

Integrated health services for older people: A systematic literature review

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Abstract

Background: The framework for integrated person-centered health services provides a public health response to global challenge, the rapid aging of the population. It relies on primary health care in order to be accessible to a large number of patients. However, connections with specialized geriatric care are necessary as well as collaboration between health professionals and social services. Little data exists on the elements required to implement this integrated care. The objective of this work is to identify in the literature the key elements of integrated geriatric care models.

Methods: To this end, a systematic inventory of scientific publications dealing with the integration of care for the elderly was carried out using databases indexed in PubMed in June 2024. The methodological quality of the included studies was assessed using the scale for assessing the quality of studies included in systematic reviews.

Results: Thus, twelve studies were included: systematic reviews (25%), 3 case studies (25%), cohort studies (16.7%), evaluative studies (16.7%), 1 cross-sectional study (8.3%), and observational study (8.3%). The region with the highest number of primary studies was Europe (66.7%), followed by Asia (25%) and America (8.3%). Six articles combined clinical, professional and organizational integration. The most commonly reported elements of these integrated care models were multidisciplinary collaboration, comprehensive assessment, and case management. General practitioners, nurses and social workers were the most frequently mentioned service providers.

Conclusion: Current literature focused predominantly on micro-level clinical integration. However, to meet the needs of aging populations, there is a critical need to generate evidence on meso-organizational and macro-systemic strategies for integrated health services. Strengthening these levels is essential for health systems to deliver person-centered, coordinated care for older persons.

Keywords: Integrated health services; Older people; Systematic review

1. Introduction

Integrated health services are health services managed and delivered in a way that ensures that all people receive a continuum of health promotion, disease prevention, diagnosis, treatment, care, rehabilitation, and palliative care services, coordinated across different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course[1]. More than 400 million people in the world do not have access to essential health care and often receive only fragmented or poor-quality care[2]. In many countries, especially in low and middle income settings, there are problems of geographical inequality in access to health services, shortages of health workers, and

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weak supply chains. The emphasis on independent, disease-specific, hospital-based curative models of care in silos further reduces the capacity of health systems to deliver universal, equitable, high-quality, and sustainable care.

As the world faces population aging and other challenges such as urbanization, the global trend toward unhealthy lifestyles, the burden of chronic diseases, multi morbidity and poly-pharmacy, rising health costs, disease outbreaks, and other health crises, the World Health Organization (WHO) advocates an integrated, people-centered approach to health service delivery as a solution. This is particularly relevant for older persons who experience complex health and social needs and are most affected by fragmented care.

People-centered care consciously adopts the perspectives of individuals and those of caregivers, families, and communities as participants in, and beneficiaries of, trusted health systems that respond to the comprehensive needs of people rather than to specific diseases, while respecting social preferences[1]. It assumes that patients have the training and support needed to make decisions and participate in their own care, and that caregivers are able to fulfill their roles fully within a supportive professional environment. The WHO Framework on integrated people-centered health services proposes five interdependent strategies: (i) empowering and engaging people and communities; (ii) strengthening governance and accountability; (iii) reorienting the model of care; (iv) coordinating services within and across sectors; and (v) creating an enabling environment[2].

While, several countries are testing initiatives aimed at implementing integrated care, initially targeting chronic diseases and older adults, the evidence remains fragmented. Given the heterogeneity of these integrated care interventions and the specific vulnerabilities of older persons, there is a need to synthesize the key components and implementation strategies of contemporary integrated care approaches for this population.

Objective

To synthesize the available evidence on the components and implementation strategies of integrated health services for older persons aged 60 years and above.

2. Methods

This systematic review was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) 2020 guidelines. The protocol for this systematic review was not registered in PROSPERO. Registration was not considered at time of study initiation as the review focused primarily on descriptive mapping of intervention components rather than effectiveness outcomes.

