DOI: 10.7860/JCDR/2017/19627.9126

Commentary

Community Medicine Section

Ways and Means to Utilize Private Practitioners for Tuberculosis Care in India

JANMEJAYA SAMAL

ABSTRACT

The growing interest of utilizing the private practitioners in improving the outreach of public health services including Tuberculosis (TB) control programme stemmed out of people's preference for private health facilities in situations where public health facilities fail to meet the expectations. In different parts of India, many models of Public Private Partnership have been tried and tested and proved successful in providing quality TB care in the concerned community. In this paper, several ways and means have been proposed to effectively utilize private practitioners for TB care in India. These strategies are discussed under different headings: (1) identification of potential private practitioners: (2) orientation of private practitioners: (3) networking of private practitioners with patients and Directly Observed Treatment Short course (DOTS) provider: (4) follow-up and sensitization of patients by private practitioners: (5) let the word of mouth work: and (6) evaluation of the involvement of private practitioners in TB care. However the following points must be addressed before utilizing the private practitioners for TB care: time constraints in notifying the disease, adherence to DOTS regime/alternative to DOTS regime, referral of patients to public health facilities for diagnosis and treatment, follow-up and sensitization of the patients and behaviour change communication and awareness in the community by the private practitioners. Few of these are mandatory for the private practitioners; most are practicable. With the effective utilization of private practitioners many problems can be sorted out that are currently plaguing the system such as irrational and excessive use of certain drugs, over reliance on chest X-ray for diagnosis, under use of sputum microscopy, lack of knowledge regarding standard treatment protocols and varied prescription practices.

Keywords: Public private partnership, Standards of TB care, TB control program, TB notification

INTRODUCTION

Government-run health-care services in low- and middle income countries (LMICs) have been modestly successful in providing equitable access to high-quality care for diseases of public health importance [1]. Due to this, in many low-income countries, much of the population, across all socioeconomic strata, turn to individual or institutional private health-care providers [1]. It has been observed that in some countries private practitioners provide better geographical access and more personalized care compared to the public healthcare providers and often outnumber the public healthcare providers [1]. Similarly, people in India have higher reliance on private sector compared to the public health facilities. People mostly prefer private sector for the health services that are not usually covered under the typical public health system. Despite being freely available as a fully centrally sponsored programme, the health seeking behaviour for Tuberculosis treatment at public health facilities is less in India. In this paper, several ways and means have been proposed to effectively utilize private practitioners for TB care in India. The reason for this is that 50%-80% of Indian patients seek medical care for TB at private health facilities [2-4]. Furthermore, the growing interest of understanding how private practitioners could be effectively utilized in improving the outreach of public health services including TB control programme stemmed out of it [5-11]. Hence, an effective collaboration with the private sector is the need of the hour to implement Revised National TB Control Programme (RNTCP) and the DOTS strategy.

SIGNIFICANCE OF PRIVATE PRACTITIONERS INVOLVEMENT IN TB CARE

The fact that more than 50% of the TB patients in India still seek care at private clinics [2-4] may probably be due to the fact that most of the people are not aware of the national health programme for TB or have an over-reliance on private practitioners. A study conducted in the year 2010 at the P. D. Hinduja National Hospital and Medical Research Centre, Mumbai, India, among TB patients not exposed to TB services offered in public sector revealed that 85% of the patients (n=200) are unaware of DOTS programme [12]. Furthermore, the consumption of first line anti-TB drugs is huge in India compared to public sector, as revealed by one of the reports. It reveals that, of the total market of USD 94 millions the public sector consumes USD 24 millions whereas the private sector consumes the rest USD 61 million [13].

Another striking feature is the delay in seeking health services which primarily happens with patients who drift from one private practitioner to other with the hope of getting rid of the symptoms. The delay in seeking health care is reflected both in diagnosis, delay and treatment delay leading to advanced forms of TB, such as Multi Drug Resistant /Extremely Drug Resistant forms of TB [14,15]. Further, women prefer to visit private practitioners as compared to men. This might be due to the social and cultural taboos prevailing in the community as getting diagnosed with TB may land women up in many social adversities ranging from divorce to social seclusions in the community [16-18]. All these above facts led to a growing interest in understanding how private practitioners could be effectively involved in improving TB control programme.

