

ENHANCING PRIVATE SECTOR CONTRIBUTION TO TB CARE IN INDIA

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The Global Fund has been a partner to India's TB control efforts since its inception. The present study was initiated with a proposition of strong need to improve private sector participation in TB programs in order to accelerate TB reduction initiatives undertaken under the GF and national funding. While some successes have been achieved in the past, these were limited in scope and impact. The private sector is a major player in health service delivery in India. Therefore, there is the need for finding ways to expand effective partnership with the private sector. Partnerships with private sector can be of many forms at various levels and these need to be initiated in consultation with various stakeholders. Thus this study was conducted starting with literature review, consultation meeting and discussions with various stakeholders.

The author is also extremely grateful to participants of the consultation meeting and with all those with whom discussion was held on individual basis. The members included those from RNTCP, NGO sector and private sector. The list is placed in Annex 1 and Annex 2. Thanks are also due to the Partnership for TB Care and Control, India and its secretariat, for providing support in organisation of the consultation meeting at LRS Institute. It also needs to be mentioned here that the LRS Institute generously allowed us to hold a meeting at their venue.

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Abbreviations

ACSM	Advocacy, Communication and Social Mobilization
API	Association of Physicians of India
ART	Anti-Retroviral Therapy
C&DST	Culture and Drug Sensitivity Test
CCM	Country Coordination Mechanism (of India)
CDR	Case Detection Rate (Central unit managing the TB control programme)
CTD	Central Tuberculosis Division
DMC	Designated Microscopy Centre
DOTS	Directly Observed Treatment - Short course
DR	Drug Resistance
DTO	District Tuberculosis (control) Officer
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
IAP	Indian Academy of Paediatrics
ICS	Indian Chest Society
IMA	Indian Medical Association
ISTC	International Standards for Tuberculosis Care
The Union	International Union Against Tuberculosis and Lung Disease
JMM	Joint Monitoring Mission
MDR-TB	Multi-Drug-Resistant Tuberculosis
MoU	Memorandum of Understanding
NGO	Non Governmental Organization
NRHM	National Rural Health Mission (India)
NSN	New Smear-Negative
NSP	New Smear-Positive
OR	Operations Research
PP	Private Practitioner
PPM	Public-Private Mix
RNTCP	Revised National Tuberculosis Control Programme
STO	State Tuberculosis (control) Officer
STS	Senior Treatment Supervisor (sub-district level)
TU	Tuberculosis Unit (sub-district supervisory unit)
UNITAID	International facility for the purchase of drugs to treat AIDS, Malaria and TB
USAID	United States Agency for International Development
WHO	World Health Organization
XDR-TB	Extensively Drug-Resistant Tuberculosis

Executive Summary

India bears 21% of the global burden of incident TB cases and estimates for 2008 show that about 131,000 MDR-TB cases emerged in India, representing over 20% of the global incidence of MDR-TB. HIV prevalence among TB patients is reported to be 4.85%. India's response to the TB situation has significant implications on TB control not only in India but globally.

The Revised National Tuberculosis Control Programme (RNTCP), incorporating all elements of the Stop TB strategy is being implemented in the entire country since March 2006. The Programme has now been achieving global targets for new smear positive case detection (NSP CDR) of at least 70% and treatment success of at least 85% (perf 2Q09). Till date >11 million TB patients have been initiated on treatment saving > 2 million additional lives (source: www.tbcindia.org accessed 16th January 2010). However achievement of targets in itself may not be sufficient to control TB disease and the Programme needs to move towards universal access.

Recent National Family Health Survey found that nearly two thirds of households (65 percent) generally seek health care from the private medical sector. The private medical sector remains the primary source of health care for the majority of households in both urban areas and rural areas. Inadequacy in public health services assumes particular significance in the shopping that patients resort to-on an average, about 6-9 providers before finally reaching the DOTS centre, which not only drains the financial base but, with the irrational prescriptions given, could well be contributing to drug resistance.

The overall conclusion from literature review is that PPM requires additional investment costs but if implemented on a large scale, the costs to the programme for PPM are comparable to public sector costs and much less than a situation where there is no DOTS in private sector. The overall societal costs for treatment in PPM settings would be much lower because of savings to patients in terms of reduced shopping before and opportunity costs during treatment.

The discussions reveal that though there is willingness amongst both public and private sector to collaborate, there is also some inertia in carving and establishing a long term sustainable partnership. The programme has developed well thought of schemes for private sector involvement and could also take several further steps in strengthening and mainstreaming PPM. Some of the initiatives would include mapping private sector strength and developing a roadmap for private sector participation. Successful PPM would require additional capacity building to strengthen local initiatives through additional staff, training existing RNTCP staff on PPM, and sustained advocacy. Local intermediary bodies at state and district level can be strengthened and PPM can be contracted out. To provide greater impetus to PPM initiatives, a private sector subcommittee under CCM can be

formed. Political commitment to PPM can be increased through sensitization of MPs particularly those from private sector. The programme can also look at successful PPM models in other sectors within country and replicate some of them

'.....Further, the government, besides strengthening the current public health system has also the challenge of fruitfully utilizing the widespread private health system to address public health goals and make it accessible to the poor at affordable prices.'

