

KEY POINTS

- Integrated primary care is a widely shared and laudable policy goal but can take many forms, with different measures to define success.
- Across Asia and the Pacific, integrated primary care reforms are motivated by a desire to improve care for patients with chronic conditions, reduce demand on hospitals, and improve patient experience by offering more coordinated care across providers.
- Examples of integrated primary care reforms include broadening the scope of community health workers for malaria into other diseases, creating community-led integrated care services for bedridden older people, providing an integrated virtual and face-to-face private primary care provider, and utilizing emerging models of integrated service delivery networks.
- This brief aims to explain what integrated primary care is, what the real-world evidence suggests can go right and wrong in its implementation, and how implementers of this concept can ensure their reforms generate genuine value.

Achieving Integrated Primary Care in Asia and the Pacific**INTRODUCTION**

Integrated primary care is a high-profile issue among health system decision-makers across Asia and the Pacific. It is an explicit and laudable policy priority of many large, ongoing health-care reforms, and is prominent in discussions among policy-makers at the local, national, and regional level. However, the definition and goals of integrated primary care are not straightforward; hence, it can be difficult to determine how this broad concept can be translated into practical reality.

Reforms in integrated primary care are a complex combination of interventions involving multiple providers, programs, and communities, and often across multiple care settings or levels.

Primary care is the foundation of effective care integration, anchoring care continuity, health system–citizen engagement, and the spread of cost-effective preventive and health promotion strategies.

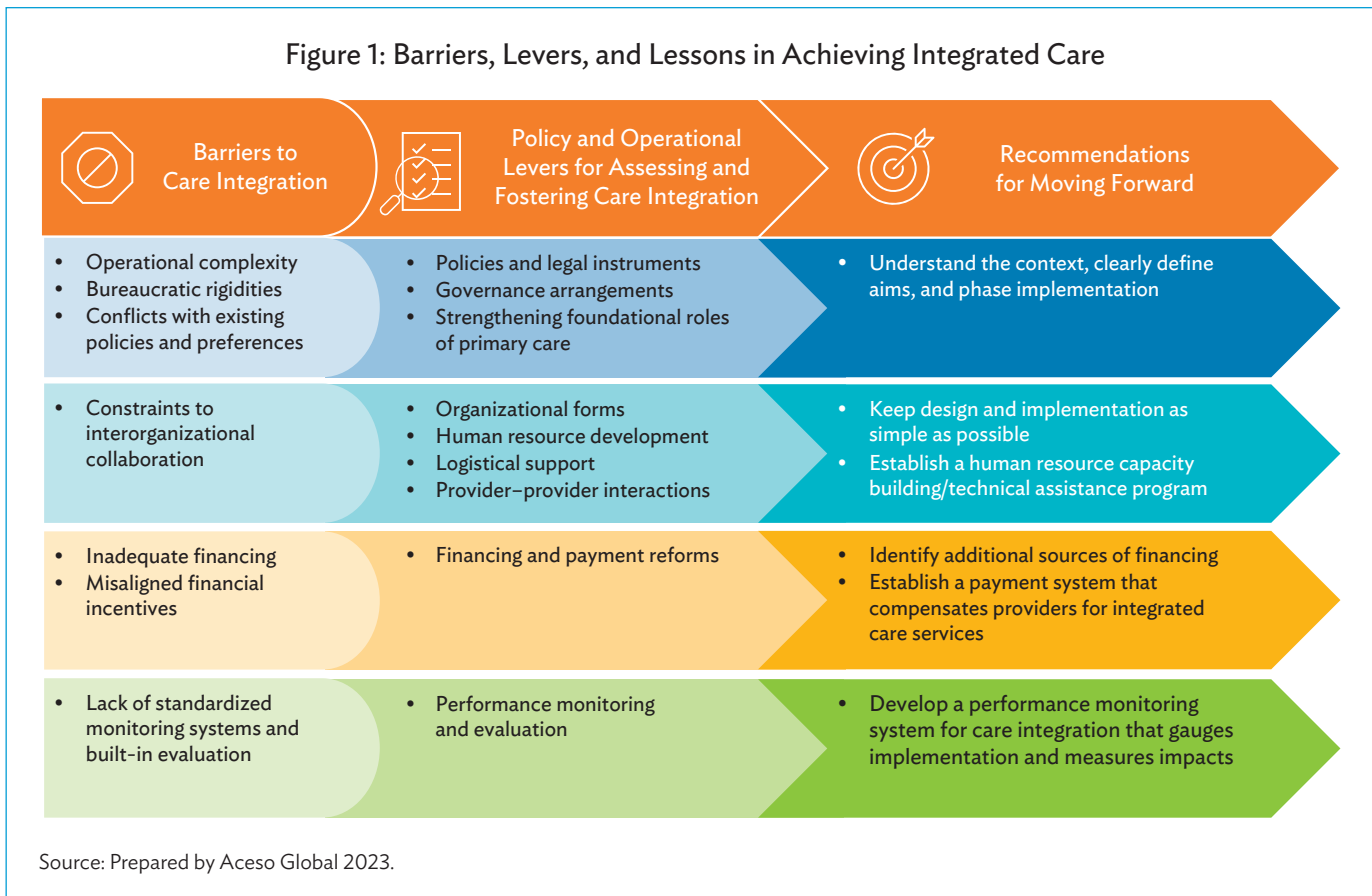
Global experiences suggest that implementation of primary care integration is extremely challenging, especially for health agencies with limited capacity to manage multifaceted, multiyear change programs across multiple care settings. In these instances, the benefits of care integration in the context of primary health care (PHC)—improved outcomes, cost efficiency, and patient experience—may not materialize.

Failed or misguided implementation of integrated primary care might result in (i) resources being concentrated in services that patients prefer not to use, (ii) guidelines that exist on paper but not in practice, (iii) duplication of effort and mistrust between professionals, and (iv) years of administrative effort that might have been better directed elsewhere. It is therefore crucial that health system decision-makers understand what integrated primary care means, how it relates to the broader strategies for care integration, what it means in practice for their system, whether it is likely to be a good solution for the challenges they face, how to achieve it, and how to know whether it has been a success (Figure 1).

Note: ADB recognizes “China” as the People’s Republic of China and “Vietnam” as Viet Nam.

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Figure 1: Barriers, Levers, and Lessons in Achieving Integrated Care



WHAT DO WE MEAN BY “INTEGRATED CARE” AND “INTEGRATED PRIMARY CARE”?

“Integrated primary care” features as an objective in nearly all health system strategies, policies, and reforms across Asia and the Pacific. It is embedded implicitly or explicitly in broader strategies and policies of “integrated care”—meaning, it is not a standalone strategy separate from that of care integration.

