



## Inhalt

- |                               |       |
|-------------------------------|-------|
| 1. Internationale Nachrichten | p. 1  |
| 2. Forschung & Entwicklung    | p. 4  |
| 3. Reportage                  | p. 8  |
| Impressum                     | p. 10 |

## Internationale Nachrichten

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### 1. TB sidetracked in the fight against HIV epidemic in Malawi

Tuberculosis seems to have fallen between the cracks in poverty-stricken Malawi's sponsor-dependent health sector. The dominating focus on HIV may have left parts of Africa with a skewed health service, say researchers.

In Malawi in southern Africa, one of the poorest nations in the world, 50,000 new cases of tuberculosis are registered every year, compared to 5000 about 30 years ago. SINTEF scientist Lisbeth Grut has identified clear signs that information about TB is not reaching out to all strata of the population as well as campaigns about HIV do.

Grut has carried out a research study that interviewed disabled people in Malawi about the knowledge of epidemics. The informants turned out to be well informed about how to take precautions against HIV. However, they were confused when the questions turned to the causes and treatment of TB. Some of them did not even know that TB is an infectious disease, while many believed that it affected only people who already have HIV, and some did not know whether or not they had been tested for TB.

"This difference in an indication that the comprehensive efforts to prevent the spread of HIV in Malawi, supported as these efforts are by a number of international organisations, are taking place at the expense of information about tuberculosis. This is a serious matter, given that resistant strains of TB are rapidly becoming more widespread," says Grut.

According to the SINTEF scientist, disabled persons' experience of TB campaigns may be a good proxy measure of the quality and availability of health services in low-income countries. This is because disabled persons in these countries tend to have poorer access to information and health services than the rest of the population.

"Lack of information is a barrier that locks many people out of the struggle against TB. This studies on individuals perception of TB in Malawi is unique and its findings are so alarming that we hope that they will inspire strengthened efforts to eliminate TB in Malawi, says SINTEF's experienced health services researcher.

"Do other low-income countries have the same problem?"

"What we know is that many development aid providers of development aid are disease-specific organisations. Some of them have focused on fighting AIDS, others on malaria. In Malawi, a country whose health services are completely reliant on aid, it looks as though the HIV campaign has made it difficult to establish a holistic way of thinking about healthcare. Something very similar is probably taking place in other poor countries. We can only hope that this will now be investigated, not least in order to document whether the fight to eliminate TB in other countries meets similar problems and a need to reorient efforts to improve health services."

A total of 89 persons were interviewed as part of SINTEF's Malawi project. Of these, 47 were suffering from various types of disability, and 11 were family members of young people with disabilities. Health-care workers and local village leaders were also interviewed. The findings showed



that the logistics that ought to support the diagnosis and treatment of TB are poorly adapted to the needs of persons with disabilities.

"Some people who had attended the clinics were turned away because of a shortage of personnel, others because they had turned up on days when the clinic's TB service was closed. It is more strenuous for people with disabilities to get to a clinic than it is for other people. If their first visit was unsuccessful, they were less likely to repeat the attempt, which is why people with disabilities tend to be worst affected by logistics problems of this sort," says Grut.

"What needs to be done to improve the spread of information and the inadequate logistics situation?"

"In many poor countries, the health services need to be restructured and their quality and capacity improved. In simple terms, this means that the number of competent health workers must be increased, and that these countries need to develop a decentralised health service that focuses on improving general health rather than on individual diseases," says Lisbeth Grut.

Source: News Medical, <http://bit.ly/1RbhPsF> (11.12.2015)

## **2. Union World Conference on Lung Health: Romania's poor relegated to antiquated tuberculosis care**

CAPE TOWN, South Africa – When Jonathan Stillo asked the medical director of a mountaintop sanatorium in Romania what she would like to change about the sanatorium, she said she would like to blow the place up and build a small, modern clinic in town where the patients are – a model that's more in-line with current tuberculosis control practices which encourage treating patients in their communities.

