

Hard gains through soft contracts: productive engagement of private providers in tuberculosis control

Knut Lönnroth,^a Mukund Uplekar,^a & Léopold Blanc^a

Abstract Over the past decade, there has been a rapid increase in the number of initiatives involving “for-profit” private health care providers in national tuberculosis (TB) control efforts. We reviewed 15 such initiatives with respect to contractual arrangements, quality of care and success achieved in TB control. In seven initiatives, the National TB Programme (NTP) interacted directly with for-profit providers; while in the remaining eight, the NTP collaborated with for-profit providers through intermediary not-for-profit nongovernmental organizations. All but one of the initiatives used relational “drugs-for-performance contracts” to engage for-profit providers, i.e. drugs were provided free of charge by the NTP emphasizing that providers dispense them free of charge to patients and follow national guidelines for diagnosis and treatment. We found that 90% (range 61–96%) of new smear-positive pulmonary TB cases were successfully treated across all initiatives and TB case detection rates increased between 10% and 36%. We conclude that for-profit providers can be effectively involved in TB control through informal, but well defined drugs-for-performance contracts. The contracting party should be able to reach a common understanding concerning goals and role division with for-profit providers and monitor them for content and quality. Relational drugs-for-performance contracts minimize the need for handling the legal and financial aspects of classical contracting. We opine that further analysis is required to assess if such “soft” contracts are sufficient to scale up private for-profit provider involvement in TB control and other priority health interventions.

Bulletin of the World Health Organization 2006;84:876-883.

Voir page 881 le résumé en français. En la página 881 figura un resumen en español.

يمكن الاطلاع على الملخص بالعربية في صفحة 882.

Introduction

Private health care providers play a prominent role in delivering curative services in the majority of low-income countries.¹⁻⁵ They are often the first point of contact for a large number of rich and poor patients and manage a significant number of patients with diseases of public health importance.¹⁻⁴ However, many private providers are known to diagnose and treat inappropriately a range of diseases, such as tuberculosis (TB),⁶ malaria,⁷⁻⁹ human immunodeficiency virus infection/acquired immune deficiency syndrome (HIV/AIDS)¹⁰ and sexually transmitted infections.^{11,12} They also tend to prescribe antibiotics irrationally.^{1-4,13} Several studies have reported that private providers rarely monitor the effects of treatment, maintain clinical records, or notify diseases of public health importance.¹⁻¹³

Contracting with private providers for health services delivery is often perceived as a possible mechanism for governments to “withdraw” or be selective in their commitment to health-care provision and a way to improve efficiency

of health-care provision by introducing market mechanisms.¹⁴⁻¹⁶

In reality however, in many countries, private providers already manage most patients and operate on a largely free health-care market, while providing low quality care.¹⁻⁴ In such instances, contracting can instead be used as a mechanism for governments to reach out and establish a working collaboration with existing private providers and to ensure that they provide high quality services at low cost to patients.

Contracting is defined as “a voluntary alliance between independent partners who accept reciprocal duties and obligations and who expect to benefit from their relationship.”¹⁴ A standard contract defines in detail the mutual responsibilities between the contractual partners, the financial conditions of the contract and the legal implications of a breach. A “softer” version of contracting, called “relational contracting,” involves mutual agreement between the collaborative partners about the general terms of collaboration. Financial transactions play a less important role.

Relational contracts are not legally enforceable, but end when either of the partners withdraw. Such contracts may have lower transaction costs and be less complicated to handle for both health authorities and providers with limited capacity to write, manage and monitor standard contracts.¹⁵

In most countries, National TB Programme (NTP) implementation of quality assured and subsidized TB diagnosis and treatment has been limited largely to public sector services. In reality, however, many patients with symptoms of TB, including the very poor, do seek and receive care from a wide variety of health-care providers outside the network of NTP services, who often provide care of questionable quality at a high cost to patients.^{5,6} Over the past ten years an increasing number of initiatives involving such private providers in TB control have been undertaken to help align their practices with national and international standards of TB care.¹⁷ Today, over 40 “public-private mix” projects for improved TB control including some scaled-up programmes are in

^a Tuberculosis Strategy and Health Systems, Stop TB Department, World Health Organization, 1211 Geneva 27, Switzerland. Correspondence to Dr Lönnroth (email: lonnrothk@who.int).

Ref. No. 06-029983

(Submitted: 22 March 2006 – Final revised version received: 6 July 2006 – Accepted: 3 August 2006)

place in 15 countries.¹⁸ These include diverse projects linking NTPs to various care providers, such as private general practitioners, specialist chest physicians, private hospitals, non-qualified village doctors, informal and formal private practitioners, and not-for-profit non-governmental organizations (NGOs). Experiences from these initiatives may be useful in understanding how to establish suitable forms of agreement when attempting to engage the private sector in quality assured management of diseases of public health importance.

We reviewed initiatives that involved for-profit providers in TB control and describe the collaborative arrangements of such initiatives, and assess their public health effects in terms of quality of diagnosis and treatment as well as contribution to TB case detection.

