

CPR

RECEIVED

SEP 24 1984

PIACT/PATH

CENTER FOR PUBLIC RESOURCES

004271

000894
5

EXPANDING PRIVATE ROLES IN MIDDLE EAST HEALTH

A Regional Strategic Planning Meeting

21

SUMMARY OF PROCEEDINGS

2980150

NEB-0150-A-00-

2072-00

I. INTRODUCTION

From April 26 through 28, 1984, Middle East private and public health sector executives and leaders gathered in Burgenstock, Switzerland to examine concrete opportunities for encouraging greater cooperation between public and private sectors in improving the health services of the region and the health status of its population. Participants from the region included private medical care providers, government health officials, private bankers and investors, university researchers, multinational and local corporate executives from a range of industries, and development assistance officers. A list of participants is attached.

The meeting was co-sponsored by the Center for Public Resources (New York), the International Chamber of Commerce (Paris), and the Arab International Medical Group (Tunis). Major support for the meeting was provided by the U.S. Agency for International Development. Other support for the meeting and associated project activities was received from Ciba-Geigy, International Hospitals Group, Abbott Laboratories, the Whittaker Corporation, and the Center for Public Resources.

Building on base-line research on private sector roles conducted by the Center for Public Resources, and published in 1983 in CPR's Beyond the Public Prescription: Private and Public Roles in Near East Health, the meeting had three fundamental goals:

- (1) To provide national governments, local business and private service providers from countries in the region, multinational companies, and development assistance agencies with the network and ideas necessary to forge national or corporate cooperative strategies in the health sector;
- (2) To expand corporate, government, and development assistance knowledge regarding the barriers to and incentives for partnerships, based on an examination of actual opportunities in the region;
- (3) To develop, to the extent possible, specific suggestions for collaborative projects, to identify the public or development assistance catalyst role in each, and to assess the private sector resources which might be brought to the partnership.

At the an opening plenary, co-sponsors and AID set the tone for the meeting by emphasizing the unique nature of the gathering, the difficulty of the task to be faced, and yet the overwhelming importance of cooperative, mutually beneficial efforts if sustainable health services were to be expanded in the region.

Meeting participants then organized themselves into five "strategy groups" designed to examine in detail the opportunities for greater private sector involvement in specific health needs and the barriers to expanding private roles. Participants in each of the groups are listed at the beginning of each subsection below. The strategy groups covered the following areas:

- (1) Health products partnerships (how trade, investment, and training decisions are made in the private sector; rationale for a method of public regulation; opportunities for joint public/private problem-solving in the region on health products issues);
- (2) Systems management and administration (the problems of health system materials management, facility administration, and information management; the resources and initiatives of the private sector; government policy on encouraging and using the relevant private resources; opportunities for cooperation);
- (3) Health systems recurrent and investment finance (the experiences and resources of private insurance, HMO, and private health system finance groups within and outside of the Middle East; their application to Middle East finance problems; rationale for and method of government regulation; opportunities for freeing up the market);
- (4) Company-managed health systems (corporations as providers of health care and preventive health programs, their reasoning in becoming involved, their specific areas of expertise; government regulations and rationale; opportunities for cooperation);
- (5) Educating the public through private outlets (current and potential roles of private pharmacies and other commercial outlets, as well as private communication expertise, which could be mobilized to expand and improve health product use; barriers to their expanded use; government policies regarding these resources; opportunities for cooperation).

This summary will review the discussions and project ideas developed within these strategy groups, as well as several overarching project actions recommended by the plenary itself.

Two caveats should be noted. First, it was recognized from the outset that problems in and solutions applicable to the individual issue areas often overlapped specific group parameters. Everything is, to some extent, dependent on everything else. Groups thus took into account ways in which their own potential project ideas would be dependent on the ideas and expertise emerging from other groups.

Second, in a meeting of this type, what happens outside the meeting rooms is as important as the proceedings of the meeting itself. Discussions were conducted, understandings built, and actual projects developed in the corridors. The reality of the resulting closer public-private relationship, and the projects that emerged, will be recorded in the success of the independent ventures being undertaken rather than in this paper.

