



Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives

*A working meeting co-convened by USAID and the World Bank, in collaboration with
the Stop TB Partnership's PPM subgroup, and organized with PATH*

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Meeting Report

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This report was written by Katherine West Slevin and Anna Forbes (independent consultants) and William Wells (USAID) based on the presentations and discussions held during the meeting. Thanks are due to all participants for their ideas and inputs.

Abbreviations

BMGF	Bill & Melinda Gates Foundation
BRICS	Brazil, Russia, India, China and South Africa
CHW	Community health worker
COPD	Chronic obstructive pulmonary disease
DOT	Directly observed therapy
IDA	International Development Association
IPAQT	The Initiative for Promoting Affordable and Quality TB Tests
IRD	Interactive Research and Development
MDR-TB	Multidrug-resistant tuberculosis
MSI	Marie Stopes International
NGO	Non-governmental organization
NTP	National Tuberculosis Program
PPIA	Private Provider Interface Agency
PPM	Public Private Mix
PSI	Population Services International
RBF	Results-based financing
SPH	Sun Primary Health
SQH	Sun Quality Health
TB	Tuberculosis
UHC	Universal health coverage
USAID	United States Agency for International Development
WHO	World Health Organization

Outcomes in brief

Meeting Goal: To improve the sustainability of private sector engagement in tuberculosis (TB) control by bringing together innovations in service delivery models and financing

- TB is concentrated in lower income populations; its control is a public good that requires financing. A range of strategies are needed to finance various context-specific public private mix (PPM) models in TB, and new mechanisms represent a significant opportunity. Sustainability of such financing relies in part on the incorporation of TB and PPM into domestic health financing streams. Currently, the predominant source of financing for PPM is input-based domestic and donor financing, but countries are increasingly exploring output or results-based financing (RBF) and financing via health insurance agencies. Social protection programs can also supplement with patient enablers. Some TB services and financing streams are better matched (e.g., direct medical services may be covered by insurance payments) but this leaves community activities to core government budgets. As such, the field needs a range of tools and schemes that can be adapted to produce the optimal PPM for each country's context. Whatever mix of financing is used, pooling of the financial resources is a critical step to reduce complexity and standardize service packages.
- A variety of entities and mechanisms can organize providers and enforce quality control. Existing PPM achievements have used the dual concepts of the National Tuberculosis Program (NTP) as steward of health standards and quality, and an intermediary as an organizing force for individual private providers. These concepts of standards and an organizing entity remain intact, but there are an increasing number of ways to implement them. Standards and quality can be strengthened by linking to accreditation and reimbursement schemes (e.g., when TB is covered by a national health insurance scheme), or by demanding certain outputs under RBF. The organizing of providers (and further quality control) can be mediated by social businesses, social franchises, and organizations that change business incentives by altering market dynamics.
- Within PPM schemes, there is an increasing need to integrate health services, both for efficiency and cost savings. Linking TB programs with high volume and/or high-income generating health services can help to improve access to care, expand TB control efforts and cross-subsidize TB care.
- The use of incentives and enablers should be considered to encourage participation in PPM. For this strategy to be effective, the field will need more information about provider microeconomics and motivations to design verifiable and reliable incentive systems.

It is now up to countries to explore how TB can take advantage of the various PPM expansion possibilities in areas such as insurance schemes, results-based financing, and the support of innovative PPM schemes – notably schemes that introduce (i) integration with other health services; (ii) new technologies; and (iii) a business-based logic. Effective engagement of the private sector requires TB control programs to look outwards – not only to other healthcare providers, but also to experts in healthcare financing, market dynamics, business planning, and other areas that are essential for a new generation of PPM work.

Introduction: The PPM concept

Tuberculosis (TB) prevalence and mortality rates have declined in recent years,¹ but an estimated 3 million cases a year still go undetected and/or unreported² and delays in the diagnosis and treatment of TB continue to be widespread. Many of these missing cases are likely to be in the private sector.

The majority of clients seeking any kind of healthcare—half in sub-Saharan Africa; two thirds in South East Asia; and four fifths in South Asia—do so in the private sector.³ This finding holds regardless of socioeconomic status, and prevalence surveys show that similar health seeking behavior applies for TB symptomatics (patients presenting with TB symptoms). Half or more clients in many countries first seek care from private health providers, who seldom report cases to the National Tuberculosis Programme (NTP).⁴ TB-associated stigma further deters many from seeking care in the exposed public sector.

In many high TB burden countries, however, the quality of TB care in the private sector is low and largely unregulated. Private providers often lack adequate training in TB screening, diagnosis and care and this results in delivery of fragmented, incomplete, and sometimes inappropriate treatment. In addition to adding risk and unnecessary cost to individual patients (most of whom are poor), this system causes delays and interruptions in TB diagnosis and treatment, fueling increased transmission and the emergence of drug-resistant strains of TB. Multidrug-resistant tuberculosis (MDR-TB) requires costly second line treatments that put increased strain on already fragile health systems.

The public health sector, when properly trained and resourced, can perform better in TB control than the private sector.⁵ Even if public services were improved and stigma were reduced so that consumers no longer avoided public facilities, however, the growing economies of low- and middle-income countries inevitably leave sizable gaps between the public demand for health services and service coverage. Private sector involvement is a proven strategy for bridging that gap. It recognizes the reality that a majority of potential TB clients are currently seeking care in the private sector.

Public Private Mix (PPM) models—those that use private resources to help accomplish public objectives –work by establishing partnerships between the public and private health systems that are financially sustainable and capable of providing high quality programs to support overall public health needs including TB control.

PPM models for TB have been established for well over a decade, and have resulted in a growing contribution of private sector engagement to reported TB cases – up to 10-40% of notifications in a number of high burden countries.⁶ Under PPM, the private sector provides either early and complete referral, or early and accurate diagnosis, for TB symptomatics. If

¹ World Health Organization. (2013). *Global Tuberculosis Report 2013*. Geneva: World Health Organization.

² World Health Organization. (2013). *Global Tuberculosis Report 2013*. Geneva: World Health Organization.

³ Private Healthcare in Developing Countries. (2008). *Private Healthcare in Developing Countries*. Retrieved from <http://www.ps4h.org/globalhealthdata.html>.

⁴ Pablos-Mendez, A. (2014, May). *Leveraging the economic transition in health to improve private and public sector TB care*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, DC.

⁵ Pai, M. (2014, May). *Quality of TB care in the Indian private sector: the challenge ahead*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, DC.

⁶ World Health Organization. (2013). *Global Tuberculosis Report 2013*. Geneva: World Health Organization.

the scheme includes private sector treatment, this should be done with quality-assured TB drugs, an evidence-based regimen, and supervision to ensure a full treatment course.

