Enhancing and maximizing participation of private health facilities in TB control

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Rationale
The Philippines, through the National Tuberculosis Control Program (NTP), has recorded significant gains in tuberculosis (TB) control through the years. The country’s rank has improved from seventh in 1998 to eighth in 2003, and ninth in 2005, among 22 high TB-burden countries across the world. However, its ranking dropped to eighth in 2013 (WHO 2014), with many of the cases still concentrated in poor urban areas. Although the target cure rate has been achieved since the Directly Observed Treatment Short Course (DOTS) was introduced, the case detection rate (CDR) for all forms of TB has stagnated between 70 and 76 percent from 2004 to 2011. In 2012, the Philippines had one of the highest rates of new pulmonary cases that were bacteriologically confirmed at 45 percent. With a population of 98 million in 2013, the prevalence of TB was reported at 438 cases per 100,000 population and the incidence was 292 cases per 100,000 population (WHO 2014).

TB remains to be a leading cause of mortality and morbidity in the country. It ranked sixth among the 10 leading causes of death, with a rate of 28 deaths per 100,000 population in 2009 and eighth among the 10 leading causes of death.
Policy Notes

morbidity in 2012 (DOH-NEC 2012). Even if the Philippines has achieved the global targets of 70 percent CDR and 85 percent treatment success rate in 2004 and has sustained them, 8 of the 17 regions (Cordillera Administrative Region, Regions IV-A, III, I, II, VII, Autonomous Region in Muslim Mindanao [ARMM], and the National Capital Region) did not achieve the CDR target, and performance of provinces and cities varied widely (DOH 2010). The annual rate of decline in incidence and prevalence has slowed down (TDF 2007). Furthermore, in terms of multidrug-resistant tuberculosis (MDR-TB), the country is now ranked seventh among 27 high MDR-burden countries.

In 2001, the Philippine Coalition against Tuberculosis (PhilCAT), with support from the United States Agency for International Development, developed public-private mix (PPM) models of DOTS in the private sector. These PPM-DOTS units have contributed to improved case finding and case holding rates. However, these gains in the private sector need to be sustained and maximized to help the country sustain the development goals and targets for TB.

This Policy Note summarizes the results from a rapid situation analysis that assessed the extent and quality of engagement of private health facilities in TB-DOTS. It provides recommendations that may help the NTP craft strategies for a more active and sustainable engagement of private facilities in TB control. Data were obtained from key informant interviews of administrators and a review of records in 12 public-private mix DOTS (PPMD) units (6 in Metro Manila, 1 in Cavite, and 5 in Davao Province). The types of PPMD units that were purposively sampled were private hospital-based (4), private university hospital-based (1), nongovernment organization (NGO) stand-alone facility (2), local coalition stand-alone facility (1), NGO-based (2), public-initiated City Health Office-based (1), and government specialty hospital-based (1). A purposive survey was also conducted among 102 private physicians attending medical conventions using self-administered questionnaires to assess practices on TB management.

Key findings

Private sector remains an important link in TB control.

Despite the free services and drugs offered in public facilities, the majority of TB patients
still go for diagnosis and treatment outside of the public sector. From 1997 to 2007, the number of people who went to health centers and DOTS centers did not increase significantly (from 24.5% to 26.7%). Although majority (53%) went to public health facilities (DOTS centers and public hospitals) in 2007, more than a third (38%) were still being managed by private practitioners and private hospitals. According to the 2007 National TB Prevalence Survey (NTPS), nearly two out of every five TB symptomatics sought treatment in the private sector (38%), with 22 percent going to private physicians, and the rest to private hospitals. Furthermore, the proportion of those who went to hospitals (both public and private) doubled (42% in 2007 compared to 20% in 1997), considering that most hospitals have not adopted DOTS.

In the 2007 NTPS, the greatest proportion of patients who went to the DOTS centers were those with no formal education (41%) and those in the first wealth quintile (49%). The proportion of patients seeking consultation at DOTS centers progressively decreased with increasing educational attainment and rising socioeconomic status. Conversely, the proportion of patients consulting with private practitioners and at private hospitals progressively increased, as the socioeconomic status (33% in the fifth quintile) and educational attainment (28% with college education) moved up (NTPS 2007).