Stillo, a member of the TB Europe Coalition and a doctoral candidate at the City University of New York, spent several years researching tuberculosis in Romania. He lived for months in one of the world's last remaining sanatoria – a throwback to an era before antibiotics when tuberculosis patients were exiled to isolated medical facilities for tuberculosis care. Thanks to cutbacks to social welfare programs, the sanatorium is often the only choice for Romania's poor who are infected with tuberculosis, Stillo explained. "The patients were at the sanatorium because they couldn't afford a home or afford to feed themselves," he said at the Union Conference on World Lung Health on Thursday.

The Soviet-era sanatorium was built in the 1930s to care for 800 tuberculosis patients and today houses between 150 and 200 patients, most of whom have multidrug and extensively drug resistant tuberculosis.

Being at the sanatorium didn't help patients, however. Stillo found after returning to the sanatorium months after completing his research there that every single one of the MDR and XDR-TB patients he had known had died.

Romania accounts for a quarter of all tuberculosis cases in Europe, and has the most drug resistant tuberculosis cases in the region. The country also has the world's lowest treatment success rate for MDR-TB, with just 16 percent of MDR-TB patients successfully completing treatment, Stillo said. This rate is similar to the "spontaneous cure rates" of patients who receive no treatment at all, according to the TB Europe Coalition.

Romania's national TB program is severely underfunded, with the Ministry of Health receiving the smallest budget as a percentage of gross domestic product in the European Union. It also lacks technical knowledge, Stillo said, which often results in medicine shortages. Romania and other Eastern European countries have problems bringing in bedaquiline and delamanid, he said, adding, "TB programs just don't know how to deal with procurement challenges."

With so many challenges to TB control in Romania, a proposed tuberculosis law is welcome news for TB patients and caregivers. The law would require several services to be available for TB patients: universal access to treatment and directly observed therapy, paid medical leave, psychosocial support and services, and even a monthly food allowance for the duration of treatment. But, Stillo said, unsurprisingly, the bill is at a standstill because of concerns over costs.



If TB control efforts in Romania and other high-burden countries remain as they are, the world will see more patients like Iulian, who Stillo met during his time at the sanatorium. Iulian was first diagnosed with drug susceptible TB in 2007, then multidrug-resistant TB in 2010, and finally was diagnosed with XDR-TB in 2012, the same year he died. Iulian and patients like him are failed by the system at every step, Stillo said. Iulian's progression to and eventual death from XDR-TB was most likely caused by a stockout in one of his medicines, Stillo wrote in this piece.

"Ultimately, what killed this man is more complicated than tuberculosis," Stillo wrote. "Iulian's death certificate says that he died of tuberculosis, but more accurate causes of death is poverty and living in a country that is unable or unwilling to dedicate the resources necessary to ensure that even the poor can be cured of TB."

**Source:** Center for Global Health Policy, <http://n.pr/1QV2jix> (10.12.2015)

### **3. White House Releases Plan To Fight Multidrug-Resistant Tuberculosis - But will it ever get the funding to get off the ground?**

The Obama administration unveiled a long-awaited plan to combat the growing threat of multidrug-resistant tuberculosis, a deadly strain of the number one infectious killer in the world.

While tuberculosis advocates are thrilled with the ambitious scope and potential unifying force of the National Action Plan, many worry whether the funds will be made available to implement it.

The plan is the first from the White House to address the global threat of MDR-TB, the more deadly strain of tuberculosis that develops after inappropriate TB treatment, head on. It recommends that the U.S. better track and identify the disease, boost international capabilities to fight it, and develop new drug regimens and vaccines.

"TB has been one of those issues that has been neglected historically by the global health community," said Eric Goosby, the U.N. special envoy on tuberculosis. "I'm very complimentary of the administration to feature MDR as the threat that it is."

Tuberculosis kills over 4,100 people a day, and the World Health Organization announced in its 2015 Global Tuberculosis Report this fall that it had overtaken HIV/AIDS as the most deadly infectious disease. Experts worry that the continued spread of MDR-TB could increase exponentially in the coming years.

