Public-Private Partnerships to End TB

STOP TB Session: Implementation in a Post-pandemic World

Petra Heitkamp, TB PPM Learning Network

Thursday 23 February

TB•PPM Learning Network

Quality TB care for all people by all providers

Learning objectives:

- Understand the implementation of Ending TB through multi-sectoral approaches as an important building block in the post-pandemic era

- Learn about concrete strategies and examples of public-private partnerships to End TB

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Outline

- What is the problem in the TB system?
  - Patient pathway
  - Where do people seek care?
  - Pandemic impact
- Why public-private partnerships to end TB
  - What is private sector, private providers and PPM
  - Contributions of PPM
- How do we engage private providers
  - What guidance exists: Plan, guidelines, PPMWG, TBPPMLN
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- PPM: Unexplored potential

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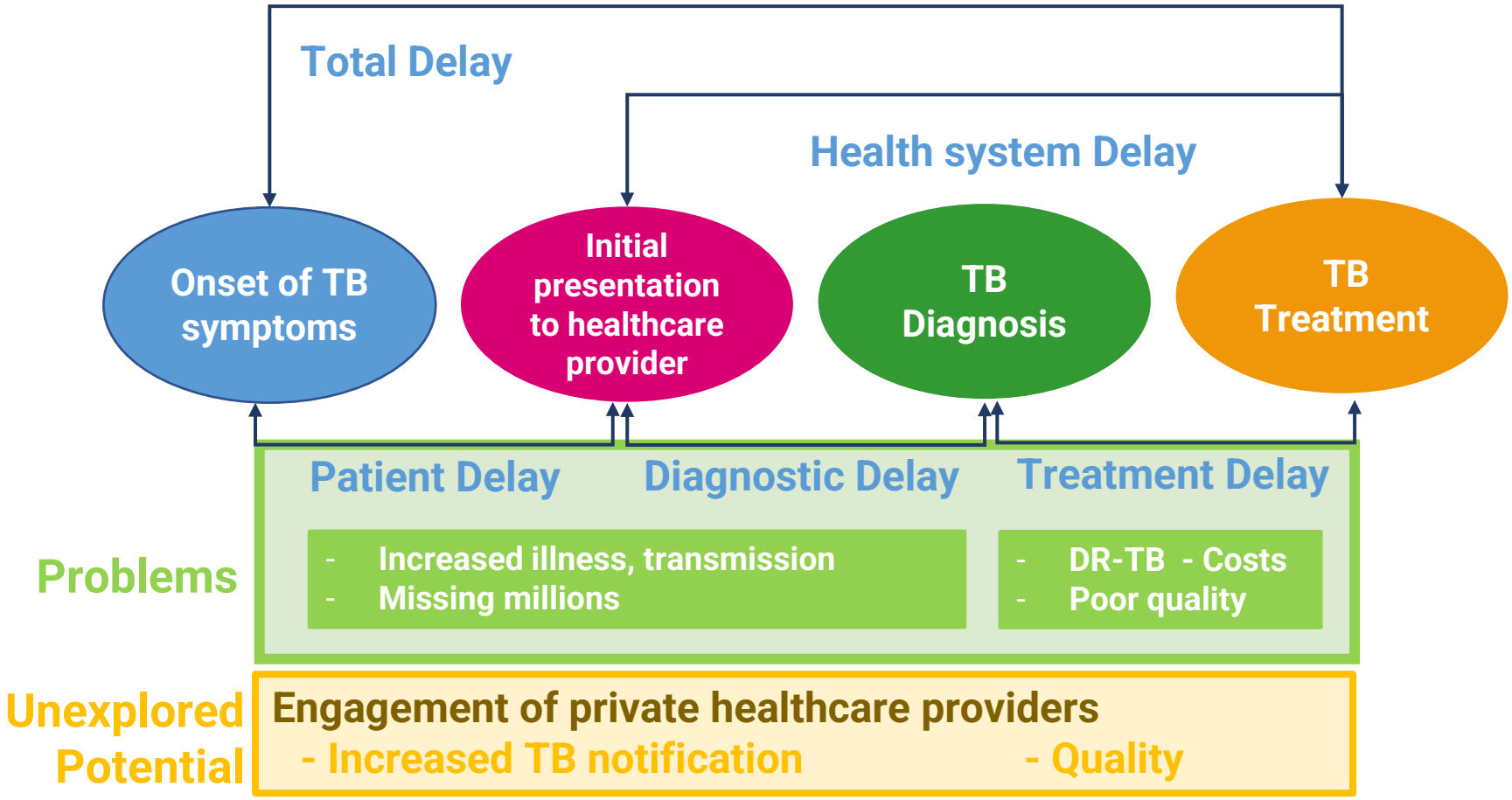
Pathway for people affected by TB

Patient pathways and delays to diagnosis and treatment of tuberculosis



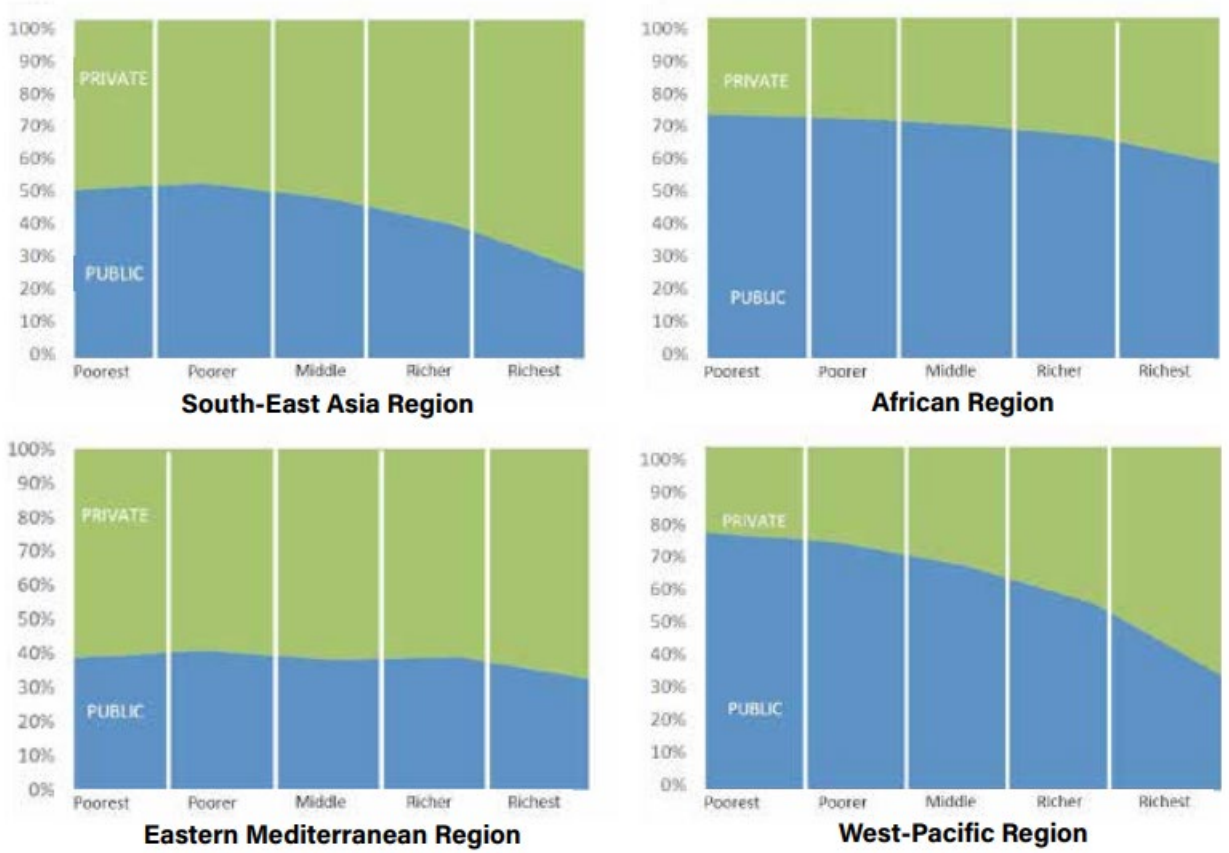
The Lancet Regional Health – Western Pacific 2020 5DOI: (10.1016/j.lanwpc.2020.100059)

People seek care in private healthcare sector

- Private providers often account for **50%-70%** of care

- In most LMIC: private providers key in healthcare
  - less-poor use formal and qualified providers
  - Poor go to informal and unqualified providers

FIGURE 1. OWNERSHIP RATIO BY WHO REGION. WEIGHTED BY COUNTRY POPULATION FROM YEAR OF MOST RECENT DHS OR MICS SURVEY[5]



2019 data presented in PPM Landscape Analysis:
https://apps.who.int/iris/rest/bitstreams/1405398/retrieve

