Integrating Vertical Programs into Primary Health Care

In recent years, an increasing number of low- and middle-income countries have committed to moving toward universal health coverage (UHC); at the same time, many are also preparing to take on greater financial responsibility for health as donor funding phases out.

These circumstances have led to discussions about integrating vertical health programs—programs that are specific to health areas such as family planning or HIV and are often funded by donors—into the broader health system.

Many donor-driven vertical programs have produced remarkable results—for example, substantially reducing the burdens of malaria, childhood illnesses, and maternal mortality; slowing the spread of HIV; and increasing the use of modern contraception. But new challenges and goals are forcing a broad reappraisal of these programs, many of which have structures and systems that, to varying degrees, stand apart from the broader health system—such as separate supply chains, financing sources, monitoring and evaluation (M&E) systems, and even facilities and staff.

Based on research conducted by Results for Development and Population Services International, this fact sheet offers a brief overview of key issues for policymakers to consider when deciding whether or how to more fully integrate specific vertical programs into their country's health system, and particularly into primary health care (PHC).

IN-DEPTH COUNTRY CASE STUDIES

Two supplementary fact sheets summarize ongoing efforts to more fully integrate vertical family planning programs into PHC in Ghana and Malawi.

GHANA   **MALAWI**

What Does Integration Mean?

In this discussion, *integration* describes the process by which a disease- or need-specific program comes to more fully share components or functions with the broader health system. This is distinct from other types of integration, including the "vertical integration" of health services across levels of care, such as through referrals and shared access to medical records. It is also more expansive than the concept of "integrated service delivery," which typically focuses on providing a full range of health services in the same location or ensuring that individual health workers can deliver a broad array of services to patients.

At one extreme are minimally integrated vertical programs. For example, in some countries the United States President's Emergency Plan for AIDS Relief (PEPFAR) has funded single-purpose HIV facilities run by nongovernmental organizations with a dedicated workforce, financing, supply chain, and M&E policies that are separate from the rest of the system. More commonly, vertical programs share some components with the broader system. For instance, immunization programs rely primarily on PHC facilities and staff for service delivery but may also conduct separate campaigns or operate dedicated supply chain and distribution systems due to special cold chain requirements.

The process of integrating a vertical program into PHC can affect just one element of the program, or it can be more complex, involving reorganization of leadership, financing, supply chains, service delivery, and more.

What Does the Evidence Show About Integration?

In some cases, integration has yielded clear benefits to those served by the vertical program, by increasing access to or the quality of priority services. Examples include integrating management of childhood illnesses into PHC delivery in Bangladesh and the addition of nutrition, infection control, and family planning to routine services in India. Integration has also improved PHC performance in some countries. For example, adding basic HIV care to Rwandan PHC centers may have contributed to increased utilization of key preventive services, especially in reproductive health.

In other settings, vertical programs have outperformed more integrated approaches in achieving disease- or need-specific outcomes. For example, Nepalese women served by village health workers who focused narrowly on family planning and immunization demonstrated greater family planning knowledge and intention to use contraceptives than those served by health workers offering a broader range of PHC services.

Elements of Effective Integration

The literature shows several key enablers of effective service integration. They include the existence of information systems and management tools within the health system that can facilitate integrated clinical practice, as well as sufficient and appropriate space to provide services (balancing the need for patient convenience with patient privacy and safety from health risks).

Effective integration also requires coordination of efforts across the health system, not only in service delivery settings but also in operations and administration, health-sector policies and strategies, reporting and information systems, and funding streams.

The research suggests several important considerations for governments and donors as they weigh whether or how to more fully integrate vertical programs into PHC, as shown below.

The context matters

Important factors include PHC performance relative to vertical program performance and the epidemiological trajectory of the health needs currently addressed by the vertical program.

Integration may require tradeoffs

Integration can improve the reach, quality, and sustainability of critical disease-specific services, but it can also dilute political attention or funding directed toward specific health needs.

Integration should go beyond service delivery

A range of program and system components, including governance and financing, should be included in integration efforts. The key components will depend on the health need and the country context.

Integration can (and often should) be incremental

A well-functioning health system is a prerequisite for effective integration, so countries can start with program components that the broader health system is prepared to absorb, while investing in system functions that need further strengthening.

A Five-Step Decision-Making Process

Policymakers may not always have definitive empirical evidence on whether or how to integrate vertical programs into PHC. The following steps—which should be embedded in routine policy and planning processes—can help inform integration decisions.