WAYS AND MEANS TO UTILIZE PRIVATE PRACTITIONERS

A high turnover of patients seeking medical care for TB at private sector health facilities is a matter of public health concern, and the effective engagement with the private sector for the implementation of RNTCP and DOTS strategy can help in controlling TB. Private practitioners will not be ready to lose their business interest or clientele; thus, strategies recommended must account for their preference to keep their business interest and profit intact with no or minimum structural reforms in the existing health system.

Identification of Potential Private Practitioners

Identification of potential private practitioners from across all *pathies* is important as practitioners from different systems of medicine do treat TB patients [2]. The identification of these practitioners can be done through various means, such as; professional and social networks and professional bodies like Indian Medical Association (IMA), Association of Chest Physicians of India etc. Social and professional networking sites such as "Facebook and Linkedin" can be used for identifying the private practitioners. The use of professional bodies for the identification of private practitioners is found in other Public Private Partnership models as well [19,20]. In addition to this, pharma representatives can also be contacted to obtain a list of private practitioners, they usually visit for drug promotion.

Orientation of Private Practitioners

Research during the last two decades shows very gloomy picture regarding the knowledge and practice of private practitioners toward TB management. In a study in 1991 about the prescribing behaviour of private practitioners, 100 doctors reported to have provided 80 different prescriptions [21]. A similar study undertaken in Mumbai and rural Pune published in 1998, reported 105 private practitioners giving 79 diverse prescriptions [2] and in a study at P. D. Hinduja National Hospital and Medical Research Centre, Mumbai 106 doctors wrote 63 different prescriptions [22]. Irrational and excessive use of certain drugs, over reliance on chest X-ray for diagnosis, under use of sputum microscopy, lack of knowledge regarding standard treatment protocols and varied prescription practices are a matter of great concern [2,15,23,24]. Hence, training of private practitioners before putting them in TB care is of paramount importance. The orientation of these private practitioners can be done by organizing CME (Continued Medical Education), workshops and seminars. These activities can suitably be organized in collaboration with medical institutions, state level agencies or training centers such as SHSRC (State Health System Resource Center). The training programme should preferably contain the following modules;

- Public health importance of TB
- Laboratory diagnosis
- Clinical medicine
- Family medicine
- Counselling and Behaviour Change Communication (BCC)

The components of family medicine, counselling and BCC are reiterated here which are largely forgotten by the private practitioners while imparting services to their patients.

Networking of Private Practitioners with Patients and DOTS Provider

In this paper a networking among the private practitioners, patients and DOTS provider is proposed. This networking is important to ensure effective utilization of private sector for the implementation of RNTCP and DOTS strategy in the community. Here, the DOTS provider would act as a bridge between public and private sector and the patient and private practitioners as well. This is unique in a sense that many of the previous models have not explored such a networking [19,24-28]. Here, emphasis is laid on the utilization of ASHA (Accredited Social Health Activist) as a DOTS provider, who is already in the health system and working on various health programmes including RNTCP. Again, DOTS provider, if accessible and acceptable to patient and accountable to health system, can play a significant role in reducing TB burden. Studies report greater involvement of ASHA as DOTS provider in many Indian states. They exhibit positive attitude and have good knowledge on DOTS and RNTCP [29-31]. Hence, this community health workforce can be properly tapped for the implementation of RNTCP and DOTS strategy. Again, this redirection won't require any structural reformation except sensitization and reorientation. Here, the functioning of ASHA would be similar to that of public health facilities. The ASHA can directly or indirectly coordinate with patients and private practitioners- directly if she accompanies the patient from the community to the private practitioner or indirectly from the private facility if the patient directly visits the private practitioner for all the activities. Here question arises, why should an ASHA, being a public sector volunteer, accompany patients to private practitioners? The answer to this question is that more than 50% of the patients visit private practitioners, both knowingly and unknowingly and with or without choice as well; hence, considering the patient's choice, a proper approach for the management of TB with this network would help to reduce the burden of TB and the disastrous outcomes such as Multi-Drug Resistant (MDR) TB/Extremely Drug Resistant (XDR)-TB.

