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A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals

Research

Recherche

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Fast-tracked article

Background: Canadians are engaged in an intense debate about the relative merits of private for-profit versus private not-for-profit health care delivery. To inform this debate, we undertook a systematic review and meta-analysis of studies comparing the mortality rates of private for-profit hospitals and those of private not-for-profit hospitals.

Methods: We identified studies through an electronic search of 11 bibliographical databases, our own files, consultation with experts, reference lists, PubMed and SciSearch. We masked the study results before determining study eligibility. Our eligibility criteria included observational studies or randomized controlled trials that compared private for-profit and private not-for-profit hospitals. We excluded studies that evaluated mortality rates in hospitals with a particular profit status that subsequently converted to the other profit status. For each study, we calculated a relative risk of mortality for private for-profit hospitals relative to private not-for-profit hospitals and pooled the studies of adult populations that included adjustment for potential confounders (e.g., teaching status, severity of illness) using a random effects model.

Results: Fifteen observational studies, involving more than 26 000 hospitals and 38 million patients, fulfilled the eligibility criteria. In the studies of adult populations, with adjustment for potential confounders, private for-profit hospitals were associated with an increased risk of death (relative risk [RR] 1.020, 95% confidence interval [CI] 1.003–1.038; $p = 0.02$). The one perinatal study with adjustment for potential confounders also showed an increased risk of death in private for-profit hospitals (RR 1.095, 95% CI 1.050–1.141; $p < 0.0001$).

Interpretation: Our meta-analysis suggests that private for-profit ownership of hospitals, in comparison with private not-for-profit ownership, results in a higher risk of death for patients.

Canadian health policy-makers are considering an expansion of private for-profit health care delivery, including private for-profit hospitals.[1] Most of the debate has focused on whether private for-profit health care facilities can contain costs more effectively,[2–4] avoid differential access to health services (i.e., two-tier medicine)[5] and avoid letting foreign investors influence Canadian health care policy through the North American Free Trade Agreement (NAFTA).[6] What has been missing from this debate is consideration of the potential health outcomes of the proposed expansion of private for-profit health services.

Health care can be separated into 2 essential and distinct components: funding

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(i.e., who pays for health care) and delivery (i.e., who owns and administers the institutions or services that provide the care). Both funding and delivery can be public or private. Public funding means paid for by government (e.g., through the use of tax dollars); public delivery means government ownership and administration of health care facilities. Private funding and private delivery can both be for-profit or not-for-profit. On the funding side, insurance companies that channel premiums to pay for health care can be private for-profit or private not-for-profit. On the delivery side, hospitals and other health care delivery institutions that are private for-profit corporations are owned by shareholders or investors. Private hospitals can also be not-for-profit institutions that are owned by religious organizations, communities, regional health authorities or the hospital boards.

Public funding is the main method by which Canadian hospitals obtain revenue. However, 95% of Canadian hospitals are private not-for-profit institutions.[5] Because Canadians commonly use the term "public hospitals" to refer to private not-for-profit hospitals, many are unaware of the private ownership and administration of our hospitals.[6]

This study addresses issues of health care delivery, rather than health care funding. We undertook a systematic review and a meta-analysis to address the following question: What is the relative effect of private for-profit versus private not-for-profit delivery of hospital care on patient mortality?

Methods

We evaluated hospital mortality rates as a component of a larger systematic review that we are undertaking to compare health outcomes, quality and appropriateness of care, and cost in private for-profit versus private not-for-profit health care delivery systems. This publication presents the results of the hospital mortality review. The study process is outlined in Fig. 1.

We used 6 strategies to identify studies: an electronic search of 11 bibliographical databases; our own files; consultation with experts from several continents; a review of reference lists from articles that fulfilled our eligibility criteria; PubMed, using the "related articles" feature for all studies meeting our entry criteria; and SciSearch, for publications that cited any studies that fulfilled our entry criteria.

We used all the studies that we were initially aware of to identify medical subject heading terms and key words for the search. A librarian (N.B.) undertook an iterative process, for each database, to refine the search strategy through testing of several search terms and incorporation of new search terms as new relevant citations were identified. The search included the following databases: EMBASE (1980–2001), MEDLINE (1966–2001), HEALTHSTAR (1975–2001), CINAHL (1982–2001), BIOETHICSLINE (1973–2000), Wilson Business Abstracts (1997–2001), EconLit (1969–2001), Cochrane Library (2001, issue 3), Dissertation Abstracts Ondisc (1861–2001), ABI/INFORM (1970–2001) and NTIS (1964–2002). Complete listings of the database search strategies are available from the authors.

Our 6 strategies identified 8665 unique citations. Teams consisting of 2 individuals independently screened the titles and abstracts of each citation and identified all citations for full review when there was any possibility that the study contained a comparison we were interested in. This screening process yielded 805 full-text publications identified by one or both of the individuals in each team for full review (Fig. 1).

We masked the results (i.e., obscured them with a black marker from the tables and text) of all publications selected for full review. Teams of 2 individuals independently evaluated each masked article to determine eligibility. Our agreement on studies evaluated within teams was excellent (κ 0.83, 95% confidence interval [CI] 0.73–0.93). All disagreements were resolved by consensus. The consensus process required individuals to discuss the reasoning for their decisions. If one individual realized that she or he had made an error, then the process was complete. This occurred in all cases, and therefore an independent third adjudicator was

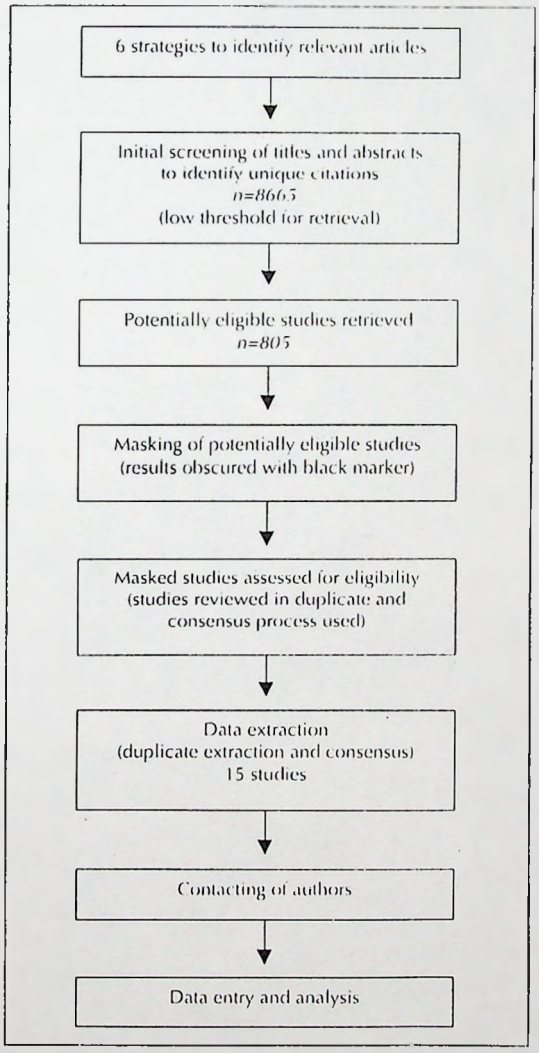

Fig. 1: Study process.

never required to resolve disagreements. Teams reviewed masked articles that they had not assessed during the screening process.

We included observational studies or randomized controlled trials (RCTs) that compared patient mortality in private for-profit and private not-for-profit hospitals. We excluded studies that evaluated health care delivery systems with a particular profit status (e.g., private not-for-profit) that subsequently converted to another profit status (e.g., private for-profit), because the comparisons are confounded by potential differences in patient populations and medical interventions over time and uncertainty regarding the time required to create functional change after an alteration in ownership status.

We assessed the following characteristics in all the observational studies that met the eligibility criteria: sampling method, type of hospitals evaluated (e.g., general medical and surgical hospitals, hospitals with maternity services), date when data collection was initiated and completed, duration of patient follow-up, source(s) of health care financing (e.g., public, private insurance), case mix of patients (e.g., medical disorders, surgical disorders), source of data (e.g., administrative database, patient chart), number of hospitals and patients evaluated, mortality results and whether there was adjustment for potential confounders in the analyses. Teams of 2 individuals independently abstracted data from all the studies that fulfilled our eligibility criteria. Disagreements were resolved by consensus using the same process discussed earlier. Our overall agreement was 93% for the data abstraction. We attempted to contact all authors when data were missing.

To eliminate hospital teaching status as a potential confounder, we included the results from private for-profit nonteaching and private not-for-profit nonteaching hospitals when these data were available. If a study reported 2 separate adjusted analyses, we included the results from the analysis with the most appropriate adjustment. We considered it appropriate to adjust for patients' severity of illness and socioeconomic status, hospital teaching status and other variables that could confound the comparison of interest. Where possible, we avoided adjustment for variables that are under the control of hospital administrators, which may be influenced by profit status and may affect mortality. These variables include hospital staffing levels (e.g., the number of registered nurses per bed, registered pharmacists per bed) after adjustment for patients' severity of illness has already been undertaken.

Before carrying out the analysis, we specified several hypotheses to test potential explanations for variability (i.e., heterogeneity) in the direction and magnitude of effect among studies. We hypothesized that the effect size may differ based on whether the analysis adjusted for potential confounders; whether we incorporated an estimate of the sample size into the calculation to determine the effect size; the duration of patient follow-up (i.e., in hospital, or for 30 days or 90 days after admission); the source of health care funding; the data source; whether the hospitals belonged to a chain or were free-standing organizations; whether the patient population was adult or pediatric; and, for studies involving US Medicare patients, whether the data collection occurred before 1984 (when US Medicare switched from a cost-based reimbursement scheme, whereby hospitals were reimbursed for the costs associated with a patient's care, to a prospective payment system whereby hospitals are reimbursed based on the patient's designated diagnosis).

For each study, we computed the relative risk of mortality in private for-profit hospitals relative to private not-for-profit hospitals (see the Appendix on the *CMAJ* Web site for details). We pooled these relative risks using a random effects model[19] and tested for heterogeneity using a χ^2 test. A meta-analysis program written by one of the authors (B.W.) was used. We evaluated a funnel plot for evidence of publication bias.[20]

The Hamilton Health Sciences Research Ethics Board in Hamilton, Ont., approved this study protocol.

Results

We identified 13 publications that reported 15 observational studies that met our eligibility criteria.[7–24] Three publications identified as fulfilling our eligibility criteria were subsequently excluded, because 2 were duplicate publications of included studies, and in one publication the patient population was a subset of a larger population from an included study.[25–27] We also identified 19 publications that we felt might be eligible but required further information or data, or both, from the authors. After contacting authors, we confirmed that these studies either did not address our study question or the authors could not provide the necessary data. Studies that did address our question but did not contain data that we could use all suggested an advantage for private not-for-profit hospitals (Table 1).[28–46]

Table 1: Publications excluded from the meta-analysis after further information was obtained from authors

Problems that precluded study inclusion	Efforts to resolve problems
Seven studies evaluated hospital mortality rates and included PFP and PNFP hospitals but did not provide data to compare the PFP and PNFP hospitals.[28–34]	All 7 authors were contacted, but they were unable to provide data.
Three studies compared mortality rates in PFP and PNFP hospitals. However, we were unable to incorporate their data as presented into our review.[35–37]	Two authors were unable to provide the data,[35,36] and we were unable to contact one author.[37] The data presented suggested a trend favouring lower mortality rates in PNFP hospitals in all 3 studies.
Six studies evaluated hospital mortality rates in PFP and NFP hospitals. The NFP hospitals were a mixture of public NFP and PNFP hospitals.[38–43]	The authors were unable to provide the data to compare the PFP and PNFP hospital mortality rates directly. Two publications reported a statistically significant lower adjusted mortality rate in the NFP hospitals,[38,39] and 2 publications reported a trend favouring lower mortality rates in the NFP hospitals.[40,41] One study did not provide information to compare the PFP with the NFP hospitals,[42] and one study was a duplicate publication.[43]
For 3 studies, we wondered whether the authors had data on PFP and PNFP hospital mortality.[44–46]	We were able to determine that 2 of the studies did not include any PFP hospitals,[44,45] and one did not include any PNFP hospitals.[46]

Note: PFP = private for-profit, PNFP = private not-for-profit, NFP = not-for-profit.

Tables 2 and 3 (Table 3 is available in electronic format on the *CMAJ* Web site) present the study characteristics and the study methodology respectively for the 15 observational studies included in our systematic review. These studies were all conducted in the United States, and in most studies patient health care was publicly funded through Medicare. Most studies included general acute care, medical and surgical patients, and one study specifically examined maternity services.[16] Data in these studies came from about 38 million patients admitted from 1982 to 1995 to 26 000 hospitals, and the most frequent patient follow-up period was 30 days after admission to hospital. All studies used administrative data.

Of the 14 studies that evaluated adult populations and adjusted for potential confounders, 6 had a statistically significant lower relative risk of death in the private not-for-profit hospitals,[5,10,11,17,20,21] and one had a statistically significant lower relative risk of death in the private for-profit hospitals (Fig. 2).[18] Meta-analysis of these 14 studies demonstrated that private for-profit hospitals were associated with an increased risk of death (relative risk [RR] 1.020, 95% CI 1.003–1.038; $p = 0.02$).

One study of perinatal mortality that evaluated 1 642 002 patients in 243 hospitals and adjusted for potential confounders also demonstrated an increased risk of death in private for-profit hospitals (RR 1.095, 95% CI 1.050–1.141; $p < 0.0001$).[16]

Two studies reported analyses that appropriately adjusted for patients' severity of illness and separate analyses that also adjusted for staffing levels (e.g., registered nurses as a proportion of all nurses, board-certified specialists as a proportion of all physicians, registered pharmacists per occupied bed).[11,20] In both studies, the risk of higher mortality associated with private for-profit hospitals decreased in the latter analysis. Hartz and colleagues reported a decrease in relative risk from 1.06 to 1.04, and Bond and coworkers reported a decrease from 1.03 to 1.01, in the analysis that adjusted for variables under the control of hospital administrators.[11,20]

We explored potential sources of variability in the study results based on our predefined hypotheses. We found different summary estimates for the studies that evaluated adult populations compared with the study that evaluated a perinatal population ($p = 0.002$); the impact of the private not-for-profit hospitals in lowering mortality was larger in the perinatal study. Because of these findings, we did not include the study that evaluated a perinatal population in the pooled analysis. The p values for the difference in summary estimates in each pair of subgroups defined in our other hypotheses were all greater than 0.10, indicating no significant difference in subgroup summary estimates. Our pooled estimate of the adult population studies with adjustment for confounding had heterogeneity ($p = 0.02$) that we could not explain. The funnel plot did not suggest publication bias (Fig. 3).

Interpretation

Our systematic review identified 15 observational studies that compared private for-profit with private not-for-profit hospital mortality. These studies uniformly met quality criteria regarding adjustment for potential confounders, in particular, patients' severity of illness or surrogate markers of severity of illness, and complete accounting of deaths. Our pooled analysis of the adult population studies demonstrated that private for-profit hospitals were associated with a statistically significant increase in the risk of death.

We are aware of 2 earlier reviews in this area. The New York Academy of Medicine has reported a qualitative review that compared access, costs, quality of care, education and research in for-profit and not-for-profit hospitals, managed care organizations and nursing homes.[4] This review only included 4 of the 15 studies we identified and

Table 2: Characteristics of studies included in the meta-analysis

Study	Type of hospital	Patient funding	Date when data collection was begun in the hospital	Date when data collection was completed in the hospital	Follow-up period for individual patients
Shortell and Hughes[17]	Community	Medicare	01/07/1983	30/06/1984	In hospital
Keeler et al[5]	Acute care	Medicare	01/07/1985	30/06/1986	30 d
Hartz et al[11]	Acute care	Medicare	01/01/1986	31/12/1986	30 d
Manheim et al[18]*	Acute care	Medicare	01/01/1987	31/12/1987	30 d
Kuhn et al[19]	Acute care	Medicare	01/01/1988	31/12/1988	30 d
Pitterle et al[10]	Acute care	Medicare	01/01/1988	31/12/1988	In hospital
Williams[16]	Maternity	Public and private	01/01/1986	31/12/1990	28 d post delivery
Mukamel et al[21]	Acute care	Medicare	01/01/1990	31/12/1990	30 d
Bond et al[20]	Acute care	Medicare	01/01/1992	31/12/1992	In hospital
Yuan et al[18]*	Acute care	Medicare	01/01/1984	31/12/1993	30 d
Lanska and Kryscio[22]	Community	Public and private	01/01/1993	31/12/1993	In hospital
McClellan and Staiger[7]	Acute care	Medicare	01/01/1994	31/12/1994	90 d
Sloan et al[6]	Acute care	Medicare	01/01/1982	31/12/1995	30 d

*Information is the same for both studies by Manheim et al and by Yuan et al.

reached the general conclusion that the studies evaluated provided no clear indication as to the superiority of either hospital system regarding the quality of care and health outcomes.[7] The second review focused on the public purchasing of private surgical services.[8] This qualitative review identified 7 of the 15 studies we included and reached the general conclusion that more research was needed.

We undertook multiple strategies to identify studies, including searching 11 bibliographical databases, and found a number of studies not included in earlier reviews (see preceding paragraph). We masked study results before determining study eligibility. Our agreement on study inclusion was high as was our agreement during data abstraction. We were also successful in confirming and obtaining information from authors (see Appendix[9]). We were able to identify 15 studies with very large sample sizes that adjusted for potential confounders.

Our systematic review has several limitations. The most important is that we were unable to identify any RCTs. It is unlikely that RCTs will ever be undertaken to study this question, thus the strongest feasible design for addressing our question is observational. However, all 15 studies we identified did adjust for potential confounders, including teaching hospital status and markers of patients' severity of illness.

A major threat to the validity of observational studies is residual confounding. Is it possible that there are factors other than private not-for-profit hospital status that explain such institutions' lower mortality rates? One such factor could be teaching status, because a much higher proportion of private not-for-profit than private for-profit hospitals are teaching hospitals. However, 3 of the studies conducted analyses that excluded teaching hospitals altogether and found a statistically significant increase in mortality in the private for-profit hospitals (RR 1.01, 1.05 and 1.05).[10–12]

Inevitably, large administrative databases have a limited ability to adjust for disease severity. Is it possible that patients in private not-for-profit hospitals were, on average, less sick? Most of the studies considered here used the Health Care Financing Administration (HCFA) database that includes data on all US hospitals that serve Medicare patients and generates risk-adjusted mortality rates that are highly correlated with detailed clinical risk-adjusted mortality rates.[13] Moreover, in the studies that reported both

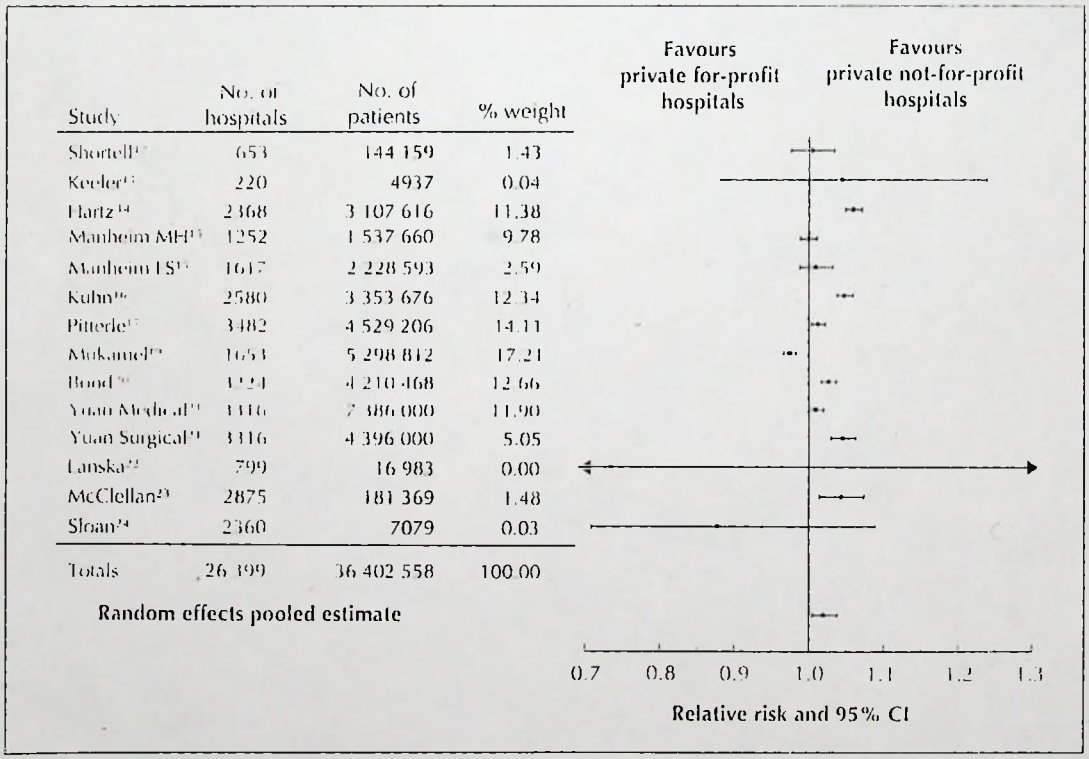

Fig. 2: Relative risk of hospital mortality for adult patients in private for-profit hospitals relative to private not-for-profit hospitals. CI = confidence intervals.

unadjusted and adjusted results for disease severity, the adjusted analysis consistently led to effect estimates that were more favourable to the private not-for-profit institutions, suggesting that private not-for-profit hospitals serve a population of patients with greater disease severity.[10,16,22] Under these circumstances, we would anticipate that residual confounding would make the private not-for-profit institutions look worse, rather than better, than the private for-profit institutions. These considerations suggest that, if anything, our results may represent an underestimate of the potential increase in mortality associated with private for-profit hospital care.

Ideally, studies would have adjusted for, or considered as explanatory factors, other variables for which data were not available. These variables include whether the physicians were hospital employees or corporate employees, or independent contractors, and their relationships with local health maintenance organizations. Finally, studies have done little to adjust for the proportion of Medicare patients versus privately insured patients in the institutions being analyzed. With respect to this last variable, however, it is likely that for-profit hospitals attracted a larger proportion of privately insured individuals. If this is the case, private for-profit providers would have more resources available, and one might expect a "spillover" effect of improved care to Medicare patients. To the extent that this is the case, our pooled estimate again biases the results against the private not-for-profit institutions.

When studies show important differences in results, rigorous systematic reviewers explore the data to see if they can identify cogent explanations for the differences. How they should proceed if they fail to find an explanation for the differences remains controversial. Some argue that under these circumstances, pooling is inappropriate. Others argue that clinicians, and in this case health policy-makers, must still make decisions, and their decisions should be driven by the best available estimate of treatment effect.[23] In the presence of unexplained heterogeneity, while inferences associated with pooled estimates are weaker, these estimates nevertheless provide the best estimate of the average effect, and thus constitute useful information for decision-makers.

The studies we pooled used similar methods to examine similar populations. Moreover, one does not require a pooled analysis to generate concern about the impact of for-profit status on hospital mortality: 7 studies provided statistically significant results that favoured lower mortality in private not-for-profit hospitals, whereas only one study had a statistically significant finding in the opposite direction.

We have no satisfactory explanation for the one study that demonstrated a statistically significant lower risk of death in private for-profit hospitals.[9] Other large studies that used data from the same database before and after this study reached the opposite conclusion.[10,16,20,21] We contacted the authors of this study and asked them to undertake further analyses to determine what may have accounted for this discrepant finding.[9] The authors declined our request.

Why is there an increase in mortality in for-profit institutions? Typically, investors expect a 10%–15% return on their investment. Administrative officers of private for-profit institutions receive rewards for achieving or exceeding the anticipated profit margin. In addition to generating profits, private for-profit institutions must pay taxes and may contend with cost pressures associated with large reimbursement packages for senior administrators that private not-for-profit institutions do not face. As a result, when dealing with populations in which reimbursement is similar (such as Medicare patients), private for-profit insti-

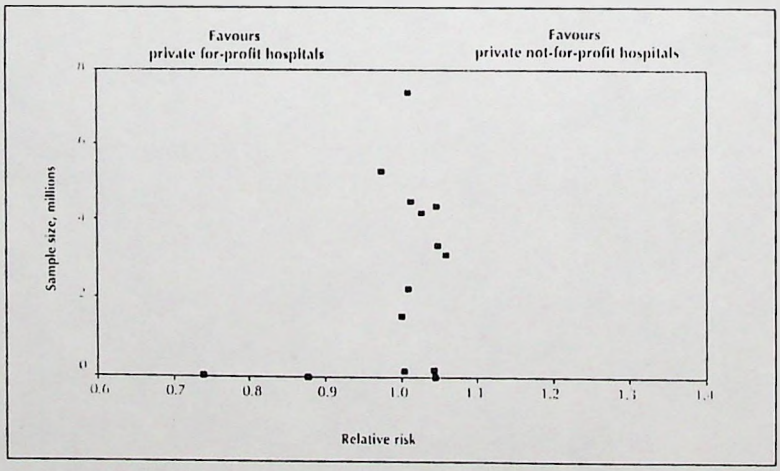

Fig. 3: Funnel plot of relative risk, in adult studies, of death in private for-profit hospitals relative to private not-for-profit hospitals.

tutions face a daunting task. They must achieve the same outcomes as private not-for-profit institutions while devoting fewer resources to patient care.

Considering these issues one might feel concern that the profit motive of private for-profit hospitals may result in limitations of care that adversely affect patient outcomes. Our results suggest that this concern is justified. Studies included in our review that conducted an initial analysis adjusting for disease severity, and another analysis with further adjustment for staffing levels, support this explanation for our results. The private for-profit hospitals employed fewer highly skilled personnel per risk-adjusted bed.[14,20] The number of highly skilled personnel per hospital bed is strongly associated with hospital mortality rates,[14,17,20] and differences in mortality between private for-profit and private not-for-profit institutions predictably decreased when investigators adjusted for staffing levels. Therefore, lower staffing levels of highly skilled personnel are probably one factor responsible for the higher risk-adjusted mortality rates in private for-profit hospitals.

Given the differences in the organization of the Canadian and US health care systems, one might question whether our results can be applied to Canada. The structure of US health care has, however, shifted dramatically over time. With the exception of a single study, the results are remarkably consistent over time, suggesting that the adverse effect of private for-profit hospitals is manifest within a variety of health care contexts. Furthermore, whatever the context within which they function, for-profit care providers face the problem of holding down costs while delivering a profit. One would, therefore, expect the resulting problems in health care delivery to emerge whatever the setting. Finally, should Canada open its doors to private for-profit hospitals, it is the very same large US hospital chains that have generated the data included in this study that will soon be purchasing Canadian private for-profit hospitals. In summary, we think it plausible, indeed likely, that our results are generalizable to the Canadian context.

The Canadian health care system is at a crucial juncture with many individuals suggesting that we would be better served by private for-profit health care delivery. Our systematic review raises concerns about the potential negative health outcomes associated with private for-profit hospital care. Canadian policy-makers, the stakeholders who seek to influence them and the public whose health will be affected by their decisions should take this research evidence into account.

Competing interests: None declared.

Contributors: P.J. Devereaux is the principal investigator for this study. He had the original idea for this study and led all aspects including design and data acquisition and interpretation. He wrote the first draft of the manuscript. Peter Choi is the co-principal investigator for this study. He made substantial contributions to its design and execution and made critical revisions to the manuscript. Christina Lacchetti made substantial contributions to the design and execution of this study and made critical revisions to the manuscript. Bruce Weaver was involved in the study design, data acquisition and analysis, and provided critical revisions to the manuscript. Holger Schunemann, Ted Haines, Brydon Grant, David Haslam, Mohit Bhandari, Stephen Walter, Humaira Khan, Neera Bhatnagar and Gordon Guyatt were involved in the study design, data acquisition and interpretation, and provided critical revisions to the manuscript. Stephen Taylor also undertook data analysis. Gordon Guyatt also provided supervisory support throughout the study. John Lewis, Terrence Sullivan, Deborah Cook, Maureen Meade were involved in the study design, interpretation of data and provided critical revisions to the manuscript.

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Reform follows failure: I. Unregulated private care in Lebanon

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This first of two papers on the health sector in Lebanon describes how unregulated development of private care quickly led to a crisis situation. Following the civil war the health care sector in Lebanon is characterized by (i) ambulatory care provided by private practitioners working as individual entrepreneurs, and, to a small extent, by NGO health centres; and (ii) by a fast increase in hi-tech private hospitals. The latter is fuelled by unregulated purchase of hospital care by the Ministry of Health and public insurance schemes. Health expenditure and financing patterns are described. The position of the public sector in this context is analyzed. In Lebanon unregulated private care has resulted in major inefficiencies, distortion of the health care system, the creation of a culture that is oriented to secondary care and technology, and a non-sustainable cost explosion. Between 1991 and 1995 this led to a financing and organizational crisis that is the background for growing pressure for reform.

Introduction

Many European countries have been or are presently going through a process of reform of the health care sector. The impetus for such reform comes from the inability to control costs, criticism of bureaucratic rigidity, and the impression of getting poor value for money (Dekker 1994). Most attention goes to the supply side, and the reform debate is dominated by a focus on administrative/financial and organizational issues (Oevreveit 1994). There is a characteristic shift towards market-derived incentives in pursuit of micro-economic efficiency (Saltman 1994) and control of expenditure.

Developing countries are increasingly interested in following similar approaches in order to control costs, but also, and this is much more a central issue than in Europe, in order to correct obvious government failures in financing and provision of health care (World Bank 1993). As in Europe, reliance on the private sector and managed markets is supposed to enhance provider efficiency through competition and the substitution of direct management with contractual relationships.

A growing number of developing countries are now embarking on reforms in which contracting out clinical services – and specifically hospital care – is a key element. The speed with which these approaches have been endorsed in development circles is in sharp contrast with the lack of actual experience and empirical evidence for success (Carr-Hill 1994). The do's and don'ts, the approaches that work and those that do not, have not been clearly identified in the industrialized world (Petchey 1995; Saltman 1994), let alone in developing countries. What little evidence there is to date indicates that in developing countries the conditions for successful introduction of such reforms are often not in place (Broomberg 1994). Appropriate regulation technologies and capacities need to be developed. Reforming the health care sector in developing countries is indeed subject to specific constraints that centre around the government's regulatory capacity and the strength of its

bargaining position (McPake and Hongoro 1995). If ultimately reform has to be evidence-based, documentation of present pragmatic efforts is essential.

