INTERNSHIP REPORT

PART I

A COMPREHENSIVE REVIEW OF HORIZONTAL AND VERTICAL HEALTH CARE PROGRAMMES IN LOW AND MIDDLE - INCOME COUNTRIES

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RATIONALE AND OBJECTIVES

- The purpose behind conducting a review on horizontal and vertical health care programs is to understand the evolution of the healthcare framework around the world.

- To assess objectively the results of the Health programmes that have been initiated since the Alma - Ata across the low and middle-income countries of the world, and

1. To delineate the understanding of what encompasses Vertical and Horizontal health care programs, Selective and Comprehensive health care and the diagonal health care approach.
2. To compare outcomes in Horizontal and Vertical Healthcare programs
3. To identify the way forward in enabling the vision of ‘Health-to-All’

HISTORY OF HEALTHCARE PROGRAMMES

1950s,60s

Independence of South-East Asian, Asian and African economies

Evolution of community based health care programme/Inability to sustain western curative based models.

1978 – Alma-Ata conference-Declaration of ‘Health-For-All’ and PHC strategy

1979 – Seen as far-sighted, Selective Primary Healthcare seen as alternate approach

1980,1990(The Small Pox Eradication, Polio initiative and Expanded Program on Immunization validate the claims of selective health care

METHODOLOGY

A systemic literature research on databases – PubMed, ProQuest, Cambridge University Press, The Economic and Political weekly.

Eligibility Criteria - Communicable diseases/ Nutritional diseases/ epidemics that affect Low-and-Middle Income countries

Segregation and Tabular summary of compiled resources

Narrative Synthesis and comparison of two different approaches to the same healthcare problem.

INTRODUCTION

Horizontal Healthcare Programmes

- serve the public, *en masse*
- financed directly by the government
- focus on all health indicators in general
- Is slow acting and takes longer time to achieve goals

Vertical Healthcare Programmes

- encompasses preventive functions
- targeting specific populations
- targeting a particular disease
- Funding is done by government or by NGOs/external institutions.
- Does short term goals in a shorter period

HORIZONTAL HEALTHCARE PROGRAMS

- "the process of bringing together common functions within and between organizations to solve common problems, developing a commitment to shared vision and goals and using common technologies and resources to achieve these goals."

- Horizontal Health care, since it is pluralised in its meaning is often also called Comprehensive Healthcare Program

- It therefore is also an intersectoral, decentralised, bottom-top approach to Healthcare problems that is more preventive than curative and less technology intensive

– The examples of vertical healthcare programmes enumerated in the paper are

1. Expanded Program on Immunisation (EPI)
2. Village Health Sanitation and Nutrition committees
3. Family Centred Approaches in rural areas in India
4. Aboriginal controlled health programs in Australia
5. Maternal Health Programs in Congo based on local beliefs

HORIZONTAL HEALTH CARE PROGRAMS	
BENEFITS	CHALLENGES
Results in Public health system strengthening	Requires time in the magnitude of several years to achieve an efficient system
Is decentralised and involves a bottom-up approach being inclusive	Requires human and financial resources, and far sighted plan planning
Allows for intersectoral approach and hence stem disease causing factors in the bud	Due to its intersectoral involvement it is bound to face opposition at all stages.

VERTICAL HEALTH CARE PROGRAMS

- are directed, supervised and executed, either wholly or to a great extent, by a specialized service using dedicated health workers.
- These programs can be of two types –

1) a separate funding, governance, organization and management
2) that have all of the above except a separate delivery

– The examples of vertical healthcare programmes enumerated in the paper are:

1. Malaria Elimination Programs (African countries in Sub-Saharan Africa)
2. Tuberculosis (TB) Control Programs (In South Asian countries)
3. The GOBI (Growth monitoring, Oral Rehydration, Breastfeeding and Immunization) strategy
4. Small Pox Eradication Programme
5. Polio Eradication Programme
6. African Onchocerciasis Program

VERTICAL HEALTH CARE PROGRAMS	
CHALLENGES	BENEFITS
Require donor-based investment due to the mass investment that goes into the program at the beginning	Useful in containing diseases when they are of epidemic scale or communicable requiring immediate intervention
The client is not involved in decision making; hence making most efforts one sided;	Easily kept away from bureaucracy and hence avoid most organizational managerial problems.
They exist as a short-term solution to the problem causing a resurgence once the intervention is withdrawn.	Though they cannot be incorporated as a long-term solution, the AIDS and APOC program are examples of how vertical programs can be incorporated into the health system eventually.

