A people-centred model of TB care

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Dr Martin van den Boom, MD, MSc PH, Technical Officer, Joint TB, HIV and Viral Hepatitis Programme (JTH), WHO Regional Office for Europe
“What it is all about!”
Opportunities of the SDG era

SDG target 3.3
Ending TB and HIV

1.4 million TB patients will be cured
3.1 million lives will be saved
Some “reasoning”

No-brainers
Benefit per dollar spent for various development targets, $

- Trade liberalisation: $2,011
- Access to contraception: $120
- Reducing tax evasion
- Increasing migration
- Reducing stunting
- Reducing tuberculosis
- Reducing malaria
- Greater pre-school access in sub-Saharan Africa
- Increasing circumcision for those at risk from HIV
- Reducing coral loss

Source: Copenhagen Consensus Centre


Annual Global Plan Research Funding Targets versus 2015 Funding
Some selected indicators: Some good news across the board

<table>
<thead>
<tr>
<th>Key indicators</th>
<th>2011</th>
<th>2015</th>
<th>2018 report data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small-scale pilot projects</td>
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<tr>
<td>Nationwide integrated programmes</td>
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<tr>
<td>Approach to drug-resistant TB</td>
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<tr>
<td>TB notification rate/100 000</td>
<td>40</td>
<td>36</td>
<td>28</td>
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<tr>
<td>Drug-susceptible success rate (%)</td>
<td>72</td>
<td>76</td>
<td>77.2</td>
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<tr>
<td>MDR-TB detection rate (%)</td>
<td>30</td>
<td>63</td>
<td>70</td>
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<tr>
<td>MDR-TB treatment coverage (%)</td>
<td>63</td>
<td>Universal access</td>
<td>Universal access</td>
</tr>
<tr>
<td>MDR-TB success rate (%)</td>
<td>48</td>
<td>51</td>
<td>54.7</td>
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</tbody>
</table>

Key progress:
- full-scale programmes
- fewer new TB cases per year
- more people treated successfully
- more drug-resistant patients diagnosed
- almost all drug-resistant patients put on treatment
- Further increase in MDR-TB treatment-success rate
- Increase of overall case detection rate from 84.1 to 87.2% (2014, 2018 respectively)

Key strategic directions

1. Full scale-up of rapid diagnosis
2. Rapid uptake of new medicines
3. Expanding patient- and people-centred models of care
4. Shorter and more effective treatment regimens
5. Research for new tools
6. Intersectoral approach to address inequities
TB-REP in a nutshell

The goal:

• Decrease burden of DR-TB

• Increase political commitment to shift to ambulatory care. Translate plans into implementation of people-centered TB models of care

Objective 1: Advocacy and capacity building

To increase political commitment to end TB through regional cooperation and evidence sharing for effective and sustainable transformation of the health systems

Objective 2: Technical Assistance

To support countries to implement effective and efficient TB service delivery systems with sustainable financing

+ Scientific Working Group and Oversight Committee
Some key elements

1. Sustainable high-level advocacy for effective TB control
   - High level policy dialogue – Focal Points, National Working Groups
   - Joint high level advocacy missions to countries
   - Bottom-up country efforts exchange of advocacy best practices

2. Regional dialogue and capacity building for sustainable health system transformation
   - Regional conference HSS for TB control
   - HSS TB Barcelona course
   - Technical assistance
   - Interregional exchange and platform
People-centred care
“Blueprint”

- TB service delivery model
- Health financing
- Human resources
- Bed forecasting tool
- Hospitalization criteria
A people-centred approach to care

Member States in the WHO European Region share a commitment to strengthen health systems for health and development and recognize the importance of moving towards **people-centred health systems**

“People-centred care is focused on and organized around the health needs and expectations of people and communities rather than on patients or diseases”
A people-centred model of TB care was defined by the TB-REP Scientific Working Group as:

“An efficient and integrated set of affordable, accessible and acceptable health services, provided in a supportive environment to prevent, diagnose and treat TB”
Further shift of TB care to the ambulatory settings

| Governance               | - Large variation in public spending on health  
|                         | - Serious inefficiencies in health systems    
|                         | - Weak coordination across sectors            
| Service delivery        | - Overinvestment in secondary and tertiary (hospital-based) care  
|                         | - Underinvestment in outpatient and primary health care 
| Health financing        | - Payment mechanisms that do not facilitate reconfiguration of existing services or collaboration across the health system 
| Pharmaceuticals/Human resources | - Insufficient access to M/XDR–TB drugs  
|                         | - Primary health care workers not sufficiently trained |
Shift TB care to ambulatory setting: Some evidence

Treating multidrug-resistant tuberculosis in community settings: a wise investment

Impact of reduced hospitalisation on the cost of treatment for drug-resistant tuberculosis in South Africa

E. Sinanovic¹, L. Ramma¹, A. Vassall†, V. Azevedo†, L. Wilkinson§, N. Ndjeka§, K. McCarthy‡, G. Churchyard‡, and H. Cox**
Ambulatory Services Delivery

Designing Care
- What set of the services should and can be delivered?