In the 2003 National Demographic Health Survey, the most common reasons given for going to public health centers were proximity (46%), cost (28%), and service (18%). Meanwhile, the reasons given for going to a private doctor were service (65%), proximity (14%), and quality of drugs (10%). These findings suggest that proximity is a strong factor in the selection of the type of health provider, but service was a stronger factor for TB symptomatics.

Various local surveys done through the years have consistently shown that the knowledge, attitudes, and practices of private practitioners are inconsistent with NTP policies and guidelines. In terms of diagnosis, there was consistent overreliance on chest x-rays as a diagnostic tool and a concomitant lack of trust in the results of sputum microscopy. Regarding treatment, various permutations of inappropriate treatment and retreatment regimens were prescribed. Overdosage was also a significant finding.

Strategies to consistently follow up patients, monitor adherence, and trace defaulters were inadequate. Perceived factors that attracted TB patients to consult private physicians were confidentiality (46%) and the flexibility in the provision of care to them (44%) (Portero and Rubio 2003).

Private sector initiatives must be enhanced, maximized, and sustained. PPM models for TB DOTS are present in all regions in the country except in the ARMM. The contribution of the PPMD units to CDR has been fluctuating significantly from 6 percent to 25 percent through the years. From 2008 to

Private-initiated PPM models that have been sustained through the years are mostly the private hospital- and NGO-based facilities as well as the NGO stand-alone facilities. PPM models that were not sustained after the initial funding from projects ended were the health maintenance organization (HMO) model and the pharmacy initiative.

**Quality of DOTS implementation among PPMD units**

The following strengths and enablers need to be maximized to sustain the contribution of the private sector to TB control.

**Structural/Governance**

Strong advocacy of key administrators in the PPMD units contributed to the success of the existing PPMD units. Influential and dedicated TB champions are potent forces for success and sustainability. However, they may also become a potential source of weakness in the partnership when they resign or retire if there is no succession planning. Strong, dedicated, and sustained support and buy-in from the administration on the private side is critical for the continued success of the partnership.

Regular dialogue with, and provision of feedback to, private providers is an important measure to continually engage with and encourage them to refer patients to the PPMD units or DOTS centers.

**Operational/Service delivery**

Adherence to direct sputum smear microscopy for diagnosis has improved significantly. All facilities surveyed provide services for direct sputum smear microscopy and all have access to chest x-ray facilities. Patients that need MDR services are referred to the programmatic management of drug-resistant TB centers.

Meanwhile, the following barriers and weaknesses need to be addressed to enhance the quality of services and sustain the demand for TB services:

- Significant variability in treatment and retreatment regimens still exist among private practitioners. Mechanisms and strategies for case holding are variable and not consistently implemented. There are no standard mechanisms for default tracing and contact management.
- TB drug supply stockouts still occur and buffer stocks are suboptimal. Drug supply is limited to fixed-dose combination with no provision for single-drug formulations for patients with adverse drug reactions or comorbid conditions.
- Continuing education and the provision of regular updates and feedback have not been sustained for most facilities. Information and education campaign (IEC) materials as well as resources to conduct monitoring and education activities are lacking.
• The extent of involvement of private providers in the PPMD units remains variable. Referral systems and networking are still suboptimal. The provision of updates and feedback to private practitioners who refer cases to the PPMD units has not been sustained. Dialogue among stakeholders is not done regularly.

**Regulation**
There are no regulatory or monitoring policies implemented by medical societies on the management of TB in the private sector. This means that there are no sanctions or disincentives if TB patients are not managed according to the NTP/International Standard for Tuberculosis Care. Training on the NTP for new physicians is also not regularly done.

The necessary policy instruments, such as the Comprehensive Unified Policy, are in place, but regulatory mechanisms in the private sector are weak.

**Financing**
Most PPMD centers charge for services to sustain operations. The Philippine Health Insurance Corporation (PhilHealth) enrollment is low at less than 10 percent for most facilities. The stigma associated with TB contributes to the underutilization of PhilHealth benefits. The process for PhilHealth reimbursement is cumbersome and unclear. In most cases, PPMD centers do not benefit from the reimbursements as these are channeled directly to the general funds of the local government units (LGUs), hospital, or NGO, as applicable. Thus, the incentive program for referring physicians did not materialize for most facilities. According to PhilHealth Circular No. 19 Series of 2003, payment to referral centers, physicians, and other healthcare workers is the responsibility of the TB DOTS center.

