TB REACH Wave 7
Engaging Private Healthcare Providers

Background

Through much of the last 25 years, TB care and prevention activities have generally focused on the provision of services by public sector providers overseen directly by National TB Programs (NTP). However, a majority of people first seek care in the non-NTP sector, even among the very poor [1], and one key reason for the missing millions is the patients who are managed in the informal and private sectors, but either not diagnosed, or not notified to NTPs. The private and informal sector ranges from pharmacies and unqualified practitioners to highly qualified formal doctors.

The systematic involvement of all relevant health care providers in delivering effective TB services to all segments of the population is an essential component of the Global Plan to End TB. To improve the quality of TB care in the private sector, 'Public-Private Mix (PPM)' approaches were developed and introduced in the late 1990s [2]. The scope of private sector engagement was subsequently expanded to include public hospitals under the ministry of health and other ministries (labelled as 'public-public mix') as well as academic institutions, informal and other non-NTP providers [3], although the stream of TB REACH funds described here is focused specifically on engagement of private providers.

Some early PPM models involved mainly training and a rather passive demand to follow NTP models. More recently, newer models of private sector engagement have developed that are more sympathetic to private sector realities and have the potential to greatly increase the numbers of care providers detecting, treating and reporting people with TB [4-7]. Small, focused interventions have shown good results [4] but, given the massive numbers of people accessing care in the private sector in most countries, new approaches that are able to scale to large numbers of private providers are needed [6-7]. Furthermore, with a few notable exceptions, large-scale efforts to engage the private sector have focused primarily on Asian countries. Efforts in other regions, especially in Africa, have not been nearly as strong despite evidence that initial health seeking behavior is focused on private providers [1]. Finally, PPM has generally required the activities of intermediary agencies, which act as an interface between the NTP and private providers, but the number of domestic organizations in high burden countries with this expertise remains limited in both Asia and Africa. More efforts are needed to develop and to scale successful approaches to better involve the myriad of different providers of care for people with TB. TB REACH seeks new models and areas of work to better involve private healthcare providers to detect and notify more people with TB.

Areas of Consideration

TB REACH provides a dedicated funding stream to support systemic, scalable and innovative interventions that engage private care providers in TB under the 'Improving detection, linkage to treatment and reporting of TB ' Category. Successful applications should address one or some of the below areas of consideration.

Demonstrate learning from previous or current efforts in private provider engagement

Three recently published documents provide important context, history and lessons learned in private provider engagement for TB: a landscape analysis of TB private provider engagement [8]; a PPM roadmap [9]; and the Stop TB Field Guide on engaging private providers [10]. Applicants are encouraged to review the landscape analysis, in particular, for strategic lessons that are relevant to their proposed area of work, and the field guide for invaluable practical advice.

Different Engagement Approaches Based on Provider Types

The PPM toolkit developed by the WHO and the Stop TB Partnership's PPM working group enumerates many of the different private healthcare provider types and organizations. Tailored engagement approaches are needed depending on the provider type. Some providers may be focused solely on referrals, others on treatment, or treatment support while others may also be included to notify people with TB.

In addition to considering these distinct "task mixes" of individual provider types, applicants are encouraged to develop proposals that link together different types of providers, especially if these efforts strengthen nascent structures and relationships already existing in the private healthcare sector. This could include methods to link referring providers to diagnosing providers, and to link from diagnosing providers to laboratories and pharmacies that provide diagnostics and drugs, respectively.

Engage Frontline Health Care Providers

Collaborating with large hospitals or large NGOs that are not reporting people with TB are likely to provide a high yield of cases per facility engaged. However, to reach all of those in need, interventions should also engage the frontline, primary care providers who are first approached by people with TB. These include, but are not limited to, formal and informal private practitioners, private laboratories, retail pharmacies, practitioners of alternative systems, and traditional healers. Frontline health care providers often remain non-engaged and largely uninterested in partnering with NTPs. However, they are critical to not only enhance case detection but also reduce diagnostic delays, cut disease transmission and minimize direct and indirect costs of care for patients and the society at large.

