

Barriers for involvement of private doctors in RNTCP – Qualitative study from Kerala, India

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ABSTRACT

Introduction: Engaging the private sector effectively has been considered as the single most important intervention required for Revised National TB Control Program (RNTCP) to achieve the overall goal of universal access and early detection. This study attempts to identify the barriers and facilitators in the involvement of private practitioners in signed schemes of RNTCP. **Materials and Methods:** Six focus group discussions - four among private sector doctors and two among RNTCP TB key workers and 10 key informant interviews were conducted. Themes were divided into private sector involvement in RNTCP, barriers for private sector involvement, facilitators for private sector involvement and suggestions for better PPP. **Results:** General feel was that private sector involvement in RNTCP was increasing. Public sector at ground level has not really understood the need to engage the private sector. Lack of capacity for public sector staff to understand and deal with private sector, power relations and not taking hospital managements to trust emerged as important barriers for engagement while private sector doctors expressed concerns over patient confidentiality and patient choices, apprehension of losing patients, inability of program to keep commitments and timely payments, poor recognition to private sector, bureaucratic hurdles and cumbersome formalities. Building locally customised partnership schemes, behaviour change for PPP, building managerial capacity of Public sector to deal with private sector, presence of an interphase agency and quality control through a participatory body were important suggestions for improvement of PPP. **Conclusion:** Strategies have to be formulated to customise partnership for private sector doctors using the flexibilities of the program. Strengthening PPP will be possible in presence of strong administrative will and the understanding that personal relationships are the best key to Public Private Partnerships.

Keywords: Private sector engagement, public-private partnership, qualitative design

Introduction

Private sector accounts for more than half of the tuberculosis (TB) care delivered in India with major challenges as far as the quality of diagnosis and treatment is concerned.^[1,2] Engaging the private sector effectively has been considered as the single most important intervention required for Revised National TB Control Program (RNTCP) to achieve the overall goal of universal access and early detection.

RNTCP has taken many steps to provide universal access to diagnosis and treatment for all patients with TB approaching private sector with significant reduction in catastrophic expenditure. These include incentivizing private doctors and chemists and engaging them through a spectrum of partnership schemes with financial support.

Private sector is well established in healthcare in the southern Indian state of Kerala, accounting for more than 70% of all facilities and 60% of all beds. Many public-private partnership (PPP) strategies for TB control started in the Kerala state during early years of RNTCP implementation itself. Kannur

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and Punalur models of public private mix had found mention in the World Health Organization (WHO) website as models to emulate.^[3,4] With the onset of the Indian Medical Association-global fund to fight AIDS, TB, Malaria- Public Private Mix projects in Kerala, large-scale training of private doctors started in Kerala using RNTCP Technical and Operational guidelines from 2005 onward.^[5] About 2000 doctors were trained in Kerala. While this project was very important and successful in advocacy for program and acceptance of RNTCP as a well-functioning program among private practitioners, the training often did not translate into full-fledged participation of the private practitioners into RNTCP, either through signed schemes or unsigned schemes.^[6]

This study attempts to identify the factors that facilitate and those factors that act as barriers in the involvement of private practitioners in signed schemes of RNTCP. The findings from this study could help policy makers and program managers to plan and implement private sector engagement.

Materials and Methods

Qualitative methods including focus group discussions (FGDs) and key informant interviews were conducted. A workshop was organized with all stakeholders to finalize the methodology and themes. An FGD guide was developed and the key themes of the FGDs were private sector involvement in RNTCP, opinion about methodology for private sector involvement adopted by IMA-RNTCP project, barriers for private sector involvement, facilitators for private sector involvement, and suggestions for better PPP.