The World Health Organization defines integrated health services as “the management and delivery of health services such that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course” (WHO 2015). This means that integrated care is concerned with achieving, from the patient’s perspective, coordination between the different health services that they need, regardless of who provides them and where they are provided.

In this context, primary care is an essential *foundational element of care integration*, taking on a new set of roles known as *integrating functions*. These functions include serving as patients’ first point of entry into the delivery system; coordinating their care across health-care

settings (e.g., making and confirming appointments, tracking referrals and discharges); assisting them navigate and transition among multiple providers; providing follow-up care; and, if necessary, arranging for social services.

The achievement of care integration depends on local objectives and conditions. Across Asia and the Pacific, the common drivers of interest in integrated care reforms are typically a combination of the following (Liu and Tang 2021):

- (i) A response to an increasing proportion of patients having multiple, often chronic diseases that do not easily fit into a traditional model of acute, episodic care delivered by individual outpatient specialties;
- (ii) A recognition that the lack of a continuous relationship between providers and patients results in patient zigzagging from provider to provider to secure a diagnosis or resolve an illness episode, contributing to high out-of-pocket and system spending;
- (iii) A desire to address “wrong siting” of care in which low severity patients—by choice or through referral—are treated at higher-level hospitals resulting in overcrowding, long waiting times, and higher costs;
- (iv) A belief that the lack of systems to control and govern how providers coordinate with each other is driving unnecessary health-care costs; and

- (v) A concern about the lack of coordination of vertical disease-specific programs, which are often operated as separate silos resulting in fragmented care.

These intentions manifest as a huge range of complex policies and interventions that are often labeled as “integrated primary care” reforms:

- Enforcing referral guidelines and networks between primary care and specialized outpatient providers;
- Integrating disease-specific vertical programs so that patients can count on a single provider to receive ongoing, timely, and comprehensive care;
- Task sharing between, and role redesign of, primary care professionals;
- Incentivizing primary care providers to engage in greater prevention and health promotion activities;
- Mandating clinical standards for the management of chronic diseases;
- Promoting interoperability across health information systems;
- Aligning the roles of different health-care planning and administration agencies; and
- Merging small PHC providers into larger organizational groups and networks.

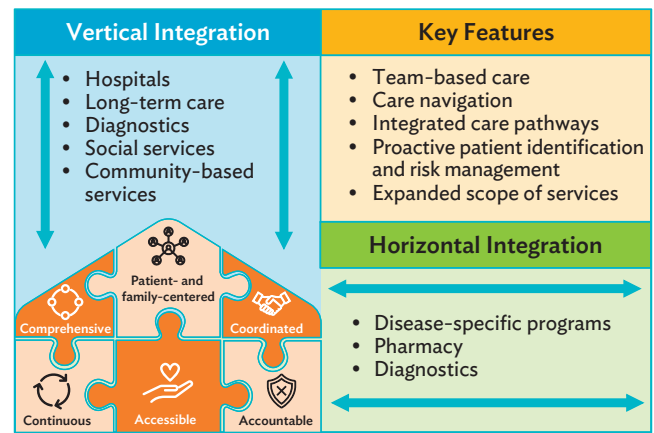
An important distinction is often made between “horizontal integration,” which focuses on different providers of primary care (e.g., vertical disease programs), and “vertical integration,” which focuses on interactions between primary care and nonprimary care providers (e.g., hospitals, long-term care homes, pharmacies, etc.). In both of these cases, primary care takes on integrating functions.

The nature of “integration” of integrated primary care reforms can occur at different levels (Valentijn et al. 2013), including:

- **Service-level integration**, which brings multiple vertical disease programs together into one service, linking PHC downward with community-based services or upward with specialty clinics and hospitals;
- **Professional-level integration**, which encourages different professional cadres to work more closely together (e.g., community health workers, general practitioners staffing PHC units, hospital specialists, or village and religious leaders);
- **Organization-level integration**, which includes aggregating multiple primary providers together, or together with hospitals; and
- **System-level integration**, which encompasses the aforementioned levels of integration where these partnerships cross through the boundaries of “cure” and “care” fields.

From a more operational standpoint, one of the most comprehensive models of integration is the concept of the “primary care medical home” (Figure 2). In principle, this model is a one-stop health-care setting providing continuous, timely, and comprehensive care. The primary care medical home fulfills a number of functions, covering both horizontal and vertical integration.

Figure 2: The Primary Care Medical Home Concept



Source: Prepared by Aceso Global 2023.

One set of functions involves bringing specific services and staff in-house within the primary care setting—e.g., co-locating teams of staff working on vertical disease programs that might target screening and treatment of particular chronic or infectious diseases, or using point-of-care diagnostics that might previously have required a hospital visit. Another involves giving the primary care medical home specific responsibilities regarding the care of their patients by other providers—e.g., making appointments for specialty care, tracking hospital referrals, and arranging for post-discharge follow-up care. There is also an important population health management role that includes proactive identification of high-risk patients for care management interventions, such as medication reviews, health coaching, or advanced care planning. A primary care medical home is not always a physical place, but can refer to services offered by an integrated team or organization that may, for example, offer digital and community-based care as well.

This multidimensional nature of integrated primary care (like the primary care medical home), on one hand, helps decision-makers engage with the many different actors, interventions, and outcomes that they might need. On the other hand, everyone in the health system can strongly support the concept without ever agreeing on what it is. This puts the onus on policy makers to be very clear about what problems they are trying to solve through integrated primary care, what it will mean practically (and for who), and what is realistically achievable within the constraints of the system.

WHAT ARE THE BARRIERS TO ACHIEVING INTEGRATED PRIMARY CARE?

The biggest leap for any integrated primary care reform is transforming policy statements into sustainable actions, anchored in the realities of local capacities and conditions. Health-care leaders need to anticipate and understand the implementation barriers that they are likely to encounter.

Figure 3: Common Barriers to the Implementation of Integrated Primary Care



Source: Prepared by Aceso Global 2023.

In the last 25 years, numerous integrated care projects, which included strengthening of primary care, have been launched in high- and middle-income countries. Some integrated care models have successfully improved quality of care, access, and patient satisfaction, although evidence of cost savings is more mixed (de Bruin et al. 2020; Steele et al. 2020). A notable global pattern is the failure to scale up integrated care initiatives and pilots, even when they have shown signs of success (Maruthappu, Hasan, and Zeltner 2015; Goodwin 2019). Understanding this lack of scale-up and the barriers to implementation is critical for health-care leaders in Asia and the Pacific to design more effective and sustainable integrated care initiatives in their own countries.

