Beyond the Public Prescription

Private and Public Roles in Near East Health

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EXECUTIVE SUMMARY

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PREFACE

The decision of the Near East Bureau of the Agency for International Development (AID) to document and analyze the health care activities of business in the Near East is an important act of leadership on the part of development professionals. The many case studies contained in Beyond the Public Prescription, detailing business roles in health services, demonstrate genuine opportunities to generate new resources for health care in the Near East.

To understand fully the broad implications of the innovative approach discussed in this Report, it is necessary at the outset to distinguish the intentions of this study from other research on private sector roles in economic development.

Our objective here is not to encourage the development of private sector enterprise within AID recipient countries or between the U.S. and those countries. Nor do we believe that public resources can be replaced with private resources as the engine of development. Rather, our objective is to illustrate and analyze how development professionals can harness the vast resources, experience, and technological expertise of business to achieve the public goals of social and economic development.

Our premise is that our huge responsibility to achieve development for billions of unfulfilled lives will require more resources than we can ever commit in the public sector. The overwhelming dimensions of development necessitate finding effective methods for making optimal use of all available resources, public and private.

This approach, quite simply, is the mandate of The Center for Public Resources (CPR). The organization was established six years ago to develop methods for mobilizing market resources to address public and human needs. Our focus is not philanthropic. Instead, we direct our efforts to understanding and enlisting the market incentives of business to respond to public problems, so that the resulting involvement is based on a pragmatic, sustaining commitment. We have seen success in this approach in the areas of education, the high costs of the legal system, and health care.

Anyone seeking sound collaboration between business and the public sector must recognize the obstacles which inhibit progress in this direction. The business of business has, of course, been perceived to be business. The public sector, in turn, has been viewed as having nearly total responsibility for meeting the monumental public and human needs here and in the developing world. The adversarial posturing of the sixties and seventies enhanced this division by reinforcing the notion that a social role for business was suspect and thus of little social utility.

In the past, we lived under an illusion of vast and unending public resources. This illusion gave support to the idea that we as a society could operate as two quite separate systems, public and private. Today, we no longer enjoy the luxury of that illusion; we can no longer sustain wasteful dichotomy. The reality of constrained and limited public resources compels us to devise methods for utilizing business resources to address crucial social issues.

The 1980's must be an era of collaborative problem-solving. Thus, the difficult task ahead is to understand how our vast reservoir of financial, technological, and professional private resources can be successfully applied to meet social needs in ways that satisfy both market and public objectives.

The degree of current business interest and involvement in meeting public needs via the marketplace is encouraging, but the process by which this involvement can be melded with public programs and goals has yet to be rigorously understood. We hope that this Report brings us a step closer to that understanding.

Whatever may be the problems in forging a genuine public-private relationship to achieve the goals of international economic development, the public official has no choice but to try -- indeed, to assume the lead. The times clearly demand a determined effort on the part of the development assistance professional to generate new resources.

At no other point has business exhibited the level of its current interest and capacity to address a variety of social problems. And at no other period have we been so starkly confronted by the reality of constrained public resources.

The ability of the development assistance professional to respond to both the opportunities and constraints of our time will chart the future course for public-private cooperation in development.

James F. Henry
President

BEYOND THE PUBLIC PRESCRIPTION: PRIVATE AND PUBLIC ROLES IN NEAR EAST HEALTH

EXECUTIVE SUMMARY

Particularly in these economic times, the developing world faces huge priorities with inadequate resources. The first casualty of the difficult decisions which thus must be made is often the health sector. Public health systems of the developing world seldom are able to generate the consistent, long-term political support necessary to defend and expand health budgets and services. Financial aid from bilateral and international assistance agencies has not been sufficient to respond to the health needs and problems facing the millions of people in the developing world.

The financial constraints in the public health sector call for new, creative approaches and resources to meet the health care needs of the Third World. In building such strategies, one formidable resource must be given greater consideration than it has in the past--that is the existing technical and financial role of the market-based (for-profit) private sector in the health systems of developing countries. This market-based private sector often accounts for 50% to 80% of the health services currently provided in these countries and includes local businesses, local private providers of health services (physicians, nurses, pharmacists), local private health facilities (hospitals, clinics, and laboratories), and multinational corporations.

Beyond the Public Prescription analyzes these private roles and resources and describes how they can be linked to public health needs in ways that compromise neither private, market objectives nor public policy goals. The focus of the Report is on the Near East, with particular reference to the experiences of Egypt, Jordan, Tunisia, Lebanon, and Morocco.

The work was undertaken by the Center for Public Resources (CPR) with support of the Agency for International Development, in keeping with CPR's mission to make more effective use of market resources and market incentives to fulfill public needs. Beyond the Public Prescription indicates for the first time how public aid and policy professionals can attract the considerable technical and financial resources of the private sector to address more effectively the region's health needs.

STATEMENT OF THE PROBLEM

Although countries in the Middle East have undergone relatively rapid development over the last ten years, measures of the health status of their people continue to be sobering:

- -- Life expectancy at birth in the Middle East is 20 years less than in industrialized countries.
- -- Even in oil-rich states of the region, the death rate for infants before the age of one year is 5 to 10 times that in Europe.
- -- One-third of the population of the region lacks adequate access to potable water and basic sanitation services.
- -- Diseases that have long been under control in industrialized nations (common diarrheal diseases, respiratory illnesses, polio, tetanus, parasitic diseases) continue to take a heavy toll in terms of disability and death in the region.
- -- Public sector budget expenditures on health hover around 1.5% of the total national budgets.
- -- Annual public sector health expenditures average about $7 per capita.

The region's strained public resources are increasingly unable to sustain a minimally-acceptable health infrastructure to address all of these health problems.

Ways must be found to leverage declining public resources by acknowledging and facilitating the application of private financial and technical resources to the health problems of the region. In carrying out their regular business operations, local business, private health services providers, and multinational corporations are often major participants in the health systems of the Middle East. These private actors provide direct health services and products. They also affect worker, and often community, health via the occupational safety, training, and infrastructure services connected with their investments. Moreover, private business houses expertise which may be applied to public programs to improve their effectiveness.

It is in the interest of national governments, public agencies, and development assistance professionals to optimize these resources and develop policy incentives for their expansion. Key leadership in these efforts can be exerted not only by national governments but, more importantly, by the public development aid professionals who

often play a key catalyst role in health sector design and finance. Unless public professionals exercise the creativity needed to leverage public resources in the private sector, the health sector will face existing or increased limits on its programs.

Actively pursuing private resources for public health programs may not be a familiar undertaking. Many public and development assistance professionals in the health sector have not had the information, professional access, or working knowledge of cooperative mechanisms needed to identify relevant private, market-based resources, to apply these to public health problems, or to develop the policy incentives needed to attract private resources to public or development assistance projects. Yet, models and experience exist on the basis of which these strategies can be built.

These professionals must also overcome a history of poor communications between public and private sectors on the spectrum of health issues which might be the targets of cooperation. Conflict more often than cooperation has characterized private-public dialogue in the health sectors of the Middle East.

There is, nevertheless, an increasing recognition, especially in the Middle East, of the very real and growing role of the private sector in resolving a wide range of health sector problems. That recognition has led to a renewed interest in defining areas of meaningful public-private cooperation which serves the interests of all parties involved in Middle East health systems: publicly-mandated agencies (local as well as international), the business world, national governments and their economic growth and equity goals, and the people of the region.

THE MEANING OF AND LIMITS TO PARTNERSHIP

This renewed interest has taken an incomplete turn. Development assistance requests for "partnership" with the private sector too often sound akin to "my agenda and your money," overtures that seek private (particularly business) resources to pursue goals and programs designed exclusively in the public sector. This is not partnership; it is philanthropy. Such philanthopic approaches can be effective responses to some types of problems. However, a purely philanthropic approach is vulnerable to shifting donor interests and is thus usually short-term. It is ill-suited to address structural health problems which require a more long-term, sustained effort.

It is only when both parties achieve their individual goals through mutual effort that cooperation becomes a partnership, and it is such partnerships, sustainable in the longer term, that are needed to address the health problems of the developing world.

It certainly should be noted from the outset that such partnership approaches may not be appropriate or efficient options for all problems in all regions of the developing world. The necessary role of the public and philanthropic sectors in many aspects of health programs in the developing world is not in question, at least not here. Drought, refugee relief, natural disaster, and epidemic disease control are but a few examples of areas in which public and philanthropic responsibility is indeed both appropriate and predominant.

Moreover, for the very poorest nations, an early reliance on public finance and aid is probably essential. In these cases, improvements in infrastructure and sanitation are prerequisite to the attraction of private capital to the economy. While investment in these infrastructure areas may eventually yield sizeable economic returns, payoff is too remote to attract the private sector. Therefore, public aid is the resource for building the foundation. Once built, however, that foundation in nearly every sector -- social as well as productive -- can attract market resources.

Even in these poorest countries, however (let alone in the Middle East), the need for additional resources and the reality of existing private roles in the health sector argue for greater public cooperation with fundamental private health resources.

What does cooperation in this market-based sense mean? What constitutes a "partnership" based on long-term, sustainable self-interest? Development assistance cooperation between public agencies and the private sector which builds on and encourages private resource involvement in health can take many forms. Among these are:

-- Application of business expertise in the design of public projects or the resolution of public health problems (e.g., expertise in system or facility management, vector control, insurance, occupational safety);

-- Joint investment in or financing of the project which results from the design process;

-- Leveraging of public resources, i.e., using small amounts of public financial resources to attract a much larger level of private resources (financial or technical) to a project or program;

-- Reimbursed utilization of existing private health programs or facilities for delivery of public health services or the training of public providers;

-- Contracting of public services provision to private organizations (e.g., management of logistics systems);

-- Development of policy incentives to encourage the expansion or improvement of health services or products provided by the private sector;

-- Joint financing of the recurrent costs of health services delivery (e.g., via the sharing of physical plant, equipment, or training programs).

In sum, all forms of market-based cooperation imply advantages for both the private and public sectors: the public sector in terms of expanded resources, broadly defined, to address public needs in a more cost-effective, well-managed manner; and the private sector (local and international) in terms of both immediate market concerns in the area (e.g., labor productivity) and the more effective provision of health products and services to those in need.

For its part, however, the public sector stands to gain one additional benefit from closer private sector cooperation. It is the very way of thinking which private entrepreneurs apply to their undertakings. The discipline of the marketplace -- financial and managerial -- produces in the private sector a dominant concern about accountability for resources, about the competitiveness of ideas (and development assistance is a competitive business -- good projects are hard to find), and about the quality of product outputs. This market-based method of problem analysis and action has much to offer the public sector in making more effective use of its own, public resources. The private entrepreneur, faced with the discipline of the marketplace, emphasizes innovation and growth. A public bureaucracy, faced with responsibility for implementing "command and control" regulations, emphasizes adherence to policy and maintenance of the existing allocation of resources. To the extent that public projects can take on a more private, entrepreneurial spirit by working closely with the private sector, project creativity may benefit.

PROJECT GOALS

Building on the above problems and partnership approaches, Beyond the Public Prescription was developed and written with these goals in mind:

(1) To collect initial baseline information regarding the nature and level of activity of various private sector actors (business and service providers) in health in selected countries in the Middle East; the policies of national governments regarding those activities; and the policy and project precedents of the major development assistance agencies involved in the region as regards private sector cooperation.

(2) To analyze that information and suggest the broad parameters of possible areas for private sector collaboration in health in the region.

(3) To use (1) and (2) above to identify both a private sector constituency for health issues in the Middle East, and the private resources and expertise to which development assistance professionals might turn in the future for further discussion of cooperation; in addition, to create within that private constituency greater sensitivity and cooperation to build development assistance policies and priorities that involve private sector resources.

