

INTEGRATED HEALTH SERVICES – WHAT AND WHY?

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 a topical issue, largely because of the rise of single-disease funding and 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 – it is important to be clear about how the term is being used. Six common uses of the term are described in this Brief.

Integration is best seen as a continuum rather than as two extremes of integrated/not integrated. Integration is about the organization of various tasks which need to be performed in order to provide a population with good quality health services.

An overall working definition of integrated service delivery is **“The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.”**

The evidence base about integration is limited, though a systematic review was published in 2007 (15). We have learned 3 important lessons:

- ▶ Supporting integrated services does not mean that everything has to be integrated into one package. In reality, there are many possible permutations.
- ▶ Integration isn't a cure for inadequate resources.
- ▶ There are more examples of policies in favour of integrated services than examples of actual implementation. Managing change may require action at several levels. It requires engagement of health workers and managers, plus a sustained commitment from senior management and policy-makers.



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 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 service” 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 Brief aims to show that integration is best seen as a continuum and is 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)

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 – 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 – what are the key functions which need to be delivered?

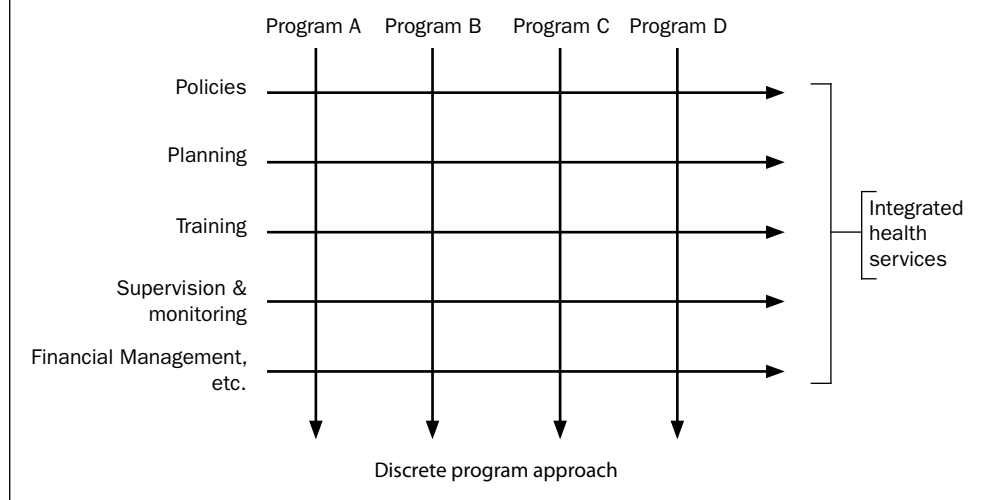
Multiple Meanings

“Integrated health services” means different things to different people. There are six main usages, but many nuances within these. Inevitably these overlap somewhat, particularly definitions 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 need to deal with the fact that many of their clients may be HIV positive; be 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
2. “Integrated health service” 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. 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 client’s perspective is the opportunity to receive co-ordinated 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 life-long 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, newborn and child care.
4. Integration can also refer to the **vertical integration of different levels of service** – for example a district hospital, 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 and support functions across different parts of the health service. For example a 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 look at all aspects of the centre’s work, ideally using a standardized checklist. This definition is illustrated by the horizontal arrows in Figure 1. Key issues include how best to provide an all-round good service for clients and how to solve problems such as a lack of co-ordination or gaps in the service.

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 or an integrated strategy for preventive chemotherapy for four neglected tropical diseases (lymphatic filariasis, onchocerciasis, schistosomiasis and soil-transmitted helminthiasis).

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 co-ordination 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, used 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)

Definitions 1-6 are best seen as continuums, rather than in terms of “integrated” or “not integrated”. 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 partner. This means that there are many hybrid versions of “integrated health services” – an example is a district TB officer who reports to the District Medical Officer and participates fully in district health team activities, but who receives TB drug supplies through a separate supply system and sends TB surveillance data through a stand-alone information system.

One working definition

The most common use of “integration” – and the meaning implied in the WHO quotation on page 2 – is a combination of definitions 1 - 5.² This can be summarized as:

“The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.”

² 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.

There are clearly many issues going on “behind” this general definition and it is useful to look at “integration” from various perspectives. (7)

For the **user**, integration means health care that is seamless, smooth and easy to navigate. 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.

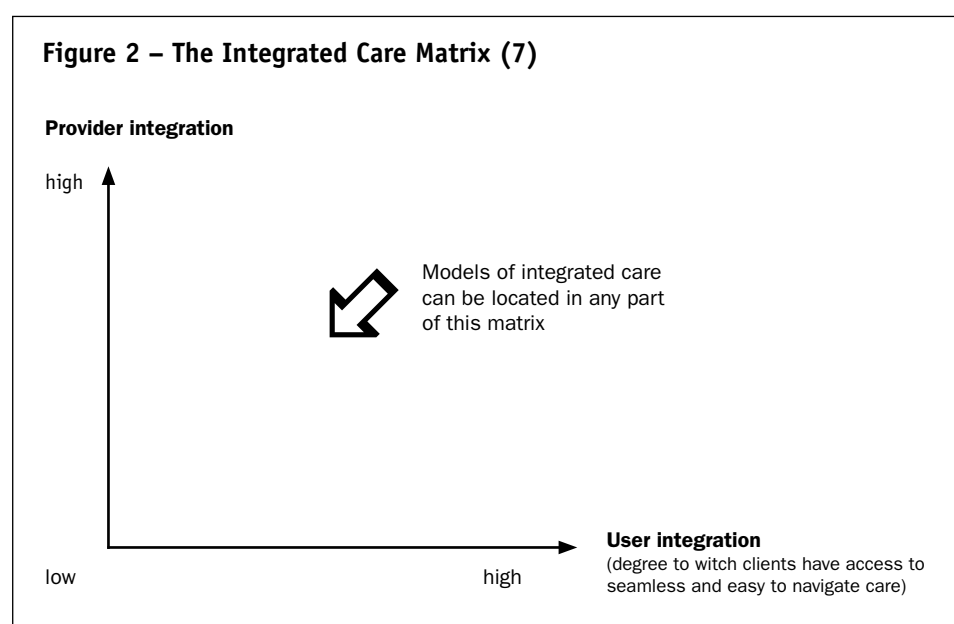
For **providers**, integration means that separate technical services (and their management support systems) are provided, managed, financed and evaluated either together, or in a closely co-ordinated way.

At the macro level of **senior 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.

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 co-ordinating the timings of ante-natal and child health clinics. 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 professional; 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 (7), which reinforces the idea of a continuum. Reference (7) 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”.



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 the 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. (8)
- ▶ 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. It is best regarded as a continuum. There are also 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 (9)
 - ▶ so that appropriate services can be provided for specific client groups such as sex workers, drug addicts or prisoners. (10)
- (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. Moreover, integration is not 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). 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. (11) 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.

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. (12, 13) We know, for example, that integrating services does not automatically lead to an uptake of family planning – indeed it can have the reverse effect. We also know that STI treatments for women can increase significantly when the treatment is integrated into broader health service delivery. (14) 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. There is little empirical evidence, at least from low and middle-income countries, 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? This conclusion about a weak evidence base is confirmed by a 2007 Cochrane systematic review of integration, which 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.” (15, page 1)

More empirical evidence from low-income countries is needed. At the same time 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.

Integration can be broken down into a series of practical questions about who does what at what levels of a health system. Being clear about these questions can be the basis for constructive discussions about the development of integrated health services.

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