However, the challenges for TB PPM include: the diversity of provider types, most with no system for tracing patients during long regimens; the multitude of fragmented providers, which creates administrative challenges for quality assurance, payments, drug distribution, and reporting; and the lack of interest by providers (who may see TB patients rarely) in complex TB-only schemes.⁷ National coverage by these models has often proven elusive, and the field is searching for strategies that would align with changing health systems.

This meeting sought to explore strategies for expanding and improving the quality of early TB detection, diagnosis and treatment of TB in high TB burden countries, with a focus on the private sector opportunities and the potential to take advantage of additional modes of financing.^{8,9} The ambitious post-2015 goals for TB elimination makes the search for sustainable models for TB control particularly pressing.¹⁰ With so many of the missing 3 million cases likely being in the private sector, an important component of the new strategy involves the expansion of public and private sector engagement through PPM models. PPM in TB features important contributions from both public-public and public-private collaborations, but the participants in this meeting concentrated on contributions from the provider type that is the most numerous and therefore the most challenging to engage: the individual private provider.

Objectives and structure of the meeting

Improvements in public sector service delivery alone will not be sufficient to achieve the post-2015 goals of a 95% reduction in TB deaths and a 90% reduction in TB incidence rates by 2035. Scalable and sustainable PPM models will be a critical contributor. Achieving these goals in a rapidly evolving funding environment also raises the pressing need to adapt TB control and PPM models to new financial flows. To learn more about these opportunities and challenges, a three-day working meeting was co-convened in May 2014 by the United States Agency for International Development (USAID) and the World Bank, in collaboration with the Stop TB Partnership's subgroup on PPM, and organized with PATH (*see original concept note, Annex A, and meeting agenda, Annex B*).

The meeting brought together TB, health financing and public-private partnership experts to identify the essential elements for the sustainability, growth and future relevance of PPM efforts. The goal was to improve the sustainability of private sector engagement in TB control by bringing together innovations in service delivery models and financing. Specifically, participants explored the following aspects of PPM efforts:

- Practical financing and incentive streams for activities that go to scale.
- Administrative structures including regulation, monitoring, and the enhanced capacity required within the public sector.

⁷ Wells, W. (2014, May). *Meeting theme: Programmatic opportunities*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, DC.

⁸ Chawla, M. *Using financing mechanisms to reach the poor and improve health outcomes*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

⁹ Meiro-Lorenzo, M. *Meeting theme: financing opportunities*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

¹⁰ Uplekar, M. *PPM in the Post-2015 TB Strategy*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

- The optimal package of interventions for sustainability.
- Incentivizing providers and consumers.
- How to identify and reach poor patients, particularly in urban areas.

This report outlines the key themes and essential elements that emerged and identifies specific areas requiring further examination.

Key themes

The three-day meeting brought together over 75 participants from donor, government, normative, non-governmental and implementing agencies (*see Annex C*) to discuss the design of PPM models for TB control. Participants identified a number of essential elements of successful and sustainable PPM models, as well as knowledge gaps and next steps.

Throughout the course of the meeting, four key themes emerged. These involved:

- Employing a range of strategies to finance various context-specific PPM models.
- Using a variety of entities and mechanisms to organize providers and enforce quality control.
- Linking TB with other health services to cross-subsidize TB control efforts and expand program reach.
- Using incentives and enablers to engage private providers and encourage patient and provider participation in TB case detection, diagnosis and treatment.

Employing a range of strategies to finance various context-specific PPM models

Rationale

A number of mechanisms exist for the financing of PPM models, and certain types of financing are better at achieving certain outcomes. TB control programs will need to assess these options and employ a combination of models and financing mechanisms to succeed. This assessment will provide NTP managers with a toolbox on which they can draw to develop appropriate and effective TB initiatives.

The sources of financing are changing. After a period of large increases in official development assistance, the most obvious trend more recently has been the sustained economic growth in many low income countries, and the graduation of many countries from low income to middle income status.¹¹ Much of the world's TB remains in these graduating countries – 46% of incident TB is in the BRICS (Brazil, Russia, India, China, and South Africa) alone – so it is an urgent task to understand how these increased domestic resources can be directed toward TB control, including PPM. An analysis of future financing trends in Indonesia provides one example of the possible phasing out of donor funds, and the increasing importance of national health insurance, and national, provincial and district government funds.¹²

¹¹ Pablos-Mendez, A. (2014, May). *Leveraging the economic transition in health to improve private and public sector TB care*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

¹² Collins, D. (2014, May). *Where and when will TB start relying more on social insurance? The case of Indonesia*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

Domestic financing brings the promise of increased sustainability. Although some private sector models may strive for self-sufficiency, TB programs will continue to need governmental involvement, oversight and investment, so the “public” part of PPM will continue to be critically important. Movement toward sustainability does not remove this need but, rather, may facilitate a better balance between the role that government can and is best suited to play and the extent to which private sector involvement can contribute to maintenance of a strong and sustainable TB response.

Potential models

Financing for PPM initiatives typically comes, or could come, from one or more of the following sources:¹³

- 1) Government budget, paying for inputs
- 2) Donor financing of inputs
- 3) Government budget, paying for outputs
- 4) Donor financing of outputs
- 5) National health insurance (administered by national insurance agency)
- 6) Government social protection (administered by the Department of Social Welfare)
- 7) Private health insurance
- 8) Out-of-pocket, including fees paid at a social business or franchise outlet
- 9) Charitable organization and CSR

An assortment of these financing sources can be combined to achieve the goal of universal health coverage (UHC)—the idea that all people should have access to affordable health services—including the financing of PPM. Each financing source has its own advantages and challenges, some of which are summarized below.

Government financing of inputs

In some countries, governments directly finance the public sector to implement PPM schemes.

Advantages

Government funding can be more predictable and reliable than other funding streams. It also brings with it the advantage of local ownership; the authority to regulate and enforce program requirements and quality assurance; and the ability to scale up and sustain programs. It establishes the public sector as not only a provider of services, but as the steward of services provided by the private sector. Finally, willingness for government to take on PPM has been increased by the results seen to date with PPM.

Challenges

The use of government financing can raise issues with regard to governance, and delays in funding and reimbursement. Government funds also tend to have more rigid requirements attached than many other funding mechanisms, making them less suitable for some necessary program inputs. Government bureaucracies may be unsympathetic to private providers, which may translate into a reluctance to: (i) establish and fund PPM schemes in the first place; and (ii) establish payment schemes that minimize paperwork

¹³ Financing break-out group. (2014, May). *Financing Provider: What mechanisms exist and which are most practical*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

and ensure that private providers receive a fair income.

Donor financing of inputs

Donors are currently supporting many PPM models.

Advantages

Donor financing has helped to establish the concept of PPM, and demonstrated that PPM is a viable method for finding significant numbers of TB cases. Donor funds have the advantage of greater flexibility and are ideal for testing new, innovative models.

