Integrated care and Pay for Performance in TB outpatient care – an adapted intervention and innovative research in Georgia

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Background - Why P4P

- **High TB burden**
  - High rate of drug-resistant TB (DR-TB)
- Improving but **suboptimal treatment outcomes**
  - Every third DR-TB patient interrupts treatment
- Main reasons of **poor adherence**
  - System factors - Side effect management suboptimal outside the capital city; Pill burden; Difficulties of DOT regimen
  - Personal factors - Poor awareness on the disease and treatment
  - Social & Economic factors

Background - Why P4P

- TB outpatient care provided by private service providers under the state funded program
- TB management is responsibility of TB specialists (doctor and nurse)
- Lack of coordination between Primary Health Care and TB care
- Low base salary of TB specialists
- Future gap in TB specialists supply - retirement age, not appealing profession
- Low interest of private sector to retain TB services – threat to sustainability

Background - Why P4P

- Policy options already in place to improve adherence
  - Financial incentives to patients
  - New treatment strategies (new drugs, Video Direct Observation)
  - Adherence consultants (available at regional level, not fully functional)
- Integration of TB care into UHC package – a future plan
- No incentives schemes among providers (in any health area)

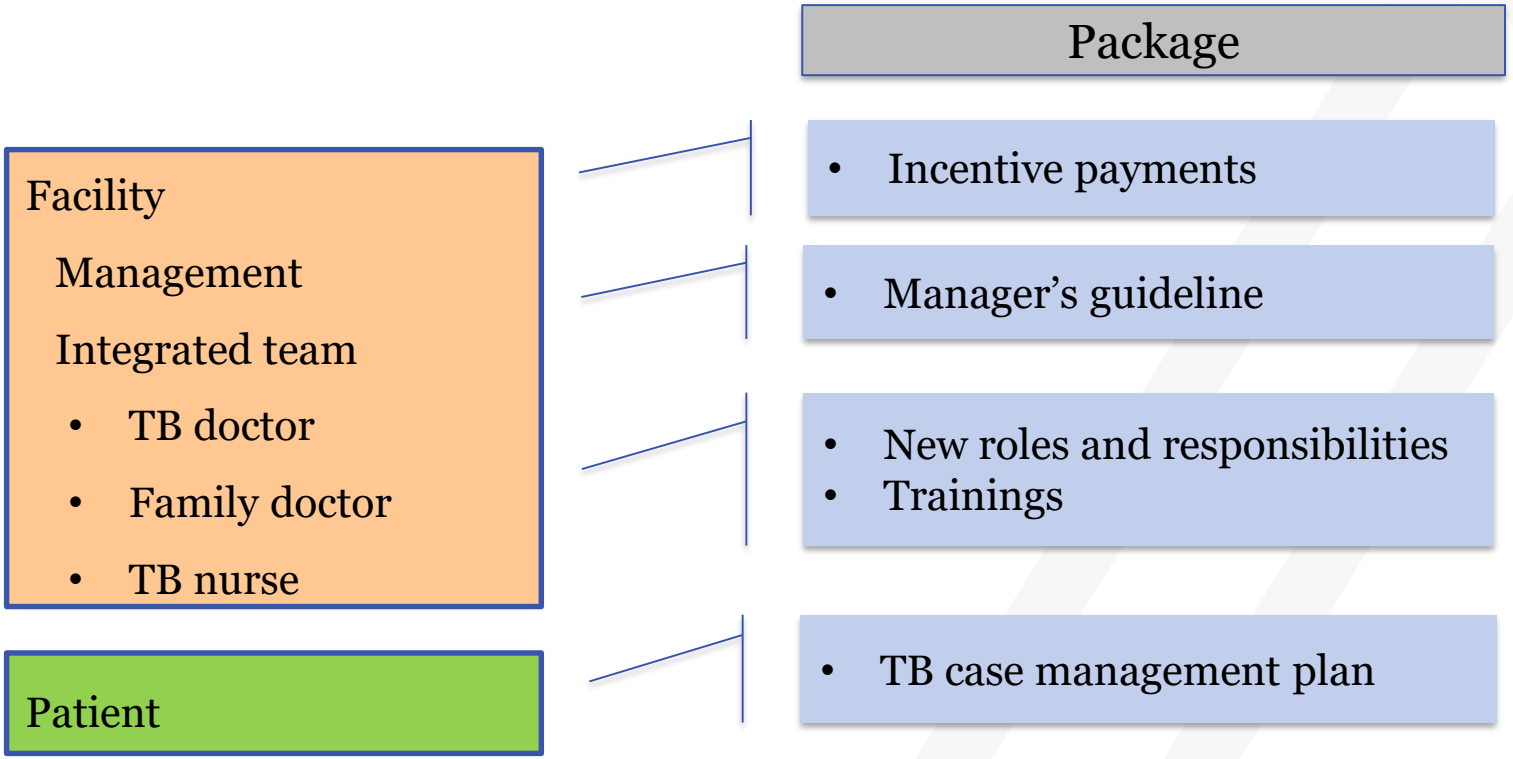
How the P4P scheme was designed

- **Program theory (PT) workshops** with involvement of researchers, policy-makers, service providers:
  - 1st PT workshop (bottleneck and potential solutions)
  - Drafting a concept of the P4P intervention
  - Development of a Program Theory
  - 2nd PT workshop (expected effects, mechanisms of change, conditions for success, contextual constraints, conditions for sustained effect)
  - Refinement of the Program Theory
- **Discussions** with policy-makers, providers to refine the scheme design

What are main features of the P4P scheme

- Patient centered approach
- TB case management integration with the PHC
- Empowerment of the patients
- Performance based payments
  - distribution among the team members based on their contribution (facility, manager, TB doctor, TB nurse, Family doctor)
  - based on the facility performance measured by a adherence to treatment reported on a quarterly basis

How the P4P scheme looks



Challenges on the way

- Complex service delivery arrangements
  - No mechanisms in place to encourage TB service provision among private service providers
  - Rural family doctors independent providers – need of addition contractual arrangements
- Public purchaser not ready to assume additional verification functions
- High turnover of key policy makers
- Skepticism towards P4P concept in general among some key policy makers

Next steps

- After pre-piloting (which is underway in two facilities) refine the scheme
- Run in 8 intervention facilities for 24 months
- Evaluate with combination of:
  - Impact evaluation (cluster randomized control trial)
  - Cost-effectiveness study
  - Realist case studies (mechanism of change, context factors that enhance or undermine the effectiveness)

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Team members

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