(In their preface note to Report of the National Commission On Macroeconomics And Health, 2005; the then Hon'ble Minister of Health and Family Welfare and Hon'ble Minister of Finance, Govt of India)

Health care services in India and TB control in context of these services

Health care services

Public sector plays a major role in health care in India in terms of planning and regulation and attempts to achieve equity through free/ highly subsidized services. Yet, public sector spending accounts for less than a quarter of the total health spending¹. Public spending (i.e. expenditures incurred by health departments of Central and State Governments) on health has gradually accelerated from 0.22% in 1950-51 to 1.05% during the mid-1980s, and stagnated at around 0.9% of the GDP during the later years.

The National Commission on Macroeconomics and Health noted that for improving health in India includes *promoting equity by reducing household expenditure on total health spending and experimenting with alternate models of health financing*. The commission also emphasizes on innovative financing models to ensure universally accessibility as the *Government would require a five-fold increase in the budget or Rs 1 lakh crore @ Rs 1160 per capita per year if it is to be the sole provider of the comprehensive package of services*.

General health care seeking behaviour

National Family Health Survey (NFHS 3)² found that nearly two thirds of households (65 percent) generally seek health care from the private medical sector. The private medical sector remains the primary source of health care for the majority of households in both urban areas (70 percent) and rural areas (63 percent). The main provider of care among private providers is a private doctor or clinic. The next most common sources of health care are public and private hospitals. Private doctors and private clinics are also the most commonly used provider of health care among various households. The NFHS 3 concludes that the *private medical sector dominates health care delivery in the country, and use of private doctors and private clinics is the primary source of health care among rich and poor alike*.

TB situation and control programme in India

India bears 21% of the global burden of incident TB cases and estimates for 2008 show that about 131,000 MDR-TB cases emerged in India, representing over 20% of the global incidence of MDR-TB. HIV prevalence among TB patients is reported to be 4.85%. India's response to the TB situation has significant implications on TB control not only in India but globally.

The Revised National Tuberculosis Control Programme (RNTCP), incorporating all elements of the Stop TB strategy is being implemented in the entire country since March 2006. The Programme has now been achieving global targets for new smear positive case detection (NSP CDR) of at least 70% and treatment success of at least 85% (perf 2Q09)³. Till date >11 million TB patients have been initiated on treatment saving > 2 million additional lives (source: www.tbindia.org accessed 16th January 2010). *However achievement of targets in itself may not be sufficient to control TB disease and the Programme needs to move towards universal access*.

However the national performance masks the variation in performance between districts and states. In 2Q09, NSP CDR of as low as 23% has been recorded in a district and treatment success rates less than 60% have also been recorded in some of the districts. There were at least 19 districts with initial default rate of 20% or more, indicating possibility of difficult access to services. The programme needs to now consolidate and sustain current achievements uniformly across all states and districts in the country, and to increase access to quality TB care for all, including DR-TB. The programme target is to uniformly achieve $\geq 85\%$ success rate amongst new smear positives and $\geq 70\%$ new smear positive detection rates in at least 430 out of the 639 districts in the country by 2011

RNTCP has developed a response plan for M/XDR-TB, which includes: prevention by quality DOTS expansion, laboratory strengthening for diagnosis and management of DR-TB under the programme, and rational use of second line anti-TB drugs. The vision of the national TB programme under the National DOTS Plus plan for DR-TB management is to provide universal access to MDR diagnosis and treatment for all smear-positive TB cases under RNTCP by 2015.

Achieving these targets means a quantum jump in programme implementation costs specifically for DR-TB and need for creation and expansion of adequate infrastructure to support the Programme efforts in this direction.

The programme has received financial support from the GF in RCC proposal 2008 and recently in Rd 9 proposal to address the challenges pertaining to access of diagnostic and treatment services both for TB and DR-TB. Funding support from some other donors like USAID for specific projects is also available. However these supports are time bound and the Programme needs to have a strategy of gradual shift from donor funding to domestic funding of all programme costs. In a recent publication in The Lancet a possibility of drop in aid by 14% or \$25 billion between 2008 and 2010 has been estimated due to shrinking of economies of rich country members of the Organisation for Economic Cooperation Development. The article also talks of recent trend by health organisations to move into the private sector to raise money in increasingly innovative ways. UNITAID, funded by airline ticket taxes, is a well known example. Companies responsible for airline tickets bought online—Amadeus, Galileo Travelport, and Sabre—have also agreed to modify their websites to enable travelers to donate to health projects when they buy tickets via the internet⁴.

Private sector

Private sector in India is vast and heterogeneous consisting of wide variety of players that are directly or indirectly involved in providing health care services. This particular paper focuses on private for profit sector that include individual health care providers (commonly known as private practitioner or PP), nursing homes, private hospitals, pharmacists selling drugs and private corporate sector. The private sector also includes practitioners of several systems of medicine and private medical colleges that run teaching hospitals on paid basis.

The nature of private sector in India also varies with the socio-demography across the country. The nature and number of private sector facilities available in urban cities differs a lot from what is available in a rural area or a predominantly tribal area.

TB control in context of health care services

The Tuberculosis (TB) control programme in India, is being implemented through the general health system. Being an integrated programme, the RNTCP depends on a

functioning health system with sufficient infrastructure, outreach and access, and adequate, well trained and motivated staff at all levels. Deficiencies in the general health-care system constitute a major barrier to further improvements in performance, especially in states with weak health systems.