Challenges

Shifts in the donor landscape and the enforced reduction of dependency on donor funds in many countries make this the least sustainable financing source in the long term. In addition, differences between donor and country/local priorities can pose challenges and threaten the relevance of programs.

Government or donor financing of outputs: Results-based financing

Both government and donor financing can be structured as results-based financing (RBF). As defined by the World Bank, RBF refers to “a cash payment or nonmonetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified.”¹⁴ RBF is an umbrella term that can reward countries, organizations, providers or clients. Also commonly referred to as pay-for-performance or pay-for-results, RBF can take many forms:

- Cash on delivery model where money is directed to government budgets for specific outcomes.
- Pay for performance schemes for community health workers (CHWs) (e.g., workers are given a set amount per client initiated and/or per client completing directly observed therapy (DOT)).
- Provider recognition programs.
- Contract-based financing to non-governmental organizations (NGOs) based on program deliverables.
- Conditional cash transfers to individuals for specific outcomes.

Currently the World Bank is supporting RBF models in 38 country pilot grants; co-financing with the International Development Association (IDA) brings the value of these efforts to ~\$2.5 billion.

Advantages

RBF has proven effective in other health sectors. For PPM, its main advantages are the focus on results (what the private sector is responsible for delivering) and flexibility. Although the private sector would have to adhere to certain quality and treatment standards, the exact organizational model that it uses to achieve the results should be up to the private sector partner. This focus on results rather than inputs is being tried in

¹⁴ Nair, D. (2014, May). *Strengthening Health System Performance & TB Care with Results Based Financing*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

Mumbai by the Bill & Melinda Gates Foundation (BMGF), which is financing PATH to achieve defined results with the Private Provider Interface Agency (PPIA).¹⁵ The hope is that the financing of successful PPM models, including PPIA and the social franchising and social business models described below, could be transitioned from donors to governments. RBF would be a natural financing mechanism to use in this transition.

Challenges

RBF faces two challenges. First, the whole system relies on results verification. This can be sustained by a standard monitoring and supervision system, but only if this system is highly functional and trusted. Otherwise, expensive sampling and cross-checking by a third party is required.

Second, RBF requires mechanisms to ensure that the flow of funds to recipients is timely (to keep recipients motivated) and transparent. Meeting participants agreed that most governments would find RBF an acceptable model but that its successful implementation requires significant upfront capital investment and political will.

National health insurance

National health insurance schemes are being introduced into many countries as their economies grow. Some of these schemes focus first on covering catastrophic expenses such as hospitalization, but countries such as the Philippines¹⁶ and Indonesia¹⁷ are including outpatient TB services in their insurance packages.

Advantages

Among the various financing mechanisms explored, national health insurance has the potential to cover the greatest number of people and services. The covered services can include not only TB treatment, but also TB diagnosis, thus removing a major source of out-of-pocket payments for the current clients in the public and private sectors. National health insurance also offers the promise of bringing what are now opposing and diverse dichotomies of health financing and purchasing (e.g., vertical vs. horizontal health programming) under one roof—leading to a more efficient and equitable system. Finally, there is the possibility of improved quality control, e.g., using credentialing as a condition for payment.

Challenges

Although many invoke national health insurance as the ultimate solution, the reality is that complete coverage by these schemes are still several years away in most countries. Early experiences have also highlighted the challenges inherent in layering a new financing scheme on top of an already complex health system. The Philippines is finding that recalibration of payments is necessary to get the right incentives to the right

¹⁵ Vijayan, S. (2014, May). *Private Provider Interface Agency, Mumbai—plans and strategies*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

¹⁶ Fabella, R.A.M. (2014, May). *Maximizing Universal Health Care for TB Control in the Philippines*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

¹⁷ Hafidz, F. (2014, May). *Integrating into UHC in Indonesia*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

providers and clients, and enrolment and accreditation must be less complex to boost participation.¹⁸ Without such fine-tuning, the desired recruitment of private providers to these schemes is unlikely.

Insurance schemes are custom-built to reimburse for medical services, but this leaves out other critical TB services (such as community case-finding, and surveillance). A public health department with a line-item budget will likely still be needed to undertake such work.

Social protection schemes

Social protection programs address a range of social risks (e.g., poverty and unemployment).¹⁹ These policies often target the lowest quintile in a population—where TB is more prevalent. Social protection schemes have been used extensively in Latin America and the Caribbean.²⁰ These models require active government involvement and a highly knowledgeable local implementer. They include the use of conditional cash transfers or other forms of subsidies.

Advantages

The TB community has not historically employed social protection as a model for TB control, but linking social protection schemes with TB initiatives could help to expand program reach substantially. Social protection schemes offer a number of tools (such as poverty maps) and lessons on how to successfully identify and track financially vulnerable patients.

Social protection schemes could potentially be leveraged to support expanded outreach for case finding and influencing behavior change. One potential opportunity for increasing case detection, for example, is to offer TB screening when clients come to collect monthly subsidies. Linking TB initiatives with social protection schemes can also help to finance enablers: patients could be provided with nutritious food or with money for transport.

Challenges

In most countries, TB is not currently included as a conditionality for receiving subsidies, so linking successfully with these programs may require significant coordination and effort on the part of TB program implementers. It will be necessary, for example, to ensure that those working in social protection programs have proper training to include TB and/or to refer clients to appropriate TB services. There is a risk of overburdening these social workers with health responsibilities.

Out-of-pocket, including fees paid at a social business or franchise outlet

In low income settings, out-of-pocket payments are the most common financing mechanism for healthcare. Some social business or franchise models (see next section) charge out-of-pocket fees for some services, while other services are free of charge.

¹⁸ Fabella, R.A.M. (2014, May). *Maximizing Universal Health Care for TB Control in the Philippines*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

¹⁹ Murrugarra, E., Silva, V. and Zumaeta, M. (2014, May). *Influencing Client behaviors: the role of social protection programs*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

²⁰ Murrugarra, E., Silva, V. and Zumaeta, M. (2014, May). *Influencing Client behaviors: the role of social protection programs*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

Advantages

Fees from clients can help to support, at least partially, the running costs of a franchise or social business.

Challenges

Out-of-pocket payments are the most regressive form of health financing. Ideally, social businesses and social franchises would be financed by payments through health insurance, RBF, or other mechanisms.

The three essential health financing functions are revenue collection, pooling of revenue streams, and purchasing services.²¹ Pooling (i.e., directing various types of public and private funding streams into one collective pool) is particularly important. Most program managers already rely on multiple funding streams, pieced together, to support their full package of services. The pooling of revenue streams would simply generalize this process—so that it occurred at a systemic level rather than at the program manager level. Pooling leads to better purchasing, with the potential for a more unified and coordinated benefits package and incentives system for public and private providers.