In most developing countries the original impetus for health care reform comes from a reaction to the government's failure to deliver health care, combined with a crisis in the financing of the health sector. Scaling down public delivery of services and the introduction of private sector competition in the provision of health care with retention of public financing is usually seen as the way to address public sector inefficiencies whilst retaining a tool for ensuring equity (Birdsall and James 1992). Privatization is further to be seen in an ideological context of shift from welfarism to monetarist macro-economics (Price 1989) but, as in the industrialized world, the debate is now moving from ideological positioning to operational questions (Belmartino 1994). In practice, reform mainly addresses urban health care systems where it focuses on introducing purchaser–provider splits so as to induce supply-side efficiency through competition, whilst keeping the State in a monopsonistic power position.

In Lebanon the impetus for health care reform also starts from the recognition of an unchecked growth of expenses for medical care. In contrast with many developing countries, however, it is not a reaction against the government's inefficiency in delivering services. In Lebanon, indeed, the State has only a marginal role in delivering health care, and a purchaser–provider split exists *de facto*. Both ambulatory and hospital care are almost exclusively private. Ambulatory care is essentially provided through private clinics financed through out-of-pocket payments. Hospital care is provided through (small) private (for-profit and not-for-profit) hospitals. For about half of the population, hospital care is covered by private or public insurance schemes. For the rest of the population, it is purchased by the State. Private hospitals are thus heavily dependent on public funding. This arrangement has proven highly inefficient, the absence of self-regulation of the private system being compounded by the absence of adequate public sector regulatory mechanisms and capacities.

This first paper documents how, in a very short time-span, unregulated privatization has created an inefficient and distorted health care system, and a non-sustainable cost explosion. The Lebanese case illustrates the strategic importance of the regulation, planning and policy setting functions of the public sector. It shows that public financing per se, without the institutional capacity and proper attention for the mechanics of regulation, does not provide sufficient leverage to avoid predictable market failures. Although the starting point for the Lebanese health care reform is different from most other developing countries engaging in reform (down-scaling public care provision is not an issue), the question of the regulation of a partly publicly financed private sector is of wider relevance.

Lacking regulatory authority – and essential reliable information – the Ministry of Health (MOH) was forced to adopt a reform strategy wherein the problems of financing of the health sector are not dealt with head-on. Tackling the organizational problems of health care delivery first provided an opportunity for building up alliances and pressure that should allow it to tackle finance at a later stage. A second paper documents the way pressure for reform has built up, and identifies the key elements on the reform agenda (Van Lerberghe et al. 1997).

Health care delivery and the civil war

Once a prosperous, upper-middle-income country, Lebanon declined during the war of 1975–1990. About one-quarter of the population emigrated during these 15 years. A 1992 study, two years after the end of the war, classified 450 000 individuals as displaced (Feghali 1992). This is a very large number considering the relatively small population of the country–approximately 3 million. Reliable demographic figures are politically sensitive and hard to come by: the last population census in Lebanon dates back to 1932. Furthermore there are some 900 000–1 200 000 unregistered foreign workers (mainly from Syria), and some 400 000 Palestinian refugees. Economic activity is picking up fast again following the cessation of internal fighting, and GDP increased from around US$ 1500 in 1992 to around US$2300 in 1994 (different sources mention different figures). In real terms, however, the per capita income is still below the pre-war level.

The war was a period of an accelerated urbanization: 85% of the population now lives in towns. It was also a period of demographic and epidemiological transition. Only 9.6% of the population is younger than five years, as opposed to the 12–13% that is common in the region. Infant mortality increased from 48 per 1000 in 1975 to 57 in the middle of the war, but then dropped to 44 in 1990. By 1992 it was down

to 34, concentrated in a limited number of areas. Preliminary results of the 1996 PAP-Child survey show an infant mortality rate (IMR) of 28 per 1000. Infectious and parasitic diseases are on the decline. The pattern of demand for care is now dominated by chronic diseases and problems related to the urban environment. For example, the most consistent finding in an analysis of the reasons for encounter in health centres in Lebanon was the high frequency of diagnosis and treatment of hypertension and diabetes (Adib 1994).

With a culture of trade and commerce, and delicate religious and denominational balancing acts that determine politics and administration, Lebanon has a strong tradition of individualism, self-reliance and private initiative. The private sector – with private-for-profit (PFP) and community-linked not-for-profit non-governmental organizations (NFP-NGO) – dominates in most fields, including health and education. Although traditionally considered reasonably competent, effective and even an attractive career possibility, public administration in Lebanon has never played a dominant role in the health sector.

Public services in Lebanon were severely affected and weakened by the war (Kronfol and Bashshur 1989). Buildings and equipment were destroyed, looted or damaged. Trained and capable people left the country (Kronfol et al. 1992), whilst those who stayed had to struggle to survive on inadequate salaries. There has been little opportunity for modernization of ideas, skills or style of work. For all practical purposes, the MOH disintegrated during the war. There was no clear policy, no means to implement it, no information to work on. The public health programmes that were active during the war period were donor driven – with major roles for WHO and UNICEF – and channelled through NGOs of various denominations. Considering the circumstances, this proved highly effective; NGOs proved to be highly flexible and able to deliver results – 89% vaccination coverage with an ongoing civil war. The MOH, however, had only a marginal role in all this.

The MOH activities were limited to contracting with private hospitals in order to deal with emergencies. This was in fact a continuation of the policy of contracting-out that already existed before the war, when the government paid the bill for some 40 000 acute care hospitalizations per year in the private sector. During the war, direct involvement of the MOH in direct provision of hospital care became marginal. By the mid-1980s, seven of the public sector hospitals had been destroyed. At some point the public sector could avail of only 200 beds in Beirut. The share of the public sector in national hospital bed capacity thus fell to less than 10% by 1984 (Anonymous 1987). By the end of the war public hospitals had only 700 partly operational beds left of the 1870 they had in the early 1970s.

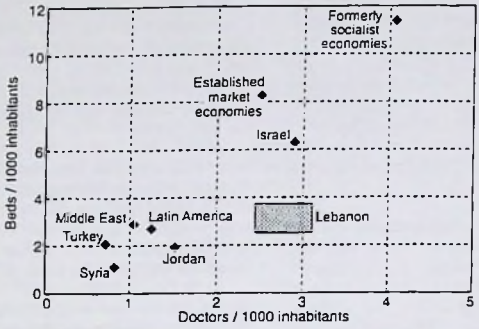
In contrast, the private sector remained very dynamic throughout the war. For example, 56% of the present private hospital capacity was created during the war years. Most of this represented development of business opportunities by private entrepreneurs for whom the war provided fresh investment capital.

But the war was also a period of major expansion for NFP-NGOs. These set up a network of health centres and dispensaries, and carried out public health programmes. Lebanese and international NGOs undertook emergency programmes with the support of donors through financial grants designated for short-term emergency aid. International NGOs expanded from 28 to 171 services. There was also an exponential growth of national NFP-NGOs. These were mainly small-scale organizations, working in underserved rural and urban poverty pockets, with emphasis on Beirut and Mount Lebanon. They focused on emergency relief and humanitarian assistance, rarely on community development work. For example, in the mid-1980s, 43% of their clients were health service and 47% relief assistance beneficiaries (Ministry of Labour and Social Affairs and Norwegian People's Aid 1985). Most NFP-NGOs depended on donations from foreign NGOs and support from political parties and factions. During the war these NGOs gained high visibility and credibility, although many were mere propaganda machines or even fronts for commercial organizations. After the war, however, this credibility was not translated into involvement in planning or policy discussions.

In summary, over the last 20 years the Lebanese health care system has developed in a largely unregulated way, following private initiative and investment. The public sector has been absent, but the country has a NFP-NGO health care delivery network with a public sector logic that has been developed on the basis of the relief operations during the war.

Ambulatory care in private clinics

Private practice has been the main source for ambulatory medical care for the Lebanese. Roughly



*Lebanon ratios are given as a range to take into account uncertainties in the data

Figure 1. Doctor and hospital bed per population ratios in Lebanon and selected other countries*

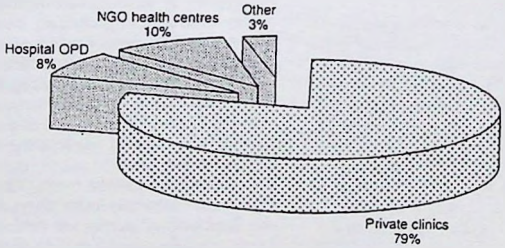


Figure 2. Sources of ambulatory care

one out of five households identifies with one medical practitioner as its 'family physician', very much in a West-European fashion though with less reliance on house calls – less than 5% of contacts are house calls (Abyad 1994; Kronfol et al. 1985).

There is an ample supply of physicians: some 8–9000, i.e. a ratio that comes close to three doctors per 1000 inhabitants. This is higher than most of the rest of the world outside the formerly socialist economies of Europe (Figure 1). The doctor/bed ratio of 0.88 is also among the highest in the world, almost three times that of OECD countries. This relative over-supply of doctors makes ambulatory care a natural career perspective.

Most ambulatory care is provided in private clinics (Figure 2). Hospital outpatient departments capture 8% and health centres, whose number increased spectacularly during the war, have expanded their share to 10%. Most of these health centres are run by NFP-NGOs; the few public health centres and dispensaries offer services of poor quality and are barely used. Health care delivery by NFP-NGOs is strategically important since in many cases their health centres are the only accessible option for the poor. Also, they

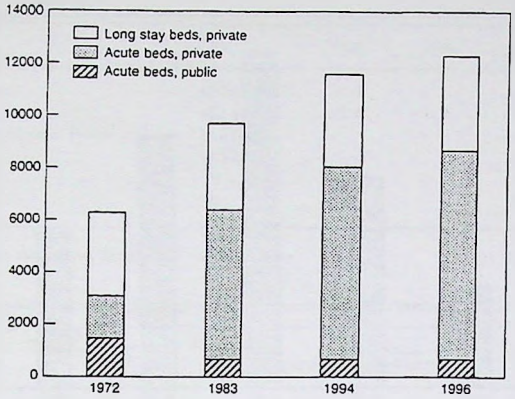


Figure 3. The expansion of hospital bed capacity in Lebanon

remain a key vehicle for programme activities such as vaccination. The set-up of these health centres is very varied and flexible. There are major institutions with lots of staff, various specialities and extensive equipment; others operate out of a rented apartment and offer only essential amenities. Some of these health centres function poorly; others offer services of a better quality level than the average private practitioner – at a lower price to the patient.

On the whole, however, the profile of care offered by NFP-NGO health centres increasingly looks like that of private clinics. This is a consequence of the changes in the environment in which the NFP-NGOs operate. Since the end of the war they have been experiencing growing difficulties in securing funds. Inputs from foreign donors to Lebanon have diminished and the trend has been to redirect funds towards the government. Furthermore, political funding related to the various factions in the war dwindled. Consequently, the importance of ensuring cost recovery became paramount. Since there is an amply supply of physicians, the NFP-NGO health centres can afford to rely more and more on non-salaried part-time physicians: an average of 8.4 per centre. Proceeds of fee-for-service payments are split between the physician and the NGO, for example on a 50/50 or 75/25 basis. The NFP-NGO health centres are thus progressively transforming into an infrastructure that is rented out to private practitioners who carry out the NFP-NGO's mission, but at the same time use the infrastructure to build up a private clientele. This phenomenon has now become so extensive – also in the government health centres – that some of the NGOs are looking for ways to limit the fragmentation of care that is the result of the multiplication of doctors who use the health centres as a recruitment basis.

When not working in a NFP-NGO setting, private practitioners function essentially as individual private entrepreneurs, most often with some specialist label, but without accreditation, control or regulations. There is thus a continuum between health centres and private practice that affects the way both function: practice in most NFP-NGO health centres becomes more 'commercial', while the PFP sector cannot ignore the *de facto* quality standards some of these NFP-NGO health centres are setting.

Hospital care in subsidized private hospitals

There are at present approximately 3.4 beds per 1000 inhabitants in Lebanon (Figure 1), more than in the rest of the region but less than in other countries with similar doctor/population ratios. The number of beds increased both during and after the war (Figure 3).

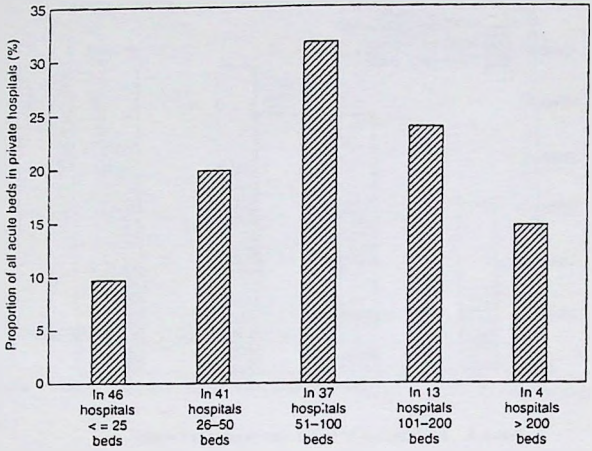


Figure 4. Most acute care beds are in small hospitals: bed share of hospitals of various sizes

More than half of the private hospitals became operational during this period. At the same time the number of public beds shrunk, both in absolute and in relative terms.

The long stay hospitals belong to the NFP-NGO sector. The short stay hospitals belong either to the public sector (6% of the total number of beds), NFP-NGOs (22%) or for-profit (FP) private organizations: individual doctors or groups of businessmen that include doctors. Most of the expansion over the last 15 years took place in the form of small-scale private acute care hospitals: 87 out of 140 have less than 50 beds. Almost one-third of all acute beds are in hospitals of 50 beds or less (Figure 4). On the average, FP-NGO hospitals are smaller than those owned by NFP-NGOs or universities.

In the 1980s, 61% of patients were admitted to voluntary and teaching NFP private hospitals, 37% to other private hospitals and less than 2% to public hospitals (Kronfol et al. 1985). The latter have now become even more marginal; since 1992 the numbers of hospitalizations, outpatient consultations, x-rays, laboratory examinations, etc. have declined by 10–20% each year. Many of these public hospitals now have bed-occupation ratios of less than 5–10%. In the meantime, the smaller PFP hospitals seem to increase their market share. This evolution is linked to the way health care is financed in Lebanon.

Health expenditures in the 1990s

It is extremely difficult to know who spends how much on health care in Lebanon. Data are incomplete and contradictory. The 1992 estimate is of US$ 301 million, i.e. about US$ 100 per person per year (Posarac 1994). Triangulation of information from various sources on 1995 yields a range of between US$ 600–862 million (Table 1): US$ 200–300 per person. Around 60% of expenditures is private money in the strict sense of the word (out-of-pocket and private insurance), while one-third is paid for from public sources (MOH and public insurance schemes, i.e. the National Social Security Fund (NSSF), the army and the Civil Services Cooperative (CSC)).

Obviously the situation is changing very fast, not only in absolute terms (doubling in less than three years), but also as a percentage of GDP. Table 2 shows that in 1992 private health expenditures were at the same level, in terms of GDP, as in established market

Table 1. Who pays the health bill?*

	1992	1993	1994	1995
Public insurance schemes	49.0 (16%)	71.0	-	130.8 (15–22%)
Public funding: MOH	45.1 (15%)	62.8	72.1	98.2 (11–16%)
Lebanese NGOs and international donors	29.0 (10%)	-	-	41.6 (5–7%)
Private insurance	41.6 (14%)	-	-	151–207 (24–25%)
Out-of-pocket	136.4 (45%)	-	-	179–381 (30–44%)
Total	301			601–859

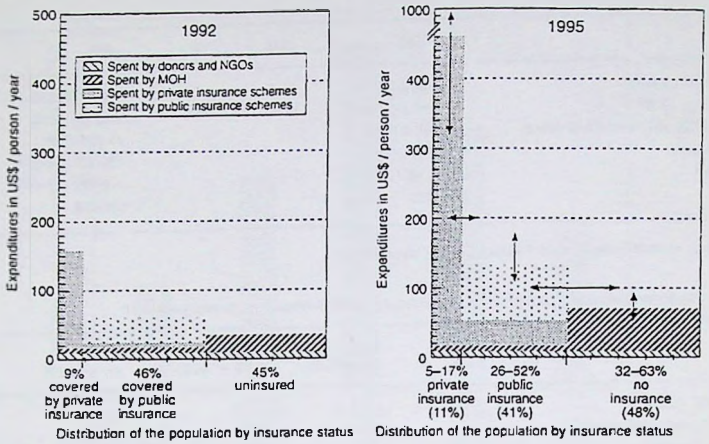
* billion; estimates adapted from Posarac 1994 and other sources

Table 2. Public and private expenditures for health (excluding donor assistance), as percentage of GDP

Area	Total (% of GDP)	Public (% of GDP)	Private (% of GDP)
Lebanon (1992 estimate)	4.8	1.6	3.2
Lebanon (1995 estimated range)	5.4–9.1	2.4	3.9–6.6
Syrian Arab Republic	2.0	0.4	1.6
Jordan	3.8	1.8	2.0
Turkey	4.0	1.5	2.5
China	3.5	2.1	1.4
Middle East Crescent (weighted)	4.1	2.4	1.7
Latin America (weighted)	4.0	2.4	1.6
Sub-Saharan Africa (weighted)	4.5	2.5	2.0
Asia (weighted)	4.5	1.8	2.7
India	6.0	1.3	4.7
Established market economies (weighted)	9.1	5.6	3.5

economies, and higher than in most of the rest of the world. Public expenditures, on the other hand, were among the lowest. By 1995, overall health expenditure in GDP terms in Lebanon appears to close the gap with the established market economies; mainly through an increase in private expenditures but also by catching up in public.

Not all these resources are uniformly distributed. Figure 5 shows who paid for whom in 1992 and 1995. NFP-NGO and donor expenditures were assigned to the whole population. MOH expenditures were allotted to the uninsured population, except for the disbursements for cardiac surgery, kidney dialysis and cancer treatment, which benefit the entire population (see below). Expenditures of the various public insurance systems were allotted to the beneficiaries of these systems and their dependants. The same goes for the expenditures of private insurance schemes. No account is taken of the possibility that some may benefit from a number of insurance schemes at the same time. Nevertheless, in Figure 5, 25% of private insurance expenditures are arbitrarily distributed over both privately and publicly insured, to take account of the increasingly common practice of subscribing to complementary insurance. Both expenditure and coverage data are rough estimations, with a considerable amount of uncertainty, indicated by the arrows in Figure 5. This makes a precise interpretation of expenditure levels difficult. With this caveat, the figure nevertheless illustrates present trends in financing.



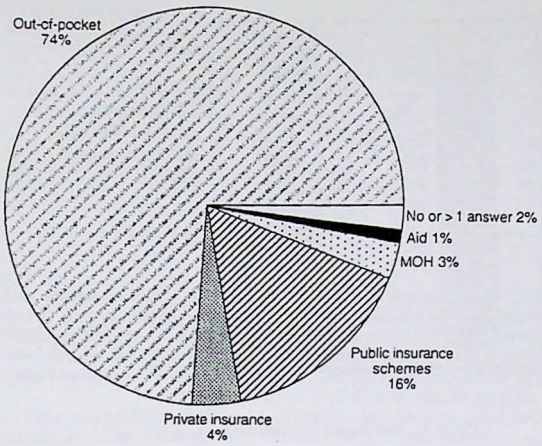
* Abscissa: proportional to number of population covered; ordinate: US$ per inhabitant per year within the coverage group
NB: The arrows indicate the range of uncertainty on expenditures and proportion of population covered. Where relevant, the average of various estimates of expenditure or population coverage has been used.

Figure 5. Non-out-of-pocket expenditures on health per person in Lebanon in 1992 and 1995, according to type of coverage*

Between 5% and 17% of the Lebanese population have private insurance coverage – estimates range widely but there is a consensus that the sector is expanding. If one assumes that private insurance coverage has gone up from 8% in 1992 to 11% in 1995, average non-out-of-pocket expenditure for this part of the population in 1995 was around US$ 460 per person (but may be as high as US$ 950 according to some estimations). Of this, US$ 13.8 was donor money or NFP-NGO expenditure, and the MOH paid between US$ 10–14 (a conservative estimate: the real figure may be significantly higher) in hospitalization costs for cardiac surgery, kidney dialysis and a number of other specific conditions. The rest, over US$ 430 per person in 1995, nearly three times as much as in 1992, was accounted for by private insurance. The latter mainly covers hospitalization, but not exclusively.

Nearly half of the population is covered by one of the three public insurance systems: army, public service (CSC), and employees (NSSF). These insurance systems were created in the 1960s following European models (Kronfol and Bashshur 1989). They more than doubled their expenditures between 1992 and 1995 (Table 1), and now reach around US$ 74 per person per year. About 40% of their expenditures are for inpatient care. People in a public insurance scheme also may carry a complementary (private) insurance (estimated here, rather arbitrarily, to contribute US$ 29 per person), and benefit from MOH (low-end estimate between US$ 10–14) and donor-NGO inputs (US$ 13.8). Total expenditure would then be around US$ 129 per person (with a range of US$ 112–168).

The rest of the population is uninsured. The MOH spent around US$ 55 per person in reimbursements to private hospitals for inpatient care for the uninsured. It does not reimburse them for outpatient care. The only other non-out-of-pocket contribution to financing health care for this part of the population is that of donors and NGOs. Overall non-out-of-pocket expenditures for the uninsured were around US$ 69 (range US$ 58–89) in 1995: more than double the figure for 1992. Setting aside the *de facto*, but



Adapted from Firkh et al. 1996

Figure 6. How people pay for ambulatory care

limited, subsidies by NFP-NGOs, the uninsured have to pay out-of-pocket for all of their ambulatory care.

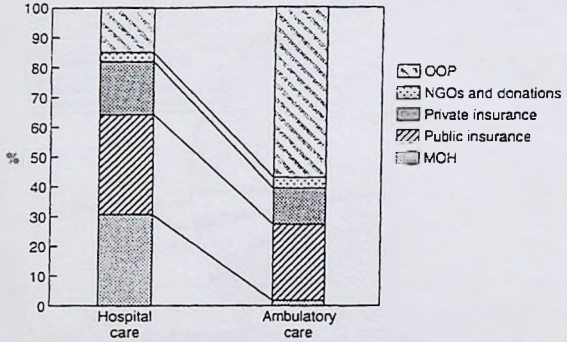
The overall impression is one of an explosion of expenditures that is most marked for the population with private insurance, but touches the rest of the population as well. If coverage for ambulatory care was eliminated, very similar expenditure levels would be expected for both the uninsured and those with public insurance, roughly between US$ 50–70 per person per year; for the privately insured, non-out-of-pocket expenditures are probably well above US$ 300.

Financing

Only one-fifth of the population relies mainly on third party payment for its ambulatory care: 16% through public insurance and 4% through private insurance (Figure 6) (Firkh et al. 1996). Ambulatory care is essentially paid out-of-pocket by 77% of the users. Ten per cent of the population rely on NFP-NGO run health centres where financial barriers can easily be overcome (low fees, possibility of free care); the rest of the population uses the services of (expensive) private practitioners. Out-of-pocket payment is the source of 74% of expenditures on laboratory services, 79% of those on drugs and 92% of those on dentistry.

Ambulatory care (slightly over half of total non-donor funded expenditure in 1992–93) is therefore fairly independent from public funding. Public insurance schemes contributed around US$ 40 million to non-hospital care in 1993. The rest was made up by private insurance, NGOs (whose contribution was estimated at US$ 6 million, probably targeting mainly the uninsured) and out-of-pocket payments. The latter have increased with the expansion of the supply of doctors, whereas the MOH was nearly completely absent (Figure 7).

The situation was very different for hospital care. The share of the public sector in directly providing hospital care is marginal. The State, however, makes use of non-public hospitals through three mechanisms. The first is the various public insurance schemes. These have arrangements to reimburse



*Estimations based on aggregate 1993 data; OOP: out-of-pocket; NGO: private non-for-profit only

Figure 7. How hospital and ambulatory care are paid for*

itemized expenses made at outpatient consultations and for hospitalizations in private hospitals. They are independent from the MOH.

Secondly, the MOH pays, through its budget, for particular categories of treatment (cardiac surgery, kidney dialysis and cancer treatment). A political decision in 1990 led the MOH to pay for such interventions in the private sector for all Lebanese citizens. This now mobilizes between one-third and half of MOH expenditure for reimbursement of inpatient care: low-end estimates range between US$ 10–14 for 1995, up from US$ 8.5 in 1992. It is not known whether beneficiaries of this MOH financing are concentrated among a particular class, or equally distributed.

The final mechanism is contracting with private hospitals that provide for reimbursement of hospitalization costs of the uninsured population. Such treatment in the private sector, paid for by the government, concerned around 40 000 patients per year during the war, and rapidly increased afterwards: 64 200 patients in 1990, 65 800 in 1991, 80 000 in 1992, 90 000 in 1995. The MOH earmarks a number of beds for subsidized patients. Each hospital is graded, and a room rate and tariffs of charges for tests, drugs, use of the operating theatre, etc. are agreed. The MOH has to give authorization for admission – based on a very cursory referral note. After hospitalization of an authorized patient, the MOH will receive an extremely detailed bill, which it has to pay without being able to exercise any control (up to 1993–95) over the justification of the cost items. There are probably no or very few countries in the world that have a billing system that is both as complicated and as uncontrollable as the Lebanese system. Misuse is rife, but although public insurance has in two instances cancelled contract arrangements with hospitals, the MOH has never been in a position to do so.

Almost half of non-donor-funded expenditure is for hospital care. The public sector provides some US$ 12 per person per year for the (affluent) privately insured through reimbursement of heart surgery, kidney dialysis and cancer treatment. It spends US$ 50–60 per person per year for the publicly insured (employees and military with their dependants), and around US$ 55 per person per year for the uninsured. All in all, public insurance and the MOH paid about US$ 80 million for hospital care provided in private hospitals in 1992, and almost twice as much in 1995. The rest came from private insurance and from the users through out-of-pocket payments. In 1992–93, 65% of private hospitals' income came from MOH and public insurance, 18% from four private health insurance schemes and only 15% from

Table 3. Sources of income of four hospitals in 1995

	MOH and public insurance schemes	Private insurance	Out-of-pocket payments
82 hospitals in 1994	67.1%	17.6%	15.3%
Hospital 1, 1995	88.4%	6.1%	5.5%
Hospital 2, 1995	76.1%	16.9%	6.9%
Hospital 3, 1995	46.0%	25.0%	20.0%
Hospital 4, 1995	51.0%	30.8%	18.2%

out-of-pocket payments. Donations account for 3% of their income (Figure 7) (Posarac 1994). A study of 82 hospitals in 1994 (Jurjus 1994) and detailed data on four hospitals in 1995 (Ramaddan 1996) confirm this pattern (Table 3).

Health care delivery, both hospital based and ambulatory, is thus essentially private and unregulated. Ambulatory care has developed outside public financing considerations. Hospitals, on the other hand, depend very much on public financing. Reimbursement of hospitalization expenses by public and private insurance schemes, and by the MOH, has been the motor of the expansion of the private hospitals. Without it, the survival of the smaller hospitals would probably be immediately endangered.

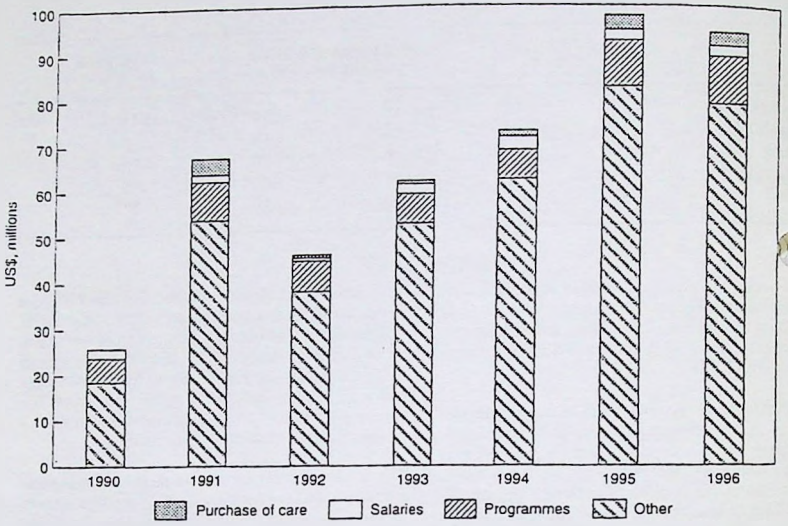
Institutional bargaining capacity

The dependency of private hospitals, and especially of the smaller ones, on public funding should put the MOH in a strong bargaining position. Nevertheless, the MOH has been unable to restrain the growth of the [illegible] of the hospital care it contracts for in the private sector. Hospital care is putting an increasing strain on its budget, as it does on public insurance (Abyad 1994). Before the war, payment of hospital care accounted for roughly one-third of the MOH budget. This then increased considerably, and since the end of the war hospital care has consistently mobilized more than three-quarters of the budget, including salaries. That is considerably higher than the OECD mean share for hospitals, excluding ambulatory care, in total public recurrent health expenditure (54% in the 1980s). Out of 60 low, middle and high income countries (Barnum and Kutzin 1993), only Malawi allocates as high a proportion of recurrent public spending to hospitals. The MOH's reimbursement to hospitals has tended to grow over the years, both in absolute and relative terms (Figure 8). In the 1970s this made up one-third of the MOH budget. Since 1991 hospitals have absorbed over 80% of the budget, peaking at 86% in 1994 – rising from US$ 18.6 million in 1990 to US$ 62.5 million in 1994 and US$ 82.4 in million in 1995. The scope for developing the other activities of the MOH within this budget frame is limited and shrinking.

The MOH is having increasing problems in obtaining the budgets to keep up with the growing requests for reimbursement of private hospital care. Public insurance schemes are also experiencing problems in securing the required government contributions. On the other hand, the MOH is unable to exert the necessary pressure to control the amounts paid to private hospitals, neither through rationing nor through the pricing mechanisms.

In theory Lebanon's MOH could have leverage over what happens in the field of hospital care, through its crucial role in the financing of hospital income (Figure 7). This leverage is, however, limited by the fact that the MOH has no authority over public insurance. It can only use its own inputs and technical authority as a basis for influencing hospital care in the private sector. In practice it has very little effective influence, for technical, administrative and political reasons, and coordination in this matter only started timidly in 1996.