This is also evident from NFHS 3 findings² that inadequacy in public health services assumes particular significance in the shopping that patients resort to—on an average, **about 6-9 providers** before finally reaching the DOTS centre, which not only drains the financial base but, with the irrational prescriptions given, could well be contributing to drug resistance.

A study published as early as 1998 mentioned that the first source of help for **86% patients** was a PP⁵; 79 different regimens were prescribed by 105 reporting PPs; Treatment adherence rate amongst patients being treated in private sector was 59%; 67% of those diagnosed in the private sector remained with PPs for treatment. Rest shifted to public health system. 3/4th of India's health expenditure takes place in private sector and 80% of qualified medical practitioners are in private sector.

Another review by LRS Institute⁶ discusses behaviour-profile of patients, and enumerates possible reasons for preference for a private health facility. A comparison is drawn between available services of the public and private health facilities, with a focus on the need for prioritisation of a private-public mix (PPM) in the RNTCP.

A more recent publication on health-seeking behaviour of TB patients in Tamil Nadu⁷, finds that the first contact in NSP cases as symptomatics was non-governmental facility for **53% cases**. Provider delay was 9 days with government and 50 with private provider. In multivariate analysis, patient delay was significantly associated with smoking and mode of travel, and provider delay with first consultation with a private provider and distance >5 km from the health facility. Twenty-five per cent of patients took more than two actions before diagnosis.

A survey in Bangalore found that the first health contact was with a private practitioner in the case of **>70% of patients**. Mean patient delay was low, at 21 days, but the mean health system delay was 52 days⁸. An interesting finding in this study was that the greater share of total costs was incurred before treatment while seeking care among various providers. The length of health seeking was on average 72 days and the total cost was on average US\$145. For poor patients, this represented more than half of the annual household income per capita, or the equivalent of 14% of annual household income.

Delays experienced by patients in accessing directly observed treatment were examined in a study in Pune⁹. In this study provider delays contributed significantly to delayed entry into RNTCP.

Patients had to resort to **multiple contacts** with providers due to limitations of these providers in diagnosing or directing patients to the RNTCP. Patients who consulted a PP participating in the public-private mix (PPM) were more likely to be suspected and referred to the RNTCP. Once the patients entered the RNTCP, the response of the system was rapid, with diagnosis offered and treatment initiated within on average 7 days.

The summary of the section is that private sector plays a significant role in health care delivery in India in general and specifically for TB care. However if the private sector is not involved, there could be significant delay and cost for the patient before being able to access quality care. *It therefore becomes imperative that a comprehensive approach in providing TB care is adopted to ensure equity of access to quality and standardised care for all patients. The approach should include all sectors including private sector by optimally harnessing the available strengths.*

RNTCP efforts in involvement of private sector

Private sector has received attention since the beginning of the Programme from both technical and administrative arms of Gol since the beginning of RNTCP. An overview of history of private sector involvement in TB care (source: Briefing document for JMM 2009: CTD)

1995	PPM model at Mahavir Hospital, Hyderabad
1997	PPM model at Ramkrishna Mission Hospital, Delhi
2000-2003	PPM Models in Delhi, Kannur, Kollam, Mumbai, Tea-gardens of North-East
2001	Schemes for involvement of NGOs in RNTCP published
2002	Schemes for involvement of Private Practitioners (PP) in RNTCP published
2002-2003	PPM activities initiated in all the RNTCP states
2003	Intensified PPM scaling up began in urban sites (14 project sites)
2004	Declaration by national IMA to support RNTCP
2005	IAP guidelines, Urban DOTS GFATM projects, expansion of intensified PPM
2007	GFATM supported IMA Project launched in six states Launching of IMPACT (Indian Medical Professional Association Coalition against TB)
2008	GFATM supported CBCI project launched in 11 states 19,000 private practitioners, 267 Medical colleges and 150 corporate houses involved
2009	Till September - 25080 private practitioners sensitized to RNTCP under GFATM project, 3334 PPs trained, 1585 DOT centres created and 46 DMCs created. IMA project included in GFATM RCC proposal and to expand to 10 more states

NGO-PP guidelines

Using the experiences gained from the collaborations with NGOs and the private sector, the Central TB Division (CTD) published guidelines for the participation of the NGOs (2001) and private practitioners (2002). Keeping in view the evolution of the programme over time, a national consultation on revision of NGO /PP Guidelines was held in January 2008. The consultation was held with >60 participants including programme managers; professional bodies like IMA, API (Association of Physicians of India), FPAI (Federation of Family Physicians Association of India) and NGO representatives. Following the consultations, the schemes were made more flexible and new schemes like Culture and DST in private labs, sputum collection and pick-up, slum scheme and TB HIV scheme were introduced. The schemes were rolled out in October 2008.

Currently, **2500 NGOs and 19,000 PPs** are working in RNTCP, out of which **54% NGOs and 67% PPs** are working without formal agreement with the programme. depends on a functioning health system with sufficient infrastructure, outreach and access, and adequate, well trained and motivated staff at all levels. Deficiencies in the general health-care system constitute a major barrier to further improvements in performance, especially in states with weak health systems.

Involvement of corporate sector

There have also been efforts to involve corporate sector, though they do not appear to as systematic and as well documented as those for private practitioners and hospitals.