Private healthcare dominates in most of the countries with the highest TB burden

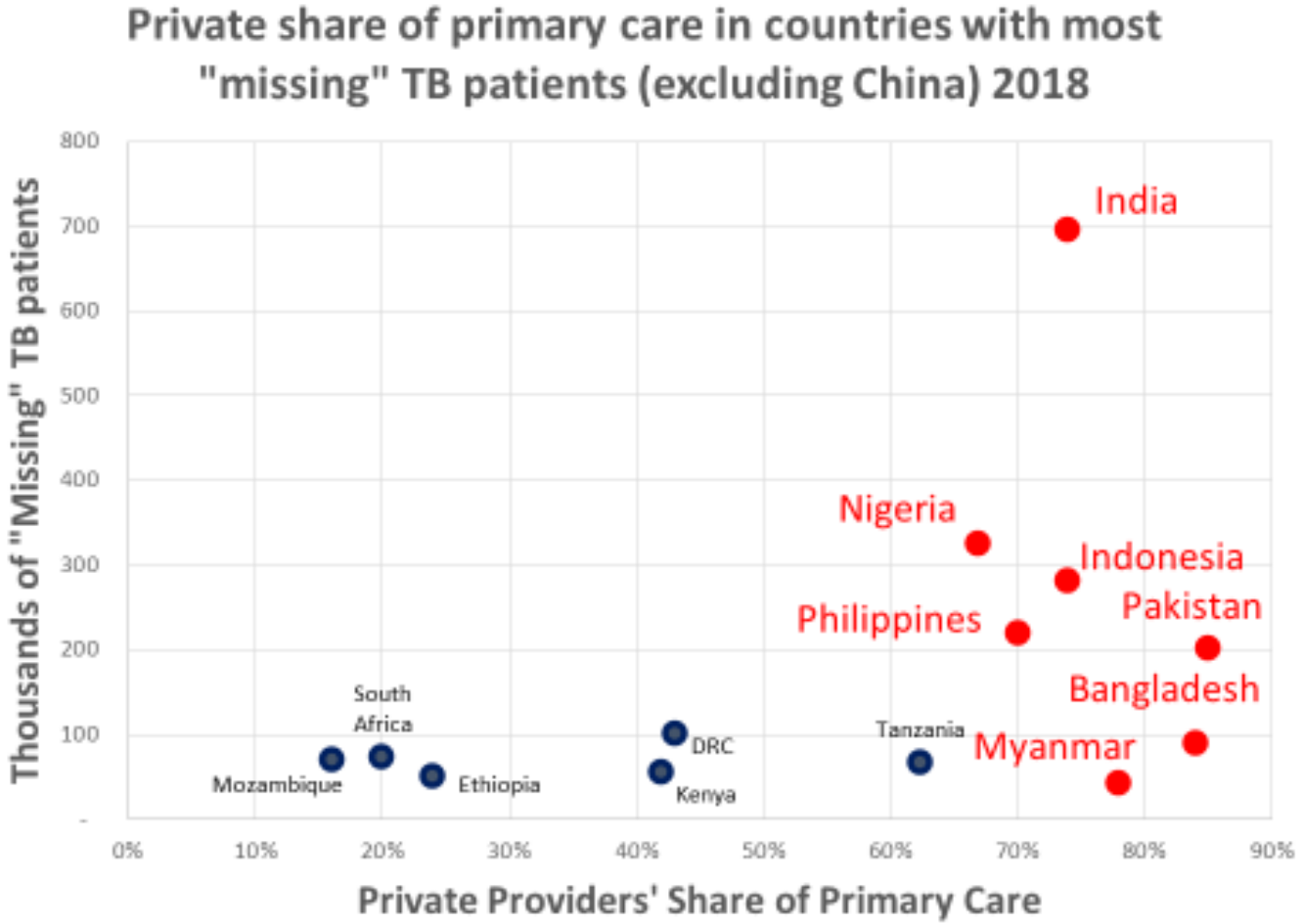
In 7 Countries

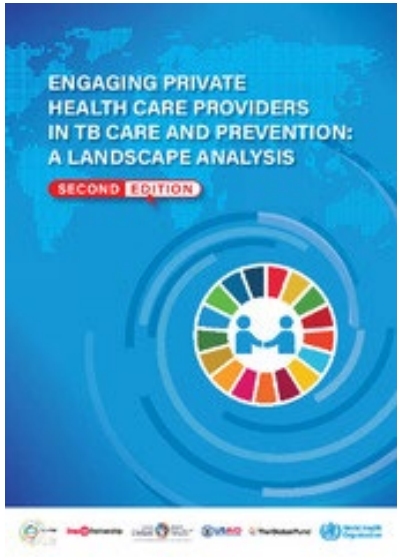
With ***56%*** of the total missing cases in 2019

Private providers account for ***65%-85%*** of initial care-seeking

Yet, they contributed just ***28%*** of total notifications

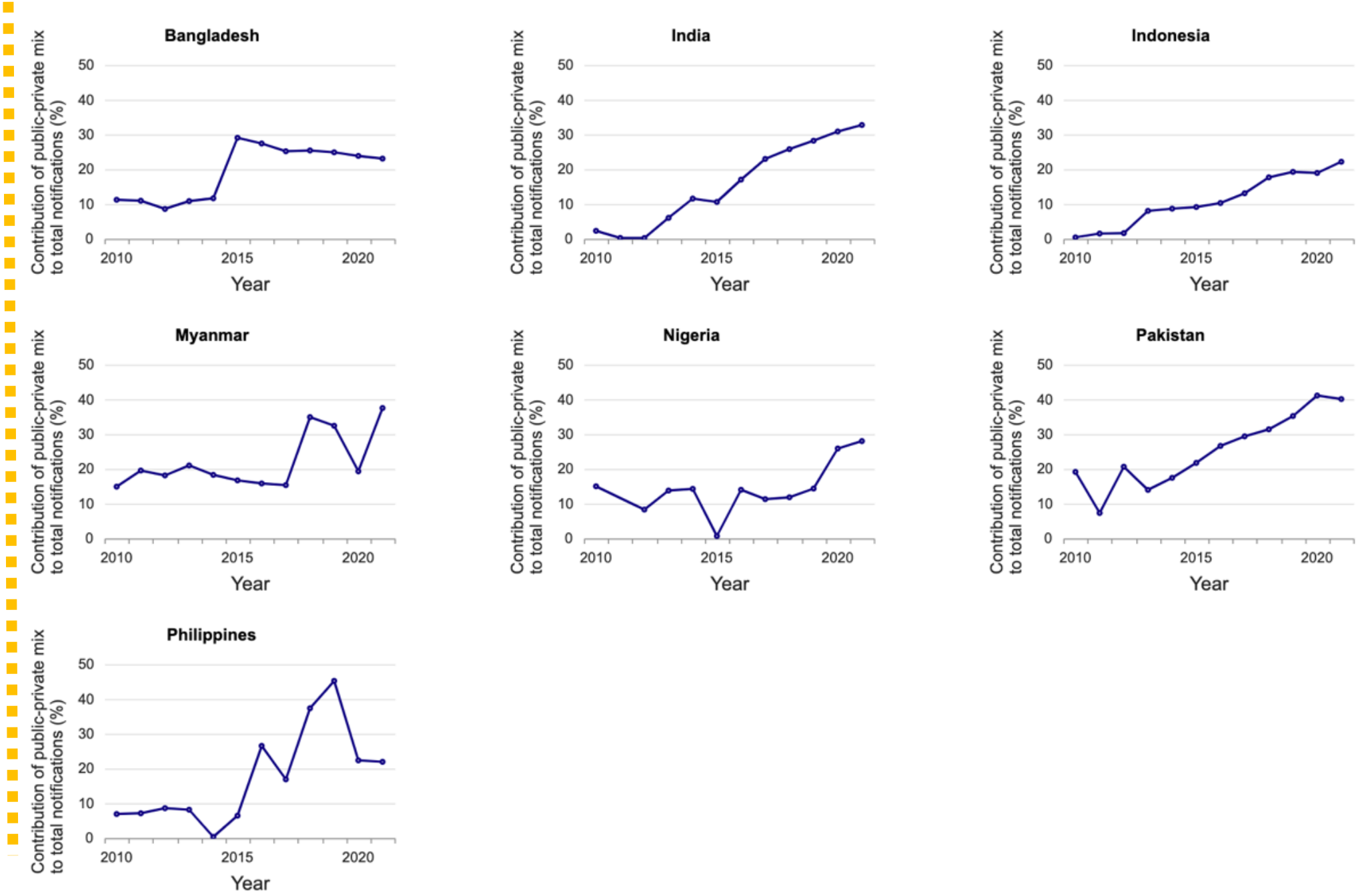
Equivalent to ***20%*** of estimated incidence





PPM contribution in 7 priority countries

Fig. 3.1.8 Contribution of public-private mix to notifications of people diagnosed with TB in priority countries, 2010–2021



COVID-19: impact on TB communities & health system

Action needed with all hands on deck

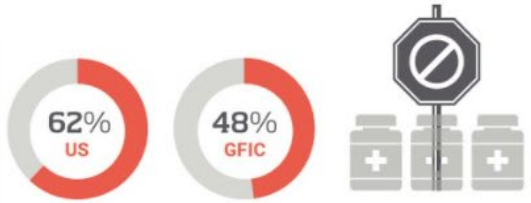
Key Findings

03 **Health systems around the world are weak and ill equipped to respond to simultaneous COVID-19 and TB epidemics.**

GLOBALLY

There is not enough personal protective equipment (PPE) for people working in TB, resulting in unsafe and challenging working conditions

Healthcare workers reported lacking PPE to safely care for people with TB and COVID-19.



Policy and program officers reported an increase in stockouts and delays of TB medicines

ACROSS BOTH PUBLIC AND PRIVATE SETTINGS

65%+ POLICY AND PROGRAM OFFICERS

reported healthcare facilities to be reducing TB services during the pandemic.

Strengthen healthcare:

Frontline health care workers and health volunteers have been the first line of defence against COVID-19 around the world. Yet, COVID-19 has weakened health systems everywhere, forcing healthcare workers to contend with unsafe working conditions. Healthcare systems need to address TB and COVID-19 in an integrated way. Fever and cough are symptoms of both TB and COVID-19, and simultaneous screening and diagnostic services are needed in both public and private health sectors.