Organizing Providers & Settings
- Who should deliver services?

Managing Services Delivery
- How the services will be covered and what incentives for providers

Improving Performance
- Capacity, skills, motivation, tools
Fig. 2. Graphical illustration of a possible patient pathway

Presumptive TB patient → Outpatient Service → Clinical Diagnosis

Treatment initiation
DOT/VOT plan
Social Support
Contact tracing

Universal DOT/VOT

Treatment

Various

Lab confirmation
☐ Yes
☐ No

DS TB
RR/MDR TB

Hospitalization

(see for details annex 1)

MDR

Treatment protocol review and revision if necessary

* See accompanying text for more details
A people-centred model of TB care for the EECA region

<table>
<thead>
<tr>
<th>Setting</th>
<th>Facilities</th>
<th>Type of care</th>
<th>Services</th>
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</thead>
<tbody>
<tr>
<td>Ambulatory</td>
<td>Health post Primary care centre (rural) Primary care centre (urban, district, oblast/region) Specialized outpatient unit Day care centre Mobile units Co-located facilities Diagnostic centre</td>
<td>Prevention (promotion and protection)</td>
<td>Health promotion and education Immunization Latent TB infection screening Latent TB infection prescription Latent TB infection administration</td>
</tr>
<tr>
<td>Community</td>
<td>Community sites (nongovernmental organization, community-based organization etc.) Mobile units</td>
<td>Detection and diagnosis</td>
<td>Active case finding Passive case finding referral Clinical evaluation TB Lab, X-ray and others as needed</td>
</tr>
<tr>
<td>Home</td>
<td>Home</td>
<td>Treatment and support</td>
<td>Treatment initiation Treatment administration and observation Monitoring treatment progress and response Prevention and detection of adverse events and comorbidities Diagnosis and treatment of adverse events and comorbidities</td>
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<tr>
<td>Inpatient</td>
<td>TB hospital General hospital with TB beds Tertiary hospital Prison hospital</td>
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<td>Medical doctors: generalists and specialists Counselling and psychological support Social support</td>
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<td>TB tasks</td>
<td>Oblast TB Center</td>
<td>City TB Center</td>
<td>Family Medicine Centers</td>
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<td>--------------------------------------------------------------</td>
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<tr>
<td>Early identification of presumptive TB</td>
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<tr>
<td>Diagnosis of TB disease</td>
<td>x</td>
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<tr>
<td>Prescription of TB treatment regimen</td>
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<td>Administration of TB treatment</td>
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<td>Supportive activities by administration of TB treatment</td>
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<tr>
<td>Monitoring TB treatment progress</td>
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<tr>
<td>Management of severe clinical conditions</td>
<td>x</td>
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<tr>
<td>Management of adverse anti-TB drug reactions</td>
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<td>Management of co-pathologies</td>
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<td>Patient (psychological help)</td>
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<tr>
<td>Patient/family support (social support, motivational payments)</td>
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<td>BCG vaccination/reading</td>
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<td>Screening for latent TB infection (LTBI)</td>
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<tr>
<td>Diagnosis of LTBI</td>
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<td>Prescription of LTBI treatment</td>
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<tr>
<td>Administration of LTBI treatment</td>
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<tr>
<td>Tracing lost to follow up TB patients</td>
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<td>Education, social mobilization</td>
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Innovative changes to payment method

• Add-on payments – they usually take a form of fee for service for specific procedures or lump-sum payment for a pre-defined period of time when certain set targets have been achieved. Pay for performance (P4P) is a classic type of add-on payment developed since the 1980s.

• Bundled payments – pre-determined payment for each type of acute episode of care provided in the hospital.

• Population-based payment – a lump-sum payment is given to groups of service providers covering all the healthcare services for a pre-defined group of population. Its main objective is the overcome the fragmentation of the healthcare delivery.
Provisional data 2017

8 out of 11 countries adopted key policies to address TB through a people-centered model of TB care.

6 countries have increased the TB share in the national health sector budget.

3 countries have increased domestic expenditure for TB.

Hospitalization rate of new TB cases has reduced from 75% in 2015 to 56% in 2017 among all 11 countries.

The length of stay of MDR TB cases in the hospitals reduced from 158 to 109 days in average among 11 countries in 2017.
Conclusions

• There is progress
• There is not enough progress to reach targets and goals
• Progress is heterogenic
• To boost progress, more innovation and bold “out-of-the-box” thinking and actions are needed
Thank you for your attention!
Questions, answers, discussion

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eurotb@who.int
eurotbrep@who.int