Integrating National Disease Control Programs: Addressing Programmatic Hierarchy for Operationalizing UHC

Dr. Priya Balasubramaniam, Prof. Subhash Hira & Prof. K. Srinath Reddy

Research Team: Ms. Binira Kansakar, Dr. Preetha Menon, Dr. Aruna Bhattacharya, Ms. Aditi Singh, Dr. Souvik Bandyopadhyay
Background- Why Disease Control Programs?

• Historical context
  - Evolved as interventions targeted to specific diseases
  - Dedicated resources devoted to programs
  - Form a niche in Public Health Systems Delivery

• Re-framing role of National Health Programs in evolving health systems
  - Role with a unified health system framework – (National Health Mission?)
Study Objectives

1. To assess the perceived level of integration among disease control programs currently under the National Health Mission (NHM) in India.

2. To identify potential operational pathways (strategies and processes) for integrating disease control programs within the framework of Universal Health Coverage (UHC).

3. To define ‘integration processes’ at the Centre and State levels.
Disease Control Programs in India

1. Reproductive and Child Health (RCH)
2. Revised National TB Control Program (RNTCP)
3. Universal Immunization Program (UIP)
4. National Leprosy Eradication Program (NLEP)
5. National Vector Borne Disease Control Program (NVBDCP)
6. National Iodine Deficiency Disorders Control Program (NIDDCP)
7. National Program for Control of Blindness (NPCB)
8. Integrated Disease Surveillance Program (IDSP)
9. National AIDS Control Program (NACP)
10. National Cancer Control Program (NCCP)
11. National Mental Health Program (NMHP)
12. National Program for Prevention and Control of Deafness (NPPPCD)
13. National Tobacco Control Program (NTCP)
14. National Program on Prevention and Control of Diabetes, CVD and Stroke (NPCDCS)
15. School Health Program
Defining Integration...

...extent, pattern, rate of adoption and eventual assimilation of health interventions into each of the critical functions of a health system, which includes, *inter alia*:

a) Governance,
b) Financing,
c) Planning,
d) Service Delivery,
e) Monitoring and Evaluation
f) Demand Generation

An ‘intervention’ in this context refers to combinations of technologies, inputs, organizational changes, and modifications in processes related to decision making, planning, and service delivery.

Additional Program Components Identified for Integration

g) Policy
h) MIS
i) Drugs & Logistics
j) Management
k) Human resources/Service delivery
l) Health Communication
Degrees of Program Integration

Spectrum of Integration emerged across and within programs and the health system.

Integration process viewed as a continuum from linkage or informal cooperation, through to coordination of activities, to complete or formal merger of two programs.

## Scale - Levels of Integration

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<td>Merger</td>
<td>Complete fusion of two or more programs to a common structure</td>
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Contextualizing Integration
Vertical, Horizontal, Diagonal...

Policy level
Drugs Logistics, IEC

Policy level
Drugs Logistics, IEC
Point of service delivery

Policy level
Drugs Logistics, IEC
Point of service delivery

UIP
RCH
NVBDCP
Mapping levels of Integration among Disease Control Programs- 2013

Management: Centre & State Operation

<table>
<thead>
<tr>
<th>RCH</th>
<th>RNTCP</th>
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<th>NPCD</th>
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<th>NACP</th>
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Management Information System (MIS): All levels

- **Level 1**: Accommodation: Programs communicate and develop a working agreement to align their activities; Referral, sharing of information
- **Level 3**: Joint operations: Pool resources and jointly carry out interventions
- **Level 4**: Consolidation: Partial merger where one or more components of a program are amalgamated; Common MIS system
## Snapshot:
### Current Integration of Disease Control Programs under NRHM