Pandemic impact on primary care

- Pandemic was more than a health crisis - a social and economic one too
- Exposed inequity within and between countries
- Not enough investment has gone into primary care
- Resulting in chronic burnout and demotivation in the health workforce
- Massive impact on the public health and primary healthcare system

"There is a need for resilient health systems anchored in primary care to meet unanticipated surges in demand while maintaining ongoing demand for essential services. This requires cross-cutting, multisectoral-sectoral effort and investment in health."

https://speakingofmedicine.plos.org/2022/12/12/the-impact-of-the-covid19-pandemic-on-primary-care-and-primary-health-care

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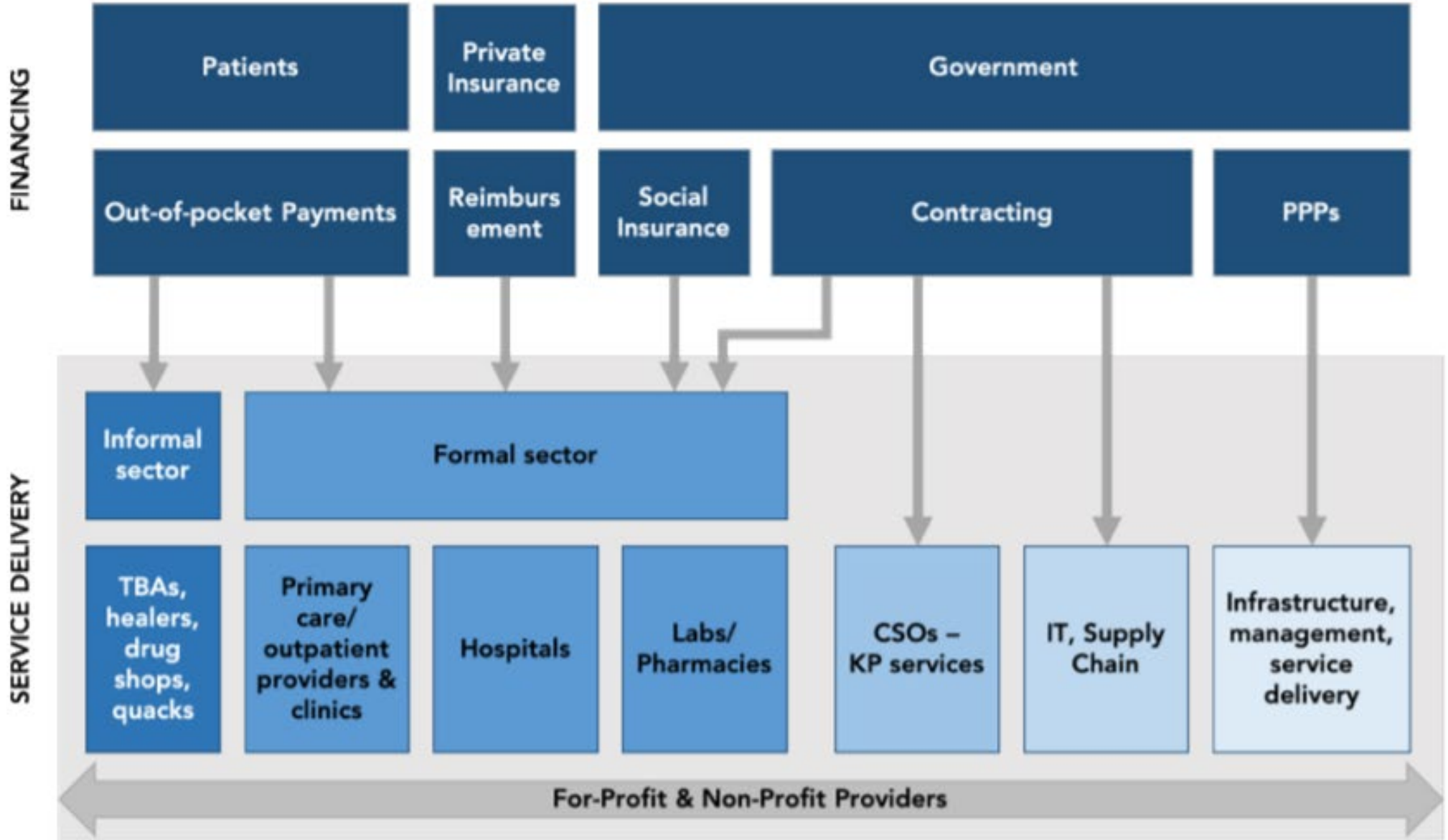
Private sector vs for-profit sector

- **“Private” means “Non-state”**
  1. Corporate sector and private sector industry
  2. Private healthcare delivery and private providers (non-profit and for profit)
- **Non-profit sector & For-profit sector**
  - For-profit health clinics, hospitals, providers (often engaged through strategic purchasing, insurance or NGOs/ intermediaries)
  - NGOs, Community and faith-based organizations (FBOs) provide healthcare (owners/ operators of dispensaries, clinics and hospitals)
    - user fees (comparable to for-profit providers)
    - integrated in public health systems (e.g. BRAC, Kenya faith-based)
- **TB services are public common good**
  - should be free to all people whether distributed in public or private market facilities

News advertisement, Canada, February 2023

Figure 1.4.1 Typology of the Private Sector in Health



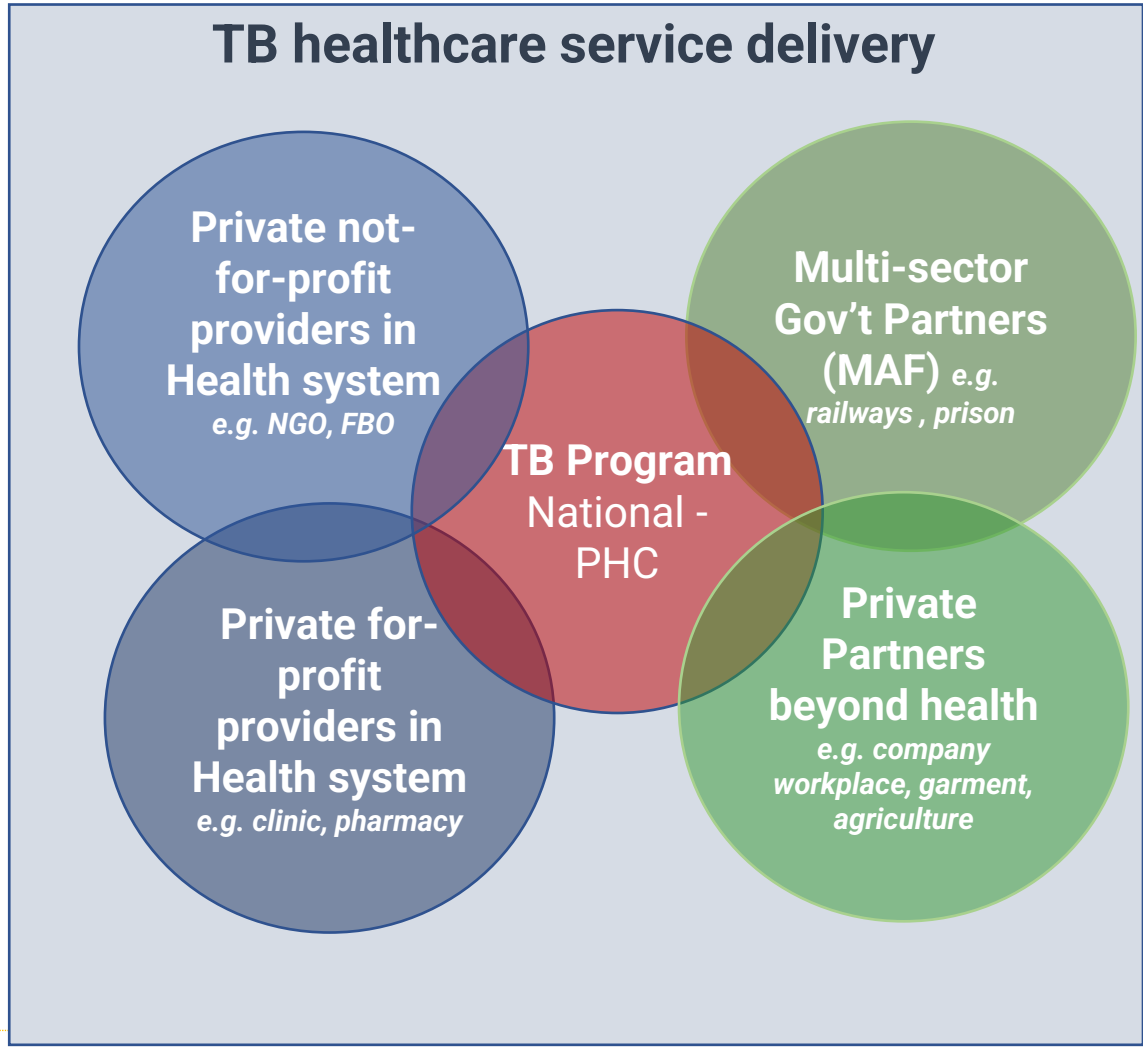
Source: Authors' elaboration

TERG report (p.39): https://www.theglobalfund.org/media/11072/terg_role-private-sector-program-delivery-thematic-review_report_en.pdf

Public-Private Mix (PPM)

- Engagement of (non)-profit healthcare facilities/ providers
- NTPs focus on public providers/ health system
- Multi-sector partners:
  - publicly-owned healthcare facilities
  - company workplace facilities

- *Private providers have greater share of the healthcare market*
  - Initial care-seeking (range 67–85%)
  - Expenditure private (51–78% of total health expenditure)
  - Anti-TB drugs delivered in private markets (15–54% of total)



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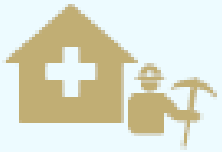
All healthcare providers need to be engaged
for quality TB care for all people