Technically, the asymmetry of information available to the purchaser (MOH and public insurance) and the provider (the private hospitals) makes it difficult for competition, in the form of preferred contracting, to occur. Lebanon's MOH has no inside knowledge on the functioning of the hospital sector. The complexity of the payment mechanism and the absence of adequate technology and trained personnel make it



* 1991 expenditures include catch-up expenditures for under-budgeting in 1990; figures for 1996 are budgeted expenditures

Figure 8. Ministry of Health expenditure, in US$ millions, for reimbursement of hospital care in private hospitals, as part of overall MOH budget*

impossible even to identify blatant misuse or inappropriate billing (Kronfol and Bashshur 1989), let alone issue guidelines for standard treatment protocols or costing norms. This deprives the MOH of control over the pricing mechanism, which, as European experience shows, is a critical tool for balancing supply and demand in regulated markets (von Otter and Saltman 1992).

The MOH thus has little information on which to base a regulation or control function. This is compounded by the fact that the MOH budget offers little scope for a personnel policy that would increase its capacity. In terms of purchasing power, the 1994 personnel budget is only 67.5% of the 1990 level. This also represents a shrinkage in relative terms: from 15.3% of the budget down to only 8.9%. With such a budget (an overall average of about US$ 3600 per employee for 1994), it is obviously difficult to retain, and near impossible to attract new, qualified staff, let alone maintain any illusion of setting up a health care provision system based on public sector employed staff. As such, the budget for personnel would be sufficient to hire staff to fulfil a regulatory role. However, this would require the MOH to rid itself of excess staff presently assigned to health care delivery, which is politically difficult. A 50% increase (in US$ terms) in the budget for salaries in 1995 brought purchasing power back to 1990 levels. This, however, does not fundamentally alter the situation, given the administrative constraints on hiring personnel in the public service.

Politically, the MOH is being urged to further promote expansion of hospital capacity rather than regulate it, and to refrain from showing preferences between potential provider-hospitals. The choice of hospitals to be contracted is basically a question of denominational and political considerations. The MOH thus cannot restrict market entry on technical

grounds. When a new small hospital starts activity, it is near impossible for the MOH to impede this, especially since it cannot provide alternative public hospital care possibilities.

Furthermore, non-market pressures and concerns with continuity of care and accessibility prevent hospital closure or stopping of reimbursement arrangements, even when market conditions suggest otherwise. Only once has the NSSF, over which the MOH has no control, had the political clout to stop purchasing care in a hospital for reasons of persistent false billings. In the Lebanese context, where denominational and political balances are all-important, the MOH itself has never been in a position to do this. Even a hospital that constantly overcharges by 60% or more remains contracted by the MOH. Theoretically the MOH has the administrative authority to intervene, but it does not have the technical means or information to make a case. The lack of technical prestige and credibility of a public service that has been absent from health care delivery and policy making for the last decade or more, further weakens its capacity to resist pressure on technical grounds. Both participation in and exclusion from the health care market are thus politically constrained. In such circumstances, it is unavoidable that there is little control over the size of costs, over their justification and over quality of care (Maynard 1991).

Without financial leverage, Lebanon's MOH has even less control over what happens in the field of ambulatory care. Even though there has been a slight improvement over the last five years, the MOH still spends less than 4% of its budget for technical activities and programmes. Primary health care accounted for only US$ 21 000 in 1991. Their share of non-budget has since increased to US$ 1 500 000 in 1995, but this remains a marginal amount compared to the bill for hospital treatment. As is the case in the field of hospital care, the MOH does not have technical authority since it has not been a significant actor in health care delivery over the last decades. And its administrative authority is extremely limited and almost impossible to carry through in a context of political interference and delicate denominational balances.

The MOH is thus left with (i) a budget that does not provide enough funds to ensure its own activities, including competitive payment of its personnel; (ii) a growing demand for reimbursement of care provided by private hospitals; and (iii) limited scope for increasing the total budget, or for further cuts in budget lines other than those for reimbursement of private hospital care. In the meantime, the economic and cultural effects of the unregulated expansion of the private sector are becoming apparent.

Incentives for inefficiency and distortion

In the aftermath of the war, the switch from emergency relief to health care delivery was to be based on a self-regulated system of private care providers, fuelled by public funds, where competition would ensure quality of care and affordability. Within five years the assumption that the sector would self-regulate (provide good quality care in an affordable and efficient way) proved false. There is ample anecdotal evidence that technical quality of care is wanting, especially in many of the smaller hospitals. There is no real evidence of growing consumer dissatisfaction as yet, but this can be expected as soon as problems with sustainability become more evident. Indeed, the mechanisms for regulation of the health sector (or rather their absence) act as incentives towards inefficiency and distort rational organization of health care delivery. They promote, and are reinforced by, a specialist-centred and secondary care oriented culture among both professionals and the public.

There are no incentives to expand the private provider's or health centre's responsibility for care beyond that of responding to immediate demand. Continuity of care is absent; for example, less than 2% of the contracts with private practitioners are revisits. Many health centres offer specialist consultations, but, in contrast, leave prenatal care to hospitals. This implies a tendency to medicalize, irrational use of drugs, and reliance on technology at the expense of communication. Hospital pharmacies have an average of 514 different items, up to 8000 in one hospital. Public funds pay for half of the 1.5 million x-ray acts made in Lebanon every year (Jurjus 1994). There are more health centres or private clinics with ECG services than with family planning activities. Little or no work is done in the field of health promotion, such as prevention of smoking. The priority given to kidney dialysis is in contrast with the absence of diabetes programmes (diabetes being the underlying aetiology for over one-quarter of kidney failure patients); the priority given to open heart surgery contrasts with the lack of primary preventions.

NFP-NGOs are presently offering an alternative of reasonably cheap and, in cases of need, free access to care for the poor. They, rather than government services, make up the social safety net for the poor in Lebanon. Their way of operating has led them to accept comprehensive responsibility for the care of certain population groups. This situation is now changing. Since their traditional sources of funding are withering, NGOs increasingly copy the workstyle of private practice: exclusive focus on those activities that have immediate income generating potential. The financial predicament of NGOs, combined with a *de facto* restriction of their mission, results in erosion of the social safety net as well as in gradual elimination of examples and models of better practice at primary care level.

These changes are clearly dependent on the absence of public funding to sustain structures accessible to the poor, and on the inability of government to influence or rationalise the way the private practitioners operate. The lack of guidelines and regulation is fuelling prescription patterns that merely respond to demand, without elements of rationalization or constraints other than the patient's ability to pay. This is preoccupying, for example, in the field of treatment of hypertension and diabetes, which was donor-sponsored for the last few years. The government is now contributing US$ 1.5 million per year to this programme, but still without treatment policy guidelines that would make it possible to control rising costs.

The lack of tools or levers for rationalizing ambulatory care is compounded by the type of political and financial incentives for hospital care. Hospitals and first level care in Lebanon are completely unrelated subsystems, both operationally and in the way they are financed. Since quality or cost-effectiveness are not determinants for purchase of hospital care, there is no real competition among hospitals. On the other hand, public subsidy for hospitalization, but not for ambulatory care, results in a *de facto* competition for patients between hospitals and first line services. This distortion carries an opportunity cost in terms of missed possibilities for efficiency gains through a division of labour between complementary first, second and tertiary care levels.

The expansion of the hospital network has taken place in an inefficient way, sacrificing overall sustainability for short-term return on singular investments. The creation of a large number of small private hospitals has resulted in an excess bed capacity in relation to the level of demand, as evidenced by a low bed occupancy (56%, compared to an OECD average of 81%), a short average length hospitalization stay of 4.8 days (less than half of that of OECD countries) (Jurjus 1994) and a hospitalization rate of 13.9 that approaches the OECD median of 16.1. A large proportion of hospitalizations in the small hospitals have no medical justification.

Lebanon now has three times more physicians per inhabitant than the average for the other countries of the Middle East. This can be expected to further fuel the growth of expenditure and the increase in hospital beds: new hospitals are already under construction. Most are so small that economies of scale are difficult. This results, for example, in under-utilization of equipment: CT scans in the smaller hospitals perform only between three and eight (often unnecessary) examinations per day. Kidney dialysis facilities could handle double the present patient load (Jurjus 1994), though the 400 dialysis patients per million inhabitants is already above the OECD median of 360.

Although manpower imbalances (e.g. only 2000 qualified nurses compared to 8–9000 doctors) will make it difficult to sustain proper functioning, hospitals aim for a level of technology that is way above that of many developed countries. The financing structure provides an incentive for the private hospitals to invest in heavy technology, since its operation will be preferentially subsidized by public funds. This has led to very rapid expansion, with little technical or economic justification. There are now five MRI in Lebanon, all located within a few kilometres from each other. At 240 cases per week the total cost can be estimated at US$ 4 400 000 per year: the equivalent of 5% of the MOH budget. There are 27 CT scans, six centres for in-vitro fertilization, and ten centres for litotripsy (Jurjus 1994). The fastest expansion is in cardiac surgery and cardiac catheterization, techniques that are automatically reimbursed by the MOH. Heavy medical technology is now more available in Lebanon than in many industrialized countries (Figure 9). Apart from the expected iatrogenic effects, this expansion of technology will further reinforce a culture of hospitalocentrism and fuel the cost explosion.

These considerable investments gamble on a continued growth of the health care market to ensure returns. Even compared to established market

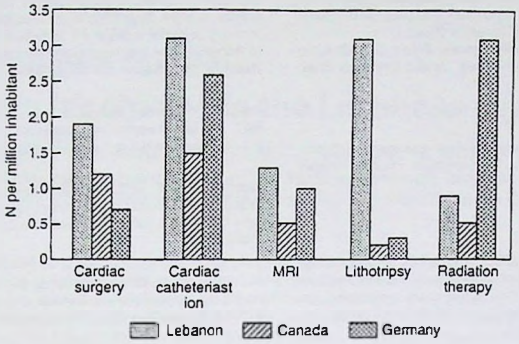


Figure 9. Selected medical technology: availablity in Lebanon as compared to Canada and Germany

economies, however, private expenditures are already high in terms of GDP (Table 2), and public expenditure is growing too fast for the government to sustain. The present predicament is that without proper regulating mechanisms, an unbearable strain will be put on the MOH and social security schemes, whereas rationing or regulating mechanisms would endanger returns on private investment.

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Reform follows failure: II. Pressure for change in the Lebanese health sector

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This paper describes how, against a background of growing financial crisis, pressure for reform is building up in the Lebanese health care system. It describes the various agendas and influences that played a role. The Ministry of Health, backed by some international organizations, has started taking the lead in a reform that addresses both the way care is delivered and the way it is financed. The paper describes the interventions made to prepare reform. The experience in Lebanon shows that this preparation is a process of muddling through, experimentation and alliance building, rather than the marketing of an overall coherent blueprint.

Introduction

In the aftermath of the civil war in Lebanon, the health care system was characterized by a very rapid expansion of private health care provision. In the absence of any regulation, this has led to a crisis situation. Private expenditures on health care are already high in terms of GDP (Van Lerberghe et al. 1997), and public expenditure is growing too fast for the government to sustain. Rationing or regulating mechanisms would endanger returns on private investment, and generate strong opposition from interest groups. On the other hand, the strain on the Ministry of Health (MOH) and social security schemes is rapidly becoming unbearable. The MOH is faced with (i) a budget that does not leave enough funds to ensure its own activities, including competitive payment of its personnel; (ii) a growing demand for reimbursement of care provided by private hospitals; and (iii) limited scope for increasing the total budget, or for further cuts in budget lines other than those for reimbursement of private hospital care. In the meantime, the economic and cultural effects of the unregulated expansion of the private sector are becoming apparent.

A first paper (Van Lerberghe et al. 1997) has described how this crisis developed between 1991 and 1995. This second paper documents how pressure for reform built up between 1994 and 1996, and identifies the key issues that, for better or worse, are on the reform agenda today. It is a reconstruction of events and positions in a rapidly changing environment, based on a reconstruction of the sequence of events, document analysis and their (often contradictory) interpretation in discussions with key players. It suffers from the biases of participant observation.

Putting reform on the policy agenda

Recognition of the need for reform usually emerges gradually among various actors with different and often contradictory agendas. It is the work of coalitions, by no means always led by the same groups. The MOH in Lebanon, which initially had a marginal role, has come to have a central position in the health reforms, using an alliance with some of the international organizations present in Lebanon. This is unusual since reform is usually put on the agenda by politicians (Hunter and Stockford 1996), professionals (von Otter and Saltman 1991) or, in developing countries, by the international development agencies, often in the wake of structural adjustment programmes (Okuonzi and Macrae 1995).

This central role for the MOH was possible because the ministry filled a policy vacuum. There is no easily

identifiable leadership in the sector. The actors are extremely diverse and fragmented, and none emerges with recognized authority. Whereas NGOs had prestige and authority during the war, both operationally and in the eyes of the public, this diminished afterwards. Professional organizations play only a limited role, and each private hospital looks after its own immediate interests. Lay politicians in Lebanon are rather indifferent to the organizational structure of health care delivery, or to proposals for change. They look at the health care system basically as one of the tools to help ensure political equilibrium. Ideologically biased in favour of hospitals, technology and private enterprise, they seem unaware of the financial predicament of the health care sector – considered a marginal problem compared to the political and economical challenges of reconstruction. Dissatisfaction with health care delivery is interpreted as an expression of the need for expansion of health care supply (physicians and hospitals), rather than as a need for rationalization and a change in policy and the health care provision model.

The ideological climate in Lebanon clearly favours private sector development, making it difficult to restrain expansion of the private sector hospital capacity or equipment. At the same time, the strategy for economic reconstruction is to be driven by public works. In the case of the health sector this means that the major focus is on hospital construction. Saudi, Kuwaiti and OPEC grant and soft-loan money is presently being used for the construction of seven, and possibly more, new public hospitals. This is clearly done more with a view to creating opportunities for public works than with a health sector development rationale.

Managers within the MOH view the prospect of having to operate these hospitals as a future budgetary and manpower nightmare. They find it difficult to envisage how they will recruit the necessary staff and liberate the operating funds, given (i) the MOH's track record in the operation of existing public hospitals; (ii) the restricted margin for reallocation of funds in a budget tied up by the present system of care purchasing in private hospitals; (iii) the scarcity of nursing staff; and (iv) the already existing hospital over-capacity in the private sector. On the other hand, they see the political necessity to (i) maintain some negotiation power by offering an alternative to the private sector; (ii) be able to deal with emergencies in case of armed conflict; and (iii) be able to refer patients that need secondary level care.

Conflicting agendas within the MOH

The current predicament of the health care sector within the MOH is by no means universally agreed. The main lines of thinking and the influences are schematized in Figure 1.

A first agenda is that of transforming Lebanon into a 'hospital for the Middle East'. In line with the private sector ideology that fuels the reconstruction policies in Lebanon today, this is an agenda that those in the MOH with a political constituency share with lay politicians. It receives support from different groups: political parties, the majority of the private sector medical establishment, interest groups within the MOH and, given the prevailing specialist and secondary care oriented ideology, the public as well. This agenda results in policy options favouring expansion of hospitals and a status quo in matters of regulation and financing mechanisms. It is made possible by the easy availability of both Lebanese and donor capital for heavy investments, and is fuelled by the high short-term returns on investment. A major advantage is that it responds to the political constraints typical for Lebanon. Decisions on hospitals and financing can be used as ways to obtain short-term political goals of maintaining or shifting equilibria within an extremely heterogeneous 'house of many mansions' (Salibi 1993).

The same group also has an agenda of reorientation towards PHC in response to pressure from their constituencies, e.g. for care for chronic patients. On this agenda they are in concordance with those within the MOH who have a more technocratic and managerial outlook. This agenda is supported by part of the medical establishment and academia: family medicine concepts are not dominant but do exist (Abyad et al. 1992). Reorientation towards PHC is also advocated by the NFP-NGOs (not-for-profit non-governmental organizations), and those within the MOH who promote it found allies in agencies like the World Health Organization (WHO) and, at a later stage, the World Bank.

The third agenda is that of control of the financing crisis. For the managers within the MOH the main impetus for reform has come from the budgetary predicament. As of 1992 the consequences of the political decision of unlimited reimbursement of certain types of care had become apparent.

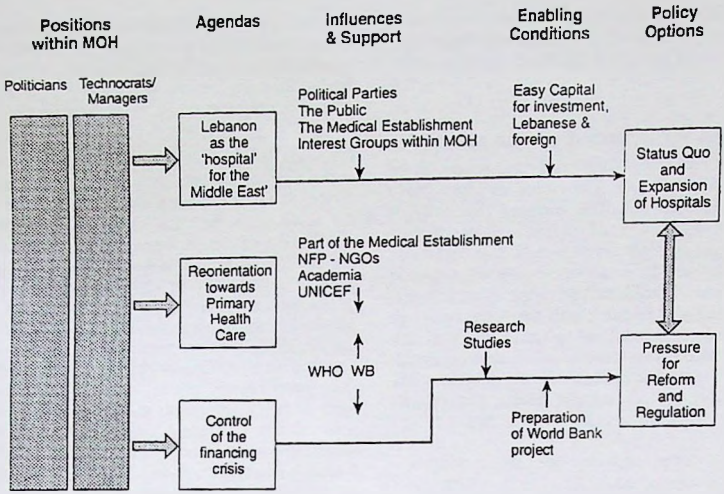

Figure 1. Agendas and conflicting policy directions with the Ministry of Health

This was not, however, the only element. The MOH also wanted to find a new and more rational equilibrium between primary, secondary and tertiary care, and to address the challenges of the epidemiological transition. Furthermore, some of these managers have a strong ideological tradition of public service, reinforced through their links with the NFP-NGOs during the war period. This makes the MOH one of the only organized groups concerned with equity and access, a concern reinforced through its links with WHO and academia.

The fusion of the second and third agenda items, reorientation towards PHC and control of the financing crisis, led to increasing pressure for reform and regulation. The challenge is to do this in a political environment with little awareness of the need and the stakes of reform, and with powerful interests pushing towards the status quo. Part of the private sector, for example, would like to get managerial control of the public insurance funds, as a way of streamlining bureaucracy and guaranteeing subsidies to hospitals.

The major constraint was the MOH's lack of recognized leadership, institutional capacity and authority to put the need for reform on the political agenda and to shape the orientation of the reform (Kronfol and Bashshur 1989). The MOH itself had little technical authority, limited political weight and few qualified professionals. Only a handful had an overview of the problems of the sector and a vision of possible ways out. Much of this had to do with the absence of information on what went on. It is revealing that even senior public insurance management staff are unable to provide a clear image of money-flows, and that the MOH has no updated inventory of health centres or hospitals in the country.

Despite its political and institutional fragility, the MOH has been taking the lead, being the body most immediately confronted with the financial consequences of the evolution of the last five years. For the MOH, both the way health care is delivered (with issues such as the equilibrium between hospital and community care, quality of care, access and equity) and the administrative-financial aspects of regulation, cost-containment and efficiency, were at stake. Very early on its priority option was one of regulation, rather than direct involvement in health care provision. This evolution was made possible by the fact

that the MOH had a better insight into the problems of the sector, which accelerated during the preparation of a World Bank loan for the reform of the health sector.

The need for information and alliances

In the first phase of putting health care reform on the agenda, research and information gathering have played a crucial role. This consisted essentially of documenting the extent of the cost explosion; the efficiencies and contradictions the health care system was heading for; and the extent of the problem of chronic diseases and ill health related to the urban environment. A flurry of research activities, funded through WHO, were contracted out to academic circles, but in close collaboration with the MOH. Besides providing information and evidence for the double agenda of organizational and financial reform, this research phase has had several important spin-offs.

First, knowledge provided the MOH with new leverage. It allowed the MOH administration to make the case for reform and, by the mere fact of knowing the sector, to progressively gain the authority to take a leadership position. Second, it fostered alliances outside the MOH and, within the ministry, a new sense of purpose. Third, this phase – with all the discussions with academia, NGOs and the international scene – allowed the MOH to make a basic strategic choice: it would aim to strengthen its policy-making and regulation functions rather than try to build a public sector delivery system.

This phase of awareness creation went on into 1994 and beyond. From 1994 onwards the MOH used the preparation of a World Bank loan as an opportunity to launch the process of reform. The aim was twofold: reorient the way health care is provided and rectify the financing structure. In order to do that the MOH had to improve its bargaining position and its policy leadership.

In current health sector reforms in industrialized countries the focus is on the pursuit of microeconomic efficiency on the production side, and on the allocation mechanisms that link finance to production (Saltman 1994). Most attempts start by concentrating on economic incentives and the financial operation of the health care system (Oevretveit 1994) in order to respond to fiscal pressure (Beaglehole and Davis 1992). Characteristic of the reform agenda in Lebanon is the sequencing of health care organization and health financing reform. Both are obviously interrelated, but the accent was put on health care reform first (with actual interventions), whilst in the field of financing, actions were limited to the preparation of future macro-level reform proposals.

Hospitals and the way they are financed are clearly at the heart of the problems of cost explosion and distortion of the Lebanese health system. This does not mean, however, that these problems can be tackled head on. The strategic role of public funding provides the MOH, *a priori*, with a good bargaining position towards the hospitals, and should allow to eliminate major inefficiencies, control costs, and provide incentives for quality assurance. In particular, the smaller, inefficient private hospitals would be very vulnerable to financial incentives and disincentives. But the MOH controls only its own inputs, not those of public insurance, and moreover, although potential and willingness are there, it is too weak technically and politically to enforce changes in the financing structure on its own. There is some margin for controlling costs, and some steps have been taken in 1994–96, but a thorough restructuring requires stronger pressure and alliances.

Such pressure does not come from ambulatory private practice as it functions now. Lebanon has some tradition of family medicine (Abyad et al. 1992) that has been built up in academic circles, but over the last year hospitalocentrism, reduction of ambulatory care and technology consumption have become dominant. Public sector health centres are not a credible alternative, and few or no officials believe that they have the potential to become so rapidly, even with major resource inputs. One of the major impediments to improving quality of care at first contact level, and using first contact level care as a lever to rationalizing hospital care, is the absence of an organizational model as an alternative to the present situation. For family doctors or general practitioners to put pressure on hospitals, they need first to start working in a different way themselves.

Currently, it appears that influencing the private sector will not be possible through mere financial mechanisms, certainly not in the short term. This would require massive state intervention, which is unrealistic given the budgetary situation and the weakness and lack of authority of the MOH. It will therefore be possible only to work through forms of pressure that are not exclusively dependent on MOH

Table 1. Interventions to prepare reform

Problem area	Interventions	Expected short-term results	Expected medium results
Hospital care: cost and quality	1994 onwards: Control billing and change price structure 1995: Autonomous public hospitals 1995: Feasibility study HMO	→Cost containment	Negotiated contracting conditions: gains in quality and efficiency
		→Regain credibility for public hospitals →Get more options	Ability to negotiate with private sector
First contact level care: quality and access	1993: WHO PHC Report 1995 onwards: Formulate programmes for control of chronic diseases 1995–6 onwards: Contracting NFP-NGO health centres: support in exchange for registration, minimum package and quality care	→Create demand for quality care	Pressure on private practitioners to improve quality
		→Accessible quality care →Capacity to manage responsibility for a defined population	Social safety net Fundholding type pressure in negotiations with hospitals
Regulation capacity	1992 onwards: Studies and research 1994 onwards: Control billling and change price structure 1995 onwards: Institutional strengthening 1996 onwards: Infrastructure coverage planning	→Alliances (especially with with social security system) and expertise	Ability to lead financing reform
		→Tools for regulation →Recognition of leadership and authority	Better control over system Ability to negotiate with private sector
Preparation of financial reform	1996 onwards: focus of studies and research on problems of financing	→Recognition of leadership and authority	Ability to market reform proposals
		→Knowledge on the functioning of the system	Ability to formulate a reform proposal
Pressure for sector reform	Capacity building (human resources documentation, information)	Favourable environment and increased control	Ability to formulate, to lead and to negotiate

administrative mechanisms: pressure from the medical community and pressure from user demand for accessible quality care.

Interventions to build pressure for reform

Pressure for reform in Lebanon built up through a series of parallel and phased interventions rather than through the marketing of an overall plan. A number of interventions were put in place in order to build a capacity, in terms of personnel and knowledge of the system, that would make it possible to create a favourable environment and gain some degree of control over the system. The aim is to provide the MOH with the ability to formulate, lead and negotiate overall proposals for reform. These different interventions are presented in Table 1.

In the field of hospital care, public hospitals became autonomous, and attempts are being made to improve their management. A major stumbling block is the absence of any links with the health centres. A feasibility study on establishing an HMO (health maintenance organization) in a Beirut suburb (Firkh

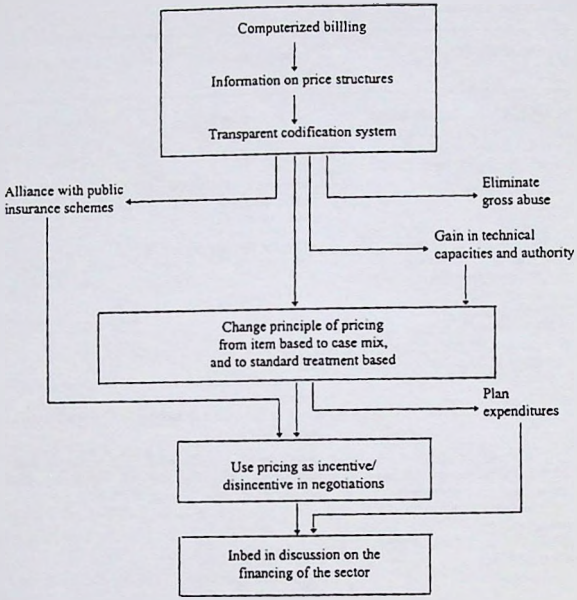

Figure 2. The strategy followed to control billing and pricing of purchased hospital care

et al. 1996) contributed in broadening the range of options that can be considered.

The key intervention, however, was the attempt at controlling the billing and pricing structure of purchased hospital care (Figure 2). Initially, this was a technical response to the budgetary emergency caused by increasing costs of purchasing care in private hospitals. A computerized system was created to allow identification of abuse and misappropriation, to get a thorough knowledge of the cost structure of hospital expenditure, and to transform the principles of reimbursement from an item-by-item to a case-mix basis. This, in turn, must make it possible to introduce elements of rationalization into hospital care (e.g. introduction of day-care) and to improve micro-level efficiency.

Transforming the pricing system requires technologies and capacities that were not available in Lebanon a few years ago but that are now being introduced gradually. It also requires the authority to follow-up on decisions made possible through this regulation technology, and to re-negotiate conditions of purchase of care in rational treatment norms – thus despite its lack of authority, the MOH was able to negotiate a 13% rebate on the bills submitted for 1995. This new strategy has been crucial in creating an alliance with the NSSF, over which the MOH has no formal control, for a common position in the negotiation of prices with private hospitals.

A second area of intervention concerns ambulatory health care. The beginning of the 1990s saw the first studies on the health sector and initial attempts to formulate disease control programmes. A further, more radical step was taken in 1995–96, when the MOH negotiated contracts with NFP-NGO health centres. In exchange for logistic support (drugs, training,

equipment etc.) NFP-NGOs are supposed to provide an agreed package of care for their population (Bobadilla et al. 1994), and to introduce quality assurance in a planned way.

With these contractual arrangements the MOH hopes for a triple effect. First, accessible quality care would be assured for the health centre's population. This answers the MOH's preoccupation with maintaining a social safety net for the poorest. Second, providing quality care is expected to enhance demand for quality care, putting consumer pressure on private care providers. A climate of changed consumer-provider expectations would be the best bet for rationalizing health care provided by individual private practitioners. Third, gradual introduction of registration combined with support on a capitation basis would give the possibility of enabling health centres to make contractual arrangements for hospital care for their registered population. These health centres would then have a role similar to that of general practitioner fundholders in the UK or primary care gatekeepers as used by some health maintenance organizations in the USA (Enthoven 1991). Pressure for a rationalization of hospital care would then come not only from the MOH, but also from part of the health care community in the capacity of patient advocates.

With this strategy towards NFP-NGOs, the MOH has a first entry point in the ambulatory care market. An overall strategy towards regulating and rationalizing private ambulatory care is still missing. At this stage it is very much an approach of seizing opportunities and creating a favourable environment. As a strategy, however, starting with the NFP-NGO health centres offers only limited perspectives. NFP-NGO health centres only cater for some 10% of the first level contacts. Fundholding in the UK, however, only covered 3% of practices three years after its introduction, and major expansion was decided when only 15% of practices were enrolled (Petchey 1995). Thus, going by this example, even with a small section of the market it should be possible to wield significant influence.

LL17.6Registration of the population and capitation payment are likely to meet with considerable resistance (Blecher et al. 1995). The technical aspects of the contractual arrangements are crucial to the success of the strategy, and still need to be tested. Politically it will probably be difficult to introduce and enforce performance-linked incentives. Nevertheless, the plethora of doctors is a favourable factor. With the high doctor-population ratio (close to 3:1000; Van Lerberghe et al. 1997), a certain degree of proletarization, or possibly even pauperization, of doctors is likely. This would create a pool of doctors among which the MOH could find candidates for collaboration in a support-in-exchange-for-quality scheme.

The major bottleneck in creating a regulatory capacity and preparing the reform of health sector financing is the lack of institutional capacity and system intelligence. Drastic change is unlikely in a fragmented society such as in Lebanon, where everything is linked; incremental change, on the other hand, would not produce results without a strong sense of direction. The MOH has had to develop and provide that sense of direction.

The interventions concerning hospital and ambulatory care have provided the MOH with a first set of instruments to initiate sector regulation. In order to capitalize on the first successes, the MOH has had to recruit new, technically qualified staff, mainly with an NGO or academic background. These new recruits have brought technical expertise and a new managerial culture. There has been visible progress in streamlining MOH administration and in its performance in monitoring, evaluation and planning. Combined with the alliances the MOH has created during the research and documentation efforts of the first half of the 1990s, this accelerated modernization is starting to pay off. The MOH now has the best, if still very inadequate, knowledge of the situation. It is now technically capable of commissioning and leading studies that give an insight into the national health accounts, health expenditure and provider patterns. This increased system intelligence does not mean that the MOH has the capacity to plan and implement a comprehensive reform, but it is now in a position to mobilize pressure for reform and to push its own public sector agenda.