There are reported to be **150 industries** involved in RNTCP at the moment. Amongst the the prominent ones involved in the programme are - Hindalco in Sonebhadra, UP; Lafarge Cement at Raipur, Chattisgarh; Tata Steel in Jamshedpur¹⁰, Reliance in Gujarat, the Aditya Birla group, Jubliant Organosys, L&T and Modicare. The latter six are also part of India Business Alliance that has been collaborating with the RNTCP. Involvement includes community activities and workplace DOTS programme. Another successful collaborations with the private/corporate sector has been with the tea estates in West Bengal, Assam and in Tamil Nadu. Beneficiaries include workers and those who are living around.

Lilly MDR-TB Partnership is being implemented in India since 2004. The target population are the TB and MDR TB patients who are supported by the community based organizations and NGOs in some of the under-served areas and slums. The project tackles the issue of stigma amongst women, decentralized home based care to MDR TB patients and educating young people on the signs and symptoms of TB. The project also works on Transfer of Technology. The activities to support media advocacy and capacity building of various stakeholders were also launched for which Lilly came out with an informative illustrative booklet which was put up on the National TB Program website as part of the resource material and adapted in various regional languages. Lilly partners with Indian Medical Association to train private practitioners and organizes guest lectures on TB and MDR TB (source: note provided by Eli Lilly).

CII sponsored corporate ART initiative where corporates are coming forward to help increase access to ART is another example of successful public private partnership. CII and India Business Alliance have been working closely with RNTCP as well.

The Hindu Group of Publications features TB-related stories, covers related events, and donates advertising space. The Hindu Group also provides TB workplace care and control services to employees, their dependents, and the community.

For diagnosis of DR-TB, private sector labs like Blue Peters Research Centre, CMC Vellore and P. D. Hinduja labs have been accredited for culture and DST while three others in private sector are in process of being accredited (status as on www.tbcindia.org on 16th January 2010)

Is RNTCP-PPM feasible in India context?

The feasibility of PPM in TB control and its potential to contribute to TB control programme in terms of improvement in performance has been well established in several projects. Some of the published studies are quoted below

Mahavir Project, Hyderabad¹: This is one of the well known early models where a private sector hospital was fully integrated into RNTCP. The setting was that of a non-profit hospital providing DOTS services to a population of 100 000 for 3 years, then expanded coverage to 500 000 in October 1998. A hospital physician visited all private practitioners, encouraged them to refer patients, and gave feedback on each patient referred. After diagnosis, patients received directly observed treatment free of charge at the trust hospital or at 30 conveniently located small hospitals operated by local private practitioners. No financial incentives were used to encourage physicians to refer patients or to provide treatment observation. Diagnosis, treatment, and case and outcome definitions were performed as per DOTS policies; medicines and laboratory reagents were provided by the government. and is well documented. The detection rate increased from 50 to 200/100 000 over the first 2-3 years of the project; 90% of new smear-positive patients and 77% of re-treatment patients were successfully treated. *One of the important conclusions was that an institution such as a non-profit hospital can serve as an effective intermediary between the government DOTS programme and private practitioners.*

A feasibility study was conducted in **Delhi by LRS institute** in PPM settings¹². In the project an incremental case notification of 47% due to PPs was observed for new cases and 29% for new sputum-positive cases. The treatment success rate for all new sputum-positive cases treated by PPs was 81%, which was not significantly different from the 86% in the public sector. Directly observed treatment (DOT) was confirmed by 95% of patients.

Another study was carried out in **rural tuberculosis (TB) unit in South India¹³**, with an objective to evaluate a rural public-private partnership model (PPPM) within the RNTCP. All of the private practitioners trained in modern medicine and the private laboratories (PL) in the area were listed. The PPs underwent training about the RNTCP, and PL staff were trained in sputum microscopy. PPPM included referral of TB suspects to the smear microscopy centres (government or PLs) for diagnosis and treatment of patients as per RNTCP guidelines. Patients were back-referred to the PPs. The DOT providers and centres were chosen by the PPs in consultation with their patients. The case detection rate, cure rate and profile of patients referred by the PPs were compared with those of self-reported patients. The annual average case detection rate increased from 66 to 75 per 100 000 population.

A **literature review** published in BMJ¹⁴ which analyzed the characteristics of public-private mix projects in India and their effect on case notification and treatment outcomes for tuberculosis. It reviewed 14 PPM projects where data was available. In all reviewed projects, the public sector tuberculosis programme provided training and supervision of private providers. Among the five projects with available data on historical controls, case notification rates were higher after implementation of a public-private mix project. Among seven projects involving private practitioners, 23% new patients positive for acid fast bacilli were attributed to private providers. In 9 of 12 projects with data on treatment outcomes, private providers exceeded the programme target of 85% treatment success for new patients positive for acid fast bacilli.

The review concludes that collaborations between public and private providers of health care hold considerable potential to improve tuberculosis control in India.

Is RNTCP-PPM cost-efficient?