Six common but interrelated barriers have emerged from recent literature, examining the implementation of care integration efforts—all of which involve foundational roles for PHC (Figure 3).

A. Operational Complexity

A fundamental rule is to “keep it simple.” Nevertheless, integrated care initiatives generally break this rule by being too ambitious and attempting to combine too many dimensions all at once.

First, countries tend to set overly ambitious aims, such as attaining full system integration. Well-known models—like the United States’ Kaiser Permanente and the United Kingdom’s system of general practice—typically evolve over decades with many supporting factors. While the opportunity and environment for sweeping reforms of primary care do occasionally emerge, it is better to *evolve* rather than *transform*, and align change programs to the capacity and capabilities of those who will be implementing them.

Second is the common tendency of incorporating multiple components and multiple partners that span multiple facets of a broader safety net system, including social services, long-term care, mental health, addiction services, infectious and chronic

disease programs, primary care, and hospital care. Research has shown that the more complex the scope, the more time is required to implement or achieve the anticipated change—and even the more time needed to show impacts (Leutz 2009). Integration fatigue can become an issue because too much may be expected of the sites subject to integration in too short a time.

Finally, implementation has failed in some countries because the existing primary care services are simply not strong enough to provide the basics, let alone embrace a complex integrated primary care approach (Hu et al. 2021). Integrating weak providers can be a recipe for failure as the providers themselves may not have the skills or capacity required to perform the new functions assigned to them.

B. Bureaucratic Rigidities and Programmatic Silos

Most health-care systems are very fragmented, with few linkages between different levels of care. Even in public sector-dominated systems, where government agencies own, finance, and operate health-care facilities, different bureaucracies operate different levels of care, and linkages are rare or even resisted.

In many low- and middle-income countries (LMICs), donor-driven vertical disease programs operate under separate bureaucratic structures, with separate personnel, information systems, and reporting requirements. Personnel in these silos are often unfamiliar with other parts of the health-care system, and managers are expected to maintain smooth internal operations and foster donor-supported program performance. In extreme cases, vertical disease programs can operate as mini-ministries in isolation from the rest of the health system. Insufficient information sharing within and across government programs and providers exacerbates fragmentation, and separate donor activities simply makes the integration agenda difficult to design and execute (Box 1).

Box 1: Lao People’s Democratic Republic— Integrating Malaria and Nonmalaria Services in the Work of Village Health Volunteers

The Lao People’s Democratic Republic (PDR) has effectively used village health volunteers (VHVs) to curb malaria incidence, with financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other community service organizations (CSOs). VHVs provide malaria-specific services, such as the provision of diagnostics, bed nets, and medicines; case referrals; and the collection of malaria incidence data. Oftentimes, they also provide other nonmalaria services, including the provision of first-aid kits, facilitation of antenatal care, and patient referrals, since they are either the sole VHV in the village or simultaneously recruited by another vertical program.

In an evaluation of VHVs who provide malaria and nonmalaria services in select provinces of the Lao PDR, weaknesses and challenges emerged in the areas of sustainable financing and operations:

- Due to a lack of central coordinating units between the government and CSOs, VHV payments were delayed;
- Disjointed information systems (DHIS2 and Google Sheets) increased the administrative burden on VHVs and resulted in duplication of efforts;
- Primary health-care centers had enough malaria commodities, but insufficient basic supplies such as gloves and first-aid kits because of lack of program planning and coordination between CSOs and the government.
- The reliance on a single source of funding limits the sustainability of VHVs, who are frequently funded by CSOs and are critical to malaria and community needs.

Sources: H. G. Napier et al. 2021. Evaluating Vertical Malaria Community Health Worker Programs as Malaria Declines: Learning from Program Evaluations in Honduras and Lao PDR. *Global Health: Science and Practice*. 9 (Supplement 1). pp. S98–S110; and M. C. Oo et al. 2022. Perspectives of Health and Community Stakeholders on Community-Delivered Models of Malaria Elimination in Lao People’s Democratic Republic: A Qualitative Study. *PLoS ONE*. 17 (3).

In many countries, fragmentation also results from decentralization, where local government units are mandated to operate one level of care (such as PHC), while provincial and central governments operate other levels (such as secondary and tertiary hospitals).

C. Conflicts with Existing Policies and Preferences

Integrated care can be constrained by existing but conflicting policies and regulations related to referral systems, chronic care practices, reimbursement rules, and program-for-results. Some countries needed to amend policies related to the care of patients with complex, chronic conditions to allow care teams to reshape care practices and create integrated care models for these conditions (Ham and Smith 2010; Nies et al. 2021).

In Asia and the Pacific, a common concern is that patients bypass lower levels of care to directly access hospitals. This can be the result of explicit policies permitting direct access to specialists, informal agreements among physicians, and preferences of patients themselves. Bypassing hinders a key objective of integrated PHC initiatives, which is to implement primary care as single point of entry and gatekeeping policies. If primary care is simply seen as a place to get a referral, patients may perceive this as an administrative barrier to getting the care they need, and may therefore contribute to care fragmentation and undermine integrated care objectives.

Another common example involves restricting reimbursements to services exclusively performed by physicians, which limits the roles of other professionals such as nurses and community health workers (Danhieux et al. 2021). In Thailand, the long-term care program budget for older people only covers case coordination provided by volunteer caregivers (Box 2). It does not cover the

Box 2: Financial Barriers to the Integration of Long-Term Care for Older People in Thailand

In 2016, The National Health Security Office, with the support of the local administration organizations, piloted an integrated long-term care program targeting 100,000 bedridden and homebound older people in 1,000 subdistricts of Thailand, with the goal to reach national coverage in 3 years. With the financial backing from the national insurance system, and locally-matched health fund resources of the local governments, community caregivers are trained to provide assessment, care management, and in-home visits to older people. It includes social care services, such as support for activities of daily living, transportation, social and economic assistance, and health-care services that encompass nursing, medicines, and rehabilitation services. Subdistricts also assign care managers to conduct eligibility assessments, identify population needs, and manage the local caregivers.

According to an Asian Development Bank (ADB) evaluation, significant progress was made in expanding access to long-term care for older people, but the most ambitious goals were not met. In 3 years, national coverage was attained and 72.5% of communities were able to implement the program. Besides implementation obstacles, ADB highlighted the financial barriers plaguing the pilot program:

- Local governments can only fund what is included in the law, making it more difficult for new program to obtain funding;
- Only case coordination is financially compensated, but not health professional and social worker services;
- The fiscal viability of the financing mechanism through the universal coverage scheme for long-term care is an ongoing concern since it is entirely funded by taxes with no cost-sharing mechanism. Projections show that new funding sources, local taxes, and tax transfers are required to sustain the program in the long run.

