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CONFERENCE ABSTRACT

Macro-level barriers to scaling up integrated care in three countries: Belgium, Slovenia and Cambodia

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Introduction: To address the increasing burden of non-communicable diseases (NCDs), global commitments have been made towards an integrated care (IC) approach. The 'SCale-Up diaBetes and hYpertension' (SCUBY) project aims to provide implementation science-based solutions through co-creation, implementation and evaluation of roadmaps for scale-up of IC for diabetes and hypertension. We analysed macro-level barriers and facilitators to IC in: a developing health system in a lower middle-income country (Cambodia); a centrally-steered health system in a high-income country (Slovenia); and a publicly-funded highly privatised healthcare health system in a high-income country (Belgium). The results of this study will provide input in roadmap-strategies for scaling up IC in these contexts.

Methods: To identify macro-level bottlenecks, documents review (scientific publications, policy documents and grey literature); practice observations; focus groups with patients, health workers and community-based actors; and in-depth stakeholder interviews with health facility managers, policy makers, civil servants (Ministry of Health and health insurance), representatives of professional associations, non-governmental organisations, implementers, academics, and patient platforms were conducted. Thematic analysis utilising the WHO global strategy on integrated people-centred health services, was conducted as a cyclical process including a deductive and inductive analysis approach. Country-specific codes were discussed and complementary literature review performed to get a comprehensive picture of the missing links.

Results: We identified differences and similarities in macro-level barriers across the three contexts. The lack of political commitment regarding NCD investment in Cambodia and the limited policy coherence due to the fragmented political structure in Belgium weaken governance for IC. In Slovenia, a change in political leadership has interfered with IC implementation. In Cambodia, the limited financial resources and allocation mechanisms for NCDs at the primary care level and a weak health information system hinder IC implementation, while in Belgium and Slovenia, the financial models are outdated, care integration is not incentivized and data sharing between different health workers is limited. Shortages in human resources for health are common challenges in Slovenia and Cambodia; however, task shifting is being addressed in all country-sites:

introducing nurses in primary care in Belgium, involving peers in support groups in Slovenia to strengthen patient empowerment and self-management, and engaging community health workers for support at the primary care level in Cambodia.

Conclusions: Common IC challenges in the three contexts are political leadership, the health financing system, health information systems and health workforce. This macro-level barriers analysis stimulates reciprocal learning. Specifically with regards to task shifting, Slovenia can learn from Cambodia on community health and peer support workers and Belgium from Slovenia on integrating nurses into primary care. Understanding the link between macro-level, contextual factors and specific health system challenges and opportunities are key to improve the implementation of IC.

Implications for transferability and limitations: Strategies to integrate care include actions to reorient care models and coordinate services towards empowering and engaging people, and to create enabling environments in systems with proper accountability and governance at the micro-meso- and macro-levels. Mechanisms to address macro-level barriers can be replicated, considering country/health system contextual factors.