II. STRATEGY GROUP DISCUSSIONS

Health Products Partnerships

Dr. Rosalyn C. King, Moderator
Dr. Ahmed Alami, Rapporteur
Christian R. Holmes, Rapporteur
Dr. A. N. Walker, Rapporteur

Gary E. Benjamin
Dr. Zakaria Gad

James F. Henry
Dr. Medhat Azmi El-Kattan

The health products strategy group began by setting forth nine areas of concern that would have to be addressed in any productive discussion of closer public-private cooperation regarding the manufacturing, distribution and use of health products in the Middle East. These nine were as follows:

- (1) clarification of business and public policy terms and their use by public and private sectors;
- (2) major product demands existing in the region, from public and private sources;
- (3) extent to which objectives of public and private sectors are compatible;
- (4) relationship between private investment opportunities and their health system impact, so that overall health care is improved;
- (5) general incentives and disincentives to trade and investment in the Middle East in both the public and private sectors, and their specific impact on health products industries;
- (6) availability of sufficient numbers of well-trained professionals and workers required by health products industries;
- (7) constraints in donor/public/private organizations which hinder partnerships;
- (8) types of projects/ventures potentially attractive to investors from within and outside the region;
- (9) ways in which donor/public/private organizations can make contact with potential private sector partners.

The group then specified eight priority targets of opportunity for closer public-private collaboration involving health products, and specified for each the major health sector or policy constraints which contribute to the existence of the problem and thus represent disincentives to expanded private sector collaboration with public agencies and resources. These eight were as follows:

Problems/Constraints

1. Joint Establishment of Health Sector/Products Priorities
 - . lack of health sector priority in development plans
 - . disparity of investment priorities within health sector
 - . lack of local financial resources to see priorities through
2. Improved Product/Sector Data Collection
 - . differences in public vs. private estimates of real demand for health products
 - . validity/reliability of data itself
 - . lack of information on diseases and distribution
 - . lack of technical information (financial as well as medical) specific to the region
3. Communities/Public Education Regarding Health Products and Use
 - . level of over- or self-medication in the region
 - . lack of effective communication tools on health in general onto which products effort could be added
 - . perception that private-sponsored product education would be product "propaganda"
4. Environmental Health Improvements
 - . lack of hygiene education
 - . lack of clean water and sanitation infrastructure
5. Training for Both Management and Technical Personnel
 - . lack of post-graduate continuing education programs
 - . brain drain
 - . variable quality of preparatory education
 - . lack of manpower recruited into the health sector
6. Strengthening of Health Products and Industries Infrastructure
 - . lack of maintenance capability/ personnel for technology
 - . weakness of products delivery system to which infrastructure is linked
7. Regulatory Reform
 - . confusion of registration requirements
 - . patent/trademark policies
8. Product Research and Development
 - . lack of market and health data
 - . pricing policies
 - . conflicting product R&D priorities of public-private sectors

Having set out a variety of areas for closer public/private collaboration and expanded private sector roles on the health products issues, the group then turned specifically to its business participants for insights as to how business would look at the consequences of such collaboration.

In essence, business interprets any opportunity for collaboration as having implications for one or more of the following methods by which it conducts its own operations:

- (1) long-term new investment
- (2) the conduct of an ongoing business
- (3) contractual agreements for specific task accomplishments
- (4) service.

Business applies different criteria when making decisions to become involved with public collaboration, depending on the type of business relationship involved.

For investments, the key criteria are the rate of return to be expected from the investment, the nature of operating control anticipated for the enterprise at issue, and the majority/minority ownership role proposed for the outside/private investor.

Collaboration which involves or affects the operation of ongoing aspects of an individual business would be evaluated largely in terms of how easily and efficiently such collaboration fits into the existing priorities and structures of that business.

The wisdom of undertaking short-term contract arrangements with the public sector to perform specific tasks is judged in terms of the duration of the contract proposed, the reliability of its terms, the

risks it implies for diverting corporate resources from ongoing business priorities, and the projected net cash inflow to the company involved.

Service or pro bono arrangements with the public sector are usually undertaken by companies without financial charge and are a normal part of doing business in the developing world. Motivating incentives for this type of public collaboration include corporate commitment to the region, a genuine desire to assist with its development, and the contribution of pro bono activities to corporate image in the region.

In essence, then, the corporate decision to collaborate with the public sector in any endeavor is a combination of: (a) the company's evaluation of its own strengths and the likelihood of its success in any market or endeavor; and, (b) the attractiveness of the market involved. If the company's own capabilities are significant and the market very attractive, for example, a long-term investment might be the prime vehicle of cooperation. If, on the other hand, the company has expertise in a particular area but the market is not attractive in terms of rate of return or does not fit easily into its other lines of business, then the company may prefer to play a short-term, pro bono role to public sector needs, offering its advice but declining any other role involving a business or financial commitment.

The strategy group then developed a matrix demonstrating the various business roles that would be most likely in relation to a series of public sector needs.

