



Scope, functioning, current problems and future of Peripheral Cancer Centers (PCCs) in India



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ABSTRACT

Public sector PCCs in India are sanctioned for and established in different geographical regions of its administrative states. PCCs are usually located away from the state's capital with the aim of increasing access of patients to common cancer therapy and to improve the cancer out-reach activities. Away from state capital in remote locations, these PCCs may escape political and administrative surveillance and may subsequently become non-functional. However, non-functional PCCs can be made functional by collective national parliamentary, state political leadership's and bureaucratic efforts. Continuous effective functioning and non-repetitiveness of past .i.e. dysfunction or cessation of function of PCCs are strongly dependent on the bureaucratic and professional commitment of the local staff.

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1. Introduction

PCCs are usually located in different administrative regions of the state in order to cater to needs of cancer patients of those regions. PCCs are equipped with facility to treat commonly prevalent malignant tumors with facility for co-ordinated referral to regional cancer centers (RCCs) or super-specialty centers for management of, for .e.g. hematological or brain tumors respectively. Aim of PCCs is to increase access of cancer patients to cancer treatment and improve cancer out-reach activities across the administrative divisions of the state [1]. However, some of the administrative divisions are located at quite far a distance and is isolated and remote from the political, economical and administrative capital of the state. Escaping surveillance of political and administrative machinery is inherent by the unique characteristics of their isolation and remote locations. In such situations, PCCs ceases to function due to local, state power or central political and overall bureaucratic factors [2,3]. Special efforts in the form of legislation, persistent political efforts and bureaucratic drive are necessary to revive the function of non-functioning PCCs [4–8]. However, survival of the revived PCCs across India is dependent on the commitment, integrity and sincere efforts of local bureaucracy and staff. In this paper, we will discuss the problems faced by PCC in India, efforts to resolve them and the challenges that are

evident and will arise in future that may push this center to the state of its immediate non-functioning past.

1.1. About PCCs and the reasons behind its closure

PCC are established with the aim of improving access to treatment and cancer out-reach activities in the administrative divisions of the state usually in the vicinity of general hospital. Administrative control of and access of patients to cancer center are the two most important factors in determining location of PCCs in the campuses of general hospitals. Usually Cobalt-60 (Co-60) tele-therapy equipment and cervical brachytherapy equipment are procured for the treatment of patients. The process of appointment of regular specialist radiotherapy doctors, nurses, radiotherapy technicians, physicists and other ancillary staff are carried-out to fortify the man-power of public sector hospital [9]. The usual pattern is that these centers function well till some of the following factors probably start to take effect in day-to-day activities. Political under-representation of region in the subsequent years of electorate democracy, political pressure from PCC staff of non-regional origin to get transfer/deputation to state capital or the local districts of origin of these staff, retirement of staff in the absence of recruitment process in public hospitals, pressure from local staff to shift patients from public health set-up to private clinics, hospitals and diagnostic laboratory, lobbying of private players for patient referral to private hospitals from general public sector hospitals rather than to public cancer centers, regular attitude of some public servants of getting benefit, salary and stability of public sector

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jobs without actually being present and/or performing their duties and absence of support, co-ordination and patronage from general hospital with respect to diagnosis, referral, supportive care and administration. To summarize, PCCs due to the aforementioned factors, like other public hospitals soon lose popularity among general public who actually visit their state capital, un-affordable private health-care providers or neighboring state capital for their tertiary specialty health issues. The outcome of exodus of patients of these backward geographical is that large majority of marginally affordable patients fail to comply the grossly subsidized prescribed investigations and default therapy in expensive metros due mostly to monetary issues [2–8].

1.2. Case example of PCC-Gulbarga (PCC-G)

Gulbarga / Kalaburagi is an administrative district in the state of Karnataka, India with Bangalore as administrative, economic and cultural state capital. Gulbarga is located about 650 kilometers (403 miles) from Bangalore and is in territory of Hyderabad-Karnataka region (HKR) of the state of Karnataka. Gulbarga is farther by travel distance from Bangalore than the administrative capitals of neighboring states of Karnataka except Mumbai. Special status was accorded to this region in 2012 due to socio-economic backwardness as compared to and remoteness of this region from the rest of Karnataka. Gulbarga is much more proximal to and better connected to neighboring state's capital of Hyderabad than its own state's capital. However, Kannada the official language of state of Karnataka is the dominant language of this region. And also, Gulbarga has good representation in state legislative assembly and hence persistent political efforts to improve the region are ongoing phenomenon [4,5,10]. Revival of non-functioning PCC-G is part of such political endeavor that has started to bear fruits. PCC-G located in administrative district of Gulbarga is controlled administratively by Kidwai Memorial Institute of Oncology (KMIO), Bangalore. Successfulness of such efforts would not have been possible without the bureaucratic support from KMIO, Bangalore [9].

