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Forum

Public–private mix for TB care in India: Concept, evolution, progress☆

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ABSTRACT

To achieve ''Universal access to TB care and treatment for all'', Revised National Tuberculosis Control Programme (RNTCP) has taken steps to reach the unreached by synergizing the efforts of all partners and stakeholders. RNTCP is engaging with private sector partners in major cities of India with primary focus on notification through innovative partnership mechanisms. The manuscript details the concept behind the public–private mix for TB Care in RNTCP, its evolution and progress over the decades in India.

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1. Background

1.1. *The relevance of PPM in India*

The non-government sector is a critical part of health care delivery in India. The private sector in India consists of a vibrant but varied set of sub-groups that provide services that are preferred by the majority of the population. The sector offers services that are generally described as being more accessible and responsive to the needs of patients. On the other hand, this sector remains largely unorganized, unregulated and unempowered, with the technical quality of some sections of the sector remaining a concern. India has millions of private health-care providers (PPs), including qualified and unqualified health practitioners, pharmacies and laboratories. They account for roughly 80% of the first contact of patients (from all socioeconomic groups) with health-care providers, and at least half of those treated for TB in India.[1] Studies conducted since the 1990s have documented the extent to

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which TB is diagnosed and treated in the private sector, as well as the prevalence of largely inappropriate diagnostic and treatment practices.[2–4] Private providers rarely request sputum microscopy and rely excessively on chest X-rays and inappropriate tests, such as TB serology, which has recently been banned by the GoI.[5] Despite the ban, serological tests continue to be performed in some laboratories, while other laboratories have replaced these with tests, such as IGRA, which are not indicated for diagnosis of active TB.[10] Most people with active TB visit more than one private provider (mostly local informal providers and chemists) and take antibiotics or other treatments, even if most of them eventually register with the RNTCP.[6] If patients do start on anti-TB drugs, they can rarely afford the full treatment and usually stop taking them as soon as they feel better. TB drugs are freely available over the counter, and prescription audits have shown that irrational prescription of TB drugs is a widespread practice, which might partially explain the emergence of MDR and XDR-TB in India.[3,4,11] Patients from low-income households lose several months of their income in the process of paying for inappropriate diagnostics and treatments before starting therapy under the RNTCP.[7] As a result, there are delays in diagnosis, unnecessary patient expenditure, and irrational or unsupported treatment. When patients finally reach the public sector, they are financially constrained, and in many cases, they have developed drug-resistant TB. Thus, diagnosis and treatment of TB in the private sector is both a problem and an opportunity.

Revised National Tuberculosis Control Programme (RNTCP) has established itself as a strong and effective way to deliver TB care in the public sector providing a firm base upon which PPM efforts can be built. While, the reality of this sector creates constraints as well as potential for improvements in service delivery of public health programmes, its integration into public health systems is the way to enable provision of service elements in a seamless continuum of care, increase coverage of health services, decrease delays in treatment, and ultimately improve patient outcomes and disease control.

2. Challenges

Many small pilot projects have been undertaken in India to engage private providers in quality-assured TB care, as specified by the national guidelines.[8] Most of these have been conducted at a very small scale, and the best business model for engaging with the private sector remains elusive.[9] Private providers are the first point of care for the vast majority of TB cases and yet, it is estimated that they contribute just 2–3% of case finding and less than 1% of case management under the RNTCP. The many challenges hampering meaningful engagement of private providers include poor relationship between the private providers and the state, which is often characterized by a deep mutual mistrust. Market forces are often powerful impediments to the adherence of private providers to government protocols. Private providers very often make considerably more profit from practices that are not in the best public health interest than from practices recommended by the RNTCP. These irrational practices are supported by the concerted marketing efforts of pharmaceutical and diagnostic companies, and often conform to the client's expectations of what constitutes quality care. The state's regulatory enforcement mechanisms are too weak to control the private market, considering its size and fragmentation.

3. Early experiments

PPM had been recognized as a requirement for effective TB control early in the programme. There are some important PPM initiatives early in the programme; one of the better examples is the systematic efforts to involve medical colleges in RNTCP. By creating national, regional, state and medical college task forces, RNTCP was successful in engaging this large sector, with about 20% of TB case notification being from these medical colleges. As early as 2003, a pilot PPM project was implemented in 14 urban sites in India. WHO-PPM medical consultants and peripheral field supervisors were recruited and posted to these districts. An expanded version of the existing routine RNTCP surveillance system collected disaggregated data from the different health-care providers. Providers were involved through a systematic process of situational analysis and listing of health-care facilities, sensitization and training of practitioners on RNTCP, training of RNTCP staff on PPM-DOTS, identification of facilities for RNTCP service delivery, memoranda of understanding and RNTCP service delivery. The data from the intensified PPM sites have shown an overall increase in the number of TB cases notified under RNTCP.

3.1. *Mahavir Project, Hyderabad*

This is one of the early models where a private sector hospital was engaged with RNTCP. The setting was that of a non-profit hospital providing DOTS services to a population of 100,000 for 3 years, and then expanded coverage to 500,000 in October 1998 in which a Tuberculosis Unit model was developed. The detection rate increased from 50 to 200/100,000 over the first 2–3 years of the project.[12]

Another early PPM project was the Kannur project (in India's southern state of Kerala). The project targeted private laboratories and was credited with a 21% increase in detection of NSP TB cases.[13]

On reviewing various early PPM projects in India, we can see some commonality. The public sector tuberculosis programme provided training and supervision of private providers; case notification rates were higher after implementation of a public–private mix project; in many projects, private providers exceeded the programme target of 85% treatment success for new patients positive for acid fast bacilli. A number of cost effectiveness studies were carried out for the PPM. 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 standard management practices for TB 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.[13–15] Using the experiences gained from the collaborations with

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