MATRIX

A NEED	B SERVICE	C ONGOING BUSINESS	D INVESTMENT	E CONTRACT
Supply Management	Advice: Order & Storage		Distribution Drugs/Contra- ceptives Warehousing	Distribution Drugs/Contra/ ceptives Warehousing
Data Collection Mass Treatment/ Cure	Advice: Disease Control	Sharing Information with Public Sector	Diagnostic Centers	Disease Control Capital Contract
R&D	New Drug Development	New Drug Development	New Drug Development	New Drug Development
Training	Quality Control Need Estimate	In-Service Training Provision	Training Centers Hospitals	Training Centers Hospitals
Hygiene/ Sanitation Water Diseases			Sewage & Waste Treatment	
Public Education	Publi- cations	Work Force Education Publications	Publications Mass Communi- cation	Publications Mass Communi- cation
Reduce Infant Mortality		New Drugs (e.g. oral rehydration)		

To assist in further development of these opportunities, the group suggested that:

- (1) a regional institution or donor agency prepare a detailed list of regional market opportunities for health products or services investments or contracts, and then communicate this widely to private business;
- (2) a country-by-country examination be made of the health products practices (investment, regulatory, etc.) which the public sector and business find objectionable in each other, so that barriers to the above opportunities can be overcome;
- (3) a sub-group of Burgenstock participants be convened to develop, from the above matrix, specific service or on-going business collaboration opportunities.

Management/Administration

Dr. Nabil Kronfol, Moderator
Peter Edmonds, Rapporteur

Mme. Nagiba Alami
Dr. Juma Khalfan Belhouf
Dr. Hamouda Ben Slama
Khaled Beseiso
Bruce Cornwell
Veronica Elliott
Salah Fakhoury

Dr. Kamel I. Khalil
Bernard Eugene Lorimer
Ronald C. Marston
Dr. Aziz El-Matri
Timothy Seims
Dr. N. A. Sliman

Discussions in this strategy group examined the common problems experienced by both public and private administrators of health facilities and systems, and the ways in which those administrators might either pool resources or encourage greater private sector investment to resolve these problems.

In the public sector, improvement of management/administration faces six barriers:

- (1) serious shortage of professional facility managers
- (2) dominance of both facility and system management positions by physicians, who are largely without management training
- (3) lack of a rewards system for initiative and innovation
- (4) the accountability of public institutions and systems to a political process and not to a private investment process which demands efficiency and resource maximization
- (5) dependence of budgetary resources on government allocation of public revenues
- (6) lack of true cost accounting procedures.

In a similar vein, health facilities themselves face a series of barriers which inhibit effective planning and management, and often limit their ability to cooperate with public health systems. These include:

- limited perspectives and commitment; effectiveness is measured by short-term profits and goals set by owners, in contrast to the long-term goals of public systems
- accountability to owners and shareholders, not to public policies and public goals;
- although competition exists and should contain prices, institutions often serve limited, isolated clientele so that cost containment motivations are not operative;
- private sector managers and facilities are isolated from public health sector planning process thus having little input into or role in desired changes in the health care system.

Given these barriers to management improvement, and indeed to public-private collaboration, what general strategies can be pursued to create greater communication and collaboration between public and private facilities and health systems, and to expand private investment and resources in health systems management?

Three initial areas of interaction were considered essential starting points:

- (1) the recruitment of trained managers into the public sector, and/or the sharing of private health sector managers with public institutions or systems
- (2) the creation of joint venture companies to serve the management needs of both the public and private sectors
- (3) alteration of health system planning mechanisms within countries to include private sector planners, thus facilitating the exchange of ideas and the expansion of the role of private facilities and resources in meeting national health care needs.

Specific project areas suggested for immediate pursuit were threefold:

1. Joint venture companies, local or international, with either all private or a mix of private and public capital. Such companies would service, via contract, the needs of both private and public health facility managers. By aggregating, in a single private company, service for a number of facilities, economies of scale in service provision could be achieved and overhead costs for individual facilities could be reduced. The resulting cost-efficiency might lead to cost

reductions for both public and private facilities and perhaps to fee reductions and thus an expanded clientele base in the private sector.

Areas particularly suitable for such an approach are:

- . technical support systems, including information management systems;
- . biomedical equipment engineering, maintenance, and repair
- . facilities management;
- . personnel recruitment and administration;
- . supplies administration
 - laundry and linen supply
 - catering
 - medical supplies procurement and management
 - pharmaceuticals procurement and management

2. Financing by public aid agencies, both regional and international, for the upstream feasibility studies necessary for such joint ventures. This would remove one of the initial cost barriers to investigating these private market options. Early development assistance involvement would also help assure potential public partners or participants that public sector and public policy needs would be taken into account in the private sector expansion.