2.1. Eligibility criteria

Study were eligible for inclusion if they met the following criteria:

- *Population:* Older persons aged 60 years and above
- *Intervention:* Integrated health services, defined according to the WHO Framework on integrated people-centered health services
- *Comparator:* Not applicable
- *Outcomes:* Any outcomes related to the components, implementation, or effectiveness of integrated care.
- *Study design:* All primary studies, systematic reviews, and policy documents published in English or French.
- *Timeframe:* Published from 2016 from 01/06/2024.
- *Exclusion criteria:* Books, grey literature, and conference abstract were excluded for feasibility reasons

2.2. Information sources

We searched PubMed from inception to 30/06/26. The reference lists of included studies were also screened for additional relevant articles.

2.3. Search strategy

The search strategy was developed using terms and keywords. For PubMed, the search combined 'Integrated Care System' [MeSH Major Topic] AND 'Geriatric Medicine', with filters for humans and publication date from 2016. The full search strategy is provided in Additional file 2 [MeSH].

2.4. Selection process

Two reviewers screened titles and abstracts, and then full texts of potentially eligible studies. Disagreements were resolved through discussion and consensus. The study selection process is summarized in the PRISMA flow diagram (figure 1). All references were managed using Zotero and screening was performed using Rayyan.

2.5. Data extraction

Two reviewers independently extracted data using a pre-piloted standardized form. Data extracted included: author, year, country, study design, sample size, intervention characteristics, and outcome measures. Discrepancies were resolved by discussion.

2.6. Risk of bias assessment

The methodological quality of included systematic reviews was assessed using AMSTAR 2. For primary studies, risk of bias was assessed using Cochrane Rob 2. Two reviewers performed the assessments independently.

2.7. Ethical considerations

As this review involved published literature and not human participants, ethical approval was not required

3. Results

3.1. Study selection

A total of 1,568 publications were identified from the PubMed database. After removing 32 duplicates, 1,536 titles and abstract were screened. Of these, 1501 were excluded. Thirty-five (35) full-text articles were assessed for eligibility, and 23 were excluded with reasons. Twelve (12) were included in the narrative synthesis. The study selection process is summarized in the PRISMA flow diagram (figure 1).