Source: ADB. 2020. *Lessons from Thailand’s National Community-Based Long-Term Care Program for Older Persons*. Manila.

actual health-care services required by older people, which are provided by health professionals and social workers, such as treatment, nursing, and physical therapists.

D. Lack of Suitable Financing and Payment Mechanisms

Existing payment models often stand in the way of integrated primary care. One important lesson is summarized by Leutz (2009): “Integration costs before it pays.” Savings take time to emerge, and cash (as opposed to notional) savings from care integration have been elusive.

Another barrier is the “unfunded mandate”: organizational partners, such as primary care units and hospitals, are expected to implement the additional tasks and complex innovations embedded in care integration, on top of their existing workloads, using their current resources.

Public systems using facility-based budgetary mechanisms to finance health care require some form of pooling to overcome financial fragmentation across providers (Suter et al. 2009). However, organizations may find financial pooling risky and unacceptable. Goddard and Mason (2017) refer to an “integration paradox,” wherein organizations lack incentives to coordinate and prefer to “protect existing activities and resources that currently rest within organizational boundaries.”

Finally, payment models in many countries disproportionately reimburse medically necessary acute care, while other services that are key to care integration are poorly rewarded, including consultations for preventive care, virtual and team-based consultations, and home-based care.

E. Constraints to Interorganizational Collaboration

Strong communication and relationships across organizations are critical to delivering integrated primary care. However, in many LMICs, provider-to-provider interactions are limited to loosely formulated referral systems. Resistance to integrated primary care programs emerges from concerns over professional boundaries and hierarchies that can translate into confusion and mistrust. Health-care systems were developed based on professional status, specialization, and compartmentalization. Introducing models that work across such compartments in both space (i.e., care coordination) and time (i.e., care continuity) can be a formidable challenge.

Another serious barrier is the lack of dedicated managerial staff, and the difficulty for clinicians to take on managerial roles. Operations managers play important roles in implementation, including overcoming active resistance to change and dealing with the inevitable fatigue of long-term transformation. The failure of integrated care programs to consider how to manage change processes and relationships across organizations is increasingly considered the Achilles heel of care integration (Miller and Stein 2020).

F. Lack of Standardized Monitoring Systems and Built-In Evaluations

The success of care integration will depend on a well-formulated system of measurement, analysis, and feedback of results. Evidence-based performance monitoring is critical to improving the working practices of care integration. Often, lack of interoperability of information systems hampers both integration and attempts to measure it. Failure to design built-in evaluations constrains the ability of decision-makers to sustain well-functioning initiatives and improve or abandon poorly functioning ones.

There is increasing consensus that evaluation of integrated care programs should be an ongoing, iterative process throughout the programs’ implementation (Goodwin 2019). This suggests a stronger focus on performance—and process—monitoring as an adjunct to impact evaluation. Monitoring provides the evidence to course-correct during the program, rather than completing the work and having an evaluation done long after the program has concluded.

WHAT LEVERS EXIST FOR ESTABLISHING AND FOSTERING INTEGRATED PRIMARY CARE?

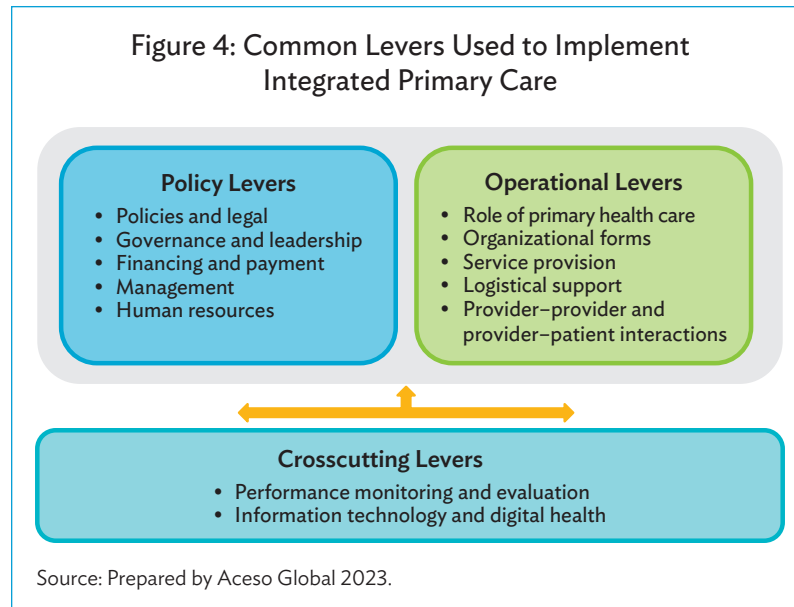
To understand how the transition from concept to implementation and scale-up can work, it is important to **understand the types of levers used to achieve integrated primary care in practice.**

Figure 4 presents a framework of three categories of levers available to policymakers seeking to pursue integrated primary care: (i) **policy levers** support and authorize desired integrated care practices through policies, regulations, financing, and governance arrangements; (ii) **operational levers** involve frontline, service-level changes to clinical practices, care models, provider organizations, and patient interactions; and (iii) **crosscutting levers** use tools such as performance monitoring and evaluation, information technology, and digital health.

The multidimensional nature of integrated care programs typically requires multiple levers to be used in combination to achieve the desired change. Box 3 summarizes one such example—the creation of local service delivery networks in the Philippines.

A. Policy Levers

Policies and legal. This lever entails securing integration-friendly policies, laws, and regulations to support and activate change toward integrated systems. An underlying issue is the need for strong political commitment and robust rationale for the formation of networks or groups of providers that will implement integrated care functions. In many European countries, for example, national policies created visions, processes, and strategies for care integration at regional levels.



Governance and leadership. Integration involves linking diverse medical care organizations, providers, and professionals. Many are accustomed to working in a fragmented organizational environment. Linking these actors will require strong governance structures to promote care coordination and accountability for results. The organizational forms for governance vary across countries. In some cities and regions in the United Kingdom, for example, integrated management boards were created consisting of participating provider representatives (Dates et al. 2018). In the Philippines, the Implementing Rules and Regulations of the Universal Health Care Act (2019) also called for the establishment of provincial and city health boards to oversee and coordinate the provincial- and city-wide integrated service delivery networks (Box 3).

Financing and payment. Many countries are experimenting with alternative payment mechanisms to incentivize providers to coordinate care, improve quality, and contain costs. These typically augment existing systems of primary care payment (capitation, global budget, or fee-for-service); however, the organizational conditions for them to be effective on their own, such as Accountable Care Organizations, rarely exist. La Forgia and Graunke (2020) highlighted two mechanisms that are relevant to primary care integration in the Asian context: pay-for-Coordination and pay-for-performance (PFP).