A total of six FGDs were conducted – four among private sector doctors and two among RNTCP TB key workers. A list of all doctors trained under the RNTCP-IMA project and private doctors involved in RNTCP signed/unsigned schemes for private practitioners was obtained. Representative sampling was done among two groups of study subjects – the doctors who were not involved in any RNTCP signed schemes as per the RNTCP guidelines for involvement of private practitioners and doctors who were involved in any of the RNTCP signed schemes as per the RNTCP guidelines for involvement of private practitioners.

FGDs were conducted at places and time convenient to participants. The aims of the investigations and implication for participation were explained at the start of the FGDs. Confidentiality was ensured and participants were given a chance to opt out freely at that stage without giving any reason. All FGDs were moderated by persons who had experience in conducting FGDs and who were fluent in the local language. The moderator ensured that the themes were fully discussed and that all participants were given a chance to express their views fully. Each FGD lasted for 30–45 min with additional 10–15 min for informal conversations. The proceedings were audiotaped with the consent of participants. One researcher recorded the proceedings, noting key themes and monitoring verbal and nonverbal interactions.

Ten key informant interviews were conducted – four government RNTCP managers, a PPM consultant who worked for IMA, a national co-ordinator for IMA PPM scheme, and four private sector doctors.

The audiotapes were transcribed verbatim. These were in Malayalam and were translated into English before coding. Themes were divided into private sector involvement in RNTCP, opinion about IMA-RNTCP project methodology, barriers for private sector involvement, facilitators for private sector involvement, and suggestions for better PPP.

The team read the transcripts and notes and reached a consensus. Any disagreements were discussed regularly within the team to reach a consensus regarding theme coding. Sections with similar coding were grouped according to the predetermined themes. Repeated themes were marked as important in red font color. All the flagged statements were put together and synthesized. Important quotations were quoted which evoked spontaneous discussion, around which a lot of time was spent and had some emotional cues attached with.

Results

Private sector involvement in RNTCP

General feel was that private sector involvement in RNTCP was increasing. There was a consensus between groups that roughly 30%–35% of private sector doctors refer cases to RNTCP. However, the uptake of formal RNTCP engagement schemes by private sector was not good.

All groups had opinion that IMA has done good work in creating “good will” for RNTCP. The methodology was good and most of the sessions were handled in a professional manner. However, the trainings did not focus on how to engage in RNTCP schemes for private sector. Poor uptake of RNTCP schemes was attributed to lack of coordinated post training actions and linking to RNTCP schemes. There was a general opinion that TB practitioners should be targeted specifically for future trainings.

Barriers for collaborating with RNTCP

The groups felt that a majority of the private sector doctors were not comfortable in sending patients to RNTCP for various reasons. Many even opined that general practitioners in small clinics now refer to RNTCP. However, doctors in big hospitals are reluctant to send their patients to another system.

“I think big hospitals and specialist prefer individualised regimen, but in case of small hospitals they used to refer the patient to Government. But in case of general practitioners they refer to RNTCP” – private sector doctor.

“Anti TB drugs are now not available in pharmacies, but only in larger hospitals” – key informant.

The barriers identified for poor collaboration of private sector with RNTCP were identified as follows. They could be classified into

1. *Public sector factors*
2. *Private sector system factors*
3. *Factors related to program implementation*
4. *Factors related to policy.*

Public sector factors

Poor initiative from RNTCP for private sector engagement

We felt that public sector at ground level has not really understood the need to engage the private sector. The initiative from their side to engage private sector ends with one time training. RNTCP staff are too much preoccupied with implementation of DOTS. The capacity of RNTCP staff to negotiate with and engage private sector is limited.

“It is very difficult for us even to meet a doctor in a private hospital. They will be busy seeing their patients. We need to wait for long time like a medical representative” – a TB health visitor.

Poor attitude of RNTCP staff toward private sector

Attitude of public sector staff has been cited as a major barrier for engagement. Many incidents were cited to highlight poor attitude of Government side staff especially field workers in RNTCP in dealing with private sector.

“I asked for a drug as ours is an approved PHI. TB worker there asked to send the patients there to get the medicines” – private sector doctor.