PCC-G was started in early 1990s as a specialty unit in the campus of District Hospital, Gulbarga. It had its share of ups and downs till the following turn of events [9]. Parliamentary special status was conferred to HKR through article 371 J in 2012. Special packages, reservation in employment to people from this region, employing only HK residents to public facilities of this region are some of the provisions of this article. Increased investment in this region leading to better living opportunities combined with exclusively recruiting the technical and specialty staff from this region to public offices has overcome some of the factors leading to cessation of function of PCC-G [4,5,10].

Secondly, constant political engagement has revived the function of PCC-G by the following. a. Weekly rotational posting of doctors from state capital cancer center to PCC-G. b. Timely recruitment of the needed man-power to restart the function of PCC-G c. Writing proposal for grants and securing the same.

Thirdly, bureaucratic machinery has responded to political efforts by posting doctors on weekly rotation to PCC-G and these doctors actually reported and worked in PCC-G for the assigned period and time. Conducting smooth recruitment process implementing the provision of article 371 J is another example of bureaucratic co-operation facilitating political will and commitment.

Finally, co-operation by local staff of PCC-G is final and crucial step in furthering the political endeavor at reviving it. PCC-G, as a result, is in the process of commissioning intensity modulated radiotherapy (IMRT) capable new linear accelerator, replacement of Co-60 source of the old tele-therapy machine, recruitment of professional radiotherapy staff consisting of faculty radiation

oncologist, faculty medical physicists (not able to still fill the post under 371 J due to non-availability of candidates) and radiotherapy technologists and renovation of entire cancer hospital complex [6–8,11].

Facilitation of acceptance and implementation of public health insurance scheme has made it possible to start treatment of more than 10 patients in a week. Physical consequence of cancer was responsible for inability of 5 patients to receive radiotherapy and were offered best supportive care (personal communication). Newly recruited doctors were trained in manual conventional planning to implement treatment without simulator for the time-being. They were also trained in three-dimensional / 3D conformal radiotherapy (3-D CRT) and IMRT planning, brachytherapy procedures including interstitial implantation for cervical cancer, supportive care and decision-making in radiation oncology at KMIO, Bangalore. It was suggested to enroll non-HKR medical physicist personnel to Ph.D. program as an incentive to retain him in PCC-G or to provide permanent post after passing an ordinance to 371 J.

1.3. Challenges faced by some public sector PCCs in India

Nearly 70% of patients planned on the day of their presentation for conventional radiotherapy will default for initiation/completion of treatment in PCCs. Not-at-all or not-in-time implementation of public or employers' health insurance scheme thereby denying the needy patients of life-saving and life-prolonging radio-therapy or radio-chemotherapy is the major administrative challenge of the time. Lack of alternative ideas to circumvent the situation on the part of professional staff is aggravating the problem of poor access to radiotherapy despite the presence of active treatment unit. Professional and administrative staff can deny treatment for reasons of audit objection while Co-60 source decay with time and lose its half-life each day.

Sick-absenteeism, poor work etiquette continue to plague local ancillary and supportive staff of public sector cancer centers. Lethargy in implementation of treatment both administratively and physically looms large as the doctors on schedule hardly plan couple of new cases during a week. Poor services in public sector hospitals, influence and pressure of private touts on health-care professionals (HCPs), patients and their care-providers are responsible for commonly witnessed problem of exodus of patients to private sector hospitals locally or to the capital city of the state.

It is a known fact that Co-60 based conventional technique can address most of the radiotherapy needs of prevailing cancer types in developing countries. However, too much reliance, off late, on newer and advanced radiotherapy planning and implementation technology and techniques by new generation of radiation oncology specialist is aggravating the problem of access in populations already having in- / under-access to radiotherapy. Young radiation oncologists, unaware / lack knowledge and commitment / unable to plan patients by conventional technique, tend to blame the system for lack of adequate needed infrastructure and technology or place radiation portals that may under-dose/miss the tumor or part of the region of radiation target. Newer technology and the associated cost are already known to prevent access to cancer and general treatment of disadvantaged masses of these socio-economically backward regions. Past lesson learned from tertiary premier cancer centers of developing countries should not be forgotten lest the fear of closing down radiation oncology treatment and residency program. Technologically state-of-art and advanced centers of state of Kashmir (1980s) and Delhi (early 2010s) have all closed down due to their inability to establish and maintain radiotherapy program despite excellent state budget. Radiation oncology departments in developing countries should not replace conventional radiotherapy techniques and technology with advanced ones. Newer and latest advances in radiotherapy

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