Follow-up and Sensitization of Patients by Private Practitioners

Follow-up and sensitization of the patients is important in TB for two important reasons. Firstly, the compliance to treatment can be ensured by follow-ups and sensitization to the patients. Patients do have a tendency to give up treatment in the middle of the course as little relief from the symptoms creates a pseudo impression of cure among them. Compliance to treatment leads to complete cure and prevents from MDR/XDR forms of TB. Secondly, after intensive phase of the treatment and after treatment completion the patients have to undergo sputum microscopy to assess the sputum conversion which can also be ensured by follow-ups and sensitization. Negative sputum conversion at each of these two levels has different treatment modalities and continuation of same treatment for a longer period. Hence, follow-ups and sensitization of patients can prevent such unwanted situations during the course of treatment. This does not require any reformation in health system rather a mindset of the private practitioners to do so.

Let the Word of Mouth Work

This is a very unique concept, as the same is not found in other models of Public Private Partnership implemented in India. This phase is proposed to disseminate the success of utilization of private practitioners to as many people in the community as possible to continue the process. It is obvious that people would seek medical care at private health facilities, and stopping them from doing so is difficult, unless the community gets aware of the public health facilities and relies upon it. Hence, till the patient community is really aware of the public health programmes "the word of mouth" of those patients who got rid of the problem with the effective utilization of private practitioners can disseminate the message to continue the process. Furthermore, the vision of India's national TB control programme is that the people suffering from TB receive the highest standards of care and support from healthcare providers of their choice. It is spelt out in the National Strategic Plan (2012-17) to extend the umbrella of quality TB care and control to include those provided by the private sector [32].

Evaluation of the Involvement of PPs in TB Care

Evaluation is of utmost importance in the implementation of any programme. Evaluation helps in understanding the success or the failure of a programme and thereby, helps in setting the future directions. Here, the evaluation can be based on two types of indicators; process indicators and outcome indicators [33].

- Process Indicator – there are primarily three process indicators;
    - Number of private practitioners agreed to be a part of this process
    - Number of orientation programmes conducted for the private practitioners

- Number of networks formed among the private practitioners - Patients-DOTS provider

- Outcome Indicator- Similarly the outcome indicators are;
  - Number of suspected cases diagnosed or sent for diagnosis by private practitioners through sputum microscopy
  - Number of patients completed the treatment
  - Number of patients cured of Tuberculosis
  - Number of cases notified by the private practitioners
  - Number of new sputum smear positive cases enrolled for treatment

By this, the impact of this process in a particular community can be assessed and further course of action can be framed. Assessing the awareness about the disease and utilization of the programs should also be assessed in the population and if the awareness is lacking in the population, awareness and motivation programs should be carried out.

PROBABLE BOTTLENECKS IN INVOLVING PRIVATE PPRACTITIONERS IN TB CARE

The strategies proposed may have some shortcomings while the same is being implemented. As private practitioners are involved in this process, following points need to be addressed before implementing the same.

Time Constraint in Notifying the Disease

Time constraint is going to be an important issue with the private practitioners owing to their busy schedule. private practitioners perceive that notification of a disease is a mere obligation or a professional-ethical consideration as there is no legal binding. But the requirement of reporting applies equally to government-run facilities and to private facilities as well. In both settings, it is the primary TB care provider or laboratory diagnostician's responsibility to ensure that the required notification is completed [34]. TB is a notifiable disease in India as per the government order dated 7thMay, 2012 and requires that all healthcare providers that have diagnosed a case of TB through microbiological testing or clinically diagnosed and/or treated for TB must report to the District Nodal Officer for Notification [35]. With the advent of information technology, notification of TB has become easier as RNTCP has its online portal of TB notification (NIKSHAY) where in providers can register themselves and notify cases. The portal is -*http://nikshay.gov.in*. Notification through the online portal may not be a time consuming affair with a true professional attitude. Some strict legal enforcement can be mulled over if notification rate is poor. Mimicking the instances of other public health legislations such as PCPNDT (Pre-Conception and Pre-Natal Diagnostic Test) etc. would be worthwhile for consideration in the case of poor TB notification.