“There was always a delay in getting drugs to private PHIs – an average of 2 days. We can’t make patients wait for so long” – private sector doctor.

“Government attitude is bad. Let them come and meet me first for getting a DMC” – told by a district tuberculosis control officer – key informant.

Power relations

Issue of power relations has been brought out by many private sector doctors in FGDs.

“Who is the boss? RNTCP workers start bossing once schemes are signed as they are giving us money” – private sector doctor.

“Imagine STS supervising doctors and STLS supervising Microbiologists?” – private sector doctor.

“Partnership means both parties are equal. How can one rule over the other” – private sector doctor.

Private sector system factors

The following things emerged as factors pertaining to private hospitals in general in engaging them to schemes signed devised by RNTCP.

Public health is being viewed as a low priority issue

Public health is being viewed as a low priority issue by private hospitals as such. Private sector is busy managing their patients and business.

“Private providers perceive TB as a clinical issue and do not always look at the public health perspectives of patient care, such as early diagnosis, infection control and prevention of transmission” – DTO.

Frequent change in paramedical staff/laboratory technicians and presence of unqualified staff in some of the institutions

Frequent change in paramedical staff and laboratory technicians has been cited as an important reason by the DTOs as an apprehension in engaging the private hospitals.

“Every time I go there, there will be a new lab technician. How many times we can train them” – DTO.

“The lab technicians in many private hospitals are not actually qualified with a degree. We cannot give lab technician training to them” – DTO.

Hospital managements not taken to trust

Hospital managements were reluctant for partnerships with government for their own reasons. This was cited as an important reason in many FGDs and key informant interviews.

“We failed in convincing hospital managements. Doctors can’t over rule hospital managements” – private sector doctor.

“Management does not like intrusion from Government sector” – private sector doctor.

Concerns of private sector – factors related to program implementation

Patient confidentiality and patient choices

Patient confidentiality was cited as the top reasons for not referring patients to RNTCP. The following are a few responses by private sector doctors in FGDs:

“My patients’ say-everybody will come to know if I go there.”

“Many patients are reluctant to take RNTCP drugs for numerous reasons. Lack of confidentiality is the prime one.”

“Patients prefer private hospitals for fear of the social stigma associate with the TB. They will lose their privacy in RNTCP”

“They don’t want to expose/disclose themselves to the society.”

“Privacy of the patient is not maintained in RNTCP”

Apprehension of losing patients

Apprehension of losing patients was cited as another reason in all FGDs.

“They will lose the follow up. Probably the patient will be followed up by the government once they get into their system.

So these doctors may be afraid that if they refer their patients they don't come back to them" – private doctor in an FGD. "Patients sent to DMC for testing were asked to take treatment from there. I was not informed. I sent in correct sputum request form with all details duly filled" – a private sector doctor – key informant.

Inability to keep commitments and timely payments

Inability to keep commitments in terms of delay in payments was cited as a reason for further engagements.

"DOTS providers are not given honorarium on time" – private sector doctor.

"When we stop DMC A scheme to a hospital for various reasons, they become indifferent" – DTO.

"Another reason why the programme managers are not so willing to enter into formal contractual arrangements is the lack of confidence in their own ability to release funds on time for supporting such initiatives" – DTO.

Poor recognition to private sector

"We were never invited for a meeting nor involved in planning process. What we have is only one time sensitization" – private sector doctor.

"At least 30% of patients in RNTCP are being referred by private sector, but they are not being recognised" – a PPP-friendly DTO.

Factors related to policy

Lack of trust in intermittent regimen

Lack of trust in intermittent regimen emerged in all FGDs. They pointed out that specialists and those dealing with extrapulmonary TB prefer daily regimen. Daily regimen was preferred treatment option of senior clinicians who have done their medical schooling in the past.

