MANAGEMENT IN HEALTH CARE PRACTICE A Handbook for Teachers, Researchers and Health Professionals	
Title	**SELECTIVE VERSUS INTEGRATED PRIMARY HEALTH CARE**
Module: 5.3	**ECTS (suggested): 0.2**
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Keywords	Primary Health Care, Public Health, Organization of Health Services
Learning objectives	After completing this module students and public health professionals should: • be aware of different approaches in implementation of primary health care; • recognize needs for analysis of advantages and obstacles of vertical and integrated health programs; • know listing of the characteristics of different models of organization of primary health care; • improve the knowledge and understanding the function of the health care system.
Abstract	The major division of health care appeared in many societies between private-curative and public-preventive health care. This influenced all types of health services, hospitals and primary health care units, as well as education of professionals and research. The opponents of integration have been pointing out negative experiences with integration because preventive services often have been "eaten up" by curative services. A special service is used in vertical programs as a vehicle to provide necessary procedures and activities to cover groups "at risk". There are several characteristics of vertical programs which determine their role in primary health care, which are analyzed in this module.
Teaching methods	Introductory lecture, exercises, individual work and small group discussions.
Specific recommendations for teachers	• work under teacher supervision /individual students' work proportion: 30%/70%; • facilities: a teaching room; • equipment: transparencies, colour flow masters, overhead projection equipment; PC and LCD projection; • training materials: readings, hand – outs.
Assessment of students	The final mark should be derived from the quality of individual work and assessment of the contribution to the group discussions.

SELECTIVE VERSUS INTEGRATED PRIMARY HEALTH CARE

Želimir Jakšić

THEORETICAL BACKGROUND

Introduction

A very frequent practical problem in planning and promoting health care is finding a balance between selective and integrated, special and general. It is, for instance, a choice between developing an infrastructure of primary health care units or stimulating specific "vertical" programs.

Theoretically balancing special and general does not represent a problem. Both are needed and inter-related. Apparently very selective programs can stimulate other health activities in the community and in fact operate as a nucleus of an integrated program. Programs which are called integrated may simply be just a collection of selective and parallel programs.

In practice the dilemma has its social roots, and one has to understand what lies behind one or another strategy. Centrally initiated projects usually have to show success in a short time. Under these conditions selective programs may actively destroy the existing health culture and infrastructure, but also blindly insisting on integration and development off infrastructure to demonstrate achievement for political benefit of local administration may also disrupt existing social networks and discourage people's participation.

Another important aspect is the cost of integration. Integration and the resulting complexity of services will increase the visible costs, but less compulsiveness and less formal regulation will reduce human costs of integration.

Different types of dilemmas

One may recognize at least four different types of headings under which appears the described type of dilemma.

Preventive versus curative services

The major division of health care appeared in many societies between private-curative and public-preventive health care. This influenced all types of health services, hospitals and primary health care units, as well as education of professionals and research. The opponents of integration have been pointing out negative experiences with integration because preventive services often have been "eaten up" by curative services. There have been reports, e.g. that community health workers are spending all their time in curative activities, in contrast to isolated vertical programs in which they performed "preventive" activities. But isolated preventive activities (like screening without intervention) have not been unaccepted by people and are a technical and ethical disgrace. The dispensary type of work was proposed as a model of combined activities, and health centres as a combined organizational unit. However, a permanent effort is needed to maintain the right balance.

Vertical programs versus health services of primary infrastructure

A special service is used in vertical programs as a vehicle to provide necessary procedures and activities to cover groups "at risk". This approach is based on a concept of functionalism, an

assumption that there exists a potent and available technology for major health problems. By division of labour and procedures one may increase the effectiveness and even more the efficiency of services solving one problem after another. This proved true in some instances where assumptions were

correct, but failed in most of others. Some targets were reached faster, but the effect was only temporary. The coverage was increased on many occasions, but contacts were intermittent, self-limiting and superficial. Services were often expensive, and the beneficial consequences died out after the project was finished. The problem of integration of vertical programs in general health services was widely recognized during the sixties and the general disappointment with the effects was strongly expressed during the seventies, and in Alma-Ata Conference. However, resistance to integration is often very strong, either because of bureaucratic powers running special programs or because of different groups in the shadows, interested in promoting a certain technology.

Specialist approach versus generalist (holistic) approach

A special case of disintegration and selectiveness in general health services developed with specialization of health workers and particularization of health sciences in many separate disciplines. This disintegration was also developing inside some of the special vertical programs mentioned above. Traditional medicine was, and is also now, often specialized. With the development of new technologies the process has speeded up. On one hand it is a sign of progress, but on the other we can observe negative phenomena. Examples include the development of technology-oriented front-line health workers, crippled by a failure to understand their role in society; work of high level specialists on specific lines in artificial circumstances less and less interested in seeing the health problem as whole and personal problems of the patient. There has been an increase in such "dehumanization" of medicine and malpractice of utilization of available resources, in which both patient and specialist are victims of the system. This problem was recognized 10-20 years ago in many countries, but solutions have been accepted with difficulties. Unequal distribution of the most expensive technology is a consequence of social pressures and preserved under the pretext that high quality has to be guaranteed by specialization. A consumer approach predominates in many circles, stating that the most expensive is also the best. These problems are very pressing in both developing and developed countries, although with different numbers of people and on different levels.