Healthcare Facilities

Private hospitals/ clinics

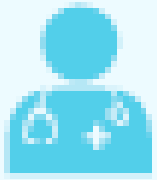
Faith-based health services



Work-site facilities

Prisons

Practitioners



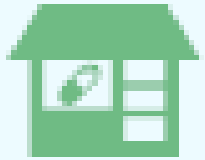
Physicians

Chest specialists

Informal/ traditional providers

Healthcare workers

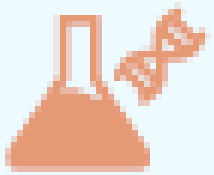
Pharmacies



Drug outlets

Medicine vendor

Laboratories



Testing centers

Value of private provider engagement

- **Find missing millions**: Close gap of private healthcare services and data-reporting
- **Quality of TB care**: prevents morbidity/mortality, drug resistance and improves uptake of Standards of Care
- **Efficiency:** overall closing delays in care cascade prevents transmission, management efficiency
- **Accelerate uptake of new TB tools**: increase coverage of WHO-endorsed diagnostics and treatments
- **Reduce Out-of-Pocket costs:** tailored financial protection and social support for patients
- **Comprehensive primary TB care**: primary healthcare closest where people seek care and integration within health system (programs on co-morbidities HIV, diabetes, nutrition, etc)

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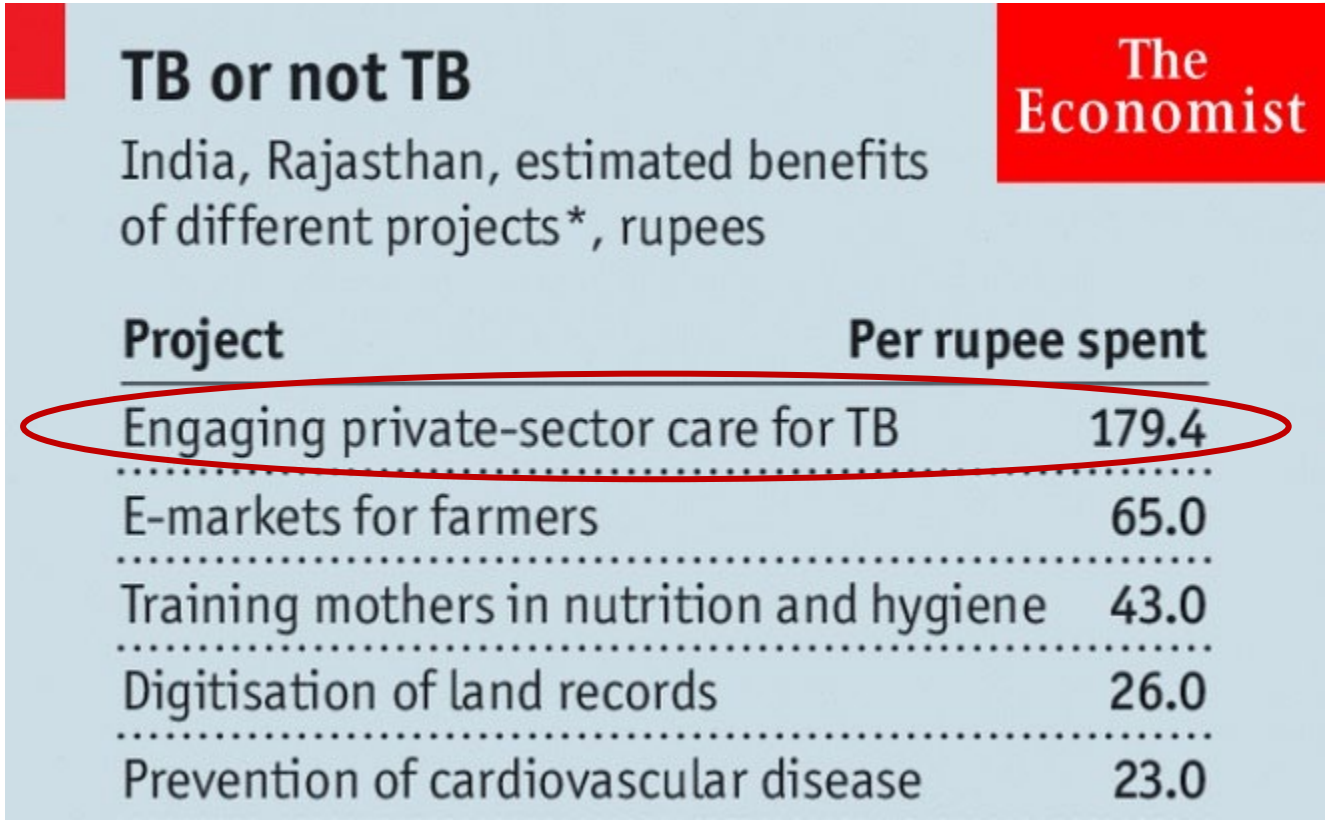
Investing in private care for TB makes economic sense

Copenhagen Consensus outlined the benefits of investing in TB care overall by 1$ invested in TB care has a $43 return in public global good.

Rajasthan priorities, supported by the Copenhagen Consensus Center, show the smart investment in engaging private care for TB as the highest ranked cost-beneficial intervention.



TB or not TB

The Economist

India, Rajasthan, estimated benefits of different projects*, rupees

Project	Per rupee spent
Engaging private-sector care for TB	179.4
E-markets for farmers	65.0
Training mothers in nutrition and hygiene	43.0
Digitisation of land records	26.0
Prevention of cardiovascular disease	23.0

Indian states are testing a new way of setting development priorities, The Economist, 2018

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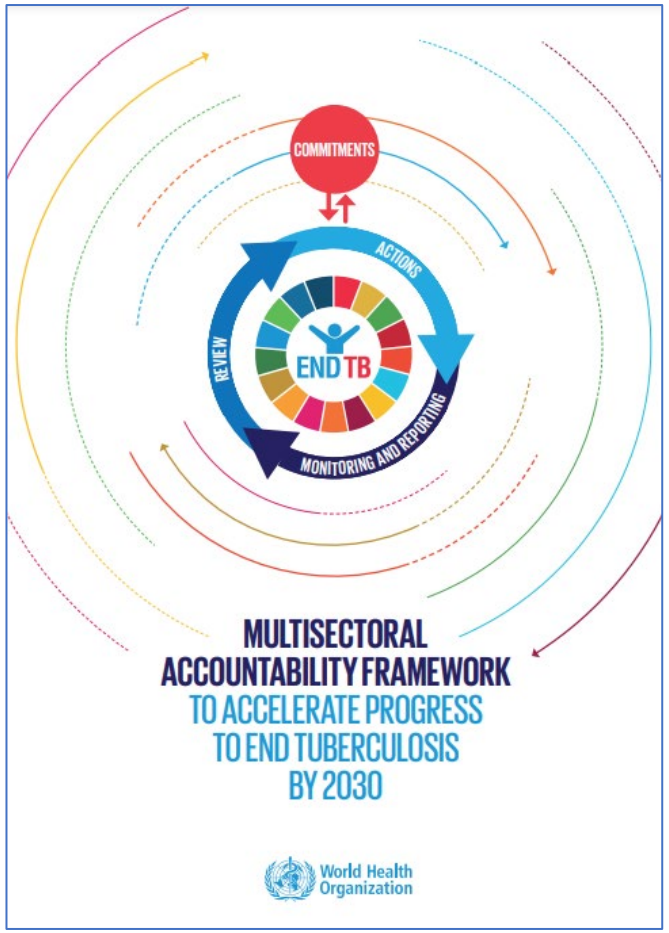
WHO – Global Plan to End TB – Global Fund



https://apps.who.int/iris/rest/bitstreams/1276221/retrieve

https://www.stoptb.org/advocate-to-endtb/global-plan-to-end-tb

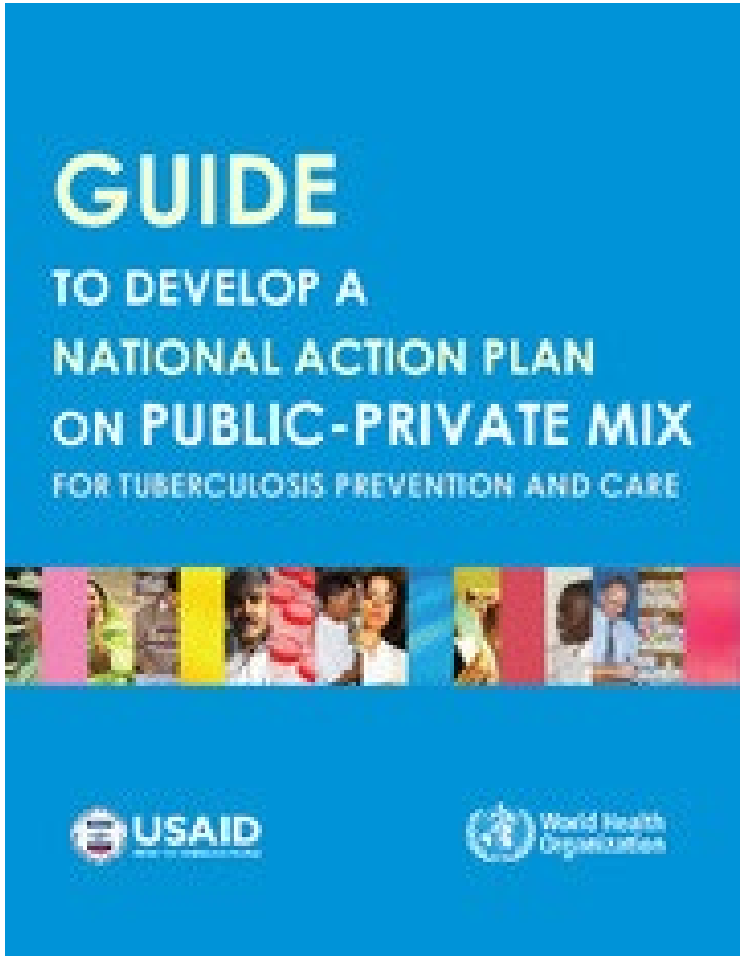
https://www.theglobalfund.org/media/12160/ps_private-sector-engagement-technical_brief_en.pdf

