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REVIEW ARTICLE

ROLE OF PRIVATE SECTOR IN RNTCP

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ABSTRACT

The health care system in India is divided into public sector, private sector, indigenous system of medicine and other agencies. Private practitioners (PPs) constitute nearly 70% of medical profession in India. The need for including the PPs in the National TB Programme had been felt since 1975. With a vision for TB free India we need to approach the missing 3 million cases. One of the key pillars towards achieving universal access is to 'expand efforts to engage all care providers'. Involvement of private practitioners (PPs) in disease programmes (both communicable and non-communicable), continues to be a major challenge for the concerned health authorities. This paper focuses on the various factors and the challenges in public private mix (PPM) strategies.

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INTRODUCTION

Down the ages, freelance individual healers have attended to sickness and ill- health in most Asian communities. (Roth Gabriel, 1987) An organized and expansive system of health care was brought in form of allopath through colonization. Health care was eventually state run in colonial times and further expanded after independence to handle major public health problems through uniform public health systems. (Bennett *et al*., 1997) Government health care systems and services further developed and expanded during 1960s and 70s with the aim of equitable distribution of health care. (World Health Organization, 2000) The decreased funding of government for health from 1980s weakened the public health system as primary health care provider. Further increase in medical personnel with decrease in employment opportunities available in public sector led to unregulated and unmitigated growth of private medical sector in Asia. Eventually public sector came to be perceived as the last option when seeking medical care. In general, "the 'public sector' includes organizations or institutions that are funded by state revenue and that function under government budgets." (Raman and Björkman, 2008) In contrast, the 'private sector' comprises those organizations and individuals that are privately owned and operate outside of government authority. (Bennett and Hygiene, 1991)

Contribution of private sector in burden of TB in India

India which bears roughly one fourth of global TB burden, over half the TB cases are treated by private practitioners. (Satyanarayana *et al*., 2011) Also the World TB Day theme, 2015 on missing three million of which the one million are estimated to be in India indicates great deal of involvement of first point of contact, that is private sector. Studies have shown that people would pay for ministrations of quacks rather than avail of free medical care from qualified doctors at government run centers. Since private practitioners take better care of patients' psychological needs, are sensitive, make services available at times suitable to clients' convenience and many such reasons have been quoted. (Uplekar *et al*., 1996; Uplekar and Sheprd, 1991; Uplekar *et al*., 1998) The private sector in India varies widely in its size, nature of service delivery and socioeconomic groups served. It consists of a wide range of providers from private medical practitioners of many different systems of medicine, including both allopathic as well as Indian Systems of Medicine and Homeopathy, paramedics and even traditional practitioners who possess no formal training. (Agarwal *et al*., 2005) In absence of a comprehensive system of quality control in the health sector, each private health care provider enjoys considerable freedom in dispensing his or her

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own 'brand' of care. Surveys further indicate that the private sector is an important source of care even where public services are available. (Bennett *et al*., 1997)

Recent advances by Government of India to reach the unreached TB population

Government of India declared Tuberculosis a notifiable disease on 7th May 2012 and with help of Nikshay for TB notification a total of >57,000 private health facilities are registered till 2013.[12] Delays in diagnosis (Uplekar *et al*., 1998), over-diagnosis of TB due to an over-dependence on X-rays, the use of multiple non-standard regimens for inappropriate durations, the lack of a mechanism to ensure the full course of treatment and to record treatment outcomes are some issues of concern in the private sector. Keeping these unavoidable issues in mind Government of India with Central TB division developed Standards of TB care in India (2014). It has clearly been stated in standard number 12 that 'Any practitioner treating a patient for tuberculosis is assuming an important public health responsibility to prevent on-going transmission of the infection and the development of drug resistance.' And to fulfill this responsibility, the practitioner must not only prescribe an appropriate regimen, but when necessary, also utilize local public health services / community health services, and other agencies including NGOs to assess the adherence of the patient and to address poor adherence when it occurs. (World Health organization, 2014)

