

MORE POTENT HEALERS

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Help my 8-year-old daughter fight Thalassemia with a Bone Marrow Transplant

In 2017, tuberculosis (TB) affected over 10 million and killed more people than HIV/AIDS — an estimated 1.3 million fatalities worldwide. With a quarter of TB cases and deaths, India's efforts are critical for the global push to ending the epidemic by 2030. But there is a problem. Well-executed programmes that screen and effectively treat potential patients can stop TB in its tracks (China halved its TB prevalence rate between 1990 and 2010), but most such programmes rely on a top-down public healthcare system. With a largely unregulated private sector that treats two-thirds of its patients, what should India do differently?

An innovative pilot that works closely with private providers may hold the key. In 2014, the Central TB Division, in partnership with local governments and two NGOs (PATH and World Health Partners), put in place a new programme in Patna and Mumbai that sought to improve the quality of TB diagnosis and treatment in the private sector. A critical part of the programme was first understanding how the private sector treated patients and the problems they faced.

To help answer this question, our team initiated the world's largest surveillance of TB care quality in those two cities, using the gold-standard method of standardised patients (SPs). Our SPs were trained professionals, recruited from local communities, who presented as patients with a pre-determined set of symptoms and responses to questions the doctors may ask. The standardisation of the case and the fact that we knew what the SPs presented meant that the care they received could be benchmarked to standards of care, and accurately compared across providers.

Importantly, the identities of all doctors in the study are completely confidential and no data linking performance to individual doctors are made available. This is not a "sting" operation; it is a genuine attempt to better understand the problems that private sector providers face in their daily practice.

Together with the Institute for Socioeconomic Research on Development and Democracy, the SPs completed 2,652 interactions at 1,203 health facilities leading to representative estimates of quality in 2014-15, just before the programmes were scaled up for implementation.

Our recently published paper showed that at the start of the programme, three key features characterised the "market" for TB care in these cities. First, only 35 per cent of patients choosing a healthcare facility at random would have been treated in a manner consistent with national and international guidelines. Penalising providers for unnecessary (potentially harmful) tests and medications reduces that fraction to below 10 per cent.

Second, these numbers are not because "all providers are low quality", but instead reflect the tremendous quality variation in both cities. Part of this variation is due to qualifications: Close to half the providers in both cities were AYUSH or informal, with MBBS providers correctly managing 46 per cent of the cases compared to 23.5 per cent for AYUSH and informal providers. But, within both groups, there were always some providers who managed every SP correctly and some who got every case wrong. There are true lotuses in this pond, but qualifications alone are insufficient to identify them.

Third, we have been told again and again that the private sector over-medicates. This is evident

in our data, but with some nuance. The good news is that anti-TB medications were almost exclusively given by providers with the appropriate qualifications, and only after obtaining the necessary lab confirmations. Neither pharmacists nor informal or AYUSH providers abuse anti-TB medications — a major concern in past TB control efforts. The bad news is the frequent use of antibiotics and, more worryingly, classes of drugs known as fluoroquinolones and steroids, both of which can mask the symptoms of TB and make diagnoses harder.

In 2014-2015, the programmes incorporated these features of the market in their scale-up plans. Since then, both Mumbai and Patna have seen significant improvements in TB notification rates among private sector providers, with greater use of microbiological tests and improved treatment completion rates. Preliminary analysis by our team on new data after the programme was in place suggests substantial improvements in case management. Our analysis is ongoing, but the signs are encouraging.

Now, the government, supported by The Global Fund, is expanding this model of private sector engagement to several cities through its Joint Effort for Elimination of Tuberculosis. It is likely that they will face a comparable situation, with high-quality, dedicated doctors practicing amidst many indifferent and mediocre providers.

Based on our experience, we propose a strategy called IFMeT that may be key to successful private-public partnerships to fight TB with four components: Identification, focusing, messaging and testing. The strategy identifies “champion” high quality providers early in the programme. We can then get quick and large returns by connecting patients with champion providers and focusing investments and training on this smaller provider group, while leaving lower volume/quality providers untouched. This “provider focusing” approach decreases the scale of the programme while retaining virtually all its benefits. In both cities, 20 per cent of the providers handled 80 per cent of the patients.

The third component is targeted messaging. Complex financial incentives that are hard to untangle in the private sector complicate efforts to reduce unnecessary medications. An alternate approach concentrates on one or two key behaviors. At this point, messaging only on the overuse of fluoroquinolones and steroids can have substantial impact on the patient’s health. Finally, under- rather than over-testing is the key problem in the private sector. Doctors need to increase testing with more X-rays, sputum tests and GeneXpert tests for patients presenting with symptoms consistent with TB. In our study, doctors given better diagnostic information like test results, made more appropriate decisions and gave fewer unnecessary medicines.

Thus, IFMeT could take a large and seemingly intractable problem and reduce it to a series of actionable, manageable steps that can help end an epidemic that kills millions of Indians.

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