Seizing opportunities to prepare for reform

The strategy of the MOH is not merely one of muddling through (Bennet and Holland 1977; Lindblom 1959), but rather of seizing opportunities to make headway where progress or experimentation is possible. The major weaknesses of this approach are that there is as yet no clear view on the future of health sector financing and no vision of how to restructure ambulatory care. Delay in tackling the financing issues is also the major criticism made by the international community. This weakness, however, may

be the strength of the MOH strategy: the groundwork is being done, and there is time for experimentation and analysis. There will thus be less risk of importing ready-made solutions which are not adapted to the Lebanese situation. This is turn will increase chances that reforming health sector financing will not merely aim at cost containment, but will actually improve health care delivery. More important still, especially in Lebanon's fragmented society, there is time for creating the necessary alliances. By the time there is an overall vision of reform, not only of health care but also of the sector's financing, the balance of power will have changed.

The key issue in the Lebanese health crisis is that of the role of the public sector. Before the war this was limited to purchase of hospital care and lip-service to providing universal access (Hayek 1980). With the war, there has been the implosion of the MOH and the expansion of the private sector, presenting a situation which is becoming untenable: the extent of the problem in financing the present system is now such that it is increasingly difficult to justify further expansion for mere reasons of political equilibrium. It seems clear now that the public sector in Lebanon will remain a marginal health care provider but that there is some scope to redefine its role in financing and regulating the sector. There is thus hope that elements of public sector rationality will be injected into what is now, still, essentially a seller's market.

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Viewpoint: Public versus private health care delivery: beyond the slogans

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In most settings, a 'public' health service refers to a service which belongs to the state. The term 'private' is used when health care is delivered by individuals and/or institutions not administered by the state. In this paper it is argued that such a distinction, which is based on the institutional or administrative identity of the health care provider, is not adequate because it takes for granted that the nature of this identity automatically determines the nature of the service delivered to the population. A different frame of classification between public and private health services is proposed: one which is based on the purpose the health service pursues and on the outputs it yields. A set of five operational criteria to distinguish between health services guided by a public or private purpose is presented. This alternative classification is discussed in relation to a variety of existing situations in sub-Saharan Africa (Mali, Uganda, Zimbabwe). It is hoped that it can be used as a tool in the hands of the health planner in order to bring more rationality in the current altercation between the public and the private health care sector.

Introduction

There is a growing interest in increasing and improving co-operation between the public and private sectors in the field of health care delivery, particularly in the developing world. A range of different explanations for this boost in interest can readily be identified. For a start, the already scarce resources for health care are dwindling yet further and linkages with the private sector may raise additional resources. There also is the gradual acknowledgement of the need to develop a *systemic* approach to health care delivery. The private sector is an important actor in this system, and can, under certain circumstances, substantially contribute to a consistent development of health systems.

Our field experience in sub-Saharan Africa confronted us with the rigidity, and even the strong emotions, that often tend to colour this debate on co-operation between the public and private sectors. The relative lack of rationality and objectivity in these discussions has contributed to a state of affairs where the concerned interlocutors clutch at their respective positions. It is common, and even natural, to notice a certain diffidence among civil servants and public health managers towards matters outside their control. The private health sector has often grown independently from the public health sector and is rarely taken into account in health planning scenarios. This has been the case in Uganda where the non-governmental sector, which generally has been in the forefront of the development of primary health care initiatives and which accounts for about 65% of the current primary health care delivery in the country, is rarely taken into account by the District Health Teams in their planning exercises. On the other hand, there is often in the private sector an excessive jealousy for its own independence, with a disregard of policy guidelines, aversion to evaluation, and hostility towards regulative measures.

It is increasingly evident that co-operation between the public and private sectors is a must in a systemic view of health service provision and in order to avoid expensive and useless duplications. In this perspective, it becomes important to move towards an ever progressive integration into the health system of all elements accepting a 'public' rationale of operation. But the definition of 'public' is, at present, somewhat hazy and needs focusing. The purpose of this paper

is to contribute to a proper definition and understanding of the terminology. We acknowledge the limitation of this paper to the specific context of sub-Saharan Africa. We intended it to be this way, since we believe the misconception to be stronger in that part of the world than elsewhere.

The confusion: what is the meaning of *public* and *private*?

In our view, one of the major stumbling-blocks in the process of understanding is the lack of consistent use and interpretation of the terminology public and private, be it conscious or not. We think attempts merely to answer the questions 'what is a public health service?' or 'what is a private health service?' would reveal the heterogeneity of views on the matter. The purpose of this paper is precisely to present some thoughts on *how* these very words 'public' and 'private' are used and to attempt to clarify *what* content they should refer to. We think that the development of a more coherent vocabulary is a necessary step in the broader process of co-operation between public and private sectors in the field of health care, or in any other social field for that matter.

In the majority of situations, the definition – both implicit and explicit – of a *public* health service refers to health care institutions *belonging* to the state. In sub-Saharan Africa, health care delivery is often supplied by private individuals and/or institutions whose ownership and/or administrative guardianship is *not* the state. In that case, the term *private* is used. It is generally understood that the public health sector should be supported by public money and protected by a series of privileges regulated by law, while the private health sector should operate on private funding, obtained through fees, donations or other means in the arena of a market oriented provision of service and of competition. This understanding is based on the assumption that the private sector is homogeneous and financially self-sustaining whereas, in reality, a remarkable heterogeneity exists in the private/non-government sector (DeJong 1991; Green 1992; Zwarenstein and Price 1990; Smith 1989).

Generally, when the service is rendered without lucrative purposes the specification 'not-for-profit' is added. The term 'non-governmental' is used to indicate organizations offering services without profit-making purposes, and whose ownership and/or administrative guardianship is not the state. We think that a distinction between public and private based on the institutional or administrative identity is not always adequate in dealing properly with the variety of existing situations.

The limits of this classification can be exemplified by the mushrooming number of non-governmental organizations operating for outright or hidden lucrative purposes. At the same time, there are public services which operate, to varying extent, on a lucrative basis, even if the intensity and the sometimes radical character of this shift in rationale within public facilities has not necessarily been the result of the planned choice of policy-makers. Examples of such shifts are the situations of some government hospitals in Zimbabwe and Uganda. In both countries, medical officers are allowed to develop private practice in tandem with their responsibilities and tasks in the hospitals. In the case of Zimbabwe, this measure is part of a broader effort aiming to attract national medical officers into the public sector in a context of massive brain-drain to neighbouring countries or to the private sector. In the case of Uganda, it grew out of a legitimate concern to increase the revenue of national doctors beyond the extremely low level of government salaries. In both countries, government officers are allowed to use the hospital infrastructure and hospital resources for treatment of private patients who pay them a fee, but without recompense to the hospital.

The gloomy prospect is one of governments ending up subsidizing – with tax-payer money – a private lucrative sector where basic measures of quality control are lacking and with a poor accessibility for lower income population groups. A 'two speed' health care system becomes a real threat – the same government would instead deny subsidies to private institutions striving, but finding it increasingly difficult, to offer financially accessible services, often at lower costs than those observed in public institutions.

The core of the matter really is that the adjectives private and public refer to the institutional or administrative identity of a given health service, taking for granted that the nature of this *administrative identity* automatically determines the nature of the *service* that is actually offered to people. In a time of reform of many health systems, with decentralization as a key element, this assumption can no longer be justified. If a distinction between public and private needs to be made, we think it cannot be based exclusively on the institutional set-up of a given service, but rather on the objectives and the output of that service.

Maintaining a distinction between public and private on the grounds of the administrative identity will only perpetuate confusion, prejudices and discrimination (positive or negative but, in either case, inadequate to the changing context). In Uganda for instance, the non-government sector (mainly Church-related not-for-profit organizations) has been able to achieve acceptable levels of health care delivery in some very remote and insecure areas of the country and in environments characterized by important social and political unrest with a *de facto* absence of the state. Nevertheless, the posting of national doctors to these institutions has become very difficult because of uncertain career and training perspectives for those who choose to work in them; nurses trained in NGO sc[illegible], which are formally recognized by the national Nursing Council and the final examinations of which are supervised by government officials, can make their way to the government service only with great difficulty; no or very little government subsidies are being allocated to NGO facilities which are considered by District Health Teams as falling outside their scope of responsibility, even when their importance for the system is openly recognized. The (private) status of these NGO not-for-profit hospitals, and the consequent refusal of support for them from government sources, clearly has hindered long-term development efforts, both for the NGO and for the state.

Such a distinction will hinder the dialogue between the different components of the health system at a time when each one's contribution and co-operation is necessary. Indeed, in the light of decentralization policies implemented in many developing countries, the institutional set-up of many decentralized 'public' health services is far less clear-cut. In the past all public health services, with few exceptions, belonged to and were financed by the state, represented by the Ministry of H[illegible]lth. Today, there is a trend towards decentralized [illegible]wnership and management by local communities, co-operatives, administrative districts etc.

Such a trend can be exemplified by the case of the network of community health centres ('centres de santé communautaires') gradually put in place in Bamako (Mali) from 1989 on. Former rural community-based experiences in the public sector served as an inspirational basis for young medical doctors who could not be hired by the government and who remained, jobless, in the capital of the country. With some initial external help, three or four health centres were organized so as to offer basic curative, preventive and promotional services. The owners of the facilities were members of community associations created for the purpose and the aim of these health centres was to provide health care to the subscribing members through a system of cost-recovery. Later, a 'second' generation of centres was put in place with virtually no external help other than small in-kind loans by existing centres. These new centres built up their revolving drug fund through the initial voluntary work of their employees. Several of them acquired grants from different donors, but only at a later stage.

The government played a promotional and regulatory role by considering these centres as active partners in its health development efforts. The existing centres constituted the starting point for geographical health coverage maps drawn up by the urban district teams. They also received small subsidies in kind from the government, especially for immunizations and family planning services. Their revenue was tax exempted and they were granted a special license to sell generic essential drugs. This support was provided in the understanding that the health centres themselves would not generate profits.

The debate on the status of these institutions is still ongoing. Legal texts have defined both the government's and the health centres' responsibilities, but the way the centres were put in place and the pressure from unemployed health workers in Bamako indicate that some of the attention has been diverted from the equitable provision of health care to the raising of revenue, mainly to hire additional staff.

An alternative classification?

What really matters to the health planner *and* to the public, are the contents, the quality and the costs of the package of services offered. For planning and evaluation purposes, and for the allocation of the meagre resources available, it is important that a clear and explicit *declaration of intent*, or mission statement, of the health care institution exists, so that the output and accessibility of these services can be evaluated. In an era of rapid change, it is also necessary to evaluate over time how, and to what extent, the performance of each health care institution fits the mission statement. Hence, we propose a different frame for the classification of health services based on their declared objectives and on their outputs. From thereon, a dichotomous classification in health services with respectively a public or private *purpose* can be proposed. More specifically, we propose a set of

purpose the health service pursues	*administrative guardianship and/or institutional identity of the health service*	
	public	private
public	a	b
private	c	d

Figure 1. Classification of health services according to their purpose and their administrative status

criteria for the classification of a health institution in the category of 'public':

- A social perspective: a concern to enhance people's well-being and autonomy in a perspective of human promotion. In the case of health services this more specifically means contributing to people's realization of a socially productive life, in a climate of dialogue between all implicated partners and in harmony with the prevailing overall socioeconomic development.

- Non-discrimination: a concern to offer people accessible and quality health care without discrimination whatsoever with regard to race, sex, religion, political affiliation, social status, income level etc. This is not in contradiction with a positive discrimination of specified population groups, deemed to be in particular need of health care (e.g. women, children, disabled people etc), or with a focus on specific health problems in the frame of vertically organized health programmes (e.g. trypanosomiasis control programme, family planning services etc).

- Population-based: a concern to take responsibility for, and to be accountable to, a well-defined population for its health care delivery. This accountability could be based on a contract with the population, specifying the mission statement of the service or institution.

- Government policy guided: a concern to comply with government health policies for the level of care provided and to fit in a broader masterplan. Should any different views arise with regard to official policy, then it is necessary that they be argued, discussed and, when possible, formalized in official agreements between the health institution and the national health authorities.

- Non-lucrative goals: a concern not to reduce the purpose of the service to profit making. This does not, of course, mean that good working and living conditions would not be a right for staff, nor that the service must be run at a loss. On the contrary, it is desirable that any service be self-sustained (this is not always possible; it is even virtually impossible in the case of district hospitals) and that its staff can work in acceptable conditions. In any event, in order to preserve the public purpose of the service, profits made should be reinvested in the same service or in other activities of social interest in agreement with the concerned population.

These criteria, which are currently being tested in the context of district health care delivery in Uganda, do not exhaust the variety of possible criteria identifiable in other contexts. Nonetheless, they provide an instrumental framework which could be used to assess the purpose of health services rather than the administrative/institutional set-up only. Both perspectives can be represented in a simple two by two table (Figure 1).

The four cells of this table can be exemplified as follows: a corresponds to National Health Service (NHS) hospitals in the United Kingdom (although the current reforms of the NHS represent a gradual shift from a to b); b corresponds to most church-related

hospitals in Uganda; a shift from a to c is taking place in many government hospitals in Uganda and in some government hospitals in Zimbabwe; and d corresponds to the situation of many hospitals in the USA. The relative strengths of the actors involved in the environment of the health centre of Bamako will determine whether these centres end up in categories b or d, or remain somewhere in between.

It is clear that the variable 'purpose' does not completely fit the nature of a dichotomous variable: indeed it covers a range of intermediate situations in the wide spectrum from public to private. The same comment holds for the administrative guardianship as well. Figure 1 is thus an oversimplification of reality. We nevertheless think that it is useful to illustrate our point. If governments agree and accept the rationale of this classification according to the very purpose of the service, then it would allow them to achieve more accuracy in targeting their support to health care institutions and organizations – both government and non-government – who serve a public purpose. The case of designated district hospitals in Tanzania or Ghana illustrates that it is possible to define consistent policies. In the case of Uganda, it appears that many (but by no means all) of the non-governmental and church-related organizations would sufficiently fit the criteria defining a 'public' service. This classification could also be helpful to distinguish organizations in the present mushrooming of private practices throughout the developing world: it may help to separate the corn from the wheat. A consistent policy would then be to support those organizations and individuals that pursue a public mission, and not only those that fit a given administrative status.

Conclusion

We have argued that a distinction between private and public based on the institutional set-up of a given service is not always adequate in defining the very nature of the service offered, the latter being of paramount importance to the health planner at any level of the health system. For example, many private hospitals and health centres in developing countries operate according to a rationale which could be defined as public; at the same time, lucrative goals are being introduced into public health services which, eventually, endanger their adequacy, relevancy and accessibility. An operational definition of what could be considered to be a public health service is still lacking. This is not without consequence at a time when, on the one hand, most governments are (or have become) unable to respond in a satisfactory way to the health needs of people, and where, on the other hand, the contribution of the private sector is called upon more and more.

This paper attempts to identify some operational criteria which would enable services to be distinguished according to their public or private rationale. These criteria do not necessarily fit each situation, but they can open up debate among health planners aiming to bring more rationality into the current altercation between public and private. They may also bring the various actors beyond the slogans and to a constructive dialogue.

What could this classification be used for? In operational settings public administrations could use these criteria to identify elements in the health system which need to fit the rationale of public-oriented health service provision. It should not be impossible to develop from these criteria some simple indicators, both quantitative and qualitative. In Uganda, for example, the criteria 'population based' and 'non-lucrative goals' are progressively being used to identify those elements of the health system eligible for integration and, sometimes, for partial financial support. But there is definitely a need for further research: the set of criteria need to be tested in a variety of different situations and precise indicators need to be designed so as to render the whole process less of a theoretical exercise.

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Behaviour of the private sector in the health market of Bombay

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In Bombay, the private sector plays a major role in providing medical care to all strata of society and these services are well utilized by everyone. Of late there have been criticisms about the quality of private medical care and there is a need for a proper policy on the development and regulation of private sector health services. This paper contributes to this by unravelling the inadequacies in the medical infrastructure and manpower, and highlighting the unethical medical practice rampant in private practice. The paper also assesses the existing regulatory mechanisms and their inability to control the quality of private sector medical care. After exposing the behaviour of the private sector, the paper suggests a holistic policy approach to increase and strengthen the public sector health services in poor areas, to develop norms to maintain quality in medical infrastructure and manpower, and to discipline unethical professional behaviour.

Introduction

It is commonly said that the private sector is more efficient, provides better quality services, meets the demands of the consumer promptly and that its services are more personal than the public sector. National, state and local governments are hard pressed for resources and would like the private sector to finance and provide good quality health services to relieve the burden of government. However, in reality, this does not seem to happen. The WHO Study Group on Evaluation of Recent Changes in the Financing of Health Services reveals that 'the promotion of the role of the private for-profit sector may result in unforeseen and negative consequences for the health system' (WHO 1992, p47).

The behaviour of the private health market is imperfect in terms of developing health. Providers decide which services to deliver based on the consumer's willingness to pay rather than on broader health needs. Often the superior quality of private sector health services is limited to non-clinical aspects like accommodation facilities. In terms of efficiency the same WHO Study Group concludes that 'although economic theory would suggest that private providers are more efficient technically, tendency to over-provide services, combined with higher prices, may mean that fewer people are adequately treated' (1992, p47). Equity is also of concern because access to private health services would depend on ability to pay.

Availability

Private sector health services have grown tremendously in India, especially in metropolitan cities like Bombay. As the income level of the city dweller goes up, his demand for health services increases in terms of both quantity and quality. Due to a resource crunch, the government cannot meet this growing demand. In addition, the geographical boundaries of Bombay have expanded rapidly over a period of time, and several slums have mushroomed in the suburbs. The Municipal Corporation has not been able to expand its medical infrastructure adequately to cover the suburbs. Therefore, private health care facilities have expanded to fill the gap left by the public sector. Another reason for the increasing availability of private sector health services is the tendency of doctors to stay in bigger cities like Bombay, leading to an oversupply of providers. This not only tends to lower prices but services are also delivered closer to consumers, further cutting indirect costs like transport costs.

Table 1. Social class, type of illness and source of treatment

	Self care/indigenous medical care	Public sector	Private sector	Total
Minor illness				
Lower class	13 (9.9)	20 (15.2)	98 (74.9)	131 (100)
Middle class	15 (6.2)	44 (18.3)	181 (75.5)	240 (100)
Upper class	3 (3.4)	9 (10.1)	77 (86.5)	89 (100)
Total	31 (6.7)	73 (15.9)	356 (77.4)	460 (100)
Chronic illness				
Lower class	6 (7.1)	19 (22.4)	60 (70.5)	85 (100)
Middle class	19 (14.6)	44 (33.9)	67 (51.5)	130 (100)
Upper class	6 (9.7)	18 (29.0)	38 (61.3)	62 (100)
Total	31 (11.2)	81 (29.2)	165 (59.6)	277 (100)
Acute illness				
Lower class	2 (3.0)	40 (58.8)	26 (38.2)	68 (100)
Middle class	2 (2.1)	49 (51.0)	45 (46.9)	96 (100)
Upper class	-	2 (7.1)	26 (92.9)	28 (100)
Total	4 (2.1)	91 (47.4)	97 (50.5)	192 (100)

In Bombay, the above-mentioned factors have led to a situation whereby private sector health services have overtaken public sector health services. In the year 1990, the private sector ran 87.9% of the total 602 hospitals in Bombay providing 39.8% of the total hospital beds (Public Health Department 1991). Other facilities like clinics and maternity facilities are overwhelmingly more numerous in the private sector than in the public sector. It was estimated that there are about 20 000 qualified doctors in Bombay of whom 14 000 are in private practice (Medico Friends Circle pamphlet, 1991).

Utilization

In terms of utilization of health services, the private sector is widely used by all strata of society in Bombay. A study conducted by Yesudian (1989) demonstrates this point. The sample survey, cutting across all socioeconomic groups (upper, middle and lower), showed that a good majority of households from all such groups used the private sector for minor and chronic ailments. Public and private sector health services were roughly equally used for treating acute illness. However, the level of utilization of private health services for acute illness increased concomitantly with socioeconomic status (Table 1).

The above study also showed that irrespective of socioeconomic status, people are willing to pay for health services (Yesudian 1989). Table 2 gives details of the mean medical expenditure incurred by the three socioeconomic groups for treating minor, chronic and acute illnesses. The findings show that all the socioeconomic groups spent money for treating these illnesses, though the sums varied between groups.

Table 2. Social class and mean medical expenditure

Social class	Mean medical expenditure		
	Short-term illness (Rs.)	Chronic illness (Rs.)	Acute illness (Rs.)
Lower class	59.30	564.70	1433.30
Middle class	85.20	497.50	1466.10
Upper class	139.90	752.60	3284.60
Total	91.70	598.70	1643.60

Approximately Rs.30 = US$ 1

Note.
1) For short-term illness, expenses were calculated for one episode for a period of two weeks.
2) For chronic illness, expenses were calculated for one episode for a period of one year.
3) For acute illness, expenses were calculated for one episode that happened within a year.
4) Items of expenditure include drugs, fees, investigation, bed charges, travel, diet and other miscellaneous items.

The study

The above information reveals that the private sector not only provides health services for the affluent classes but also for the poorer sections of society. People are willing to pay for health services, and so the private sector is going to expand further in the near future. This process will be speeded up by resource scarcity in the public sector. However, so far, there is no policy to decide the direction of private sector expansion. As a result, the private sector is proliferating and is the most disorganized sector of service delivery.

Of late, there have been several complaints against the private sector. Some of the private doctors and institutions have been taken to law and consumer courts. In two such cases, compensation has been awarded to the patients. This has led to closer scrutiny of the private sector by the media and public interest groups. Though a need is felt to regulate the private sector and to have a definite policy on its development, there is virtually no information available about the behaviour of the sector. Even a description of the complexity of the private sector is not available.

Objectives

This paper represents a first exploration of the complex behaviour of health service providers in the private sector. The paper aims to:

a) Understand the different forms of the private sector operating in the city of Bombay;
b) Critically analyse the delivery of health services in the private sector;
c) Assess the existing control/regulation mechanisms;
d) Consider the policy options available to regulate the private sector.

Methodology

The study obtained its information mainly from secondary sources and from 15 informants who hold key positions in the health sector. Their characteristics are given in Table 3. The key informants included hospital administrators, senior clinicians and members of social action groups interested in the health sector.

Critical analysis of the private sector

The private facilities in Bombay range from modern sophisticated hospitals serving the needs of affluent classes to clinics operating in dilapidated rooms in slums run by semi-qualified people. Private sector health services can be broadly classified into three categories: hospitals, nursing homes, and clinics. Nursing homes can be maternity homes, small medical facilities, or both medical and surgical facilities. Types of nursing homes and clinics vary widely in terms of services offered, type of ownership and charges. Some clinics dispense medicines, while others issue only prescriptions. Considering the varied nature of the nursing homes and clinics, it is difficult to draw their profile.

Several articles have been published recently criticizing the private facilities in Bombay. Newspaper headings like 'Private hospitals in morbid state' (*The Times of India*, August 10, 1992), 'Shrines to Mammon, private hospitals offer no solution', and 'Unregistered nursing homes thrive in city' (*The Times of India*, August 10, 1992) reflect the situation of the private sector health services.

Table 3. Characteristics of respondents

Age group	Frequency	Education	Frequency	Occupation	Frequency
35–44	5	Postgraduate medical deg.	8	Senior hosp. executive	6
45–54	7	Postgraduate medical dip.	6	Senior med. teacher (prof.)	4
55 and above	3	Other postgraduate deg.	1	Middle level hosp. manager	2
				Senior private practitioner	2
				Social activist	1
Total	15	Total	15		
				Total	15

In one of the medico-legal cases filed by a public interest group in the High Court, the court instructed the Deputy Municipal Commissioner in charge of Health to form a committee to find out the situation in private nursing homes. The salient features of the committee's findings are given below.

a) A majority of nursing homes are substandard, most of them being housed in tiny flatlets (e.g. 200 sq.ft.);
b) One seventh of them are actually in sheds or lofts in slums;
c) Seventy seven per cent do not have scrubbing rooms;
d) Less than one third have qualified nurses;
e) Some have operation theatres (OT) as pathetically small as 48 sq.ft. or 6 × 8 ft.;
f) Some do not disinfect the OT more than once a week, some do it once in three days and hardly any after every operation;
g) None incinerate any infectious waste material, but instead dump it in municipal bins, from where scavengers are known to pick out needles, syringes, etc. for recycling – a horrendous health hazard;
h) A majority of them claim to be maternity homes, but only a third have labour rooms;
i) Over a third of all wards and half of beds in them are 'dirty' and mostly are poorly lit;
j) None of them keep records of notifiable diseases; only 10% record births and deaths; and hardly any display their licence prominently.

(*The Times of India*, 1992a)

Further information was gathered from the key informants. They provided information on various problems related to physical location, disposal of waste, equipment, manpower, medical malpractice, and medical negligence. The responses to the questions asked of the key informants are divided into responses related to big hospitals, responses related to nursing homes and clinics in non-poor areas, and responses related to clinics in poor areas.

Physical location

A majority of the respondents (9 out of 15) said that private hospitals are situated away from residential localities and are neither hazardous nor a nuisance to the public. However, they felt that nursing homes and clinics in both poor and non-poor areas are situated closer to residential buildings or are a part of the residential buildings causing a nuisance and posing health hazards to residents.

Probing further, the respondents said that the presence of private nursing homes or clinics in and around residential buildings led to an increase in noise, traffic jams and vendors. Admission of patients with infectious diseases posed a problem to the residents. Deaths and serious accident cases created commotion in these areas and psychologically affected the residents, especially children.

Disposal of waste

According to the respondents, hospitals normally have a proper system to dispose of waste. On the other hand, nursing homes and clinics, in both the poor and non-poor areas, do not have incinerators. Lifts in the buildings are used to carry infectious wastes causing health hazards to residents. Waste, which includes surgical materials, dressing materials, placenta and disposables, is usually thrown in public dustbins. Even if it is contained within plastic bags, rag-pickers open the bags and scatter the contents. Occasionally amputated toes or limbs are found in the garbage bins scaring the public.

Equipment

Most of the respondents felt that private hospitals and nursing homes were well equipped. They were asked whether modern equipment and technology were necessary in these private sector facilities. It is interesting to note that the respondents justifed the use of modern technology in the hospitals but did not approve its use in private nursing homes and clinics.

Three major reasons were given to justify the use of modern technology in private hospitals. Firstly, the public sector hospitals are not able to improve upon and update technology and hence modern technology should be encouraged in private hospitals. Secondly, if modern technology is available in private hospitals, rich patients will use them leaving the public facilities for the poor. Finally, since the private sector is highly commercialized and competitive, updating technology is very essential to attract patients.

Those who opposed modern technology in the private sector gave the following reasons. Patients are likely to undergo more investigations, some of which may be unnecessary. This will increase the cost of treatment for the patient. The competitiveness among the private sector facilities (hospitals, nursing homes and clinics) to update technology will lead to unethical practices and commercialization of the medical profession.

Proper maintenance of equipment in critical areas such as ICU, ICCU, casualty and OT is important for patient care. Almost all the respondents felt that the private hospitals maintained their equipment well in critical areas of medical care. However, the private nursing homes and clinics, it was agreed, do not: they may use second-hand equipment which is unreliable, poorly maintained and operated by untrained personnel.

Manpower

Less than half of the respondents felt that private hospitals have the skilled manpower to operate modern equipment. In the case of nursing homes and clinics, almost all respondents felt that they do not have trained manpower and the quality of medical care will thus suffer, leading to complications.

Some hospitals and many nursing homes appoint non-allopathic doctors, i.e. doctors trained in ayurveda, unani and homeopathy, as resident doctors. The respondents felt that these doctors cannot handle emergency situations. Mishaps can occur in administering drugs and transfusion of blood. One case was reported in which wrongly matched blood was given resulting in the death of the patient.

The respondents said that there was an acute shortage of qualified nurses in private nursing homes and clinics. Half of the respondents felt there was a shortage of nursing staff in hospitals. All the respondents agreed that patient care would suffer badly if qualified nurses were not employed. Unqualified nurses would be unable to recognize emergencies and to cope with such situations until the arrival of a doctor. There is also the possibility of administration of the wrong drug. The respondents were highly critical of nursing homes and clinics, many of which used illiterate or poorly educated women as nurses. One respondent estimated that two-thirds of private nursing homes employed such persons for providing nursing care. These nurses can neither monitor the condition of the patients nor can they handle special equipment in areas like the OT and the ICU.

Misuse of privileges

Since private doctors play an important role in providing specialized care in public sector hospitals as honorary staff members, an attempt was made to find out whether they misuse the privileges that they receive in public hospitals for personal gain. Most respondents acknowledged that this happens.

Honorary consultants working in public sector facilities as honoraries admit their private patients to public hospitals, especially to teaching hospitals, and provide treatment. If the consultant's private facility does not have a particular piece of equipment for diagnosis or treatment, he makes use of such a facility in the public hospital and charges the patients for it. Also, if patients in the public hospital can afford to pay, such patients are diverted to private clinics. Normally, patients believe that an honorary consultant will offer better service in his private clinic or nursing home. It was also alleged that if a piece of equipment was available both in the public hospital and in the clinic or nursing home, some honorary consultants would ensure that the public hospital equipment broke down, so that the patient could be moved to the private facility for investigation or treatment.

Medical malpractice

Due to the proliferation of the private sector in Bombay and the competition arising out of it, there is a possibility of professionals indulging in medical malpractice to survive the competitive environment. Most of the respondents (12 out of 15) agreed that medical malpractice was rampant in the private sector. They also listed the kind of malpractice prevalent in the city.

'Cut practice' is one such malpractice, where the general practitioner, consultant, nursing home owner and investigation centres (e.g. private laboratories and X-ray centres) collude with one another to squeeze the patient. Whenever a referral is made, the referring doctor receives a portion of the fee charged to the patient by the receiving person. For example, if a general practitioner (GP) refers a patient to a consultant, the consultant will pay the GP up to even 40% of the fee he charges the referred patient. Often, the patient is referred to several consultants and investigation centres unnecessarily. The patient not only incurs unnecessary expenses but his treatment gets delayed. Unnecessary and costly investigations are carried out and even unnecessary surgery.

Another area of malpractice is issuing false certificates and medical bills. Some private doctors earn money by issuing medical certificates to healthy individuals. These doctors also give fictitious medical bills to individuals, who were neither sick nor have undergone treatment in their clinics, charging a fee for this dubious service. This helps the individual to claim medical benefits, even though he was not ill.