DATA SUMMARY

The extensive data included in the full Report provide an important analytic framework within which public agencies and development assistance professionals can formulate a proper and effective approach toward public-private cooperation in the region. The following overview summarizes the complex data and highlights key issues analyzed in full detail in the complete Report.

A. Economic Environment

All countries under consideration in this Report evidence a strong and urgent need for attracting private investment to attain national economic goals. The ability to finance increasingly complex and costly development plans is dependent upon the ability of a country to take advantage of its total resource base, private and public, and to attract domestic and foreign private investment capital to its economy.

Despite their common need to maximize private capital, however, the economies in the Middle East reflect varying levels of state control, are faced with various constraints upon their growth, and, therefore, have instituted varying strategies for identifying and attracting private capital to their development goals.

Jordan, at one end of the spectrum, is a comparatively free enterprise system, with a reputation for effective government economic management and direction. But despite this solid economic reputation, the country's economy suffers from limited natural resources and raw materials. Joining Jordan at the free enterprise end of the spectrum is, of course, Lebanon, noted as the commercial and banking center of the Middle East. However, under continued strife and destruction, virtually all of Lebanon's economic resources are currently targeted toward reconstruction.

In the middle is Egypt. Although most production continues to be state-controlled, Egypt, beginning in the mid-1970's, has taken major steps to open its economy to private sector participation. A successful role for the private sector, however, is hampered by structural economic difficulties including high inflation and a strained agricultural system.

At the other end of the spectrum is Tunisia's state-controlled economy. Although relatively strong to date, the country's economy must contend with a future reduction in oil resources and current high unemployment. Another firmly state-controlled economy. Morocco suffered a particularly poor year in 1981 due to both an extensive drought which destroyed agricultural production and a collapse of the market for phosphates, Morocco's most important export.

All of the above countries, except Lebanon, are pursuing ambitious five-year development plans, with investment targets of $10 billion in Jordan, $23.9 billion in Egypt, $14 billion in Tunisia, and $17 billion in Morocco. All plans emphasize the role of the private sector as a partner in economic development. Jordan is hoping that about 50% of its investment financing will be forthcoming from the private sector; Egypt, 25%; and Tunisia, about 40%. Lebanon continues to rely on the private sector for reconstruction, and Morocco is hoping that three-quarters of its development financing can be generated from private sector investment (which also includes capital from major public-private joint ventures). In Egypt, private investment is directed toward small-scale industries although some major state-owned industries are seeking private sector joint venture partners. In Tunisia, private capital is being channeled toward medical, mechanical, and electrical equipment industries, and in Morocco, toward textiles, chemicals, and agribusiness. All plans emphasize industry, agriculture, and tourism as priority sectors for development.

These countries all operate with large national budget deficits. Morocco's deficit rose 50% between 1980 and 1981, and Egypt's deficit is nearly $3 billion, almost equal to the amount it receives from foreign aid sources. While a few key exports such as oil and phosphates, remittances from workers in oil-rich Arab states, tourism, and foreign aid help to keep these countries afloat, the need for foreign financing is uniformly acute. Over 50% of Jordan's budget is financed from foreign sources. $400 million from foreign sources is expected this year for Tunisia, $2.5 billion for Egypt, $1.5 billion for Morocco, and over $2 billion for Lebanon.

It is clear that neither public revenues nor foreign aid are sufficient to fund expensive development plans and implement national economic goals. Thus, creating the right environment for private investment has become a priority for all countries concerned.

B. Indigenous Business

Given these economic realities, national interest in domestic private capital is growing in each of the focus countries of this Report. However, seldom does that interest extend to the health or human resources activities of those local businesses. Nevertheless, in each of the countries, local business does, or has the potential to, provide health services or interact with a variety of health care problems in very cost-effective ways. There are, thus, many opportunities for closer cooperation between business, government, and development assistance to improve health care. Material in this section of the full Report contains not only data regarding the status of local business activities, but also case study illustrations of the local health roles for:

- -- ACDIMA
- -- Al-Hikma Pharmaceuticals Company, Jordan
- -- Kuwait Oil Company
- -- Health Services in State-Owned Corporations (Morocco)
- -- Misr Spinning and Weaving Company, Melhalla Elkubra, Egypt
- -- Cairo Company for Beverages, Egypt
- -- Nasr Company for Manufacturing Televisions, Egypt
- -- Helwan Iron and Steel, Egypt
- -- Nasr Paint and Chemical Company, Egypt
- -- Jordan Electricity Company
- -- Jordan Phosphate Company, Ltd.
- -- Jordanian Insurance

1. Health Products Industry

In general, the health products industry in the Middle East is oriented toward the formulation and packaging of imported pharmaceutical substances or toward the manufacture of pharmaceuticals under license from multinational corporations.

Jordan: The domestic industry in Jordan supplies 24% of the country's $47.2 million pharmaceuticals market. In 1981, 62% of sales in the domestic market were in the private market, and 35% of the pharmaceuticals in the country were purchased by the Government. Jordanian industry is a major exporter of pharmaceuticals to the Arab world.

There are four major indigenous pharmaceuticals producers in Jordan, two of which are publicly-held and two of which provide interesting studies of the public or regional linkages of Jordanian industry to broader health sector questions. In 1981, there were 1,664 basic kinds of drugs registered on the Jordanian market, yet less than 10% were produced by the four domestic companies.

Egypt: In 1980, sales of pharmaceutical products in Egypt totaled $304.5 million, 80% of that value accounted for by local production. Of total consumption, 17% derives directly from government expenditures. 70% of the 3,200 pharmaceutical products registered and sold on the Egyptian market are manufactured by domestic public sector manufacturers.

There are two types of private or quasi-private companies involved in Egypt's health products industry: producers of drugs and large distributors of imported dose-form drugs and medical equipment. All seven of the purely indigenous pharmaceutical products companies (without foreign participation) are state-owned. Their product lines are limited, their production facilities often outdated, and their financial status dependent on government subsidies. They do, nevertheless, give Egypt greater import substitution capability in pharmaceuticals than nearly any other country in the region. Until recently, the two public medical products import and distribution companies have had a virtual monopoly on the import of fine chemicals, dose-form drugs, and medical equipment. In the last few years, however, the easing of import restrictions has given rise to several new private companies in this area of medical imports.

Tunisia: 80% of total pharmaceuticals sales in Tunisia come from imports. Local production of the remaining 20% is centralized in the Central Pharmacy of Tunisia (PCT). PCT is also responsible for all drug and chemical imports and distribution. Thus, the public sector exerts a virtual monopoly on local production of pharmaceuticals and on the import of fine chemicals and finished dose-form drugs.

2. Non-Health Products Manufacturers

The health-related activities of private sector manufacturing industries are generally not comprehensive or well-organized. This, in large part, is because the costs of such programs are high compared to the size, capital, and revenue of what are usually small companies in the local private manufacturing sector. However, two types of health-related activities are discussed in this Report: integrated health services provision programs, and occupational health and safety programs. Ample opportunity exists for development assistance to provide incentives for program expansion and linkages among indigenous business and multinational corporations.

3. Banking and Finance

The banking sector throughout the Middle East has grown stronger as economic policy has come to emphasize the role of private capital in development finance. Moreover, local banks are already involved in private sector health finance, both in terms of health products industries and in terms of financing for private providers and facilities. Thus, opportunities may exist in Jordan, Egypt, Tunisia, and Lebanon for local financing and management linkages with development assistance and public health projects.

4. Insurance

Growth in the private indigenous insurance industry is a recent phenomenon in the Middle East. The health insurance industry is primarily a government-controlled, quasi-public agency responsible for providing a range of OHS treatment and medical care.

In Egypt, delivery of health insurance is a highly-structured, relatively sophisticated system known as the General Organization of Health Insurance (GOHI), a government agency covering approximately 2.5 million people. Its organization, delivery capabilities, and financing are discussed in detail in this Report.

Several private insurance funds have also been established in the private sector, as parts of companies or associations desiring to increase the health benefits of their members. But the growth of these private funds is thwarted by the mandatory employer payment to GOHI, even when a private system is preferred and used.

Health insurance in Tunisia is provided by the Caisse Nationale de Sécurité Sociale (CNSS), which covers private employees, and the Caisse Nationale des Retraites et Prévoyance Sociale (CNRPS), which covers civil service employees. In addition to CNSS and CNRPS, individual employers negotiate private health insurance packages with private insurance companies to provide added coverage. Private health insurance has been rendered necessary by lack of services provided under the public system. Yet, employers, as in Egypt, must pay a double fee (one to the Government and one to private companies) to secure private coverage.

In Jordan, the Social Security Corporation is responsible for providing health insurance. However, the Government is currently exploring ways to develop a comprehensive insurance coverage system with a mix of public and private delivery.

Lebanon has historically served as the insurance center for the Middle East. Health insurance, however, is largely part of the National Social Security Foundation (NSSF), which is an independent public institution for non-public employees. The NSSF insures about 290,000 workers, or about 900,000 beneficiaries. Insurance benefits are paid for major medical and hospitalization expenses and for maternity programs. To date, NSSF coverage has not been extended to include occupational illness or diseases.

C. Indigenous Private Providers

In the Middle East, private providers are a fundamental part of the health systems of nearly all countries. Data in this section of the Report are supplemented by several cases which illustrate the nature and extent of private service delivery in the region, including:

-- Najjar Hospital, Beirut;
-- Suez Canal University Group Practice, Ismailia, Egypt;
-- Alsalam Hospital, Cairo;
-- Private Pharmacies and Family Planning in Egypt;
-- International Medical Center, Rabat.

In Jordan, approximately 50% to 60% of health care is provided through private channels. There are 26 private hospitals in Jordan with 1,045 beds, and 1,250 private outpatient clinics. In many cases, particularly as regards pharmacists and dentists, private personnel greatly outnumber their public counterparts. The monthly income of private physicians is double that of government physicians, a differential which accounts, in part, for private sector growth. In addition, 60% of all pharmacies in Jordan are privately-owned.

Tunisia's private medical sector is a much less obvious force in health care provision, yet it represents a significant resource in the nation's health system. A majority of "medical centers", essentially clinics with 10-15 inpatient beds per facility, are privately-owned. Most are located in Tunis. Although very few major hospitals are private, investment in private health care facilities -- centers and clinics -- is substantial, over $18 million between 1978 and 1982. This is nearly equal to the investment achieved in the public health sector in the same period. Approximately 27% (400) of Tunisia's physicians are employed in the private sector, and 50% of this group practice in Tunis. About 14% of Tunisian-trained nurses are employed in the private sector. Nearly all pharmacies in Tunisia are privately-owned, although they rely on the public Central Pharmacy of Tunisia for their imported and domestically-produced supplies.

In Lebanon, the private sector had been the traditional provider of approximately 80% of the country's health care. Because of the war, accurate information on the current status of the health sector is difficult to obtain. As might be expected, there is a severe shortage of medical personnel in rural areas. Of the 2,000 physicians in Lebanon, the vast majority practice in the private sector and work in Beirut. There are about 100 private for-profit hospitals in Lebanon, and private outpatient dispensaries number about 150. Over the past ten years, there has emerged a serious financing problem between public and private sectors. Since private sector facilities have risen to meet the country's growing health care demands, public funds have gone into reimbursement of services delivered in the private sector. A lack of strict public sector management and oversight of these reimbursement mechanisms has resulted in a hemorrhage of public finance to pay for publicly-contracted but unmonitored service delivery in the private sector. This situation will need to be resolved in a non-confrontational manner if the public and private sectors wish to continue to work together.

The most is known about the private health sector in Egypt. 12,000 private physicians practice in Egypt, 4,000 of whom are in rural areas. There are also 280 inpatient medical facilities and 478 polyclinics in the private sector. About two-thirds of these facilities are located in Cairo and Alexandria. There are 363 private laboratories in Egypt, and it is clear that the private health sector is growing rapidly. Private investment in health facilities is estimated at LE 50 million a year, double the public investment in health. Of the 16,000 pharmacists registered in Egypt, 13,000 work in the private sector.

