CORRESPONDENCE

Public-private imbroglio: why should TB patients suffer?

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In India, tuberculosis (TB) remains a major public health problem despite the continued efforts of the Revised National Tuberculosis Control Programme (RNTCP). About 3 million people who developed TB in 2012 were missed by national notification systems, of which 31% were in India.¹ There is low case detection rate for multidrug-resistant TB (MDR-TB) across the globe, including India.

Private health care providers play a major role in providing curative services; nearly 46% of TB patients are treated in the private sector or outside the RNTCP.² Evidence suggests that about 50% of retreatment cases registered in the RNTCP were recently treated outside the programme setting.³ The prevalence of drug-resistant TB among retreatment cases is 12–16% in India.⁴ Although there has been some progress in testing programme-registered patients, no information is available from the private sector, which accounts for nearly half of all TB patients in India; most of these are not managed well and are thus at a higher risk of drug resistance.

While India's National Strategic Plan (2012–2017) for TB control talks about extending RNTCP services to the private sector, the operational guidance is still not clear; one such aspect that needs attention is access to culture and drug susceptibility testing (CDST).⁵

It is imperative to screen sputum samples of all retreatment TB cases by DST, irrespective of the source of treatment provider. In the programmatic management of drug-resistant TB (PMDT), only those patients registered under the RNTCP, 'programme patients', undergo DST, depending on the criteria implemented for screening patients in the district. The patients' sputum samples are screened at RNTCP-accredited DST laboratories for drug resistance using diagnostic tech-

nologies such as line-probe assay, solid culture or GeneXpert.

However, current PMDT guidelines remain inflexible on the subject of examining sputum samples referred directly from private health care providers. These 'private sector patients' are channelled to the RNTCP, and only then are they screened for DST, during which significant time has elapsed, thereby increasing morbidity and mortality among such patients. To strengthen ongoing TB control efforts in the country the RNTCP should be more flexible and include the private health sector in the provision of quality TB diagnostic services. This endeavour will not only benefit TB patients in India, it will also ensure timely notification to the programme. The confidence gained in the private sector will pave the way for smooth implementation of public-private sector strategies currently envisioned.

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