Medical negligence

Poor sterilization of instruments has been observed in private hospitals, which can cause Hepatitis-B or even HIV infection. Many respondents complained about negligence in post-operative care in private hospitals. Often, the surgeon who performed the surgery was not available to take care of post-operative complications, even in big private hospitals. In the recent past, two such cases in two leading private hospitals resulted in deaths. The hospitals and the surgeons were sued in the consumer court and asked to pay huge compensation.

Often intravenous fluid administration and monitoring are carelessly done, leading to complications. Improper and wrong administration of drugs are observed in private sector facilities; such negligence can be due to the employment of unqualified nurses. Specialists often neglect patients in the lower grade beds, especially those in the general ward. Similarly substandard materials and services may be provided depending on the person and situation. The lack of coordination between investigation and diagnosis habitually leads to delayed treatment.

Referring to private medical practice in slums one respondent remarked, 'slum practice is an entity in itself and medical ethics are not known to the practitioners or best ignored by them'.

Regulation of the private sector

The above section has highlighted all the negative aspects of the private health sector. During the last year, there has been increasing pressure for the regulation of this sector and dialogue is continuing at various levels to work out an appropriate mechanism. The media is playing a key role in exposing medical negligence and medico-legal cases. Activist organizations like Medico Friends Circle (MFC) and the Association for Consumer Action on Safety and Health (ACASH) are spearheading the cause of the patients. These organizations consist of socially conscious doctors, lawyers, social workers and others.

Existing regulations

The Bombay Nursing Home Registration Act (1949) is a major act regulating private hospitals and nursing homes. Local bodies like the Municipal Corporation are supposed to implement the Act and registration should be renewed every year. The Act has a provision for inspection. Private hospitals and nursing homes have to provide information in terms of staff, equipment, floor space, accommodation facilities, and sanitary conditions.

In spite of this Act, over one hundred nursing homes in the city are not registered. The Public Health Department staff of the Municipal Corporation seldom visit private hospitals and nursing homes. Though the Act states that local bodies should formulate by-laws suitable to their situation, the Municipal Corporation of Greater Bombay (MCGB) has not formulated any specific standards or norms for establishing private facilities. Standards are very vague and use the term 'adequate' in most places.

In a recent judgement of a medical negligence case (December 4, 1991), the Maharashtra High Court judges remarked 'The Court notices that the implementation of the Bombay Nursing Home Registration Act, 1949, in Greater Bombay has not been satisfactory' (Desai and Sawant 1990: App. 56 of 1991 in W.P. No. 2269 of 1990). The Court has directed the formation of one Apex Committee and three Zonal Committees consisting of municipal officials, representatives of the Maharashtra Medical Council (MMC), senior doctors employed by the public sector and social workers. The Committees were

given 'the power to oversee and supervise the implementation of the Act and to make appropriate suggestions and recommendations in that regard to the competent authority' (App. 56 of 1991 in W.P. No. 2269 of 1990).

The Maharashtra Medical Council (MMC) and Indian Medical Association (IMA) also regulate medical practice through the investigation of complaints regarding the individual doctor's professional behaviour. However, over a period of time, people's confidence in them has decreased. Narrating his experience with the IMA and the MMC, Raghunath Raheja, whose wife died allegedly due to medical negligence, states that when a complaint was made to these bodies, they did not reply. He then went to court to force the MMC to take up his case. Again he had to go to court to force the MMC to give their decision, which took six months. As for the nature of the hearing of the case by the MMC, Raheja states 'it was just a farce. Statements blatantly changed to favour doctors, papers lost, officials lying in court. You can't expect justice from them, one has to go to court, which takes years to decide a case.' (Iyer 1992) This reflects the people's lack of confidence and frustration in dealing with professional bodies.

The National Consumer Grievance Redressal Commission under the Consumer Protection Act, 1986, takes care of the grievances of consumers and is quick to respond to complaints. Recently, and for the first time, a medical negligence case was brought to the Commission and the aggrieved party was awarded compensation of Rs.700 000. However, the private hospital refused to appear before the Commission and challenged the jurisdiction of the Commission in judging hospital services. The IMA has also supported this stand. Doctors argue that medical service is not a consumer item, the doctor-patient relationship is based on trust, and patients should not question their decisions or seek to penalize them for untoward outcomes (Iyer 1992).

Conclusions

Private sector medical facilities have proliferated tremendously in Bombay. All levels of curative care are available to each strata of the population including the poor. These medical services are well utilized by all sections of the community. However, after analysing the opinions of experts (key informants), we have found that the private sector provided substandard medical services in every respect. Private nursing homes and clinics are widely spread all over Bombay but they lack proper physical infrastructure and manpower. Medical malpractice and medical negligence seem to be rampant in the private sector. Therefore, we conclude that more and more people in Bombay are using more and more substandard health services. This is so especially in slum areas, where people are exposed to unethical and unhygienic medical practice endangering the health of the poor.

Policy directions

Policy related to the private sector in Bombay should be directed towards two major issues: (i) direction of expansion of the private sector vis-a-vis the development and strengthening of municipal health services and (ii) measures to control/regulate the behaviour of the private sector in such a way that it contributes to health development. These two policy areas are not independent of each other but are related. The policy related to the regulation of the private sector will surely affect the extent and direction of expansion of the private sector. It should be the intent of the policy to make use of regulatory mechanisms to guide the growth of the private sector in the right direction.

Improvement of the health of the poor depends mainly on preventing diseases and providing maternal and child health services. The private sector does not take much interest in this area of health services, preferring to concentrate on curative services. The Municipal Corporation should therefore create more health centres and strengthen the existing ones in slum areas. According to a study conducted by Yesudian (1988) in a slum situated on the periphery of the city, slum dwellers do not use municipal services because of long waiting hours, long distances (incurring transport cost) and brief contact with the doctor. Therefore, there is a need not only to increase municipal health care facilities in slum areas but also to increase the services available within each municipal health facility, to reduce waiting time and increase contact time with the doctor.

The private sector should be given incentives, e.g. tax benefits, to start more secondary and tertiary level facilities in the city. Today, all the major health care facilities are run by the Municipal Corporation. Private participation in some of the major municipal facilities situated in non-poor-areas should be encouraged. This policy approach will relieve municipal resources, currently spent on their major facilities, to be utilized in smaller primary level facilities situated closer to the slum areas. Strengthening of municipal facilities in slum areas will force/encourage the private facilities in slums to improve their quality of service.

Developing an appropriate regulatory mechanism for the private sector is an arduous task. Some efforts have been made in the recent past to describe certain norms for different types of medical facilities, and some senior medical professionals and doctors belonging to certain social action groups have suggested such norms (*The Times of India* 1992b). But the Private Hospital Owners Association found these norms unreasonable (Kerkar 1992). Moreover, these efforts were intended to streamline the functioning of private nursing homes operating in middle-class areas. The policy should focus its attention more towards private practice in slum areas, if it wants to improve the health status of the people.

Norms should initially concentrate on the physical environment, physical structure and the kind of manpower used in private sector health care facilities. If norms ensure minimum standards of a hygienic environment, adequate and clean space and qualified manpower, the quality of the private health services will improve, especially in slum areas. Other norms related to oxygen facilities, blood transfusion, laboratory, operating theatre and equipment should be taken up as the second level of regulation. These norms will be mainly applicable to bigger nursing homes operating in non-poor areas. The present defunct Bombay Nursing Home Regulation Act (1949) should be replaced by a new Act incorporating the above aspects.

Implementation of the regulation is more important than formulating the norms. The Public Health Department of the Municipal Corporation should undertake this responsibility, vesting it exclusively in a Deputy Executive Health Officer with an adequate number of field staff. If they can monitor and take action on the physical environment, physical structure and manpower in private facilities, a tremendous quality improvement can be achieved.

With regard to the unethical behaviour of medical professionals, the MMC still has a major role in disciplining its professionals. However, the Deputy Executive Health Officer should be given the power to identify unethical practices and report them to the MMC for action.

This paper has revealed that, at least in the context of Bombay, unregulated expansion of the private sector will do more harm than good for the health sector and the people. Further, no policy can address separately the issues related to the public and the private sectors. A holistic approach is needed to direct and regulate the growth of the private sector in Bombay. On the whole, a regulated private sector and a strong public sector will benefit its population.

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given 'the power to oversee and supervise the implementation of the Act and to make appropriate suggestions and recommendations in that regard to the competent authority' (App. 56 of 1991 in W.P. No. 2269 of 1990).

The Maharashtra Medical Council (MMC) and Indian Medical Association (IMA) also regulate medical practice through the investigation of complaints regarding the individual doctor's professional behaviour. However, over a period of time, people's confidence in them has decreased. Narrating his experience with the IMA and the MMC, Raghunath Raheja, whose wife died allegedly due to medical negligence, states that when a complaint was made to these bodies, they did not reply. He then went to court to force the MMC to take up his case. Again he had to go to court to force the MMC to give their decision, which took six months. As for the nature of the hearing of the case by the MMC, Raheja states 'it was just a farce. Statements blatantly changed to favour doctors, papers lost, officials lying in court. You can't expect justice from them, one has to go to court, which takes years to decide a case.' (Iyer 1992) This reflects the people's lack of confidence and frustration in dealing with professional bodies.

The National Consumer Grievance Redressal Commission under the Consumer Protection Act, 1986, takes care of the grievances of consumers and is quick to respond to complaints. Recently, and for the first time, a medical negligence case was brought to the Commission and the aggrieved party was awarded compensation of Rs.700 000. However, the private hospital refused to appear before the Commission and challenged the jurisdiction of the Commission in judging hospital services. The IMA has also supported this stand. Doctors argue that medical service is not a consumer item, the doctor-patient relationship is based on trust, and patients should not question their decisions or seek to penalize them for untoward outcomes (Iyer 1992).

Conclusions

Private sector medical facilities have proliferated tremendously in Bombay. All levels of curative care are available to each strata of the population including the poor. These medical services are well utilized by all sections of the community. However, after analysing the opinions of experts (key informants), we have found that the private sector provided substandard medical services in every respect. Private nursing homes and clinics are widely spread all over Bombay but they lack proper physical infrastructure and manpower. Medical malpractice and medical negligence seem to be rampant in the private sector. Therefore, we conclude that more and more people in Bombay are using more and more substandard health services. This is so especially in slum areas, where people are exposed to unethical and unhygienic medical practice endangering the health of the poor.

Policy directions

Policy related to the private sector in Bombay should be directed towards two major issues: (i) direction of expansion of the private sector vis-a-vis the development and strengthening of municipal health services and (ii) measures to control/regulate the behaviour of the private sector in such a way that it contributes to health development. These two policy areas are not independent of each other but are related. The policy related to the regulation of the private sector will surely affect the extent and direction of expansion of the private sector. It should be the intent of the policy to make use of regulatory mechanisms to guide the growth of the private sector in the right direction.

Improvement of the health of the poor depends mainly on preventing diseases and providing maternal and child health services. The private sector does not take much interest in this area of health services, preferring to concentrate on curative services. The Municipal Corporation should therefore create more health centres and strengthen the existing ones in slum areas. According to a study conducted by Yesudian (1988) in a slum situated on the periphery of the city, slum dwellers do not use municipal services because of long waiting hours, long distances (incurring transport cost) and brief contact with the doctor. Therefore, there is a need not only to increase municipal health care facilities in slum areas but also to increase the services available within each municipal health facility, to reduce waiting time and increase contact time with the doctor.

The private sector should be given incentives, e.g. tax benefits, to start more secondary and tertiary level facilities in the city. Today, all the major health care facilities are run by the Municipal Corporation. Private participation in some of the major municipal facilities situated in non-poor areas should be encouraged. This policy approach will relieve municipal resources, currently spent on their major facilities, to be utilized in smaller primary level facilities situated closer to the slum areas. Strengthening of municipal facilities in slum areas will force/encourage the private facilities in slums to improve their quality of service.

Developing an appropriate regulatory mechanism for the private sector is an arduous task. Some efforts have been made in the recent past to describe certain norms for different types of medical facilities, and some senior medical professionals and doctors belonging to certain social action groups have suggested such norms (*The Times of India* 1992b). But the Private Hospital Owners Association found these norms unreasonable (Kerkar 1992). Moreover, these efforts were intended to streamline the functioning of private nursing homes operating in middle-class areas. The policy should focus its attention more towards private practice in slum areas, if it wants to improve the health status of the people.

Norms should initially concentrate on the physical environment, physical structure and the kind of manpower used in private sector health care facilities. If norms ensure minimum standards of a hygienic environment, adequate and clean space and qualified manpower, the quality of the private health services will improve, especially in slum areas. Other norms related to oxygen facilities, blood transfusion, laboratory, operating theatre and equipment should be taken up as the second level of regulation. These norms will be mainly applicable to bigger nursing homes operating in non-poor areas. The present defunct Bombay Nursing Home Regulation Act (1949) should be replaced by a new Act incorporating the above aspects.

Implementation of the regulation is more important than formulating the norms. The Public Health Department of the Municipal Corporation should undertake this responsibility, vesting it exclusively in a Deputy Executive Health Officer with an adequate number of field staff. If they can monitor and take action on the physical environment, physical structure and manpower in private facilities, a tremendous quality improvement can be achieved.

With regard to the unethical behaviour of medical professionals, the MMC still has a major role in disciplining its professionals. However, the Deputy Executive Health Officer should be given the power to identify unethical practices and report them to the MMC for action.

This paper has revealed that, at least in the context of Bombay, unregulated expansion of the private sector will do more harm than good for the health sector and the people. Further, no policy can address separately the issues related to the public and the private sectors. A holistic approach is needed to direct and regulate the growth of the private sector in Bombay. On the whole, a regulated private sector and a strong public sector will benefit its population.

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Carrot and stick: state mechanisms to influence private provider behaviour

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The behaviour of private sector health care providers will depend critically on the environment within which they operate. A bewildering array of possible regulatory and incentive setting structures exist. Most developing countries have the basic legislation for regulation, but there are frequently difficulties in enforcing such controls. While process aspects of quality of care regulation are often the responsibility of professional organizations, these organizations may have limited incentives to be active in ensuring high quality medical care. There has been less experience with the use of incentives to encourage appropriate behaviour amongst private providers: this appears a promising area for further work. Above all, adequate information is essential both for the enforcement of regulations and the application of incentive mechanisms.

Introduction

While policy analysts continue to debate the comparative efficiency of public and private health care providers (Bennett 1991; Institute of Medicine 1986; McLachlan and Maynard 1982), it is becoming evident that neither provider is inherently more efficient. Their performance is contingent on factors external to the provider, and factors dependent on the internal organization of the provider. The external environment includes public demand for services, societal expectations of providers, and the regulatory framework within which minimal standards for the provision of services are laid down. Internal factors include the organization's or individual provider's objectives, and its management structure and culture. As the state has a clear role in ensuring safe and appropriate health service provision for the population, it must have mechanisms through which to liaise with private health care providers. This paper is concerned with aspects of this relationship, between private for-profit providers and the state.

Areas of concern in this relationship become apparent if it is viewed as a 'principal–agent problem' (Gravelle and Rees 1992; McGuire et al. 1989). This theory is based on a relationship where a principal (the state) authorizes an agent (the private provider) to make decisions on his or her behalf. Theory tells us that when the objectives of the principal do not coincide with those of the agent, conflict will arise in their relationship. This is further exacerbated if the principal has limited information about the agent's decisions.

Given that the state has a responsibility to ensure health services are available to all the population, a divergence of objectives between the state and the private for-profit sector can be anticipated. The state aims towards equitable service provision and the private sector is driven by the desire to maximize profits. For example, a physician may over-provide care in order to generate higher levels of income. This is costly to both the individual and society and may compete with objectives of the state, such as increasing access to care. As health care is a complicated and highly differentiated product, information about medical decision-making usually resides in the hands of a limited number of professionals. This further exacerbates problems for the state in keeping its role as principal. Principal–agent problems also occur in countries which require the medical profession to be self-regulating through a professional body: the professional body's objectives are likely to differ from those of the state.

Theory predicts that principal-agent problems will be reduced as the objectives of principal and agent approximate, and as more information becomes available about the agent's decisions and the objectives of the principal. The challenge for policy makers is, therefore, to identify mechanisms and structures to bring about these changes in the health sector. Relevant mechanisms which include regulation, advocacy, incentives, and monitoring systems, must be shown to work, to be manageable without overburdening the agent or principal with administration, and to be achievable at limited cost.

This paper begins by exploring the problems associated with the private sector, and then moves on to the various strategies that have evolved to deal with the principal-agent (state-provider) problems. The complex institutional structures that have developed (which include government regulation, professional body self-regulation, purchasers of health care and consumer organizations) are brought together in a conceptual framework. Experiences with regulation are considered, using examples drawn from country case studies presented at a recent workshop on the public/private mix in health care (Bennett and Mills 1993). This article is one of the outcomes of this workshop, and the authors are indebted to the workshop participants for their contribution to the thinking and examples summarized here.

In discussing the private sector it is useful to distinguish between finance and provision of care. Our focus is on provision, but in many developing countries most private care is paid for out-of-pocket; so there is both private provision and private finance.

Private sector behaviour

Private for-profit providers are primarily motivated by making money. It has been argued that this orientation means private providers are unlikely ever to perform for the good of people, and can never contribute to the public health goals of the state (Roemer 1984). The dominance of this argument led some countries to ban the private for-profit sector, whilst others simply ignored it. Yet bans on private care have had negative consequences for the whole health system: the 1977 Tanzanian Act banning private practice led to the emigration to other countries of an estimated 200 physicians (Mujinja et al. 1993). It is also inappropriate to ignore such providers as they may provide a large proportion of the total care delivered within a country, particularly at primary level (Table 1). In particular, private providers may be the only sources of care in slum areas (Garner and Thaver 1993) and other under-served localities.

Table 1. Number of private for-profit practitioners in selected countries

Country	Number of private doctors	Number of private general practitioners	Private doctors/all registered practitioners (%)
Bombay	20 000	14 000	n/a
Papua New Guinea	61	61	25
South Africa	11 650	8 000	59
Pakistan	n/a	38 000	n/a
Zimbabwe	833	n/a	66
Malawi	0	35	16

Source: Country background papers for 1993 LSHTM workshop

In general, five main problems are associated with private for-profit provision: objectives geared to maximize profits; failure to address public health: lack of integration with government health services; attraction of professionals out of the public sector; and provision of poor quality or inappropriate services.

Concern for profits

The profit motive is often regarded as beneficial to the customer as it is assumed that the supplier will be made sensitive to the preferences of the consumer, and so provide a better product. In health care, the situation is complicated as the health professional temporarily holds the knowledge, power and responsibility for the patient's health. The private provider may use this power to maximize profits: this may be done at the patient's expense, through, for example, excessive investigations or promoting more expensive treatments and procedures even in the absence of evidence of their effectiveness. The profit-motive may over-ride good clinical practice: this is exacerbated by the patient's limited ability to evaluate care received.

Profits are the difference between revenue received and the cost of the care. A provider can increase his/her profit by raising prices, increasing the quantity of care, or lowering costs. All of these strategies are observed in private health care markets in the developing world. In Bombay, researchers observed both overcharging and over-provision of care (Yesudian 1993). In Uganda, new small private clinics and commercial pharmacies have created a culture in which patients associate good care with the availability of injections and other drugs, regardless of medical appropriateness (Asiimwe and Lule 1993). In India, unsafe drugs such as steroids may be given for minor illnesses (Greenhalgh 1987) and sedatives used inappropriately. High technology equipment may be bought to attract patients and then over-used to cover the costs of acquisition, as in Thailand (Nittayaramphong and Tangcharoensathien 1993). Over-provision and cost-escalation may be exacerbated in countries with health insurance. For example, rapid growth in health care expenditure in South Africa has been partly attributed to an increase in the number of people covered by health insurance (Price, this issue).

Private sector providers, particularly in poorer areas, may cut costs by providing low quality care. Private hospitals may rely on unqualified, less costly, staff (Yesudian 1993; Nittayaramphong and Tangcharoensathien 1993). Standard hygienic practices may be ignored. For example, a recent government committee set up to investigate private nursing homes in Bombay found that none incinerated infectious waste materials (Yesudian 1993).

Concern with profit-making may lead private providers to behave in ways which are considered ethically unacceptable. In Bangkok a woman who severed one of her fingers in a domestic accident was asked to make a deposit of Baht 30 000 (approximately £700) before a private hospital would treat her (*The Nation* 1992).

Ignoring public health

Public health is concerned with preventing disease and promoting health; improving medical care; promoting health-related behaviour; and controlling the environment (Detels and Breslow 1991). Public health activities within a country often operate through strategies which are likely to affect whole segments of the population, such as community water and sanitation improvement schemes and increasing available information on health promotion. Such 'public goods' are available even to those who have not paid for them. Thus, they undermine market approaches to the provision of goods and services and, possibly, reduce the likelihood of private sector involvement in such activities.

Other aspects of public health include the preventive aspects of medical care, where some of the benefits associated with services (such as whooping cough immunization in children) accrue to individuals other than those receiving the service (as the likelihood of developing the disease is reduced for all infants in the community). If left to the market such services may be provided at a level below that which is socially optimal. Concern for profits, for example, may lead private practitioners to fail to promote preventive practices, which reduce morbidity and the resultant number of consultations.

Nonetheless, private providers in countries such as Pakistan, Malaysia, India and Papua New Guinea are providing aspects of preventive medical care, particularly immunization for children. These activities depend on the consumer perceiving the product to be of value and therefore worth paying for. It has been proposed that the state should provide incentives for private practitioners to carry out medical preventive care for the public good. In Malaysia, the Ministry of Health promoted Hepatitis B immunization for children under one year by providing the vaccine at a fixed, subsidized rate to private providers, then allowing them to charge a fee through which they made a profit. The scheme was undermined, however, when a new vaccine became available which was cheaper than that provided by the state.

Private practitioners might also have a key role in the early detection of disease, if they can be encouraged to use screening procedures for groups at risk of specific diseases where screening efficacy has been demonstrated. Private hospitals in India are now promoting 'preventive

packages' of care including complete health 'check-ups' and screening. However, the impact on health of such packages are by no means proven. Problems are particularly likely to arise when the screening process, which may involve expensive diagnostic tests, is used for individuals or in circumstances where the benefit has not been demonstrated, or where the interval between screening episodes is inappropriately shortened. Such problems may arise where, as in Bombay, private providers run diagnostic centres more because they create profits than because of their public health contribution (Yesudian 1993).

Poor integration with government services

The private sector tends to be atomistic and scattered in contrast to the, generally, monolithic and centrally planned public sector. Public sector organizations have the capacity to be standardized with respect to activities, staffing and procedures; however, they may be slow to respond to localized needs or preferences. On the other hand, private providers may be more sensitive to local demand, but may fit poorly into referral mechanisms. They are unlikely to be integrated into Ministry of Health (MOH) information systems and are often unevenly distributed, locating where there is willingness and ability to pay rather than need.

Lack of information about the number and type of cases treated in the private sector can make health sector planning extremely difficult, particularly when forming public health strategies. Public health specialists may not have access to the epidemiological information negessary for planning. Such data are particularly important when patients seek private sector care for some symptoms and public sector care for others. For example, patients with sexually transmitted diseases or women who have suffered domestic violence, may be more likely to seek private sector care. Quantifying and delineating the public health problem and forming an appropriate strategy then becomes problematic.

Exodus of staff from the public sector

Large differences in income between public and private workers are common and may lead to a 'brain drain'. Trained personnel may leave the public service to work full time in the private sector, so creating skilled personnel shortages in government facilities. In Zimbabwe, two thirds of the physicians and state registered nurses work in the private sector. Alternatively, personnel may undertake activities in the private sector in addition to public sector work, possibly resulting in the neglect of public sector duties. Many countries perceive this to be one of the key problems associated with private sector growth.

Poor quality of medical practice

Private for-profit providers often work under isolated conditions without peer review (formal or informal) of their work. Such isolation may contribute to a decay in medical skills and endanger professional ethics. The effects on clinical practice of this isolation combined with the need to make a profit has been little studied. One evaluation of prescription patterns in Bombay showed that few private practitioners knew the World Health Organization recommended drug therapies for tuberculosis and leprosy (Uplekar 1989a and b).

Framework for analysis

For planners in countries considering ways to improve service provision to the whole population, careful analysis of the existing relationship between the state and the private sector is required. A short checklist of questions can help to elucidate these relationships, to be used in considering actual and potential mechanisms for improving the relationship between the state and private providers within a particular country (Table 2).

Table 2. Checklist for planners delineating the relationship between the state and private providers

- What are the objectives of existing regulation: do they seek to limit itemized fees-for-service, stop excess provision, prevent poor practice, or a combination of these?
- Is the regulation concerned with basic infrastructure characteristics, the training and accreditation of staff, or does it actually consider the outcome of care?
- What is the balance between incentive options (the 'carrot') and regulation (the 'stick')?
- Who are the agents responsible for setting rules and incentives, monitoring implementation, and enforcing sanctions if rules are transgressed?
- Are the regulatory approaches active, seeking out low quality providers, or are they passive, awaiting presentation of complaints?

Yet state/private provider relationships can rarely be reduced to a simple test. Planners need to understand the politics, organizational relationships, and power balance between various players. To assist in this process, a conceptual framework has developed (Figure 1). It depicts the main agencies in the health care system in terms of quality assurance, regulation and incentive setting, and the key relationships between them. It is discussed in detail below.

Frequently there is a difference between the intended and actual operation of the various legislative, financial and regulatory measures operating at the interface of the state and private practitioners. What can be achieved will vary in part according to the level of economic development in the country, the strength of professional ethics, and the relative power of different interest groups.

The state

The state's influence is related to its power bases:

Legislative power – the state is able to lay down binding rules and regulations, and to enforce such legislation with sanctions. Rules may cover levels of taxation in the private sector, standards of care to be met and registration procedures. Although government may choose to delegate some of its authority to another body, such as a professional organization, such power is still sanctioned by the state.

Power over resources – the state usually has significant influence over the allocation of scarce goods, such as access to training and foreign exchange, although this influence does not reflect a monopoly. It may create financial incentives for providers to behave in certain ways, for example, by offering small payments for public health activities. The state may also be a significant third party payer and thus able to structure incentives through its purchasing power.

Power over information and accountability – information gives actors in the system a rationale for action. The state may provide information itself or alternatively use its powers to enforce providers to be accountable to other agents.

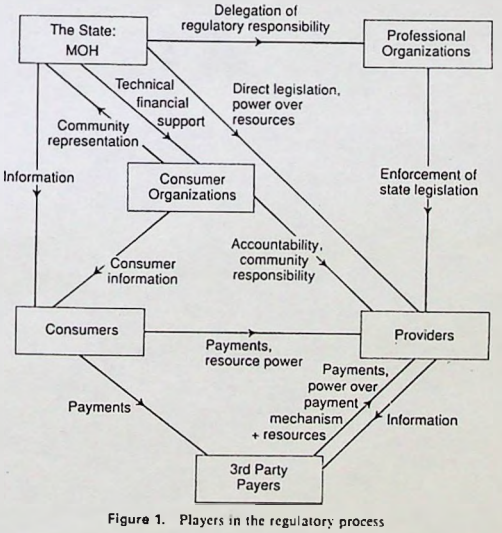

Figure 1. Players in the regulatory process

The state is likely to have extensive interactions with different agents in the health care system. It may act directly to regulate providers, or indirectly through professional bodies and by strengthening accountability to consumers.

The state, however, is far from being a homogenous single-purposed body. At the central level different ministries may effect regulatory control. For example, the Ministry of Finance has power over taxation. The Ministry of Health may be responsible for registering providers. Different levels of the state (central government, provincial, district, municipal authorities) may each have different roles to play in the regulatory process. Competing priorities between different sectors of the state may reduce the effectiveness of proposed regulatory mechanisms as well as of incentives to provide certain services.

Purchasing agents

These agents may be small private insurance schemes, large compulsory health insurance, medical benefits schemes or the state itself. Such agents may have a key role in affecting process aspects of the quality of care, and are frequently the only agents with sufficiently detailed information (e.g. about drug prescription and treatment procedure patterns) and expertise to use this information.

Purchasing agents may use monopoly power to negotiate prices with private providers. The adoption of different payment mechanisms may also have a direct effect upon provider behaviour.

Professional bodies

These include both state-sanctioned medical, nursing and other professional councils, whose principal purpose is to act as regulator, and Medical Associations which are essentially voluntary representative organizations. In some countries, such as the USA, the regulatory function of the professional organization is not supported by law and the Medical Association carries out both regulatory and representative functions. Even where there are two separate bodies the dividing line is not always clear. Professional bodies are likely to be involved in setting training curricula, qualification levels, medical discipline, controlling advertising, conditions of employment and pay.

Consumers

Individual consumers have a direct control over providers through their purchasing power. By shifting demand between providers where they find care to be of an unacceptably low standard (or too expensive) they may affect provider behaviour. However, limited information may restrict the consumer's role in the health care sector.

In addition, consumer complaints may lead to disciplinary action, consumers may succeed in influencing policy decisions through the political process and consumer organizations may act as effective lobbyists for the concerns of individuals.

Community representation

A variety of forms of community organization may be active in the health sphere, reflecting the interests of groups of consumers as well as the wider community. Such organizations include hospital boards, family practitioner committees, consumer groups, advocacy and lobby groups, and residents' associations. As Figure 1 suggests, these institutions may channel information and thus affect power relations between three different agents: the state, consumers and providers. For example:

- hospital boards and family practitioner committees may present community perspectives and community needs to providers;
- consumer organizations and the media may provide information about different providers to consumers thus assisting them to exercise their purchasing power;
- community health committees may present community needs to government, for example, over the location of new private services.

The state may encourage the development of such organizations through financial and/or technical support.

Provider of care

The 'providers' box of Figure 1, the object of regulation, includes a diverse range of individual private providers, private midwives, dentists, doctors, nurses, as well as the institutions with which they are associated, pharmacies, clinics, hospitals and nursing homes.

Suppliers

Suppliers of inputs such as drugs and equipment may have considerable influence over providers, particularly private sector providers. For example, drug company advertising often has a strong influence on prescribing practice and may be complemented by financial and in-kind incentives directed at private practitioners, chemists and drug sellers (Kamat 1993).