Overall assessment of the level of private providers in these countries indicates a sizeable and growing role for private sector health delivery, and a current and potential role as a partner with the public sector.

D. Role of the Multinational Corporation

Multinational corporations play a variety of major roles affecting health and health care in the developing world. A general description of these roles is accompanied by case material illustrating the specific application of private, corporate responses to health problems for the following corporations:

- -- Montedison-Farmitalia/Carlo Erba Training Programs in the Near East;
- -- Seward Surgical;
- -- Merck/Frosst Quality Control in Lebanon;
- -- Allied Chemical Corporation;
- -- Ciba-Geigy in Egypt;
- -- Conoco in the United Arab Emirates;
- -- Exxon in Libya;
- -- Shell International Petroleum, Ltd.;
- -- Goodyear Tire and Rubber Company in Morocco;
- -- Amoco in Egypt;
- -- Unilever in the District of Etah, India;
- -- ARAMCO in Saudi Arabia;
- -- Warner-Lambert in Egypt;
- -- United Medical Enterprises in the United Arab Emirates;
- -- Whittaker Corporation in the Yemen Arab Republic;
- -- Control Data Corporation and the DEVELOP Data Base;
- -- Barclays Bank International Development Fund;
- -- Fluor Corporation in Algeria;
- -- Ballast-Nedam in Saudi Arabia;
- -- Davy McKee Corporation.

1. Health-Related Products Industries

The health role of the major medical and pharmaceuticals producers is a major and crucial one. The extent of the market for imported pharmaceuticals and medical equipment alone is a quick measure of the important role this industry plays in health care in the Middle East. In Egypt, the total market for pharmaceuticals and medical equipment in 1981 was over $434 million, $393 million of which was for pharmaceuticals and $41 million for medical equipment. 70% of the pharmaceuticals are manufactured in Egypt, yet practically no medical equipment is manufactured in the country. Imports account for approximately 75% of the Jordanian pharmaceutical market, and virtually all medical equipment is imported there. The approximated value of pharmaceutical imports into Lebanon in 1980 was nearly $60 million, and virtually all medical equipment is imported from the U.S. and Europe. In Tunisia, approximately 80% of the country's pharmaceuticals and all medical equipment are supplied via imports, in large part from France. The Tunisian private sector imports more than the public health delivery facilities. The total import bill is just over $103 million.

Thus in these countries, pharmaceutical/medical supply companies are major actors for health delivery, since in most cases local production is limited. In addition, in some cases, entire companies have been created within a multinational corporation just to serve the specific health needs of the developing world.

Foreign investment in health product industries, except in Egypt, is not substantial in the focus countries of this Report. Yet, the technical expertise, quality control, and manufacturing resources of the industry, when it does invest, make it an important potential actor in health systems. Foreign investment in the health industry can also lead to higher standards for personnel and production facilities. MNC's training of personnel and product quality standards can be utilized by the public sector to raise overall drug quality among local producers. Cooperative training programs for private and public medical personnel on new drug treatment could also be implemented jointly by development assistance and the private sector.

MNC's spend 5%-8% of annual pharmaceutical sales -- the major leaders spend 15% -- on research and development. Examples of public sector support of and cooperation with this R&D are illustrated in the full Report. The new products and disease process knowledge which resulted are shown to play a major role in the effectiveness of health care systems.

2. Non-Health Products Manufacturers

The health roles of general manufacturers investing in the Middle East are often significant and may provide extensive opportunities for public sector cooperation. The various examples of the many health roles are as follows:

-- General health services for staff/families and surrounding local populations. These health services include disease screening, general care, preventive care, and emergency care. The coverage and type of these health services depend upon the company, the production site, the needs of the community, and the evolution of the corporate investment itself. In general, MNC's invest in a wide variety of resources to assess, provide, and maintain effective health services. These programs represent an open opportunity for a partnership role with public agencies.

-- Disease and vector control programs are, at times, important aspects of multinational corporate investments, particularly those located in remote or rural areas. These programs are often undertaken jointly with governments or universities, and normally extend disease control services to all communities in the geographic area of the investment.

-- The viability of adequate occupational health and safety programs and industrial pollution control in the developing world are direct concerns of multinational corporate management. Most MNC's attempt to implement the safety standards used in their home country settings, and have established models for effective planning, training of personnel, and implementation of such programs in the Middle East.

3. Health Management

Among the most recession-proof industries over the past five years has been that focused on health system management. These companies house significant resources, technical expertise, personnel, and facility management systems of importance to health programs in the developing world. As their international portfolio has expanded, they have become more deeply involved with and experienced in the management and delivery of health services in remote areas.

4. Information and Communications

Among the fastest-growing industries in the world are those related to the collection, processing, and communication of information, and those which act as the communications interface between corporate products and consumers. The resources and expertise of companies in both types of industries have been largely ignored by public health managers and health project design specialists in the developing world. Yet, these resources have been successfully applied to Middle East development problems in the past to the benefit of both the corporations and the public health systems.

5. Banking and Finance

Commercial banking and finance are seldom considered relevant resources by public health sector professionals in governments or development assistance agencies struggling with health project design. Yet, foreign commercial banks can provide the capital for health products manufacturers, may offer project financial management expertise, and have themselves created unique financing facilities for local private sector development.

6. Insurance Industry

The insurance industry is an important potential actor in the health sector in the Middle East. Presently, overseas activities of insurance companies of industrialized countries are very limited and highly regulated. Yet, despite the lack of major industry precedents in the region, industry leaders foresee realistic possibilities for appropriate financing options and private financing schemes to upgrade health insurance in the region.

7. Construction and Engineering

These industries are major employers in the Middle East and thus can be both providers of a wide variety of health services and, at the project's end, suppliers of health care facilities.

E. The OPEC Connection

Distribution of government-controlled surplus in OPEC countries has primarily been via direct bank deposits (49%), government securities (8%-15%), direct investment in OECD countries (19%-24%), and direct loans to Arab and other developing countries (12%-16%). Funds are also channeled through multilateral institutions such as The Arab Investment Company (TAIC), whose goal is to stimulate private sector development. The health sector has not been a major recipient of these monies, but precedents and potential exist for such investments, as is illustrated by two case studies:

-- Kuwait Real Estate Investment Consortium and the Tawfiq Clinic, Tunisia;

-- The Queen Alia Heart Institute, Jordan

Private investors with oil-surplus capital (some $50 billion) invest primarily outside the Arab world. Within the Arab world, Egypt has been the main recipient for construction and tourism projects. Interestingly, some of the most powerful private investors in the oil-surplus countries of the Middle East are women, which may

have implications for future funding of some aspects of health care system development. The current level of private Arab capital in Middle East health systems is small, but experience with and sensitivity to health care sector opportunities is beginning to build.

F. Impact of Developed Country Policies

At times, regulations in developed countries impede the natural course of private sector investment abroad. In developing potential incentives and possibilities for linkages with the private sector, development assistance should be aware of the potential impact of these regulations on the viability of expanding various private corporate roles. Regulations discussed in this Report include tax disincentives to foreign investment and regulatory disincentives to the development of tropical disease pharmaceuticals.

G. National Government Policy

Several national government policies are of specific relevance to private health industries or providers. Awareness of these policies is essential in analyzing the potential for expansion of private health sector activities.

1. Private Provision of Services

Only in Lebanon does a history of direct policy incentives -- an overall laissez-faire policy -- operate to encourage private sector expansion. However, due to private service reimbursement problems and eight years of war, the current public policy is to emphasize greater public regulation of private service delivery and expansion of public service delivery.

In Jordan, there is little government interference on private service delivery, except for legislated ceilings on personnel and facility fees. The Government has taken a positive, supportive role to encourage private delivery within a comprehensive insurance scheme for the country.

Egypt has begun to encourage a more active private sector role in the delivery of health services to complement the level of hard-pressed public delivery. With a few exceptions, however, the Government has yet to provide clear and direct incentives for private providers.

In Tunisia, private service delivery is a separate activity outside the public health system. However, immediate opportunities are present for the creation of incentives which respond to both plans to distribute health personnel and facilities more equitably and incentives to improve service finance.

2. Private Investment in Health Products

Lebanon's policy toward private investment in health products is, again, the most laissez-faire of the four countries.

Jordan has demonstrated generally supportive policies toward domestic production; however, it has not fully opened the health products industry to expanded private investment. The most important policy incentives available to Jordan are those which would allow greater amounts of capital into private companies or those which would allow joint ventures with larger multinational corporations.

Egypt actively encourages both multinational and domestic investment in both the pharmaceutical and medical supply industries. However, Egypt's distribution and pricing policy for pharmaceutical products is very stringent and closely regulated, resulting in low profitability levels for public and private enterprises.

Tunisia's policy toward health products investment is most centralized. Centralized control over chemical inputs and product lines and emphasis on regional development limit the expansion of private roles in this sector.

3. Occupational Health and Safety

Although most countries have OHS legislation, enforcement is difficult, trained personnel are hard to find, OHS equipment is expensive, and OHS policy is handled by a variety of government departments, making management of the policy difficult to implement. Tunisian, Jordanian, and Egyptian experiences with OHS legislation and its enforcement are described in this section.

4. Patent and Trademark

The issue of intellectual property is a divisive one for multinational corporations and developing countries. Egypt, Lebanon, and Tunisia all exclude pharmaceuticals from patentability, thereby limiting the local manufacture of drugs patented in other countries, and also limiting MNC interest in investing in the local drug industry. Only Jordan has no specific exclusions.

H. Development Assistance

Development assistance relations of many "donor" countries with middle East "recipient" governments have become tightly intermeshed packages of project grant aid, fixed commodities financing, and commercial trade credits. The table on the following pages outlines the roles of major development agencies in the region and indicates their private sector policy and experience.

Development Assistance Summary

Agency Name	Aid Expenditure $ millions: Fiscal Year	Aid Expenditure $ millions: Amount	Type of Aid	Private Sector: Policy	Private Sector: Precedent*	Health Sector Project Precedents	Focus on Arab Nations	Middle East countries emphasized, if any
1. Kuwait Fund for Arab Economic Development	1982	769.5	technical asst. grants, loans	supportive	yes/G	none	yes	Tunisia
2. Abu Dhabi Fund for Arab Economic Development	1982	34.7	loans, equity, credit guarantees	supportive	yes/G	none	no	Tunisia
3. Saudi Fund for Development	1981/82	609.5	loans, grants	not via direct finance; can co-finance where private sector is present if Saudi loan remains public		yes, minor hospital-level facilities	no	Jordan, Morocco, North Yemen
4. Arab Fund for Social & Economic Development	1982	237.2	loans	supportive	yes/G	none	yes	Egypt, Jordan, Tunisia
5. OPEC Fund for Development	1982	366.4	loans, grants	supportive	yes/G	yes, minor hospital-level facilities	no	-
6. Islamic Development Bank	1982	527.8	loans, credit guarantees, equity	supportive	yes/G	none	no	-
7. Agency for International Development (U.S.)	1982	6500.0 worldwide	grants, loans, technical assistance	supportive	yes/H	yes, all types, but few with private sector	no	Egypt, Jordan, Morocco, Lebanon, Yemen Arab Republic
8. Overseas Development Administration (U.K.)	1981	2000.0	grants, loans	none	-	yes, all types	no	Egypt, Yemen Arab Republic, Jordan

TABLE E.S. 1 (cont.)

