

Why we need to evaluate the quality of tuberculosis care in South Africa's private health sector

To the Editor: Poor-quality tuberculosis (TB) care is now a larger barrier to reducing mortality than poor access.^[1,2] South Africa (SA) has one of the highest TB burdens globally. Despite ongoing efforts to improve access to testing and treatment in primary care settings,^[3] only half of South Africans with drug-susceptible TB and 22% with rifampicin-resistant TB successfully navigate TB care pathways in the public sector.^[4] Furthermore, a recent study showed that 29% of South Africans with TB symptoms first report to the private sector.^[5] Delays in TB diagnosis have been reported in the public and private sectors.^[6,7] Efforts to evaluate and improve quality of TB care must therefore involve both sectors.

The standardised patient (SP) methodology, which involves the training of individuals to act as 'mystery patients', has helped to identify early bottlenecks in the TB care cascade. SP studies in India, China, Kenya and SA^[8-12] have shown that, with regard to TB testing, higher-level clinics generally do better than lower-level clinics, formal practitioners outperform informal practitioners, and public providers perform better than private health carers (Fig. 1).^[13] In a recent study, providers at public clinics in urban SA performed comparatively well – sputum for GeneXpert (Cepheid, USA) testing was collected in 84% of SP encounters, HIV testing was done in 47%, and unnecessary prescriptions were provided for only 26%.^[8,13] SA's leading role in prioritising TB in policy and practice possibly contributes to its strong public sector performance.^[14-16] However, it is unclear to what degree recent advancements in TB screening and care recommendations have permeated the private sector.

In other high-burden countries, such as Kenya and India, when SPs presented with classic TB symptoms, nearly all private practitioners were found to dispense and collect fees for medications, including antibiotics and steroids.^[13] Such clinical practices could delay diagnosis and/or harm patients with undiagnosed TB.^[13] In SA, however, general practitioners (GPs) cannot profit from medication dispensing and many include the cost of common medications in their consultation fee, thus removing financial incentives for dispensing, as has been suggested in other

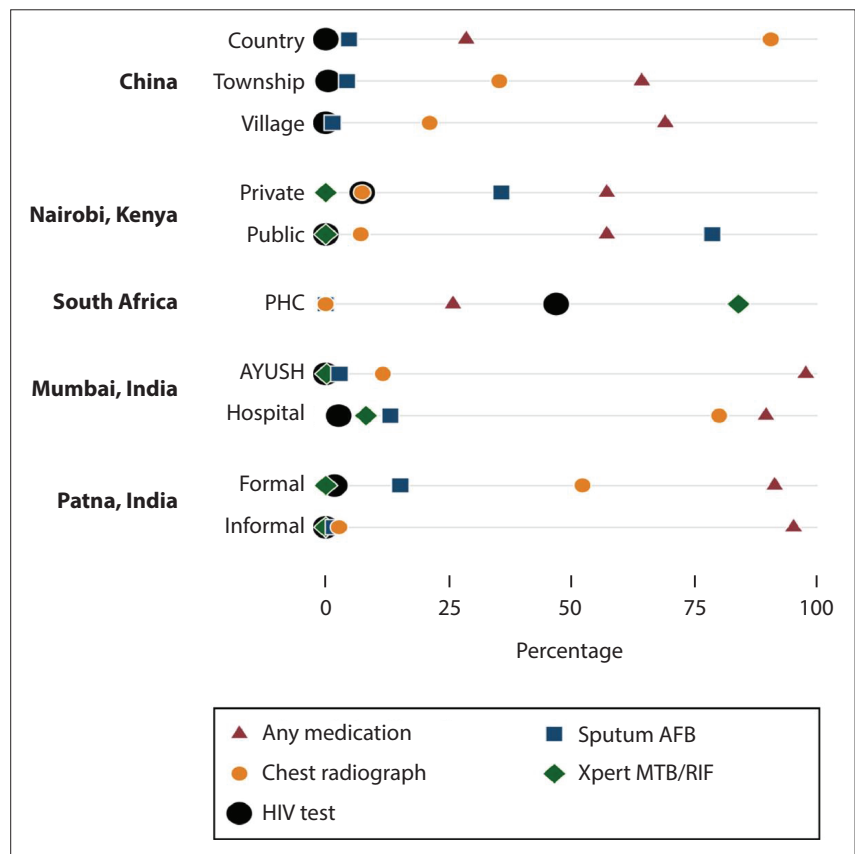


Fig. 1. Key findings of standardised patient studies on how suspected tuberculosis was managed.^[13] (PHC = primary health centre; AYUSH = practitioners trained in Ayurveda, Yoga and naturopathy, Unani, Siddha, and Homeopathy; AFB = acid-fast bacillus; MTB/RIF = Mycobacterium tuberculosis/rifampicin.)

settings.^[13,17] In India, private practitioners are commonly involved in TB treatment,^[18] and referral to the public sector for free TB testing and treatment is as low as 4%.^[11] Conversely, SA physicians do not traditionally treat TB in the private sector^[19] and there are few existing public-private TB programmes. Hence, private GPs may be more likely to refer patients with TB to the public system. A systematic study evaluating quality of care, including drug dispensing and referral practices, would identify current practices in the private sector, as well as strategies for more effective GP engagement.

TB remains a daunting health problem in SA. Efforts to improve access to TB care must be coupled with commensurate efforts to improve healthcare quality. SP studies have been used in high-burden settings to describe the quality of TB care. As nearly one-third of symptomatic TB patients first present to the private sector in SA, the SP methodology would be a useful approach to understand and describe current practices among private healthcare providers.

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