3. Creation of a "Middle East Regional Health Center" to foster collaborative projects in the region and to facilitate public-private communication and cooperation. The Center should be:

- . financed from both public and private sources;
- . small in staff, lean in funding, and focused on the goals and needs of the region;
- . concerned primarily with the identification of areas for and the collection of data to support joint venture undertakings and private resource expansion.

In the group's opinion, such a Center should have three immediate priorities:

1. Establishment of training seminars in management which could be held throughout the Arab World, aimed at senior private and government officials. Seminars would be on a workshop basis, two to three weeks in duration, concentrating on management problems through case studies prepared by the Center. These seminars would also serve as a national caucus for identification of specific problems in a given country.
2. Concentration on the problem of funding hospitals and medical service development in the region. For example, the Center should investigate the feasibility of establishing either revolving funds or banking institutions in the region which could provide low cost financing solely to health sector projects.
3. Rationalizing existing and planned medical and health facilities to provide the most cost-effective combination of private and public health care services.

Recurrent and Investment Finance

Adrian Griffiths, Moderator
Marsha Rosenthal, Rapporteur

Khogali Abubakr
Dr. A. Alaoui
Maitre S. Annabi
Mekki Chekir
Dr. Mohamed Dewidar
Dr. S. M. Diaey
Dr. Yahya Farag
Gail Garinger
Dale Gibb

Dr. Nadim Haddad
Ridha Hamza
Neila Haouas
Hans Koenig
Nadim Matta
Dr. Adnan Mroueh
Jeremiah Norris
Dr. Sadok Ouahchi
Susan Ueber Raymond

The finance strategy group examined a broad range of general problems in the health systems of the Middle East which inhibit adequate health services provision. The group then focused on those problems for which (a) money was a problem, and (b) joint financing (public/private) was a possible solution.

The six areas thus considered were as follows:

- 1) the intra-sectoral allocation of financial capital in health systems and/or the amount of investment capital available in both the public and private health sectors.
- 2) the lack of efficient or widespread cost recovery mechanisms in the health sector, and therefore (a) the dependence of service expansion on hard-pressed government budgets and (b) the limitation of private systems to clients able to pay fee-for-service arrangements.
- 3) a lack of management skills, including financial management, in health systems and facilities throughout the region.
- 4) the lack of timely and accurate data, especially regarding financial issues and opportunities; the lack of expertise in the health sector on financing issues; and, the lack of communication between the public health sector and private business regarding project needs and opportunities.
- 5) government regulations which constrain private or joint financing ventures in the health sector.
- 6) differing levels of compensation for personnel employed in public versus private health systems.

It was acknowledged that many of the potentially finance-amenable problems of the health sector were intricately intertwined with political or regulatory issues. For example, if health services are politically defined as a free, public good, then the most appropriate, well-designed, sophisticated cost-recovery options available are

simply not practically viable. When it comes to the heart of many of the finance issues and solution, changes in the definition of the health sector within the national economy and changes in political will are often fundamental prerequisites to action.

Controlling for these policy barriers, however, the group suggested a number of project areas which might be undertaken to address the financial needs outlined above.

As regards levels of available capital for health infrastructure or services, two major project areas were discussed. First, there was considerable discussion of the possibility for attracting increased levels of capital to the health sector via the creation of a regional health sector bank, similar to development banks available in other sectors of economic development such as agriculture. Such a bank could be jointly capitalized, perhaps with varying rates of return, by public agencies and private investors, and would provide finance both for infrastructure projects and for service expansion projects. Criteria could be established which would allocate some or all of that finance to underserved geographic areas, under-developed health services, or aging plant and equipment of health product industries.

An alternative, especially in the area of drugs and medical equipment, would be to pursue joint ventures for industrial development in the health sector, combining the capital of the regional Arab development funds with that of private or quasi-private industry to expand the numbers and types of health products produced in the region. Little regional market information is available, however, and market studies would be a necessary prerequisite for such joint ventures, as a number of fairly major changes in drug pricing regulations in some countries in the region.

As regards cost recovery, it was recommended that a pilot project be undertaken in at least one country in the region to develop and evaluate the use of Health Maintenance Organizations (HMO's) and other capitation plans to finance service provision. It was recommended that such an experiment involve services both to a subsidized population and a paying population, to ensure that such systems would be responsive both the poorer groups as well as to the middle-class.

As a variation on this solution, it was also suggested that a similar experiment might be undertaken using re-insurance concepts to cover high-risk populations. Re-insurance is normally used by private insurance companies to spread risks across the industry. One company will become the lead insurer and then distribute bits of the risk to other insurance companies. Although the mechanism is not generally used in the U.S. and Europe for the health sector, in Middle East health systems, particularly where governments dominate all insurance systems, the government insurance agency could become the first party insurer for poor "high-risk" populations, subsequently selling pieces of the risk to private companies. A variation of this approach is employed by HMO's in the U.S. which use other insurers to cover losses incurred by the HMO's from high-loss (e.g., chronically ill) enrolled patients.