Agency Name	Aid Expenditure $ millions: Fiscal Year	Aid Expenditure $ millions: Amount	Type of Aid	Private Sector: Policy	Private Sector: Precedent*	Health Sector Project Precedents	Focus on Arab Nations	Middle East countries emphasized, if any
9. Canadian International Development Agency	1981	1500.0	grants, loans, export credits	supportive	yes/G	yes, minor	no	Egypt
10. European Economic Community	1981	1700.0	food subsidies, trade preference, loans	supportive	yes/G	yes, minor urban health	no	Egypt, Jordan, Tunisia
11. Japanese Agencies	1981	2600.0	grants, loans, technical assistance	supportive	yes/G	yes, hospital-level services; disease control	no	Egypt
12. IBRD/IDA	1982	19139.0	loans	supportive	yes/G	yes, minor	no	-
13. International Finance Corporation	1982	611.8	loans, equity	supportive	yes/H	yes	no	Egypt, Jordan, Tunisia
14. WHO	1982	111.0	technical asst.	mixed	yes/H	yes	no	-
15. UNIDO	1981	35.9**	technical asst.	mixed	yes/G	yes	no	-
16. UNCTC	1982	9.03**	N/A	negative re: multi-nationals; positive re: indigenous business		yes, research	no	-
17. UNDP	1981	731.6	grant, technical assistance	none	-	yes, minor	no	-
18. UNICEF	N/A	N/A	grant, commodity, technical assistance	supportive	yes/H	yes, only recently	no	-

* Yes/G = General cooperation projects, but not in the health sector.
Yes/H = Private cooperation precedent is in the health sector.
** Budget.

As noted in the table, few agencies have both the private sector policies and experience with implementing those policies in the health sector. Thus, the building of sustainable project partnerships between development assistance actors and the private sector will be a rather uncharted course, but certainly not impossible or unprecedented.

PROCESS OF INTERACTION

If public and development assistance professionals are to forge a public health partnership with private sector health activities, then they must understand not only the nature and level of these activities, but the web of relationships and interdependencies that link the various private actors together in their health sector roles.

This understanding of process as well as data can become a roadmap for directing public policy and development assistance actors to those private sector health partnerships which are most appropriate and which have the greatest likelihood of success.

Beyond the Public Prescription analyzes this process of interaction, and possible public/development assistance roles via the use of hypothetical situations based on case material and the extensive personal corporate interviews which were part of the data collection phase of the Report.

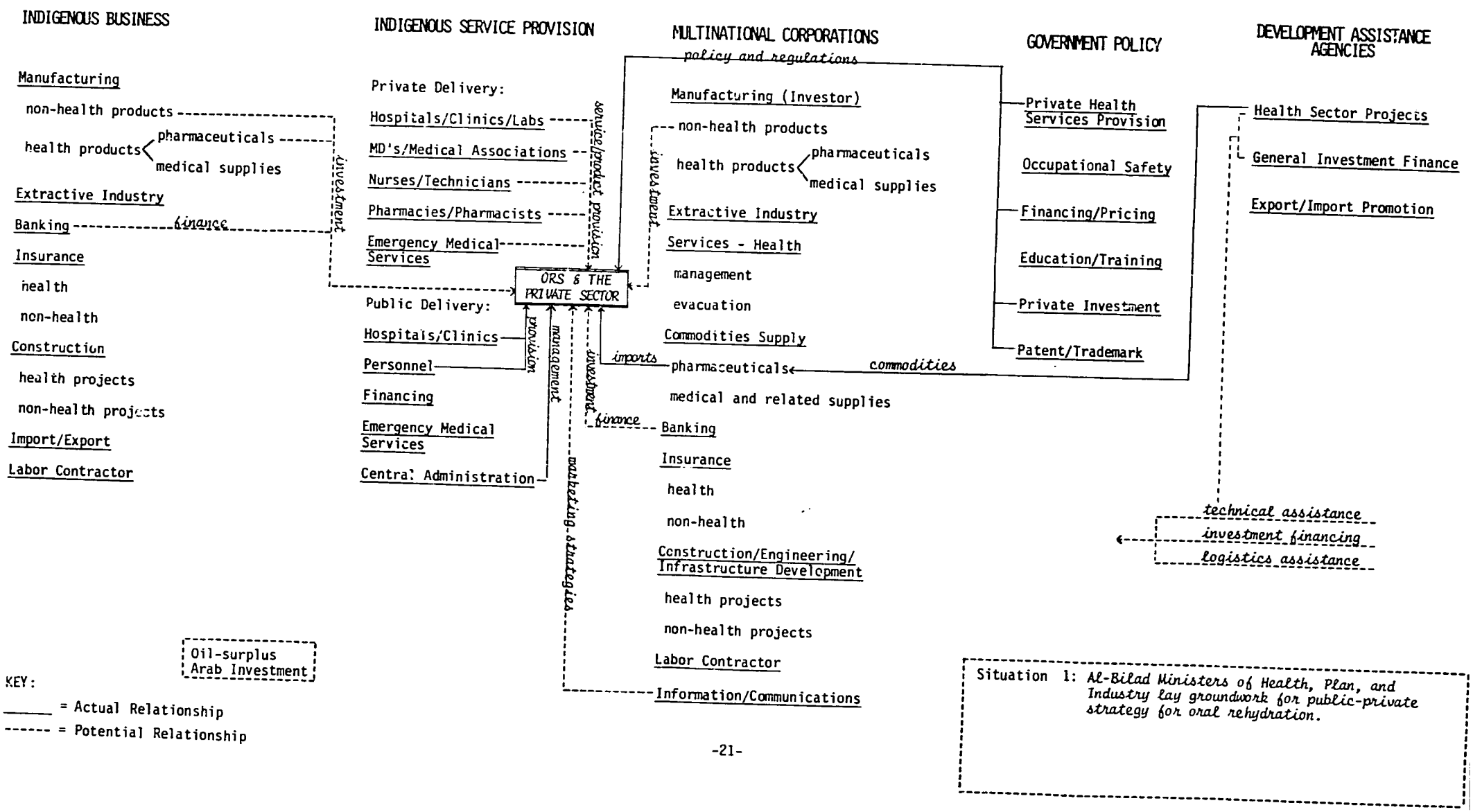
Nine hypothetical situations in a country called "Al-Bilad" are found in the full Report. Three of these are included in this Executive Summary, along with charts diagramming the many interactions and points of contact between public and private sectors in health activity.

1. THE PRIVATE SECTOR AND ORAL REHYDRATION

As in most developing countries, one of Al-Bilad's primary public health problems, for adults as well as (and more severely) for children, is diarrheal disease. Until recently, the Ministry of Health of Al-Bilad and its cooperating development assistance agencies have been combatting the problem on two fronts. First, using commodity credits from the aid agencies, the Government has been importing large quantities of oral rehydration salts (ORS) packets produced in the U.S. and Europe. ORS is a simple combination of salt, sodium bicarbonate, potassium chloride and sugar which, when combined with water, restores to the body the fluids, nutrients, and minerals lost through the dehydration associated with diarrhea. Distribution of these special packets is one of the keystones of the Government's attack on the mortality resulting from diarrheal disease.

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET



The method for that distribution has been reliance on and expansion of the public system of maternal/child health clinics. All programs in these clinics have emphasized the importance of oral rehydration and have provided free distribution of ORS. On the recommendation of an expert provided by an aid agency, a modest public education campaign has also been undertaken, largely using two-color posters placed in clinics, hospitals, and government ministries.

The results have been less than desired. Major logistics problems have left most of the imported ORS deteriorating on the docks or in warehouses. Yet, no local firms have the capability to produce either the salts or the liquid rehydration product.

There has been no expansion in subsequent demand for additional ORS among those mothers who have previously visited the public clinics and participated in the education programs. The number of serious child-dehydration cases seen in the public hospitals has not declined. No one in the public sector seems to know what the status of diarrhea treatment is in the private health systems, or what programs are being undertaken there.

Returning from an international conference on oral rehydration the Minister is frustrated by his apparent inability to achieve results in the face of the relative simplicity of the ORS solution. Not only is the current effort not having much of an impact, he feels it may not even make much long-term sense. One of Al-Bilad's primary exports is sugar, for example; why get into a position of having to import a product one of whose four ingredients is sugar? Furthermore, why rely so heavily on production or marketing in the public sector at all? The Minister arranges a meeting with his two close friends, the Ministers of Industry and Plan, to discuss the situation and forge a solution that both meets Al-Bilad's immediate needs and creates long-term supply, marketing and distribution channels to support and supply public health programs, private health facilities, and the general marketplace.

The plan derived is four-pronged. The current public maternal/child health programs would be retained and supplied in so far as possible with the imported product. As a stopgap measure, there are few alternatives. However, the Minister of Health would seek expanded grant assistance to improve the logistics end of the distribution problem.

The Ministry of Industry confirms the Minister of Health's suspicion that no local companies, drug or food, produce oral rehydration products, weaning commodities or other fluid consumer commodities upon which oral rehydration fluids or salts production could be built. The Minister of Plan, however, notes that two months ago, two representatives of the Scandinavian Foods Corporation had visited his office

to discuss procedures and opportunities for investment in Al-Bilad. Prior to the meeting, one of his staff had done some checking and found that among the company's many beverage products is a consumer soft drink, marketed widely in Europe, for use by both professional and amateur athletes to counter dehydration from many aerobic sports. In essence, the product resembles ORS-plus-water. The Ministers decide that the second prong of the plan would be to contact Scandinavian Foods and put the company in touch with a local drug or food producer for discussions on a possible joint venture, one product of which would be understood to be a local version of the company's rehydration soft drink, to be marketed in local food stores, as well as packets of ORS to be made available to private pharmacies and government health programs. The Minister of Plan agrees to contact the Minister of Economy and begin developing an investment package of financing, tax holidays, and import incentives to attract Scandinavian Foods. The Minister of Health would also notify the appropriate bilateral aid agency and commercial officer regarding the venture and request that their headquarters staff contact and encourage the company at its Stockholm headquarters. If this strategy of joint venture private investment fails, the Minister of Health will approach development aid agencies for investment financing to assist local private food and drug businesses to expand their product lines to include ORS and fluids.

On the marketing side, it is generally agreed that the poster campaign had lacked both the breadth of distribution and the quality needed to attract attention and get parents interested in obtaining ORS. Even if the Ministers assumed that the investment deal would go through, that local products would be available in the general market, and that the Scandinavian Foods joint venture would, in its own self-interest, ensure that the advertising of the product attracted the public, at best this process would not culminate in market demand for at least two or three years. How could public demand for ORS and its fluid equivalent be raised in the near term? The Minister of Health agrees to approach a development aid agency for technical assistance, and to insist that the assistance come, not from university communications "specialists" this time, but from an international advertising company itself, either via an unpaid, public service arrangement or via contract paid by the aid agency. Moreover, the Minister of Plan suggests that the request be made explicitly for the long term, so that the outside industry representatives would be available to adjust the campaign as it developed. Before the call is made, the Minister of Industry agrees to have one of his staff research the best advertising firms so that the Minister of Health would have some concrete suggestions for the aid agency.

Finally, it is clear that outlets for the ORS and rehydration fluids must be expanded. The private providers of health care and health products deliver upwards of three-quarters of the health care in Al-Bilad and invest annually as much as the Ministry of Health in the national system. Their cooperation has to be sought immediately,

and the products made available through their clinics, programs, and stores. The Minister of Health agrees to call the directors of the physicians' and the pharmacists' syndicates as well as the heads of the ten major private facilities in the country for an emergency meeting on the subject. The Minister of Plan agrees to see that the Prime Minister opens the meeting and underlines the Government's commitment to developing a sustainable solution to the diarrhea problem.

As the meeting adjourns, the Minister of Health draws a deep breath and picks up the phone to fight the next battle, selling the private/public strategy to the holders of one of the financial keys, the international aid agencies.

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2. AL-WATAN, AL-BILAD AND MEDICAL MANAGEMENT, LTD.