Lack of flexibility in RNTCP

Lack of flexibility in RNTCP in terms of DOTS emerged as a reason in many FGDs.

Not attractive schemes

Many of the schemes were not attractive to private sector hospitals as such. Nonattractive schemes were cited as an important reason.

"Most of the schemes are not attractive to private sector" – private sector doctor.

Private sector is different

Patients coming to private sector and the motives of private sector are different from public sector. The NGO/PP schemes are not specifically designed to modern medicine private hospitals. The schemes totally ignored the heterogeneity of private sectors. The PPM-TB policy

has categorized all types of PPs under one broad group as "private providers."

"Many patients coming to private hospitals can afford tests and medicines. They are not expecting free. If it is affordable to them, then why should we provide the tests free of costs?" – private doctor.

"Private sector should not be considered as an extension of the public sector while monitoring the schemes. Many of the indicators like 2% of adult OPD referral to DMC and geographic population norms are not applicable to private hospitals" – private hospital doctor.

Financial incentives versus nonfinancial incentives

The general view was that the schemes try to view everyone through the lens of financial incentives. Private sector needs compensation for expensive procedures. Other than that, financial incentives are not a must for private sector engagement. Motivation among the doctors who co-operated well was not incentive-based.

"Money is not everything and private sector is willing to collaborate even without financial assistance. Non-financial incentives like recognition, trainings, involving them in planning and review meetings and giving them equal status is more than enough for private sector to engage in TB control" – key informant.

"The collaboration will be better if we avoid financial transactions. The moment money comes in, public sector starts dominating over private sector" – key informant.

Bureaucratic hurdles and cumbersome formalities

Although the policy for private sector engagement is good at top level, bureaucratic hurdles are considered as the major barrier for PPP schemes.

"Ensuring continuity of schemes every year is a tedious process. So much of formalities were involved in it" – private sector doctor.

"MoU is something everybody is afraid of" – private sector doctor.

"I will terminate the contract" and "I will downgrade their status from scheme A to scheme B" – these were the words used by a DTO – key informant.

Suggestions for better private sector engagement

The following suggestions emerged as solutions for better private sector engagement for TB control activities in the state.

Guiding principles for PPP

- Partners should be equal
- Mutual trust between the counterparts
- Trust on confidentiality of patients
- Appreciating and recognizing efforts of partners

- Promoting standards of TB care rather than trying to “pull” patients to RNTCP
- Ensure quality of care through a participatory body
- Bring in local partnerships
- Involve mutually acceptable interface
- Participatory approach to decision-making
- Innovations at regional level.

Role of public health system in PPP

- Initiate and own the process of partnering with private sector
- Offering nonfinancial incentives such as appreciations and recognitions
- Involving major partners in policy making
- Involving private sector doctors/staff during quarterly/monthly review meetings
- Providing all technical inputs and support
- Consolidated data and updates to be circulated to all partners.

Legislative frameworks, policies, and operational strategies: A policy would need to be adopted and strategies developed to allow private participation as equal partners in planning, implementing, monitoring, and evaluating PPPs. PPPs have to be allowed to develop at the operational level at which these are to be implemented.

Implementation through local coordination committees

Local coordinating committees may be set up at district level to rapidly and effectively operationalize PPPs. These committees should comprise public sector staff at the local level, prominent practitioners, and representatives of their associations (IMA, QPMPA).

Behavior change for PPP and building managerial capacity of public sector to deal with private sector

Inculcating PPP behavior among the public sector staff and training them on how to deal with private sector is important.

Role of an interface agency

Indian Medical Association, in the current context, will be a mutually acceptable interface for TB control in the state. The role of IMA will be to bring in two sectors together and to involve in “difficult-to-solve” issues.

Sustaining partnerships: This demands a lot of advocacy, flexibility, simplified recording and reporting system, provision of technical assistance, and so on. Short-term results of such ventures with heavy inputs may be very promising and encouraging.