Cost efficiency of PP involvement in **Kannur** (in India's southern state of Kerala) project was carried out. The project targeted private laboratories and was credited with a 21% increase in detection of NSP TB cases¹⁵. The annual total estimated cost of the project was US\$8712-\$11 611. The cost per private provider recruited varied between US\$22 and US\$54. The cost per additional pulmonary TB patient privately diagnosed was US\$14-\$18. In the most conservative scenario, the cost per additional patient notified was US\$29-\$36. The cost per new acid-fast bacilli-positive patient successfully treated was US\$47-\$51. The cost per laboratory retained after 18 months was between US\$250 and US\$291. The conclusion drawn was that higher notification rates would improve cost-effectiveness. *This evaluation highlights that although PPM may be an effective intervention to improve case notification and possibly improve quality of care, it is not free. The public health care system still incurs significant costs when implementing such collaborations, largely attributable to training, outreach efforts and grant-in-aid.*

A study on the costs and effectiveness of pilot PPM-DOTS projects in **Delhi and Hyderabad** using documentary data and interviews was published in Bulletin of WHO¹⁶. The cost of PPM-DOTS was compared with public sector DOTS and non-DOTS treatment in the private sector. In this study the average cost per patient treated was US\$ 111-123 for PPM-DOTS and public sector DOTS, and US\$ 111-172 for non-DOTS treatment in the private sector. From the public sector's perspective, the cost per patient treated was lower in PPM-DOTS projects than in public sector DOTS programmes (US\$ 24-33 versus US\$ 63). DOTS implementation in either the public or private sectors improved treatment outcomes and substantially lowered costs incurred by patients and their attendants, compared to non-DOTS treatment in the private sector (US\$ 50-60 for DOTS compared to over US\$ 100 for non-DOTS).

The study concludes that PPM-DOTS can be an affordable and cost-effective approach to improving TB control in India, and can substantially lower the economic burden of TB for patients.

Another study on costs faced by patients before and during treatment¹⁷ in **Bangalore** suggests that TB patients spent a total of **US\$145**, on average, before starting treatment with the RNTCP. About half of this amount was due to direct costs. Indirect costs to patients, which represented 38% of the total costs, corresponded to an average of 30 days lost from work while seeking care for TB. The remainder of these costs was for payment of interest on loans, direct costs for attendants and wages lost from work for attendants. Patients who faced a total delay of >10 weeks faced on average double these costs (US\$216) compared to those patients with a lower total delay (US\$106)

The overall conclusion drawn from such studies is that PPM requires additional investment costs but if implemented on a large scale, the costs to the programme for PPM are comparable to public sector costs and much less than a situation where there is no DOTS in private sector. The overall societal costs for treatment in PPM settings would be much lower because of savings to patients in terms of reduced shopping before and opportunity costs during treatment.

Discussions

It is evident that PPM in RNTCP is feasible and will lead to cost-efficiency making a strong case for enhancing private sector contribution to TB care in India. However there are areas that need to be focussed while scaling up PPM in RNTCP

- Private sector could have an important **role** in:
 - ◆ Expansion of outreach specifically in difficult/ tribal areas and in remote rural areas needs private sector support.
 - ◆ Scaling up diagnostic and treatment services for DR-TB
 - ◆ Post treatment rehabilitation of patients
 - ◆ Involvement of pharmacies
 - ◆ Interactions and specifically with industry associations and consumer protection forum
 - ◆ Areas of interest for private sector also include - ACSM, Information and Communication Technology, Management Information Systems, Supply Chain strengthening and, innovative product development, distribution and marketing
- While most PPM projects have been successful in demonstrating PPM contribution to TB care and control, these have largely been in isolation and have not been scaled up
- **Recognition** of private sector contribution is important. This also means that indicators to measure contribution are developed and tools to collect such indicators. It is difficult for RNTCP to measure contribution of each and every sector on routine basis. Success stories can be showcased through newsletters.
- Associations for **alternate systems of medicines** have not been approached
- Increase **demand in community** for free drugs and DOTS as a service package can motivate private practitioners to provide DOTS services.
- The new Schemes for involvement of private sector are user friendly. However they need to be **explained better** to physicians and NGOs as private sector feels that the schemes are 'complicated'. There is also a demand for flexibility
- Private sector participation should not be seen as extension of public services. There should be **flexibility to accept rational and proven practices** even when they are beyond the existing national guidelines
- **Coordination of efforts** will help save resources. There is an opportunity for linking between GF R9 project and existing GF supported IMA project. Other opportunities where gaps can be filled through support of funding agencies
- To have a specific focus, there is need to **distinguish between industries** that are specifically affected by TB like mines, weaving, carpet, tea gardens, and industries that may not consider TB a bigger problem for the specific industry but would be willing to serve the community as part of their Corporate Social Responsibility.
- Global best practices and success examples can be considered for replication.