National Action Plan PPM

- Implemented in Bangladesh, Ethiopia, Ghana, Kenya, Malawi, Namibia, Nigeria, Philippines, Tanzania, Uganda, Zambia
- Not all countries will have existing intermediaries to easily plug into planning
- Need adaptation to local context, experimentation and learning

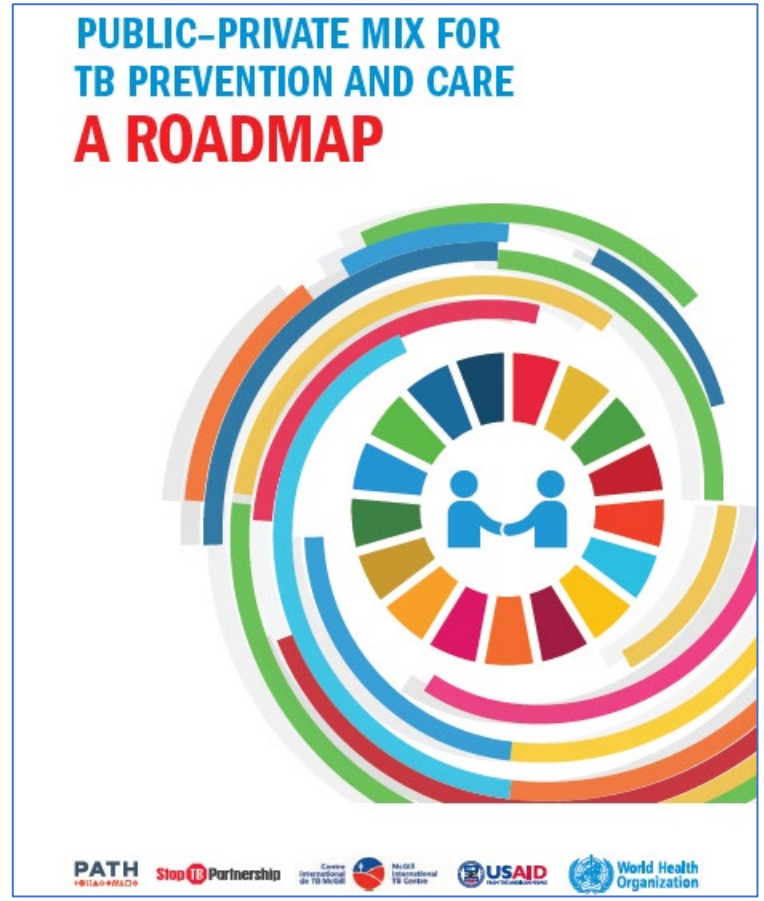
Table 1: Simple task mix for TB PPM

	Provider type #1	Provider type #2	Etc.
Refer (identify and refer symptomatics)			
Diagnose (identify symptomatics, request and interpret diagnostic tests and prescribe treatment)			
Treat (periodically check on patient progress and re-supply drugs)			
Follow-up (adherence monitoring, and recording and reporting)			



https://apps.who.int/iris/rest/bitstreams/1460961/retrieve

All providers need access to quality TB tools and be engaged to End TB



https://www.who.int/publications-detail-redirect/WHO-CDS-TB-2018.32

We have a plan how to engage private sector providers

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Quality of people-centered TB care

Standardized Patient research:

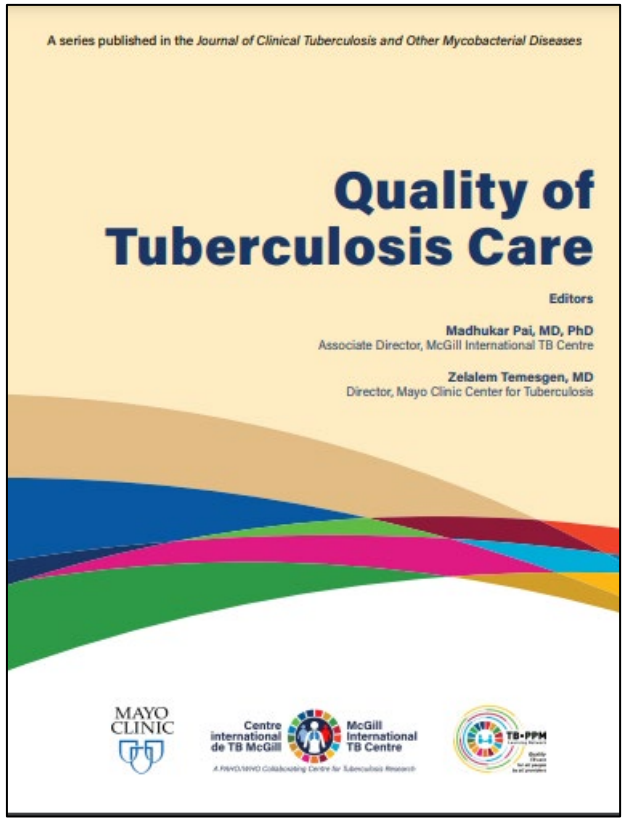
- Low rates of testing, referral, variety diagnostic tests, high costs

What can be done

- Guidelines and regulatory framework: Standards of TB care
- Policy and systems for quality assurance of healthcare practitioners and facilities (licensing, certification, registration, accreditation);
- Program: Quality control monitoring mechanisms
- Accountability: client surveys, data transparency, peer-to-peer

Location	% correctly managed	% referred	Reference
Mumbai, India	37%	15%	Kwan A et al
Patna, India	33%	10%	
Nairobi, Kenya	33%, private for-profit 40%, private FBO	4%, for profit 10%, FBO	Daniels B, et al.
3 provinces in China – village and township clinics	28%, village clinics 38%, township clinics	28%, village clinics 18%, township clinics	Sylvia S et al.
2 provinces in South Africa	63.41%	56.95%	Boffa J et all

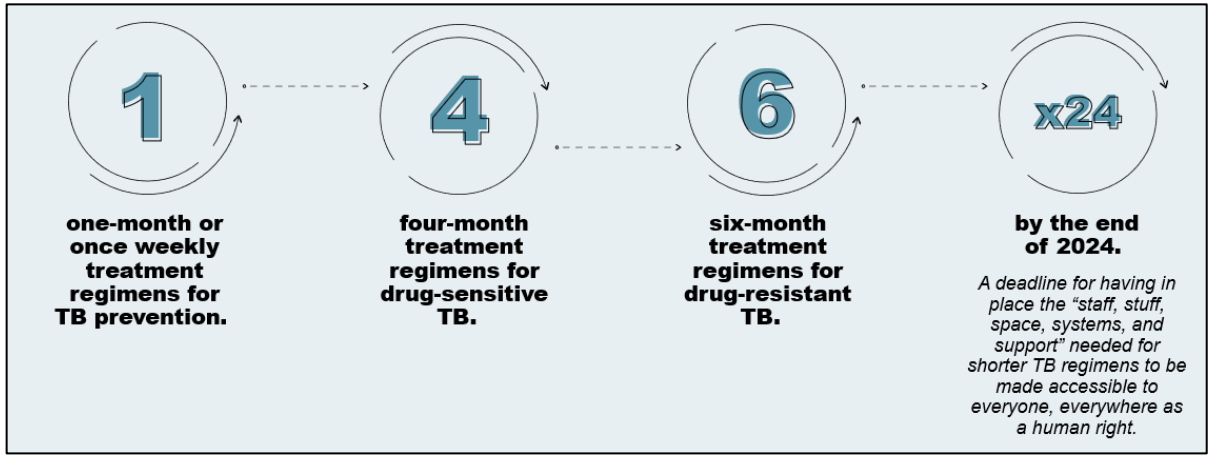
Proportion of patients with TB symptoms who are correctly managed or referred by private providers, according to Standardized Patient studies

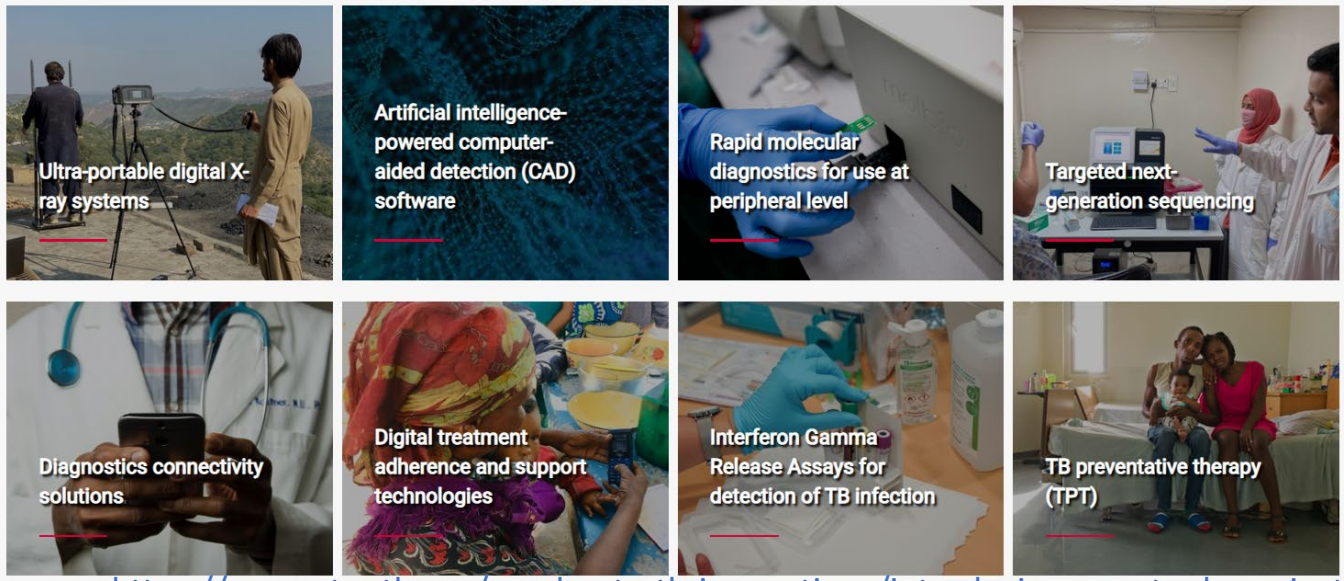


Download for free:
https://www.mcgill.ca/tb/files/tb/quality_tb_care_ebook.pdf

New tools need to be available to all

- Private healthcare providers often last to get access to new tools
- Barriers with regulations and guidelines
- New opportunities need to be made available to all providers to serve all people
  - Shorter TB regimens (1/4/6x24 campaign)
  - Diagnostic tools
  - Vaccines





