may be only one obstetrician or even only one doctor. At a tertiary hospital, there will be a range of specialists. Increasing degrees of specialization are an essential part of a well-structured delivery system. They also put an extra obligation on managers to make services easy for clients to use, and to make efficient use of equipment, supplies, space and staff.

At the m*acro level of* ***senior health managers and policy-makers***, integration happens when decisions on policies, financing, regulation or delivery are not inappropriately compartmentalized. This means bringing together different technical programmes, but also considering the whole network of public, private and voluntary health services, rather than looking at the public sector in isolation. It means bringing together different development partners. Examples of integration of ***inter-sectoral policy*** have already been given.

Organizational integration happens when there are mergers, contracts or strategic alliances between different institutions.

Professional integration happens when different health professions or specialties work together to provide joined-up services. An obvious example is coordinating the timings of ante-natal and child health clinics.

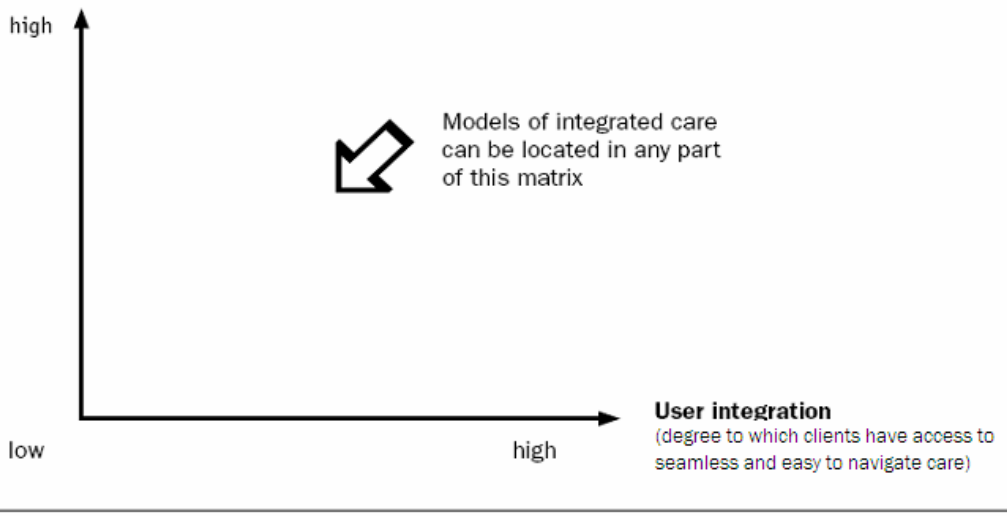
[4] This is less true for industrialized countries, where "integration" tends to be used more in the contexts of (a) links with social services and/or (b) insurance.

[5] The concept of 'integrated care pathways' aims to shift clinicians and managers to thinking more about the 'patient journey', which then leads to thinking about integrated services. An Integrated Care Pathway aims to have the right people, in the right order, doing the right thing, at the right time, with the right outcomes, and all with attention to the patient experience.

The first challenge in professional integration is to have the appropriate range of skills available in the health service; the second challenge is to ensure that different professional groups collaborate effectively. Skill mix can be tackled by employing a number of different types of professionals; it can also be improved by assigning a broad range of tasks to one specific cadre – this is what is meant by a multi-purpose health worker.

Many permutations of integration from the users' and providers' perspectives are possible. In some models of care, despite high levels of provider integration, users may experience low levels of integration in their access to care or vice versa. These ideas are portrayed visually in Figure 2 below *(8)*, which reinforces the idea of a continuum. Reference *(8)* also provides a practical example: 'Imagine a primary care centre that has organized its professionals in a network, but where communication between them is poor. Though this centre may appear integrated from a provider perspective, for the user, navigating the system has not been made any easier. From his perspective, care is still fragmented'.

Figure 2 – The Integrated Care Matrix (7)



Integration – key considerations

In the past, discussions about integration have been rather polarized – this Brief aims to show that integrated service delivery is best seen as a continuum and that it involves technical discussions about the various tasks that need to be performed in order to provide a population with good quality health services.

1. Arguments for and against integration

Many benefits are claimed for integrated health services – they can be cost-effective, client-oriented, equitable and locally owned. The "cost" part of cost-effectiveness is based on the idea that it is more economically efficient to share resources (particularly human resources) than have them devoted to one particular disease. The "effectiveness" is based on the idea that it makes sense to deal with a whole person (plus his or her family, sexual contacts, etc.) rather than focussing separately on just one health problem in an individual.

An integrated health service is not *necessarily* equitable – one can imagine a well-integrated but very inequitable system, because of, for example, a strong urban bias. The idea here is that an integrated service

has more chance of ensuring more equitable access across the spectrum of priority conditions than do a series of single-issue programmes.

Integration has its critics, who deploy the following arguments:

- Especially in countries where the wider health system does not function well, it makes no sense (or is too risky) to change a separate programme which works well. The high quality work of a programme which provides a rather narrow range of services to an excellent standard is jeopardized by integration. There are also concerns that allocation of financial resources to a particular health priority may be reduced.
- The desire for integrated services ignores *realpolitik,* which is currently dominated by an interest in targets, short time-frames and sound-bites. If the health sector is to attract attention and financial support, it needs to be able to show significant reductions in specific diseases *(9)*.
- AIDS exceptionalism – i.e. the argument that the nature of the HIV epidemic means that it is important to regard HIV/AIDS services as a special case which needs to be well-resourced, expanded quickly and "protected" from the inefficiencies of the broader health system. As with all these supposedly yes/no arguments, the reality is more nuanced, along a continuum of integration. AIDS exceptionalism does not imply that no HIV/AIDS services can be integrated.