Public Private Mix

In the earlier days of the Revised National Tuberculosis Control Programme, the concept of Public-Private Mix (PPM) had mainly considered only the collaboration between the national TB programme and the private health sector, through the involvement of private hospitals and Private Practitioners (PPs). Now the concept has gained a broader meaning and is seen as a strategy to diagnose and treat TB patients reporting to all sectors of health care. PPM has been defined by World Health Organization as 'strategies that link all entities within the private and public sectors (including health providers in other governmental ministries) to the national TB programme for DOTS expansion'. Between 2000 and 2002, many models of public-private collaboration in the RNTCP came up in places such as Delhi, Kannur, Kollam (Kerala), Mumbai, Meerut (UP) and teagardens of the North-East. Using the experiences gained from collaborations with Non Government Organizations (NGOs) and the private sector, the Central TB Division published guidelines for the participation of the NGOs (Involvement of Non-Governmental Organisations in the Revised National Tuberculosis Control Programme; guidelines published by the Central TB Division, 2001) and private practitioners (Involvement of Private Practitioners in the Revised National Tuberculosis Control Programme; guidelines published by the Central TB Division, 2002). NGOs are actively involved in the community because of their accessibility and flexibility of services and play an active role in health promotion in the community. Presently, more than 1,000 NGOs are providing services as per RNTCP guidelines. The NGO must be registered under the Societies Registration Act, should have a minimum of three years' experience in the area of operation, and must have available infrastructure and staff. It must have an established health facility, with a proven track record in health care activities. The normal period of agreement will be three years, to be renewed annually only on the basis of satisfactory annual reports of activities, evaluation of performance by the DTCS and recommendation for extension. The Central TB Division has actively interacted with the management of large corporate houses and advocated for their involvement in RNTCP activities, following which many business houses have adopted the RNTCP. Over 100 corporate sector units are now involved in the RNTCP, such as a sugar mill in Uttar Pradesh, and tea gardens in the North-East and West Bengal. Industries like Coal India in West Bengal are also contributing to the success of the programme. The participation of tea estates in the RNTCP in Dibrugarh in Assam and Jalpaiguri in West Bengal has given especially encouraging results. In the year 2003-04, tea garden hospitals detected 42 percent of the new smear-positive cases in Dibrugarh and 32 percent cases in Jalpaiguri. (Agarwal *et al*., 2005)

Health care services provided by public sector undertakings such as Employees' State Insurance (ESI), Railways and Central Government Health Services (CGHS) also cater to a large segment of the society. Now ESI, the Railways and CGHS, as well as the Ministries of Defense, Steel, Coal, Mines, Petroleum and Natural Gas, Shipping, Power, Chemicals and Fertilizers, have given directives to their respective health facilities to adopt the DOTS strategy, and patients are being registered under the RNTCP at the respective health facilities. (Agarwal *et al*., 2005) RNTCP has had interacted with the major organizations of corporate house like Confederation of Indian Industries, World Economic Forum, Federation of Indian Chamber of Commerce and Industry (FICCI) and the trade unions.

The PPM initiative was scaled up in 12 cities in 2003. The providers were classified into six basic categories: state government health services; government facilities outside state government (ESI, Railways, etc.); medical colleges; the private sector; NGOs; and the corporate sector. Initial trends from the intensified PPM pilot sites show that the systematic involvement of various health sectors can lead to an increase in case detection. Encouraged by the early results of the project, the Central TB Division expanded the project to another eight cities in October 2004. (Agarwal *et al*., 2005)

Challenges

However, over a period of 7-8 years there was a felt need for revision of the schemes of PPM in view of newer initiative like DOTS plus, TB-HIV collaboration to improve access of DOTS for TB patients. Following areas are identified for collaboration with NGOs:

1. TB advocacy, communication and social mobilization scheme
2. Sputum collection center scheme,
3. Sputum pickup and transportation scheme
4. Designated microscopy centre scheme
5. Laboratory technician scheme
6. Culture- DST scheme
7. Treatment adherence scheme
8. Urban slum scheme
9. Scheme for TU
10. TB-HIV scheme

The top-down PPM-TB policy initiatives are too technical in their implementation; this has widened the barriers of mistrust within the TB programme. (De Costa *et al*., 2008) To deal with

an unorganized private sector at the sub district level for example, the TB programme needs to be flexible enough. The experiences of people implementing DOTS and their abilities to deal with the patients need to be explored exhaustively and accordingly, and support them with appropriate strategies for ensuring the success of TB control efforts. (Salve *et al*., 2016)

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