The political environment is an important determinant of how these agents interact. Whilst the medical profession is renowned for protecting its members and their interests, at least in a democracy with a free press there is the potential for making the profession more accountable to the public. The media may encourage a flow of information between different agents and thus, for example, help inform consumers of their rights, or convince government of priority community concerns. In most countries prosecution as a way of controlling private sector behaviour is a last resort. The United States is an exception. Expensive litigation is frequent, so health care professionals insure themselves against prosecution (at great expense) and may undertake tests and procedures which are not strictly necessary but protect them against potential medical malpractice litigation (so-called defensive medicine). Extensive litigation may undermine the development of trusting relationships.

Experience with regulation and incentives

Basic legislation concerning practitioner registration, training and dangerous or unethical clinical practice is present in many countries. Currently, donors emphasize strategies that include state incentives to modify private care provision (encouraging good clinical practice, appropriate care, provision of services for the public good, and more equitable geographical service provision). However, experience with this method of modifying provider behaviour has little history and is limited. So far little proper evaluation of its impact has been undertaken.

Direct state regulation

The state may intervene in a variety of ways: by registering practitioners; by specifying minimum standards for premises; by setting price ceilings for items of service; by controlling location of premises; and by specifying a mandatory period of government service after training.

Minimum standards of care set by the state usually concern the structural aspects of care. Basic service configurations, minimum facilities required to operate as a clinic or hospital, and standard training curricula are all often defined by the state. In Thailand the Medical License Division of the Ministry of Public Health has two arms: one is responsible for the annual registration of facilities, the other, the Inspection unit, is responsible for surveying private facilities and ensuring that they meet specified standards, such as minimum space for beds and availability of toilets. In Malaysia there are similar regulations regarding the premises of private practitioners.

Price regulation by government appears rare. Key informants in a survey in Bombay felt that it would be beneficial, but would have to vary according to the standard of care offered (Yesudian 1993). Providers may also structure fee schedules in different ways. Unless the pricing mechanism used by private providers is well understood, it may be difficult to make any definite regulation.

Direct government control over the quantity of care provided also appears uncommon. In Thailand there has been some discussion of the potential for 'Certificate of Need' regulation for controlling new investments – however, the success of such legislation in the US has been mixed. Too often the criteria determining which investments should and should not be allowed are insufficiently clear. Secondly, if hospitals are banned from investing in one type of equipment then there may be a 'squeezed balloon' effect with resources flowing into other types of capital items.

Several countries have attempted to influence the location of private providers as a way of improving the integration of private providers into the national health care system. In Tanzania applications to open a private practice or hospital must state the location, size of population served, distance from the nearest health facility and staff to be employed. This is to avoid the duplication of facilities, although apparently the location criteria are applied more strictly in rural than ur-

ban areas (Mujinja et al. 1993). In Pakistan the government provides tax exemptions for private practitioners setting up practices in rural areas (Aga Khan 1993).

Governments seem to have used a considerable range of mechanisms to counteract the problem of 'brain drain'. Many stipulate that doctors, nurses and paramedics trained at the expense of the state must complete a certain period of public sector service before transferring to the private sector. Specific financial incentives may also be offered in order to retain public sector staff. Nepal, Pakistan and Thailand all have a 'non-private practice' allowance, although in the former two countries it appears that many practitioners engage in private practice and still receive the allowance. In Thailand special incentive payments are shortly to be introduced so that public sector doctors receive extra payment according to the number of patients seen – an imitation of private sector payment mechanisms. Finally, non-financial incentives, such as training prospects and promotion structures, may also be important in retaining staff.

Efforts to overcome the isolation that private providers may feel, and thus raise standards of care, may include training. In Nepal a programme to train private pharmacists appears to have been quite successful (Kafle et al. 1992). Less formal 'training' initiatives, such as inviting private sector participation at MOH conferences, may also improve skills and generate incentives for appropriate practice. The MOH in Zimbabwe is promoting the idea of peripheral hospitals being 'adopted' by private health care practitioners. In Malaysia private consultants are being 'contracted in' to supply specialist services in three districts on a trial basis (R Bharathanlingam, personal comment). Such schemes should provide extra manpower for public hospitals whilst also serving to keep private providers in touch with MOH treatment guidelines and policy.

Governments tend to be active in the area of public health, but the approach here often seems to be one of incentive setting rather than regulation. Incentive payments or the provision of free supplies may be used to encourage private providers to offer preventive services. Several countries such as Malaysia, Nigeria and Iran have pursued this strategy (WHO 1991).

Regulation through professional bodies

It is common for the state to give authority to a parastatal or professional organization to monitor and enforce standards of care in the private sector. In many industrialized countries these state-sanctioned arrangements have developed from previous, informal arrangements (Moran and Wood 1993). In developing countries the institutions have often been especially established. In Ghana the range of such institutions established by statute includes:

- the Private Hospitals and Maternity Homes Board, established (1958) to inspect and supervise private hospitals and maternity homes and to register their names;
- the Pharmacy Board (1961) to regulate the pharmacy profession and to control the supply, manufacture, storage and transportation of drugs;
- the Medical and Dental Council, and the Nurses and Midwives Board (1972) set up to (i) prescribe standards of professional conduct, (ii) uphold and enforce such standards by the disciplinary powers conferred upon it by decree, and (iii) keep registers of duly qualified practitioners (Asamoa-Baah et al. 1993).

Professional organizations are generally run by members of the profession and are responsible for monitoring medical standards. This monitoring often concerns aspects of accreditation, professional training and examinations, and disciplining members for poor professional conduct. In most developing countries professional organizations tend to take a passive role in setting minimum standards, and simply react to complaints brought to them. Their effectiveness in performing this task is very variable. In India there are reports that people have lost confidence in at least one Medical Council as it has been slow to investigate allegations of medical negligence and has even been accused of manipulating the facts. Increasingly complainants are seeking redress in the courts under the Consumer Protection Act, rather than from the professional organization (Yesudian 1993).

There are many ways in which professional organizations could adopt a more active role: they could institute medical audit techniques, establish regulatory review bodies or introduce accreditation schemes. Medical audit, for example, may consider diagnostic, investigation and prescription patterns, length of hospital stay and treatments given. Some review processes focus on identifying, and then investigating, providers/institutions with the highest costs of drug prescription or diagnostics. Monitoring outcome measures is probably both more difficult and less common. Nevertheless, exploration of basic rates such as hospital wound infection rates and case-fatality rates may be worthwhile, as well as the institution of routine audit for adverse outcomes such as maternal and perinatal death.

Many of the review processes depend upon the willingness of private providers to collaborate and to provide the information necessary to judge services. Establishing incentives for collaboration may assist such review. One incentive currently being explored in Mexico is the use of accreditation schemes. This was promoted by the National Secretary of Health and was agreed upon through two national conferences. Accreditation is to be carried out by a national, non-governmental, non-profit institution. Participation is voluntary but it is hoped that hospitals will join the scheme in order to gain accreditation (Garner and Lorenz 1992).

Professional organizations may also be involved in fee setting. In Malaysia professional organizations set fees as guidelines for private doctors, but it is difficult to ensure that they are adhered to (R Bharathanlingam, personal comment). Informing consumer organizations and publicizing such information may be of value.

The role of consumers and community organizations

With the increasing, worldwide emphasis on democracy and on the importance of accountability within organizations responsible to the public, the role of consumers and their organizations is becoming more formalized. The establishment of hospital boards is one example: such boards often include community representatives who are supposed to both strengthen the management of hospitals and represent community preferences. Hospital boards at private not-for-profit hospitals in Uganda have been established for a long time, but this idea is now being extended to the public sector (Asiimwe and Lule 1993). Similar moves are under way in Ghana (Asamoa-Baah et al. 1993).

Patients' charters are also proving popular; both the UK and Malaysia have recently established such charters. The nine point charter drawn up by non-government organizations in Malaysia is designed to protect patients' rights, such as the right to safe health care, and the right to a choice of care. It is planned to cover both public and private providers (*The Strait Times* 1993).

For consumers and the wider community to play an active role they must be aware of their rights, and clear complaints procedures must be established and publicized. The media and community organizations are critical in developing this role. In Bombay the media has exposed episodes of medical negligence (*Times of India* 1992) and activist organizations such as Medico Friends Circle (MFC) and the Association for Consumer Action on Safety and Health (ACASH) have provided financial and technical support to complainants.

Consumer activism may also be encouraged through information, education and communication campaigns. For example, current campaigns in Thailand aim to educate workers under the Social Security Scheme, so that they no longer associate high quality care with multiple drug prescription.

The limitations of consumer and community organization activity need to be recognized. Although consumers may prove to be good judges of certain characteristics of health care they are probably unable to judge clinical quality. Even if consumers can evaluate care received they are frequently unwilling to complain. Ministry of Health officials in Ghana suggest that the social distance between Western trained physicians and much of the population would prevent complaints from surfacing. In many of the poorer developing countries consumers are unlikely to be supported by consumer organizations as these are little developed.

Major problems of regulation

Professional self-interest

The experiences of many developing countries suggest variable success in using incentives and regulatory mechanisms to structure private sec-

tor behaviour. Major problems with implementation of legal and regulatory frameworks are evident. In Bombay, a High Court Justice hearing a medical malpractice case commented that the implementation of the Bombay Nursing Home Registration Act 1949 in Greater Bombay had not been satisfactory (Yesudian 1993). Interestingly, many industrialized countries have also recently acknowledged problems of regulatory failure (e.g. Stacey 1992, Rosenthal 1992).

Many of the regulatory problems centre around the role of professional organizations or parastatal regulatory bodies which are run by professionals. It is often not clear who is responsible for professional behaviour, how behaviour is monitored, and what penalties exist. The political power of the medical profession, its tendency to protect its members, and the ethos of clinical freedom makes regulation, both by the profession itself and by external bodies, problematic. Professional organizations may have relatively easy access to information about provider behaviour and have the professional knowledge enabling them to regulate. Their objectives may, however, be *too* similar to those of the providers they are supposed to be regulating for them to play an independent monitoring role.

Nevertheless, it is in the interest of the professional organization to identify imposters and those who may bring the medical profession into disrepute. As McGuire et al. (1989) observed 'To secure the agency relationship the medical profession has recognized that certain expectations are imposed about its behaviour'. In order to secure monopoly power, professional bodies have attempted to prevent the commercialization of the relationship between provider and patient. Advertising is a good example: banning advertising reduces the commercial element in the physician–patient relationship, but at the same time reduces the information available to consumers, perhaps making it more difficult for them to make a rational choice of provider.

Most of the medical malpractice cases heard by professional organizations in developing countries concern blatant negligence or unethical conduct rather than ineffective medical practice. This may be because in many parts of the developing world physicians do not have a monopoly on medical care: there are many substitutes for the Western qualified doctor. For example, in Ghana the government agreed that non-qualified drug-sellers could sell drugs, in order to redress the urban–rural imbalance in drug availability. But now there may be little incentive for the trained pharmacist to act properly or for the self-regulatory mechanism to ensure that they do. On the one hand, the availability of substitutes creates greater competition, on the other, it increases commercial tendencies and may destroy trust in the patient–provider relationship.

The inherent difficulties of government monitoring of private providers suggests that there is a need to build a trusting relationship between government, professional organizations and the private sector. Training in a public health and population-based approach, increasing awareness of professional ethics and improving clinical standards, including audit procedures, may play a critical role by bringing the objectives of professionals and their organizations closer to that of government. During initial training an emphasis upon public health may orient providers for life. This in turn suggests that providers' training should remain the responsibility of the public sector (or a conscientious private not-for-profit sector). In Mexico it has been noted that private training schools are much more focused upon curative personal care and neglect public health, despite the fact that the government ultimately controls the curriculum (WHO 1991).

Lack of information

Both regulation and incentive setting require information to operate. At the most basic level there needs to be a list of all private providers so that government and other regulatory bodies know whom they are regulating. This is often achieved through compulsory registration. In some countries, such as Thailand, registration is carried out on an annual basis. In this case it would be possible to make re-registration conditional upon the provision of certain information concerning provider behaviour. In other countries, such as Mexico, private providers are not required to re-register. This creates problems, with defunct providers remaining on the list. Although the government or a parastatal body may be responsible for registering private institutions, it is normally a professional body which registers the practitioners themselves.

In many developing countries, little information about the private sector and its activities is available. In others, at least some data are collected, for example on the incidence of new cases of communicable diseases seen by private providers. In Malawi all private practitioners are required to submit monthly reports detailing the number of patients seen and their diagnostic groups; the limited number of private providers makes this a relatively easy task (Ngalande Banda and Simukonda 1993). A key problem of information collected from private providers is its validity. In Thailand the MOH carries out an Annual Health Resources Survey requesting data both on the structural characteristics of private providers (particularly human resources) and data on activity. Within the Bangkok metropolis the response rate is extremely low (approximately 30%) and throughput data are thought to be consistently under-estimated in an attempt to avoid taxes.

Government also requires information from professional organizations in order to ensure that they are acting as effective regulatory agents. Medical Councils, for example, could be required to report the number of cases heard each year, how quickly cases were heard, and what the outcomes were. If certain patterns of negligence, abuse, or low standards become apparent, they could be required to indicate what action they intend to take and how the intervention will be monitored. In order to counter charges of 'excessive medicalization' more lay people or consumer representatives could be put on Council boards.

Information also appears to be the critical issue in terms of direct regulation by government. Monitoring is crucial both to the implementation of incentive mechanisms and regulatory controls. Government must be able to check whether or not providers are falsifying data in order to gain more under the incentive mechanisms, and government must be able to monitor private providers so it can take action when providers violate regulations.

Government organizational structure

Regulatory capacity requires a considerable degree of decentralization, and local responsibility and authority. Private sector interests are often powerful and local (district, provincial or regional) health managers may have difficulty in asserting authority over private providers. In Malaysia, it is recognized that the international companies which own plantations do not always fully meet their statutory requirements in terms of health care provision for the workers, but local health staff rarely feel in a position to pursue this with the companies (R Bharathanlingam, personal comment).

Lack of funding and resources may also prove a substantial obstacle to successful regulation. Local health managers are short of the time, transport and skills to be able to effectively monitor and regulate private sector behaviour. The various regulatory boards established by statute in Ghana (Asamoa-Baah et al. 1993) only recently started to receive funding from the state. Previously they were so poorly staffed that they did not exercise any regulatory power at all. Government in the developing world is likely to be less 'entrenched' than that in the industrialized countries, and there are rarely sophisticated computerized national insurance or tax systems making it easier to identify and penalize unlicensed practitioners.

Sadly, it is not only markets that fail, but also governments. Governments must be sure that they will actually improve on the market failure before intervening (Stiglitz 1989). Government failure may be more or less benign. At the less benign end of the scale are problems of corruption. There is a very real danger that inspection agencies such as the environmental health department and the private sector registration department seek illicit rents rather than enforcing regulations. Bureaucrats may seek to expand the size of their own agency rather than effectively carry out their job. For example, public insurance organizations may be resistant to computerization which would allow them to monitor provider behaviour much better, but simultaneously could reduce employment.

Conclusions

It is clear that the institutional structures which have developed in the health care sector, ostensibly to protect patients, are complex. Their evolution has been strongly influenced by profes-

sionals: it may be more accurate to view regulation as a mechanism to protect the professional and preserve the income of health care providers. Regulatory responsibility should, therefore, not be left to professional organizations alone. Change is necessary, with careful monitoring of its effects. One hypothesis that needs testing comes from the principal agent model: incentives need to be structured in such a way that it is in the interests of professional organizations to regulate and private providers to offer good quality care. In this process it is important that research examines the information needs of regulation and incentive setting. The more limited experience with incentive setting, especially in promoting public health, needs to be extended. Incentives may be used to encourage provision of services in areas of greatest need; to provide immunization and family planning; to ensure appropriate management of communicable diseases; and to provide useful information on the health priorities in populations.

Priorities for action will depend on the sophistication of a country's health care system, the size of the private sector, and the level of economic development. Governments should focus first on those areas where private practice is actually causing harm; inadequate sterilization procedures, unskilled staff giving sophisticated treatments, refusal to treat emergency patients and extreme cases of dangerous or unnecessary medical intervention. Government action can then be extended to review whether ineffective or unnecessary care is being provided. As the private sector expands in middle-income countries, there is a need to shift from structure-oriented regulation to more sophisticated practice-oriented regulation through quality assurance programmes. However, these initiatives cannot be developed without political will or in the absence of government and professional managerial capacity to carry them out.

Generating national debate about the role and behaviour of private providers may also be an important strategy. Such a debate may raise consumer awareness about possible hazards of seeking private sector care, stimulate the development of non-government organizations protecting consumer rights, encourage professional organizations to be more active regulators and perhaps limit the health care provider's abuse of power. The media can play a role in furthering these debates, providing information and highlighting failure to fulfil ethical and statutory obligations.

The potential for research to contribute to these developments is large and under-explored. This paper has attempted to consider the anatomy of regulatory structures and incentive-setting mechanisms but much more needs to be learned from the experiences and developments within countries. Immediate questions include the potential benefits and dangers of using particular forms of incentives, the value of accreditation schemes combined with quality assurance programmes, and the use of financial incentives to stimulate better quality care.

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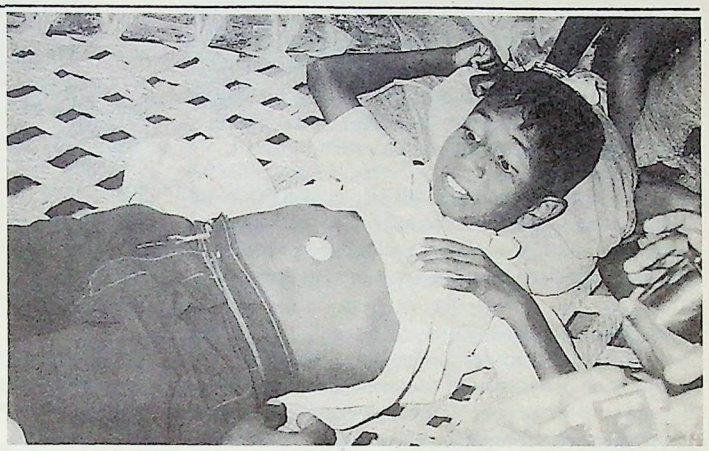
What's happening to health care?



An Indian boy suffering from stomach-ache tries moxibustion, a traditional Japanese treatment. Moxa, a common herb, is burned at low heat on the appropriate pressure point.

PRIVATE HEALTH CARE SERVICES - A BOON OR A BANE?

By Dr. T. N. Manjunath (Manju), India, OMC 1987

Worldwide, many countries are now pursuing privatization of health care services. Governments are retreating from their previous commitments to overall health care provision. But can privatized health care really lead to better health for all? If patients/customers have enough information and power to choose the best services and to insist on safe hospital management, privatization in the health sector may offer better health care. However, in many countries, the general public probably does not have sufficient knowledge or power regarding health to regulate private health practitioners. This article looks at some of the public health issues involved in private health care, focusing on Mysore, India. The author, OMC alumnus Dr. Manjunath, finds that more regulation and monitoring, by consumers and by government, is needed to protect Mysore's health now that doctors are in business for themselves.

Background to privatization - Twenty years from Alma Ata

After the signing of the Alma Ata Declaration in 1978 by WHO and its member countries, the slogan "Health for All" started gaining ground. This goal was to be achieved through community based Primary Health Care (PHC) with an emphasis on improvement of services for the poor.

However, with the winds of globalization sweeping developing countries, in the 80s and 90s many governments were forced to accept structural adjustment programmes (SAP) in return for International Monetary Fund (IMF) loans. Financially-troubled governments were forced to open up their markets and privatize previously state-run enterprises and services, including the health sector. While the private sector is now promoted as creator of efficiency and growth, government action and control is seen as the cause of inflation, If health sector privatization is to benefit the Indian public, including the poor, we must have decent standards of treatment and mangement in both public and private health care institutions. debt and economic recession.

This credo has had serious consequences for the health of the poor. Pursuing privatization, governments reduced spending on social sectors, including public health. Preventive and promotional programs, traditionally the domain of government sector because they do not offer quick profits for the service provider, have been hit hard.

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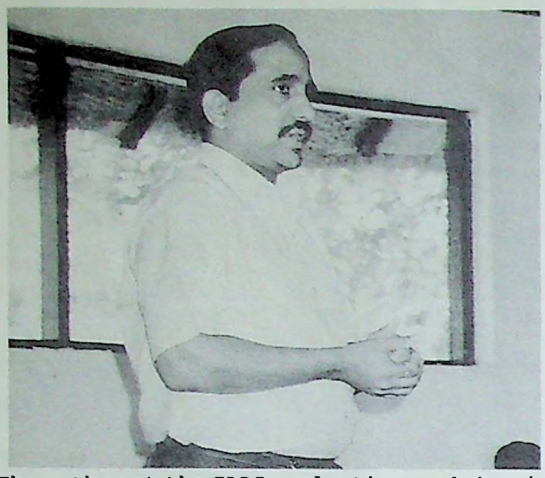

The author at the ILDC evaluation workshop in Deenabandu, India, January 1998.

Mother and child health care (MCH), immunization, safe drinking water, sanitation, communicable disease control/ prevention and other primary health care services are all adversely affected. These cuts have hurt the poor most.

Privatization in India

In India as in many other countries, the health sector is becoming privatized and commercialized, resulting in worse health for the poor. Free curative care offered by the government has become even less accessible due to budget cuts. Perhaps even more worrying is the change in the primary motivations of health care providers - privatized services mean more health professionals are directed primarily by the profit motive. Private sector health care is expensive - and a profitable business investment. Pharmaceutical giants, liquor companies, and big industries motivated solely by profits are now running 5-star hospitals. Church hospitals, set up by missions to serve the poor, now operate within this competitive system. Many such hospitals are pushed into getting expensive equipment to keep up with the private sector. Making enough money to maintain equipment and recover costs becomes the driving force of practice. Doctors are forced to become business people. Once a humanitarian service, health care is now viewed as a commercial sector with profits as the only motive behind care, concern and service to the needy.

With the current international support for privatization, profit driven curative health care is taking precedence over preventive community based health care. Further, along with privatization and reductions in subsidies, the prices of essential life-saving drugs, are becoming very high, as commercial pharmaceutical companies pusue profits.

Another problem with privatization of the health sector in India is that it worsens the regional inequality in health care provision. Availability of hospital beds ranges widely from the highest level in Kerala to the lowest in Jammu & Kashmir and Orissa. There are high rates of use of private sector services in both urban and rural areas and across all income groups. Nowadays, even among the lower socio economic classes, one third of episodes of hospitalization use private facilities. For acute illness, private practitioners provide the majority of treatment at all economic levels. But private practitioners tend to concentrate in wealthy urban areas where they can make an easy living.

Further, without effective government regulation, quality of service in the private health sector is unlikely to be maintained by market forces alone. Some surveys show that private health care workers are under qualified. The problem is that ordinary health care consumers do not have specialized knowledge of health care, and there is no reliable information on which private practitioners offer quality services.

The social role of health care facilities is to restore and maintain the health of the population. However, they also have the capacity to damage local health, both through poor treatment, and through careless handling of contaminated hospital waste. Since private practitioners are primarily concerned with their own patients and profits, they may have less interest than government practitioners in maintaining the health of local residents through safe management and disposal of hospital waste. This issue, too, shows the inherent dangers of privatization of health care. It also underscores the need for appropriate government regulation and monitoring of private health facilities.

Privatization in Karnataka

Health care facilities in Karnataka were almost exclusively in the hands of government till twenty five years back. However, over the last few decades, the number of private hospitals and nursing homes in Mysore city has grown rapidly. With standards of health care at government hospitals declining steadily (in the eyes of public at least), more and more people are going to these private hospitals and nursing homes (Private Health Institutions or PHI) whenever they fall sick or need surgery. Today, privately owned health care facilities far exceed government owned ones, and most Mysoreans depend on the nearly 50 PHIs that operate in our city.

But the average consumer does not know which hospital or nursing home provides what kind of services and facilities, nor what rates they charge. Without this information, it is difficult for consumers to decide which PHI to go to in any given situation to get the best value and care for their money.

Survey of private health institutions in Mysore

To fill the information gap from the perspective of health care consumers, Mysore Grahakara Parishat, a consumer awareness and guidance organization, conducted a survey of all PHIs in Mysore city, focusing on services, facilities, and fees. The survey had the following specific objectives: 1) to document the type of health care facilities offered by private health care institutions; and 2) to find out how these hospitals dispose of waste.

A list of all the private health care institutions in Mysore city was compiled from various sources including the telephone Yellow Pages. Omiting outpatient clinics, we were left with a total of 44 institutions.

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A 40-item questionnaire was carefully designed to cover all types of PHIs, and was mailed to every institution on our list. Unfortunately, most of the PHIs were very apprehensive about answering our questionnaire. Even after repeated phone calls, personal visits and explanations as to the purpose and usefulness of the study, only 23 of the 44 PHIs agreed to participate. It is our hope that when they see this report being widely used by potential customers, they will realise that sharing information with the public is beneficial to them in the long run and will participate in future editions of this survey.

Findings - Lack of knowledge, lack of control

First, only 13 of the 23 PHIs are registered. This suggests that the government lacks basic information of and control over private health practitioners.

Only 12 of the 23 PHIs provide emergency medical care. Eleven common investigations (blood, biochemical, microscopic, histopathological, X-ray, ECG, Immunoassay, Echo Cardiogram, Fibrillator, Ultrasound and CT scan and Ventilator) were listed in the questionnaire. Seven of the 23 PHIs had the capacity to carry out more than half of There was widespread reluctance to disclose rates charged for conducting investigation and other services. Only 4 PHIs provided this information. There was great variation among the rates charged.

The PHIs gave little concern to hospital waste disposal. However, insanitary disposal of hospital waste poses major hazards to public health. Used dressings, plaster casts, syringes and needles, and mutilated organs are simply thrown out on the pavements in front of the hospitals. The hazardous waste is not separated and incinerated as it should be. In a few cases, the waste is burnt in the open air, which leads to emission of toxic gases into the environment. Rag pickers (scavengers) are also commonly said to contract diseases by picking through hospital waste. One wonders what sort of treatment *they* can afford...

The need for government and consumer monitoring of private health care

The implications of the rapid growth of private health care institutions have been overlooked by the government. There is no legislation or control over the rapid growth of the private health care institutions. At the moment, it is difficult even for the wealthy to benefit from the mushrooming of private facilities, as they have no reliable information on which to choose a good doctor. For those who have little money to pay for treatment, the situation is worse. In order to make the private practitioners accountable to their customers/patients, there must be open information about the costs and effectiveness of services.

Meanwhile, these private practitioners, concerned primarily with their own profits, are posing a health risk to the community at large by careless disposal of hazardous waste. Both government and consumer groups must take more active roles in regulating and monitoring such hazards to public health.

Health sector reform case study:

Cost-recovery and equity in the health sector: the experience of Zimbabwe

by Kevin Watkins

What effects will the current economic crisis have on the health of Asia's people? As parts of Asia brace for structural adjustment, now is a good time to review recent experience with World Bank-led health sector reform. The case here is from Zimbabwe, Southern Africa.

Introduction

Recent years have witnessed a marked shift in debates on human development. there is now an overwhelming consensus among donors, multilateral agencies and governments that access to basic social welfare provision is central to human development. Primary health care has been identified as a priority area, since inadequate access to basic preventative and curative provision carries a high price for individuals and for society. Unhealthy children, to take an obvious example, are unable to benefit from the opportunities created by primary education - and poor educational achievement is a recipe for slow economic growth, the loss of employment, and increased poverty.

However, over the past decade, in the face of economic problems, the resurgence of poverty-related infectious disease, and population growth, the poorest countries have struggled to maintain the provision of basic health services. Various prescriptions have been advanced for redressing the widening the widening gap between need and financial resources. One such prescription is cost-recovery. Rooted in market-oriented approaches to health finance, user-charges have been recommended by international agencies such as the World Bank and aid donors, to mobilize new resources and rationalize service delivery. In addition to closing the health financing gap, it is claimed that cost-recovery programs, supported by targeted exemption systems, enhance equity (fairness to all) by increasing the quality and quantity of services available to the poor.

This article reviews the experience of Zimbabwe under a cost-recovery program, introduced in the context of a

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structural adjustment program worked out between the national government and the World Bank. It concludes that the cost-recovery program has excluded vulnerable populations from access to basic health provision. The poorly-planned exemption system has generally failed to protect the poor. Meanwhile, the national cost-recovery scheme has failed to mobilize significant new resources.

Background to structural adjustment: gains in human welfare, stagnant economy

In the decade after independence in 1980, Zimbabwe achieved some of the most dramatic improvements in human welfare in sub-Saharan Africa. Life expectancy, one of the most sensitive indicators of general health trends, increased from 55 to 64 years. Success in combating preventable diseases halved the infant mortality rate to 50 deaths per 1000 live births (compared to 93 for sub-Saharan Africa), and the under-five mortality rate fell to 80 (compared to 170 for sub-Saharan Africa). Parallel improvements were achieved in maternal mortality rates. Over the same period, primary-school enrolments doubled and the secondary-school population increased almost ten fold, reducing illiteracy rates to less than 10 per cent.

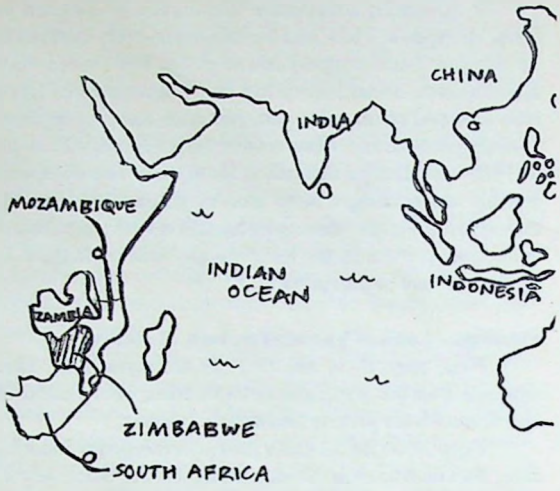
These gains reflect the Zimbabwe Government's explicit policies of pursuing equity through increased public investment in primary health care and basic education. During the 1980s, health sector spending increased from 2 per cent to 3 per cent of GDP, while the share of budget spending on health doubled to 6.4 per cent.

However, these human welfare advances need to be set in context. Government of Zimbabwe estimates for 1990/1991 suggest that around one-quarter of the population lived below the poverty line, around one-quarter of them unable to meet basic nutritional needs, while in rural areas, one-third of all children exhibit malnutrition. Moreover, since the late 1980s, there has been a worrying reversal in human welfare gains, with maternal and child mortality rates rising as a consequence of HIV/AIDs.