Adherence to DOTS Regime/Alternative to DOTS

The process proposes a networking of private practitioners -Patients-DOTS provider where the DOTS provider can provide the DOTS regime at the private clinic and follow the same procedure as in public health facilities. By this, the private practitioners are also not going to lose the patient and their professional fees and the patient gets the standard drugs for treatment. This is also envisioned by the National Strategic Plan (2012-17), which extends the umbrella of quality TB care and control to include those provided by the private sector [32]. Again the standards of TB care developed by WHO's India country office in collaboration with various professional bodies, is a strong testimony that the private sector has accepted it and is going to adhere it by simply following the professional ethics. These standards are primarily intended to be used in order to enhance quality and mutually acceptable engagement with private healthcare providers and other nongovernmental facilities to enhance TB care in India. These standards thus, constitutes as an important tool to achieve the goal of universal access to quality TB care in India [36].

Referral of Patients to Public Health Facilities for Diagnosis and Treatment

Prompt, accurate diagnosis and effective treatment of TB are not only essential for good patient care, but also serve as the key elements in the public health response to TB and the cornerstone of any initiative for TB control. The private sector holds a factual predominance of health care service delivery in India. Engaging the private sector effectively is the single most important intervention required for India to achieve the overall goal of universal access to quality TB care [36]. Similar to the adherence to DOTS regimen the private practitioners can also refer the patients for diagnosis and treatment to public health facilities. By doing so they are not going to lose the patients and the patient favourably gets the standard diagnosis and treatment.

Follow-up of the Patients and Sensitization

Follow-up and sensitization is very important for ensuring patient compliance and treatment completion. The process of follow-up and sensitization do not really require a great effort in the part of a doer. It requires a sense of determination to spread the message and create a TB free society. It does not require any structural or functional reformation rather a civic sense to ensure achieving the goal of universal access to quality TB care.

Behavior Change Communication and Awareness in the Community by the Private Practitioners

Akin to follow-up and sensitization, creating awareness in the society and instilling change in health seeking behaviour do not really require any structural or functional reformation but a determination to do so. The private practitioners can do it by themselves or can take the help of DOTS provider for doing so. This is of utmost importance as a changed society cannot be expected without change happening in its each member. Private practitioners can definitely be of great help in doing so and ensuring universal access to quality TB care.

RECOMMENDATIONS

Role of private practitioners in TB care is of paramount importance in India as more than 50% of the TB symptomatic visit private practitioners for seeking help. India has already achieved the targets (85% cure rate and 70% case detection rate) of RNTCP since 2007 and RNTCP has got a 100% coverage rate under DOTS strategy. However, the scourge of TB continues unabated in both rural and urban communities in India. At this juncture, the only way out is to understand the health seeking behavior of TB symptomatic and act accordingly. As it has been revealed from various studies that people typically prefer a private health facility at the initial phase of treatment thus, addressing the private sector would invariably lead to TB control owing to the obvious health seeking behavior of Indian TB symptomatic. However, the flip side of the coin is that the treatment and prescription behavior of private health providers is not appropriate and very often serves as the main reason of converting drug sensitive TB cases in to drug resistant TB cases. Many efforts are being made at different level, government and non-government, to address this issue however very little could only be achieved. Recently the Govt. of India and WHO came together to develop "Standards of TB care in India" to be used by practicing physicians to treat TB cases however the ground level implementation of the same remains skeptical. Thus, it is high time in the part of the private practitioners to ponder over their contribution to the society they serve and behave appropriately to make the society TB free.

CONCLUSION

Private sector practitioners can be of paramount help in controlling TB if properly oriented and utilized. In this paper, every effort has been made to address two important aspects; to keep the business interest of the private practitioners intact and to implement these strategies with no or minimum structural reforms in the existing health system. The paper gives a clear idea that both these aspects have been given due care while devising these strategies. Hence, implementation of these strategies seems doable considering the above facts. Again, preventing people from using private health services in India is really a herculean task. Hence, keeping this premise in mind, the strategies can be successfully implemented with private sector. By doing so, many untoward effects can be curbed that are currently plaguing the system such as irrational and excessive use of certain drugs, over reliance of chest X-ray for diagnosis, under use of sputum microscopy, lack of knowledge regarding standard treatment protocols and varied prescription practices.