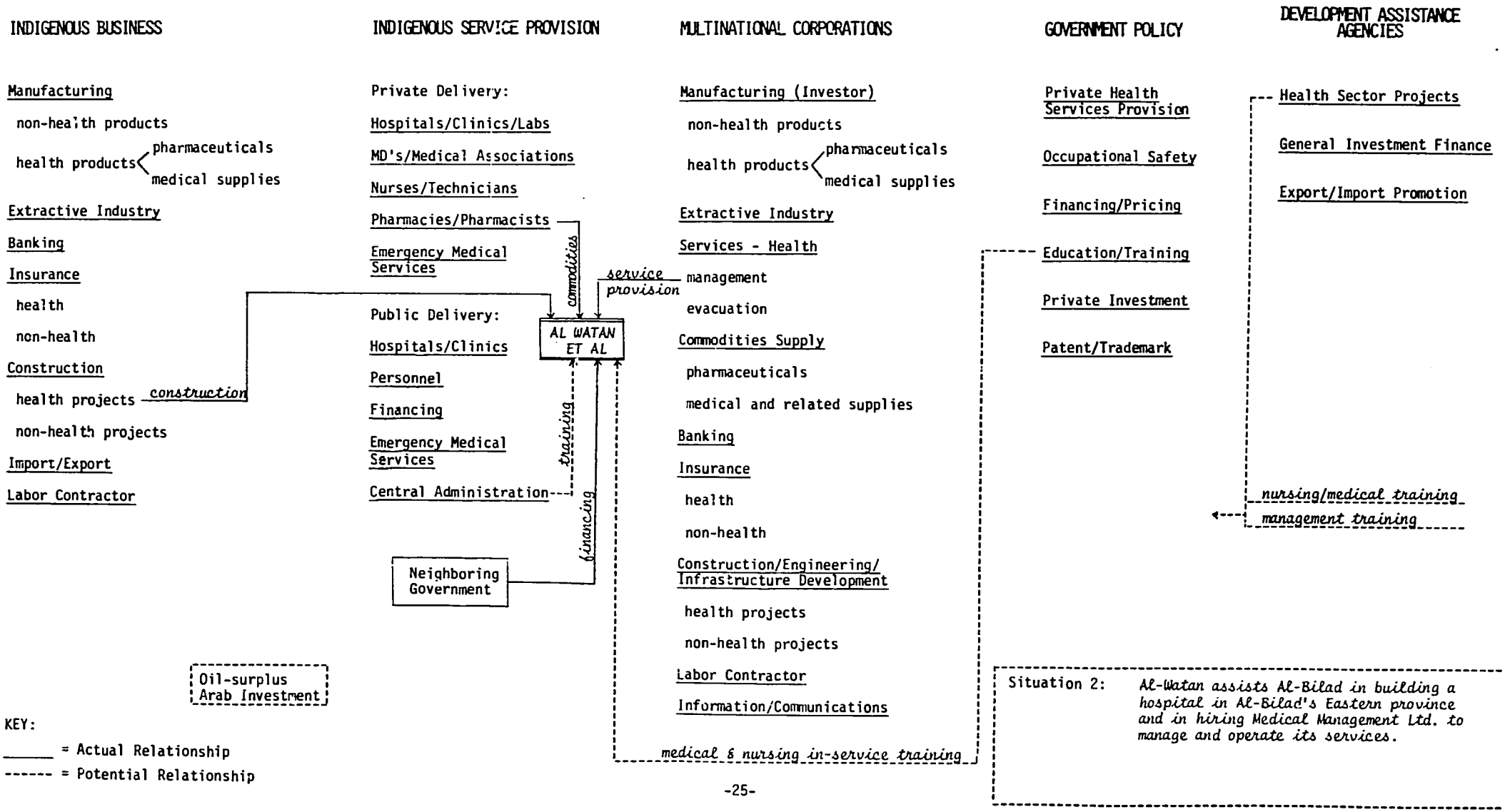
Several years ago with the assistance of its neighbor, Al-Watan, Al-Bilad built a new (and the only) hospital and outpatient facility in the heart of Al-Bilad's eastern province. Upon completion of the facility, however, Al-Bilad found its resources to be insufficient to fully staff and operate the hospital. It thus turned once again to Al-Watan for advice and assistance. Al-Watan responded positively and suggested Medical Management, Ltd., a British facilities design and management firm as a contractor to staff, operate, and manage the facility.

In the last year, Medical Management has brought the facility beyond the point of full operation. Overwhelmed by the demand for services in the province, the facility's management has searched for a way to deflect some of the demand from the central hospital and clinics. Its solution has been to purchase two MASH-type tents (mobile tents usually used to provide medical/surgical facilities in military combat areas) and transport vehicles, and to conduct outpatient and minor surgery clinics in the more distant areas of the province. Twice a month these units go out for four-day periods to provide services in the rural mountainous areas. In turn, they also act as emergency transport vehicles, bringing the more difficult cases back to the hospital for treatment.

In this, as in all of its projects, Medical Management has taken particular concern with quality control and in-service personnel training. The hospital has a small library, which contains up-to-date copies of all key professional journals. Both physicians and nurses are regularly given skill up-grading seminars by visiting Medical Management trainers, and, if part of the project for longer than two years, are sent to a major medical or nursing school in Europe or Britain for refresher work.

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET



Thus, among the many opportunities for public and development assistance collaboration with the Medical Management facility is personnel training. The facility represents not only an up-to-date hospital training setting, but also an opportunity for rural service delivery training using the mobile MASH units. The opportunity is significant in Al-Bilad since the Government and development assistance agencies spend nearly a half million dollars a year to train public physicians and nurses abroad and to bring in outside technical experts to provide in-service skill up-grading to public personnel. That figure could be drastically reduced if an arrangement could be made to link into the Medical Management facility.

A second area of training opportunity is in facilities management. The Medical Management staff is highly trained in health management skills, and, of necessity, has learned to adapt that sophistication to the needs of and realistic possibilities in the remote province. That pragmatic experience together with the underlying sophisticated skills is almost desperately needed in Al-Bilad's public health facility system, where most managers are part-time and poorly trained. Again, the public and development assistance sectors could approach facility management about arranging both on-site training and a series of management seminars in Al-Bilad's capital city for Ministry of Health personnel.

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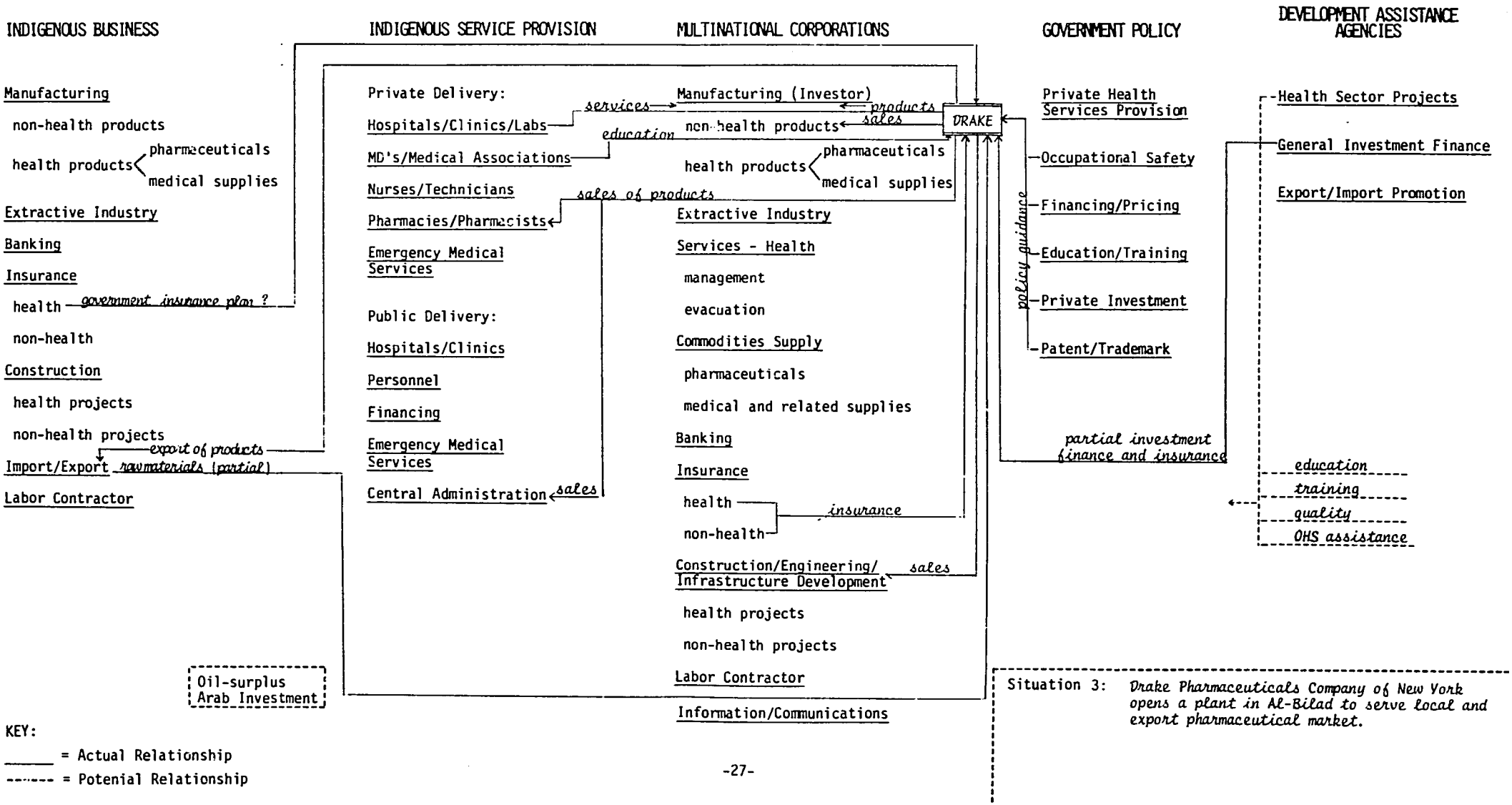
3. DRAKE PHARMACEUTICALS COMPANY, NEW YORK

After many false starts and investment delays, the Drake Pharmaceuticals Company, the second largest multinational drug and chemicals firm in the world, with plants on nearly every continent, last year completed construction of a wholly-owned pharmaceuticals plant in Al-Bilad's port city. The facility will produce basic drugs for the local and export market and employ 3,000 workers. Drake will also sell to Al-Bilad's military and public health systems through existing procurement channels but at preferential prices.

Given the importance of sanitary practices to product quality control, Drake's Al-Bilad management is particularly concerned about worker hygiene. Drake maintains a health and hygiene office at the plant staffed by three public health/sanitation specialists, one of whom is a U.S. citizen and two of whom are nationals of Al-Bilad whose skills were up-graded in Drake-financed courses in the U.S. prior to the plant's opening. An extensive worker education system is in place in the plant to train employees formally and informally in hygiene practices.

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET



Occupational health and safety standards are those of the Drake Company in the U.S. A five-bed dispensary is maintained at the plant, with a local private physician on-site for normal employee health examinations five mornings a week. Drake is in the process of negotiating with a private group practice and a local private hospital for emergency and other health care benefits for employees and their families. Drake management is unclear at this point as to how a financing scheme for these services will fit in with the policies of the Ministry of Health. Drake has few contacts in that Ministry, as all project negotiations were held with the Ministers of Finance, Economy, and Plan.

Manager and technician training for its skilled employees is financed by Drake at U.S. and European institutions. Drake is not enthusiastic about this situation because of the expense involved in the face of fairly high managerial turnover (the company's experience in other developing countries has led it to expect a 20% per year turnover of local skilled and managerial personnel), but the technical programs in Al-Bilad's post-secondary schools leave much to be desired. If the company could find a local, skill-up-grading alternative, it would seriously consider changing its managerial and technical training approach.