Meanwhile, in contrast to the experience of South-East Asian countries, Zimbabwe's achievements in human development were not matched by economic performance. From 1980-1990, per capita incomes declined marginally, as population growth outstripped economic growth. By 1990, the economy seemed unable to shake structural barriers to growth. Particularly, high structural unemployment and a large budget deficit were already threatening the social sector even before the adoption of the 1990 adjustment program, and some form of adjustment was inevitable. It was against this background that Zimbabwe embarked on a program of structural adjustment and radical health sector reforms under the guidance of the IMF and the World Bank.

Health sector reforms: World Bank recommendations

During the second half of the 1980s, the World Bank became increasingly involved in debates on health sector reform in Zimbabwe, publishing two reports on the subject in 1992. While recommending particularly stringent collection efforts in central hospitals offering tertiary



Zimbabwe Factfile

Area: 390,580 sq km
Climate: tropical
Population: 11,423,175 (1997 est)
GDP per capita (purchasing power parity): $2,340 (1996 est)
Labor force: 70% in agriculture, 22% in transport and services, 8% in industry
Unemployment rate: at least 45% (1994 est)
Infant mortality rate:72.6/1000 live births (1997 est)
Life expectancy: 49 (1996 est, UNICEF)

Source: 1997 World Factbook, http://www.odci.gov/cia/publications/factbook/

care, reports also recommended huge increases in outpatient fees at rural hospitals and increased charges for maternity provision.

In order to maintain equity, the World Bank stressed the need for exemption systems to be put in place. However, there was no consideration of administrative capacity to operate such systems, and no costing of their operations. The authors of the reports assumed that, armed with documents and information such as patients' income tax returns and land holdings, "admission clerks could then interview patients upon arrival at the hospital" and determine a fair rate of cost-recovery" (World Bank, 1992a). But from the colonial period to the present day, entire revenue and tax departments in Zimbabwe have failed to ascertain appropriate tax liability. It is almost surreal how far the World Bank researchers were from life in Zimbabwe. Their optimism is quite breathtaking.

... And government implementation

By contrast to the World Bank's approach, the Zimbabwe Government had previously attached over-riding importance to equity, attaching relatively little impor-

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tance to cost-recovery. By 1990, however, when the adjustment program was being negotiated, it was apparent that the World Bank had convinced the Zimbabwe government of the merits of cost-recovery. This was especially true in the Ministry of Finance, which was faced with the challenge of closing the budget deficit while maintaining political legitimacy. Under the 1991-95 Framework for economic reform, cost-recovery in health was to be increased from Z$15m in 1989/90 to Z$60m by the end of 1995. Health spending was to be maintained at 2.7 per cent of GDP.

Following adoption of the adjustment program, the Ministry of Health issued a circular demanding more rigorous enforcement of user-fee collection at all health facilities, from rural clinics up to central hospitals. At the start of 1994, a new fee structure was adopted for the first time since independence. Even at the primary level, fees increased from Z$1 to Z$6.50. Previously free, ante-natal care costs increased to Z$10. District hospital fees also rose sharply to encourage rural patients to go first to rural health clinics.

The influence of the World Bank was crucial in forcing the issue of cost-recovery on to the domestic political agenda. However, the program which actually emerged differed from the Bank's recommendations in a number of important respects. Most importantly, the Bank had stressed the importance of retaining fees at the facility in which they were collected, to improve service quality and protect equity. In the event, the Ministry of Finance, which became the driving force in adopting cost-recovery, saw cost-recovery as a source of general revenue and as a means for meeting the IMF's targets for budget stabilization. Another area in which the actual program differed from the Bank's recommendations concerned exemption procedures. World Bank teams had consistently argued that the Z$150 exemption threshold was too low to protect vulnerable populations. In the event, that threshold was retained for over a year, before being slightly raised.

At the same time, there was an unprecedented decline in priority social-sector spending. Between 1990/91 and 1995/6, health spending fell from 6.2 per cent to 4.2 per cent of total government spending, and from 3 per cent to 2 per cent of GDP. In per capita terms, there was a decline in health spending from Z$55 per capita in 1991 to Z$32 in 1995. Preventative care budgets, the most cost-effective part of the system, have fallen by one quarter. Real wages of health personnel have fallen by a third, fuelling an exodus of staff and a loss of morale. According to a 1995 World Bank report, drug shortages have become common and health service provision has deteriorated in both qualitative and quantitative terms.

Counting the costs: the social effects of adjustment

It is probably impossible to pinpoint cause and effects of adjustment programs. Nevertheless, there is a consensus that the post-1990 adjustment period was one of severe hardship and deepening poverty, with two major droughts reinforcing economic pressures. Simultaneously, real wages fell, crops and livestock were lost due to drought, and prices rose. Studies suggest that low-income houses cut down on food consumption, with women and children bearing the severest cuts. In the health sector, this period also saw the dramatic spread of HIV/AIDS, with HIV-related illness becoming the leading cause of death in the 25-44 age group. This background is important to any review of the social-sector reforms, as it made public investment even more essential to protecting human welfare.

Unfortunately, in a gross oversight, the Zimbabwe government and the World Bank did not include any integrated large scale monitoring system to evaluate effects of the policy reforms. However, a variety of other sources indicate, following the stricter enforcement of fee collections in 1991, low-income groups were forced either to delay or reduce health care. One early study by Hongoro and Chandiwana found that outpatient attendances dropped by 18 per cent by the end of 1991, while inpatient admissions went up by 12 per cent. One possible explanation is that patients started to seek health care only when it was absolutely necessary.

The most comprehensive data comes from five sentinel-site surveys carried out by UNICEF and the Ministry of Public Service, Labor and Social Welfare under their Social Dimensions of Adjustment Program. Among the most relevant findings, the following suggest particularly powerful causal links between cost-recovery and exclusion from vital services:

The percentage of children whose diarrhea was not treated at a clinic because parents regarded it as too expensive increased from 9 per cent of the total in 1993 to 22 per cent in 1994. This shift coincided with a 117 per cent increase in health fees at rural hospitals and health centers. Similarly, in January 1993, cost-recovery was introduced for condoms. In the same month, the number of condoms distributed by survey site health centers fell from an average of 53,033 in 1992 to 28,988 in 1993. Before-and-after studies at specific health facilities reinforce the broader survey evidence.

Other studies show, in Zimbabwe ante-natal registration of pregnant mothers has greatly reduced both maternal death in childbirth and the perinatal mortality rate. Unregistered mothers are some four times more likely to die in childbirth, and the perinatal mortality rate (total of death rates of children during the period of 28 or more weeks of pregnancy and one week after birth) for unregistered mothers (251 per 100,000 live births) is around five times higher than for those who registered for ante-natal care. But use of reproductive health services appear to have been particularly sensitive to the effects of cost-recovery. Ante-natal clinic registration also fell from 1990-92, whereas maternity admissions increased, along with an increase in unbooked deliveries and increase in babies born-before-arrival (BBA).

By delaying or obstructing entry to the health system, cost-recovery imposed enormously high human costs on vulnerable people. It also caused extra costs for the health system in treating health problems which could have been

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solved more cheaply earlier. The following account, taken from a 1992 study by A. Renfre summarizes both dimensions:

"In October 1993, a 23 year old woman was admitted with a miscarriage which had resulted in infection in her womb. She was taken to theatre where an operation to clear away the remains of the pregnancy was performed and she was given antibiotics to treat the infection. On discharge from hospital, she was given a prescription for antibiotics for a further week so that the infection would be completely controlled. She could not pay for the tablets so she went home without them. A few days later she was re-admitted with further bleeding and evidence of continuing infection. Again she was taken to theatre and again she was given antibiotics and then discharged... Again she could not afford the tablets so she did not take them. About five weeks later she was yet again admitted, this time with very severe infection, peritonitis and anemia. She died a few hours after admission."

Failure of the exemption system

From the outset, the World Bank consistently stressed the importance of developing an exemption system to protect the poor. In practice, however, there was a considerable time-lag between the more rigorous enforcement of cost-recovery in 1991, and the establishment of a viable exemption system. This resulted in the partial or total exclusion of vulnerable communities from the health system at a time when both poverty and health needs were growing.

In 1991, with the support of the World Bank and other donors, the Zimbabwe Government introduced the Social Development Fund (SDF), a welfare scheme including food-money, and assistance with school fees and health fees. Elaborate targeting mechanisms were established, and yet no new budget was agreed until 1992, and no extra staff were employed to implement the new system.

In 1993, an independent report by Kaseke and Ndaradzi into the operation of the Social Welfare Component of the SDF concluded that the food-money scheme was reaching only about 3 per cent of the target population and the school-fee scheme only 20 per cent. The following were among the most serious obstacles identified: 1) the high cost of applying compared to the benefits received; 2) time lag in benefit payments; 3) shortfalls in funding due to poor planning; 4) stigma of accepting welfare; 5) fees charged by local elders and teachers for application documents. A Government of Zimbabwe-UNICEF sentinel survey report also indicates there was also a lack of information/publicity concerning the SDF. By 1995, still only around one-third of the eligible population had applied. The main reason given for not applying was "lack of knowledge" of how to apply.

Furthermore, the threshold level for exemption was far too low. In 1994, adjusted for inflation, the exemption level was around 20 per cent below the rural poverty line and 90 per cent below the urban. Since 1994, inflation has averaged over 20 per cent, but the exemption line has not been adjusted upwards, further eroding the real value of the index.

The result is that many poor people have been excluded from claiming exemption. Using the World Bank's poverty line data, around 25 per cent of Zimbabwe's national population, and 30 per cent of the rural population, do not have sufficient income to purchase adequate food, shelter, education, health, and transport. This entire group merit exemption - an option which would mean an enormous administrative burden, while at the same time reducing revenues from cost-recovery.

Alternatives to cost-recovery: the challenge

Considering the high social costs associated with user-fees, the benefits in terms of resource mobilization have been negligible. In fact, taking into account the costs of collecting and accounting for fees collected, it is probable that cost-recovery resulted in a net loss of resources. Both quality and quantity of services deteriorated despite the additional burden being placed on households.

To its credit, the World Bank has now acknowledged the problems associated with cost-recovery. In 1995, a Country Economic Memorandum conceded: "There is evidence that the fee exemption system under which poor people are entitled to claim free treatment has not worked well, and that fees undermined access to health services for vulnerable sections of the population." The Memorandum went on to recommend the suspension of all fees for ante-natal, maternity and child health services, and free services for basic preventative care, immunizations - and treatment of infectious diseases. Reflection on the Zimbabwean experience also appears to have prompted a review in some parts of the World Bank, with one recent research report strongly recommending the withdrawal of user-fees on basic services except as a last resort. While this is good news, viewed more critically, the outcome of cost-recovery in Zimbabwe was entirely predictable; and more effective monitoring of impact and consideration of the eveidence provided by UNICEF would have led to an earlier review of the policy advice which had been given.

In Zimbabwe the budget situation is still unsustainable, and will get worse without action to reduce debt and contain future borrowing. The question is, how can priority social services be protected during the budget stabilization program? I suggest a three-pronged strategy aimed at increasing revenues, reallocating resources in the social sector, and making social sector spending a priority in government budgets.

First, though it may be politically difficult, the government should move to increase taxes on high income groups, in terms of income tax, land tax, and ending of tax concessions aimed at high income groups.

Secondly, resources in the social sector should be reallocated primary level facilities where social and economic returns will be the highest. While Zimbabwe performs better than most African countries in allocating resources to the primary level, the $6 per capita spending at the primary level is below the $9 minimum recommended by the World Bank - and the share is declining. Moreover, there is scope for increased cost-recovery in

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the central teaching hospitals, and in charging private users, such as insurance companies, full costs for public services.

With regard to this third element of a budget stabilization strategy, there are tough political choices to be made. Subsidies to loss-making parastatal corporations constitute a major budgetary burden. In some cases, subsidies are justified by the need to maintain food-security. But in other cases, subsidies are more related to ensuring political patronage than for creating equity and national wealth. Reallocating such subsidies to the social-sector would mean far higher benefits in terms of social and economic development. Defence spending, too is inflated in relation to need. To achieve equity in health provision and to enhance prospects for future growth, this spending, too, should be reallocated to health and education.

Conclusion

Debates about cost-recovery in health services raise important questions about the future direction of health policy reform. With financial constraints deepening in many countries, it appears likely that there will be continued political pressure to charge users for services. The challenge is to ensure that the interests of the poor are not overlooked - and that the problems associated with cost-recovery are better understood.

The Zimbabwean case clearly illustrates the dangers of introducing cost-recovery without careful consideration of appropriate timing and methods. Cost-recovery at the primary level was introduced at a time when communities were suffering extreme hardship as a result of two droughts. The poorly-planned exemption system failed comprehensively to protect the poor.

One further lesson from the Zimbabwean case is that effective monitoring should be an integral part of cost-recovery reforms. The only systematic source of information on the effects of adjustment were provided by UNICEF's surveys. Unfortunately, the findings have not informed policy choices.

Regarding participation, accountability, and the quality of service provided at the community level, the claims made for cost-recovery are not supported by evidence from Zimbabwe. Hospital clerks and local social-welfare offices are not accountable to communities in any meaningful way, and lack the capacity to decide which individuals are able to pay.

The adjustment process in Zimbabwe clearly illustrates how ideological influence, political decisions, and economic crisis interact to shape policy outcomes in the social sector. The World Bank and donors promoted their own ideology - social sector reform models stressing markets. Political decisions have been taken within a largely unaccountable domestic political system in which the interests of the poor are at best weakly defended, and in which donor influence - both financial and intellectual - is considerable.

At the national level, cost-recovery clearly has an important role to play in resource mobilization. The evidence from Zimbabwe suggests that efforts should be concentrated at upper levels of the health system, and that cost-recovery should be avoided, except at a last resort, at the primary level. Cost-recovery must be seen as one element in a wider strategy for publicly financing a basic health care system available to all. There are, however, other equally important priorities: measures to increase public revenues through progressive taxation, a shift in allocation towards primary facilities, increased budget priority for key social sectors, and donor support to reduce debt and increase aid allocations for health and primary education. *(Excerpted from "Cost-recovery and equity in the health sector: issues for developing countries" by Kevin Watkins, Oxfam UK & Ireland Policy Department. For more information, contact OXFAM at 274 Banbury Rd., Oxford OX2 7DZ, UK. OXFAM also has a homepage at www.oneworld.org/oxfam/))*

Council for Health and Development (CHD) Statement on Privatization

(The following is an excerpt from the March 1998 policy statement of CHD, one of AHI's related Filipino organizations. The views expressed are those of CHD, not of AHI. For a full statement , please contact CHD at P.O. Box AM-463, Sta. Mesa, Manila, Philippines.)

EVERY CITIZEN DESERVES A HEALTHY LIFE. THE GOVERNMENT IS RESPONSIBLE TO PROVIDE ITS CITIZENS WITH ACCESSIBLE AND AFFORDABLE HEALTH CARE.

Why we oppose privatization of health services

Health is recognized as a basic human right. This right is enshrined in international covenants and in the Philippine Constitution...

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Privatization is a refusal by the government of its responsibility to the people; it even places the burden on others (like NGOs, churches and private groups) to do what it does not have the political will to do. The Department of Health should ensure and promote public health - the people's health. Too often, the Department of Health (DOH) instead encourages and assists private enterprise for profit at the expense of the Filipino people.

Why privatization?

Government officials claim that the privatization of health services is intended to improve the quality of care. But the real purpose is to "save money" - to repay unjust loans, and for projects that benefit the local elite and foreign investors.

And at the same time, the national budget allowed for health continues to get smaller. Less than 2.5 percent of the budget is spent for health, while 10 percent is spent on militarization. Privatization of health services is being done to cut the health budget even more!

Effects of Privatization

When health services are privatized, health becomes a business, and the first concern of owners is to earn profit. Costs for health are already increasing (30-40 percent just in the past four months!) Health services are increasingly being denied to those who need them most...

Conclusion

The Council for Health and Development, a national organization of more than 50 community-based health programs, strongly rejects the government's move to privatize health services. Privatization of health care is the abandonment of the government's responsibility to the health of its people...

Privatization of health services will bring more death and disease instead of what it promises as "health for all by the year 2000..."

Hope (for health) lies in the people who are aware of their rights, vigilant to protect them, and organized to work together for the common good.

INSIDE JAPAN

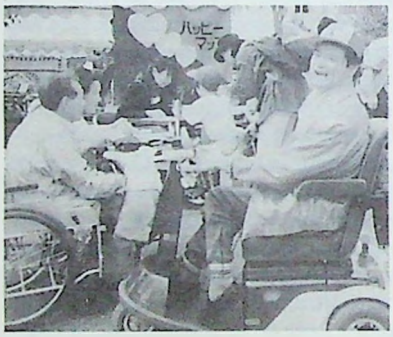
New NPO Law Promises Legal Status for Citizens' Groups

March 1998 marked a turning point for civil society organization in Japan. After a three-year struggle in parliament, the Non Profit Organizations (NPO) Act was passed.

Up to now, Japanese voluntary organizations have had few choices for legal status. Most of them are not large or established enough to pass the government's stiff requirements for recognition as legal entities. (AHI has been offially recognized as a juridical foundation since 1980.) As a result, most small NGOs have operated under the personal name of their leader, without any independent legal status. Now, the NPO Act will allow small voluntary organizations to register as independent legal entities. Thus, the law recognizes the importance of the "third sector" in society, with values and abilities separate from both the for-profit sector and government.

Prospective NPOs will now be evaluated mainly on the basis of application documents. They must also meet a number of basic requirements, such as having a full-time staff of at least ten workers. Overall, these requirements are far less stringent than the previous ones. Nevertheless, some sticking points remain to promote the full participation of voluntary organizations in Japanese society.

First, local authorities still have great control over prospective NPOs, despite their lack of understanding about citizens' organizations. In order to register, organizations still require the approval of local authorities. Local authorities also maintain the legal power to disband NPOs at their own discretion. Citizens' organizations are therefore pressing for guidelines to ensure that local authorities' pass the necessary ordinances to promote NPO participation, according to the spirit of the NPO Act.



The NPO Act will support citizen's groups like Happy Map, pictured here, which works in Nisshin to make the city accessible to people in wheelchairs.

Second, although NPOs need tax exemptions to make them financially viable, the NPO Act has left this essential point to be decided three years' hence. Citizens' groups are calling for immediate establishment of a system of tax exemptions to promote NPO activity.

Third, citizens' groups, too, still need to do some serious thinking. The aim of the NPO Act is to make it easier for citizens' groups to contribute to society. These groups must consider, then, what and how they can best contribute. In particular, this will involve more openness and accountability regarding organizational finances and activities. For small organizations this may be mean a substantial extra workload as accounting procedures become stricter.

In practical terms, many Japanese NGOs already have legal recognition as corporations or foundations, and others are too small to consider applying for official NPO status. At the Nagoya NGO Center, there are 25 member organizations (including AHI), all locally-based NGOs. Of them, only the NGO Center itself has announced its intention to apply for legal NPO recognition. Its experience will be closely watched by other local groups.

A Pact to Guide Global Investing Promises Jobs - But at What Cost?

Japanese Citizens' Groups Say NO to MAI

Based on an article of the same name by Peter Ford Christian Science Monitor, Feb. 25, 1998.

It is a pioneering treaty that will boost foreign investment worldwide and bring higher wages, and greater prosperity in its wake.

It is a disastrous surrender to giant corporations, leaving governments and citizens powerless to control the activities of multinationals.

These are the two radically opposing views of a document few people have actually seen, but which hopes to set legally binding rules for companies around the world who invest across borders.

A cornerstone of the 21st-century world economy, the Multilateral Agreement on Investment (MAI) will be "the constitution for a single global economy," in the words of Renato Ruggiero, head of the Geneva-based World Trade Organization.

The MAI was to be signed in April at the annual meeting of the Organization for Economic Cooperation and Development (OECD), the "rich man's club" of 29 industrialized nations. Unable to reach agreement, the negotiators now have another extension to work out the deal, which was supposed to be completed a year ago.

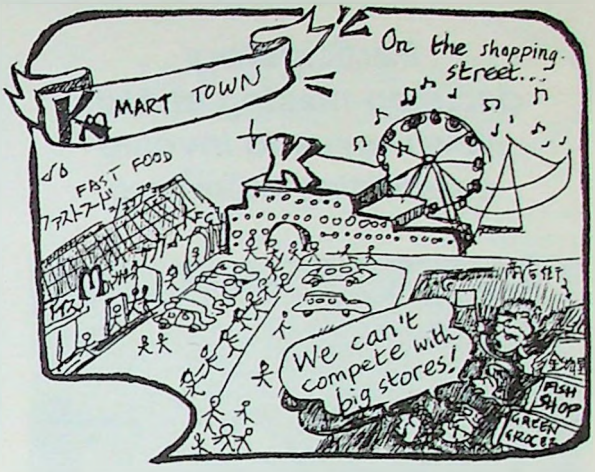
After three years of quiet negotiations in the OECD, the treaty came under increasingly vocal attack by citizens' groups worldwide, who say it will give corporations the right to ride roughshod over local legislation.

Foreign investment - whether it's a Japanese Nissan auto-plant in the United States, or an American Compaq compuuter assecmbly line in Taiwan - is worth over $8 trillion, and it's going up by $350 billion a year. OECD officials say the planned accord will simply level the playing field for foregn investors, ensuring that governments treat them on an equal footing with domestic companies.

Investing afar can be risky

Investing abroad is riskier than it is close to home. The investor is less familiar with local languages, customs, and laws, and more worried about being cheated. The MAI would encourage more foreign investment (and thus promise jobs and socioeconomic benefits) by offering protection against some of the risks.

But it would also strip national and local governments of some of their authority. Under MAI rules, for example, a Japanese city council would not be allowed to



"What does MAI mean for our lifestyles?" Cartoon by the Japanese anti-MAI coalition.

set standards for a foreign corporation that was bidding on a contract. The municipality could not insist that the company hire a certain percentage of its workers from the local community or ask that it leave some profits in the country.

Balance rights with responsibilities, accountability, and transparency

The main problem from the ordinary citizen's perspective, is that the MAI aims to expand the rights of multinationals, without expanding their legal obligations to society and the environment. Moreover, it is being decided by a small group of bureaucrats at the OECD, rather than in a more open, global forum where developing countries and ordinary citizens have a stronger voice.

For these reasons, protesters from around the world, linked through the Internet, have been ringing alarm bells about the implications of the MAI. The critics range from community activists in the US, to French cinema directors and actors who worry that Hollywood will swamp them if laws that favor local productions are outlawed.

Japanese Citizens' Groups Say NO to MAI

Japanese citizens' groups, have joined together in opposition to MAI in its current form. Since February 1998, more than 50 organizations (including the Nagoya NGO Center, of which AHI is a member) ran a national advocacy campaign. A lecture series and leaflets publicized the dangers of the MAI, and petitions and a letter-writing campaign organized lobbying of politicians. The groups also carried out a survey of local authorities to find out how much they knew about the MAI. Of the 83 authorities which responded, 77% reported that they did not know about the deal, which could seriously limit their authority to govern in their own local region. Citizen's goups still have a lot of publicity work to do.

Participatory decision-making at AHI: New moves to involve supporting members

At the AHI Plaza, AHI supporters, staff, and board discuss their roles in AHI's future, March 1998.

ILDC alumni and counterpart organizations know AHI as a center for participatory training. But, on the home front, AHI is still wrestling with the issue of participation by its own supporting members and board members. For the AHI secretariat, the past six months have seen a special focus on listening to the voices of supporting members - almost 8,000 of them, spread all over Japan - as well as to partners throughout Asia. It's still just an intriguing beginning.

Last year's AHI Festival included focus group discussions with supporting members. Next, from November to December 1997, a series of local AHI Kaiin no Tsudoi (Supporters' Gatherings) were held between supporting members and AHI staff at six major cities around Japan. And in March, a one-day workshop, the AHI no Hiroba (AHI Plaza) again brought together supporting members, board members and staff to share views and collaborate on rethinking and developing the organization. These efforts to facilitate more active participation by supporters and the board members are part of the overall program of evaluation and organizational development, in which the roles and relations of AHI stakeholders are being reconsidered.

In the past few years, AHI has become more conscious of the need for openness, transparency and accountability to its stakeholders. But old habits die hard, and the critical voices of supporting members have been essential in bringing about improvement in the organization's way of working. In the mid 90s, supporters called for more openness regarding AHI money matters, and as a result, since fiscal year 1994 the annual financial report has been sent each year to all supporting members. Further, in 1995 supporting members criticized the secretariat's one-sided decision to approach only board members and other limited benefactors for a special anniversary fundraising campaign. In response, the campaign was publicized to all members, and an additional ¥11,955,874 (approx. US$100,000) was raised for the organization. Supporting members are also gradually taking on more responsibility to carry out work formerly done by staff, including organizing the annual AHI Festival and the Talk Matsuri. They are also taking more initiative for developing certain aspects of AHI. One group, for example, has set itself the task of translating Asian writing into Japanese. Another group introduces AHI by running a handicrafts and information stall at community bazaars.

Steps to an open, learning organization

Thus, AHI is now taking essential, if wobbly, steps to becoming a more open, learning organization. At this stage, a key role for the secretariat is creating opportunities for different stakeholders to get to know each other, as a basis for working more effectively. The Supporters' Gatherings and AHI Plaza were such opportunities.

Supporters' Gatherings were held in Tokyo, Osaka, Kyoto, Fukuoka, Hiroshima, and Nagoya. A wide range of supporters took the time to participate and offer their insights to AHI staff, deepen their own understanding of Asian health issues, and clarify what sort of organization they want AHI to be. Although the discussion was rewarding, the number of participants was small. Staff realized once again there is still a long way to go to gain the active participation of supporting members. Further, it became clear that different supporters have different needs and different styles of committment to the organization. For some, sending a yearly contribution is sufficient; others want to participate in festival activities; and others want to be involved in decision-making.

The next opportunity included board members, as well as staff and supporters, in a deeper discussion of AHI's past and future roles in sharing with the peoples of Asia. This took shape as the AHI Plaza, held at the AHI building in Nisshin. Again, participants included first-time visitors to AHI as well as long-time supporters. To provide a common start, the day began with presentations by AHI staff introducing AHI's history and current training programs. After sharing a casual lunch, participants split for small group discussions, focusing on two main issues: 1) "The future of AHI - What is its role?"; and 2) "AHI and Me - How shall I participate?."

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HERE AND THERE

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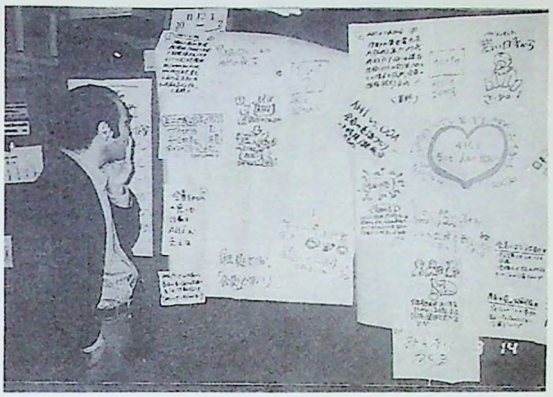

Participants' views in graphic form. One poster says, "Don't just look - get in and stir things up."

Supporters' voices

Given the range of views, it is quite difficult to sum up the workshop. The following are just a sample of the many opinions voiced:

"I like AHI because it's a people to people movement. A name like "Human Plan' would be better."

"It's a pity even grassroots health work turns into politics. It's better to just focus on local health issues. Then it's easier to raise funds in Japan, too."

"To me it's important that AHI is based on Christian faith and lifestyle."

"We need to involve more young people in AHI."

"What's going to happen after Dr. Kawahara (AHI's founder and director)? We have to make the organization strong enough to continue without him."

"Japanese ODA has changed a lot. Now JICA also emphasizes participatory community development. So what's special about AHI? Given the policy changes, should we accept ODA money and work more closely with Japanese government organizations?

"AHI started in part as a way to express our sorrow for the cruelty of the Japanese invaders in Asia before and during World War II. That's still an important issue."

"Most AHI supporters are from cities in Japan. I think it's important to build links between rural areas in Japan and other countries in Asia."

"AHI is like a big drum. The members are the drumsticks. Together we make enough noise and rhythm to speak to society."

What kind of drum are we going to be? What sort of rhythm? Most importantly, who will be the drummers?

The next discussions between supporting members and secretariat are planned for summer, when AHI's Indian partner, Hari John visits Japan. Watch for the next installment...

Let's DOH it at AHI!

Visit from Dr. Juan Flavier

Those familiar with the Philippine health sector will recognize the most famous slogan of former Minister of Health, Dr. Juan Flavier, during his service at the Department of Health (DOH). Once a country physician, during

Dr. Juan Flavier "dohing it" with AHI's Taka Nakashima, AHI, April 1998.

the Marcos era Dr. Flavier worked with the NGO International Institute of Rural Reconstruction. He is now a senator in the Philippine national government. And if he ever feels ready for another career change, his quick wit assures him a job in TV comedy.

This multi-talented star of community based health action also has long links with AHI. During a recent visit to Japan, Dr. Flavier and a staff of four stayed at AHI for three days, visiting local hospitals which offer combined acupuncture and conventional "Western" treatment. The visit was a research trip to investigate Japan's experience with legal regulation of acupuncturists, for reference in drafting a bill to legalize and establish minimum qualifications for acupuncturists in the Philippines.

As part of his lifelong work to bring affordable, quality health care to the Filipino people, Flavier is promoting a variety of legislation to incorporate alternative treatments within the Filipino national health system. In the past few years, Dr. Flavier has been a major force behind legislation to employ more herbalarios or traditional Filipino herbalists within the public health system. In December 1997, his Traditional and Alternative Medi-

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HERE AND THERE

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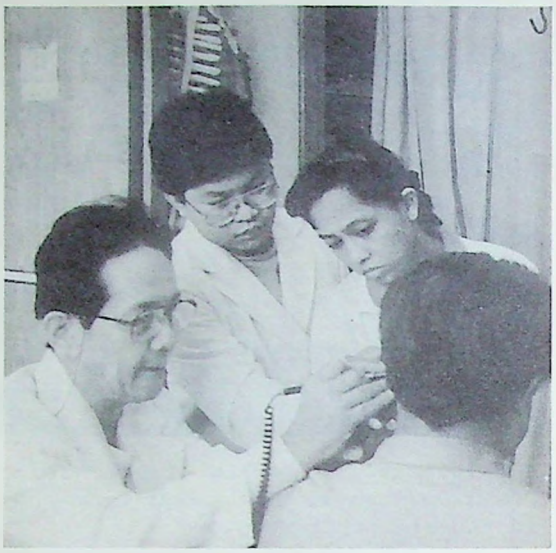
cine Act (TAMA) became law. One of its major achievements was the establishment of the Institute of Traditional and Herbal Medicine, which will conduct more scientific research into the effects of indigenous medicinal herbs. This sort of scientific evidence is important in gaining credibility in general, and especially to counter the arguments of powerful physicians' lobbies and pharmaceutical companies, who see the use of alternative medicines as a threat to their business interests.