The private sector incurs a substantial cost to put up and maintain a PPMD center. To sustain clinic operations, it is necessary that a fee for services be charged to patients. With PhilHealth-enrolled patients making up less than 10 percent of their client list, the viability of these PPMD units is threatened unless the mother unit continues to subsidize the operations as part of their corporate social responsibility.

**Policy issues and recommendations**
The government and the private sector should continue to collaborate to sustain the gains in TB control and prevent the spread of MDR-TB. This can be achieved by implementing expanded/integrated quality DOTS services sustained by continued political commitment, strengthened health systems, and financing and regulatory mechanisms.

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The following recommendations are proposed to sustain the gains in the private sector, enhance the quality of services, and prevent the development and spread of MDR-TB, which is more costly and resource intensive to manage.

**Service delivery**

**Policy issue: Quality of services**
Enhance and sustain the quality of DOTS services to increase referrals from private providers and to promote demand for services through the following interventions:

- Develop and pilot a short message service-based information system to facilitate the referral and tracking of patients and defaulters, facilitate the referral and feedback system among DOTS facilities and private providers, sustain and promote referrals from private providers, and strengthen partnerships between private providers and PPMD units.
- Consider setting up a hotline information system. Send acknowledgement messages to referring physicians regarding the status of patients referred to the DOTS centers. Provide a readily accessible listing of quality-assured microscopy centers and PPMD facilities.

1. Review the national and local procurement and distribution system of anti-TB drugs to ensure an uninterrupted supply. Consider outsourcing the procurement and distribution system to a third party. Provide stocks of single-drug formulation for patients with comorbid conditions and adverse drug reactions.
2. Conduct targeted, sustained IECs to increase the demand for services and to promote the availability of quality-assured DOTS services at the PPMD units. Intensify public education campaigns regarding TB signs and symptoms and the availability of free drugs.

**Policy issue: Equity of services**

1. Focus on target zones where TB burden is highest to improve access to DOTS in high-burden areas (e.g., urban poor communities) and among high-risk groups (e.g., laborers, teachers, patients co-infected with TB-human immunodeficiency virus [TB-HIV], patients with MDR-TB, diabetes mellitus patients with TB).
2. Map private providers in the priority areas and define a referral network, including a review of referral mechanisms and policies to generate and sustain referrals.

**Structural/Governance**

1. Adapt training modules to the needs of the facility. Conduct regular training and updates especially for new clinicians/health-care providers. PhilCAT may need to evaluate the effectiveness of the DOTS training workshops.
2. Pursue active collaboration with medical societies to disseminate and advocate adherence to the revised NTP Manual of Procedures. The PhilCAT and the NTP should continue engaging actively the Philippine Medical Association, the Philippine Academy of Family Physicians, and the Philippine College of Physicians in targeting general practitioners, family medicine specialists, internists, and other nonspecialists to adopt the DOTS strategy, possibly through the creation of TB task forces in their respective societies.

3. Consider succession planning for key administrators in terms of having TB champions. Plan for human resource development and capacity-building activities to ensure that trained staff are available to continue and sustain program activities at the national and local levels.

4. Consider identifying and capacitating existing hospital laboratories in strategic locations as laboratory hubs for TB diagnostic services to boost case finding. Additionally, consider centralizing TB diagnostic services in the PPMD units rather than in the hospital laboratory, similar to the local coalition university-based hospital model in Cavite.

5. Saturate communities with health-education messages and health-promotion activities. Disseminate the patient’s charter on TB care.

**Monitoring and evaluation**

1. Maximize the use of the electronic health information system to generate timely quality data essential for monitoring of performance indicators at the managerial level and for the monitoring of service delivery components at the local and national levels.

2. Strengthen the surveillance system through an enhanced National TB Registry that incorporates PPMD indicators.

**Regulations**

**Policy issue: Quality of DOTS services**

The NTP, PhilHealth, and PhilCAT need to review policies and standards for the certification, accreditation, and reimbursement of DOTS facilities, including streamlining and harmonizing of processes to accelerate accreditation. Develop performance-based standards for recertification and renewal of accreditation. Review the standards and regulations for quality assurance, including the standards for MDR-TB, TB-HIV, and TB in the workplace.

Review the accreditation and licensing policies and processes for private laboratories. Training and certification need to be expanded to include private laboratories. Publish/advertise a list of accredited DOTS facilities and sputum microscopy centers.