Quality control: Through a participatory body would be appropriate.

Monitoring and evaluation of public–private partnerships

Local branches of medical associations (IMA, IAP, and QPMPA) should be involved in the appraisal of PPPs, and prominent

members should undertake monitoring of PPPs in adjoining areas by mutual consent.

Discussion

There is much strength within the private sector, which offers several opportunities to RNTCP to tap for improving accessibility and acceptability. They need to be included in public policy, which at present largely ignores their presence. Despite the fact that RNTCP has taken so many initiatives to upscale the engagement of PPs, their participation has been not up to expectations. Thus, this calls for a strategic approach to address the barriers and gaps.

This study tried to explore the perception of all stakeholders in identifying barriers for private sector engagement in signed schemes of RNTCP in Kerala. It has been felt that there was a very low degree of “willingness” among both sectors to enter into any formal relationship. This, in turn, perhaps reveals a low degree of confidence in each other’s ability to comply with conditions required in such contracts. However, entire private sector is willing for TB control in the state and that need to be used optimally. Many of the issues emerging from the FGDs have been documented previously also.^[7,8] The joint monitoring mission conducted in 2009 and 2012 have shown that delays and nonpayment of reimbursements for the implementation of schemes prompted private practitioners to stay away from signing any new schemes. In addition, only 4% of the state’s allocation is for PPM, and out of this only one-third is being actually spent.^[9,10]

The Standards for TB Care in India has been developed by a collaborative effort of Government of India Central TB Division and WHO country office for India as a way to engage with the Indian private sector for effective TB prevention and control.^[11] TB management in the private sector of Kerala seems to follow reasonable standards of care. A published study reports that in two major cities of Kerala, 94% of the 124 participated TB practitioners prescribed a complete four-drug regime (HREZ) for a minimum of 6 months to treat drug-sensitive TB.^[12]

Conventionally, public health programs elaborate on private sector engagement and PPPs. Models thus developed were mostly incentive-based engagement or business purchase models with huge financial implications. Reasons for poor public-private partnerships vary from lack of mutual trust between sectors to poor consideration of market forces. The key reasons behind the success of several partnerships are the clear understanding and delineation of the roles, responsibilities, and accountabilities of both public and private sectors on the basis of skills and expertise of each stakeholder. There are evidences to suggest that instead of a centrally administered uniform model, services may be decentralized to develop locally appropriate models of partnerships with PPs. More than that, it needs to be understood that personal relations are the best key to PPP.

Strategies have to be formulated to customize partnership for private sector doctors using flexibilities of the program.

Sensitizing the government sector staff on the need of PPP and how to deal with private sector would be helpful. Emphasis needs to be given for building local partnerships. Nonfinancial incentives also need to be promoted along with financial incentives. A mechanism for feedback to private doctors has to be developed. The key word needs to be shifted from RNTCP to TB control. Strengthening PPP will be possible in the presence of strong administrative will and the understanding that personal relationships are the best key to PPPs.

There is an air of optimism surrounding PPPs in Kerala. Used judiciously and fitted to local circumstances, they clearly have the potential to drastically change the TB-related healthcare landscape in Kerala. PPPs will survive only if the interests of all stakeholders are taken into account. This means detailing specific roles, rights, and responsibilities, establishing clear standards, providing training for public sector managers, active dissemination of information, and constantly refining the process to make the system more efficient. The public sector has to lead by example and be willing to redefine itself and work with the private sector. The latter must in turn be willing to work with the public sector to improve mutual cooperation and understanding. It is critical that the driving principles for such initiatives be rooted in “benefit to the society” rather than “mutual benefit to the partners” and should center on the concept of equity in health. They should complement and not duplicate state initiatives and should be optimally integrated with national health systems without any conflict of interest. Development of a PPP in itself should not be seen as an outcome, but a process and an output; it is important for partnerships not to just exist in form but to contribute to improvements in health outcomes.

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