Over 480,000 people worldwide are estimated to have developed MDR-TB this year, and the disease has about a 50 percent cure rate, if treated. Over 75 million additional people could lose their lives to MDR-TB in the next 35 years, estimates a recent United Kingdom report. While there are only a hundred or so cases of MDR-TB currently in the United States, the airborne nature of the disease and its growing presence around the world adds up to a global health threat.

"TB anywhere is TB everywhere, and we really need to look at how to reduce the risk both domestically and globally of MDR-TB ... recognizing if we don't act now, it will get worse," said Dr. Rebecca Martin, the acting director of the Center for Global Health at the Centers for Disease Control and Prevention. "What this plan affords us is really an opportunity across the U.S. government to promote the coordination of U.S. government resources both in our domestic and global efforts."

The White House's proposal to deal with the disease is ambitious, with a call to "initiate treatment for 25 percent of patients with MDR-TB in 10 countries with the highest burdens of MDR-TB" by the end of 2016 alone. The National Action Plan would require early check-ins with the secretary of state, the secretary of health and human services, the administrator of the U.S. Agency for International Development and heads of other relevant departments over the plan's five-year span, which ends in 2020.

The plan aims to treat 200,000 additional MDR-TB patients, on top of the 360,000 additional patients who are already accounted for in the U.S. Government Global TB Strategy 2015–2019, which is a separate plan. Treating these additional 560,000 patients in the 10 countries with the highest burden of MDR-TB would most likely include working more extensively with China, Russia and India.

Achieving these goals will depend on the ability to mobilize funds from the private and public sector. The plan notes that its ultimate success will be "subject to budgetary constraints and other



approvals, including the weighing of priorities and available resources by the Administration in formulating its annual budget and by Congress in legislating appropriations."

Funding would need to be increased by at least \$112 million in the next year to hit the National Action Plan's ambitious goals, according to David Bryden, a tuberculosis advocacy officer for Results, a nonprofit advocacy group.

Prior to the release of the plan, the Obama administration had proposed cutting USAID's TB funding by nearly 20 percent over the last three years, though Congress stopped it.

Two similar action plans on MDR-TB, released by the CDC in 1992 and 2009, laid out very similar goals for prevention and research -- but they never got the funding to get off the ground.

Yet Dr. Anthony Fauci, the director for the National Institute of Allergy and Infectious Disease, believes the unifying call of the plan will help make funding for tuberculosis a higher priority at the National Institutes of Health, USAID, CDC and other U.S. agencies. "That's what you'll probably see across agencies, the prioritization of this," he said. "I think we'll be able to implement the national action plan."

Fauci said the plan could set a global example. "It's ... an effort to mobilize the political will and additional financial in-kind commitments from other donors -- bilateral, multilateral donors, private sector partners, the governments from the affected countries. So one of the positive spinoffs is to ... galvanize the will and the political commitments of others to focus on latching onto this plan."

Dr. Mario Raviglione, the director of the WHO's global TB program, echoed Fauci, saying he hopes the National Action Plan motivates greater investment in combating MDR-TB around the world.

"This bold move by the United States, I hope it's followed ... by a similar type of attitude and bold moves by other European countries," Raviglione said. "Especially in Europe, people are simply ignoring the fact that MDR-TB is at the border."

For Joanne Carter, the executive director of Results, the plan could become not only an example for other countries, but a model of ambition in dealing with this global health crisis.

"We see it as a really important Christmas present. We're really, honestly, just happy [it came out] ... in advance of final revisions of the 2017 budget."

**Source:** Huffington Post, <http://huff.to/1NM4LDM> (23.12.2015)

## Forschung & Entwicklung

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### 1. Plant-based drug can fight resistant TB

Scientists from India and the US say they have discovered a group of compounds that can kill *Mycobacterium tuberculosis*, the bacterium responsible for causing tuberculosis (TB), by disabling a major defence mechanism it uses to survive in the human body.

Amit Singh at the department of microbiology and cell biology, centre for infectious disease and research at the Indian Institute of Science, Bangalore, says, "These compounds show tremendous promise as lead scaffolds for the development of new, anti-TB treatments. Specifically, these compounds inhibit the function of a critical enzyme responsible for survival of *M. tuberculosis*."