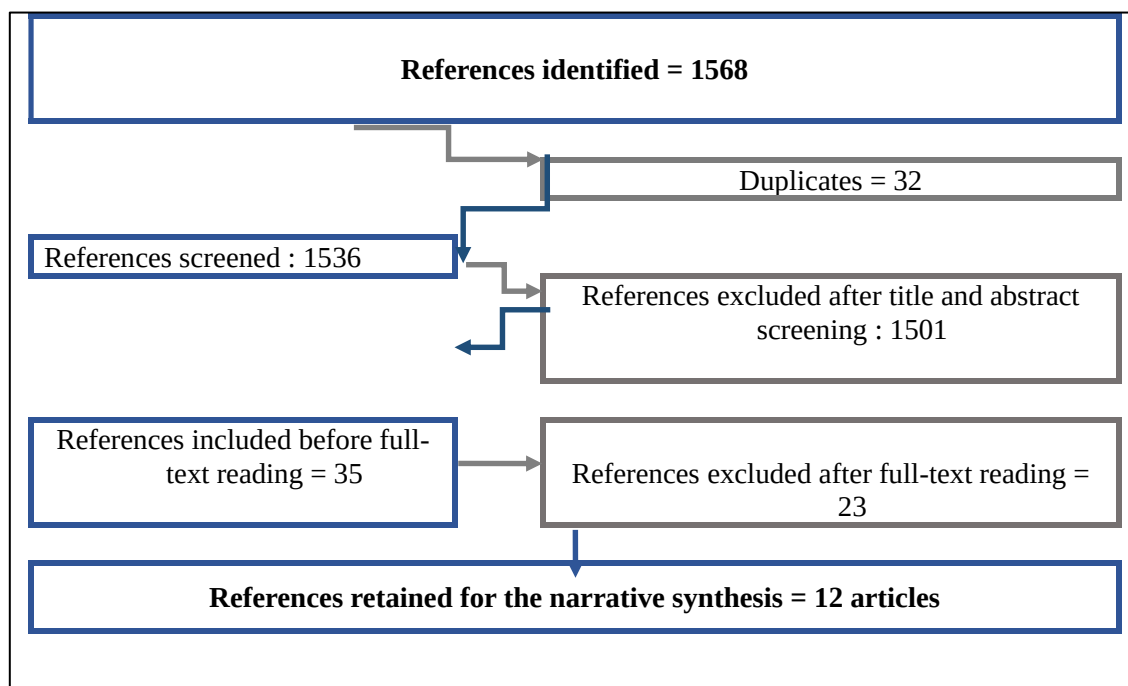


Figure 1 PRISMA flow diagram

3.2. Characteristics of the included studies

The 12 included studies were published between 2016 and 2023. The study designs included 3 systematic reviews (25.0%), 3 case studies (25.0%), 2 cohort studies (16.7%), 2 evaluative studies (16.7%), 1 cross-sectional study (8.3%), and 1 observational study (8.3%). Most studies were conducted in Europe (n=8, 66.7%), followed by Asia (n=3, 25.0%)

and the Americas (n=1, 8.3%). Spain was the most represented country (n=5, 41.7%). The characteristics of the included studies are presented in Table 1.

Table 1 Characteristics of included studies

N ^o	Author, Year	Country	Study design	Population/Setting	Quality
	Sanchez et al., 2017	Spain	Case study	Hospitalized and outpatients	Moderate
	Bytyci et al., 2019	Austria	Case study	Type 2 diabetes patients aged 65+	Moderate
	Busetto et al., 2017	Germany	Case study	Patients with complex geriatric comorbidities	Moderate
	Ha et al., 2017	Singapore	Cross-sectional study	Patients with dementia	High
	Pérez et al., 2019	Spain	Cohort study	Adults aged 80+ with frailty	High
	Vallecillo et al., 2018	Spain	Observational study	People living with HIV and substance use disorders	High
	Palmer et al., 2019	Multiple EU countries	Evaluative research	Adults aged 65+ with multimorbidity	Moderate
	Vestjens et al., 2018	August 3, 2018	Evaluative research	Frail adults aged 75+ living in community	High
	Kivelitz et al., 2021	Germany	Systematic Review	Elder adults with multimorbidity	High
	Choi et al., 2020	South Korea	Systematic review	Long-term care and nursing home patients	Moderate
	Mas et al., 2023	Spain	Cohort study	Adults aged 65+	High
	Sano et al., 2023	Japan	Systematic Review	Adults aged 65+	High

3.3. Characteristics of interventions

One third of the studies (33.3%) reported a combination of interventions at multiple levels: micro-clinical, micro-professional, and meso-organizational. Macro-systemic level interventions were poorly documented.

The interventions were multifaceted. The most frequently reported elements were: multidisciplinary team care (n=7, 58.3%), comprehensive geriatric assessment (n=6, 50.0%), and community care (n=6, 50.0%). Other elements included personalized care (33.3%), patient and family empowerment (25.0%), use of health information systems with ICT (16.7%), and evidence-based practice (16.7%).

These elements were mapped onto the five strategies of the WHO Framework on integrated people-centered health services. The most common healthcare providers involved were general practitioners (50.0%), nurses (33.3%), social workers (33.3%), and specialists (25.0%). A summary of the integrated care models is presented in Table 2.