1. Articulate the objectives of integration.

2. Understand the status quo.

3. Identify integration options.

4. Assess the options and make decisions.

5. Monitor implementation and make adjustments.

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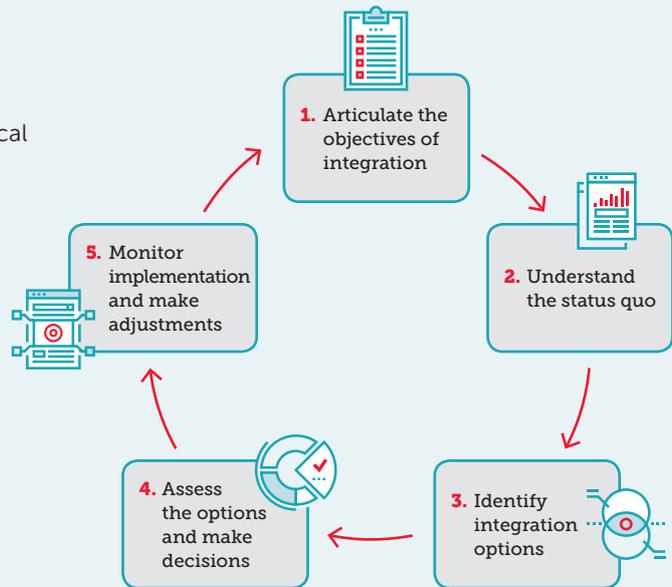
ARTICULATE THE OBJECTIVES OF INTEGRATION

Policymakers who are interested in integration should be able to clearly explain how it will contribute to broader health objectives, such as improved efficiency, while also understanding how various constituencies will evaluate integration proposals. Health-sector stewards and PHC advocates may be most interested in systemwide effectiveness and efficiency, while vertical program implementers, advocates, and funders may be most concerned about the needs of the populations their programs serve. Once policymakers clarify their objectives, they should marshal government, civil society, and donor resources to determine what integration would require in practice and identify the likely enablers and risks throughout the health system and the vertical program in question.

Step 2.
UNDERSTAND THE STATUS QUO

Characterizing the current relationship between the vertical program and the broader system is critical to integration decisions because it helps clarify options. For example, in some cases the discussion may be about the shared use of health facilities and human resources. Elsewhere, it may be about financing and benefits policies, such as bringing vertically funded services into a national health insurance scheme's package of covered services.

It may be useful to look at the relative strengths of individual functions and components of vertical programs and health systems. For example, vertical programs—especially those funded by donors— typically have strong planning, monitoring, and oversight to satisfy requirements linked to their dedicated funding. They also often engage more effectively with nonstate service providers than does the rest of the system. These strengths may provide models for PHC in general.

Step 3.
IDENTIFY INTEGRATION OPTIONS

The next step is to develop a set of options, which might range from maintaining the status quo to completely integrating any standalone components of a vertical program with PHC. Many options will be partial or incremental, such as bringing some separate program functions more fully into PHC while retaining some dedicated components. When developing options, policymakers should consider the private sector, particularly if the vertical program in question already makes use of nonstate providers.

No matter their focus, integration options should be laid out in detail so all stakeholders have a clear understanding of what will change and what will stay the same, including in terms of institutional and individual roles and responsibilities, flow of funds, and accountability mechanisms. This will enable analysis of how these changes might affect patient experience and access, staff training and workload, program performance, costs, and overall system efficiency.

Step 4.
ASSESS THE OPTIONS AND MAKE DECISIONS

Decision-making should be based on a consultative approach that recognizes an array of considerations—technical, practical, fiscal, and political—and helps policymakers build support for whatever actions they decide to take. It is often difficult to estimate the costs and benefits of various options, so approaches that embrace a range of decision-making criteria can be valuable. Such approaches also allow for an incremental and adaptive integration process that includes implementing M&E measures and taking corrective action as needed.

Step 5.
MONITOR IMPLEMENTATION AND MAKE ADJUSTMENTS

In rare instances, an argument can be made for rapid, wholesale integration, such as with the unexpected withdrawal of donor funding or an unusually fast rollout of a new national health insurance system. But the impetus for integration is typically foreseeable, and changes to the health system and funding landscape usually unfold more gradually. Consequently, it is important to monitor each stage of integration to determine whether the desired results are being achieved, identify obstacles to smoother implementation, provide early warning of any adverse effects, and make adjustments—or even reverse course—as needed.

Benefits and Risks of Integration

Integration of vertical programs into PHC is not without risk to the outcomes that vertical programs aim to deliver. Vertical program constituencies can be wary of relying on broader health systems, which often fall short of their promise to provide high-quality, coordinated care that meets individual, community, and population health needs. Some disease-specific advocates also resist integrated approaches for fear that they will dilute political attention and funding for their own priorities.

But integration need not be an all-or-nothing or all-at-once proposition. It can be an incremental and deliberative part of routine health reform. Health systems and vertical programs are rarely monolithic; therefore, careful analysis of their constituent parts is essential, along with open acknowledgment of health system weaknesses that may jeopardize outcomes when vertical program functions are absorbed into the larger system.

FOR A MORE DETAILED DISCUSSION,

see *Integrating Vertical Programs into Primary Health Care: A Decision-Making Approach for Policymakers* and the Ghana and Malawi case studies at **www.r4d.org/ integrating-vertical- programs**.

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A DECISION-MAKING APPROACH FOR POLICYMAKERS

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RESULTS FOR DEVELOPMENT

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