https://www.treatmentactiongroup.org/1-4-6-x-24/ - *This work is led by the 1/4/6×24 Campaign Coalition, an international network of TB survivors, researchers, clinicians, activists, and civil society professionals who advocate for communities affected by TB.*

https://www.stoptb.org/accelerate-tb-innovations/introducing-new-tools-project

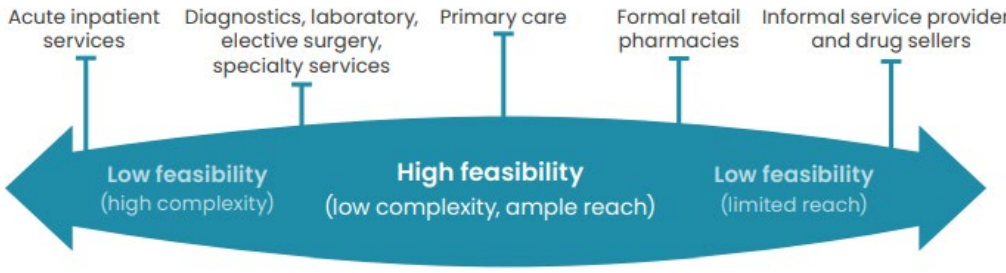
Stop TB Partnership hosted by UNOPS

Understand: situation analysis

Build understanding

- Situation analysis/ market intelligence: data and mapping
  a. TB data
  b. Healthcare provider data (how many providers? where they operate? who they sell to? on what terms?)
- Identify what works (well/not) and what are context factors
  - Understanding the possible role for different Healthcare providers (refer, diagnose, treat, follow up)
  - Availability and sales volumes of TB drugs in the private sector
- Identify and evaluate the underlying reasons for these supporting functions and rules not being performed well
- Assess feasibility, cost, impact of interventior

FIGURE 2.2: **Assessment of the feasibility of intervention in (stylised) market systems**

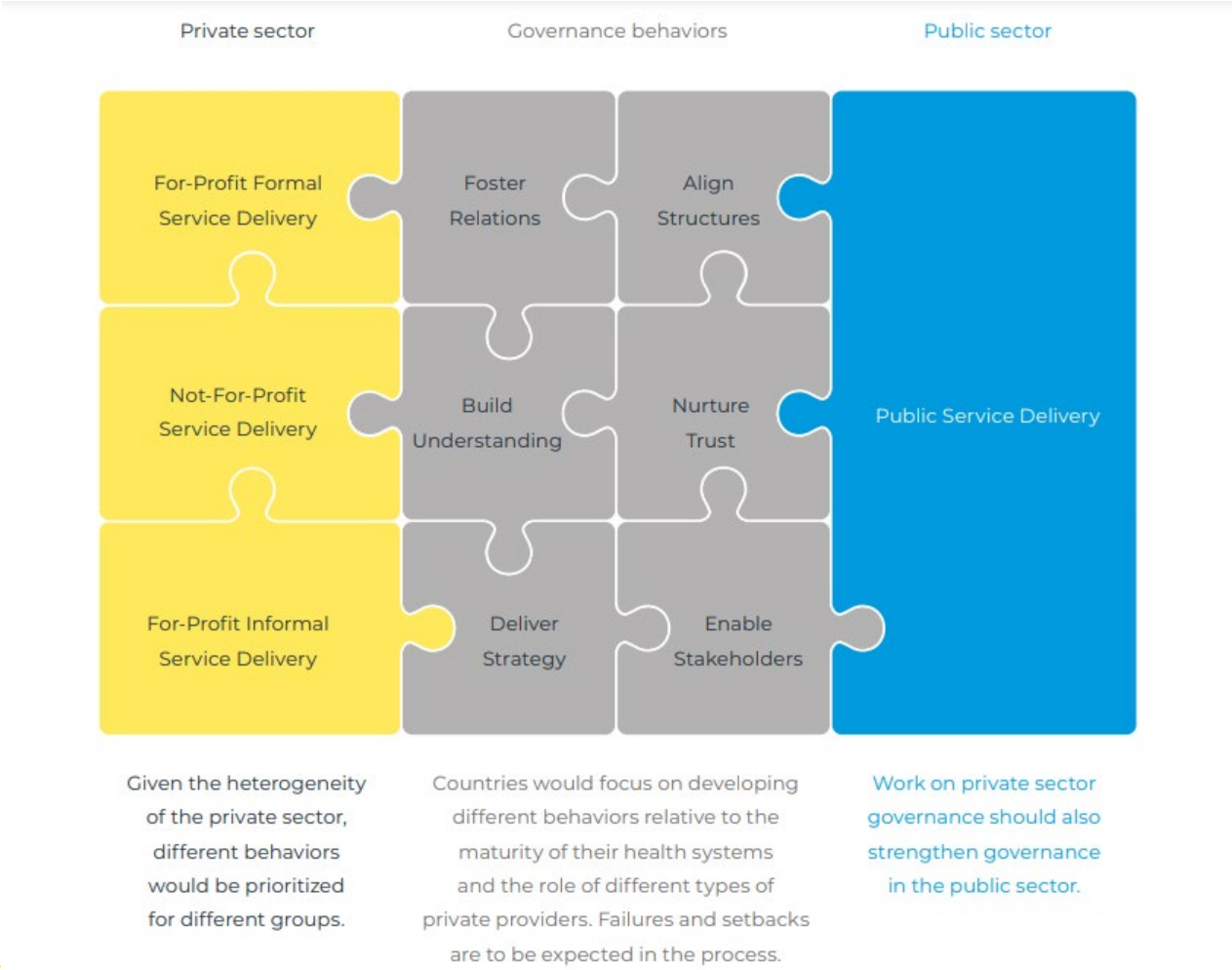


MM4H Course

Partnering: public-private dialogue

Partner

- Dialogue - partnership
- Governance behaviours
  1. Build understanding
  2. Build Mutual trust
  3. Develop and nurture relationships:
     - Skills / aptitude to understand private healthcare providers
     - Skills / capacity to build, nurture relationships with NTP (at all relevant levels) and local health and administrative authorities, as well as any relevant community-based or patient organizations
  4. Deliver strategy
  5. Align structures
  6. Enable stakeholders



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Targets and Advocate

- Setting ambitious targets

Table 3: Selected targets from India's National Strategic Plan Tuberculosis (TB) Elimination, 2017–2025

Target	2015 baseline	2020	2025
Private TB notifications	• 184 000	• 2 000 000	• 1 000 000
Private contribution to total notifications	• 11%	• 56%	• 50%
Proportion of private notifications with microbiological confirmation	• 2%	• 30%	• 45%
Treatment success rate among privately-notified TB patients	• 13%	• 90%	• 90%
Proportion of private providers receiving honorarium or incentive through Direct Benefit Transfer	• 0	• 80%	• 90%

- Advocacy
  - ***Political:*** High-level commitment 'business unusual'
  - ***TB professional***: Advocate for highest quality TB standards
  - ***People:*** Create demand for accredited TB care and support from all healthcare providers, and accountability on implementation

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Allocate funding

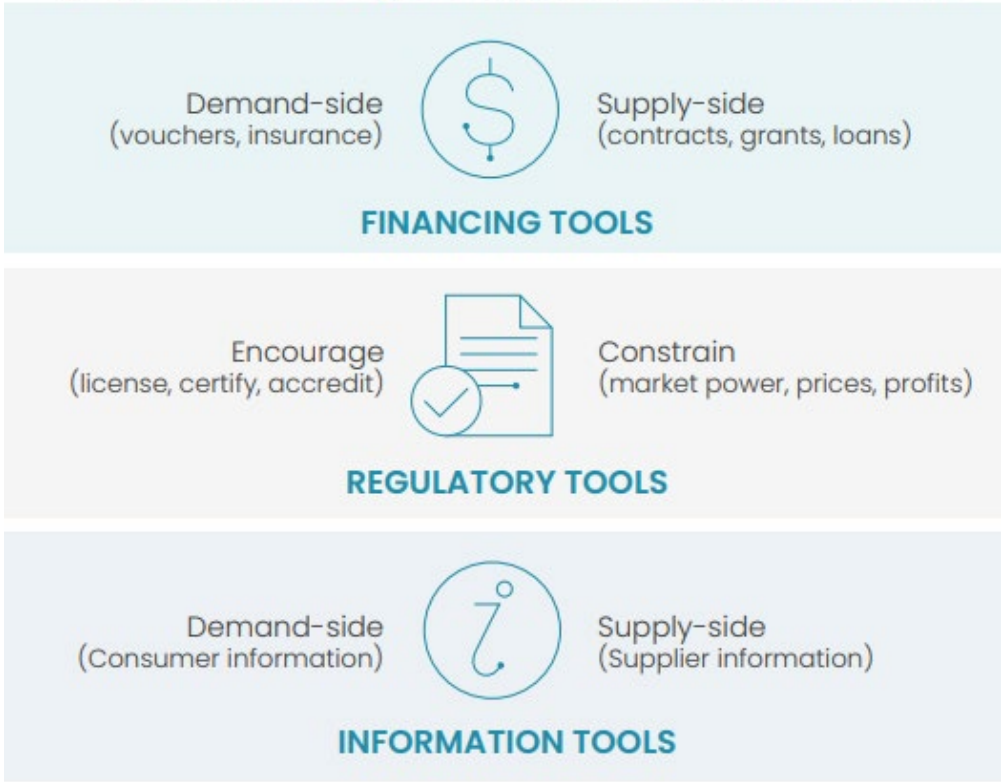
- Financing systems:
  - Budget allocations with line-item budgets and expenditures
  - Salary-based compensation
- Strategic purchasing: how health service providers are paid for the delivery of services -- linking transfer of funds to providers on aspects of their performance or health needs of population
  - *Procurement of services of an intermediary agency*– Contracting, Outsourcing - for engaging, supporting and monitoring private providers who are supplying TB care and prevention
  - *Procurement of clinical TB services from individual providers or clinical care entities*, often via payments made by a social health insurance scheme. Social Health Insurance (SHI) schemes towards the overall goal of Universal Health Coverage (UHC)
- Reforms and new financing mechanisms