Methods

We identified published articles and reports of interventions involving for-profit private providers in national TB control efforts in low-income countries for review by the following methods.

- A Medline search for articles published (irrespective of the language) between 1980 and 2005 inclusive, using the following keywords in various combinations: tuberculosis; DOTS; DOT; private; private health care; evaluation.
- Continuous review of Centers for Disease Control and Prevention's email list, "TB-Related News and Journal Items Weekly Update," between July 2002 and February 2006.
- Direct contact with NTPs, NGOs and academic institutions from 1999 onwards.
- Reference lists of all articles and reports were also screened for relevant references.

Definitions

A "private health-care provider" was defined as any for-profit health-care provider not owned by the government, including pharmacies as well practitioners of traditional medical systems.

A "for-profit" health-care provider was defined as a self-employed individual private practitioner or an institution that provided services for a fee and not on a charitable basis.

"Involvement in national TB control efforts" was defined as having an agreement with the NTP to carry out

one or several tasks relevant for implementing DOTS, including referring TB suspects, diagnosis of TB, treatment and defaulter tracing and keeping records and reports.

Technical assessment of quality of care

Assessment of quality and treatment outcome was normative, based on benchmark performances as defined by WHO.¹⁹ These included:

- Diagnostic quality: At least 65% of all registered pulmonary cases should be sputum smear positive.
- Case management quality: 100% of registered cases should be treated with an NTP recommended regimen under direct observation at least in the intensive phase.
- Treatment outcome: treatment success rate for new smear positive cases should be 85% or higher.

Evaluation

Our search yielded 20 articles and project reports evaluating 15 initiatives involving for-profit providers in eight countries (Table 1).^{20–38} Information on the technical assessment of quality of care mentioned above was available for all initiatives (Table 2) with the exception of one that did not report treatment results because our evaluation was done before treatment results were available.³⁰

The studies we reviewed included several initiatives that involved not-for-profit NGOs as intermediaries for the involvement of for-profit providers. These intermediary NGOs operated under an agreement with NTPs to either implement all aspects of the TB programme in the designated geographical area, including interaction with for-profit providers^{20,22,25} or manage certain aspects of the interaction with for-profit private providers, such as sensitization, training, supervision, and/or monitoring of individual private providers.^{30,32,35,38} Since the intermediary NGOs played a central role in these initiatives, we also partly describe the collaboration between NTPs and NGOs.

Findings

Role division and collaborative agreements

We found that 13 of the 15 reviewed initiatives targeted individual self-employed for-profit private practitioners

(Table 1). In all initiatives, private providers were trained and instructed to follow standardized procedures for diagnosis, treatment and monitoring as per the respective national guidelines. In all but two initiatives, free drugs were distributed from the NTPs to private providers on the conditions that they: followed recommended diagnostic procedures and disease classification; followed recommended treatment regimen; dispensed the drugs free of charge to patients; supervised treatment; and followed standards for referral, recording and reporting. In one initiative,³⁴ drugs were provided through an NGO at a subsidized rate to for-profit providers based on similar conditions. These "drugs-for-performance contracts" were verbal in relation to for-profit providers in most initiatives, though certificates and/or signposts stating that the provider had been "accredited" by the NTP were used by some.^{25,35,38} Direct monetary incentive was used in one initiative only.^{28,29} In the initiatives we reviewed, none used formal competitive tenders. The contract could be ended either by the private provider exiting the agreement, or by the NTP (or the intermediary NGO) withholding further drug distribution.

Eight of the 15 initiatives we reviewed also involved intermediary not-for-profit organizations. These intermediaries were national branches of international NGOs,^{22,35,38} a charitable hospital,²⁰ a medical association,³² research institutions,^{25,30} and a national TB association.³⁴ All these not-for-profit organizations had a formal agreement with the NTP defining their division and responsibilities. Two^{20,21,32} had contractual agreements detailing payments made by the NTPs to the not-for-profit organizations, while the not-for-profit organizations contributed their own financial resources in the other four. The legal status of these agreements was not well described in any of the studies.

Technical assessment of quality of care

We found that the proportion of smear positive cases of all cases registered ranged between 35% and 96% (Table 2). While directly observed treatment (DOT) was reported in all studies except in three initiatives,^{28,31,38} detailed information on actual DOT was available from five studies only. In Delhi (India), 95% of patients treated by private providers in

Table 1. Type of private providers, tuberculosis (TB) control functions, and collaborative agreements in reviewed initiatives