Pay-for-Coordination has been used extensively to incentivize providers to coordinate care for the chronically ill across different service providers. This is to compensate providers for the additional work of managing patients with chronic conditions, such as (i) coordinating care between providers in multiple settings; (ii) information sharing about care delivery and outcomes between providers, including investments in electronic medical records; and (iii) reducing unnecessary use of, and referrals to, higher levels of care.

Pay-for-performance is a provider payment method in which providers are compensated for meeting specific benchmarks or outcomes connected to care delivery. PFP has been applied

Box 3: Service Delivery Networks in the Philippines: A Work in Progress

Since the early 2000s, the Philippines has been strengthening care integration in service delivery through the development and testing of organized network arrangements. The Universal Health Care (UHC) Act of 2019 launched a new and more extensive phase of network formation—i.e., the province- and city-wide health-care provider networks, which draw on the experiences and lessons learned from piloting service delivery networks (SDNs). Using the framework of the three levers (policy, operational, and crosscutting), an assessment of existing SDNs was conducted in two provinces in 2019–2020 to inform the planning and implementation of health SDNs under the UHC Act. The assessment found that SDNs focused on strengthening (i) primary care, especially through linking community health workers with primary care facilities in rural areas; (ii) referral systems, especially for mother, newborn, and child health (MNCH); (iii) community engagement; and (iv) training of barangay (neighborhood) health workers for MNCH. The assessment identified a number of opportunities and challenges.

Policy levers. The SDNs benefited from an enabling political environment at the local government unit level. While no formal policy framework existed, SDNs were established through local ordinances. Governance structures were constituted through the creation of SDN boards consisting of local and regional health officers and program managers. The boards themselves established technical working groups to manage SDN operations, conduct workforce needs assessments, and provide technical assistance to the fledgling SDNs. However, key managerial components were not developed for SDNs as an entity, including standard operating procedures, procurement, supply chain, and human resource management systems. Another limitation was the absence of a financing mechanism for SDNs. SDNs were financed mainly as part of the regular health budget and received insufficient and irregular funding.

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Box 3: Continued

Operational levers. From an organizational standpoint, SDNs can best be described as a *loosely linked arrangement*, in which interfacility interactions are governed through memorandums of understanding between facilities and boards. These agreements specified roles and responsibilities, including referral and transportation arrangements. More organized forms have yet to take shape. In terms of service delivery, the assessment found that the SDNs focused on introducing primary health care (PHC)-based integrated care through the use of registries for pregnant women, newborns, and patients with noncommunicable diseases (NCDs), as well as guidelines or pathways for treating specific conditions (MNCH, hypertension, diabetes). However, implementation varied considerably. Activities to improve vertical integration focused on upward referrals for MNCH and emergency obstetric care, and to a lesser extent, NCDs. Other aspects of vertical integration, such as fostering patient navigation, population management, multidisciplinary team for NCD management, PHC gatekeeping, and integrated care patient pathways, were absent. The assessment also showed that SDNs have not implemented activities related to horizontal integration of vertical programs.

Crosscutting levers. The results show that with the possible exception of referrals, performance monitoring in both provinces relates primarily to the data reporting requirement of the broader delivery system, including disease-specific vertical programs, and did not pertain to SDN performance per se. Health workers compile data and indicators required by government and programs financed by development partners. The government has yet to create a nationwide set of indicators or a monitoring system for SDNs. Finally, most facilities report installing electronic medical records, which provide patient and treatment information, but the systems are unable to share data across facilities.

Source: G. La Forgia. 2020. *Service Delivery Networks in the Philippines: Results of an Assessment and Readiness Survey in Batangas and Sorsogon*. Report presented to the Department of Health, Philippines, and the World Bank. Washington, DC: Aceso Global.

extensively in primary care and hospital settings. PFP has led to primary care physicians seeing more patients, offering more services, making fewer unnecessary referrals, and treating more complex patients—all important objectives of integrated PHC.

Similar to pay-for-coordination, PFP programs typically are built on top of existing payment mechanisms and are directed to providers for fulfilling benchmarks, following guidelines, and reporting performance data (Tsiachristas et al. 2013). Governments or insurers select the indicators for the activities or services they seek to incentivize. These can include (i) adhering to standardized clinical processes, (ii) improving patient safety, (iii) lowering hospital admissions and emergency room utilization, (iv) financing start-up costs to invest in information technology infrastructure, and (v) developing managerial capacity to track patient flows and outcomes.

Management. Transitioning from fragmented organizational arrangements to more coordinated and integrated arrangements is

a complex and long-term endeavor. Some observers recommend developing a change management strategy to guide the change process, thereby making the organizational culture open to change and learning (Goodwin, Stein, and Amelung 2017; Garside 1999). Essentially, the organization seeks to create a managerial environment to enable an integration culture that values openness over blame, influence over power, and team-based and collaborative work processes over top-down arrangements; and promotes innovative change, problem identification, and learning by frontline service providers.

Human resources. The rise of chronic illnesses globally necessitates the development of a professional workforce that can coordinate continuous treatment for patients with ongoing conditions, rather than just treating acute conditions. There are two main approaches to addressing this need: (i) investing in workforce development and training, and (ii) reforming care organizations and processes based on the multidisciplinary teamwork principle.

