Public Private Interface Agency (PPIA)
ACCELERATING TB ELIMINATION IN INDIA THROUGH PRIVATE SECTOR ENGAGEMENT

PATH's PHC Insights Series

Strengthening people-centered primary health care (PHC) is likely the most cost-effective approach to achieving sustainable health and social impact. It is the foundation of health systems that put people first, address diverse health needs, and leave no one behind. These case studies highlight PATH's work in designing, implementing and scaling people-centered initiatives. We focus on actions that have worked to help communities, countries, and regions move towards people-centered PHC, while also suggesting future directions to be leveraged. The case studies utilize suggested levers from the WHO Operational Framework for PHC to frame current and future actions.[1]

The key insights from PPIA include:

- Mapping, designing for, and engaging the private sector was critical for bridging a service delivery gap.
- National and municipal political will created an enabling environment for innovation to improve the status quo.
- The e-voucher system simplified referrals, patient tracking, and provider reimbursements.

Engaging the private sector in service delivery

The Need

Tuberculosis (TB) is the sixth-leading cause of death in India and threatens the country's rapidly growing urban communities.[2] Primary health care providers play an important role in diagnosis, referral to, and completion of TB treatment. However, *private* providers manage an estimated 1.1 million 'missing'—diagnosed but unreported—TB cases and are the first point of contact for almost 80% of TB patients.[3] In light of this, the Mumbai Mission for TB Control recognized that engaging the private sector would be critical in successful TB control and monitoring efforts.[4,5] Alongside two community-based organizations, and with the support of the Bill & Melinda Gates Foundation, PATH supported the development of a Private Provider Interface Agency (PPIA) in Mumbai. PPIA networks and partners with formal and informal private providers to notify the government of new cases, improves access to care by streamlining diagnosis and treatment processes and reducing financial barriers, and engages community-based partners and an innovative technology platform to improve case management and treatment success.

The Results

By identifying barriers and targeting the platform to address these, PPIA was able to increase private sector case notifications in Mumbai from 2% (3,000) of total notifications in 2013 to 47% (22,260) in 2017.[4] The time between first symptom and TB diagnosis decreased by 20% and 80% of patients completed treatment.[6] Initially funded by the Bill & Melinda Gates Foundation in partnership with the government of India, PPIA served as a successful proof-of-concept. The model has been taken over by the government health care agencies who are looking to expand geographically and integrate with management of other health conditions.[7]

PHC Levers

Political commitment, leadership and coordination at all levels accelerated action

The government of India called the private and public sectors to action in the National Strategic Plan for TB Control, 2012-2017.[8] In January 2012, Mumbai reported the first totally drug-resistant TB cases.[9] The Municipal Corporation of Greater Mumbai—in partnership with the Central Tuberculosis Division, World Health Organization, and the Bill & Melinda Gates Foundation—galvanized around the urban TB crisis and formed the Mumbai Mission for TB Control (MMTC) in 2012. MMTC's marching orders were to improve active case finding in slums, increase access to rapid diagnostics and effective treatment, engage the private sector, ensure infection control, empower communities, and strengthen organizations.[8] With national and municipal political will, an enabling environment emerged for innovative ways to engage the private sector in TB management; so formed PPIA. Three cities— Patna, Mehsana, and Mumbai—were chosen to participate in the pilot based on established relationships and buy-in from municipal government and district and state TB program leaders. While the National Strategic Plan is specific to TB control, it explicitly calls out approaches aligned with the components of PHC, including but not limited to: multisectoral action, universal community access to diagnosis and treatment, patient-friendly services, integration with health systems, and mobilized communities. Because of its PHC-oriented foundations, PPIA offers a service delivery model to potentially address a wider gambit of essential services.

[1] WHO, UNICEF. Primary health care: transforming vision into action. Operational Framework, draft for consultation, 2018.
[2] Country Profile: India. Institute of Health Metrics and Evaluation.
[3] Venkatachalam P, Memom N, Yeh D. Bold Philanthropy in India: Insights from eight social change initiatives. The Bridgespan Group; September 2018.
[4] Mumbai Mission for TB Control, India. Stop TB Partnership; 2014.
[5] CTD and WHO Country Office for India. Universal Access to TB Care Concurrent Assessment Report. WHO; May 2016.
[6] Mistry N, Rangan S, Dholakia Y, et al.(2016). Durations and delays in care seeking, diagnosis and treatment initiation in uncomplicated

pulmonary tuberculosis patients in Mumbai, India. PLoS ONE 11(3): e0152287.
[7] Vijayan S. Finding the missing millions: the importance of private sector engagement for eliminating tuberculosis. PATH; January 2019.
[8] National Strategic Plan for Tuberculosis Control 2012-2017, Central TB Division, Directorate General of Health Services, Ministry of Health & Family Welfare; March 2017.
[9] WHO India. Mumbai Mission for TB Control: Towards universal access to TB care.

