Walking the Last Mile in TB

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ABSTRACT

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India has the highest burden of tuberculosis. In 2009 out of the estimated global annual incidence of 9.4 million TB cases 2 million were estimated to occur in India.1 The TB problem is further compounded by the existence of drug resistant TB, HIV associated TB and several socio economic and health factors that promote continued transmission of the disease.

To achieve TB free India, RNTCP has now adopted a new vision document for the 12th five year plan (2012-17). Aiming for universal access the programme plans to reach the unreached by

- Early detection and treatment of at least 90 % of estimated TB cases in the community, including HIV – associated TB;
- Initial screening of all re- treatment smear- positive TB patients for drug – resistant TB and provision of treatment services for MDR- TB patients;
- Offer of HIV counseling and testing for all TB patients and linking HIV- infected TB patients to HIV care and support;
- Successful treatment of at least 90 % of all new TB patients, and at least 85 % of all previously treated TB patients;
- Extended RNTCP services to patients diagnosed and treated in the private sector.

Private Doctors and hospitals have the right and duty to participate in the national programme. It is time that Govt. walks that extra mile to take them along. PPM needs an institution different from the Govt hierarchy. It is an established fact that PPM needs an interface. PPM needs dedicated staff and budget flowing through this interface. IMA has been involved in PPM DOTS for the past two decades. Through IMA GFAT M RNTCP project it has sensitized 70325 and trained 12232 private doctors. 4031 DOT centers and 66 DMC shave come up in in private clinics and hospitals.

Keywords: Tuberculosis, Drug resistant TB, RNTCP, PPM.

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INTRODUCTION

India has the highest burden of tuberculosis. In 2009 out of the estimated global annual incidence of 9.4 million TB cases 2 million were estimated to occur in India.[1] The TB problem is further compounded by the existence of drug resistant TB, HIV associated TB and several socio economic and health factors that promote continued transmission of the disease.

On a national scale TB accounts for 17.06 % of deaths from communicable disease and 3.5 % of all causes of mortality. More than 80 % of burden in TB is due to premature death. WHO has estimated TB mortality in India as 2,80,000 in 2009. With the implementation of RNTCP death due to TB has come down by half. The services of RNTCP are available throughout the country. To achieve TB free India, RNTCP has now adopted a new vision document for the 12th five year plan (2012-17). Aiming for universal access the programme plans to reach the unreached by

- Early detection and treatment of at least 90 % of estimated TB cases in the community, including HIV – associated TB;
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- Extended RNTCP services to patients diagnosed and treated in the private sector.

Public- private mix is a revolutionary concept that it attempts to bring two diverse sectors together. The dynamics and concern of both the sectors are different. India has the largest private sector in health care. Surveys have indicated that 47% of TB care happens in private sector.[2] That roughly translates into 10 % of the Global burden. Engaging Indian private sector will

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yield substantial progress in TB care in the country. Systematic and sustained engagement of diverse TB care providers is essential for a variety of reasons: to improve access to TB care; to reduce patient costs and inconvenience; to achieve early case detection; to promote rational use of Anti – TB drugs; to prevent M/XDR- TB; and to move beyond 70 % case detection for universal access to quality – assured TB care. Uncommitted efforts and insignificant engagement of care providers outside RNTCP could potentially undo the consistent efforts and commendable achievements of the national TB programme.[3]

The basic principles of care for persons with or suspected of having, tuberculosis are the same worldwide; a diagnosis should be established promptly and accurately; standardized treatment regiments of proven efficacy should be used together with appropriate treatment support and supervision; the response to treatment should be monitored; and the essential public health responsibilities must be carried out. Prompt, accurate diagnosis and effective treatment are not only essential for good patient care; they are the key elements in the public health response to TB and are the corner stone of the TB control. This, all providers who undertake evaluation and treatment of patients with TB must recognize that, not only are they delivering care to an individual, they are assuming an important public health function that entails a high level of responsibilities to the community, as well as to the individual patient.[4]

The issues in PPM start with the definition. Including non RNTCP public sector and Govt medical colleges in the definition of 'private' has in effect sabotaged the real' private'. With the result the 'difficult' private was kept for 'some other' day while the 'bogus' private was given the precedence. Not that they did not deserve consideration but the error in definition has resulted in indifference in developing a strategy and infrastructure in reaching out to the private doctors and hospitals that are treating substantial number of TB patients. Even at this rate only 2 % of RNTCP budget is spent on the improperly defined private sector. Needless to say a substantial portion of this allotment goes to the medical colleges. The good thing is that now we have an institutional structure for the medical colleges through the three tier task forces. The contribution from the medical colleges is more than 15 % in case detection.

Private Doctors and hospitals have the right and duty to participate in the national programme. It is time that Govt. walks that extra mile to take them along. PPM needs an institution different from the Govt hierarchy. It is an established fact that PPM needs an interface. PPM needs dedicated staff and budget flowing through this interface. IMA has been involved in PPM DOTS for the past two decades. Through IMA GFAT M RNTCP project it has sensitized 70325 and trained 12232 private doctors. 4031 DOT centers and 66 DMC shave come up in private clinics and hospitals.

1. The Government should separate NGO schemes from the schemes for private sector. The dynamics and capability are different. Methodology and strategy required are different. Tools and incentives are different. Separation will bring out the best out of both sectors through better focus and intensity.
2. All the schemes have been designed from the Programme's point of view of what is required for the programme. If we can invert the telescope and see what the private sector can contribute, it will be much more user friendly.
3. The private sector needs to be further divided:
    1. Private Doctors
    2. Private Hospitals

Private Doctors can be further divided into

1. General practitioners
2. Specialists

Incentives for private practitioners could be both

1. Non financial
2. Financial

Non financial incentives like recognition, certification branding, and sponsorship to TB conferences will work with private practitioners. Financial incentives have to be adequate and appropriate and have to be delivered with dignity. Private hospitals have to have financial incentives in addition to value addition like branding.

Suggested activities for private doctors:

1. Referral: Eligible for non financial incentives only. Govt should enlist the participating private doctors nationwide. The private doctor should be eligible for updating of knowledge and training programmes.
2. Case holding: The clinic/institution of the private doctor should function as a PHI. The responsibilities of the PHI should be handled by the private doctor .The incentives should be both non financial and financial.
3. For specialists
    a. In addition to referral and case holding the

specialists may be allowed to practice as per ISTC. The required public health services and drugs may be provided by the Govt. The participating specialist should notify the case and also share appropriate information. He would be eligible for non financial incentives only.

b. Participation in DOTs plus activities: both financial and non financial incentives may be provided.

Suggested activities for private hospitals

1. Function as PHI
2. DMC
3. DOTS Plus activities
4. CME programmes for local doctors
5. Health education

All activities should entail to branding as well as financial incentives.

IMA should intensify and widen its participation by taking up more public health responsibilities. Let IMA grow into its own shoes. We owe it to our nation.

END NOTE

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