Delay in tuberculosis care: one link in a long chain of social inequities

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In public health teaching, tuberculosis (TB) has been a traditional example of how disease occurrence is determined by the triad agent, environment, host. And it has since long been standard textbook knowledge that there are strong socioeconomic determinants behind all three components: The agent is more prevalent and is spread more easily in conditions of crowding and poor hygienic conditions, and under these conditions several host factors are also more prevalent, such as malnutrition and alcoholism.

In recent years another dimension has been added to the socioeconomic patterning of TB: An already very solid mass of research has highlighted the social and economic aspects of care and follow-up of patients with TB. A recent example of this research is the paper by Wang et al. in this issue of the journal, on differences in both patient’s delay and doctor’s delay in the diagnosis of TB, when comparing residents and non-residents (rural immigrants) in Shanghai.

To put the work by Wang et al. in perspective, the social patterning of treatment and care of TB can be seen to result from four different factors: 
(i) Adequate knowledge of TB, so that potential patients seek health services for advice and examination. 
(ii) Appropriate access to health services. 
(iii) Making the correct diagnosis promptly so that appropriate measures can be taken and 
(iv) Assuring adequate medication, compliance with treatment and follow-up of patients.

Good general lay knowledge of TB is important for both health care seeking and adherence to treatment. Studies from Malaysia, China and Vietnam have shown that treatment is often delayed due to poor knowledge, particularly in lower socioeconomic groups. Many in these groups are not aware of the risks associated with long-standing cough, they are not reached by national programmes and they do not recognize the need for prompt case detection, follow-up and treatment.

Access to health services is a basic condition for assessment, diagnosis and treatment. Among the main barriers to access are distance to health services, lack of insurance coverage and cost for visits. Language and other cultural barriers are also important. The findings by Wang et al. suggest that immigrant status in the Shanghai context does not only imply lower income and lack of insurance, but also fear of losing one’s job if the employer finds out about the disease.

One aspect of inequity in making the diagnosis promptly is differences in doctor’s delay, as reported by Wang et al. The authors suggest different handling procedures in the health care system as one explanation for this, as has been found in studies comparing urban and rural areas. They point out that immigrant patients who are non-residents and uninsured tend to be lost in the referral procedure. Another dimension is gender differences in tuberculosis diagnosis, as has been found in several studies from Vietnam. Wang et al. did not find significant gender differences in delay, perhaps due to low number of subjects.

Although follow-up and treatment are not addressed by Wang et al., it is clear that migrant status and poor insurance coverage strongly impede correct follow-up and maintenance of treatment. On a global scale, Uplekar et al. have pointed out that a large proportion of patients in high prevalence countries such as India, Pakistan, Philippines and Uganda have their main contact with private practitioners, and that many of these tend to deviate from recommended tuberculosis management practices. Many of these practitioners are found in urban slums.

In addition to giving further evidence for social determinants in the detection and care of patients with TB, the paper by Wang et al. illustrates how monitoring patient’s delay and doctor’s delay can be an important part of quality control in TB care. Measures specific to TB could be taken to alleviate the problem, such as free TB care, as suggested by Wang et al.

Barriers in access to health care are, however, not limited to TB, and the problem of access to care for immigrants and other disadvantaged groups is a major problem all over the world. Furthermore, this example from China, albeit not unique in the world, shows how a situation with a high proportion of uninsured persons in combination with high cost for treatment (relative to income) may seriously hamper TB control.

While a recent report from the WHO (19 March 2007) has shown that the global TB epidemic has levelled off for the first time since the WHO declared TB a public health emergency in 1993, concern should be raised over phenomena in society that might strengthen the social inequity in detection and care of TB. The findings by Wang et al. illustrate how rapid urbanization, migration and differential access to care may lead to inequities in TB care.

References