Drake's Al-Bilad plant is also undertaking a series of educational seminars for local physicians regarding diagnostic and therapeutic approaches to the major diseases and health problems of Al-Bilad.

The presence of the Drake plant and the company's extensive experience in the developing world provide a number of opportunities for public and development agency cooperation. Moreover, those agencies hold the keys to several of Drake's problems, and thus the company has a direct incentive to work with development/public agency programs, provided the programs are relevant to its business needs and expertise.

Among the overtures agencies might make to the company are:

-- Expansion of its physician seminars to include public health physicians and ministerial personnel;

-- Initiation, perhaps with development assistance seed financing, of similar pharmacist in-service education programs;

-- Technical assistance relations with the Ministry of Health on issues such as product quality control, thereby also giving Drake its needed contacts in the Ministry for an insurance decision on its employee health program;

-- Expansion of its worker hygiene education programs to include general health and nutrition information provided by development assistance and public agencies;

-- Cooperation with health and post-secondary business institutions to improve curriculum and teaching.

Drake has developed programs and procedures that will serve its purposes. Thus, it is unlikely to initiate the public dialogue. Its experience, problems, and programs are such, however, that it is likely to be receptive to development assistance "good offices" and joint financing for programs that serve both its needs and those of public agencies.

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PROJECT OPTIONS

Four general categories of project options are available to development assistance. These options represent areas in which private resources/networks/expertise could be matched with and therefore expand the availability and cost-effectiveness of aid resources in the interest of the former's market concern and the latter's public mandate. These options are summarized below; a full analysis of the advantages and disadvantages of each category is contained in the full Report.

1. Expansion of Existing Project Areas

A number of opportunities are available for simply grafting private linkages onto existing project areas already pursued by aid agencies. Since such private sector "components" of projects would be fairly small, however, it is unlikely that they would leverage much in the way of private finance. For the most part, project activities in this system would need to be largely aid-financed, but could expect varying degrees of private sector technical assistance and in-kind contributions. Examples of these project components and the ways in which they build on existing public and private health systems are explored in detail in the full Report. In brief, these examples include:

-- In-service training for private pharmacists to improve diagnostic skills;

-- Improvement of national logistics and warehousing systems;

-- Provision of technical assistance to develop national policy options for government-private sector relations in health;

-- Provision of short-term training funds to government health sector officials to gain business skills, knowledge, and management techniques.

From an aid agency's point of view, the advantages of this Option and these types of project components are clear. Not only do they build on and/or maximize existing private roles, they also:

-- Are consistent with existing public mandates;

-- Do not require major project portfolio revision;

-- Build on existing professional capability within aid agencies and thus do not necessarily require skill retooling among aid agency staff;

-- Do not require major organizational changes within aid agencies, i.e., do not require that project development time-frames be greatly altered, since there is little corporate finance involved;

-- Are consistent with, or at least do not violate, national government policy within many countries in the Middle East.

The disadvantages of an exclusive reliance on this approach to private relationships hinges not on what these components accomplish, but on what they do not accomplish. The levels of private resources and expertise are significant in the Middle East, are growing rapidly, and have potential for even more rapid expansion. The relatively minor project portfolio adjustments represented by additions to existing ways of distributing aid, if relied on alone, do not take full advantage of the resource-leveraging opportunity aid agencies and national governments have in the health sectors of the Middle East.

2. New Projects Consistent With Tradition

Aid agencies' second option is to take project portfolio diversification one step further. This option would expand project activity into new areas which have not to date been part of the agencies' substantive concerns; which build on private sector resources, expertise, concerns, and needs; but, which remain consistent with the types and structure of projects within the existing project portfolio. Examples of projects which would implement a decision to pursue this option include:

-- Assistance in the creation of private sector-government partnerships to implement sustainable, enforceable, occupational health and safety standards and systems;

-- Project initiatives in the design, capitalization, and operation of private or quasi-private insurance scheme alternatives to public financing;

-- Training for development assistance professionals in basic business concepts and structures, and information exchange with business executives on goals and operation of development assistance to (a) provide forums for business executives to meet and exchange views with development assistance counterparts, and (b) increase the ability of the development assistance professionals to communicate effectively with business;

-- Projects for training national government officials on dispute resolution techniques to resolve conflicts and confrontation between the private sector and national governments over health issues.

The advantages for aid agencies in initiating new project areas such as those illustrated in Option 2 above are severalfold. While these project areas expand the agencies' substantive involvement in development, they nevertheless remain consistent with agency mandates which emphasize government-to-government aid relations. Furthermore, projects under Option 2 do not require structural or project-approval timeframe alterations in public aid agency procedures. Finally, by working more fundamentally with the private sector at all stages of project development, such projects may, in the medium-term, leverage greater resources than the simple project component option described previously.

The disadvantages to Option 2 are at least twofold. For many public agencies, it will require new, albeit not radically new, technical skills on the part of agency health staffs (e.g., occupational health and insurance expertise). Second, the option retains the traditional framework of aid agencies as public sector intermediaries or financiers, and thus limits the ability of the agencies to become engaged in the more fundamental private resource-leveraging opportunities described in Options 3 and 4 below.

3. New Innovative Project Directions

Charting a new course, aid agencies can begin to leverage their funds to address fundamental health systems problems -- investment and recurrent finance. Although this category of project has the potential for attracting high levels of private financing and cooperation, it would entail major structural and staffing changes in the aid agency. Examples include:

-- Cooperation with major international or local banks to capitalize a health sector equivalent of a development bank. The bank could offer small loans to private health practices, provided that these practices were established in underserved areas. Second, the bank could provide financing for plant expansion and equipment of private health products industries to produce key drug commodities such as ORS.

-- Exploration of private finance alternatives for health sector projects. The public aid agency could become a technical and/or financial bridge between the public and the private health sector, providing project technical design assistance and financing the early feasibility studies required by private financial institutions.

-- Provision of direct capital finance for private and state-owned plant and equipment in the health services and products industries.

The advantages of such projects involve both their use of leveraging and their direct pursuit of key production and market bottlenecks that inhibit rapid expansion of private (and public) production and service provision systems.

For most public aid agencies, however, the disadvantages of Option 3 are probably fairly imposing. Not only is the identification and assessment process for such projects unfamiliar to aid health officers, there are few health sector precedents in the development assistance community to which they could turn for guidance and re-assurance. Four additional disadvantages also make Option 3 difficult to implement.

First, these potential projects require staff professional capabilities (project finance, banking, etc.) which are not normally found in health bureaus.

Second, because Option 3 envisages financial leveraging and co-financing and/or involvement directly in production industries, it would require speeding agency project review and approval processes. Few financial institutions, for example, will wait out a two-year project review and approval process before an agency even decides to become involved as a technical and financial bridge for a quasi-private health venture. Private banking institutions, when faced with such (for them) small projects, think in terms of weeks, not years, to approval.

Furthermore, once a project is established (e.g., the Health Development Bank), private sector partners will be expecting a minimum of bureaucracy and a maximum of financial or product turnover from

the investment. Speedy decision processes, even within aid projects, are not one of the strengths of development agencies. The structural changes that would be required in aid agencies to carry out such projects would be significant, unless those agencies would be willing to become passive partners in the projects and forego hands-on management and oversight.

Finally, Option 3 type projects begin to alter, at least, superficially, the usual mandates of public assistance agencies (i.e., grant and commodity support to national governments). New, innovative project directions would require major financial commitments on the part of public agencies. Those commitments would probably reduce the amount of financing available within aid budgets for traditional project areas. Although that restructured assistance budget would ultimately attract greater net resources to the health sector, the superficial (and erroneous) impression would be of an agency turning from its public mandate to private markets. It thus would be a project shift difficult to defend in some policy forums. Although the link between private markets in the health sector and the affordability of public programs for the "poorest of the poor" is tightly forged, this is normally not the way development assistance in health is conceptualized.

4. Direct Investment

The fourth option for public development assistance is to undertake a direct investment or equity role in local health products manufacturing operations or health service provision facilities which address both public health priorities and private sector interests in a country. This option is best illustrated by the activities and structure of the World Bank's affiliate, the International Finance Corporation (see Chapter 10 of the full Report).

As with Option 3, however, for most public aid agencies, implementing this option would require substantial changes in agency process and structure and, in many cases, would also require changes in their legislative mandates to allow direct investment activities.

TAKING ADVANTAGE OF THE OPPORTUNITIES

The extraordinary potential for development assistance and government agencies to expand and direct a significant level of private sector health activity to address public health goals creates at least four program options:

-- No response, which would forego a valuable opportunity for more effective projects and resource-leveraging.

-- Immediate initiation of project identification within aid agencies. This would take advantage of existing opportunities, but would also risk alienating private sector actors by not involving them in the project identification process. The private sector would need to be given the opportunity for serious input into project formulation, not just into project finance, if it is to view itself as an equal, valued partner with an on-going interest in the project's success.

-- The conduct of individual national seminars or conferences to identify the key substantive issues between public and private actors involved in an individual country's health sector and to catalyze the various interests of the government, development assistance, and business in individual countries into a constituency for a partnership solution to those problems. Lasting cooperation between public and private actors in the health sector requires that all actors be party to partnership decisions. The private sector is not courting development assistance or public agencies; if anything, the opposite is true. Thus developing a constituency within the local private sector (and, at times, within sections of the local government itself) is an important first step if all sectors are to work together over the long-term.

-- The conduct of a region-wide meeting (or meetings) to create a regional constituency favoring health sector cooperation. Despite the value of smaller meetings which focus on the specific needs of and potential partners in individual countries, there are valid and important justifications for initially moving beyond individual countries to the creation of a regional partnerships constituency. Much remains to be learned, understood, and absorbed about the process of forging public-private partnerships to address health problems in the region. What are the elements of interaction and project formulation which lead to successful sustainable partnerships? And, how can these positive experiences be broadened to respond to other project areas in other countries? Moreover, a history of public-private conflict may inhibit immediate, pragmatic national dialogue within some countries. If placed within a precedent, region-wide concern with health cooperation, however, such national meetings might become more viable.

CONCLUSION

All of the data and analysis contained in Beyond the Public Prescription can be summarized in three statements:

(1) Maximizing all available resources is crucial in the underfinanced health sectors of the Middle East.

(2) Private resources are currently being extensively applied to health care delivery in the region and have great potential for being expanded if their utility is recognized by public and development decision-makers.

(3) Designing the incentives for that expansion and the partnerships for seeing it through will not be easy, but the effort is and will be essential to the coordinated and expanded delivery of adequate health care in the region.

Clearly, there is much to be learned in this relatively uncharted area of market-based partnerships in the developing world. It is equally clear, however, that such self-interested partnerships represent a promising prospect for meeting public needs. To capitalize on this opportunity, changes in perspective within all sectors are required. Public agencies must be more creative in the development of policies for attracting market resources to address public problems. Business, local and international, must develop more effective means, in its own self-interest, for working with and taking advantage of public incentives and opportunities. Development assistance must make a determined effort to catalyze private relationships, and accept an early leadership role in mediating the differences between public and private actors. The health problems of the Near East are serious; the human and financial stakes are high; the opportunity for joint action is real; the payoff can be to the advantage of all.

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COUNTRY DATA PROFILE

Samples of Private Sector Data for Individual Countries

NATIONAL ECONOMICS AND THE PRIVATE SECTOR

JORDAN

- Over the last 8 years, economic growth has averaged between 7% and 8% per year.
- 1981-85 Development Plan projects $10 billion in investment, half to be sought from the private sector.
- 59% of investment in the 1976-80 Plan originated in the private sector.
- 51% of Jordan's $2.4 billion budget is financed externally, largely via aid from the U.S. and Arab states.
- Half of Jordan's labor force (60% of the non-farm employed) is employed in the government and military sectors. Private industry employs 25% of the labor force.
- Much of private sector investment in Jordan is focused on export-oriented industries.
- A third of Jordan's GDP is accounted for by remittances from Jordanians working abroad.