Site ^a	Start year	On-going 2006	Type of private for-profit providers	TB control functions of involved private for-profit providers ^b				Drugs-for-performance contracts ^c	Monetary incentives	NGO ^d intermediary
				Re-ferral	Diagnosis	Treatment	Defaulter retrieval			
Hyderabad, India ^{20,21}	1995	Yes	Physicians and non-allopathic practitioners	Yes	No	Yes	Yes	Yes	No	Yes
Damien Foundation, Bangladesh ²²	1997	Yes	Non-allopathic practitioners	Yes	No	Yes	Yes	Yes	No	Yes
Yangon (Shwepyitha), Myanmar ²³	1998	No	Physicians	Yes	Yes	Yes	Yes	Yes	No	No
Kathmandu Valley, Nepal ^{24,25}	1998	Yes	Physicians and pharmacies	Yes	No	Yes ^e	No	Yes	No	Yes
Makati, The Philippines ²⁶	1999	Yes	Hospital	No	Yes	Yes	Yes	Yes	No	No
Kannur, India ²⁷	2000	Yes	Physicians and private laboratories	Yes	Yes	Yes	Yes	Yes	No	No
Ho Chi Minh City, Viet Nam ^{28,29}	2001	No	Physicians and pharmacies	Yes	Yes ^f	Yes ^e	No	No	Yes	No
Pune, India ³⁰	2001	No	Physicians and non-allopathic practitioners	Yes	No	Yes	Yes	Yes	No	Yes
Yogyakarta, Indonesia ³¹	2001	Yes	Hospitals ^g	No	Yes	Yes	No	Yes	No	No
Delhi, India ^{21,32,33}	2001	Yes	Physicians (some with laboratories)	Yes	Yes	Yes	Yes	Yes	No	Yes
Nairobi, Kenya ³⁴	2001	Yes	Physicians	Yes	Yes	Yes	No	Yes	No	Yes
Mumbai, India ³⁵	2001	Yes	Physicians and non-allopathic practitioners	Yes	No	Yes	Yes	Yes	No	Yes
Mandalay, Myanmar ³⁶	2002	Yes	Physicians (some with laboratories)	Yes	Yes	Yes	Yes	Yes	No	No
Dhaka, Bangladesh ³⁷	2003	Yes	Physicians (some with laboratories)	Yes	Yes	Yes	Yes	Yes	No	No
Yangon (SQH Franchise), Myanmar ³⁸	2004	Yes	Physicians (some with laboratories)	Yes	Yes	Yes	Yes	Yes	No	Yes

^a The name of the site is followed by the study reference(s) in superscript.

^b NTP or intermediary nongovernmental organization responsible for all functions not mentioned in respective initiative, including training, supervision, quality control and overall surveillance.

^c Whether anti-TB drugs were provided from the national TB programme to private providers, on the condition that providers followed programme guidelines for diagnosis and treatment and dispensed anti-TB drugs free of charge to patients.

^d NGO = nongovernmental organization (not-for-profit).

^e Not including pharmacies.

^f Only chest specialists, not including pharmacies and general practitioners.

^g Both public and private hospitals.

the project confirmed treatment with DOT and free drugs when they were interviewed at the end of treatment.³² In the Damien Foundation initiative (Bangladesh), random urine tests for isoniazid revealed adequate levels in 98% of the tested samples.²² In Yangon (Myanmar),³⁸ 87% of patients interviewed during treatment reported that

they had received DOT. In Yogyakarta (Indonesia), patient visit-intervals to the hospital DOTS clinics for drug collection (family DOT) were found to vary between two and four weeks, though the national policy stipulates weekly visits and family DOT.³¹ We found similar visit intervals being reported from Ho Chi Minh City (Viet Nam).²⁹

In the studies we reviewed, treatment success rates for new sputum smear positive cases, treated in accordance with the DOTS strategy including provision of free drugs to the patients, ranged between 75% and 96%. Of the total 16 801 new smear positive cases evaluated in the different initiatives, 15 050 (89.6%) were reported to be successfully

Table 2. Quality of care indicators in reviewed initiatives

Site ^a	Number of NSP ^b cases evaluated	NSP treatment success % (95% CI) ^c	Per cent SS+ ^d of all PTB ^e % (95% CI)	NSP default rate % (95% CI)	Change in NSP case detection %
Damien Foundation, Bangladesh ²²	14 035 ^f	90 (90–90)	NE ^g	NE	NE
Hyderabad, India ^{20,21}	908	96 (95–97)	77 (72–82)	5 (4–6)	NE
Yogyakarta, Indonesia ³¹	386 ^h	75 (71–79)	NE	NE	NE
Kathmandu Valley, Nepal ^{24,25}	309 ⁱ	92 (89–95)	71 (68–74)	1 (0–2)	+15%
Mumbai, India ³⁵	296	81 (77–85)	NE	12 (8–16)	+11%
Dhaka, Bangladesh ³⁷	263	93 (90–96)	35 (32–38)	4 (2–6) ^j	+10%
Delhi, India ^{21,32,33}	168	81 (75–87)	50 (45–55)	14 (5–23)	+36%
Mandalay, Myanmar ³⁶	114	90 (88–93)	NE	5 (3–8)	28%
Ho Chi Minh City, Viet Nam ^{28,29}	107	61 (52–70)	38 (33–43)	34 (25–43)	+18%
Yangon (SQH Franchise), Myanmar ³⁸	99	84 (77–91)	66 (59–73)	8 (3–13)	+9%
Kannur, India ²⁷	85	92 (86–98)	88 (85–91)	5 (0–10)	+19%
Nairobi, Kenya ³⁴	55	84 (74–94)	NE	5 (0–11)	NE
Makati, The Philippines ²⁶	37	84 (72–96)	69 (61–77)	5 (0–12)	NE
Yangon (Shwepyitha), Myanmar ²³	32	88 (77–99)	96 (91–100)	3 (0–9)	NE

^a The name of the site is followed by the study reference(s) in superscript.