Table 2 Summary of integrated care models and key elements

N°	Author, Year	Population and setting	Level of integration	Type of integrated care	Key elements	Reported outcomes
1	Sanchez et al., 2017	Hospitalised and outpatients	Clinical: Micro Professional: Micro Organisational: Meso	Comprehensive assessment ; Hospital-to-outpatient care transition ; Prevention of re-hospitalisations and adverse events	Comprehensive geriatric assessment ; Community care units ; Collective patient management by professionals	Reduced length of hospital stay, cost of care and unnecessary hospitalizations
2	Bytyci et al., 2019	Type 2 diabetics aged ≥ 65 years	Clinical: Micro Professional: Micro	Comprehensive geriatric assessment ; Collaborative care ; Care planning	Comprehensive geriatric assessment ; Personalised care	Accessible and quality health care
3	Loraine et al., 2017	Complex geriatric comorbidities	Clinical: Micro Professional: Micro Organisational: Meso	Early complex geriatric rehabilitation ; Multidisciplinary ; Comprehensive geriatric assesment	Community care units, Patient empowerment and involvement ; Trans disciplinary collective management of patients by professionals ; Evidence-based practice, Health information system using ICT	Poor use of health services ; Administrative procedures ; Staff frustration
4	Ngoc et al., 2020	Patients with dementia	Clinical: Micro Institutional: Macro Organisational: Meso	Hospital-to-community partnership	Outpatient clinic consultation ; Comprehensive, accessible, responsive, personalised, trans disciplinary, accountable, and transparent care	Improved health utility, patient behavioural problems ; Reduced caregiver burden
5	Perez et al., 2019	Patients aged ≥80 years with at least on sign of frairty	Clinical: Micro Professional: Micro Organisational: Meso	Integration of primary care, geriatric medicine, and community ressources	Frailty screening ; Comprehensive geriatric assessment ; Community-based multidisciplinary intervention (physical activity sessions, promotion of mediterranean diet, health education, medication review)	Improved physical function and frailty markers
6	Vallecillo et al., 2018	PLHIV + substance use disorders	Clinical: Micro Professional: Micro	Patient-centred multidisciplinary care	Health care ; Substance use treatment ; social support	Decrease in discharges against medical advice

7	Palmer et al., 2019	Patients aged ≥ 65 years with multiple comorbidities	Clinical: Micro Professional: Micro Organisational: Meso	Integration between and hospital care services ; and between health professionals from different specialties and disciplines	Regular comprehensive patient assessment ; Coordinated multidisciplinary teams ; Personalised care ; Evidence-based practices ; ICT information système	Good practices for chronic diseases ; Healthy ageing
8	Vestjens et al., 2018	Frail patients aged ≥ 75 years living in community	Clinical: Micro Professional: Micro Organisational: Meso	Proactive integrated primary care system, Multidisciplinary collaboration	Home frailty screening ; Comprehensive multidisciplinary assessment ; Collaborative management ; Medication review ; self-management support	Improved well-being
9	Kivelitz et al., 2021	Multiple comorbidities	Clinical: Micro	Multidisciplinary person-centred care ; Collaboration with the community	Patient-centred management ; Clinician-patient communication ; involvement of patient, family and friends ; physical, cognitive and emotional support	Improved well-being and quality of life
10	Jung-Yeon., 2020	Long-term care and nursing homes	Clinical: Micro	ICT-based integrated care system	Comprehensive geriatric assessment, Personalised management ; Management of potentially inappropriate medications ; Rehabilitation ; and videoconference consultation	/
11	Mas et al., 2023	Patients aged ≥ 65 years	Clinical: Micro Professional: Micro Organisational: Méso	Multidisciplinary collaborative care	Multidisciplinary management teams, composed of primary care and hospital care services, municipal social services and community services	Improved quality of care
12	Junko et al., 2023	Patients aged ≥ 65 years	Clinical: Micro Professional: Micro	Meeting the needs of older adults based on their intrinsic capacity (ICOPE)	Coverage of medical and long-term care ; Economic support ; Support for daily living	Maintenance on functional capacities of older adults

4. Discussion

4.1. Summary of main findings

This review examined the elements of integrated care approaches for older adults based on 12 studies in which quality scores were generally moderate. This evidence comes from developed countries where health service governance and delivery operate according to public and private financing models. The integrated care interventions reported in the studies were diverse, targeting clinical and professional levels as previously reported in this earlier review [3,4]. Multidisciplinary team care, comprehensive geriatric assessment, and case management were the most common elements identified in integrated care interventions. These findings are consistent with the WHO ICOPE approach [5]. These elements are effective for integrated care approaches targeting the management of older adults with multi morbidity [4].