EGYPT

- Average economic growth over the past five years has been 9% per year, largely due to petroleum and tourism sectors.
- Law 43 (1974) initiated Egypt's Open Door Policy to attract local and foreign private investment.
- Foreign private investment totaled $400 million in 1980, compared to $100 million in 1977, but 64% of all foreign investment projects have been in banking/finance. Only about 80 foreign companies have made equity investments in Egypt, and rarely in the productive sectors.
- Public sector continues to account for 80% of industrial output and 70% of investment. In 1982, however, one-third of government-owned industries ran losses that amounted to one-half of their total capital.
- Planners project a need for $5.9 billion in private investment to finance the current Development Plan.
- 54% of all light industry workers are employed in private enterprises.
- 68% of private foreign exchange went to purchase capital goods in 1982.
- External budget support totaled $2.5 billion last year.

TUNISIA

- Tunisia's 1980-81 economic growth rate was 6%.
- The Government is the prime source of investment capital, but 40% of investment in the productive sectors of the economy is expected to come from private sources.
- Unemployment is among Tunisia's most acute economic problems. In 1980, 49% of the men under 25 years of age were without jobs, compared to 29% in 1966.
- Tunisian trade unions recently negotiated a 30% increase in the minimum wage, an amount triple the country's rate of inflation.
- 45% of investment in manufacturing industries is private capital, compared to 24% during the 1960's.
- 75% of the employed Tunisian labor force works in private establishments.
- 40% of foreign investment is in construction materials and 20% is in food processing.

LEBANON

- At the end of 1980, estimated losses to Lebanon's economy from 6 years of internal strife were $5.1 billion.
- 80% of that loss was in the private sector.
- In the late 1970's, between 82% and 88% of annual investment was in the private sector.
- The country's main economic asset is its well-educated population. The war has had contradictory effects on this asset. On the one hand, 300,000 citizens have emigrated, draining the country of key technical expertise. On the other, remittances from these emigres have kept the country financially solvent.
- Approximately $2 billion of external finance is required to meet current budget deficits and reconstruction needs. To date just under $400 million of that amount has been received.

MOROCCO

- In 1981, Morocco's GDP declined by 1.6%, largely as a result of a drought which devastated agricultural output and of a soft phosphate market.
- 68% of projected investment in the 1981-85 Development Plan is to be sought in the private sector.
- Most planned private investment is being targeted at manufacturing and construction industries. The Plan projects no private investment in the country's social development sector.
- To cover its budget deficit, Morocco is seeking $1.4 billion in external aid financing.

COUNTRY DATA PROFILE

Samples of Private Sector Data for Individual Countries

INDIGENOUS PRIVATE BUSINESS

JORDAN

- There are 5,000 private industrial establishments in Jordan, but only 10% employ over 100 workers. However, these account for 95% of industry's fixed assets and 89% of the value added by industry.
- Between 1976 and 1980, 670 new private factories were licensed, 30% in the chemicals industry.
- The domestic pharmaceutical industry supplies 24% of the country's $47.2 million pharmaceuticals market.
- 62% of the domestic pharmaceuticals market is in the private sector.
- Four domestic pharmaceutical companies serve the Jordanian market, two of which are privately-held and two of which are joint government-private ventures.
- In 1981, the value of domestic pharmaceutical companies' exports was equal to that of their domestic sales.
- Occupational health and safety programs in private domestic manufacturing and energy industries are often limited due to the cost of equipment and the lack of personnel trained in OHS procedures.
- Revenues in the insurance industry have risen rapidly in the last 10 years. The Government is attempting to include private providers in a new national health insurance scheme.
- The private banking sector is a major source of investment financing in the country. 19 indigenous banks operate in the country, but 45% of all commercial banking business is held by the private Arab Bank of Jordan.

EGYPT

- Egypt's 4,000 private light industry establishments account for over 50% of total investment in such industries as leather, woodworking and engineering.
- 80% of the drugs in the Egyptian pharmaceuticals market are domestically produced.
- Only 17% of pharmaceutical consumption is accounted for by direct government purchase; the remainder of the drug market is in private hands.
- 70% of local pharmaceuticals production is accounted for by seven state-owned companies. The remainder is from multinational joint ventures located in the country.
- Until recently, all of the drug and medical supply import market was in the hands of 2 state-owned companies. Recently, several smaller, privately-owned companies have emerged to compete and reduce that figure to 70%.
- Health provision activities of private manufacturing companies normally include rudimentary occupational safety programs. Broader health service provision is limited, but in some cases large companies offer extensive health programs.
- Although 65 private banks have been created in Egypt in the last 8 years, their emphasis has been on financing trade, not on capital finance for development projects.
- Much of the health insurance market is controlled by the quasi-public General Organization of Health Insurance. GOHI covers 2.5 million people and operates 20 hospitals.
- There are also 144 private insurance funds in Egypt, most operated by agencies, syndicates or companies wishing to increase health benefits of their employees or members.

TUNISIA

- Indigenous pharmaceutical production, import and distribution, is largely controlled by the Central Pharmacy of Tunisia (PCT).
- Total value of PCT production in 1980 was $8.7 million, 17% of PCT's turnover.
- Health insurance for public employees is provided by the Caisse Nationale des Retraites et Prévoyance Sociale (CNRPS), covering 1.5 million persons.
- Private sector employees are covered by the national health insurance fund, Caisse Nationale de Sécurité Sociale (CNSS).
- In addition, a variety of health insurance schemes (for government employees) and group health insurance contracts (for private employees) are negotiated with private insurance carriers to provide additional coverage. The value of this activity is estimated to be $20 million per year.

LEBANON

- Reliable data is not available regarding the current level of domestic drug production in Lebanon. Drug counterfeiting problems, originating from illegal, unlicensed plants, are serious.
- Local, private commercial banking remains the source of most capital for private industry, including that in the health sector. 69 private commercial banks currently operate in the country.
- The National Social Security Foundation, with approximately 900,000 beneficiaries, operates the government-controlled health insurance system. It relies on the country's private health services sector, however, for the provision of beneficiary care.

MOROCCO

- 80% of the pharmaceuticals in Morocco are locally formulated/manufactured by 17 different drug manufacturers.
- Total value of locally-produced drugs is approximately $120 million per year.
- 90% of the raw materials used by local drug companies, however, are imported.
- 95% of locally-produced medicines are manufactured under license from multinational corporations.
- The major state-owned corporations provide extensive employee health services, outside the Government's public health system. These companies operate their own hospitals and clinics, hire their own private physicians, or contract with private service providers for extensive employee medical care programs. Annual corporate budgets for these services can be as high as $4.5 million.

COUNTRY DATA PROFILE

Samples of Private Sector Data for Individual Countries

INDIGENOUS PRIVATE SERVICE DELIVERY

JORDAN

- Between 50% and 60% of the health care in Jordan is provided through private channels.
- Public and private investment in health infrastructure is nearly equal.
- There are 26 private hospitals in Jordan, accounting for over 1,000 beds.
- Over 90% of the country's pharmacists are employed in the private sector.
- 60% of the country's pharmacies are privately-owned.
- Approximately half of Jordan's physicians work in private practice.

EGYPT

- There are approximately 12,000 private physicians in Egypt, 4,000 of whom are located in rural areas. Many of these personnel are government employees with part-time private practices.
- Private health facilities in Egypt include approximately 280 hospitals 478 licensed poly-clinics, 12,210 outpatient clinics, and 363 private laboratories. Approximately two-thirds of these facilities are located in Cairo and Alexandria.
- Of the 16,000 pharmacists registered in Egypt, 13,000 work in private pharmacies or in private manufacturing companies. There are over 5,000 private pharmacies in Egypt.
- Private health sector investment is almost double that of the Government in its public health system.
- Experimentation with for-profit group practices associated with public teaching hospitals is underway.

TUNISIA

- Private investment in health facilities between 1978 and 1982 totaled $18.5 million, approximately equal to Government investment in public health infrastructure.
- 80% of Tunisia's medical center beds are in private institutions. However, most hospitals are publicly-operated.
- Approximately 27% (400) of Tunisia's physicians are employed in the private sector. 50% of these private physicians are located in Tunis.
- Approximately 14% of Tunisia's nursing personnel work in private facilities.
- 651 of the country's 785 practicing pharmacists (83%) are employed in the private sector. 40% of these are located in Tunis. Although the numbers of pharmacists in rural areas are small, rural governorates have the greatest rate of growth for private pharmacies, largely due to the saturation of the Tunis market.
- Private Arab investment has been a key factor in development of Tunisia's private clinic system.

LEBANON

- Current data on private health personnel and facilities in Lebanon are difficult to obtain due to the population dislocation and facility damage from the war.
- In the 1970's, approximately 80% of the country's health services were provided in the private sector.
- It is estimated that 2,000 physicians are in private practice in the Beirut area.
- 100 for-profit private hospitals are licensed in and around Beirut, with a total of 3,000 beds. Half of these are located within Beirut.
- Approximately 150 private outpatient dispensaries are registered, but their services are few and periodic.

MOROCCO

- Nearly 50% of the physicians registere in Morocco are in private practice. 35% of this group of 900 physiciens are non-Moroccan.
- 60% of the private medical practices are in the Casablanca-Rabat-Kenitra-Tanger axis.
- 14% of Morocco's nursing personnel are in the private sector, as are nearly all the country's dentists and pharmacists.
- Most private personnel practice in small office settings.
- There are only 79 private clinics in the country, with 2,400 inpatient beds. That figure is 10% of the nation's hospital beds.
- 80% of pharmaceutical distribution in the country takes place via private, retail pharmacies.

COUNTRY DATA PROFILE

Samples of Private Sector Data for Individual Countries

NATIONAL GOVERNMENT POLICY

JORDAN

- Government policy is supportive of private health services provision and seeks expanded private investment in health products industries.
- Occupational health and safety regulations are detailed but difficult to enforce.
- Private joint venture partners are being sought by the Government for several health care products investments. However, capitalization ceilings on private enterprises limit the production capabilities of privately-held drug manufacturing companies.

EGYPT

- Recent policy changes are encouraging public physicians in rural areas to establish part-time private practices. As a result, over 50% of public physicians are remaining in rural areas, once their public tours of service are completed.
- Multinational and domestic private investment in health care products industries is encouraged.
- Occupational safety regulations are detailed, but do not apply to the small businesses which dominate the private industrial sector.

TUNISIA

- Tunisia has instituted few incentives for private health service delivery or for private investment in health care products industries.
- Indeed, the country's patent and license policies discourage foreign investment in health care products manufacturing.
- Occupational health and safety regulations are detailed and relatively strictly enforced due to the strong trade union presence in the country.

LEBANON

- To date, there has been little public policy regulation of or interference with private health services provision. Indeed, many government health services have been delivered in the private sector and the latter has been reimbursed from public budgets.
- Because these reimbursement mechanisms have not been well monitored and have become a significant drain on public finance, however, stricter formal control policies are expected in the future.
- Public health policy is also moving in the direction of greater regulation of private services, and expanded delivery of health services by public institutions.
- Drug quality control, pricing, and counterfeiting problems have led to current efforts to change past laissez-faire policies in the pharmaceuticals sector and to regulate pharmaceutical products and production more closely

MOROCCO

- Private investment in health products industries is encouraged but product lines are subject to government approval.
- There are few regulations discouraging private medical practice, but service quality in private facilities must adhere to publicly-developed standards.