A government's general revenue health budget can be cumbersome to work with. But in a growing economy it typically comprises the largest and least regressive funding stream entering the health financing pool, making it a key component in this scenario. Merging it with private resources, and using that combined pool for budgeting, allocation and management purposes, could result in a framework that—rather than only funding programs—focuses primarily on paying for services for people. Public and private providers could both be paid for outcome-based client services. In such a system, many of the civil service salaries would be removed from the civil service budget and put into the pooled health budget, resulting in leverage with regard to performance and productivity that does not exist in systems that have separate public and private funding streams.

The concept of pooling at this level constitutes a paradigm shift and the path “from here to there” may be difficult to envision. But it may also be integral to achievement of the vision of UHC. Achieving the goals of UHC will clearly require some massive shifts in national health care financing frameworks. Pooling may be one of the tools that makes such a shift possible.

Knowledge gaps

We know that some financing streams are better adapted than others to funding various services. For example, health insurance payments are better at paying for direct medical services, whereas government line budgets are better at paying for community-based preventive services.²² But more thinking is needed around how different funding streams and financial mechanisms can work together to fund pieces of an overall TB strategy harmoniously. For each country, further investigation is needed to analyze the models and funding mechanisms currently in use and the advantages, challenges and the potential

²¹ O'Dougherty, S. (2014, May). *Health Financing and UHC Relationship and How It Can Help Link Private Healthcare Providers to the Broader Health System*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

²² Hafidz, F. (2014, May). *Integrating into UHC in Indonesia*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

scalability and sustainability of each (while considering projections for future sources of health financing). Government procurement systems may need streamlining or adjustment to adapt to results-based financing and contracting. Finally, health financing lessons from outside of the TB field may provide important insights for the future direction of engaging the private sector in TB control.

Using a variety of entities and mechanisms to organize providers and enforce quality control

Rationale

In the original conception of PPM, there were two critical actors above the private providers. The NTP acted as a steward for diagnostic and treatment standards, and an intermediary organization translated those standards to the multiplicity of different private providers. Although the types of delivery models have proliferated, the basic requirements for these two components—a steward of technical standards, and an organization that consolidates providers—remain.

Quality concerns in private sector TB diagnosis and treatment have been well documented. The use of inappropriate diagnostics and variable, non-recommended regimens are both common. So the need to stress quality issues in PPM is clear. Indeed, this drive for quality and greater organization in the health sector is a central theme more broadly in health systems strengthening, so TB has the opportunity to lead the way for other health areas.

Consolidating individual private providers—either into formal organizations or into more informal networks with shared quality standards—could bring efficiency gains, improved service standards and quality of care, strengthened referral systems, more positive client experiences and, thus, higher rates of care seeking and retention in care. Models that accomplish some or all of these tasks successfully, and do this while preserving provider autonomy and treating clients holistically (rather than treating individual symptoms), may have the greatest effect on the success of TB control initiatives and health systems overall.

Health system regulations—and their enforcement—may also need to be revisited. A lack of regulations (or a lack of enforcement) can result in the provision of services at a standard that is the lowest common denominator. Ideally, however, regulations allow the public sector to act as a steward of the entire health system, while supporting innovations that promote responsible medical practices.

Potential models

Traditional PPM models have contributed significant case finding, and targets in some countries have been increasingly ambitious.²³ Given the past challenges of transitioning from pilots to scaled-up PPM activities, however, the meeting participants also examined other models.

The **PPIA** model in Mumbai will maintain the essential principles of PPM in its programmatic design. In its financing, however, there are important differences. It uses

²³ Qadeer, E. and Rutta, E. (2014, May). *Setting Targets for Private Retail Pharmacies Engagement in TB in Pakistan*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

vouchers to target services, and emphasizes service packages and targets that would be a natural fit for future RBF by the public sector.²⁴

Social franchising “works by creating a highly visible network of health care providers that are contractually obligated to deliver specified services in accordance with franchise standards under a common brand. Through training and ongoing monitoring, social franchising ensures that these standards are upheld and that services reach populations most in need”.²⁵ Aimed at improving the quality of care as well as the client experience, social franchises typically offer a range of services to clients while providing their franchisees with branding, quality training, supervision and lower priced commodities in exchange for meeting franchise-wide quality standards.

Franchises can be created by public or private sector entities. Private health care franchising was initiated by family planning providers (primarily the International Planned Parenthood Federation and Marie Stopes International (MSI)) at a time when provision of family planning services was highly controversial and public access to such services was scarce in low-income countries. Instead of creating new networks, most social franchisers use a fractional franchise model in which existing providers are identified and recruited into a branded franchise network with the aim of coordinating and improving care.

Currently, Population Services International (PSI) and MSI are the largest implementers of social franchises in developing countries. Growing out of family planning and reproductive health, this model is now expanding to include other health areas including TB. In Myanmar, for example, PSI’s successful fractional franchise, Sun Quality Health (SQH), is successfully expanding TB screening, diagnosis and treatment (see next section).

The **advantages** of this model are that patients are already seeking care from private providers. Using a franchise model allows for the training, supervision and regulation of this sector of private health care. Franchisees (the providers enrolled in a franchise) are required to meet quality standards to retain their membership.

Franchisees, in return, are offered a number of incentives including lower-priced commodities, training, branding and a higher volume of patients—elements that help them to grow their business. Patients benefit by receiving a specific, monitored standard of care, an advantage difficult to come by in the private sector.

Social franchising can strengthen the individual provider but also change norms across the sector on how an adequate level of service delivery is defined and maintained. The emphasis on quality packages of care makes it a good fit for support by RBF.

The **challenges** of social franchising are that it is labor intensive and requires substantial support to franchisees in the form of supplies, job aids, reporting and referral systems, and monitoring and evaluation systems. Franchisors supply their franchisees with training, materials and regular evaluation (in the form of accreditation) to ensure their ability to deliver high quality services. To support these activities, franchisors require money, which

²⁴ Vijayan, S. (2014, May). *Private Provider Interface Agency, Mumbai—plans and strategies*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

²⁵ Cook, M. (2014, May). *The Future of Social Franchising: Achieving Quality and Scale in TB*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

currently comes primarily from donors. In the future, more sustainable sources for franchisors would be domestic health financing (e.g., through RBF) and franchise fees paid by the franchisees.²⁶

Convincing providers to participate in social franchising can be challenging. This challenge is further increased with regard to TB because it may generate little or no income. Lastly, questions remain around the sustainability of this model with regard to TB. The evidence for its sustainability largely comes from family planning, which is focused on driving normative behavior change at the population level.

Under a **social business model**, high-quality, low-cost services are sold in order to finance social objectives. Because the model generates its own revenue, social businesses have the potential to become self-sustaining.