4.2. Comparison with existing literature

A low proportion of organizational and systemic integration interventions was observed in the included studies compared to clinical and professional integration. The predominance of clinical and professional integration is consistent with the findings of studies on the development and implementation of care models in general [6-8]. This disproportionate emphasis on micro-level interventions is explained by the complexity of addressing the health system as a whole [9]. Strengthening the health system and adapting it to population aging requires targeted and specific interventions at all levels of the health system [10]. Moreover, while a disproportionate focus at the micro level may lead to change and effectiveness at that level, it will not necessarily be sustainable within a broader system without appropriate consideration of the interactions between the different levels. The WHO Framework on integrated people-centered health services provides important guidance on which to build and should serve as a model.[6-9]

4.3. Implications for practice and policy

In the included documents, less emphasis was placed on outcomes related to patients' care experiences and their functional abilities. Despite the fact that integrated care advocates for people-centered care, the outcomes reported in most studies tend to be service- or system-centered, thus reflecting the empirical orientation of traditional health systems and services toward disease. In this era of health service integration, there is an urgent need to orient interventions and measures to better reflect people-centered outcomes and care experiences in order to support the delivery of people-centered care, which constitutes the main objective of the WHO approach to healthy ageing and to the establishment of effective and sustainable health and care systems [11].

Strengthening the capacity of multidisciplinary staff to better deliver integrated care models and respond to the needs of older adults is a key recommendation of the WHO World Report on Aging and Health and is consistent with emerging evidence supporting the provision of integrated care for older adults with complex health needs [12]. In this review, interventions targeted capacity building for general practitioners, nurses, and social workers to provide integrated care. This addressed health and social protection needs, combated multi morbidity, and specifically helped maintain physical and mental capacities, which are key domains of intrinsic capacity [13].

The diversity of health and social care providers included in integrated care interventions also highlights the need to equip them with competencies to deliver integrated care and to diversify care teams in certain contexts [14-15]. A contemporary understanding of integrated care practices that supports communication and the sharing of care and responsibilities among health and social care providers, as well as the involvement of family and community services, is also necessary. All of this will require targeted interdisciplinary professional development for the current and emerging workforce, as well as systems to support integrated care practices [16].

4.4. Strengths and limitations

A strength of this review is the use of two independent reviewers for screening, data extraction, and quality assessment, and the application of the Rainbow Model and WHO Framework as coding frameworks. However, several limitations should be noted. First, the search was limited to PubMed and to publications in English and French, which may have introduced selection bias. Second, the heterogeneity of study designs and outcomes precluded meta-analysis. Third, the lack of PROSPERO registration may limit transparency, although methodological rigor was maintained through adherence to PRISMA 2020. Finally, most evidence came from high-income countries, limiting generalizability to low- and middle-income settings.

Abbreviations

- CGA: Comprehensive Geriatric Assessment
- IC: Integrated Care for Older People
- PRISME: Preferred Reporting Items for Systematic Reviews and Meta-Analysis
- PROSPERO: International Prospective Register of Systematic Reviews
- WHO: World Health Organization

5. Conclusion

Worldwide, population aging poses numerous challenges to the health system. In 2016, WHO proposed the Framework on integrated people-centered health services aimed at reorienting health services, placing the individual, family, caregivers, and communities at the center of concern, with services that better meet needs and are coordinated within and outside the health sector. It has been tested in many countries around the world. This review shows that integrated care strategies for older adults focus particularly on micro-clinical processes and that there is a relative lack of evidence regarding integration strategies at the meso and macro levels. The key elements of existing models include multidisciplinary team care, comprehensive assessment, and case management. This evidence can help inform the design of integrated care interventions for older adults and patients with chronic conditions and inform the implementation of the WHO Framework on integrated people-centered health services.

Compliance with ethical standards

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Disclosure of conflict of interest

The authors declare that they have no competing interests.

Availability of data and materials

All data generated or analyzed during this study are included in this article and its supplementary files. The full search strategy is available from the corresponding author on reasonable request.

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Author's contributions

- HDAD and MJE: Conceptualization, Methodology, Literature search, Study selection, Data extraction, Validation Writing original draft
- Critical revision: All authors read and approved the final manuscript

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