Policy frameworks

Policy & Regulation

- **Overall national policy on PPM for TB**
- **Notification:** Policy, regulations, enablers and enforcement mechanisms for notification of TB cases
- **TB Drug sales/ AMR:** Policy, regulations and enforcement mechanisms regarding sales of anti-TB drugs and inappropriate diagnostics;
- **Quality:** Policy and systems for quality assurance of healthcare practitioners and facilities (licensing, certification, registration, accreditation);
- **Contracting/ strategic purchasing:** Policy, systems and specialist staff dedicated to contracting and to purchasing of packages of health services.

FIGURE 3.2: **The tools of government for health market systems**



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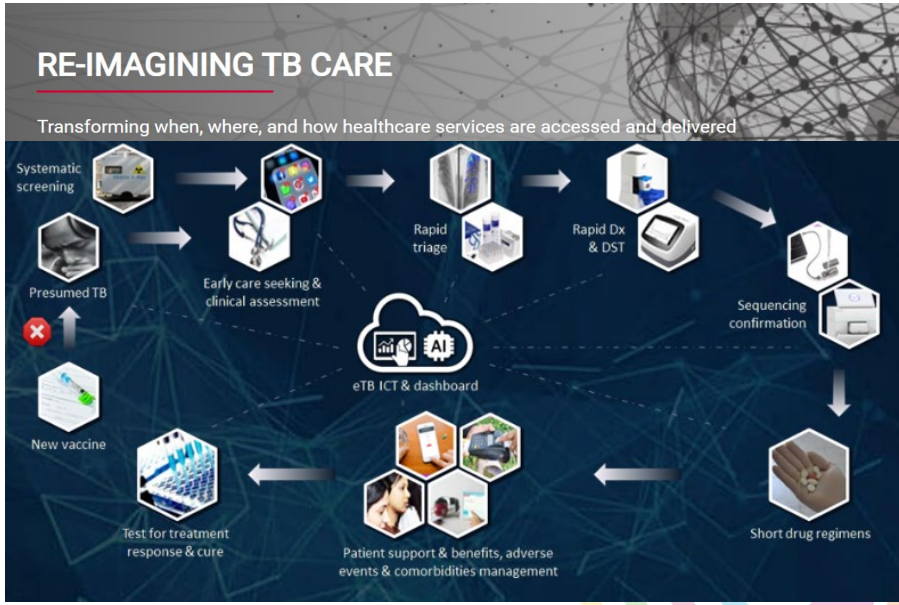
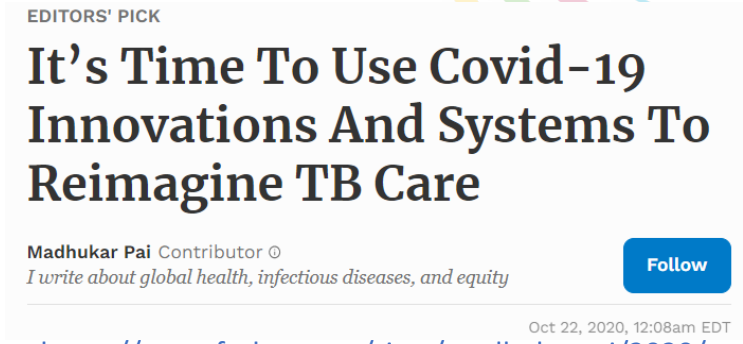
Digital technologies

Digital technologies

- ***Innovations:*** basic SMS messages, call centers, geospatial technologies, low-cost tablets and smart phones, fingerprint and iris scanners, barcodes and QR codes
- ***Functions***
  - case notification and reporting
  - communication of diagnostic results
  - payments to providers and patients
  - adherence support and monitoring
  - overall performance management
- ***Tool is only as good as it's use***
  - training, ownership, funding



https://www.stoptb.org/accelerate-tb-innovations/re-imagining-tb-care


EDITORS' PICK

It's Time To Use Covid-19 Innovations And Systems To Reimagine TB Care

Madhukar Pai Contributor

I write about global health, infectious diseases, and equity

Follow

Oct 22, 2020, 12:08am EDT

https://www.forbes.com/sites/madhukarpai/2020/10/22/time-to-tap-covid-19-innovations--systems-to-reimagine-tb-care/?sh=127b69f5494d

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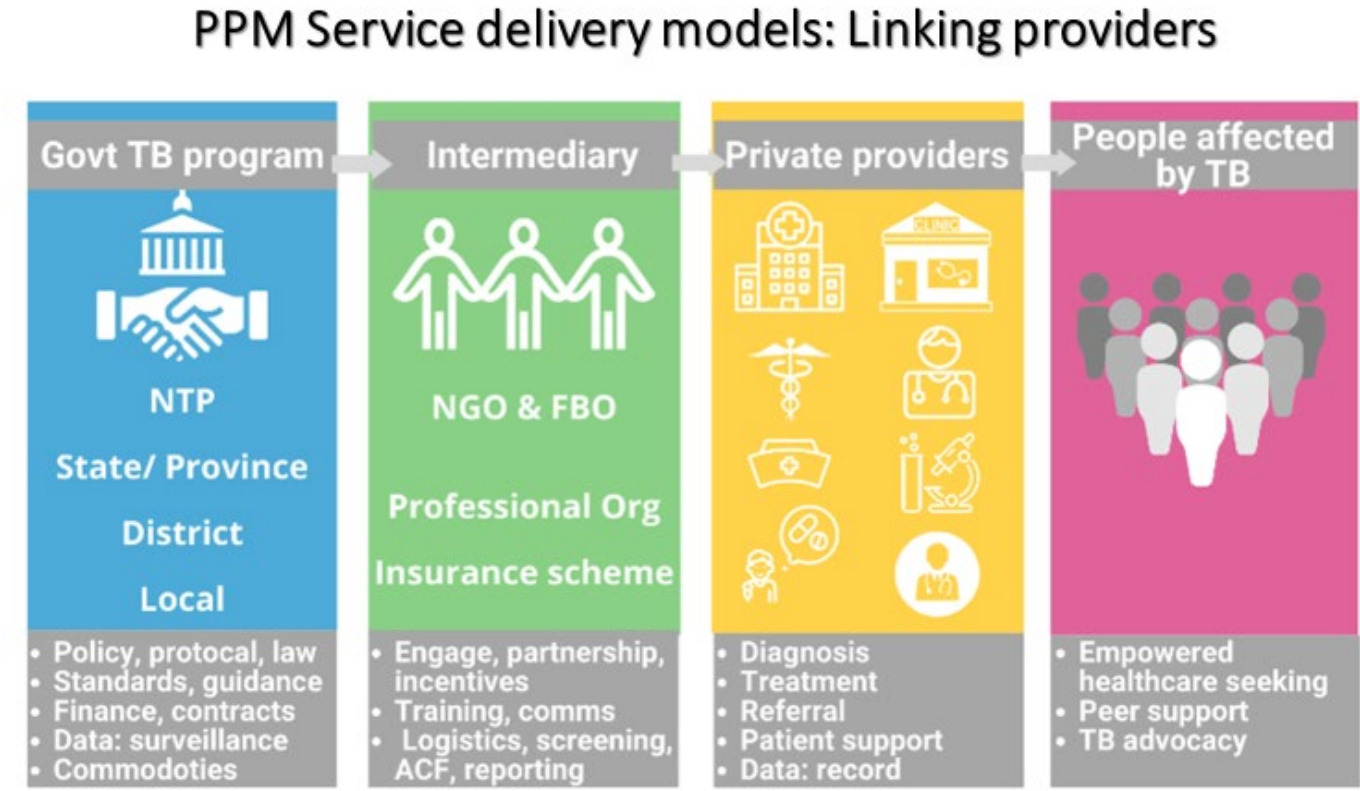
Delivery model

Incentives

1. ***PPM plans "task mix matrix":*** Negotiate roles, responsibilities and value for stakeholders
2. ***Incentives:*** Award and recognition is more important than financial costs/benefits
3. ***Train and equip***: Low-intensity, high-frequency sensitization sessions in clinic
4. ***Ensure private patients' access to diagnostics and treatment***
5. ***Data management systems for reporting, monitoring and evaluation***: field workers, digital, apps
6. ***Link private patients to support services:*** Access to nutritional and other forms of social support and adherence counselling