The study, supported by the National Institutes of Health, India's ministry of science and technology and the Wellcome Trust-Department of Biotechnology alliance was published November in *ACS Chemical Biology*.

Singh says the new compounds "belong to the ellipticine plant alkaloid family, which also is active in targeting cancerous cells". He adds that the "active compounds have exerted a very high activity against drug-resistant *M. tuberculosis* strains isolated from patients of Indian origin." Alkaloid-containing plants have been used from ancient times to treat diseases or as intoxicants.

India has the highest burden of TB in the world with an estimated two million cases annually, with many individuals infected with the multi-drug resistant (MDR) and extensively drug-resistant (XDR) strains as well.

Some 95 per cent of deaths from TB occur in developing countries in Asia and Africa. The six



countries that stood out as having the largest numbers in 2014 were China, India, Indonesia, Nigeria, Pakistan and South Africa.

Kate Carroll, chemistry professor at the Scripps Research Institute, Jupiter, Florida, and lead author of the study, stresses that individuals infected with dormant bacteria do not show any symptoms but may serve as a reservoir for *M. tuberculosis*. "The problem is that this reservoir is gigantic with an estimated two billion people in the world carrying latent TB infection."

"These new compounds have shown potent bactericidal activity against active as well as dormant form of drug-susceptible and MDR/XDR strains, as well," Carroll says. "Currently, we are testing their effectiveness in animal models of TB infection and once their pre-clinical and clinical effectiveness is confirmed, these compounds or their analogs can be potentially used in the treatment of MDR/XDR TB as well as persistent TB infection."

Carroll says the new compounds may be given alone, or more effectively, as a combination of multiple drugs. "These compounds can break a key bacterial defence and potentiate the action of other anti-TB drugs as well as kill persistent *M. tuberculosis* bacterium on their own," she says.

Singh's lab has also generated a series of compounds that were found to exert efficient killing of drug-resistant superbugs. He proposes "targeting mechanisms involved in resisting oxidative stress or elevating the levels of oxidative stress inside bacterial cells" as strategies against TB infection.

**Source:** SciDev.Net, <http://bit.ly/1RZBEmr> (21.12.2015)

## 2. Could A New Berry-Flavored Pill Help Stop Childhood TB?

A six-month course of pills for tuberculosis can ward off lifelong disability or death. But children with TB have to take the same drugs as adults, and getting kids to swallow those large, foul-tasting tablets is no easy task.

So for global health groups — and parents around the world — the arrival of kid-friendly, berry-flavored TB medicine is a big win. Researchers debuted the new treatment this month at the annual Union World Conference on Lung Health in Cape Town, South Africa.

"TB is already such a long struggle," said Monique Davids, a Cape Town-based mother of two children with TB who spoke at the conference. "At least the treatment doesn't have to be such an ordeal anymore."

Many children with TB never complete their treatment because they reject their cut or crushed-up portions of adult-sized pills. The new strawberry- and raspberry-flavored medicines dissolve in water and come in precise kid-sized doses. "Making a kids' version of this medicine is obviously a no-brainer," says Dr. Mel Spigelman, president of the nonprofit TB Alliance, which helped coordinate the development of the new medication. "But it's taken a really long time because unfortunately, we live in a world where if you can't make a big profit on something it doesn't get done too quickly."

Pharmaceutical companies have had little financial incentive to develop medication for TB, which generally affects the poorest of the poor communities worldwide, Spigelman says. The TB Alliance, with funding and support from UNITAID, USAID and other health groups, lobbied several pharmaceutical companies until it found a couple that were willing to develop the kid-friendly medicine.

The World Health Organization has approved the new drugs through an expedited process, and the governments of several countries are beginning to review the drug as well, Spigelman says. Kenya has already placed an order and will begin distributing the drugs within the next two or three months.

It will cost about \$15 for a six-month course of these medications — right now, the adult doses cost between \$14 and \$22 for a full course.