^b NSP = new sputum smear positive tuberculosis.

^c CI = confidence interval.

^d SS+ = sputum smear positive.

^e PTB = pulmonary tuberculosis.

^f Evaluated cases are those treated by private village doctors, which includes also cases diagnosed by the coordinating not-for-profit nongovernmental organization and then referred to primary provider(s) for treatment supervision.

^g NE = not evaluated.

^h Data not disaggregated for public and private hospitals.

ⁱ Evaluated cases include those treated in not-for-profit nongovernmental organization facilities.

^j Based on sputum smear conversion at three months.

treated. The change in case detection attributable to the collaboration was evaluated in eight studies. All these initiatives were associated with increased case detection, varying between 10% and 36% over an evaluation period ranging between nine months and three years (Table 2).

Discussion

Engaging private providers can improve TB control

Results of our review suggest that different types of for-profit private providers can be effectively involved in TB control. In all but two initiatives, the treatment success rates were above 80%, which were as good or better than the treatment success rates in the NTP facilities in the same settings.³⁹ This is noteworthy considering the low treatment success rates of around 50% reported in various previous studies of TB treatment results in the private sector.^{40,41} The treatment success rate was less than desired (75%) in Yogyakarta, reportedly due to difficulties with case holding in a hospital-based TB clinic with a large catchment area.³¹ The treatment success rate was

unacceptably low at 61% only in the Ho Chi Minh City initiative which had many inadequacies, such as treatment regimens not being fully standardized, free or subsidized drugs not being offered and treatment observation not being undertaken.²⁹

The increase in case detection rates of new smear positive TB cases in the initiatives we evaluated varied between 9% and 36%. The wide range is partly due to different baseline case notification and timeframes (varying between nine months and three years) for the evaluation of change in case detection. Furthermore, as the proportion of available private providers who were actually involved varied greatly between the sites, these figures are not directly comparable.

We found that of the total pulmonary TB cases, the proportion of sputum smear positive cases was above the target of 65% in six out of nine initiatives for which these data were available. Private providers have been reported to rely generally on chest X-ray for the diagnosis of pulmonary TB rather than on sputum smear microscopy.^{5,6} These findings indicate a shift from use of X-ray only

to the use of sputum microscopy in the majority of initiatives.

Drugs-for-performance contracts can help engage private providers

Our review revealed that agreements between the NTP (or an intermediary NGO) and for-profit providers were largely informal and verbal. Stipulations about monetary incentives or compensations were present in one initiative only. The complete absence of competitive tenders for contracts indicates the reluctance on the part of NTPs to resort to formal and complicated procedures to elicit collaboration. All initiatives (except one) had drugs-for-performance contracts between private providers and the NTP or the intermediary NGO. While relational contracts aided the collaboration between stakeholders by clarifying the role division and mutual responsibilities, they were not exhaustive and did not define penalties of breaches beyond the understanding that either party could withdraw from the collaboration if the performance of the counterpart was unsatisfactory. Though informal in nature, the distribution

of drugs was based upon well defined performance criteria and thus introduced accountability and operated as an important performance incentive. We identified other incentives, such as access to quality diagnostic services free of charge, free continued education and association with a reputed government programme, that were of importance to the for-profit-providers to initiate and sustain collaboration.^{25,30,32}

For-profit providers involved in the different initiatives were those already being used by people with TB. The NTPs continued their existing activities and were complemented by private providers. However, the Hyderabad (India) and Bangladesh initiatives started when the NTP had not yet covered all geographical areas, and intermediary NGOs served to establish NTP coverage in selected districts.

Our results imply that “soft” relational contracts were indeed effective in most initiatives and sustained over several years in many. On the flip side however, the process of reaching an agreement on role division and mode of collaboration was long-winded in several initiatives, sometimes stretching over a year or more.^{24,25,29,32,35} Barriers of mutual mistrust, lack of experience of public-private collaboration, and lack of experience of public health work in the private sector, can make the task of developing a working relationship seem daunting for both the private and the public stakeholders. Not all initiatives we reviewed were successful^{29,30}; and one initiative had required substantial re-boosting of commitment among involved partners before becoming a success.^{24,25} The “relational” aspect of collaboration, including constant dialogue, openness to change and stepwise development of collaborative terms, seems to be essential, whereas preparing formal contractual terms on paper seems less important.