Interactive Research and Development (IRD)'s project is a classic example of a social business model.²⁷ IRD's TB Reach projects in Pakistan, Indonesia and Bangladesh are funded in part by the fee-based diagnostic and treatment services for diabetes, anemia, blood pressure, and lung health (including TB) marketed by IRD. The project uses a number of creative strategies, including the use of performance-based incentives, to stimulate business.

The **advantages** of social business models include integration (see next section) and potential sustainability.^{28, 29} Social business models that provide care in multiple health areas may be more approachable by people reluctant to seek TB screening and care because of TB-related stigma. These models can also reach a more diverse range of clients and facilitate rapid increases in TB screening and case finding. While an initial investment of capital is necessary, social business models have an inherent potential to become self-sustaining, particularly with the cross-subsidization between disease areas.

Among the various **challenges**, social businesses require substantial capital investment. Integrating multi-disease care has been shown to generate additional revenue and expand program reach, but IRD has also required significant investment from TB REACH and UNITAID. The current income from clients covers rent and utilities, and the amount of income is expanding. But, for now, donor financing is needed for salaries, equipment, and commodities, including digital x-ray machines, and GeneXpert machines and cartridges.³⁰

Perhaps the steepest challenge in using a social business model is its reliance on fee-for-service care. Providing high quality services at affordable, often subsidized, prices can be more attractive to clients than free services, but most people with symptomatic TB are poor

²⁶ Cook, M. (2014, May). *The Future of Social Franchising: Achieving Quality and Scale in TB*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C..

²⁷ Khan, A. (2014, May). *Social business models for scaling Xpert MTB/IRF: challenges in expanding to additional countries*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

²⁸ Farrell, M. (2014, May). *Social Franchising: Issues of Sustainability*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

²⁹ Cook, M. (2014, May). *The Future of Social Franchising: Achieving Quality and Scale in TB*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

³⁰ Khan, A. (2014, May). *Social business models for scaling Xpert MTB/IRF: challenges in expanding to additional countries*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

and may not have the ability to pay even a nominal fee. There may be opportunities in the future, however, to tap into more sustainable financing sources such as health insurance payments.

In addition to these service delivery models, the **financing schemes** from the previous section also offer opportunities to improve quality and demand higher standards. The achievement of quality standards can be a condition for disbursement of both RBF and health insurance payments. For example, an accreditation scheme that includes TB is being built into the Indonesian national health insurance scheme.³¹

Knowledge gaps

Training and education, supervision, monitoring and regular evaluation are primary elements in many PPM models. Each element has the ability to help improve the quality of care at individual facilities, but they cost money. More comparative research is needed to understand which of these models produce the greatest impact and cost effectiveness. To establish long-term financial support, each model will need to assess and access the various financing streams outlined in the previous section.

Linking TB with other health services to cross-subsidize TB control efforts and expand program reach

Rationale

Several arguments suggest that integration of TB with other health services will be particularly important for PPM initiatives. First, PPM features prominently at the first step of TB control—the point of health seeking by individuals with non-specific symptoms—and thus is operating in a general, not specialist, healthcare environment. Hence there are many opportunities to include other health conditions that are being treated in the same facility. Second, even in a high TB burden environment, TB is a relatively rare diagnosis. A PPM scheme will therefore be more attractive and cost-effective if it includes multiple disease areas. This rationale is only getting stronger as TB incidence decreases and increasingly TB is being taken up by the general health system, rather than solely by NTPs. Third, TB is a disease of the poor, with a lengthy treatment, and any private sector TB services will likely need to be cross-subsidized by services where higher fees can be charged.

Linking TB programs with those that target diabetes, asthma, chronic obstructive pulmonary disease (COPD), anemia, HIV and/or malaria, for example, can help to identify a greater number of TB cases—particularly among those who would otherwise not seek care due to TB-specific stigma. It allows PPM efforts to benefit from infrastructure already established by other sectors and programs.

Potential models

In Myanmar, the SQH social franchise established by PSI has gradually expanded to cover 61% of townships and 16% of private providers in the country.³² It has survived by

³¹ Hafidz, F. (2014, May). *Integrating into UHC in Indonesia*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

³² Zarni, S.O. (2014, May). *PSI/Myanmar TB control program Public Private Mix (PPM) Model: Service integration, incentives and sustainability*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

incorporating a growing array of health areas—after starting with a focus on reproductive health, it subsequently added HIV, sexually transmitted infections, pneumonia, and TB. TB represents only 1% of the SQH clients, and 0% of their franchise income, and thus the franchise is clearly reliant on the other health areas for survival. And yet the model contributes 15% of TB case finding nationally. An additional strength is the Sun Primary Health (SPH) network of midwives and community health workers, which was established in 2008. It acts as a feeder network for SQH, and is also based on the idea of responding to multiple health conditions.

The social business model established by IRD, initially in Pakistan, also provides TB care along with other health services. The initial focus was on symptom screeners in general practitioners' offices, but stand-alone clinics are now being added. Modest fees are charged for routine screenings, such as chest x-rays, HbA1c tests for diabetes, and desktop spirometry for COPD and asthma.

In different initiatives, the packages of interventions will vary. These choices reflect not only shared epidemiology (e.g., TB and diabetes), but also a shared skill set of providers, shared symptoms of client populations, shared accessibility of the necessary equipment and technology (i.e., start-up costs that are not too high), and a shared business logic in which services can cross-subsidize.

The private sector is becoming increasingly involved – and increasingly organized into larger entities – in the health economies of most countries. Corporate entities uninterested in addressing TB and other diseases of the poor will create for-profit care delivery systems focused on profitable conditions such as diabetes and COPD. This may reduce the opportunity to establish social businesses and other PPM approaches capable of cross-subsidizing TB care with the profits generated from the provision of care for conditions more common among affluent and middle class populations. There is therefore an opportunity to act now to establish social businesses, before these purely profit-driven businesses are dominant.

Knowledge gaps

For these new models of PPM delivery, business planning remains a gap. Business planning in this context requires not only an understanding of current expense and income streams, but reliable projections about how these yields might change over time as disease burdens, health-seeking behaviors, and health financing all change, and as these models aim to be self-sustaining.

Meeting participants identified four dimensions of sustainability for a PPM scheme:

- 1) What makes the scheme eligible for support from the government sector (allowing it to happen, supplying free TB drugs, etc.);
- 2) Financial and operational sustainability of the intermediary organization (including social businesses and social franchises) itself;
- 3) What makes it attractive for providers to participate; and
- 4) What is sustainable for patients in terms of fees and co-payments.

Analyses of PPM models, taking into account all four of these dimensions of sustainability, would provide a more complete picture when deciding on future expansion and, in particular, which non-TB services to include.