Some of the specific constraints and challenges for scaling up PPM

- RNTCP has apprehension on **quality of services** provided by private sector. The quality parameters for RNTCP are provision of diagnostic and treatment services under DOTS as per the guidelines. Current mechanism to ensure quality relies on supervision, which is taken in a very narrow sense. Generally the STS supervising the doctor is not acceptable to the PPs. Supervision and monitoring should be through a mutually acceptable mechanism. On the other hand private sector ensures quality of services in timings, accessibility and patient-friendliness of staff.
- Private sector apprehension on **financial viability, individualistic attention to patients, followup and transparency**. There have been instances of delay in payment of remunerations/ incentives to physicians participating in PPM. Mechanisms to ensure timely payments should be in place. Compensation under some of the schemes is considered very low. RNTCP is willing to compensate the additional costs to private sector which are rational and justified. However there does not appear to be a mechanism to find out how much exactly these costs are. Further, compensation from RNTCP also needs to be matched with private contribution to the disease control.
- There is particular hesitation amongst doctors in **signing a MoU**. This is also evident from RNTCP's own figures where substantial participation of private sector is without signing of a MoU. Private sector feels that there is reluctance at DTO level in signing of MoUs and DTOs face a cumbersome process for release of funds. DTOs need support from private sector and other stakeholders outside the programme to clear administrative hurdles.
- Though RNTCP has identified 'Sputum collection and transportation' as one of the weak areas where private sector can support the Programme in extending its outreach, there are very few private providers interested in taking up this scheme.
- Private sector feels that there is **limited engagement of private sector in planning** and involvement is sought mainly at the implementation stage. This feeling comes despite the fact that RNTCP reports that consultation on new schemes for private sector involved more than 60 participants including representation from professional associations.
- Private sector feels that there is **unclear vision and lack of information** on potential engagement specifically with corporate sector. Though having consensus on involvement, there is lack of a value proposition and action agenda. Programme needs to do a gap analysis for corporate sector;
- **Little documented evidence** of those involved. It is also felt that lack of documentation is also due to lack of interest amongst private sector in recording and reporting DOTS activities. This seems an extra workload and they do not see any value addition to their work.

Such challenges were also highlighted by Dr Uplekar while discussing barriers to collaboration in his paper published in 2003¹⁸. Some of them are enlisted here

- There persists formidable **ideological opposition** to leaving TB care to the private sector
- Public sector perhaps do not consider PPs a problem serious enough to divert Their attention from their current activities
- Programme managers are too **preoccupied** with implementation of the demanding public sector DOTS programmes

- It is difficult to **organize private sector** as they are too large a group, unorganized and spread out
- There are **few success stories** to show that collaboration is possible and can succeed

Joint Monitoring Mission (JMM) 2009 view points on PPM in India¹⁹

Revised schemes for involvement of private sector is one of the acknowledged achievement of the Programme for enhancing private sector participation. The mission had following general observations on PPM:

- Engagement of private care providers **does not seem to be a high priority**. There is a lack of trust and enthusiasm between public and private sector to engage with each other for a common purpose and efforts made to engage NGOs and PPs appear to be patchy. This specific issue is also highlighted in a study undertaken in Ujjain district, Madhya Pradesh, India²⁰. The authors conducted a cross-sectional sample survey of private providers to study willingness and motivation to collaborate. Most providers were aware of the RNTCP and found willing to collaborate. However none of the providers had ever been contacted by the RNTCP. The authors conclude that enthusiasm in the private sector has not been effectively exploited by the RNTCP.
- The available staff at all levels have **little capacity** to undertake PPM activities seriously. A training module to first prepare RNTCP staff to implement PPM is yet to be developed
- **Very low state and district expenditures** on PPM - during 2008, the total budget expended under the NGO/PP schemes amounted to Rs 28 239 385 (or US\$ 588 000) representing just 1.5% of the total state-level TB expenditure.
- The name of the referring non-programme provider is rarely recorded and no feedback is sent.
- Cases of delays as well as non-payment of reimbursements for the implementation of schemes.
- Anti-TB drugs were widely available in private pharmacies without a prescription.

The mission teams highlighted the absence of an alignment of the advocacy, communication and social mobilization (ACSM) and PPM approaches.

Publication by FICCI²¹ proposes that model for public-private mix needs to be based on themes of **partnership, equity, governance, risk sharing and transparency**. The document also highlights that the government's inclination to rely entirely on the private sector is constrained by its **unwillingness to dilute its responsibility/ accountability for the quality of service provided, the costs involved and prior experience** with the private sector, which has not been very encouraging. In addition, the high risks relating to financial sustainability have discouraged private providers from venturing into rural and non-tier 1 towns, where the need for infrastructure creation is paramount.

How PPM projects in RNTCP could be made successful

The key reasons behind success of several partnerships is the clear understanding and delineation of the roles, responsibilities and accountabilities of both public and private sector on basis of skills and expertise of each stakeholder. There is also complete transparency and trust in the operational and strategic issues which ensure leverage of skill sets.

REACH, which acts as an intermediary NGO between RNTCP and Private sector in Tamil Nadu state of India, report that initial handholding and continuous advocacy with private sector is important for success of PPM. The study reports that in the project undertaken by REACH six hundred PPs underwent sensitisation about the RNTCP, after which the proportion of PPs adopting DOTS increased significantly ($P < 0.001$), and the majority (72.8%) used sputum testing for diagnosing TB as compared to baseline (33.3%). The proportion of PPs who used X-ray alone for diagnosis declined to 16.0% from a baseline of 45.4%. There was an increase in the percentage of PPs (55.2%) using sputum testing to declare a cure in their TB patients compared to baseline (22.6%)²².