The hope, Spigelman says, is that this new formulation will help cut down the number of childhood TB cases worldwide. The disease remains one of the world's biggest killers, even though nearly all cases can be cured, according to WHO. According to the latest WHO statistics, TB killed 1.5 million people last year — and 140,000 of the victims were children.

The disease spreads through the air when an infected person coughs or sneezes. It usually affects the



lungs. Left untreated, it causes patients to cough up blood as their bodies waste away — until they die. Around half a million people worldwide develop a drug-resistant form of TB that's exceedingly complicated to cure.

Since the symptoms can be mild for months, the illness can be difficult to detect, especially in children, Spigelman notes. The most common diagnostic method involves using a microscope to look at a sample of saliva and mucus coughed up by a patient. But TB bacteria can look very similar to bacteria that cause other infections. And often kids don't produce enough sputum to properly examine. "Think about it — if you try to tell your 1-year-old, 'Will you please cough in this cup and give me some of your sputum,' you're not going to go very far," Spigelman says. "So the next step is developing a simple test to reliably diagnose TB."

"Don't get me wrong, this new medicine can make a big impact," he adds. "But we've still got a ways to go."

**Source:** NPR, <http://n.pr/1QV2jix> (22.12.2015)

### **3. Did poor bedside manner cause the rise of multidrug-resistant TB?**

The Stop TB Partnership recently published Every Word Counts, Suggested Language and Usage for Tuberculosis Communications, the language guide for those involved, either directly or indirectly, in addressing the tuberculosis epidemic. The document called for people with TB infection to be put at the centre of the global TB response, starting with “acknowledging that the language commonly used to speak about TB must evolve.”

Our decades of working with people with HIV and AIDS taught us, as the guide suggests, that “language influences stigma, beliefs and behaviors, and may determine if a person feels comfortable with getting tested or treated.”

Yet, I wonder whether part of reason for producing the Every Word Counts document is that TB caregivers and service providers, doctors, nurses, lab technicians and DOT providers risk treating TB patients like problems to be solved, rather than people to be helped and healed.

This was the premise of the hugely successful U.S. TV show *House* in which an unconventional, misanthropic medical genius saved patients from obscure illnesses while ignoring their humanity. That kind of brusque, dispassionate induction certainly made for compelling television, but could it also be a partial reason behind the rise of drug-resistant infectious diseases, including TB?

A 2012 article in the *Journal of Tuberculosis and Lung Disease* noted that the powerfully negative connotation of words such as “defaulter” and “suspect” placed blame for the disease and responsibility for adverse treatment outcomes on just one side: people with TB. Is it any wonder that patients fail to complete their treatment or don't return for checkups if they are made to feel guilty? Tuberculosis remains one of the world's most deadly diseases, killing three people every minute. Each year 9 million people develop TB and 1.5 million die from the disease. About three in every 100 new cases of TB could not be treated with first-choice antibiotics. While it's completely right to call for \$56 billion to bring an end to TB, we should not underestimate the importance of genuinely involving the patients themselves and their communities as active participants in diagnosis and treatment.

World Vision has seen the significant impact of so-called sponsor schemes such as Grameen in Somalia, where community volunteers commit to help TB patients in successfully completing their treatment courses. We have also seen how powerful counseling and appropriate communication skills can be at every stage of identifying and treating TB infection.

Both of these interventions are less about clever techniques aimed at solving a problem, and more about recognizing that at the centre of it all is a person in need of compassion and genuine care. This is why, at this year's Union World Conference on Lung Health in Cape Town, South Africa, World Vision opted to offer a one-day workshop on counseling skills for TB caregivers, largely based on our experiences in India.

We have learned that effective TB programming should include TB-counseling training, and that counseling must happen at every stage of diagnosis and treatment — from cough to cure. Social





workers, psychologists, doctors, technicians and community health workers can all be equipped to establish and ensure a patient-centric approach in disease management that builds patient-provider trust and co-ownership of the course of treatment. Basic training in such ‘soft skills’ as interpersonal communication, negotiation, conflict resolution, time management and team building can equip service providers to better explore and shape a client’s attitude to their diagnosis and treatment. Such training will also make providers think twice about automatically speaking to patients and their loved ones from a place of authority and technical expertise, using the kind of lexicon Every Word Counts seeks to avoid.