It is our opinion that drugs-for-performance contracts should be based on the acceptance by all parties that performance needs to be monitored. The compulsory TB recording and reporting system (which all private providers involved in diagnosis and treatment of TB in the reviewed initiatives had to conform with) seemed to create a good basis for quality monitoring. There is a need for continuous supervision of the private providers by the NTP and/or intermediary NGO. To achieve this,

strong commitment for supervision and monitoring was highlighted as an important success factor in several initiatives.^{22,25,32,35,38} This would require the contracting NTPs to have sufficient management and supervision capacity to monitor private providers. Thus, the contracting party for a drugs-for-performance contract needs to have management capacity to reach a common understanding concerning goals and role division with private providers as well as have the capacity for quality monitoring of private providers. We found that the capacity to handle legal and financial aspects of contracting was less important for relational drugs-for-performance contracts.

Can relational contracting help scale up priority health interventions?

Many of the initiatives we reviewed were small-to-medium-sized and run by dedicated individuals. Thus, in such situations the need for formal contracts may be limited, while they become more important when applying working models to nationwide scale. The Government of India has developed guidelines for private sector involvement in TB control, including a set of standard schemes for different roles in TB care with well defined criteria for participation as well as clearly defined financial conditions.^{42,43} Availability of well defined schemes regardless, private providers in India tend to prefer informal agreements. The pros and cons of using formalized schemes versus informal agreements need to be evaluated. Unpublished observations from the Philippines suggest that a scheme to formally accredit private providers to allow access to the “TB package” within the national health insurance could increase the private provider coordination with the national TB guidelines. It is possible that a standard contractual arrangement may be required to scale up private sector involvement in TB control. Formal certification or accreditation mechanisms may be required, backed up by stronger regulation. Nevertheless, the examples of large-scale sustained initiatives that we reviewed, such as the involvement of more than 10 000 village doctors in rural Bangladesh over a nine-year period,²² showed that at least in some settings it is possible to sustain and scale up with informal, but well defined, drug-for-performance contracts, without the need

for direct financial incentives.

Drugs-for-performance contracts may be a viable mode of collaboration with for-profit private providers to help scale up other priority public health interventions as well. Experiences from TB control suggest that suitable interventions for drugs-for-performance contracts include those for which people often seek care in the private sector; there is a need to expand delivery beyond public health care infrastructure to improve access; there are clear and measurable performance criteria; and private providers have a motivation to participate. This may apply to anti-retroviral therapy, diagnosis and treatment of sexually transmitted diseases and malaria treatment.

Limitations and strengths of the review

Our review did not attempt to compare relational contracts with standard contracts or other types of agreements and does not therefore allow conclusions about the comparative advantage of relational contracting over other alternatives. The overall positive results across the studies we reviewed should be interpreted with caution due to the possibility of publication bias. It is expected that unsuccessful initiatives are less likely to be evaluated and reported. Furthermore, some of the reviewed initiatives were very small, and the pooled result across all initiatives was strongly influenced by positive outcomes of the two large initiatives in Bangladesh and India (Table 2).

The strength of our review was that it covered initiatives that involved a broad range of for-profit practitioners, including traditional and semi-formal practitioners as well as medical doctors and other health professionals. However, a factor limiting this generalizability was that seven of the eight countries covered in this review were Asian and all but one of the initiatives was in an urban setting. Published experiences from other regions and rural areas are still scarce. Our review focused on involvement of for-profit providers, mainly individual practitioners, and thus results should not be generalized to not-for-profit organizations and institutions, many of which are delivering TB care to defined catchment populations under various types of agreements with NTPs. ■

Competing interests: none declared.

Résumé**Engagement productif des prestataires privés dans la lutte antituberculeuse : des bénéfices bien réels sans contrat léonin**

Au cours de la dernière décennie, on a observé une rapide augmentation du nombre d'initiatives impliquant des prestataires de soins de santé privés («à but lucratif») dans les efforts de lutte contre la tuberculose. Nous avons analysé 15 de ces initiatives sous l'angle des dispositions contractuelles, de la qualité des soins et des succès obtenus dans la lutte antituberculeuse. Dans le cas de 7 d'entre elles, le programme national de lutte contre la tuberculose (PNT) traitait directement avec des prestataires exerçant une activité lucrative, tandis que dans le cadre des 8 autres, le PNT collaborait avec des prestataires à but lucratif, par l'intermédiaire d'organisations non gouvernementales à but non lucratif. Toutes ces initiatives sauf une faisaient appel aux prestataires à but lucratif en passant avec eux des contrats relationnels «Médicaments contre prestations», c'est-à-dire que les médicaments leur étaient fournis gratuitement par le PNT à la condition explicite qu'ils les distribuent gratuitement aux patients et qu'ils respectent les directives nationales en matière de diagnostic et de traitement. Nous avons constaté que, pour l'ensemble des initiatives, 90 %

(plage de variation : 61 - 96 %) des nouveaux cas de tuberculose pulmonaire à frottis positif avaient été traités avec succès et que le taux de détection de la tuberculose aurait augmenté de 10 à 36 %. Nous avons conclu que les prestataires à but lucratif pouvaient participer efficacement à la lutte antituberculeuse par l'intermédiaire de contrats informels, mais bien définis sous l'angle de la condition : médicaments contre prestations. La partie contractante doit être en mesure de parvenir à un accord concernant les buts et la répartition des rôles avec les prestataires à but lucratif et de surveiller le contenu et la qualité de leurs prestations. Les contrats relationnels de type Médicaments contre prestations n'exigent qu'une prise en compte minimale des aspects juridiques et financiers couverts par les contrats classiques. Nous sommes d'avis qu'une analyse plus poussée s'impose pour évaluer si ces contrats «souple» suffisent pour élargir la participation des prestataires privés à but lucratif à la lutte antituberculeuse et à d'autres initiatives sanitaires prioritaires.