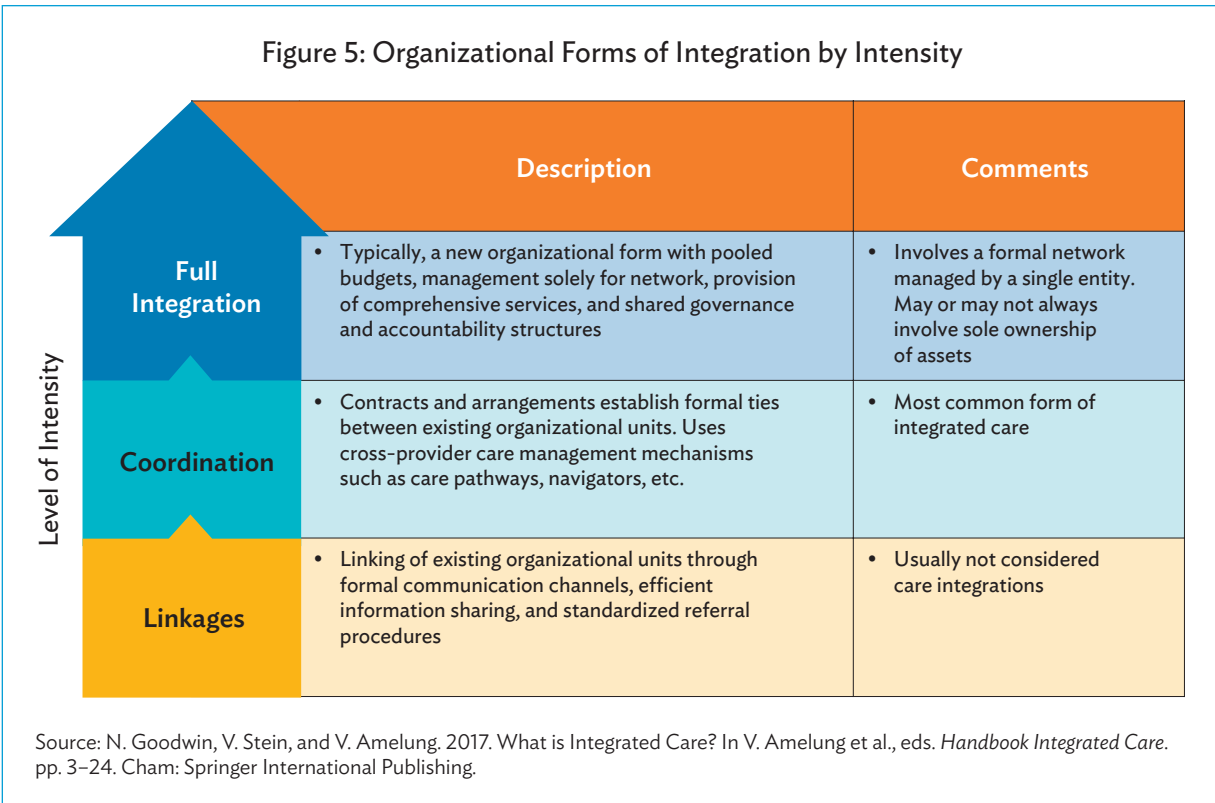
The first approach requires defining the skills and competences needed for integrated primary care and investing in the training required to translate these, including adjusting the mix of specialties and credentials that this might require. A priority is often communication skills, which are key to effective integrated primary care. From a patient perspective, strong communication skills help equip them with the knowledge and information they need to make smart health-care decisions.

The establishment of multidisciplinary teams within primary care providers is a well-documented and successful approach to achieving integrated care across the globe (Hujala, Taskinen, and Rissanen 2017; Drewes et al. 2012; Meeuwissen et al. 2012). Multidisciplinary teams achieve skill flexibility through role replacement, delegation, and enhancement across clinical and nonclinical employees. Multidisciplinary teamwork can be further supported by multidisciplinary care protocols or pathways—also known as integrated care pathways—and information sharing (Busetto et al. 2017).

B. Operational Levers

Role of primary health care. Perhaps the most important foundation for effective care integration is building strong PHC providers from the start. Integrated primary care entails primary care providers performing a highly complex role: serving as the first point of contact for patients, a gateway to the wider health system, a provider of continuous and comprehensive care often linking between multiple specialists, and a prevention-focused population health manager (Valentijn et al. 2013).

Organizational forms refer to the structural design and arrangement of PHC providers, including responsibilities, decision-making channels, and interactions to accomplish integration activities and achieve continuous collaboration (Evans et al. 2017). Figure 5 summarizes the most common organizational forms of integrated care, which can vary in intensity. Although full organizational integration with a single budget is an ideal form, in most countries, the “coordination” and “linkages” forms are often employed as these are more realistic and do not require major structural reorganizations.



Service provision refers to the nature of integrated care as a package of promotional, preventative, and curative services delivered across different provider levels in a coordinated manner. Early integrated care programs often targeted specific patient groups with chronic and complex diseases, like diabetes and hypertension, or populations with specific needs, such as the elderly and pregnant women. Other countries include social services in their integrated care packages. There is considerable evidence to show that care continuity provided by integrated services results in better health outcomes (WHO 2015; Nolte 2017). This strategy, however, only benefits the specific target population. A longer-term, yet ideal proposition is to integrate across disease management programs as a first step toward creating a system-wide model that is more appropriate for the typical patient who may suffer from multiple conditions (Nolte 2017).

Logistical support is an under-recognized building block for care integration, particularly in LMICs where the basic functioning and capacity of the delivery system may just be insufficient to support care integration. Assessments of integration readiness in the Asian, African, and Latin American regions identified logistical issues as key barriers to care integration, and highlighted areas that most often require strengthening at primary care level as part of a care integration agenda (Topp et al. 2018):

- Drug and medical supply stockouts, which limit service provision and undermine community confidence;
- Medical transportation systems for both health workers and patients;

- Centralized coordination and appointment systems for providers and patients;
- Decision-support tools that facilitate diagnosis and treatment, such as intranet or online applications with clinical protocols and guidelines;
- Cold chain and other vaccination infrastructure; and
- Provision of diagnostic and screening services to support referrals to hospitals and specialty care.

Provider-provider and provider-patient interactions are key nexuses within the health-care system that can be leveraged to promote care integration at the front line. Collectively, these interactions are sometimes referred to as clinical integration. The following table outlines the core ways to integrate care through provider-to-provider interactions and their corresponding implementation strategies.

C. Crosscutting Levers

Performance, monitoring, and evaluation. A well-designed system of measuring, analyzing, and reporting results is critical to the long-term success of integrated care. Box 4 shows how some countries have created their performance frameworks for care integration. Robust performance monitoring promotes good governance and accountability, as well as providing evidence for the continuous improvements required to implement care integration. However, it is important to note that monitoring is an adjunct to, not a replacement for, impact evaluations.