<table>
<thead>
<tr>
<th>DISEASE CONTROL PROGRAM</th>
<th>VARYING STAGES of PROGRAM INTEGRATION of DCP WITHIN NRHM</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCH</td>
<td>Policy &amp; Governance, Planning, co-Financing, Service Delivery, M&amp; E, MIS, Drugs, Manpower, Health Communication.</td>
</tr>
<tr>
<td>RNTCP</td>
<td>Policy &amp; Governance, <strong>Planning, co-Financing</strong>, Service Delivery, <strong>M &amp; E</strong>, <strong>MIS</strong>, Drugs, Manpower, Health Communication.</td>
</tr>
<tr>
<td>UIP</td>
<td>Policy &amp; Governance, Planning, co-Financing, <strong>Service Delivery</strong>, M&amp; E, <strong>MIS</strong>, Drugs, Manpower, <strong>Health Communication</strong>.</td>
</tr>
<tr>
<td>NVBDCP</td>
<td>Policy &amp; Governance, Planning, co-Financing, Service Delivery, M&amp; E, <strong>MIS</strong>, Drugs, <strong>Manpower</strong>, Health Communication.</td>
</tr>
<tr>
<td>IDSP</td>
<td>Policy &amp; Governance, Planning, co-Financing, <strong>Service Delivery</strong>, M&amp; E, <strong>MIS</strong>, Drugs, <strong>Manpower</strong>, Health Communication.</td>
</tr>
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<td>NACP</td>
<td>Policy &amp; Governance, Planning, co-Financing, <strong>Service Delivery</strong>, M&amp; E, <strong>MIS</strong>, Drugs, <strong>Manpower</strong>, Health Communication.</td>
</tr>
<tr>
<td>NPCB</td>
<td>Policy &amp; Governance, <strong>Planning</strong>, co-Financing, <strong>Service Delivery</strong>, M&amp; E, <strong>MIS</strong>, Drugs, <strong>Manpower</strong>, Health Communication.</td>
</tr>
</tbody>
</table>

*Red text: Lack of Integration*
**Study Sample**

<table>
<thead>
<tr>
<th>States</th>
<th>State/Centre Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assam</td>
<td>Policy makers; Academia; Program implementers; NGO’S; CBO’S; Civil society stakeholders; Media; Private Sector; Multi-Bi Lateral organizations; Donors</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
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<tr>
<td>Karnataka</td>
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<tr>
<td>Gujarat</td>
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<td>Tamil Nadu</td>
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<tr>
<td>Kerala</td>
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<td>Centre-Delhi</td>
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<td>FGD 1</td>
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<tr>
<td>FGD 2</td>
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<tr>
<td>Total</td>
<td>128</td>
</tr>
</tbody>
</table>

*State selection based on health indicators in NFHS.*
Data Analysis

Transcription and Quality Check

A-priori Codes

Develop Codebook

Coding KI, FGD

Inter-Coder Reliability

Atlas.ti and R statistical software
Findings

Quantitative
State of Integration- 3D view

<table>
<thead>
<tr>
<th>q1</th>
<th>q2</th>
<th>q3</th>
<th>q4</th>
<th>q5</th>
<th>q6</th>
<th>q7</th>
<th>q8</th>
<th>q9</th>
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<td>Policy</td>
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State-wise estimates of Integration across Program Components

KE = Kerala; TN = Tamil Nadu; GJ = Gujarat; KA = Karnataka; AS = Assam; MP = Madhya Pradesh

CP = Cooperation: Q1, Q2
CB = Collaboration: Q3, Q4, Q5
JF = Joint Funding: Q6
JP = Joint Programming: Q7, Q8, Q9, Q10

Cooperation: Q1 & Q2 (policy, joint guidelines); Collaboration: Q3, Q4, Q5 (PIP, M&E); Joint Funding: Q6; Joint Programming: Q7, Q8, Q9, Q10 (drug procurement, IEC, MIS, service delivery)
Findings

Qualitative
Approaches to integration concepts and contexts....

“Integration” interpreted at two levels as by various stakeholders

First level

One level - ‘how specific individual components of different disease program/s can be integrated’, vs...

Second level

‘how different functional areas of programs can be integrated’ within the health system for greater efficiency. (NHM-UHC)
Understanding Integration

Wide spectrum of points at which integration takes place: such as funding, common human resources and service delivery levels Inter-sectoral-convergence.

Used interchangeably with other terms such as convergence coordination, collaboration.

Health programs need to be viewed in relation to the overall health system and NRHM (now NHM).

“...integration is the convergence of the different health programs by which we can gain a maximum output out of limited resources....” (Government Representative, Gujarat)

Is an ambiguous term.
Benefits of Integration

Program Efficiency and Effectiveness

Optimum Utilization of Resources

Improved Health outcomes & Continuum of care

Integrated Health services

Greater accessibility and affordability

Greater Flexibility

“...increasing efficiency, minimizing waste and reducing duplication of efforts”. (FGD 1, New Delhi)
Obstacles to Integration

- Centre-State level disparities
- Dissolution of programme boundaries - Loss of programme focus
- Lack of ownership, power struggles and turf battles
- Disconnect between Program Design & Delivery
- Multiple Funding Channels
- Human Resource issues
- Poorly coordinated administrative structures

“….. the real problem is that every vertical program has developed its own job description, has its own training program and each of the other departments do not know what is happening and the monitoring and evaluation programs are all over the place”.