Flavier is known for his brilliance as a communicator, his knack for social marketing in the health sector. The name TAMA, too, was chosen for its catchy, sassy message. As an answer to the M.D.s who called the bill "wrong," in Tagalog "tama" means "correct."

The acupuncture law project aims to set standard qualifications for practitioners, and to give treatment explicit legal status. At present in the Philippines, acupunctue is not specifically illegal, but it is not officially recognized. Legal status is an important step in increasing the use of this low-cost and effective treatment, stretching the government health budget, thus allowing it to care for more of the health needs of the poor.

AHI Promoting Acupuncture in the Philippines

AHI, too, is promoting the use of acupuncture in the Philippines via training in the Oriental Medicine Course (OMC). Of the 64 OMC participants to date, 24 have been Filipinos. These alumni have since trained many more people in their regions (see, for example, the letter from Josie Isidro in the previous issue). AHI also has informal links with other influential acupuncture promoters in the Philippines, such as the Acupuncture Research and Training Center (ARTC), a Filipino NGO.



Filipino participants Cesar Cussion and Chona Segismundo of the Community Medicine Development Foundation in the Oriental Medicine Course, 1991.

Last year's OMC participant was a Filipina physician, Dr. Abigail (Abby) Tauli. Abby works as program physician for CHESTCORE Program, a community-based health organization in Benguet, Northern Luzon. As an M.D., she is legally qualified to treat patients using acupuncture. Currently, though, health volunteers have no formal legal approval for giving such treatment. If Flavier's acupuncture bill is passed it will be easier for Abby's organization to serve more needy people in this mountainous region.

CALL FOR ARTICLES:
WHAT'S THE NEWS?

YOUR EXPERIENCES AND OPINIONS MAKE THE AHI NEWSLETTER

In the next two issues we plan to highlight health care policies in Asia. In particular, we would like to share experiences and views on:
1) Changes in government health policy;
2) The trend toward GO/NGO collaboration;
3) The trend towards privatization of health care services.

What's the situation in your country or area?
Submission deadlines:
End of August, End of December 1998.

WRITE IN YOUR OWN LANGUAGE IF YOU PREFER.
AHI Volunteers will translate your article into English.

Please send your contributions to AHI newsletter to:
THE EDITORS
Ui Shiori
Mela Berkowitz
Send by regular mail, fax, or e-mail.

HERE AND THERE

TSUBOI-SAN GETS ON HIS BIKE - TO SUMATRA

Last year, AHI supporting member Kaoru Tsuboi cycled around the island of Sumatra, Indonesia. On his gruelling trip, Mr. Tsuboi was struck by the friendliness of the local people, and the peculiar legacy of Japan's military occupation. At AHI, Mr. Tsuboi is a member of the Fundraising Committee, which works to recruit new supporting members and drum up financial support for the organization's activities. He is also involved in a range of community activities, including a wheelchair twin basketball league and a study group on Indonesian culture.

Tsuboi-san on the road in Sumatra.

I have no willpower. So after deciding to cycle around Sumatra I announced my plan to my friends so they wouldn't let me change my mind.

It's a total of 2,000km from Banda Ache at the northen tip of Sumatra Island to Indonesia's capital, Jakarta, in Java. "I'll manage," I told my friends. But never having cycled long distance, privately I had big doubts. So two months before my scheduled departure on September 1st, through the heat of Nagoya's summer, I cycled 50~100km each day to build up my strength.

From my friends there were two types of reactions. First, there were the people who immediately said, "Fantastic! I want to go, too!" although they knew almost nothing about the journey I was contemplating. Then there were those who immediately belittled it - "What for?" they asked. Both groups had one key point in common: they didn't know the first thing about Sumatra. Most people knew that Singapore is on the tip of the Malay Peninsula, but they didn't know that Sumatra is just across the Straits, that it lies right on the equator, or even that it is part of Indonesia.

Why Sumatra?

You may wonder why I chose Sumatra. Actually, my long affair with Indonesia began 30 years ago, when I was a university student. As a member of my university's "Expedition Society" I visited Borneo twice and fell in love with Southeast Asia. In those days there was very little information available, and visiting really was an adventure. Later, after graduating from college, I entered a trading company selling electrical appliances, and for three years, from 1975~78, I was posted to Jakarta. During my stay I traveled extensively in Java, by car and plane. But I managed only a brief trip to Sumatra and always wanted to go back for a more leisurely look around.

Last year came my chance. With restructuring in my former company, I opted to leave. Finally I had the three things I needed - strength, time and money. It was now or never.

Start from Banda Aceh

From Jakarta I traveled by boat and bus to Banda Aceh, the northernmost point in Sumatra. The big moment came on September 16. At 6:45a.m. I set off from my hotel, cheered on by the owner, a former Japanese army volunteer. I had bought my bicycle a couple days before and had it kitted out with basket, lamp, and luggage rack. Praying for a safe journey graced by charming ladies, I named it Arjuna, after the hero of Indonesian Waayang shaddow puppet plays.

No sooner had I started than I was surrounded by local people cheering me on. Children on their way to school shouted out "Hello, mister!" Drivers beeped and waved. At first I greeted each one with a polite "Yo! Selamat Pagi!" (Good morning.) But there were just so many, I soon shortened it to "Yo!" Already I was enjoying the unique delights of a bicycle trip -- stopping when and where I wanted to enjoy the scenery and chat with people along the way. Many, many of the discoveries and joys of my journey were only possible because I was cycling.

When I got back to Japan a lot of people asked me what I thought about as I rode. Actually, going uphill I had no energy spare to think of anything but "When will this damn hill end? Going downhill it would be dangerous to think of anything but staying in one piece and on my bike. On the flat parts of paddy fields and coconut trees, what did I think about? Unfortunately my thoughts were not as noble as people seemed to expect. Mostly it was something like, "That lunch was too spicy, and expensive, too!"

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HERE AND THERE

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or "Tonight I want some chicken satay and a good cold beer..." I also thought about the history of Japanese occupation in the area. The Japanese army marched along the routes I took, and ran cruel brothels in the area...

The best part of the trip started each day after finishing my ride. After showering I'd head to a nearby street stall for a glass of beer with ice, and long chats with the locals. Each day the questions were the same: "Why are you going by bicycle?" "Where are you going to?" Though they didn't say it, the villagers must have thought I was weird, doing something so hard with not a penny to show for it.

Legacy of Japan's Occupation

One of the highlights of my trip was in the town of Siborongborong, on Lake Toba. The town's peculiar name means "He who knows, knows." During the Second World War, Siborongborong was home to a sake factory run by the Japanese army, and produced a rice wine by the name of Toba Nishiki. The best Japanese sake is said to be made in the cold of winter, so I wondered about the taste of Toba Nishiki, brewed right on the equator... The former sake factory is now used as a livestock research center by the Indonesian Ministry of Agriculture. Reminiscing about chilled sake, I took a swig of my local coconut liquor, Tuak.

On my way back to my hotel I came across a group of people singing and playing the guitar. The Batak people of northern Sumatra are known for their beautiful polyphonic music. The group I met that night were also helped by a good dose of Tuak. One old man suddenly broke into song in Japanese - a wartime marching song about the rising sun in the eastern seas. Apparently, he had been a reserve in the Japanese army. Meeting a Japanese person after so many years must have brought back memories. He kept singing marching songs over and over. In fact, on this trip I met many old people who can still speak Japanese even 50 years since the occupation army left. "How's Mr. So and So?" they asked me, checking on the health of their former superior officers. "Young people nowadays can't speak any Japanese," they complained, even though the period of occupation was a hard time, with not enough food to eat or clothes to wear. The reserves must also have faced rough treatment in the army. They spoke a little of those hardships, but more than anything, the sight of a Japanese traveler seemed to make them nostalgic for the past. Their responses made me realize that even I, born after World War II, cannot escape from the legacy of Japan's actions during the war.

On September 29, I rode uphill for six hours to the hilltop town of Bukittinggi. At 900m above sea level, it is cool despite it's location on the equator. The vast Sianok Valley, the Grand Canyon of Indonesia, spreads out to the southwest. As I neared the town, the cloud thickened, and I saw people wearing masks over their mouth and nose. I found out later it was the effect of forest fires. The sun can't break though the clouds, and in places the smoke is as thick as fog. Even Sianok Valley was out of sight.

During World War II Bukittinggi was the headquarters for the 25th Regiment of the Japanese Army. I walked around the town following a copy of a wartime map. The former headquarters is now used by the Indonesian army, and the army hospital is still used as a hospital. The former military police barracks and the Japan Cinema building are still standing after fifty years. The railway is gone now, but the station building remains, and I could still read the station sign.

Sited overlooking the vast panorama of the Sianok Valley, is the Army Headquarters air raid shelter, now known as the "Japanese Hole" and one of the town's tourist attractions. At the entrance there used to be a relief panel showing laborers allegedly forced to dig the shelter and then bayoneted by the Japanese forces. Early last year, however, the panel was removed as there is no conclusive evidence of forced labor or civilian killings at the shelter. In Japan, Koshida Ryo's Ajia no Kyokasho ni Kakareta Nihon no Senso ("Japan's War in Asian Textbooks") states "Three thousand laborers were mobilized to build the underground headquarters, and all of them were killed upon completion of the facility." In a 1986 report, the Hokkaido Shimbun Newspaper stated "Hundreds of thousands of forced laborers were involved in construction of underground facilities, and many of them died in service." However, former Senior Lieutenant of Payrolls at Bukittinggi, Honjo Hiromichi, notes in his "Construction Log" that the building work was completed in three months, that there was not a single injury, and that the laborers were well treated and paid a daily wage through the Bukittinggi city government. Nearby, however, is the Umbilin Coalmine and the railway which carried its yield to Singapore. Up to 30,000 Indonesian forced laborers and Dutch prisoners of war were involved in the construction of the railway, and many of them perished at work.

Epilogue

On October 21st, after 36 days and 2,850km, I finally reached the capital, Jakarta. Where shall I go this year? Privately, I'm already planning, but it's still a little early to pressure myself by announcing it to my friends.

LEARNING BY DOING ~ ILDC EVALUATION IN INDIA

From January 12-15, AHI course alumni in India gathered at the Deenabandu Training Center, South India, to contribute their insights to the ongoing AHI program evaluation. The India workshop had three basic aims:
1) To assess the impact and significance of the AHI ILDC as well as the Oriental Medicine Course;
2) To assess AHI's capability and management system in organizing these training programs;
3) To share information regarding the courses and their impact with AHI supporting members.

AHI has an especially long history in South Asia, and particularly Southern India. Since AHI's foundation in 1980, course participants, facilitators and resource people from the region have been contributing to AHI's courses and to its organizational development. In terms of numbers of ILDC participants, with a total of 67 alumni, India is second only to the Philippines (74 alumni). After seventeen years of wholehearted collaboration, then, it is high time for a formal general evaluation of AHI's courses and their impact.

The evaluation program consisted of two parts, an Evaluation Workshop held at the Deenabandu Training Centre, AHI's counterpart in India, followed by Field Visits to the working areas of two ILDC alumni, from January 16-22. The 26 evaluation workshop participants were primarily ILDC alumni from the past ten years, but also included a number of community development and health workers from pre-ILDC years, and Oriental Medicine Course alumni. Sessions were facilitated by AHI staff member Taka Nakshima, three alumni participants, and ILDC resource person Dr. Desmond D'Abreo.

From professional development to social impact

Preliminary findings are already clarifying the strengths and weaknesses of AHI's training program. During the first day's session, participants each reflected on their own career history and then represented this self-evaluation in visual form, as a "liferoad map." (See picture this page.) A common pattern in participants' liferoad maps, was a sharp fall or block to growth upon returning to work after the ILDC. Many reported that the ILDC was a period of great learning and re-energizing. However, upon returning to work, they faced barriers to implementing what they learned in the course. Either the sending organization or their communities were not ready to accept the participants' new ways of thinking. This suggests the demand for increased follow-up from AHI for ILDC alumni, and the importance of involving the sending organization as a stakeholder in ILDC participation.

Still smiling: workshop participants in Deenabandu, January 1998.

Further, while individuals reported that they themselves had grown tremendously after the ILDC, during discussion of the micro and macro level changes in Indian society, most participants also felt that conditions on the micro or local level had worsened. Does this mean that the ILDC has little impact at the grassroots level? Or does it mean that the individual participants are pessimistic about social change? Or does it mean that when participants discussed the "micro-level situation in India" they were not referring to their own working area, but rather to India in general? It may also be that the positive effects of alumni's work at the local level are canceled out by negative macro-level trends. There are still many points to clarify to achieve an evaluation report which accurately reflects participants' views.

Learning by doing participatory evaluation

Through this process of clarifying and sharing different people's viewpoints, the evaluation process is facilitating learning by both course alumni and by AHI training staff. Particularly, through the Indian program, AHI staff are learning and developing more effective methods for participatory evaluation. AHI staff are committed to the concept of participatory evaluation, because it fits with the organization's vision of development towards empowering, people-centred, people-controlled ways of working and living. However, participatory evaluation is very open-ended and process-centred, which makes it difficult to finish with clear and solid conclusions. One issue to emerge regarding the evaluation itself was the need for various types of data in order to meaningfully measure the effects of training.

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HERE AND THERE

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Ups and downs: liferoad map of John Augustine, 1995 March ILDC.

In particular, one dilemma now being faced is achieving balance between "objective" standardized data, and "subjective" assesments. The dilemma was clear in the evaluation of change in alumni's attitudes and behavior. Since the ILDC focuses on attitude and behavior change of participants, evaluation workshop participants also considered this point. Specifically, each participant assessed his/her own attitude and behavior changes. While this self-evaluation is valuable, it would be more convincing as program evaluation if it were complemented by supervisors' or coworkers' evaluation of the participants' attitude and behavior change. Further, if partipants were to support and illustrate their self-evaluations with reports of concrete events, their statements would become more understandable and credible.

Participants' recommendations to AHI

Participants' recommendations to AHI urged more follow-up for alumni, a greater role for local core groups of alumni, and a focus on advocacy as well as grassroots work.

The training program evaluation has been continuing with workshops in Indonesia and the Philippines, and using different methods in other countries. Findings will be compiled and analyzed by AHI staff, course alumni, counterpart organizations, board members and outside experts, and put together as a report around the end of the fiscal year.

MESSAGES TO OUR FRIENDS

AHI's Taira Heads For The Courtroom

Six years ago Taira Kazuki got in another fight, with a motorcycle gang, and woke up in Aichi International Hospital, where AHI founder Dr. Kawahara is director. That was his first meeting with AHI. A few months later he had given up his job at a local rice warehouse and was a full-time AHI staff member. He says, "I happened to have a friend who's a nurse at the hospital. While I was waiting for my X-rays she went and called (former secretary general) Yoshi Ikezumi. She thought we might get along."

"We started talking. I told him how I was so frustrated with being treated as a second class citizen just because I'm from Okinawa (the islands between mainland Japan and Taiwan). I had come over to the mainland when I was 19. I wanted to see why my friends all came back home so bitter and strange. Besides, there's not much work in Okinawa. Little by little I started to understand what it means to be Okinawan in Japan. To start with, one time I was just about to sign a contract to rent an apartment. Suddenly, when the landlord saw my name he realized I was Okinawan and suddenly refused to rent to me. And when I was working at a gasoline station, some customers would look at my name on my uniform and say, "Get someone else." Another time I saw a hospital survey by the local doctors' association. One of their questions to hospital directors was, "Do you accept nurses of Okinawan descent?" Little by little the people around me all started to look like enemies. I got scared of telling people my name. I changed the Okinawa number plate on my car. And I started getting in fights for the smallest reason. But I didn't want to go home. There's no work, it's too small, and then, there are the American bases – I don't want to face those headaches all the time."

So Taira-san became an AHI staff member, and for the past six years, he has been involved with AHI's domestic programs, including AHI's speech festival, Open House and other local events, study tours, and administrative work on AHI membership. He has also made a unique contribution as AHI musical director, composing the unofficial AHI song, "We are the Asians." As well as singing and composing, he plays five instruments, including the sanshin, a sort of Okinawan banjo.

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MESSAGES TO OUR FRIENDS

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Taira-san is unusually talented in other ways, too. Young, handsome, and outgoing, he has a gift for communicating and connecting with all sorts of people, as well as a straightforward generosity. While AHI tends to have a serious, and churchy image among local people, Taira-san brought a light and easy charm to the organization, attracting fans among men as well as women. For him, communicating with ordinary Japanese citizens is now a key issue for AHI, as the organization is losing supporting members. "People join AHI because they want links with other Asian peoples, through AHI. AHI has a responsibility to respond to its supporting members, and it should have confidence in its special role. If AHI really communicates with supporters, they will not leave."

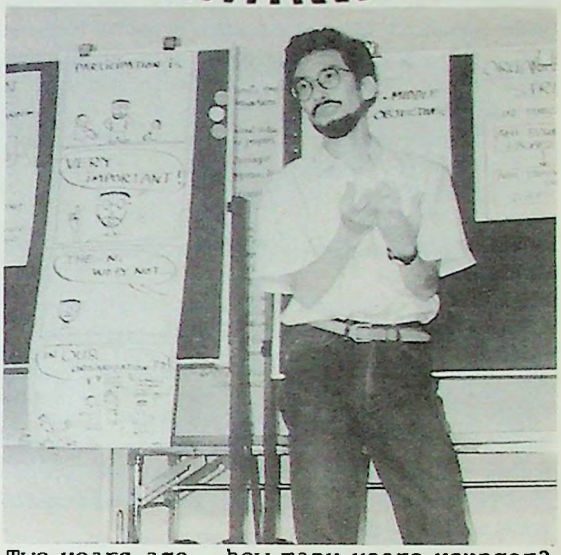
Looking back, Taira-san says he learned a great deal during his time at AHI, about Asia and its people, and about the struggles of other groups which face discrimination, in Japan and in other countries. He also calmed down a little. Six years ago, faced with discrimination, he responded with frustration and anger. At AHI he began to think instead, "What should I do to improve the situation?" This new outlook is now leading him to a new challenge, studying to become a lawyer. No more streetfights, Your Honor.

Sing out! Taira-san at the AHI Open House, October 1996.

Taira-san is succeeded by new AHI staff member, AKITA Machiyo. Akita-san is fluent in Sinhalese (the main language of Sri Lanka), so some alumni may already have received birthday greetings from her in their language. Watch for an introduction to Akita-san in the next issue.

Sato-san Sets Sail:

An interview with AHI's new general secretary



Two years ago - how many years younger? Sato-san as ILDC participant/observer, 1996 Sept-Oct.

In June Mr. Sato celebrates his first anniversary at the helm of AHI. Looking back, he commented on the road which brought him to his new career. In the next issue, the report continues with Mr. Sato's first year review .

Sato Hikaru worked as a physician for 19 years before joining AHI as general secretary. Asked if it was difficult to give up his work as a doctor, he answers, with typical understated wit, "Don't you think 19 years is enough?"

Dr. Sato's dream

The story starts when Sato was still a high school student considering going to medical school. As the son of two Christian physicians, in the close-knit world of Japanese Christian physicians, Sato met AHI founder Dr. Kawahara, and even spent a summer as a volunteer intern in Dr. Kawahara's Nagoya hospital.

But for the next 10 years or so, Sato drifted away from mainland Japan, focused on his dream of serving as a physician in South India. During his travels as a student, he had been impressed by the Christian Fellowship Hospital, south of Madras, and set out to work there someday. His image, he recalls, was of himself in a white coat,

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MESSAGES TO OUR FRIENDS

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sitting behind a simple doctor's desk, with a mass of poor, sick, brown people lining up for his help.

After completing medical school, in preparation for his planned work in India, Sato found his first placement in the subtropical island of Okinawa. He soon had another opportunity to prepare as he was accepted for two years' advanced study at the London School of Hygiene and Tropical Medicine. Now with a wife, Sumiko, and small child, the promising young physician took his next step towards India.

Sato's colleagues at the London School were excellent physicians from throughout Asia and Africa. Little by little, they shattered his dream.

A different way to serve - "Nagoya people are pretty impressive"

On an intellectual level, Sato already believed people would generally be better served by health workers from their own country, sharing the same language, culture, and community. In his colleagues in London, he found not only skilled physicians, but also wonderful human beings - full of energy, humor and love - dedicated to their work promoting the health of their country people. Now on a gut level, too, he began to question his dream of going to work in India.

Meanwhile, the Indian High Commission still refused to issue Sato a working visa. He was tempted by an offer of work in South Africa. But his wife, pregnant with their second child, was ready to return to Japan. Sato chose family. Back in Tokyo, he continued to apply for a working visa for India - to no avail.

It was around this time that he began to learn more about AHI. In fact, he had heard of the organization while in London, as his father was one of the founding board members. Sato, born and bred in Tokyo, recalls, "I thought, Nagoya people are pretty impressive and aware of development issues, to start and support an organization which offers only indirect aid for health promotion and training for self-reliance. I hadn't thought Japanese people were ready for that." Perhaps, he thought, this is a more effective way for me, a Japanese, to contribute to health care and be close to the lives of other Asian peoples.

"Lucky to be involved in AHI at this time of change"

After a break of 10 years, then, he contacted his former mentor, Dr. Kawahara, looking for a way to get involved in AHI. He was offered work in internal medicine at the Aichi International Hospital, nextdoor to AHI , where Kawahara is director. The question was, what could he do at AHI? Within a few years, to his surprise, he found himself in a new career as manager of an NGO, AHI's third general secretary. Following the charismatic first generation of leaders, Kawahara, Yamashita and Ikezumi, is not an easy task. And this is not an easy time for AHI, as it moves to develop and institutionalize. Sato describes himself as the third anchor in a long relay,

charged with conserving some elements and adapting others. "It would have been fun to continue as a physician, too. But I felt it was time for a new challenge. I'm really lucky to be involved at this period of change in the organization. It's an unusual chance to play a role in shaping AHI's future."

In the next issue, the report continues with a look back on Sato's first year as AHI general secretary.

NEWS FROM FRIENDS

SRI LANKA

Recently the plantation workers in my field area participated in a 13-day strike by 350,000 tea and rubber industry workers. Due to inflation, since 1994 the prices of essential food items have shot up. However, while the government has increased public servants' salaries, the wages of plantation workers remain unbearably low, far below the wages of other laborers. There are two important background issues to the strike. First, 80% of the plantation workers are of Indian (Tamil minority) origin. Second, the plantations were privatized in 1992 as part of the government's structural adjustment program.

Nearly all the plantation trade unions united in the original demand, asking for an increase from the previous Rs.83/- per day to Rs./125 per day, still below the typical wage of Rs.150/ per day for ordinary daily laborers. However, the company management dragged their feet, and the plantation workers began their general strike on 5 February 1998.

At this stage the companies agreed to sit down to talks with the trade unions. They were offering Rs.93/- per day, while the unions were prepared to accept Rs.105/-. The deadlock continued until the President of Sri Lanka intervened. Finally an agreement was reached for Rs.95/- per day and Rs.6/- as allowance, for a total of Rs.101/- per day. After 18 months the unions will negotiate with the management for a further increase.

As a NGO involved in the plantation sector, my organization, the Institute of Social Development (ISD), supported the strike and conducted several grassroots level workshops to motivate the workers to join the strike. Apart from this, with the initiative of the ISD, a Civil Forum was formed in the plantation sector, including trade unions and NGOs as constituent members.

Although they could have won Rs.105/-, the trade unions lost an opportunity. This has given rise to anxiety among the plantation workers, which is likely to adversely affect future struggles in the sector. Hence, as one

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NEWS FROM FRIENDS

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of its awareness programs, the ISD plans to conduct a workshop for trade union representatives in the near future. **(P. Muthulingam (Muthu), 1994 Sept-Oct ILDC)**

INDIA

I very much want to communicate with the AHI Board of Directors about the new training policies they are considering. First of all, AHI's training opportunities should be kept open to people from a range of professions, not only for medical people. Health cannot exist in isolation -- it involves agriculture, education, culture, and environment. I do agree that there are alarming new challenges in the health (medical) sector, and there is definitely a need for health sector training. However, at the same time, intersectoral coordination must be encouraged even more to achieve holistic health.

Secondly, I want to stress the Oriental Medicine Course. This sort of course is badly needed for countries like India where ordinary people cannot afford allopathic medicine. The short courses on acupuncture, ICN therapy and herbal medicine are of great importance, and AHI should offer them frequently.

The third point I want to make regards the current process of globalization. Globalization is bringing up many new issues for community-based health. We must frame our strategies accordingly to be effective. This is why I feel topics such as social, economical, political and cultural analysis of community should be the focus of future training at AHI, to help communities become conscientized and empowered for health. **(Anil Rananavare, 1986 June-July Interantional Course)**

NEPAL

In Nepal nowadays the NGO culture has become regressive. The number of NGOs is increasing, but the total outcome is trivial. Sometimes, rather than improving the situation of the poor, these organiazations increase the burden on society. This has induced me to renew my commitment to the community by changing the prevailing practices of these so-called NGOs.

Together with some like-minded friends, I formed an NGO, the Society for Action and Research for Sustainable Development (SOARS), and am now serving as President. We aim to fight against the new exploitation started by so-called NGOs and to help the most vulnerable members of the society. The ignorance of these people towards the functioning of NGOs and in assessing their own problems leaves open too much room for exploitation.

At SOARS we have already conducted training courses on gender issues, legal awareness, local implications of economic policies, management and participatory planning for NGOs, community-based organizations and self-help groups, and leadership training for social workers. All these courses were conducted in rural areas, some with the assistance of local community-based organizations. So far, it seems that the training is worthwhile for the participants. They gained self-confidence, realized the need for self-reliance, and learned skills for problem analysis. **(Nirmala K. C., 1994 May-June ILDC)**

INDONESIA

Darmayanti with former General Secretary Yoshi Ikezumi in Jakarta, 1987.

Thank you so much for the birthday wish. Your attention made me very happy, and for a while I could forget the monetary crisis we are facing in Indonesia.

We are now having a very difficult time, but we believe with God everything can be solved. We hear a lot of rumors and information from friends and from the internet. I assure you that it is still safe to visit Indonesia. Please come! **(Darmayanti Saludung, 1985 Sept-Oct, International Course)**

We are now thinking hard how our organization, CBR-DTC, can overcome the impact of the monetary crisis. Some of my NGO colleagues in Solo have limited their activities because of the crisis. I trust that my organization can get through these problems. **(Emilianus Elip, 1996 May-June ILDC)**

I still work in Jakarta Islamic hospital, owned by Muhammadiyah. I am Head of Research and Development Programs. At Muhammadiyah, my main work is sill in community development. Now my project is developing a health and medicine post in a rural area to help the poor people from villages obtain health care and inexpensive medicines. **(Ms. Atikah Zaki 1986 June/July International Course)**

I am still at PERDHAKI for family planning training. In addition, I am now working on an AIDS program.

It's very interesting to develop ways for the health staff to motivate and involve the community - motorcycle

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NEWS FROM FRIENDS

(Continued from p.19)

drivers,vegetable peddlers, and young people - in AIDS prevention events. As more people learn about AIDS, they can spread correct information to other people.

In 1996 I participated in a course in Switzerland on "Health Care and Management in Tropical Countries." And in 1997 I took a course in Jakarta on Disaster Mangement. So I've been very busy.

I am very grateful to AHI, for the valuable training, and also for remembering me through birthday cards and the newsletter. My warm greetings go out to all AHI's staff. At other institutes, I have never experienced this sort of personal touch. I'm learning a lot from your model. It is important to touch all participants one by one. **(Elizabeth Surkalim, 1990 May-June International Course)**

BANGLADESH

In 1996 I earned a diploma on environmental issues from the Nehru Foundation in Gujarat, India. In the same year, my organization, BRAC, formed an Environment Group, of which I am a member. The Group has started an Environment Awareness Program (EAP) that will cover the Women's Health Program. We also designed and conducted an awareness orientation for all BRAC senior level staff in October 1996. The awareness program will be conducted with field level staff as well as the members of our village organization. Ten training specialists were selected and participated in a six-day TOT course in early September, 1997.

BRAC has started the following activities, down to the village level: public sanitation, waste management, bio-gas, EAP for BRAC-school children, soil fertility program, organic farming, afforestation and awareness raising, solar and wind energy projects, arsenic pollution testing of tubewells in BRAC field areas, development of alternative drinking water sources (pond preservation, DTW installation, and rain water collection).

I would be glad if friends from different parts of Asia could share their suggestions and experience regarding the above environmental issues. **(Shahajan Chowdhury, 1988 Sept-Oct International Course, c/o Ganu M. Bary, P.O. Santir Hat Via Mohajan Hat, P.S. Mirsarai, Dist. Chittagong, Bangladesh)**

PHILIPPINES

I am very happy to be involved with AHI again for the evaluation activities, and to know that after all these years AHI is still firm in its commitment to Asia.

For three years now I have had a consultancy with a nationwide community health project, and I still teach at the Davao Medical School. My family is well, too, and my husband is very much involved in church activities. **(Millet A. Ty, 1987 May-June International Course)**

CAMBODIA

Mr. Ith Sarin with his 11 month old daughter.

I became a father! **(Ith Sarin, 1993 May-June ILDC)**

I really gained a lot from the training at AHI. I realize this now I am a student at Cairo Demographic Center, Cairo, Egypt. Here, I can use my AHI experience to discuss and share with participants from different countries. Especially, my learning at AHI on globalization and sustainable development has been very useful in my current course. **(Po Samnang, 1996 Sept-Oct ILDC, currently studying in Cairo for one year.)**

Let's keep in touch!

What's happening in your world? Any suggestions for the newsletter? What do you like? What should we change? What sort of information do you want?

Write and tell us!

AHI's e-mail address has changed. Our new address is: ahi@jca.ax.apc.org