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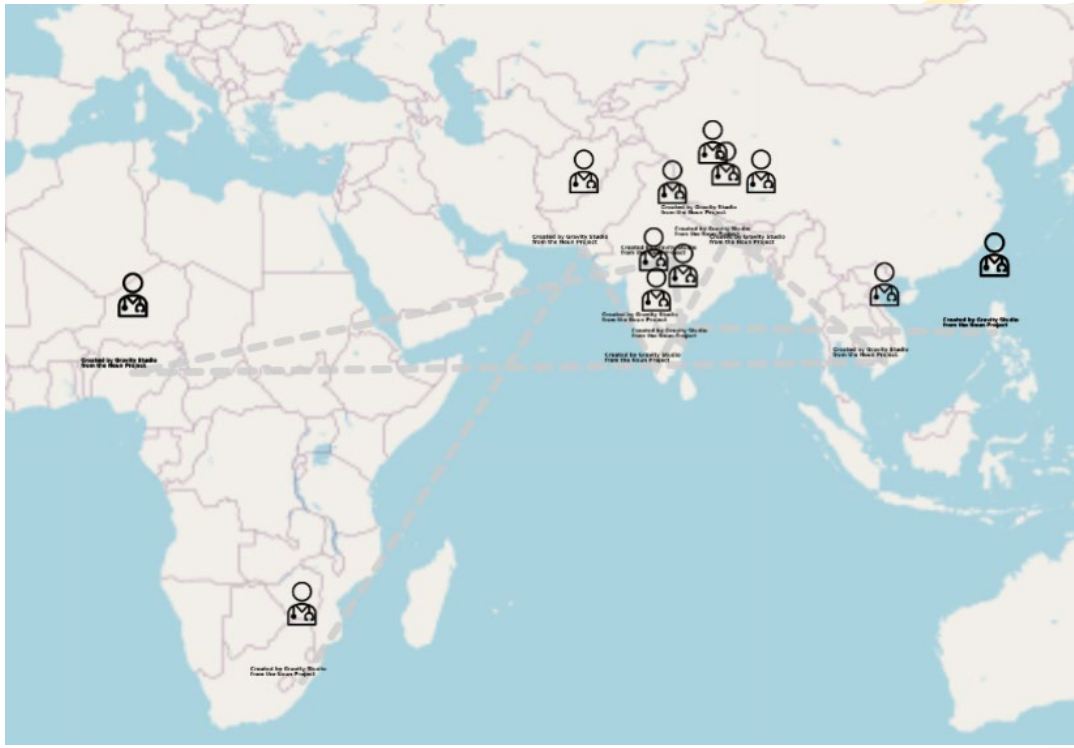
Flexible adaptation to local context

Adapt to context

- There is no single implementation intervention – health markets differ
- Standardization limits scale and effectiveness
  - *TB standards* on diagnostic/ treatment
  - *Generic features* (mapping, governance behaviours, training, etc)
  - *Flexibility* in types of providers, staffing, enables/ incentives, digital tools, referral
- Awareness of culture and eco-system
- Focus on outputs and outcomes (e.g. submitting data rather than which form to use)

TBPPM Features stories



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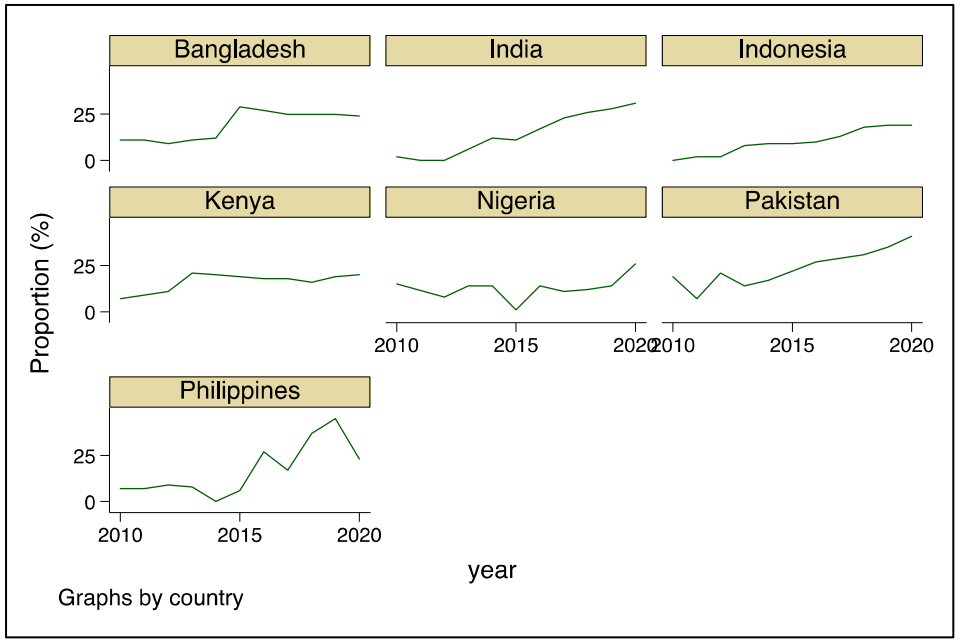
Monitoring, Evaluation, Accountability

Monitor

Monitoring and evaluation of private healthcare efforts needs to be part of the national TB program and efforts

Global level: only private sector TB notification



WHO PPM Dashboard

Other data related issues in the private sector

Policies: mandatory notification and enforcement of such policies

Systems: stand alone, TB module may be not existent or not available at all.

Scope: inconsistency in indicator definitions, inadequate quality-of-care data

END TB

Outline

- What is the problem in the TB system?
  - Patient pathway
  - Where do people seek care?
  - Pandemic
- Why public-private partnerships to end TB
  - What is private sector, private provider, PPM
  - Contributions of PPM
- How do we engage private providers
  - What guidance exists: Plan, guidelines, PPMWG, TBPPMLN
  - What does that look like in practice?
- Steps in the TBPPM Roadmap
- PPM: Unexplored potential

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Reality check: Constraints to private provider engagement for TB

Bias towards public provision	Insufficient funding	Lack of understanding of private healthcare markets	Entrenched approaches
Few champions or orchestrators of system transformation	Fragmentation of the private market	Weakness of key health systems	Shortage of experienced and qualified implementers
Few inspiring models at scale	Challenges specific to TB	Market forces	More attractive competing priorities

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UNHLM Year 2023: TB, UHC and PPR
Healthcare providers are at the heart

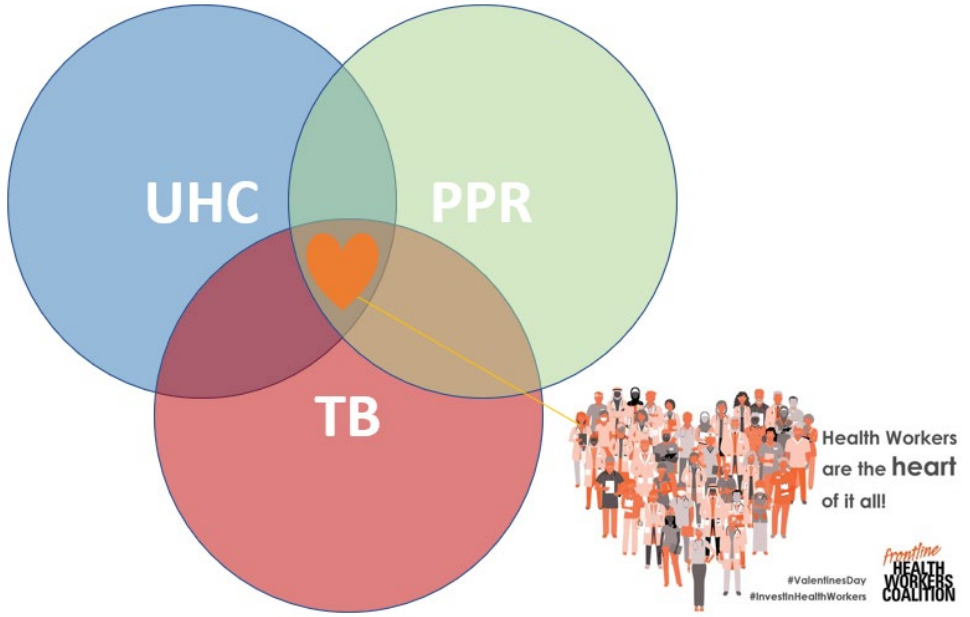
COVID-19 has shown the world what can be moved if we invest in a response to a pandemic. Now we need to Invest, innovate and improve…

Investing in healthcare providers = investing in pandemic preparedness

- First to face people with illnesses, call out potential outbreaks
- Resilient health system can mitigate impact of future pandemics

Healthcare providers and TB programs are a pillar for UHC

- UHC is about access to medicines and care and reducing costs
- TB programs have a strong coverage of essential, quality health services, health prevention, diagnosis, treatment and surveillance – PPM offers the link



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What are take home messages for you?

URGENCY: Scale up PPM – unexplored potential

- Advocate: engagement of all providers for quality TB care for all people
- Utilize Global Fund for new proposals bringing in intermediaries
- What can you do?
  - Government: policy, guidelines, standards, training, link mechanisms, partner dialogue
  - TB Professionals/ physicians: network, train, educate TB standards
  - Community/ advocates: create demand for private providers to be accredited/ engaged/held accountable
  - Research: expand the evidence base, implementation research

PARTNERSHIPS: multisectoral action is the way forward

- Within Health: engaging all HC providers, pharmacy, labs
- UNHLM: link TB into UHC and Pandemic preparedness agenda

THANK YOU

TB•PPM Learning Network

Quality TB care for all people by all providers

Please Join the TB•PPM Learning Network

(Digital platform and online community supporting the Stop TB Partnership PPM Working Group)

www.tbppm.org

(Twitter: @tb_ppm)

McGill Summer Institute Course

"Engaging all health providers to End TB (PPM)"

12-16 June 2023

https://www.mcgill.ca/summerinstitute-globalhealth/

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