Problems in management and financial skills were thought best resolved via the creation of some type of regional training institute which would provide both in service management training for existing personnel in the public and private sectors, and basic management

training for new managers. Such an institute would be located in the private sector, would be for-profit, and thus would attract private investment. Its response to public sector needs might be guaranteed by the creation of a joint public-private board of directors. It would sell its training services to both public (and development aid) institutions and the the private sector, perhaps with a sliding-fee scale offering lower prices to public agencies.

Ultimately, it was thought that such an institute could also undertake a data collection and dissemination function to resolve the data availability problem noted above. In addition, it could house expertise in the development of financial packages in the health sector which could be made available to both private and public project managers and project investors. In the interim, the group suggested that both the Internatinal Chamber of Commerce (Paris) and the Center for Public Resources (New York) should be encouraged to develop data resource centers on Middle East health systems and health system financial parameters/opportunities to assist those interested in health sector investment in the region.

Considerable discussion took place regarding the application of financial incentives packages, long used in other development sectors, to health sector problems. Tax and trade incentives could be developed to encourage expanded private sector investment in the health sector, both in terms of health product industries and in terms of service provision projects. Moreover, such incentive plans could be developed in such a way as to target investment to certain underserved regions or constrained services, or to health products in short supply in the public and private health systems. It was noted

that leadership in the public health sector has seldom turned to such readily available finance or economic tools to resolve problems of service or product availability. Yet, particularly in the Middle East, where rapid development has resulted from such strategies in other economic sectors, precedents for applying such tools are widespread.

Finally, it was noted that considerable opportunity for savings existed in public health programs, and therefore considerable opportunity for private investment, if major government health systems would simply choose to purchase certain types of health or medical services from independent private entrepreneurs rather than investing themselves in service infrastructure and provision. Especially in the area of specialized services (e.g., laboratory services, specialized surgical procedures, psychiatric services), public investment in infrastructure and financing for operating costs can be extremely cost inefficient. Use of private vendors and the establishment of competitive bid arrangements for services could both expand the level of service available within countries and reduce costs. This approach was thought to be particularly applicable to national social security systems which are relatively well-financed, serve large populations for long periods of time, and have greater need of tertiary-level services. It was recommended that public social security systems and development aid agencies join together to experiment with instituting such purchasing arrangements and to evaluate the degree to which such arrangements encourage private health sector investment.

Company-Managed Health Systems

Dr. Sarah Loza, Moderator
Franz Herder, Rapporteur

Dr. Robert Allbaugh	Dr. Zein Khairullah
Dr. Haroutune Armenian	Dr. Khalil Kutran
Dr. Galal Elleboudy	Joy Mallory
Dr. Hachemi Garaoui	Dr. Salah El Din Shash
Dr. Ishaq Jallad	Dr. Ahmed Tahri
Dr. Abdel Salam Kamhawi	Dr. C. L. Whetstone

Largely unnoticed by development and public health leaders, corporate mining, manufacturing, and infrastructure investors and contractors have increasingly become major health care providers in the Middle East. This trend toward corporate provision of employee, dependent and community health services is likely to expand further as domestic and international private investment increases and as the pressure of rapid urbanization on urban public health services leaves those services overwhelmed and unresponsive to corporate needs.

Members of this strategy group, representing both multinational and domestic companies with extensive health programs in the region, broke their discussions into four parts:

- areas of corporate dissatisfaction with medical services in the region;
- the advantages and disadvantages of expanded corporate roles in health services provision, disease control and health promotion;
- the prerequisites for such expansion, either in terms of public policy change or project design.
- possible cooperative projects for further investigation.

After reviewing the size and scope of the model medical operations represented by their own corporate systems, group participants isolated four problem areas for further discussion:

- 1) expansion of the numbers of private companies which recognize the utility of providing medical services and disease prevention programs to workers;
- 2) improvement in occupational and environmental health and safety (OHS) programs and resources;
- 3) cost containment and alternative insurance programs with potential for application to corporate medical systems;
- 4) access to improved information on all aspects of health conditions and policies which affect worker health and productivity.

All company executives saw serious barriers to expanded corporate initiatives in addressing any or all of these problem areas. In no particular order of priority, the barriers identified were as follows.