A COMPARISON BETWEEN TWO TB CONTROL PROGRAMMES WITH DIFFERENT STRUCTURE AND IMPLEMENTATION FRAMEWORK

- In order to compare the two types of Healthcare approaches, a comparison between TB control Programs implemented in two TB intensive countries has been done – China and India.
- While India had maintained a predominantly vertical approach China has shifted to integrating its TB program into its PHC program; thereby reducing finance, improving quality, and reducing pathways.
- Both countries seem to utilize their respective private healthcare systems – India using a Public Private Mix to incentivize the private sector and China using a similar strategy of result based financing.

COMPARISON BETWEEN TWO TB CONTROL PROGRAMMES

	TB control Programs in the Peoples' Republic Of China	TB control Programs in India
Health Burden in the TB population	The greatest burden of TB amongst patients is with regard to MDR-TB apart from the case load of newly incident cases.	high number of undetected case load and a large number being attested to nutritional causes.
Organization	The TB Program evolved from a CDC led model; using separate TB clinics and TB departments within CDCs to a more integrated model. In 2011, the function of TB diagnosis and treatment was shifted to designated hospitals due to want of healthcare personnel. Integration of the programme into the primary healthcare service system	

Activities done to expand access to care	“Local Centres for Disease Control and Prevention offices reimburse patients’ expenses” and enabling designated private hospitals to provide care	• Enable subsidy schemes in the private sector • Improve access to microscopy in the public sector
Financing	The Chinese Tuberculosis control program uses results-based financing to incentivize the TB program.	uses Public-Private Mix schemes to enable involvement of private partners to participate in the Tuberculosis control program. Grant-in-Aids are given to establishments depending on the population served. This system is based upon results-based financing.
To improve quality	• Improve referral systems and sample transport; • reimburse patient expenses; • enhance mobile health, case management, and adherence support; • improve management of side-effects of MDR tuberculosis treatment	• Improve private sector quality through provider training, supervision, regulation, and subsidies; • provide patient retention incentives, nutritional support, and link to social welfare

HEALTH OUTCOMES - TB

	CHINA	INDIA
SPECIFIC OUTCOMES MEASURED	• TB incidence - 60 per 100,000 mortality rate of three per 100,000 • 71000 (8.19%) undiagnosed cases of TB • MDR-TB cases; 66000 (7.62%) • HIV cases living with TB; 18000 (2.07%) • Treatment Success Rate; 93% • TB treatment coverage rate; 92%	• TB incidence of 198 per 100,000 mortality rate of 33 per 100,000 • 700000 (26%) undiagnosed cases of TB • MDR-TB cases; 130000 (4.83%) • HIV cases living with TB; 92000 (3.42%) • Treatment Success Rate; 81% • TB treatment coverage rate; 74%

– Finally, to conclude it is possible to say that Horizontal/ comprehensive, decentralised health care is the most obvious choice to better health in all countries; however at the same time selective primary health care is as important in situations in less educated societies or when a sudden or vital action is needed to prevent rapid spread of a disease.

PART 2

HEALTHCARE DELIVERY SYSTEMS

OBJECTIVES

1. To provide how healthcare management can be improved through better strategic planning
2. The types of health care systems around the world – welfare based and entrepreneurial health care systems
3. Leadership to improve health care management
4. Healthcare innovation from the high performing health systems around the world

COURSE CONTENTS

- It includes videos for the presentation on health care systems around the world and research literature on the healthcare management innovations and leadership globally.

1. The healthcare systems of the world
2. Health Strategic Planning
3. Positive Deviation In Healthcare
4. High Reliability In Healthcare
5. Facets Of Patients and Health Outcomes
6. Relationship between Health Literacy and Physical Health

LEARNING METHODOLOGY

- The entire course was divided into five modules over ten weeks.
- Videos for Health Care systems and Research articles for the rest of the modules were provided.
- Discussion Forums were conducted after every module where students were allowed to present their opinions and queries regarding the topic of discussion.

KEY LEARNINGS

I THE HEALTHCARE SYSTEMS OF THE WORLD

1. THE UNITED STATES OF AMERICA - - is a mixture of private and public - where 70% are non-profit leaving the remaining for profit-60% of health insurance is provided by employers- care involves preventive care, curative inpatient care and prescription drugs

– Health Insurance is of two types- Medicare and Medicaid

– Medicaid is a state-based program that provides health care for namely –

i) kids under 6 years of age up-to 133% FPL (Federal Poverty Line)

ii) kids (6-18) up-to 100% of FPI

iii) State Children's Health Insurance Plan (SCHIP) ups these to 300% FPL in most states.