Of course using insensitive words when speaking to those affected by TB is not the only reason for the rise of MDR TB. However, a patient-centred approach employing the right vocabulary — plus compassionate counseling techniques that demonstrate sincere concern for TB-affected individuals, their close social circles and family members — will ensure most people with TB seek and complete treatment. This will give the bacterial infection much less opportunity to adapt and thrive.

**Source:** Devex, <http://bit.ly/1JJBmTk> (08.12.2015)

#### **4. First new TB drugs in half a century reach just 2% of people who need them**

Cape Town, 3 December 2015—Nearly three years since the first of two new tuberculosis (TB) medicines became available, the drugs remain out of reach for people who need them, with just two percent of people eligible for these treatments actually receiving them. The drugs bedaquiline, produced by Johnson & Johnson (Janssen) and delamanid, produced by Otsuka, are the first new TB treatments to become available in half a century, and offer hope for people with drug-resistant forms of TB. Médecins Sans Frontières (MSF) called on the two companies to ensure faster global access to these drugs by registering and making their products available in affected countries and offering affordable prices to low- and middle-income countries.

Tuberculosis is a curable disease that continues to kill around 1.5 million people per year, with new cases of drug-resistant forms affecting nearly half a million people annually. According to World Health Organization, barely a quarter of people thought to have multidrug-resistant (MDR-TB) were put on treatment in 2014, with only about half of those successfully completing treatment. For people with an even more severe form of the disease, extensively drug-resistant TB (XDR-TB), the treatment success rate drops to just one in four.

“It’s beyond infuriating to know that there are medicines out there that could offer hope to people who have exhausted all other treatment options, but that so few people have access to them,” said Dr. Grania Brigden, MSF Access Campaign TB Advisor. “What’s the point of a new potentially life-saving treatment if the people who need it the most cannot access it?”

Data from MSF projects and elsewhere show improved responses in treatment using the drug bedaquiline with culture conversion rates of 84%, 97%, 75% and 77% after six months of treatment in XDR-TB patients in Armenia, France, Russian Federation (Chechnya) and South Africa respectively.

Access to bedaquiline and delamanid is severely limited. Less than 3000 people have received bedaquiline as of November 2015. Only about 100 people have received delamanid through compassionate use programmes. These numbers are pathetic considering there are an estimated 48,000 people with XDR-TB globally and at least twice as many with pre-XDR-TB and MDR-TB who would meet WHO criteria for the new drugs.

One major barrier to accessing these drugs is the fact that they remain registered in only a limited number of countries, with bedaquiline registered in just seven of the world’s 27 high MDR-TB burden countries, and delamanid registered in just four countries, none of which has a high MDR-TB burden (Japan, Germany, the UK and South Korea). Delamanid has not been registered in any of the countries where the clinical trials took place.

The companies that produce the two drugs have set up limited donation programmes, but the cap on the number of treatment courses is far below the need, and certain high-burden countries are completely excluded. South Africa, for example, is not eligible for the bedaquiline donation, and there is a quota on how many countries in Central Asia can receive the donation. Rollout has also



been slow, with Georgia, the first recipient of the bedaquiline donation, starting to receive treatments a full ten months after the donation programme was first announced. Otsuka announced its own donation programme in April, committing to provide delamanid to 20 percent of people diagnosed with MDR-TB by 2020, however no further information has been provided by the company since it was announced. These donation programmes not only fail to meet the needs of patients today, but also serve to obscure the need for these drugs to be priced affordably for all developing countries, so that governments and treatment providers can procure adequate quantities to meet patient needs on a sustainable, long-term basis.

Another barrier is the high price set in countries where on-going donation programmes do not apply. The new drugs are being added to a treatment regimen that already costs between US\$1,800 to \$5,000 per treatment course. Bedaquiline has a tiered pricing structure ranging from \$900 - \$30,000 for a six month treatment and a six month course of delamanid currently sells for \$33,600 in Japan. A recent study by researchers at Liverpool University showed future regimens containing bedaquiline or delamanid could be priced at less than \$500 per treatment course.