First, the policy-making process in such areas as occupational health and safety is almost purely public in nature. Policies are formulated by government regulators, poorly explained to companies, and only inconsistently enforced. Thus, companies have little idea as to what is expected of them or why, and, in turn, receive little encouragement to work more closely with public regulators to address OHS needs.

Second, corporate finances for health care services are limited. This is true for both multinational and local corporations, although the problem for the latter is most severe. The capital cost of equipment for improved systems, most of which would need to be imported,

is beyond the means of local companies. This is especially true for those small to medium-sized operations which represent the vast majority of Middle East business. On the services cost side, the problem is one of increased costs for providing services which in theory are to be provided by national social security systems. In many countries, companies pay 10% of total wages into these systems, which are designed to provide, among other things, full employee health services. In fact many of the social security systems do not meet regular employee needs. Normally, however, corporate expenditures for duplicate internal health service systems do not remove the 10% payment requirement. Thus, there is little financial incentive for companies to expand their own internal services. If, however, social security policy allowed expanded corporate efforts to be an offset against the 10%, an incentive for expanded corporate roles would exist.

Third, there was agreement in the group that few cost containment precedents exist within Middle East companies or between those companies and their contractual health care providers. Since the private systems are based on open-ended fee-for-service arrangements, corporate management often sees expanded health benefits programs as an uncontrolled drain on already limited company resources.

Fourth, there is a serious lack of data or case study material available in the region on OHS, worker health, or model corporate health systems. This shortage impedes both the definition of further corporate health roles needed and the creation of a corporate sensitivity to the utility of those roles as regards worker productivity. It also means that corporate medical directors seldom have available

the data and material necessary to convince top management to invest greater amounts of scarce company resources in health programs.

Fifth, corporate medical services manpower is in short supply. Few technical personnel are available in such specialties as OHS program design, and few managers are available to handle corporate health systems or to design the enforcement and reward programs that would lead to successful corporate health and safety campaigns. Moreover, those personnel who are present in the region have no professional group or association to aggregate and express their views and priorities, either to public policy-makers or to corporate managers.

From this analysis, participants suggested six project areas for further investigation:

- 1) improved access for local companies to capital for OHS equipment and supplies, possibly via the regional bank described by the management/administration group;
- 2) creation and/or upgrading of training facilities in the region for both basic and in-service training of OHS technicians and professional education in OHS and company health system needs and programs. Such training facilities could be developed in the private sector and run on a fee-for-service basis.
- 3) creation of an organization or institution to collect and supply improved regional information in a variety of areas, including:
 - comparative national regulations and regulatory procedures;
 - insurance and self-insurance schemes and options, and models of their application in larger local companies or multinational corporations in the region or elsewhere in the world;

22

- experiences of companies in the region in charging employees for medical care, as a "brake" on utilization and thus an escalating health care cost for the company;
- epidemiological data on environmental and work hazards;
- standards to be applied in such areas as pre-employment health screening tests;
- management of employee health information systems.

- 4) conduct of feasibility studies to examine the viability of creating private sector management companies which could provide via contract both direct medical services and technical advice to small companies. This would reduce per-company costs for health services and OHS education, and thus might serve as an incentive for the majority of Middle East businesses to become involved in employee health programs.
- 5) conduct of regional workshops to communicate technical financial, and service "state of the art" and issues broadly to the region's corporate medical managers and to companies not currently involved in employee health services. Ideal sponsors for such workshops would be the local Chambers of Commerce.
- 6) creation of a professional association or organization for corporate medical directors and other OHS and employee health professionals. Such an association would serve as a vehicle for private sector collaborative participation in relevant areas of public policy-making. Illustrative of such areas are

the development of regulatory structures and procedures, and the development of enforceable OHS regulations, and the reform of social security system regulations to provide private sector rebates or offsets for health services provided by corporations.

Educating the Public Through Private Outlets

Lenore Cooney, Moderator
S. T. Darwazah, Rapporteur

Dr. Yahya Al-Bably
Rena Brimelow
William Darnell
William Ferretti
Anne Glauber
Dr. Brahim El Gharbi
Robert Haladay
Dr. Mohamed Harbi
Dr. Farouk Hassan
Wafik A. Hassouna
Dr. Ibrahim Ishaq

Pamela Johnson
Dr. Hussien Al-Katta
Dr. Mohamed Kubati
Fatma Madhkour
Aziza Ouahchi
Clarence Pearson
Effat Ramadan
Dr. Mohammed Sharaf
Aracelia Vila
Lee Williams

. Perhaps the most unique, and therefore difficult strategy group of all, the group on Public Education combined participants from the private public relations, advertising and communications industries with public policy leaders and private health care providers. The group's mandate was to examine, on the one hand, the private sector resources which might be brought to bear on public health education problems and, on the other, the private sector outlets that might be mobilized to see that resulting education programs reach the majority of the region's population.

