Managing Non-Communicable Diseases at A Secondary Level Hospital

Sir,

Non-Communicable Diseases (NCDs) are currently managed mostly in tertiary hospital and in private sector. Here we describe our experience of management of NCDs at a public sector secondary level hospital at Comprehensive Rural Health Services Project, Ballabgarh, a Collaborative project between All India Institute of Medical Sciences and State Government of Haryana.

The NCD clinic is operational here since 2001. It is held once a week on Thursday afternoons. A NCD file is made for registered patients. Standard guideline protocol was developed for Diabetes Mellitus (adapted from recommendations of Indian Diabetes Association) and for hypertension (from JNC-6 report). Only first line drugs are provided by hospital. Nominal fee is charged for basic laboratory investigations.

An evaluation was carried out in October 2006 to review functioning of this clinic. Data were collected by reviewing case files and interviewing the concerned doctors. A total of 314 files from 2002-2005 were reviewed. Outcome variables were duration and regularity of follow-up, adherence to protocol, control of disease status and operational problems.

Average new registration was around 2 patients per clinic and attendance was 40-50 per clinic. Forty-six percent were men. About a third of the patients were above 50 years, and 27.7% in the age group of 41-50 years. Of total patients, 118 (37.6%) were hypertensive and 80 (25.5%) were diabetic. Seventy-four (23.6%) had both hypertension and diabetes. The rest had Coronary Artery Disease.

Seventy-nine patients (18%) were lost to follow-up. Mean duration of follow-up was 2.5 years and mean number of visits was 19.7/year/patient. In 94% of patients, initial drug was prescribed according to “the protocol.” Initial Blood Pressure was recorded for 93% and measurements as per guidelines were done for 72.7% of patients. Initial weight and height was measured for 45.9% and 26.1% of the patients. Ophthalmologic examination was recorded for 15.6%.

At enrolment, mean Systolic BP and mean Diastolic BP for the hypertensives were 154.6 and 97.27mm of Hg and at evaluation the mean was 139.41 and 86.42 mm Hg respectively. The mean fasting blood sugar for the diabetes patients at enrolment was 172.7 gm/dl and post-prandial blood sugar level was 241 gm/dl and at the time of evaluation, the mean was 124.2 and 187.67 gm/dl respectively. These do indicate, on an average, treatment has been effective in bringing down levels of blood pressure and blood sugar.

However there were major challenges in running the NCD clinic. One is operational issues in running the clinic (availability of ophthalmologist during clinic time, maintenance of instruments and patients’ records). Non-pharmacological component of treatment like counseling and behavioral modification was not included, due to non availability of counselor and dietician. Adherence of the standard protocol by doctors was difficult because of frequent rotation of doctors posted.

Our experience shows that NCDs can be managed at the secondary care level hospitals too, and this will greatly reduce the load in the tertiary hospitals. While resources are necessary, leadership and team building are more important for creating a paradigm shift in the health care.

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