2. SWITZERLAND

- universal health coverage where since 1996 the Federal Health insurance Act has mandated that all residents but statutory health insurance from private health insurance companies.
- It requires one to purchase insurance even sometimes retroactive to arrival
- **Coverage is comprehensive being for Physicians, Drugs, Medical Devices, Home health care and preventive services** (Screening, Immunisations and examinations)
- Dental care is not provided under the umbrella of services, also eyeglasses and contact lenses are only covered for children
- High out of pocket spending is the issue for the health care system of Switzerland; also doctors are under constant pressure to keep health care costs low and

II HEALTH STRATEGIC PLANNING

Product development	Process of Strategic Planning
Establish a unique, far-reaching vision	Organize preplanning
Attack critical issues	Structure effective participation
Develop focused, clear strategies	Think strategically
Differentiate from competition	Manage implementation
Achieve real benefits	Manage strategically

III POSITIVE DEVIATION IN HEALTHCARE

- Positive deviant healthcare can be understood as identifying the healthcare resources in a given community and using the assets inherent in a society to improve health outcomes.
- a social and behavioural change mechanism that is easily adapted into a community due to its conformance with the communities' beliefs and practices and may already, in instances in practice within the community.
- Three processes that facilitate positive deviation are –
- Social Mobilisation
- Information gathering
- Behaviour Change

IV HIGH RELIABILITY IN HEALTHCARE

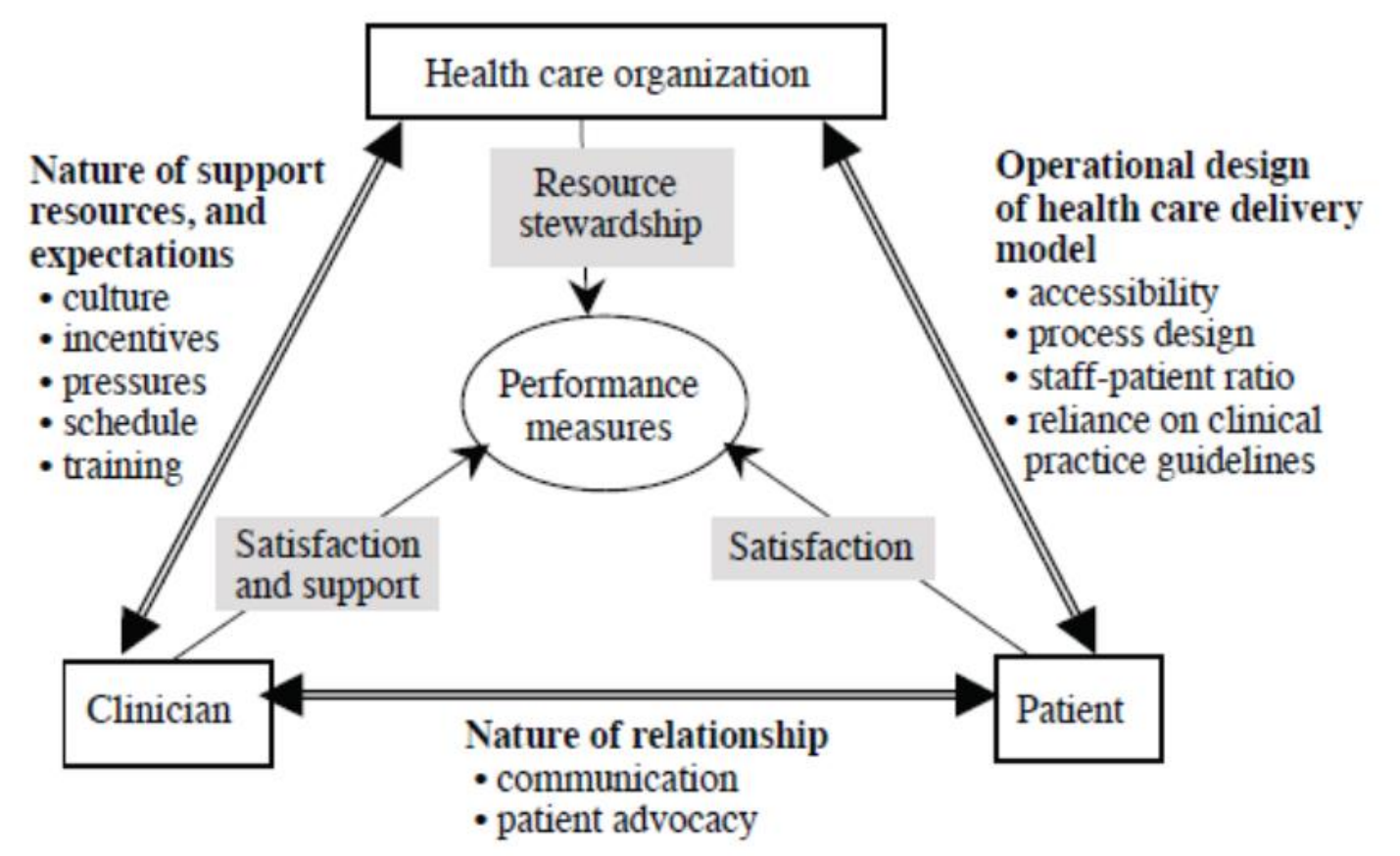
- High Reliability Organisations are those that have achieved a high degree of safety in-spite of functioning in hazardous conditions; like aviation and nuclear power. This is due to the reason that health hazards are considered a normal occurrence by default.
- Weick and Sutcliffe have elaborated the most elaborate description of high reliability care as an environment of "collective mindfulness" in which workers look for small problems that may contribute to a risk to the organization
- They include five high reliability principles –