Resumen**Ventajas de los contratos relacionales: contratación productiva de proveedores privados en la lucha contra la tuberculosis**

En el último decenio han proliferado rápidamente las iniciativas que recurren a proveedores de atención sanitaria privados con ánimo de lucro en las actividades nacionales de lucha contra la tuberculosis. Examinamos los acuerdos contractuales, la calidad de la asistencia prestada y los resultados obtenidos en la lucha contra dicha enfermedad en 15 iniciativas de ese tipo. En siete de ellas, el Programa Nacional contra la Tuberculosis trabajaba directamente con proveedores con ánimo de lucro, y en las ocho restantes colaboraba con proveedores con ánimo de lucro a través de organizaciones no gubernamentales no lucrativas. Exceptuando un caso, en todas las iniciativas se recurrió a «contratos de medicamentos por prestaciones» para hacer participar a los proveedores con ánimo de lucro, esto es, el Programa les proporcionaba los medicamentos de forma gratuita, pero insistiendo en que se dispensaran también gratuitamente a los pacientes y con arreglo a las directrices nacionales en materia de diagnóstico y tratamiento. Observamos que en todas las iniciativas

el 90% (intervalo: 61%-96%) de los nuevos casos bacilíferos de tuberculosis pulmonar habían sido tratados satisfactoriamente, y que las tasas de detección de casos aumentaron entre el 10% y el 36%. Nuestra conclusión es que los proveedores con ánimo de lucro pueden participar de forma eficaz en la lucha antituberculosa mediante contratos informales, pero bien definidos, de medicamentos por prestaciones. La parte contratante debe poder llegar a un consenso sobre los objetivos y el reparto de las funciones con esos proveedores, y vigilar el contenido y la calidad de sus servicios. Los contratos de medicamentos por prestaciones reducen al mínimo la necesidad de ocuparse de los aspectos jurídicos y financieros de los contratos ordinarios. Consideramos que es conveniente realizar un análisis en mayor profundidad para determinar si esos contratos simplificados bastan para extender masivamente la participación de los proveedores privados con ánimo de lucro en la lucha contra la tuberculosis y en otras intervenciones de salud prioritarias.

ملخص

مكاسب كبيرة من عقود مُبَسَّرَة: الإسهام المثمر للقائمين على القطاع الخاص في مكافحة السل

والمعالجة. وقد وجدنا أن 90% من حالات السل الرئوي الإيجابي اللطاخة قد عولجت معالجة ناجحة في جميع المبادرات (المدى 96.61%) وأن معدلات كشف حالات السل قد ازدادت بمقدار يتراوح بين 10% و36%. واستنتجنا أن القائمين على الرعاية من القطاع الخاص الذي يستهدف الربح يمكن أن يسهموا إسهاماً فعّالاً في مكافحة السل من خلال عقود غير رسمية، ولكنها محدّدة بتقديم الأدوية مقابل أداء العمل. وينبغي على الطرفين المتعاقدين التوصل إلى فهم مشترك للأهداف وتقسيم الأدوار التي ينبغي على القائمين على الرعاية من القطاع الخاص الذي يستهدف الربح القيام بها مع مراقبتهم من حيث الجودة والمضمون. إن العقود التناسبية لتقديم الدواء مقابل أداء العمل تقلل الحاجة للتعامل مع الجوانب الاقتصادية والقانونية لعمليات التعاقد الكلاسيكية إلى أقصى حد ممكن. وقد نحتاج للمزيد من التحليل لتقييم مثل هذه العقود الهشة وفيما إذا كانت كافية للنهوض بمدى إسهام القطاع الخاص الذي يستهدف الربح في مكافحة السل وفي التدخلات الصحية الأخرى ذات الأولوية.