Core Action Areas and Their Corresponding Implementation Strategies to Facilitate Provider-to-Provider Interactions

| Core Action Area | Implementation Strategies |
|---|---|
| Primary health care as the first and focal point for population health | <ul style="list-style-type: none"> • Use empanelment to facilitate population health management • Stratify risks of empaneled population • Strengthen and target gatekeeping • Expand accessibility |
| Multidisciplinary teams | <ul style="list-style-type: none"> • Define team goals, composition, roles, culture, and leadership • Develop cross-provider teams • Promote interdisciplinary education |
| Care management and navigation | <ul style="list-style-type: none"> • Integrate care around the individual user to promote more patient-centered care • Form individualized care plans between care teams and patients • Designate staff as patient care coordinators or case managers who maintain constant contact with patients, organize their care, help them navigate the delivery system, and coach them to manage their own conditions • Develop a standardized instrument for evaluating patient needs that are applicable in all provider settings • Provide proactive follow-up care |
| Expanded facility roles | <ul style="list-style-type: none"> • Redefine the roles of facilities, especially hospitals, within a vertically integrated network • Establish provider-to-provider relationships through technical assistance and skill building (e.g., hospital educational outreach) • Transfer hospital services to intermediate units such as specialized ambulatory surgery units and long-term rehabilitative and palliative care units. These interventions can involve substitution of hospital services, rotation of hospital staff, and educational outreach. • Consider hospital outreach and “hospital at home” initiatives, in coordination with primary health-care providers. These initiatives usually involve direct hospital outreach by hospital professionals to homes and community-based social and behavioral health services. |
| Horizontal integration | <ul style="list-style-type: none"> • Link primary care and public health services, especially vertical programs |
| Integrated clinical pathways and dual referral systems | <ul style="list-style-type: none"> • Craft integrated pathways to facilitate integration and effective patient transitions across provider levels • Develop decision-support tools for providers • Promote functional dual referrals within integrated facility networks |
| Patient self-management | <ul style="list-style-type: none"> • Work with patients to change behavior and adopt a healthy lifestyle, empowering them with knowledge and education to make sound health and health-care choices • Train health providers to educate and support patients in self-managing their conditions |

Source: Author’s compilation from various sources.

Box 4: Developing Performance Framework for Care Integration

Some countries have developed an evidence-based performance framework for care integration. These frameworks define a standardized but balanced set of indicators to assess processes, implementation, patient outcomes, quality, costs, and patient experience.

Additionally, they promote stakeholder engagement, establish data collection systems, set targets, validate data, provide feedback to frontline providers, and monitor success and failure. The implementation of these frameworks has produced high-quality information systems that improve data collection, analysis, and use.

Source: E. Nolte et al. 2016. Integrated Care: A Synthesis of Experiences in Three European Countries. *International Journal of Care Coordination*. 19 (1–2). pp. 5–19.

In contrast, countries that have yet to develop a nationwide set of indicators for integrated care tend to rely on reporting requirements of the broader delivery system that may not be relevant to care integration, and undermine efforts to move to a new mode of delivery. They may also delegate indicator formation to local government units and facilities responsible for care integration. But staff generally have little experience with monitoring systems, and are already struggling with understanding design and implementation issues related to care integration.

Digital health. A strong e-health platform is the backbone of an interconnected delivery system in digital health (Bates and Bitton 2010). It enables cross-facility communication, while also allowing health workers and patients to participate in care management and clinical decision-making via electronic health record (EHR) platforms. EHR implementation is costly and time-consuming. Countries can start with inexpensive web-based “light” EHR programs that allow electronic charting and data storage and sharing. The Praava experience in Bangladesh (Box 5) shows how digital health investments can improve health-care access.

Box 5: Praava: Integrating and Innovating Care in Bangladesh through Digital Health

Although public health care in Bangladesh has improved, challenges to overall health-care quality persist. Praava Health Care, a local private provider, saw an opportunity to provide convenient, affordable, and high-quality care by using an out-patient clinic approach (“hub and spoke” model) to provide check-ups, diagnostics, and outpatient treatments for acute and chronic diseases. A multichannel “bricks and clicks” model coordinates in-person and virtual patient interactions, helping them integrate patient care across their outpatient clinics, pharmacy, and lab. Staff store patient records and results in Praava’s health information system and electronic health record system, which are also accessible to patients. In 2018, the app was expanded to include an e-pharmacy for online refills and symptom checker, concierge care for noncommunicable diseases, remote monitoring, and alerts to get checked out if symptoms worsened. The coronavirus disease (COVID-19) pandemic brought opportunities to also integrate with the public health-care system: Praava became one of the government’s preferred suppliers during the pandemic, establishing a national COVID-19 hotline, conducting testing, and allowing Praava staff to provide treatment at expanded sites throughout the capital, Dhaka. Further investments in interoperable data will allow more targeted analyses, and adoption of artificial intelligence will support risk stratification and population health management.

Source: L. Marchand. 2021. *Praava Health: Reinventing Healthcare in Bangladesh*. Columbia CaseWorks Case ID No. 220408. New York City: Columbia Business School, Columbia University.

The coronavirus disease (COVID-19) pandemic accelerated the use of technology to deliver health services, including telemedicine to provide care and mobile applications to establish appointment and scheduling systems, as well as strengthen patient engagement and communication in support of care management. However, data integration in terms of interoperability and governance continues to be a challenge due to information technology infrastructure fragmentation and immature regulatory environments for data sharing.

WHAT ARE THE KEY LESSONS IN DESIGNING AND IMPLEMENTING INTEGRATED PRIMARY CARE INITIATIVES IN ASIA AND THE PACIFIC?

The ultimate goal of an effective health system is to provide the right service at the right place, at the right time, and at an affordable cost. Achieving this goal represents a challenge for countries in Asia and the Pacific, particularly in light of the increasing burden of noncommunicable diseases, aging societies, an unfinished mother and newborn care agenda, emerging infectious diseases, fragmented service delivery systems, and weak primary care. Care integration—and its correlate, integrated primary care—has emerged as an important strategy to improve health-care delivery

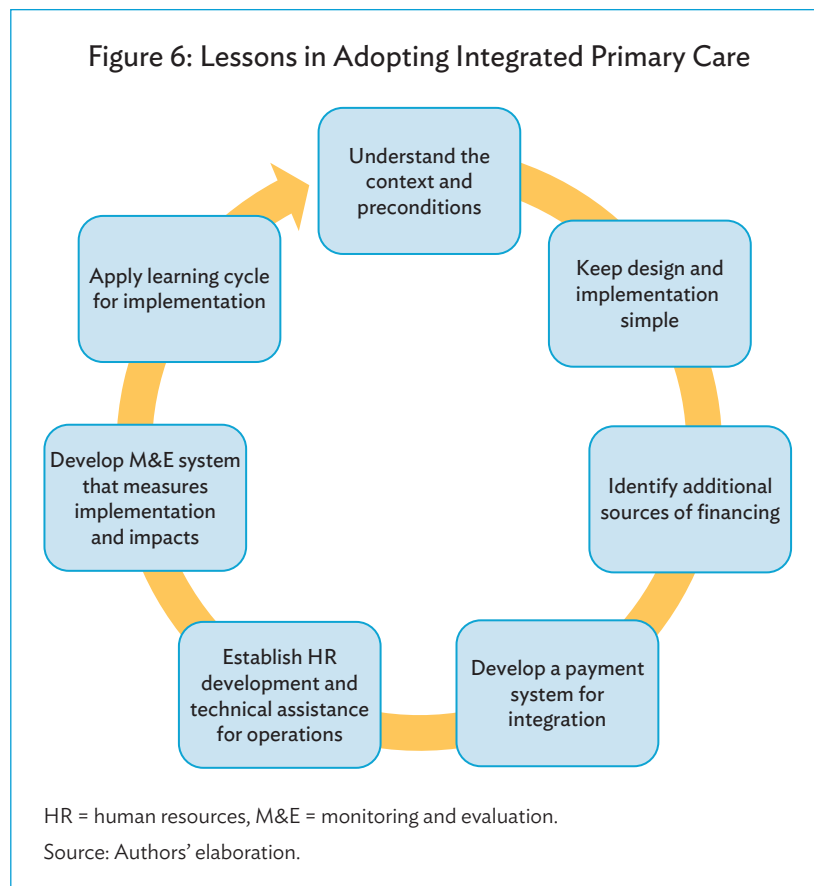
and the quality thereof. However, it represents a major shift in how health services are financed, organized, managed, and delivered, and global experience shows that implementing this strategy has proven complex. While part of the problem lies with the difficulty in changing provider behavior, care integration also suffers from a bewildering array of conceptual, organizational, and intervention variants. It is difficult to identify which variants are best suited to deliver on policy objectives in any given context. All too often, integrated care is seen as a silver bullet for multiple system ills.