Using incentives and enablers to engage private providers and encourage patient and provider participation in TB case detection, diagnosis and treatment

Rationale

Perhaps the prime challenge to expanding TB control through the use of PPM models is determining how best to get both patients and providers to participate in schemes that insist on certain minimum standards, including case reporting and full treatment regimens.

Patients are often focused on symptomatic treatment rather than a proper diagnosis. As clients in the private sector, they may resist the attempts of private providers to refer for proper care. This challenge requires careful messaging at the community level, and accreditation and reimbursement schemes that reward private providers for the appropriate behavior.

The meeting featured a debate on whether “Moral persuasion and peer pressure, rather than financial incentives, should be the philosophy underlying private sector engagement in high TB prevalence countries.”³³ Those advocating for the use of non-financial incentives and enablers argued that:

- 1) Performance-based incentives have an uneven effect and may, in fact, worsen the quality of care for conditions or procedures not specifically addressed by the incentives.
- 2) Moral persuasion may be the only practical mechanism where financial systems are limited (e.g., Cambodia and Bangladesh private pharmacy PPM).
- 3) Once moral persuasion has reset behavior norms to a better standard of care, the change is self-sustaining.
- 4) TB prevalence is not high enough for TB-related incentives to really affect the bottom line of private providers.

Moral persuasion requires strong advocates at the local level.

The proponents of financial incentives stated that:

- 1) Private providers are medical professionals with a moral obligation to provide care, but they are also business owners who need to manage their time to effectively support and build their practices.
- 2) TB is not going to win out as “the most deserving of free labor.”
- 3) Private providers work in a market with competition. Low quality providers will always be able to price out high quality providers. Incentives are needed to bring the high quality providers to an equal footing.
- 4) The income levels of the doctors are very small. So financial incentives are critical to them, and there is a need to improve payment overall. If services are provided, there needs to be payment.
- 5) TB patients—the majority of whom are poor—require enablers that will ease barriers to accessing care.

The audience favored the latter arguments, but noted that the need for incentives is not equally strong for all provider types. Non-specialist doctors have few TB patients and would

³³ Hopewell, P., Asokan, R.V., O'Dougherty, S. and Yadav, P. (2014, May). *A PPM debate: Moral persuasion and peer pressure, rather than financial incentives, should be the philosophy underlying private sector engagement in high TB prevalence countries*. Conducted at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

rather have the kind of broad reputation boost potentially provided by a social franchise. Pharmacies are more focused on business margins and thus may be more in need of incentives to prompt action. Most in need of financial support are those—such as the symptom screeners in the IRD scheme—who spend all their time on TB schemes. Of course, any incentive system requires a lot of context-specific thinking about verification and monitoring.

Potential models

For patients, enablers are forms of assistance or support designed to alleviate barriers that patients may experience in accessing TB services. Some of these barriers include:

- The stigma associated with enrolling in TB programs and/or seeking TB care;
- The out-of-pocket cost of diagnostic tests and/or treatments;
- Barriers to enrolling in national and/or social insurance health schemes or other social protection programs;
- Barriers to adhering to and completing treatment (e.g., lack of transportation to and from clinics, food, compensation for time out of work, etc.).

These costs are not typically covered by insurance. Faith- or community-based organizations or other NGOs may provide the needed assistance (such as food, transportation, support groups, etc.), based on donor or government funding. Other enablers include: facilitating patient enrollment in national and/or social insurance schemes by offering point-of-service enrollment assistance; and linking TB patients with social protection programs that offer subsidies and/or other poverty prevention interventions. The linkage of private sector clients to these services was recognized as an area requiring greater attention.

For providers, financial incentives can provide encouragement to improve their knowledge of TB screening and treatment and maintain an active TB practice despite the fact that is not lucrative and may, in fact, not even pay for itself. Some PPM schemes compensate for this directly with “Pay for Performance” or RBF of TB care.

Additional, non-financial incentives for these programs may include:

- Providing awards, certifications and/or recognition to providers. For private providers, this kind of recognition could help to set them apart from other providers and increase their overall client base.
- Appealing to a provider’s social responsibility (i.e., the use of moral persuasion and peer pressure).
- Offering information, support, training/capacity building, networking and access to lower priced health commodities.

For example, when surveyed, providers participating in PSI’s social franchise model in Myanmar reported that training, access to lower cost drugs and tests, and a reputation boost leading to increased patient volumes were the primary reasons they participated in these programs.³⁴ In all cases, incentives will need to be tailored to their specific audiences and contexts in order to achieve the desired outcome.

³⁴ Zarni, S.O. (2014, May). *PSI/Myanmar TB control program Public Private Mix (PPM) Model: Service integration, incentives and sustainability*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

Rather than introducing new financial incentives, The Initiative for Promoting Affordable and Quality TB tests (IPAQT) is analyzing and then changing the existing financial incentives in the TB diagnostics market.³⁵ According to an IPAQT analysis, profit margins in India were steering providers towards serum-based TB diagnostics, even though these diagnostics had attracted a first-ever negative recommendation (i.e., that they should not be used) from the World Health Organization (WHO) Global TB Programme. IPAQT negotiated reduced wholesale prices for quality-assured TB diagnostics, and passed on those savings to private laboratories as long as they: (i) kept their retail prices below an agreed-upon maximum; and (ii) reported any resulting TB cases. This is a successful combination of market dynamics, business analysis and regulation in pursuit of a public health goal.

Knowledge gaps

There is general agreement that there is a role for incentives and enablers in changing behavior norms but a lack of clarity on what works or how to effectively monitor incentive programs. In order to optimize incentive-based interventions, the following knowledge gaps need to be addressed:

- What do providers need or want? The lack of published information on health microeconomics (most notably on the income sources and amounts for informal providers and chemists, and therefore what kinds of incentives might work for these target groups) constitutes a significant gap in current knowledge.
- What is the patient's pathway to care? A better understanding of this pathway, and the barriers and decision points along the pathway, will enable better design of PPM programs.
- What behavior changes are needed and why (i.e., why are providers not appropriately screening and treating for TB)? IPAQT provides one example of such an analysis, but more is needed for other provider types and other countries.
- Who will be responsible for paying for enablers?

Performance-based incentives (both financial and non-financial) are common in other disease areas, and the pharmaceutical industry has deep and potentially useful experience in disseminating information about new medical practices. Lessons from these and other efforts should be distilled to help inform future incentive-based initiatives for TB control.

Conclusions and next steps

Discussions from the three-day meeting highlighted a number of key components and considerations for successful engagement of the private sector in TB control initiatives. There was consensus that, in order to expand program reach and increase early TB case detection, it is necessary to recognize that a majority of TB symptomatics are currently seeking care initially in the private sector and that, for a variety of reasons, a significant percentage of TB cases are not detected and/or not reported.