Because of their diverse backgrounds and the differing incentives that drive the private communications industry (which focuses first on defining what the public wants) and the public sector (which focuses

first on defining what the public ought to want), the participants spent considerable time comparing their approaches to defining public needs and selecting communications/education programs and strategies to respond to those needs.

The group then outlined a set of public health needs which might, if carefully defined, be responsive to comprehensive public education programs using both private industry expertise and private outlets.

The five priority areas were:

- personal hygiene
- infant mortality/illness
- fertility/family planning
- water-transmitted diseases
- proper use of medication

Four other subject areas, although perhaps not of as high a priority, were also considered to be amenable to private resources or approaches and to be representative of important public needs in the region: smoking, drug and alcohol abuse, accident prevention (automobile, poison, chemical, home), and blood donation.

The group then decided to take one problem area and to outline a major public relations campaign directed at that problem, in order to illustrate both the comprehensive nature of such a campaign and the strategy that the private communications industry would apply to that problem.

The public health need chosen was the expanded use of oral rehydration therapies to reduce infant mortality. The campaign assumed the availability of a consumer ORT product that could be



purchased and/or distributed through all types of outlets (health, food, sundries, etc.) and/or a viable product that could be made up in the home.

The first question to be addressed is the definition of the consumers of the education campaign. Who must be won over to the need and/or the solution? The group then specified three sets of consumers:

Leadership: those who are important in making the campaign viable or in giving it credibility

- . President of the country and his spouse
- . Minister of health
- . physicians/medical syndicate/professional associates
- . religious leaders
- . donor agencies
- . university professors
- . Minister of information
- . schools/teachers/nurseries

Intermediaries: those who will be the bridge between the message and the product

- . product manufacturers and distributors
- . pharmacies
- . major employers
- . primary health care workers
- . MCH/private clinics
- . donor agencies
- . non-health product outlets, e.g., food stores, kiosks, etc.

End Users: Those who will receive the message and seek out the product for infant needs

- . mothers
- . physicians
- . primary health care workers
- . grandmothers
- . older children
- . baby sitters
- . schools/teachers/nurseries

The second question which must be addressed in designing a public relations campaign for ORT is the definition of the values of each category of campaign consumer. What is important to each? What are the desires or values on which the campaign could capitalize? For each category, the group suggested the following values as vulnerable to a public relations approach:

Leaders: what do they value that would make them endorse or support/approve such a campaign?

- . prestige
- . a public perception that they are concerned about dying children
- . re-election
- . to do a better job
- . a "piece of the action" on a national effort
- . promotion of their profession
- . improvement in the nation's health status
- . to save public money
- . ability to measure results of the effort, so that their own effectiveness is publicly demonstrable
- . conformance with their mandate (e.g., aid agency conformance with legislative mandates)

Intermediaries: what do they value that will convince them to produce/distribute or promote ORT products?

- . profit/markets
- . sales
- . doing their jobs (schools, health providers, etc.)
- . cost savings of ORT as a therapy (providers)
- . reduction in work load (providers)
- . public service

End Users: What do they value that would make them purchase and use the product?

- . healthier children
- . reduction in work load
- . success of services offered; accomplishing something

Given these values, the third question is what barriers stand in the way of linking the product to the value? Among the barriers which need to be taken into account in message design were:

- . physical access to the product
- . cost relative to consumer purchasing power
- . water quality/availability
- . common perception of the problem (is diarrhea perceived as a sickness in children?)
- . time
- . physicians' perception of their own prestige
- . the link in the region between patient confidence and physician services

- . nature of physician training, which focuses on more technological, sophisticated, physician-dependent solutions to problems
- . technical problems associated with the product, e.g., ensuring the correct concentration of oral rehydration salts in water

Recognizing the barriers, the fourth question is how to sell the campaign or product to each group. Given the values, what vehicle or approach will win cooperation in the campaign or use of the product?

The approach strategy must be more individually-specific than the definition of values. For example, a Minister of Health whose background is medical/scientific will be "sold" on the campaign by scientific or economic information, while a Minister whose constituency is more political in nature will respond to arguments emphasizing his public profile or prestige. A Minister of Information is likely to be "sold" by the fact of the Minister of Health's involvement. Individual physicians will be "sold" by the endorsement of their medical syndicate, but that endorsement is much more problematic, given the barriers described above. Distributors might be "sold" on forcefully marketing the product and giving the public education campaign large play if the government were to give them protected franchises for distribution for a limited period of time.