Health services versus community approach and self-care

This is disintegration of health services from other aspects of community life and health from other sectors. This aspect of selectiveness is widely present, but not yet fully recognized and completely understood. It is a complex problem involving understanding of social change in communities and their influences on health, distribution of power decision- making, recognition and acceptance of alternative organizations. In the last 10-15 years a breakthrough was made in better understanding that lay people themselves are and should be active in health care.

It is wrong to choose only one side: prevention or cure, vertical programs or general services, specialists or generalists, health services or community involvement. It is always both, but with different balances and a different focus according to circumstances such as population density, kind of health problem, training of health staff and changes in time.

The decisive circumstances

The effects of special vertical programs are related to the fact are they connected with an existing general permanent infrastructure in the community or built in a vacuum. The permanent structure has to be reliable from the standpoint and experience of people. The structure can be any of the following social institutions: local government, health units, schools, political organizations, voluntary organizations, etc.

There are several characteristics of vertical programs which determine their role in primary health care. One of them is the prevalence of health needs and technology capable to solve the problem; example: smallpox eradication. Time needed to solve the problem and terminate the program may be the critical issue.

The examples are centrally planned vertical programs to control some of the endemic diseases.

With resistant problems in which the solution require active contribution of people and changes in their behaviour, it is most important that special vertical programs interact with local people and existing permanent communal services, like schools, health units, voluntary organizations, etc. This is best seen in some experimental and evaluation studies in the field of nutrition and sanitation.

In a situation where health services grow, it is common experience that some of the vertical programs coexist side by side with general health services. To overcome this separation, a formal "integration" is proposed so that working groups of a vertical program are organized as separate units inside regular services. At least some information and coordination of work are forced, and the problem of status or differences in wages and salaries is diminished. Organizing such integration is often very difficult because of changes in authorities and responsibilities, and a double command arising as a management problem.

A similar situation may be produced following the division of labour inside general health services, when some parts of programs grow fast and gradually organize themselves as separate service units. We have a phenomenon that growing produces disintegration. Maternal and child health, dispensaries for special diseases or separate population groups, occupational

Health services, preventive services, etc. can demonstrate such a tendency inside primary health care. If they additionally have or develop a separate authority on a higher level of services or administration, there is a very similar situation which can happen after formal integration of parts of vertical programs into general services. This is then an apparently integrated service but actually functioning as a selective program.

Examples are common in services providing permanent health care for problems considered to have great importance (MCH, tuberculosis control, cardiovascular diseases, etc.).

How to make the best balance

Selective approach and integrated approach may both have positive and negative consequences, depending on time and circumstances. In that sense the two strategies are not completely opposed.

Positive consequences of selective approaches include:

- momentum in motivating people;
- fast results;
- increased coverage;
- efficient use of certain specific resources.

Among negative consequences one may list:

- limited duration of effects;
- tendency to develop petrified structures;
- waste in manpower;
- development of narrow professional interests (separate kingdoms);
- inefficient use of resources and poor participation of people in the long run.

The **integrated approach** building into the permanent general infrastructure has these potential advantages:

- interaction with people and supporting participation;
- permanent long-range results;
- equitable coverage (if this is one of the chosen aims);
- motivating local resources and stimulating self-reliance.

As negative consequences one may consider:

- "the drop in the sea" effect;
- unfavourable results, such as prevention suppressed by curative services;
- slow development;
- "poor quality".

In real life selectiveness and integration are the poles of the same system and the time dimension is neglected: the transformation of services from differentiated to integrated, and than again to differentiate is overlooked. The essential differences are shown in Table 1.

In decision to foster one or another approach, the following arguments are important:

1. Type of **health needs** which are prevalent or most important:
In circumstances in which chronic diseases and long lasting problems prevail, when many multiple diseases and problems appear when prevention has to be stressed, when psychological and social aspects are important, and when continuity of care is needed - in all these situations an integrated approach has advantage.

2. Participation and **involvement of people:**
When a free choice of services and a closeness of services are needed, when equity needs to be stressed, when one has to utilize potentials of primary groups (families, voluntary organizations etc.) for health care, and when an inter-sectoral approach is needed - the integrated approach again should be the first choice.

Table 1. Two understandings of primary health care (PHC)

Methodology	Effective programs (vertical initiation)	Building local capabilities (horizontal spread)
Success criterion	Evidence of efficacy	Sustained self-reliance
Objective *Typical vehicle*	Solution of selected health problems Quantitative management	Comprehensive health improvement Social action (qualitative)
Horizons *Impact*	Short-term Limited and temporary	Long-term Slow and culturally conditioned

3. The **socio-economic position of health services:**
When financial restrictions are expected for a longer time, when a planned and coordinated development of the whole system is desirable, when a tendency is visible that there are dysfunctions in the system (inadequate training, poor management), and when flexibility of the system in relation to changes in environment is needed - in most of the described occasions the integrated strategy might be more useful.

4. The choice is never completely free. It depends on **political circumstances:**
To obtain full effect of developing an integrated infrastructure it is important that decentralization, community participation and inter-sectoral approach are politically stimulated.

EXERCISE

Task 1

Answer the following question: Was message of Alma-Ata Declaration development of horizontal or vertical primary health care? You may check the recommended readings.

Task 2

Two groups of students should confront in arguing one for vertical programs and the other for horizontal (comprehensive) primary health care.

Task 3

Discuss in the small group: Why is idea of vertical programs and selective primary care related to libertarian ideology and comprehensive primary care closer to social and egalitarian attitudes?

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