لوحظت زيادة متسارعة خلال السنوات القليلة المنصرمة في عدد المبادرات التي يشارك فيها القائمون على الرعاية من القطاع الخاص (الذي يعرف بأنه يستهدف الربح) في الجهود الوطنية لمكافحة السل. وقد راجعنا 15 مبادرة من هذه المبادرات من حيث الإجراءات التعاقدية وجودة الرعاية والنجاح الذي تم إحرازه في مكافحة السل. وقد كان البرنامج الوطني لمكافحة السل يتعامل مباشرة مع القائمين على الرعاية من القطاع الخاص الذي يستهدف الربح في سبعة برامج، أما في البرامج الثمان المتبقية فإن البرنامج الوطني لمكافحة السل تعاون مع القائمين على الرعاية من القطاع الخاص الذي يستهدف الربح عبر منظمات لاجهوية لا تستهدف الربح. وقد لجأت جميع المبادرات لاستخدام (عقود تقديم الأدوية مقابل أداء العمل) لإتاحة المجال أما القائمين على الرعاية من القطاع الخاص الذي يستهدف الربح للإسهام بالعمل؛ وذلك بأن يقدم البرنامج الوطني لمكافحة السل الأدوية مجاناً لضمان أن القائمين على الرعاية من القطاع الخاص الذي يستهدف الربح يوزعونها مجاناً للمرضى، وأنهم يتبعون الدلائل الإرشادية للتشخيص

References

1. Bennett S, McPake B, Mills A, editors. *Private health providers in developing countries: serving the public interest?* London: Zed Books; 1997.
2. Brugha R, Zwi A. Improving the quality of private sector delivery of public health services: challenges and strategies. *Health Policy Plan* 1998;13:107-20.
3. Smith E, Brugha R, Zwi A. *Working with private sector providers for better health care: an introductory guide*. London: Options & London School of Hygiene and Tropical Medicine; 2001.
4. Mills A, Brugha R, Hanson K, McPake B. What can be done about the private health sector in low-income countries? *Bull World Health Organ* 2002; 80:325-30.
5. *Health systems: improving performance. The world health report 2000*. Geneva: WHO; 2000.
6. Uplekar M, Pathania V, Raviglione M. Private practitioners and public health: weak links in tuberculosis control. *Lancet* 2001;358:912-6.
7. Cong LD, Yen PT, Nhu TV, Binh LN. Use and quality of antimalarial drugs in the private sector in Viet Nam. *Bull World Health Organ* 1998;76:51-8.
8. Kamat VR. Private practitioners and their role in the resurgence of malaria in Mumbai (Bombay) and Navi Mumbai (New Bombay), India: serving the affected or aiding an epidemic? *Soc Sci Med* 2001;52:885-909.
9. Brugha R, Chandramohan D, Zwi A. Viewpoint: management of malaria — working with the private sector. *Trop Med Int Health* 1999;4:402-6.
10. Sheikh K, Porter J, Kielmann K, Rangan S. Public-private partnerships for equity of access to care for tuberculosis and HIV/AIDS: lessons from Pune, India. *Trans R Soc Trop Med Hyg* 2006;100:312-20.
11. Chalker J, Chuc NT, Falkenberg T, Do NT, Tomson G. STD management by private pharmacies in Hanoi: practice and knowledge of drug sellers. *Sex Transm Infect* 2000;76:299-302.
12. Voeten HA, Otido JM, O'Hara HB, Kuperus AG, Borsboom GJ, Ndinya-Achola JO, et al. Quality of sexually transmitted disease case management in Nairobi, Kenya: a comparison among different types of healthcare facilities. *Sex Transm Dis* 2001;28:633-42.
13. Chuc NT, Tomson G. "Doi Moi" and private pharmacies: a case study on dispensing and financial issues in Hanoi, Vietnam. *Eur J Clin Pharmacol* 1999;55:325-32.
14. Perrot J. *The role of contracting in improving health systems performance. Discussion paper number 1- 2004*. Geneva: WHO, 2004. EIP/FER/DPE.04.1.
15. Palmer N. The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries. *Bull World Health Organ* 2000;78:821-9.
16. McPake B, Banda EE. Contracting out of health services in developing countries. *Health Policy Plan* 1994;9:25-30.
17. Tuberculosis Coalition for Technical Assistance. *International Standards for Tuberculosis Care (ISTC)*. The Hague: Tuberculosis Coalition for Technical Assistance; 2006.
18. World Health Organization. *Public-private mix for DOTS. Towards scaling up. Report of the Third Meeting of the PPM Subgroup for DOTS Expansion*. Geneva: WHO; 2005. WHO document WHO/HTM/TB/2005.356.
19. World Health Organization. *Tuberculosis handbook*. Geneva: WHO; 1998. WHO document WHO/TB/98.253.
20. Murthy KJ, Frieden TR, Yazdani A, Hreshikesh P. Public-private partnership in tuberculosis control: experience in Hyderabad, India. *Int J Tuberc Lung Dis* 2001;5:354-9.
21. Floyd K, Arora VK, Murthy KJR, Lönnroth K, Singla N, Akbar Y, et al. Cost and cost-effectiveness of public and private sector collaboration in tuberculosis control: evidence from India. *Bull World Health Organ* 2006;84:437-45.
22. Hamid Salim MA, Uplekar M, Declercq E, Aung M, Daru P, Lönnroth K. Turning liabilities into resources: the informal village doctors and TB control in Bangladesh. *Bull World Health Organ* 2006;84:479-84.
23. Zaw W, Sein W, Aung TN, Myint K, Cho W, Phyu P, et al. Case load and treatment outcome of pulmonary tuberculosis patients with DOTS strategy implemented by general practitioners in Shwepyithar township. *Myanmar Med J* 1999;43:8-12.
24. Hurtig AK, Pande SB, Baral SC, Newell J, Porter JD, Bam DS. Linking private and public sectors in tuberculosis treatment in Kathmandu Valley, Nepal. *Health Policy Plan* 2002;17:78-89.
25. Newell JN, Pande SB, Baral C, Bam DS, Malla P. Control of tuberculosis in an urban setting in Nepal: public-private partnership. *Bull World Health Organ* 2004;82:92-8.
26. Quelapio ID, Mira NRC, Abelada MR. Directly observed therapy — short-course (DOTS) at the Makati medical center. *Philippine J Microbiol Infect Dis* 2000;29:80-6.
27. Kumar MK, Dewan PK, Nair PK, Frieden TR, Sahu S, Wares F, et al. Improved tuberculosis case detection through public-private partnership and laboratory-based surveillance, Kannur District, Kerala, India, 2001-2002. *Int J Tuberc Lung Dis* 2005;9:870-6.
28. Quy HT, Lan NTN, Lönnroth K, Buu TN, Dieu TTN, Hai LT. Public-private mix for improved TB control in Ho Chi Minh City, Vietnam: an assessment of impact on case detection. *Int J Tuberc Lung Dis* 2003;7:464-71.
29. Quy HT, Lönnroth K, Lan NTN, Buu TN, Dieu TTN. Treatment results among patients treated by private lung specialists involved in a public-private mix project in Ho Chi Minh City, Vietnam. *Int J Tuberc Lung Dis* 2003;7:1139-46.