(Government, Kerala)

“… that loss of focus might actually lead to things falling between the cracks and unfortunately we have seen in India this happens frequently. If that is taken away and it is integrated into the general health system, there is a danger that it becomes nobody’s baby”.

(NGO, Karnataka)
## Potential Pathways to Integration

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<th>Processes</th>
<th>Enabling Environments</th>
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<td>• Strong Leadership (Political will)</td>
<td>• Joint Review Meetings</td>
<td>• Sense of shared ideology among decision makers</td>
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<tr>
<td>• Identify Integratable Program Components</td>
<td>• Mandatory improved Data-sharing platforms (HMIS)</td>
<td>• Community participation</td>
</tr>
<tr>
<td>• Inter-sectoral Linkages</td>
<td>• Financial and Technical Audits</td>
<td>• Sense of ownership</td>
</tr>
<tr>
<td>• Regulatory Body</td>
<td>• Delegation of powers</td>
<td>• Involving non-traditional stakeholders</td>
</tr>
<tr>
<td>• Strategy for Human Resources</td>
<td>• Comprehensive M&amp; E systems</td>
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“...so you choose programs that you would like to integrate and in your choice of programs what would you like to integrate, what would be the common aspects you would like to see? So these programs have a sense of commonality in terms of outcome like TB, Malaria”. (Government Representative, Madhya Pradesh)
CONCLUSIONS & RECOMMENDATIONS
# Scale - Levels of Integration...

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Conclusions

- Autonomy of health programs sacrosanct, but rigid verticalisation has created ‘silos’ and inefficiencies;

- Political leadership and support of high-level bureaucracy important facilitators;

- Straight-jacketing of state PIPs and ‘one-size-fits-all’ norms impose inefficient restrictions on States leading to lack of ownership at State level;

- ‘Bi-polar’ model at State level i.e. Programs working through State DHS and others through State Societies. Caused fragmentation, replication, and inefficiencies.
Conclusions

- Tremendous support at Central and State levels for UHC. Integration of National Health Programs will improve quality of services, health outcomes and lower health costs.

- UHC framework entails cashless provision of four critical services through National Health Programme platforms:
  1. free generic medicines
  2. free diagnostic tests,
  3. provision for free transport to health facilities and
  4. basic nutrition for mother and child at no cost

- UHC & NHRDA: appropriate platform for holistic delivery of services.
Recommendations

1. Create a pan-Indian platform for joint integration strategies with both Centre and State.
   **HOW?** Government of India has established the NHM.

2. Reduce Centre-State dichotomy by accommodating State centred priorities.
   **HOW?** Allow States to design operationally flexible national health programs.

3. Make proactive data sharing mandatory among National Health Programs;
   **HOW?** Strengthen HMIS through joint training of administrators and field staff in data collection, management, quality and analysis to improve programme performance and coverage.
Recommendations

4. Establish autonomous National Health Regulatory and Development Authority (NHRDA) at Central and State levels;

**HOW?** Set quality assurance parameters and enforce joint monitoring and evaluation mechanisms for integrated systems.

5. Coordination with different stakeholders, traditional medicine providers like AYUSH;

**HOW?** Foster a shared ideology on integration among programme heads through jointly driven PIPs and scoping exercises.

6. Identify areas of integratability between programs.

**HOW?** Common elements of compatible programmes will lend better to integration at policy, procedural and service delivery levels. (HIV-TB, Tobacco-Cancer)
Recommendations

7. Optimize and rationalize human resources for effective integrated delivery of services;
**HOW?** Calibrated joint training of programme personnel, develop a public health cadre, recruitment pools and joint skill building exercises across programmes.

8. Strong political and bureaucratic leadership at regional and central levels with a vision for integration;
**HOW?** Recognize champions among bureaucrats and implementers to better integrate programme components.
- Encourage wider Inter-sectoral convergence.
9. Proactive P-P-P;

**HOW?** Selective integration of private sector with public health programmes in areas of: management, services delivery, quality control, supply chain logistics, human resource training & infrastructure with contractually bound monitoring mechanisms.

10. Initiate policy level reforms for Human Resources;

**HOW?** Recruitment, remuneration, career trajectory, joint guidelines and capacity building. Pilot integrated pooled recruitment and training amongst the larger programmes.

- Incentivize implementers with a sense of ownership through freedom of decision-making.
ACKNOWLEDGEMENTS

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Thank You