In practice, an "always good" versus "always bad" debate about integration is not helpful. On the ground, integration is about practical issues of how to deliver health services to those who need them.

2. Lessons for successful integration

Three main lessons emerge from the literature about successfully developing integrated health services:

a. Supporting integrated services does not mean that everything has to be integrated into one package, or necessarily delivered in one place. It **does mean** arranging services so that they are not disjointed and are easy for the user to navigate. This in turn means providers have management support systems (e.g. for medicines or financial management) that help make this happen, and also make the best use of resources.

   There are also, however, arguments in favour of some "single-issue-style" provision:

   - As a short-term measure in fragile states
   - For the control of some epidemics and the management of some emergencies *(10)*
   - So that appropriate services can be provided for specific client groups such as commercial sex workers, drug addicts or prisoners (*11)*.

b. Integration isn't a cure for inadequate resources. Integrating two separate programmes may provide some savings, but integrating new activities into an existing system can't continue indefinitely without the system as a whole being better resourced. For example, a given workforce of nurses cannot be expected to add more and more duties to their workload without expanding the overall workforce at some point. *Quality* of care can also be affected by integration and, hence, needs to be regularly monitored. Nor is integration a cure for something that simply doesn't work. A public system with no track record of regulating the quality of private providers may decide to "integrate" private provision of priority services, but this will not change the underlying problem of non-existent regulation of private provision.

c. There are many more examples of policies in favour of integrated services than there are of actual implementation *(8)*. It involves a mix of political, technical and administrative action. People are asked to change the way they work. Control over money and staff may need to change. Incentives may need to be altered. Potential forces for "disintegration", such as powerful interest groups or tightly earmarked funds that encourage the development of parallel management systems, may have to be actively managed.

Legitimate concerns need to be addressed and ways found to get "single issue" champions on board. Developing integrated health services requires a full-scale “hearts and minds” commitment, backed up by guidance, such as that from the South African Department of Health *(12)*. Activities at the operational level often rely too heavily on training alone and need to be complemented by changes at the management level. Otherwise, there are situations such as new working practices for health workers (who may be asked to change their hours of work, for example, to better meet clients’ needs) which are not reflected in the documents and procedures of the Human Resources Division.

There is a need to look for good "entry points" where change is feasible and judged necessary to improve services and make better use of resources. Specific programme needs have to be considered - not everything needs to be done at once. In practice, integration is often a messy, rather 'bitty' process.

3. A weak empirical base

The empirical base for many of the above arguments is weak. Most research work has focussed on reproductive health and integration *(13, 14)*. We know for example that the integration of STI management is sometimes beneficial and sometimes not appropriate. So we know that the *move* from disease- or population-specific programmes to integrated services has risks as well as benefits and needs to be managed carefully. Empirical evidence, at least from low- and middle-income countries, is limited for the more basic question: As we develop and expand service delivery, is it right to assume that concentrating on integrated services is the best approach? A Cochrane review of integration concluded:

> “Few studies of good quality, large and with rigorous study design have been carried out to investigate strategies to promote service integration in low and middle income countries. All describe the service supply side, and none examine or measure aspects of the demand side. Future studies must also assess the client's view, as this will influence uptake of integration strategies and their effectiveness on community health.” *(16, page 1)*

While more empirical evidence from low-income countries is needed for this topic, Cochrane-style systematic reviews are likely to yield only limited additional information. More thought needs to be given to other more appropriate study designs. Experience from high-income countries should not be ignored - provided it is carefully interpreted.

Conclusion

“Integration” is used by different people to mean different things. Combined with the fact that this is an issue which arouses strong feelings, there is clearly much scope for misunderstanding and fruitless polarization.

In practice, however, integration can be broken down into a series of practical questions about who does what at what level(s) of a health system. Being clear about these questions can be the basis for constructive discussions about the development of integrated health services. Questions to be asked include:

- What problem are we trying to solve? Is it user dissatisfaction with services, or government concerns about costs and inefficiencies? What do we want to achieve?
- At what level(s) of the health system does the problem manifest itself? This may be anywhere from the primary level of care to national policy-making.

- What needs to be done at each level identified, to result in better services for users, and better use of resources? "Things to do" can relate to organizational structure; support systems such as financing or information; job descriptions and other personnel issues, or better information for clients.
- Who can help solve the problem? Who will be affected by the proposed changes? Will they want to change? How do we get them on board? Have the politics of the issue been fully taken into account?
- Are there some feasible "entry points" from which to start?
- What will happen if we don't change?
- How can we tell whether the changes have resulted in better services?

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This brief was prepared by Catriona Waddington, HLSP and Dominique Egger, WHO Department of Health System Governance and Service Delivery, on behalf of the WHO Working Group on Service Delivery. It has been peer reviewed. See www.who.int/healthsystems for additional resource materials on health system topics.