Participants also agreed that no one-size-fits-all approach exists. A number of PPM models and funding mechanisms were explored, each with its own advantages and challenges. Success lies not in identifying which is the favored model, but rather in generating and gathering evidence regarding the effectiveness and utility of each, which healthcare

³⁵ Dabas, H. *IPAQT: Using business incentives to shape TB Diagnostics in India*. Presented at Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives, Washington, D.C.

environments favor each one, and how these models can work in concert to improve overall TB control. The field needs a range of tools and schemes that can be adapted to produce the optimal public-private mix for each country's contexts. This was highlighted during the country work, in which the country teams came up with very different proposals, but all drawing upon the technical areas presented earlier in the meeting. Using a mix of financing mechanisms and service delivery models not only allows for creative designs and expanded reach but also increases the sustainability of programs by diversifying their funding.

In an environment fraught with financing shifts, the question of how PPM models can reach scale and be sustained becomes an urgent one. Governments need to remain the stewards of countries' health systems but those systems have to be sustainable and to incentivize private sector participation. This is challenging given that TB service delivery should result in minimal out-of-pocket payments, based on the poverty of most TB patients. The use of incentives for providers and enablers for clients are important tools to reduce barriers to accessing, providing, and adhering to high quality care. PPM initiatives to date have shown that, used with skill and creativity, such incentives and enablers can improve the overall quality of care, expand case finding and treatment uptake, and thus, prove their cost effectiveness. Raising the overall standard of care and creating healthier behavior norms around care seeking and provision is a lasting benefit to a country.

Going forward, the various opportunities outlined during the meeting and in this report need to be explored and pursued at the country level. Each TB program will need an understanding of:

- What motivates and deters people from seeking care;
- Which incentive schemes will best motivate providers in private and public systems;
- The timelines and dynamics for projected changes in healthcare and TB financing, including the introduction and expansion of health insurance schemes;
- The cost-effectiveness and business plans of existing and potential PPM models—including which models and funding mechanisms are best suited for various aspects of TB control and which have the potential to reach scale and be sustained;
- How governments and intermediary organizations can best work together, including the more frequent use of results-based financing.

This information will allow countries to explore how TB can take advantage of the various PPM expansion possibilities in areas such as insurance schemes, results-based financing, and the support of innovative PPM schemes—notably schemes that introduce (i) integration with other health services; (ii) new technologies; and (iii) a business-based logic.

Effective engagement of the private sector requires TB control programs to look outwards—not only to other healthcare providers, but also to experts in healthcare financing, market dynamics, business planning, and other areas that are essential for a new generation of PPM work. Sustainability in the post-2015 era will necessarily be less about acquiring additional resources and more about using existing resources more efficiently, creatively and in ways that are optimally responsive to the real challenges and circumstances we face as we seek to finally achieve control over TB.

Annex A: Concept Note

Meeting Goal: Improve the sustainability of private sector engagement in TB control by bringing together innovations in service delivery models and financing.

Background: To achieve the post-2015 goals for tuberculosis (TB), passive case finding in the public sector will not be enough. Earlier detection and treatment of TB will be essential. In many countries, particularly in Asia, far more TB symptomatics initially seek care in the private sector than in the public sector. TB symptomatics and patients may eventually make it to National TB Programs (NTP) sanctioned sites, but by then too much transmission and resistance amplification occurs in the private sector.

Several major challenges for private sector treatment of TB include: i) patients and providers lack knowledge and incentives to provide effective diagnostics or to complete treatments; ii) fee structures in the private sector encourage incomplete therapy, as patients may not be able to finance the later months of their treatment; iii) lack of incentives and systems for the private sector to share information on patients, treatments and treatment outcomes with NTPs; and iv) private sector lacks capacity to support patients through treatment completion.

There have been multiple responses to these challenges, including public-private mix (PPM) collaborations and regulation, and each comes with positive and negative points. New approaches are needed to integrate TB detection and/or treatment as a sustainable activity for all providers while reaching the populations most in-need.

Countries are experimenting with social businesses and with the “contracting” of private and public providers to expand the provision of good quality care, including TB. Also, many countries have social protection programs for the poor. These are outside the health sector but have the capacity to identify and reach the poorest and incentivize patients. Colleagues working with results based-financing (RBF) and social protection (SP) programs at the World Bank have accumulated experience on incentivizing the poor, service providers and programs with implications for the private sector and NTPs for program design, monitoring, and results evaluation. ‘

Purpose: A three-day working meeting will address the issues posed above specifically for private sector engagement, including the optimal package of activities, identifying and reaching poor patients, increasing treatment compliance, financing incentive streams for activities that go to scale, and administrative structures including regulation, monitoring, and the enhanced capacity required within the public sector for this purpose. The meeting will be co-convened by USAID and the World Bank, and organized by PATH. The first two days of the meeting will include a broad group designed to generate ideas. The third day will involve “country tables” to focus on ways to operationalize those ideas in specific country contexts. Output from the meeting would include a document outlining essential elements for sustainability, growth and future relevance of PPM efforts (including social businesses) and the intersection with existing pro-poor programs in countries in the context of growing economies. Lessons from this meeting will be leveraged in a June meeting that will aim to direct Global Fund concept notes to include the relevant programmatic steps.

Annex B: Agenda

Public Private Mix (PPM) Models for the Sustainability of Successful TB Control Initiatives

A working meeting co-convened by USAID and the World Bank, in collaboration with the Stop TB Partnership's PPM subgroup, and organized with PATH

May 27-29, 2014

The Special Events Hill Center at the Old Navy Hospital
921 Pennsylvania Avenue SE, Washington DC, USA



Meeting goal: Improve the sustainability of private sector engagement in TB control by bringing together innovations in service delivery models and financing.

AGENDA

Start	Finish	Speaker	Topic
<u>TUESDAY, MAY 27TH</u>			
8AM	8.30AM	Registration and light breakfast	
Opening session: Context (Chair: Cheri Vincent)			
8.30	8.45	Ariel Pablos-Mendez, USAID	Leveraging the economic transition in health to improve private and public sector TB care
8.45	9.00	Mukesh Chawla, World Bank	Using financing mechanisms to reach the poor and improve health outcomes
9	9.15	William Wells, USAID	Meeting theme: programmatic gaps and opportunities
9.15	9.30	Montserrat Meiro-Lorenzo, World Bank	Meeting theme: financing opportunities
9.30	10.00	Minni Khetrapal, Municipal Corporation of Greater Mumbai	The challenge of urban TB, and approaches to integrating public and private sectors
10.00	10.30	Break	
Influencing provider behaviors: using results-based financing and health insurance			