REFERENCES

[1] Lonnroth K, Uplekar M, Arora VK, Juvekar S, Lan NTN, Mwaniki D, Pathania V. Public–private mix for DOTS implementation: what makes it work? Bulletin of the World Health Organization. 2004;82:580-86.

[2] Uplekar M, Juvekar S, Morankar S, Rangan S, Nunn P. Tuberculosis patients and practitioners in private clinics in India. Int J Tuberc Lung Dis. 1998;2(4):324-29.

[3] International Institute for Population Sciences (IIPS) and Macro International 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I.

[4] Kelkar-Khambete A, Kielmann K, Pawar S, Porter J, Inamdar V, Datye A, et al. India's Revised National Tuberculosis Control Programme: looking beyond detection and cure. Int J Tuberc Lung Dis. 2008;12(1):87-92.

[5] Hanson K, Berman P. Assessing the private sector: using non-government resources to strengthen public health goals. Boston: Harvard School of Public Health; 1994.

[6] Bennett S, McPake B, Mills A, editors. Private health providers in developing countries. London: Zed Books; 1997.

[7] Brugha R, Zwi A. Improving the quality of private sector delivery of public health services: challenges and strategies. Health Policy and Planning. 1998;13(2):107-20.

[8] Lönnroth K. Public health in private hands. [dissertation] Gothenburg: University of Gotheburg; 2000.

[9] Uplekar M, Pathania V, Raviglione M. Involving private practitioners in tuberculosis control: issues, interventions and emerging policy framework. Geneva: World Health Organization; 2001. WHO document WHO/CDS/ TB/2001. 285.

[10] Smith E, Brugha R, Zwi A. Working with private sector providers for better health care: an introductory guide. London: Options and London School of Hygiene and Tropical Medicine; 2001.

[11] Mills A, Brugha R, Hanson K, McPake B. What can be done about the private health care sector in low-income countries? Bulletin of the World Health Organization. 2002; 80:325-30.

[12] Pinto LM, Udwadia ZF. Private patient perceptions about a public programme; what do private Indian tuberculosis patients really feel about directly observed treatment? BMC Public Health. 2010;10(1):357.

[13] Global Alliance for TB drug development. Pathway to patients: charting the dynamics of the global TB drug market. 2007. TB Alliance, New York.

[14] Sreeramareddy CT, Qin ZZ, Satyanarayana S, Subbaraman R, Pai M. Delays in diagnosis and treatment of pulmonary tuberculosis in India: a systematic review. Int J Tuberc Lung Dis. 2014;18(3):255–66.

[15] Kulkarni PY, Kulkarni AD, Akarte SV, Bhawalkar JS, Khedkar DT. Treatment seeking behavior and related delays by pulmonary tuberculosis patients in E-ward of Mumbai Municipal Corporation, India. Int J Med Public Health. 2013;3:286-92.

[16] Uplekar M, Rangan S, Ogden J. Gender and tuberculosis control: Towards a strategy for research and action. Geneva: World Health Organization; 2000. (WHO/CDS/TB/2000.280).

[17] Sundar R. Household survey of health care utilization and expenditure. Working paper No.53, NCAER, New Delhi. 1995.

[18] George A, Shah I, Nandraj S. A study of household health expenditure in two states: A comparative study of districts in Maharashtra and Madhya Pradesh. Mumbai/ Pune: The Foundation for Research in Community Health; 1997.

[19] Rangan SG, Juvekar SK, Rasalpurkar SB, Morankar SN, Joshi AN, Porter JD. Tuberculosis control in rural India: lessons from public-private collaboration. Int J Tuberc Lung Dis. 2004;8(5):552-59.

[20] Murthy KJ, Frieden TR, Yazdani A, Hreshikesh P. Public-private partnership in tuberculosis control: experience in Hyderabad, India. Int J Tuberc Lung Dis. 2001;5(4):354-59.

[21] Uplekar MW, Shepard DS. Treatment of tuberculosis by private general practitioners in India. Tubercle. 1991;72:284–90.

[22] Udwadia ZF, Pinto LM, Uplekar MW. Tuberculosis Management by Private Practitioners in Mumbai, India: Has Anything Changed in Two Decades? PLoSONE. 2010;5(8):e12023. doi:10.1371/journal.pone.0012023.