CASE STUDIES INCLUDED IN

BEYOND THE PUBLIC PRESCRIPTION: PRIVATE AND PUBLIC ROLES IN NEAR EAST HEALTH

I. INDIGENOUS BUSINESS

Case 1: Arab Company for Drug Industries and Medical Appliances, (ACDIMA)

The Arab Company for Drug Industries and Medical Appliances, established to increase the region's self-sufficiency in the manufacture of pharmaceuticals and medical supplies, has become a major force in the region's drug and medical supply investments. Among its projects are investment in a multimillion dollar antibiotics plant and construction of glass container factories for drug packaging.

Case 2: Al-Hikma Pharmaceuticals Company and Health Education, Jordan

In 1981, Al-Hikma Pharmaceuticals Company, whose product line includes a limited number of anti-tussives, developed and produced public health education brochures on the causes and treatment of coughs and their possible indication of bronchial disease.

Case 3: Kuwait Oil Company

Kuwait Oil currently provides health care to over 60,000 people in Kuwait, both employees and non-employees. Services are primarily provided by the Ahmadi Hospital with a staff of over 600 and a budget of over $17 million, and include general, surgical, dental, preventive, pharmaceutical and nursing services.

Case 4: Health Services in State-Owned Corporations, Morocco

Two of Morocco's major state-owned corporations, the Office Chérifien des Phosphates and the Office National des Chemins de Fer, maintain extensive hospital and outpatient clinic facilities for their thousands of employees. These are organized and administered by the

companies independently from the Government's public health system, at an annual cost of nearly $10 million. Two other major state-owned companies, the Office National des Transports and the Bureau de Recherches et de Participation Minière, also provide extensive worker health services, although via contracts with private providers and facilities.

Case 5: Misr Spinning and Weaving Company, Mehalla Elkubra, Egypt

Misr Spinning and Weaving provides a wide variety of health services to its employees, their families, and the surrounding community via the company's 200-bed hospital and 23 outpatient clinics. Company management is actively seeking to upgrade the quality and diversity of these services.

Case 6: Cairo Company for Beverages, Egypt

The Cairo Company for Beverages, which employs over 1,000 employees, provides medical check-ups prior to employment and periodically to all workers for early detection of occupational or other diseases.

Case 7: Nasr Company for Manufacturing Televisions, Egypt

This publicly-owned company provides the following OHS care to its employees in accordance with national regulations: free first aid, periodical medical check-ups, and training in occupational health and safety procedures.

Case 8: Helwan Iron & Steel Factory, Egypt

This large publicly-owned company attempts to provide a range of preventive occupational safety measures in such areas as air purification, materials storage, and continuous cleaning of equipment. But, the company's reliance on public funds and the age of its equipment make these procedures difficult to maintain.

Case 9: Nasr Paint and Chemical Company, Egypt

Although the work environment and materials of the chemical industry represent serious occupational health and safety hazards, OHS programs have been largely ineffective due to lack of materials and aging plant technology.

Case 10: The Jordan Electricity Company, Amman

An extensive worker safety and training program has been put in place to reduce the likelihood of electrical accidents, injuries and deaths among workers. In addition, the company runs a series of emergency medical procedures courses for workers to instruct them on the correct rescue techniques for any person felled by electric shock.

Case 11: The Jordan Phosphate Company, Ltd.

Mine safety programs are extensive. In addition, the company operates health clinics, with resident physician and nursing personnel, at each mine site and its own ambulance service to evacuate injured personnel to local hospitals. The greatest company problem in enforcing its safety rules is worker inability to read or failure to heed safety warnings.

Case 12: Jordanian Insurance, A Move Toward the Private Sector

In conjunction with the Pharmacists' Syndicate, Jordan is currently assessing methods to establish a comprehensive medical insurance scheme. The scheme would allow freedom of choice of hospital, physician and pharmacy for beneficiaries, and utilization of all services from the public and private sectors.

II. INDIGENOUS PRIVATE HEALTH SERVICE PROVIDERS

Case 13: Najjar Hospital, Beirut

Two private Lebanese doctors own Najjar Hospital which is a 70-bed facility with about a 90% occupancy rate, staffed by 65 physicians and nurses. All medical and surgical services, except cardiac and vascular surgery, are provided.

Case 14: Suez Canal University Group Practice, Ismailia

In the first attempt in Egypt to mix private practice incentives with public facility service, the Medical Facility of the Suez Canal University has established a Group Practice system for physician faculty members. Revenues from the practice are split between the practicing physicians and the University's educational program. As a result, the University is able to attract and keep quality professors for the Medical Faculty, obtain additional revenues, and deliver quality health services to the area.

Case 15: Alsalam Hospital, Cairo

The 100-bed Alsalam Hospital was established by a small group of private Egyptian physicians. In addition to serving its patients, the hospital has contracts with 24 local and foreign companies to cover employee health insurance for over 9,000 employees.

Case 16: Private Pharmacies and Family Planning in Egypt

In a departure from its normal reliance on public channels, the Egyptian Ministry of Social Affairs has commissioned a local private organization, Family of the Future, to procure and distribute family

planning products through private pharmacies and private medical groups. With management assistance from the Triton Corporation and product advertising campaigns developed by Porter Novelli and Associates, the Family of the Future project is targeted both at carving out a private sector market for family planning materials and demonstrating that such public programs in the private market can be financially self-supporting.

Case 17: International Medical Center, Rabat

A group of private Moroccan physicans, a consortium of local banks, and several foreign investors have joined together to develop and provide state-of-the-art medical services in Morocco's private sector and to contract to the Government and private corporations for the provision of in- and outpatient medical care. In addition, the group is establishing a foundation, affiliated with the Medical Center, to encourage and support clinical research on diseases endemic in the country.

III. MULTINATIONAL CORPORATIONS

Case 18: Montedison-Farmitalia/Carlo Erba: Training in the Middle East

This major pharmaceuticals company has instituted a series of top-level roundtables and conferences in the Middle East to improve the flow of recent diagnosis, research, and therapy information to private hospitals and physicians.

Case 19: Seward Surgical

Seward Surgical has focused on research and development that has led to production of medical supplies, equipment, and pharmaceuticals specifically targeted for use in developing countries.

Case 20: Merck/Frosst Quality Control in Lebanon

The MSD/Frosst plant in Lebanon has implemented a series of quality control procedures and training for its staff which are typical of the way in which MNC pharmaceuticals subsidiaries operate in the developing world.

Case 21: Allied Chemical Corporation and Vaccine Technology

This company has developed a product that can be used to safeguard the quality of vaccines in the developing world. The products testing and distribution are being undertaken by public sector institutions.

Case 22: Ciba-Geigy in Egypt

For the last two years, Ciba-Geigy has joined with the Government of Egypt health authorities in a skin diseases project in Gharbia Governorate in the Nile Delta. Ciba-Geigy has assisted the project with some finance and, in a more major way, with technical assistance. After only 15 months of operation, the project has made a major contribution to the Egyptian health care scene by reliably identifying a previously unknown major leprosy problem in the Nile Delta.

Case 23: Conoco in the United Arab Emirates

Conoco's medical care system in the United Arab Emirates is one of the most extensive in the Middle East. It includes research on health problems and facilities, and operation of major modern hospitals and outpatient clinics in both populated and remote areas.

Case 24: Exxon in Libya

In Libya, Exxon provided, via a network of clinics, both industrial and community health care for expatriates and its Libyan employees and their families. Since 1980, the medical program has been administered by a government-appointed (but Exxon-paid) Libyan medical director.

Case 25: Shell International Petroleum Co. Ltd.

In a wide variety of settings, Royal Dutch Shell establishes medical clinics to provide both inpatient and outpatient services to employees and surrounding communities.

Case 26: Goodyear Tire and Rubber in Morocco

Goodyear operates a health care program for local employees in its plant in Morocco. The service provides general health education and first aid, and is a clearinghouse for work accidents. Goodyear pays for local physicians and all materials.

Case 27: Standard Oil Company (Indiana) in Egypt

Where Amoco has sole ownership of resource exploration or production, health service provisions are made by a corporate medical director, including contracting for local private health facilities to provide occupational, emergency, and general health care for employees and their families. Joint ventures, however, entail an entirely different system of management responsibility.

Case 28: Unilever in the District of Etah, India

Hindustan Lever (a Unilever subsidiary) established an Integrated Rural Development Programme (IRDP) to provide health education, local financing, and agricultural services to more than 35 villages in India. It is an important example of a partnership approach to health and economic problems.

Case 29: ARAMCO in Saudi Arabia

For many years, ARAMCO provided extensive and nearly the only health and medical care in the Eastern province of Saudi Arabia, reaching over 127,000 employees and their families.

Case 30: Warner-Lambert in Egypt

The company's occupational health and safety programs and training are some of the most sophisticated. Its OHS programs in Egypt and around the world include safety engineering to prevent accidents, industrial hygiene, and fire protection.

Case 31: United Medical Enterprises Ltd. in Abu Dhabi

Under contract to the Abu Dhabi National Oil Company, Allied Medical Group (AMG), a company within the British UME group, manages and delivers medical services in hospitals and clinics in remote areas.

Case 32: Whittaker Corporation in the Yemen Arab Republic

Whittaker's health systems management business in the Middle East includes the management and operation of the Al-Salam Hospital in a remote area in the Yemen Arab Republic.

Case 33: Control Data Corporation and the DEVELOP Data Base

A trend-setting corporation in many aspects of its work, Control Data Corporation's overall goal is to meet social needs via the marketplace. It thus provides information and data processing products in such areas as education, vocational training and rural development. In the international arena, the company's DEVELOP data base provides subscribers with on-line access to detailed descriptions of technologies, processes, networks, organizational profiles, literature, marketed products, and research in progress in a variety of developing country economic sectors, including health.

Case 34: Barclays Bank International Ltd.: International Development Fund

Barclays has established a development fund to bridge the gap between commercial finance and development assistance in the areas of agriculture, industry, and commercial projects. Although health sector funds have not been specifically supported, it is a significant example of a private banking role in development.

Case 35: Fluor Corporation in Algeria

This major construction and drilling firm established a series of medical clinics, hired nurses and physicians, acquired supplies and drilled for water in the southern Sahara in Algeria. All health services are available to employees, their families, as well as to the nomadic populations of the area.

Case 36: Ballast-Nedam in Saudi Arabia

In the mid-1970's, Ballast-Nedam undertook to build eleven complete towns in Saudi Arabia. The company had to provide health services for its work force in empty desert areas. Hospitals, clinics, and other facilities were built. Water wells were drilled and a water quality control program established.

Case 37: Davy McKee

Davy McKee's approach to health services as part of its construction projects is most comprehensive and includes vaccination services, emergency care, sewage systems, nutrition surveys and programs, as well as programs to address the mental health of employees and their families.

Case 38: The Corporate Response to Lebanon's Reconstruction

In response to Lebanon's need for reconstruction assistance in 1982, a wide range of corporations with business interests in the Middle East stepped forward to provide millions of dollars in aid and more in materials and in-kind services to assist in rebuilding and in the provision of emergency health and medical services to Beirut refugees.

IV. OPEC INVESTMENT

Case 39: Kuwait Real Estate Investment Consortium and the Tawfiq Clinic, Tunisia

The clinic, providing private health services, is a joint venture between private sector agencies and individuals; 70% is held by non-Tunisian oil-surplus investors including 20% by the Kuwait Real Estate Investment Consortium, 30% by the Islamic Development Bank, and 20% by Saudi investor, Salah Kamel. The remaining 30% is Tunisian-held.

Case 40: Queen Alia Heart Institute, Jordan

Arab royalty has played a quiet, behind-the-scenes role in financing health infrastructures throughout the Middle East. For example, Sultan Qaboos Ibn Sa'id of Oman gave $19.6 million to Jordan for construction of the 100-bed Queen Alia Heart Institute, inaugurated in Amman in April 1983.