Incentive structure

Performance-based financial incentives can be a useful approach to improve private sector participation and the service performance, but are not an essential condition. Financial incentives come with challenges for record verification and timely and transparent disbursement. Financial incentives based on clinical diagnosis may provide perverse motivation for over-diagnosis. Good recording and verification systems and other checks and balances are needed to avoid this. Ideally, financial incentives to private providers would be part of a national system, such as a national health insurance payment – any opportunities along these lines should be pursued, at least by initiating a policy dialogue. Financial payments should also be dependent on quality of care (see below).

Besides financial incentives, motivation, moral persuasion, provider trainings, the provision of timely feedbacks on referrals, and free extras can be also used. Additionally, free services can be offered to patients as an incentive, such as vouchers for free anti-tuberculosis drugs and laboratory tests, such as chest X-rays, sputum smears and Xpert® MTB/RIF or Ultra. Private providers also appreciate their patients receiving support with adherence and treatment completion.

Appraisals and Training to Ensure High-Quality of Care

There is considerable evidence that quality of TB care is suboptimal in the non-NTP sector [11]. The essence of private sector engagement is to replace low-quality, expensive and inefficient health care provision with rapid, affordable, and correct diagnosis and treatment and to link people already being treated in the private sector with national notification systems. Private practitioners may not believe or agree with NTP regimens, and manage people with TB differently, and possibly sub-optimally. Therefore, quality of care should be monitored and targeted feedback provided to improve performance over time. Quality of care also includes notification and adherence monitoring (see below).

Notification and Adherence Monitoring

Non-NTP practitioners, even those who are highly qualified, typically struggle to undertake two critical non-clinical tasks: prompt recording and reporting of required data; and adherence monitoring. Thus, applicants should explicitly outline their interventions to assist in these two areas. Applicants are encouraged to make use of technology for both tasks and to connect with and between providers. This could include the development of software, procurement of portable equipment for data entry at field level, use of call centers, and the training of staff on data entry and management.

Intermediary Organization

It may be critical to introduce an intermediary organization (such as an NGO or medical association) between the NTP and health providers involved, to improve operational management. The intermediary organizations build an NTP–NGO–private link by aggregating, mobilizing, training and supervising non-NTP health providers, as well as notifying cases to NTPs and coordinating with NTPs for free drugs and follow-up, which also relieves the stress on overburdened NTP staff.

Market-Driven Interventions and Access to Domestic Financing

Long-term growth and sustainability of efforts to engage private sector providers will require access to domestic financing – which could include out-of-pocket payments but would ideally consist of government financing through either contracts or insurance payments. Applicants should consider any opportunities or activities to allow them to tap into these income streams in the longer term.

Social businesses provide one possible model for private sector engagement efforts. The key characteristic of these programs includes the integration of multiple disease areas: multi-disease activities provide greater patient volumes, an income stream to support the TB activities, and a greater draw for providers, but TB is included as a requisite part of the business model. In the future, social businesses could make ideal recipients for results-based financing from governments and for payments from national health insurance schemes. Income from these businesses could in theory lead to more sustainable programs.

Funding Priorities

Organizations that meet the TB REACH funding eligibility criteria are encouraged to apply for this funding stream. However, the TB REACH's Proposal Review Committee will give preference to those applicants who:

1) Have a local (national or subnational) organization as the sole or primary funds recipients and implementer (compared with large international organization); and
2) Have clearly identified a gap in current engagement (and lack of existing engagement models) either in a particular geographic area and/or with certain type(s) of providers – with reference to any existing situation analysis of current gaps, including those in the costed PPM action plans available for Bangladesh and the Philippines in Asia, and Ethiopia, Ghana, Kenya, Malawi, Namibia, Nigeria, Tanzania, Uganda, and Zambia in sub-Saharan Africa.

Conclusion

A systematic involvement of all relevant health care providers in delivering effective TB services to all segments of the population is essential to reach the 90-(90)-90 targets set up in the Global Plan and the new End TB Strategy. It is clear that business as usual approaches are no longer adequate to deal with the vast, fragmented and largely unregulated private care sectors in many countries. The missing

millions will remain invisible until the private sector is engaged to offer better quality care of persons with TB or TB symptoms.

In the Wave 7 call for proposals, TB REACH provides a unique opportunity to explore newer ways to engage private care providers in TB, exploit new tools and attempt to go beyond pilots to scale interventions at the national level.

Reference

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