The PPM model described in this article focuses on developing long-term, sustainable partnerships with PPs, **making them key stakeholders** in TB control. To encourage a sense of ownership of the programme, PPs were supported in managing their patients themselves in their clinics, without worrying about losing them. This partnership allowed PPs flexibility in referring patients, using private microscopy centres and planning treatment according to RNTCP guidelines. Protecting doctor-patient relationships and adding value to their practice by obtaining free drugs for patients from the system were key factors in inciting PPs to join the programme. The study also concludes that **support of social workers required as one-to-one meetings** have a positive influence; the workers also undertake initial home visits and default retrieval.

A comparison of processes and outcomes of four public-private mix (PPM) projects on DOTS implementation for tuberculosis control in New Delhi, India; Ho Chi Minh City, Viet Nam; Nairobi, Kenya; and Pune, India was undertaken by Knut Lönnroth et al²³. The design was a cross-project analysis of secondary data from separate project evaluations. The analysis suggests that an effective intervention package should include the following provider-side components: (1) orienting private providers (PPs) and the staff of the national TB programme (NTP); (2) improving the referral and information system through simple practical tools; (3) the NTP adequately supervising and monitoring PPs; and (4) the NTP providing free anti-TB drugs to patients treated in the private sector. The study concludes that getting such an intervention package to work requires that the NTP be strongly committed to supporting, supervising and evaluating PPM projects. Further, using a **local nongovernmental organization or a medical association as an intermediary may facilitate collaboration**. Investing time and effort to ensure that sufficient dialogue takes place among all stakeholders is important to help build trust and achieve a high level of agreement. In the New Delhi project, stakeholders conducted active dialogue during the 18 months before the project was launched and throughout the project.

A publication by FICCI and Ernst & Young on public-private partnership in health care²¹ states that existing PPM initiatives are largely **local and prompted by instances of visionary leadership and social entrepreneurship**. The scalability and replication of current models remains a challenge.

Experience of individual organizations also finds that corporate sector involvement is challenging. A sustained initiative to sensitise company doctors and link up local NGO support would be needed to upscale corporate participation which is relatively untapped in India.

Future direction

- **Mapping of private sector** - the mapping exercise should not only include physical presence but also strengths of the private sector and specifically corporate sector in terms of expertise and core competence. Chambers of commerce, Corporate houses and the Partnership for TB care and Control can support the STOs and DTOs in the mapping exercise.
- Each state and district draws up their **annual plan** for TB control in which programme gaps are identified and means to address them are planned. Within these gaps the STO and DTO could identify, in discussions with various stakeholders, what support private sector could offer to bridge the gaps.
- **KAP studies** to further identify the behavioural barriers within both public and private sector towards PPM could be carried out. The studies can be part of the OR studies. This would need to be followed by context specific advocacy for both public and private sector. The aim should be to build trust and developing mechanisms to acknowledge contribution.
- **Sustained advocacy** for PPM may be made part of the regular ACSM activities. The ACSM nodal person at the State TB Centre could be trained in organising sustained advocacy for PPM directly and through NGOs, professional bodies and other such interface. As part of advocacy activities, desk-reference type information sheets on NGO/PP guidelines could be developed and circulated amongst various stakeholders. The programme also needs to continue work with media and private media agencies specifically training of journalists to understand TB as a problem. The Programme could consider instituting prize for best TB coverage
- One of the important factors for success of several PPM projects has been **local initiatives**. The State should encourage and support these local initiatives by training of DTOs in PPM with specific focus on how to administer and manage RNTCP schemes and how to bring innovations in various PPM structures locally. This, however, would also start with **development of a PPM module for the public sector**, as also recommended by JMM 2009
- Mechanisms should be developed to further strengthen private sector participation in planning stage itself. This also calls for **strengthening communication** channels where individual entities have an opportunity to express their opinion. Such channels could be a web-based forum, meeting of partners in a cascading manner or other forums.
- Indicators that **quantify contributions** from private need to be developed - contributions not only in terms of increased CDR and treatment success rates but also improvement in quality of services, awareness generated, acceptability of DOTS by peers, discussion of DOTS related issues in various forums and reducing provider related delays at various levels could be some indicators. This may not be part of routine reporting but random basis or part of internal evaluation carried out by RNTCP.
- Consider creation of an **India Fund for priority diseases like TB**. Various mechanisms to contribute to this fund can be developed like direct contributions from corporate sector; levying nominal charges on high-end/ luxury services e.g as being done by UNITAID through a nominal air-travel fee.