“With two new TB drugs now available and increasing evidence of their potential value in treating MDR-TB, clinicians must have access to the full toolbox of potentially effective drugs, so they can create individualised regimens that offer DR-TB patients the best possible chance to survive,” said Dr. Brigden. “J&J and Otsuka need to commit to making their drugs available in all affected countries as soon as possible and provide affordable prices; no regimen should cost more than \$500 per person, including with the use of these drugs.”

**Source:** MSF, <http://bit.ly/1PI0I01> (05.12.2015)

## Reportage

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### 1. Why the profit-driven market model doesn't work in health care

“Is medicine a business or is that an oxymoron?” asked the moderator of panel members convened by Leadership Charlotte recently.

When I started my medical career, we reflected on the nature of medicine – namely, whether it was an art or a science. No one talked about the business of medicine.

Healing medicine has been practiced for over 2000 years, and scientific medicine for more than 100. The perception of medicine as a business is relatively new.

We now view medical care as a commodity, much as we view buying shoes. Though the market model is pervasive, it does not apply to everything. Some services remain public goods such as police protection, fire protection, and education. I posed this question to our audience: Why do we view health care as different from education, to which most of us believe all children are entitled?

Applying the market model to medical care is a poor fit. Many factors interfere with choice, on which market models rely, in health care. When patients have decisions to make about medical care, they are often scared, vulnerable – and sick. If your doctor tells you you need an MRI because you might have a brain tumor, you are unlikely to do extensive research to see which is the cheapest or most accurate – or if an MRI is actually indicated. And, if you research a medical intervention, you are likely to find cost information opaque – and reliable quality measures even more elusive.

A for-profit system creates perverse incentives. Insurance companies make money for investors when they provide less care. For-profit medical institutions have troubling outcomes. Investor-owned hospitals are more expensive. Death rates are higher in for-profit hospitals and dialysis units.

Drug companies make more profits when they sell newer drugs, still patent-protected. This leads to promotion of new drugs as safe, such as rofecoxib (Vioxx), an anti-inflammatory. After being widely prescribed, it was linked to thousands of deaths.

This incentive to promote new drugs obscures the fact that it is generally better to take an old drug rather than the glittery new drug being promoted. Also obscured is the fact that often non-drug treatments are superior. For instance, exercise is often as effective a treatment for depression as





antidepressant medications.

Your neighbor's health care has different implications for you than most things that we view as commodities. While we are unaffected by which shoes our neighbors buy, their health and health care affect us. For example, we are better off if the sick server at our local restaurant can see a doctor and have the flu or tuberculosis diagnosed and treated.

One of the biggest casualties of the marketization of medicine has been the doctor-patient relationship. When I started my practice, the patient and I were the only ones in the exam room. Now, the room also contains an insurance company, an administrator and a coding specialist. Though invisible, they all have something to say about what the doctor does.

Is the "business of medicine" its future or a blip in a distinguished history that spans centuries? Do the words of our exemplars still inspire us? If so, let Sir William Osler, father of modern medicine, have the last word: "We are in the profession as a calling, not as a business. . . Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed."

**Source:** The Charlotte Observer, <http://bit.ly/1Sv54lr> (18.12.2015)

## 2. Can the world really "end" tuberculosis?

Tuberculosis is on the decline worldwide. That's the good news! The bad news is that TB remains endemic in scores of countries around the world and sickens millions each year. The international community is going to need to make a huge push in the next 15 years to achieve the Sustainable Development Goal of eliminating TB by 2030

At an international meeting in Cape Town last week, The 46th World Conference on Lung Health, global health watchers got a sneak peak into how the WHO and partners plan to meet this goal.

The WHO reports that while TB deaths have nearly halved since 1990, but 4,400 people are still *dying every day* from disease; 1.5 million people, worldwide, died from TB in 2014. As conveyed last week in Cape Town, that's 1.5 million, too many, given that TB is preventable and curable.