payments (Chair: Mukund Uplekar)			
10.30	11.00	Dinesh Nair, World Bank	Can Results based financing (RBF) be used to strengthen health system performance including TB care?
11.00	11.10	Dinesh Nair and Monique Vledder, World Bank	Discussion on RBF
11.10	11.40	Sheila O'Dougherty and George Oommen (Abt)	Health Financing and UHC Relationship, and How It Can Help Link Private Healthcare Providers to the Broader Health System
11.40	11.50	David Collins (MSH)	Comment: Where and when will TB start relying more on social insurance?
11.50	12.10	Firdaus Hafidz, University of Gajah Madah	Integrating TB into UHC in Indonesia
12.10	12.30	Allan Fabella, IMPACT	Integrating TB into UHC in Philippines
12.30	1.00		Discussion on UHC
1.00	2.00	<i>Lunch</i>	
Influencing client behaviors: conditional cash transfers (Chair: Celine Garfin)			
2.00	2.40	Edmundo Murrugarra and Veronica Silva, World Bank	Panel: Social Protection perspectives on addressing health demands: challenges and lessons
2.40	2.50		Discussion on conditional cash transfers
2.50	3.20	<i>Break</i>	
Existing TB Models and their scalability (Chair: Knut Lonnroth)			
3.20	3.45	Aamir Khan, IRD	The IRD experience, and challenges in expanding to additional countries
3.45	4.10	Harkesh Dabas, CHAI	IPAQT: using business incentives
4.10	4.35	Shibu Vijayan, PATH India	PPIA Mumbai's plans and strategies
4.35	5.00	Saung Oo Zarni, PSI Myanmar	Service integration, incentives and sustainability of a TB program in existing social franchising in Myanmar
5.00	5.30		Discussion on TB models
WEDNESDAY, MAY 28TH			
Lessons from outside TB, and transitioning to group work (Chair: Joshua Obasanya)			

8.30	9.00	Light breakfast	
9.00	9.20	Maggie Farrell, USAID SHOPS	Social franchising: issues of sustainability
9.20	9.40	Marcie Cook, PSI	The future of social franchising
9.40	10.00		Discussion on social franchising
10	10.30	Break	
10.30	11.00	Madhu Pai, McGill	Quality of TB care in the Indian private sector: the challenge ahead
11	11.45	Persuasion: Phil Hopewell, UCSF; and RV Asokan, IMA Incentives: Sheila O'Dougherty, Abt; and Prashant Yadav, Uni Michigan	A PPM debate: Moral persuasion and peer pressure, rather than financial incentives, should be the philosophy underlying private sector engagement in high TB prevalence countries
11.45	12.00		Feedback from audience
12	12.15	Ejaz Qadeer, NTP Pakistan; and Edmund Rutta, MSH	Target setting in Pakistan
12.15	12.30	Mukund Uplekar, WHO	Post-2015 PPM: thinking ambitiously
12.30	1.15	Lunch	
Break-out groups			
1.15	1.30	William Wells, USAID	Summary of group work
		<u>Group moderators</u>	<u>Topics for break-out groups</u>
1.30	3	Marcie Cook, PSI	Determining the optimal package of interventions for sustainability
		Aamir Khan, IRD	Financing providers: what mechanisms exist and which are most practical?
		Suvanand Sahu, Stop TB Partnership	Incentivizing consumers: what payments are needed and when?
		Madhu Pai, McGill	Administrative structures, and regulation and monitoring
		Hideki Mori, World Bank	Access: mechanisms to target the urban poor
3	3.30	Break	
3.30	5:15	Report back	20 mins per group

<u>THURSDAY, MAY 29TH</u>			
8.30	9.00	Light breakfast	
Country break-out groups			
9	10.30	Celine Garfin	Philippines
		Joshua Obasanya	Nigeria
		Dyah Mustikawati	Indonesia
		Minni Khetrapal	India
		Ejaz Qadeer	Pakistan
10.30	11	Break	
11	12.40	Report back	20 mins per group
12.40	1	Closing comments	

Annex C: List of participants

Meeting Participants	Organization
Sheila O'Dougherty	Abt Associates
Oommen George	Abt Associates
Fran du Melle	American Thoracic Society (ATS)
Phil Hopewell	American Thoracic Society (ATS)
Peter Small	Bill & Melinda Gates Foundation
Minni Khetrapal	City TB Officer, Municipal Corporation of Greater Mumbai (MCGM), India
Amy Israel	Eli Lilly and Company MDR Partnership
Brett Maitland	Foreign Affairs, Trade and Development Canada
Whitney White	GBCHealth
Allan Fabella	IMPACT, Philippines
Dr. Narender Saini	Indian Medical Association (IMA)
R.V. Asokan	Indian Medical Association (IMA)
Aamir Khan	Interactive Research and Development (IRD)
Harkesh Dabas	IPAQT / CHAI
Madhu Pai	IPAQT / McGill University
Tara Ornstein	IUATLD
Mustapha Gidado	KNCV Nigeria
David Collins	Management Sciences for Health (MSH)
Edmund Rutta	Management Sciences for Health (MSH)
Olivia Oxlade	McGill University
Paul Schaper	Merck Pharmaceuticals
Celine Garfin	NTP manager, Philippines
Dyah Mustikawati	NTP manager, Indonesia
Joshua Obasanya	NTP manager, Nigeria
Alexandria Alberto	PATH
Fozo Alombo	PATH
Lal Sadasivan	PATH

Shibu Vijayan	PATH India / PPIA
Marcie Cook	Population Services International (PSI)
Petra Stankard	Population Services International (PSI)
Saung Oo Zarni	Population Services International (PSI) Myanmar
David Bryden	RESULTS
Christina Synowiec	Results for Development Institute (R4D)
Shan Soe-Lin	Results for Development Institute (R4D)
Suvanand Sahu	TB REACH /StopTB Partnership
Brenda Waning	UNITAID
Janet Ginnard	UNITAID
Firdaus Hafidz	University Gajah Madah, Indonesia
Ravi Anupindi	University of Michigan
Krishnapada Chakraborty	University Research Co., LLC (URC)
Neeraj Kak	University Research Co., LLC (URC)
Amy Piatek	USAID
Ariel Pablos-Mendez	USAID
Cheri Vincent	USAID
Mary Sanitato	USAID
Nida Parks	USAID
Shyami deSilva	USAID
William Wells	USAID
YaDiul Mukadi	USAID
Maggie Farrell	USAID
Sheila Desai	USAID India
Yolly Oliveros	USAID Philippines
Prashant Yadav	William Davidson Institute
Dinesh Nair	World Bank
Edmundo Murrugarra	World Bank
Hideki Mori	World Bank
Jaime Bayona	World Bank

Montserrat Meiro-Lorenzo	World Bank
Mukesh Chawla	World Bank
Diana Weil	World Health Organization (WHO)
Knut Lonnroth	World Health Organization (WHO)
Monica Dias	World Health Organization (WHO)
Mukund Uplekar	World Health Organization (WHO)