Engagement with private sector to mainstream TB care improved quality of services

In India, nearly 80% of people with TB approach the private sector for diagnosis and treatment first.[7] Taking a whole systems approach, PPIA worked with local CBOs to map Mumbai's fragmented private sector. In Mumbai alone, PPIA mapped 3,772 formal private providers, 4,813 informal private providers, and 2,710 private pharmacists.[3] The Indian School of Business helped develop incentive mechanisms targeted to providers. PPIA field officers then pitched the model to private providers: join the PPIA network and receive diagnostic and treatment subsidies for patients. Coordinated referral systems offer the added benefit of consistent patient flow to the private providers. By 2015, PPIA was working with 22% of formal private providers mapped, 30% of informal private providers, and 11% of private pharmacists.[3] PPIA improved not only provider compliance with standardized treatment regimens, but also patient compliance. India is not alone in its strong private sector prevalence; private providers often account for over 50% of service delivery in many LMICs.[1]

ICT systems leveraged to manage patient care and provider reimbursements

PPIA designed an e-voucher system which offered three advantages: easy referrals, more robust patient tracking, and seamless payment and reimbursement. Easy referrals reduce administrative barriers to seeking care, support high-quality service delivery, and incentivize private providers to comply. Because the e-voucher system links directly with the national case notification and drug regimen tracking databases, providers, program managers, chemists, laboratories, and health care administrators are equipped with better data for decision-making.[10,11] Linking the patient through the e-voucher to these critical metrics allows PPIA to follow up directly with patients having trouble completing the regimen. Patients receive phone call and SMS text reminders and are visited by trained staff from local CBOs who provide psychosocial support. From 2014 through 2016, PPIA tracked over 38,640 patients in Mumbai; 78% of patients completed treatment.[3] PPIA's payment and reimbursement mechanism through the e-voucher removes the financial burden from the patient. The efficiencies and payment assurance offered to the provider serve as incentive to comply with best practices.

Promising future directions

PPIA successfully piloted a model for engaging the private sector in TB management and continues to scale geographically across India and to hypertension management in Mumbai. As it does, we see this as a potential model for PHC by expanding the scope of private sector service provision, engaging the community, and integrating M&E systems and PHC-oriented research.

Expanding the scope of services to ensure comprehensive care throughout the life course

Private providers are the first point of contact for many seeking health care, particularly in urban environments. Progress towards comprehensive PHC could start by expanding the PPIA model to include essential packages of PHC services.[12] The funding and incentive models in PPIA present an opportunity to target and prioritize PHC service delivery through strategic purchasing or performance-based financing.

Engaging the community and stakeholders to jointly define problems and prioritize solutions

A study conducted by McGill University and the World Bank in Patna and Mumbai is helping to target improvements to patients' interactions and experiences with private sector-provided TB care.[13] Taking a more community- and patient-driven approach to defining problems and prioritizing solutions will be key as the model pivots to address other disease conditions and patient populations.

PHC-oriented research and M&E

PPIA's embedded data collection platform enables rapid testing and analytics on the effectiveness of the model and the relative contribution of each input. This type of rapid, iterative testing—when combined with an adaptive management approach to applying the findings—is critically important to strengthening health systems and primary care. Using these data, the efficiency and impact of PPIA could be optimized through machine learning; for example, by identifying geographic hot spots or providers whose throughput could be improved. Qualitative insights driven by social science research methods can help identify why and how PPIA works, and how it is influenced by context, thus enabling faster scale-up and transfer to other settings.

[10] Nikshay.
[11] 99dots
[12] Essential Health Services: India. WHO, July 2015.

[13] Kwan A, Daniels B, Saria V, et al. (2018) Variations in the quality of tuberculosis care in urban India: A cross-sectional standardized patient study in two cities. PLOS Medicine 15(9); e1002653.