Consistent with the October 2015 release of WHO's Global Tuberculosis Report, the convening in Cape Town reinforced that, in order to complete the job, a paradigm shift from *reducing TB* to *ending TB* will be necessary, and laid out the prescription:

One of the applicable lessons from HIV- the disease currently ranking alongside TB in preventable and curable killers- is that stigma is a roadblock along the continuum of detection, treatment, and prevention. Juliet Vivien Nalumu is an HIV-positive mother in Uganda and a "mentor mother" with mothers2mothers. She shared her story at the conference about being HIV-positive and pregnant; the stigmatization was one of the largest contributing factors in the delay of her treatment and preventing the HIV transmission to her twin babies. The misperceptions and misconceptions of a disease can quite literally have lethal effects in creating a gap between detection and treatment.

The same can be said of TB. "There is a misconception around the mask", exclaimed president of The International Union Against Tuberculosis and Lung Disease, José Luis Castro, as he spearheaded the #UnMasktheStigma campaign, both at the conference and on the Twittersphere. "Behind the mask (referring to protective face masks required for TB patients), we are all the same"; a highly promoted theme by The Union and the global TB community. The gap between stigma and interruption of disease detection and management remains a public health crisis. According to WHO's report, in 2014, of the 9.6 million who fell ill with TB, 6 million (62.5%) actually reported it. The report went on to find that worldwide, more than a third (37.5%) of TB cases in 2014 went undiagnosed or were not reported.

(The danger of not reporting data is that in the absence of this critical information, government officials and public health agencies cannot have any longitudinal or trending analyses, and cannot make informed decisions on prioritizing and distributing resources; something The Union North America and Bloomberg Philanthropies Data For Health Initiative is working to address)

You guessed it: One of the primary themes and commonalities across the TB dialogue is that we must grow and maximize the resources available and close the funding shortfalls. In order to close the diagnostic and treatment gap, sufficient funding will need to be made available by all WHO Member



States. Last week's meetings in Cape Town proposed a solution that's been a top contender among solution finders: tobacco product taxation. The proposed solution would impose an excise tax on tobacco products and, subsequently, use the funds to finance health research and access to treatment. The current proposed models present a significant step in the marrying of two concurrent goals: addressing risk behaviors in lung health (smoking cessation) and earmarking the tax funds to achieve TB and broader lung health measures; a simple idea that appears to be a win/win strategy for both fiscal health and public health.

According to the World Health Organization funding shortfalls amounted to \$ US 1.4billion of the US \$8billion needed to efficaciously implement full-scale interventions. In order to meet TB elimination goals, science will need to be heavily funded. Specifically, we're talking extremely advanced research into new diagnostics, drugs and vaccines (especially for those MDR-TB), as well as facility resources, and community health channels. In order to accomplish this, an annual funding gap of *at least* US\$ 1.3billion is needed, according to the WHO TB report).

The "End TB Strategy"- adopted by all WHO Member States- serves as a roadmap to "reduce TB incidence by 80% and TB deaths by 90%, and to eliminate catastrophic costs for TB by 2030". Completely eradicating TB (adopted as one of the Sustainable Development Goals), is nearly within reach, but in the hopes of it not being evasive, cooperation will be needed to see this last leg through to fruition.

WHO Director-General, Margaret Chan, stated that "The report shows that TB control has had a tremendous impact in terms of lives saved and patients cured. These advances are heartening, but if the world is to end this epidemic, it needs to scale-up services and critically invest in research.

So, yes, let us celebrate the achievements that have been made in reducing TB mortalities, but not forget about the work that still needs attention to achieve total eradication. "Despite the gains, the progress made against TB is far from sufficient", Dr. Chan warns.

Mr. Castro reminded audiences last week in Cape Town that "Know, Share, Act" should be an overarching reminder to the ending-TB approach. The paradigm shift to ending TB calls for larger-than-ever- and significantly more unified- commitment to eliminating the disease.

So reset your stopwatches to 2030 and to the 61st World Conference on Lung Health (Date and Location TBA).

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## **Impressum:**

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