[23] Yadav A, Garg SK, Chopra H, Bajpai SK, Bano T, Jain S, Kumar A. Treatment practices in pulmonary tuberculosis by private sector physicians of Meerut, Uttar Pradesh. Indian Journal of Chest Diseases and Allied Sciences. 2012;54(3):161.

[24] Thakur JS, Kar SS, Sehgal A, Kumar R. Private sector involvement in tuberculosis control in Chandigarh. Indian Journal of Tuberculosis. 2006;53(3):149-53.

[25] Dewan PK, Lal SS, Lonnroth K, Wares F, Uplekar M, Sahu S, Granich R, Chauhan LS. Improving tuberculosis control through public-private collaboration in India: literature review. BMJ. 2006;332(7541):574-78.

[26] Lönnroth K, Uplekar M, Arora VK, Juvekar S, Lan NT, Mwaniki D, Pathania V. Public-private mix for DOTS implementation: what makes it work? Bulletin of the World Health Organization. 2004;82(8):580-86.

[27] Newell JN, Pande SB, Baral SC, Bam DS, Malla P. Control of tuberculosis in an urban setting in Nepal: public-private partnership. Bulletin of the World Health Organization. 2004;82(2):92-98.

[28] Quy HT, Lan NT, Lönnroth K, Buu TN, Dieu TT, Hai LT. Public-private mix for improved TB control in Ho Chi Minh City, Vietnam: an assessment of its impact on case detection. Int J Tuberc Lung Dis. 2003;7(5):464-71.

[29] Sagare SM, Bogam RR, Murarkar SK, Patil UP, Ghate MM. Knowledge, attitude and practices of ASHAs regarding tuberculosis and DOTS. Indian Journal of Science and Technology. 2012;5(3):2401-04.

[30] Kohli C, Kishore J, Sharma S, Nayak H. Are Accredited Social Health Activist workers aware of their and role and responsibilities. Int J Med Res Health Sci. 2015;4(3):616-21.

[31] Bhawnani D, Verma N, Tiwari A, Bandhi G. Assessment of knowledge and practice of Tuberculosis health visitors and health workers under Revised National Tuberculosis Control Programme in Raipur district of Chhattisgarh state. National Journal of Medical and Dental Research. 2014;2(3):18.

[32] National Strategic Plan (2012-17) for Tuberculosis. Directorate of Health Services, Central TB Division, Ministry of Health & Family Welfare, Government of India, New Delhi. Available from: http://www.tbfacts.org/wp-content/uploads/2016/01/NSP-2012-2017.pdf (Last accessed on 07/02/2016)

[33] World Health Organization. A guide to monitoring and evaluation for collaborative TB/HIV activities – 2009 revision. Available from: http://www.who.int/hiv/pub/tb/hiv_tb_monitoring_guide.pdf (Last accessed on 05/02/2016)

[34] Guidance tool for TB notification. Available from: http://tbcindia.nic.in/pdfs/Guidance%20tool%20for%20TB%20notification%20in%20India%20-%20FINAL.pdf (Last accessed on 05/02/2016)

[35] Notification of TB in India available from: http://www.tbcindia.nic.in/pdfs/TB%20Notification%20Govt%20%20Order%20dated%2007%2005%202012.pdf (Last accessed on 08/02/2016)

[36] World Health Organization. Standards of TB Care in India, WHO SEA Regional Office and Central TB Division, MOHFW, Govt. of India; 2014. Available from: http://www.searo.who.int/india/mediacentre/events/2014/stci_book.pdf (Last accessed on 10/02/2016).

PARTICULARS OF CONTRIBUTORS:
1. Independent Public Health Researcher, Bhubaneswar, Odisha, India.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:
Dr. Janmejaya Samal,
C/o. Mr. Bijaya Ketan Samal, At-Panasapalli, Po-Bangarada, Via Gangapur, Dist-Ganjam-761123, Odisha, India.
E-mail: janmejaya_samal@yahoo.com

FINANCIAL OR OTHER COMPETING INTERESTS: None.

Date of Submission: **Feb 18, 2016**
Date of Peer Review: **Apr 07, 2016**
Date of Acceptance: **May 24, 2016**
Date of Publishing: **Feb 01, 2017**