On the other hand, vehicles for selling the end-users are much more generic. Careful naming of the product, for example, is always important to take advantage of essential consumer values. Promotion of the product via a wide range of outlets and techniques is necessary under any circumstances. Such outlets include: meetings, rallies, factories, TV interview/talk shows, celebrities, films, movie theaters, schools, clinics, private pharmacies, food stores, billboards, etc.

The point here is that matching an effective sales "pitch" for product or education campaign to the values of specific audiences requires careful understanding of the perceived needs and desires that motivate each audience to action.

The fifth question is, of course, what or who will be empowered to design and implement the public relations campaign and to see that the product is, in fact, in the marketplace?

The strategy group suggested the creation in each country of a private "Society for Infant Care," financed with seed money from a donor agency, which would involve professionals from the medical community, pharmaceutical or other producer industries, universities, and government in designing and overseeing the campaign. The Society could be staffed by one or more loaned (or retired) executives from the public relations/advertising/communications industry to organize the Society and campaign. An outstanding question is whether the Society would act beyond that campaign and would actually distribute and sell the ORT product. In large part, that role would need to be determined by the Society's "charter members" and by overall government policy.

In concluding, the strategy group made two specific project recommendations.

First, it was felt that the group's enthusiasm for the ORT public relations campaign was a measure of the immediate viability of such an effort. It was thus recommended that the campaign be undertaken on a pilot basis in one country in the region, for possible replication throughout the area.

Second, the group felt that the expanded viability of such an institutionalized public-private approach to public health education in the region would be stymied by the region's lack of an institution which could be charged with:

- (a) encouraging public sector recognition and use of private resources and outlets in public health education;
- (b) serving as a clearinghouse for the distribution of health education materials and techniques in the region;
- (c) creating and selling new health education materials (e.g., a child health encyclopedia) in the private marketplace as a supplemental source of income;
- (d) organizing internship or in-service training programs within the public relations/advertising/communications industry for public sector personnel to improve their public education/communications skills.

The creation of such a Pan-Arab Institute for Health Education, which would be private and at least partially self-financed, was recommended as a project for further investigation.

III. RECOMMENDATIONS OF THE PLENARY

After reviewing all of the above concepts, barriers, and project ideas, the plenary of participants at Burgenstock recommended three overarching institutional arrangements which would be targeted either at maintaining the momentum of the meeting or at aggregating similar ideas from individual groups into general, regional projects.

First, the participants felt there was an immediate and ongoing need:

- 1) to sensitize both the private and public sectors in the region to the potential for cooperative health sector investments represented by the project ideas above;
- 2) to develop a network within and among countries to promote the idea that health is both an important public policy area and also good business;
- 3) to organize national or regional workshops on public-private collaboration in the area of health policy generally, or health projects/investments specifically;
- 4) to encourage feasibility studies in the project areas described above.

It was thus felt that a steering committee, composed of a subgroup of Burgenstock participants, should be organized as an on-going force in the region. This steering committee would carry out the above functions and would communicate its program to Burgenstock participants as well as more broadly in the public and private sectors of the Middle East, perhaps via some type of official newsletter.

Second, several of the individual group project ideas called for variations of a regional health center focused on one or more substantive areas. It was recommended that these ideas be combined and that a feasibility study be undertaken for the development of a private Middle East Regional Health Studies Institute. The Institute would have three functions:

- 1) training, both basic and in-service, of public and private personnel from the region in all of the areas cited by the strategy group;
- 2) research and materials development in such areas as OHS, public education, and cost recovery;
- 3) conduct of feasibility studies for projects involving private, or a mix of public-private capital, which projects could later be referred to the regional development bank described below.

The Institute would need start-up seed financing, but would ultimately be self-supporting. It would market and sell its products (e.g., training programs, research products, technical advice), with a sliding scale of fees as between its public and private sector clients. Its Board of Directors would be composed of both public and private sector leaders, however, to ensure that the Institute's program of activity responded both to public needs and to the private marketplace.

Third, a similar feasibility study was recommended for the creation of a regional development bank for the health sector in the Middle East. This bank would have both a "small business" window to serve the small loan needs of private practices, laboratories and businesses, and a major lending or loan syndication capacity to participate in larger project ventures. The bank would be capitalized by a combination of donor agencies and private investors, and would be privately managed. As with the Institute, however, its Board would be comprised of both private and public sector leaders to ensure that its lending portfolio served mutually beneficial needs.

The Institute and Bank, taken together, would create for the region's health sector the self-supporting technical and financial capability to create and ensure for the future close and mutually beneficial private and public sector collaboration aimed at the sustainable improvement of health for the people of the Middle East.