Nonetheless, considerable documentation is emerging on care integration experiences in high- and middle-income countries. There is a growing body of knowledge about the enablers and barriers of care integration. This final section provides guidance for countries in Asia and the Pacific as they develop policies and devise implementation strategies involving integrated primary care. Figure 6 presents a summary of key lessons.

1. Define the aims, understand the context, and phase implementation. Before embarking on any integrated care program, health-care leaders must think carefully about what it is they are trying to achieve and in what ways their understanding of integrated primary care is likely to meet these aspirations. A critical first step is to conduct a rapid assessment of current conditions and capacities for any proposed care integration effort. The assessment should determine the potential building blocks and barriers to care integration, determine readiness to implement integration policies, identify local pilots that have the greatest potential for success, and understand the concerns of key stakeholders. A recent assessment instrument for integration readiness developed by the Joint Learning Network is a good place to start (La Forgia et al. 2018).

Any initiative should incorporate a phased approach, allowing sufficient time for the aforementioned assessment, stakeholder consultations, prototype(s) design, capacity building and testing through pilots, and evaluating results. Launching any initiative in localities where PHC services are deficient or require major investments and upgrading should be avoided.

2. Keep design and implementation as simple as possible. Policy makers should consider developing a simple model of primary care integration that is aligned with conditions and capacities, while building on existing strengths. Any design should avoid an all-or-nothing approach, such as attempting integration of multiple services and functions across multiple organizations all at once. It is important to keep integration efforts within the realm of the health-care services, at least initially. Attempting to incorporate other systems, such as social services, long-term care, or addiction services, within integration efforts can complicate and ultimately undermine health-care integration, as these systems tend to have their own policies, rules, bureaucracies, and cultures. The focus should be structured around a limited set of functions, health services, and beneficiaries that can improve access and quality, while laying the foundations for both scale-up and deeper forms of integration in the future. Two examples are (i) the PHC-based disease management model for the chronically ill and the elderly, and (ii) the medical home model.



3. Identify additional source(s) of financing. Successful implementation of care integration requires additional funding to improve care coordination and provider performance as the expectations are for more intense and continuous service provision that goes beyond what has been expected in the past. In cases where existing funding is insufficient, countries must consider alternative funding sources, such as multilateral development banks, governments, private partners, and local revenues.

4. Develop a payment system that compensates provider teams for integrated care services and activities. Which payment mechanism will be most effective in promoting care integration in a given setting will depend on the ultimate policy goals, the nature and effectiveness of existing payment mechanisms, the underlying managerial and technical capacity, and information technology architecture of both purchasers and providers. All built upon and are used in conjunction with existing mechanisms, and involve an additional payment beyond that dispensed through the current system.

Financial incentives should be large enough to encourage provider coordination, but not so high as to reduce focus on regular services or to lead providers to classify regular services as qualifying for additional payments. Providers must be compensated to keep patients' records, communicate with other providers, and allow time to follow performance guidelines.

5. Establish a human resource capacity development and technical assistance program to support integration at the operational level. Many countries lack the capacity to implement managerial, financial, and clinical integration effectively. Participating organizations and providers will require significant and ongoing capacity building and technical assistance, as well as support for any capital investments, such as digital health, in addition to learning from one another through the proposed learning collaboratives.

More specifically, the government could consider establishing a special integration fund with the active support of development partners to support investments in human resource capacity building, technical assistance, digital health innovations, and capital investments. Ideally, donor funds can also cover operational costs at the onset.

6. Develop a performance monitoring system for care integration, as well as a built-in evaluation system that measures impact and evaluates implementation processes.

This involves crafting a monitoring and evaluation framework, identifying relevant metrics and methods, and developing an effective monitoring system to track and assess results over time. An impact evaluation should be built-in to any pilot. The framework should be consistent with international best practices, especially in terms of the dual challenge of measuring care

integration processes and performance. For both challenges, it is particularly important to apply indicators specific to integrated care. This requires understanding the aims of the initiative, anticipated outcomes, time frame, how processes and results will be measured, and the robustness and feasibility of proposed metrics. Fortunately, documentation exists on the *what* and *how* of measuring care integration to help planners identify metrics that are relevant to policy and project objectives (EU 2017; McDonald et al. 2014; La Forgia et al. 2018).

Finally, performance measurement should be linked to action at all levels. Performance data must be shared with all levels of the delivery system so that all providers become active participants in improving care integration, primary care, patient experience, referrals, quality of care, etc. Establishing formal and regular feedback loops will help identify service gaps and care integration while supporting continuous learning and correction.

7. Implement a learning cycle approach to implementation.

Complex innovations, such as integrated care, require a “cycle of improvement since making progress is always nonlinear and usually a messy affair” (Goodwin 2019). To work effectively, providers must understand the operational practices, roles, and capacities of all participating clinical settings. Frontline practitioners and their organizations need formal and informal ways to coordinate care, such as negotiation, communication, and coaching. Countries should consider creating learning collaboratives for networks of organizers and providers of care integration projects. Collaboratives can emphasize co-design, joint testing and analysis, and sharing activities and innovations. Building or strengthening interorganizational and provider-to-provider interactions, creating a shared vision, and forming cross-provider multidisciplinary teams to implement integrated care activities can be the initial focus.

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