Knut Lönnroth et al.

30. Rangan SG, Juvekar SK, Rasalpurkar SB, Morankar SN, Joshi AN, Porter JDH. Tuberculosis control in rural India: lessons from public-private collaboration. *Int J Tuberc Lung Dis* 2004;8:552-9.
31. Voskens J, Prihatini S, Wuryaningtyas B. *Evaluation of the hospital DOTS linkage project in DI Yogyakarta*. Jakarta: Ministry of Health, KNCV and WHO; 2003.
32. Arora VK, Sarin R, Lönnroth K. Feasibility and effectiveness of a public-private mix project for improved TB control in Delhi, India. *Int J Tuberc Lung Dis* 2003;7:1131-8.
33. Arora VK, Lönnroth K, Sarin R. Improving case detection of tuberculosis through a public-private partnership. *Indian J Chest Dis Allied Sci* 2004; 46:133-6.
34. Mwaniki DL, Kariuki JN, Kamigwi AG, Gathua S, Pathania V, Kutwa A. *Investigation towards a strengthened public-private partnership for tuberculosis control in Kenya — the Nairobi case study*. Nairobi: Kenya Medical Research Institute, Kenya Association for Prevention of Tuberculosis and Lung Diseases, National Leprosy and Tuberculosis Programme and World Health Organization; 2002.
35. Ambe G, Lönnroth K, Dholakia Y, Copreaux J, Zignol M, Borremans N, et al. Every provider counts: effect of a comprehensive public-private mix approach for TB control in a large metropolitan area in India. *Int J Tuberc Lung Dis* 2005;9:562-8.
36. Maung M, Kluge H, Aye T, Maung W, Noe P, Zaw M, et al. Private GPs contribute to TB control in Myanmar: evaluation at a PPM initiative in Mandalay Division. *Int J Tuberc Lung Dis* 2006; 10:982-7.
37. Ali A. *Progress report on public private partnership pilot project, Bangladesh*. Report to WHO. Dhaka: The Public Private Partnership Project; 2004.
38. Aung T. Sun Quality DOTS patient survey — an evaluation of the PSI Sun Quality DOTS franchise, Myanmar. Report to WHO. Yangon: Research and Communication Department, Population Services International, Myanmar; 2005.
39. World Health Organization. *Global tuberculosis control — surveillance, planning, financing*. Geneva: WHO; 2004. WHO document WHO/HTM/TB/2004.331.
40. Lönnroth K, Thuong LM, Lambregts K, Quy HT, Diwan VK. Private tuberculosis care provision associated with poor treatment outcome: comparative study of a semi-private lung clinic and the NTP in two urban districts in Ho Chi Minh City, Vietnam. National Tuberculosis Programme. *Int J Tuberc Lung Dis* 2003;7:165-71.
41. Uplekar MW, Juvekar SD, Parande DB, Dalal DB, Khanvilkar SS, Vadair AS, et al. Tuberculosis management in private practice and its implications. *Indian J Tuberc* 1996;43:19-22.
42. Ministry of Health and Family Welfare. *Involvement of non-governmental organizations in the Revised National Tuberculosis Control Programme*. New Delhi: Central TB Division, Ministry of Health and Family Welfare; 2001.
43. Government of India. *Involvement of private practitioners in the revised national tuberculosis programme*. New Delhi: Central Tuberculosis Division, Ministry of Health and Family Welfare; 2002.