The Bureau of Food and Drugs and the Department of Health should enforce the
regulation of not dispensing anti-TB drugs without a prescription. The quality of anti-TB drugs should also be monitored regularly. Health programs in workplaces would benefit from monitoring and evaluation (e.g., conduct situation analysis of health programs in workplaces, schools, etc.).

Financing

Policy issue: Sustainability of private-sector initiatives
The control of TB is a responsibility of the national government as it relates to public health. Financing of private-sector initiatives for TB control is insufficient and fragmented. The establishment and scale-up of private-initiated PPMD units are primarily donor-driven and sometimes uncoordinated. This results in competition for referrals and the overlapping of catchment areas. Part of the national budget needs to be allocated for monitoring and evaluation activities to sustain the quality of NTP and PPMD services.

The relevance of the structure and components of the existing PhilHealth benefit package needs to be reviewed considering recent developments in diagnostics and changing epidemiologic trends. Explore the possibility of including TB-DOTS treatment as one of the requirements for the conditional cash transfer program. Advocate with LGUs for financial allocation. Address persisting issues on the stigma associated with being labeled as TB patients. Hold dialogues with PhilHealth and institutions in-charge of PPMD operations (e.g., LGUs, NGOs, hospitals) for the efficient processing and channeling of reimbursements from the PhilHealth TB outpatient benefit package. Both the private and public side need to discuss sustainability issues to reduce out-of-pocket expenses related to TB.

Reexamine the incentive program for referring physicians by crafting guidelines for referral fees and/or increasing the premium for quality TB DOTS services rendered by DOTS providers. Explore the feasibility of contracting out DOTS-trained private providers who are willing to integrate TB DOTS services into their clinic. PhilHealth reimbursement will be performance based and contingent on the completion of treatment according to the NTP guidelines. Social franchising through HMOs or preferred private providers is another model to explore (e.g., for the workforce, teachers).

Social franchising of TB services through the HMO model has the following potential strengths that can be revisited:

- Wide clientele base provides large catchments for case detection.
- HMO clinics with a large network of physicians and with multispecialty services provide opportunities for referral and standardization of TB management in accordance with the NTP.
- Case detection can be integrated into the general health services of the clinic, which can minimize stigma.
• Policyholders can avail of health services from any of the clinics based on proximity to their residence or place of work. Private-initiated PPMD units need to develop strategies for cost recovery apart from PhilHealth reimbursements. Strategies that could be explored include expanding services beyond pure DOTS (e.g., bundling other services such as pre-employment evaluation; expanding networks with third-party payers and other health-care service providers; price differentiation among the indigents, the insured, and the uninsured).

Opportunities for corporate involvement and investment in TB control extend beyond the workplace control of TB. Areas of engagement that the NTP could explore with the corporate sector and pharmaceutical companies include:

• Implementation and expansion of TB services in the workplace.
• In-kind contributions of expertise and products in the areas of financing, data collection and management, drugs supply and delivery operations (especially of second-line drugs for MDR-TB), and social marketing campaigns.
• Development and manufacture of new diagnostic tools and anti-TB drugs, and partnership with the academe and the government in the conduct of developmental research.

Companies/business processing offices designing programs to fight TB among employees, their families, and communities should know that:

• TB is curable without hospitalization and that treatment costs are minimal.
• After a short initial phase of effective treatment, workers can usually resume normal duties.
• Detecting and curing TB early will prevent its spread among workers, their contacts, and the community.
• Implementation of a corporate TB program that follows the DOTS strategy is the cornerstone of successful TB treatment and control.

Cost-effectiveness analysis of strategies for TB control in developing countries has shown that the DOTS treatment of new smear-positive cases is the priority since it is the most cost effective. The addition of other interventions (e.g., treatment of MDR cases as well as smear-negative and extrapulmonary TB), however, is also highly cost effective (Baltussen et al. 2005). Substantial scaling up of all three interventions is needed. Improving case finding implies that coverage must be expanded to those who do not have access and to MDR-TB, TB-HIV, smear-
negative, and extrapulmonary TB cases. The following themes for operations research are recommended to guide fund allocation to determine the correct mix of interventions and the strategy for expanding services:

- Cost effectiveness of expanding services for MDR-TB on top of existing DOTS services for smear-positive TB cases using updated surveillance rates.

References