- There is need to have clear **operational guidelines or a separate scheme for involvement of corporate sector**. The current guidelines appear a bit restrictive for corporate sector and hence a new scheme for corporate sector involvement within existing guidelines could be developed in consultation could provide a roadmap.
- Where corporate sector is willing, but do not have implementation structure, they can support the programme **through local, experienced NGOs**. The state can act as interface here where they have a list of NGOs having experience and doing considerable work in the field. Corporate sector entities in the state can look to support such NGOs in their ongoing work or newer work as deemed necessary by the STO and DTO.
- The programme should empower **intermediary organizations** such as NGOs and IMA to scale up PPM activities. PPM can be **contracted out** to some such strengthened organizations. Here the importance of linking GF RCC and Rd 9 proposals also comes up. The community support groups being planned to be established as part of Rd 9 proposal should establish communication channels with IMA and other professional bodies outside the ambit of IMA to promote involvement of all providers in facilitating DOTS. The intermediaries could strengthen the feedback system where the outcome of referrals is reported back to PPs. The intermediaries could also support the PPs in record keeping.
- Innovations could be tried in form of a **TU in selected districts in each State exclusively for PPM**. The TU would have supervisory mechanism specifically for PPs in the district and the staff sensitised to specific PPM needs and would report to DTOs. However this TU would have additionally a supportive role to promote PPM and also carry out advocacy activities in coordination with state advocacy officer. The funds can be spent through the head - NGO-PP involvement, through social insurance mechanisms or the state/ district could also consider getting it funded through interested corporate houses in the state. Similar suggestion also appears in the book 'Covering a billion with DOTS'¹⁰
- Support areas like **technology transfer**, helping quick accreditation of laboratories for Culture and Drug Sensitivity Testing and pre-qualification of 2nd line anti-TB drugs are some areas that RNTCP is already working on. However it is highlighted here to emphasise greater focus and wider involvement of private sector in this area. Support from external agencies might be required specifically for **supporting pharma industry in pre-qualification** and funding technology transfer. Other areas to increase scope of contribution of private sector in MDR-TB should be explored.
- Business organisations and UN bodies like ILO, WEF have vast amounts of **materials, training tools and information material for private sector**. The Programme could collaborate and use these opportunities to improve services, promote rational care and tap funds from private sector.
- Possibility of formation of a PPM/ Private sector involvement **subcommittee under CCM** can be considered. The subcommittee can provide oversight on greater private sector participation and facilitate integration of private sector in future proposals.
- **Sensitise MPs from private sector** on priority diseases and possible ways in which private sector can contribute.
- Engage with **private pharmacies**, drug regulatory authority and other stakeholders on a wider scale to stop irrational prescriptions and OTC sale of anti-TB drugs. This was also part of recommendations made by JMM 2009. Anti-TB drugs should be widely

available but can be restricted to institutions linked to the programme and sell only rational formulations. Private pharmacies could also display list of PPM centres and where drugs as per standard regimen are available. It was informed that such meetings have recently been organised in Delhi and Kerala. Other states should also be encouraged for the same.

- Consider making **TB a notifiable disease**. This will help curb irrational prescriptions.
- Replicating innovations from other sectors²⁴ -
 - ◆ Chiranjeevi Yojana (2005-2006), Gujarat: An innovative *health financing* scheme covered through PPP for emergency obstetric care and emergency transport services, for women in BPL category.
 - ◆ Janani Suvidha Yojana, Haryana: Increase access to safe delivery services and institutional delivery for urban BPL women through private health providers and referral arrangements with Government institutions, *using vouchers*
 - ◆ Voucher Schemes for Institutional Delivery, Uttar Pradesh (Agra, Kanpur, Bahraich) and Uttarakhand (Haridwar): Use of vouchers as a mechanism for demand-side financing where Reproductive and Child Health (RCH) services for BPL women and children are provided through private practitioners. *Such demand side financing of TB patients could be useful where public health services are meager/ not available and patients need to go to private sector for treatment.*
 - ◆ Immunisation drive Kerala: A campaign to strengthen immunisation coverage in the State through intensive IEC/BCC campaigns and intersectoral convergence of the Education and Health departments. A planning and review exercise will be undertaken through inter-sectoral co-ordination committees to be constituted at the district, education district, sub-district and school levels by involving officials from related departments such as Health, Education, Social Welfare and LSGIs and representatives of Parent Teachers Association, IMA, IAP, opinion leaders, religious leaders and NGOs. *TB programme could similarly involve other sectors for enhanced communication at local level.*
 - ◆ Community Health Insurance for BPL in Uttarakhand and health insurance in Mizoram: Though both states have tried different models, the schemes aim to enhance accessibility to care through private sector. *These schemes could include treatment cost of TB in private sector while ensuring that treatment is provided as per the national protocol.*
 - ◆ Debit Card for ASHAs, Kerala: In order to ward off delays in payment of incentive to ASHAs, the State has introduced the system of paying incentives using debit cards. *This could be explored to ensure timely payments for private sector participants in TB as well*

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Annex 1

Consultation meeting on enhancing private sector contribution to TB care in India (23rd December 2009)

Participants list (alphabetic order)

1. Ms Amrita Nayak, The Union
2. Ms Anjali Sakhiya, Mamta-HIMC
3. Mr Apam, Mamta-HIMC
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5. Dr K Hemachandran, USAID
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7. Ms Kawalpreet Kaur, The Union
8. Dr Khalid Umar Khayyam, LRS Institute
9. Mr M B Naidu, LRS Institute
10. Dr Nalini Krishnan, REACH
11. Dr Neeta Singhla, LRS Institute
12. Dr Oomen George, Abt Associates (Representing IMA)
13. Mr Peter Small, Gates Foundation
14. Dr Puneet Dewan, WHO-India
15. Mr R K Sahu, Abt Associates
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17. Mr Ramesh Babu, Mamta-HIMC
18. Dr Ramnik Ahuja, CII
19. Dr Rohit Sarin, LRS Institute
20. Dr Rupak Singhla, LRS Institute
21. Mr Subrat Mohanty, The Union
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Annex 2

Discussion over e-mail/telephone/personal meeting (Alphabetic order)

1. Dr K Hemachandran, USAID
2. Dr L S Chauhan, DDG (TB)
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11. Dr Shruti Sehgal, CTD
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