1. HROs are preoccupied with failure, never satisfied that they have not had an accident for many months or many years
2. Being able to identify the subtle differences among threats may make the difference between early and late recognition
3. Sensitivity to operations
4. Commitment to resilience
5. Deference to expertise; by going to the most experienced individual rather than moving by hierarchy.

- HROs tend to not become complacent by hazards in work environments lest they become ‘contaminated’ by its presence. They tend to nip this in the bud.
- Another factor seen in HROs is the resistance to simplicity; or the one size-fits-all practice as is seen in hospital practices.
- Thirdly is the lack of sensitivity of health care workers to small problems that may be within their view or work area. In addition, intimidating behaviour by superiors further complements the problem.

V FACETS OF PATIENTS AND HEALTH OUTCOMES

- Hospital care or institution care involves three facets that constantly interact with each other and influence the patient, clinician and organizational quality outcome in general



Health care Delivery Triad

Factors that influence healthcare clinical procedure processes are

- Patient satisfaction
- Perception of service delivery
- Nature of interactions with staff
- Nature of communication with clinician
- Personalized care
- Accessibility
- Responsiveness/timeliness of care

Those influencing patient outcomes are

- Health outcome
- Clinical performance measures

VI MANAGEMENT OF HEALTH DISPARITY

- “A health disparity/inequality is a particular type of difference in health (or in the most important influences on health that could potentially be shaped by policies); it is a difference in which disadvantaged social groups—such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination—systematically experience worse health or greater health risks than more advantaged social groups.”
- Up-to the late decades of the 20th century, there seemed to be more emphasis on the health inequalities between the social groups in a country and less on those between different gender groups or ethnic groups; , this presents a skewed picture owing to **the predominance of these groups** and a shift of average to the disadvantaged side

- The most common measure used to compare groups are – Rate ratio, Rate difference, Population attributable risk relative indices of inequality, and concentration curve and index.

- Comparison of ungrouped individuals using economic factors such as the Gini-Coefficient (to measure economic inequality; based on income) may be done.
- The “index of dissimilarity” (ID) has been proposed by some authors (86) to measure the magnitude of disparities across diverse kinds of groups, The ID for a given health indicator sums differences between rates in each subgroup and the overall population rate, expressing the total as a percentage of the overall population rate.

VII RELATIONSHIP BETWEEN HEALTH LITERACY AND PHYSICAL HEALTH

– “capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”

- needed to make appropriate health decisions.”

– Some of the tests used to measure health literacy are –

1. Rapid Estimate of Adult Literacy in Medicine – tests the ability of a person to spell a group of health-related words
2. Test of Functional Health Literacy in Adults (TOFHLA) [reading and numerical tests]– requires patients to fill gaps in health-related passages and perform numerical tasks that are done in health management.
3. Newest Vital Sign (NVS) – asked to answer questions on a label on an ice cream passage regarding nutrition.

CONCLUSION

- Health care systems around the world vary depending upon the society that has developed over centuries and health care problems vary amongst individuals.
- While health care technology has improved to a point where the genetic makeup of individuals can be assessed for identifying their genetic dispositions to certain diseases, the same cannot be said about the adoption of different managerial practices to achieve higher patient satisfaction, quality of care and cost efficiency.
- It is imperative to adopt parallel procedures both from other organizational structures apart from health care institutions if they benefit the capacity of the same. Such is the example that HRO (**High Reliability Organizations**) provides us.
- Similarly, is **Positive Deviance** that **refers to adoption of sustainable health care practices from within the community itself**. Such cost-effective models increase the trust of backward communities in concurrent health developments and organizations