Beyond the Public Prescription

Private and Public Roles in Near East Health

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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 a wide variety of health services, demonstrate genuine opportunities to generate private/business 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 argue that public resources can be fully 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.

Certainly 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. Unfortunately, we in the United States understand

those obstacles quite well. America, more than other industrialized countries, has traditionally divided the roles of the private and public sectors into two distinct arenas. 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. From the 1960's through the 1970's adversarial rhetoric enhanced this division by reinforcing the notion that a social role for business, based upon market interests, 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 good news may be that experience in this endeavor is running well ahead of our understanding of the dynamics of how that collaboration can take place. We need to understand those dynamics if we are to build that experience to a critical mass of activity.

The current responsiveness of the market sector to many areas of public need is impressive. For example, as the U.S. evolves from a production-oriented economy to a service, high-tech and research-oriented economy, whole industries have emerged to assume important roles in health, education, and other areas that were once perceived to be the exclusive realm of the public sector. The corporate organization has become a social institution to a degree that corporate managers seldom understand and too few would care to admit. For sound business reasons, many corporations have become major resources in such areas as preventive medicine and health care, human resource development (in the United States alone business spends $30 billion on training and education per annum) and energy conservation. By mandate, American corporations have become involved (too often kicking and screaming) in equal opportunity, the environment and occupational health and safety. The significance to development of broad institutionalization of these responsibilities and the emergence of significant innovative programs in these areas should not be discounted. These trends have been international as well. For example, this Report documents a range of areas in which multinational and indigenous business are current and potential actors in health care in the Near East.

This degree of business interest and involvement in social issues 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, for developing sustainable public/private collaboration is difficult and requires a greater awareness of market incentives and a sophisticated approach toward applying these incentives to a public agenda.

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 pursue opportunities for greater use of private resources.

At no other point in recent memory 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

FOREWORD

The economic and social problems of nearly every nation remain severe. Yet, government budget reductions in the face of sluggish, recession-prone economies have made difficult the resolution of those problems by the government and non-profit sectors alone, if such purely public resolution was ever realistic at all. A worldwide interest has been building to find methods for addressing public needs which do not rest solely upon massive outlays of public funds. Leaders in the public and private sectors are searching for a new perspective -- a new, creative way of thinking about how market incentives can be effectively mobilized to respond to public problems.

With this approach in mind, the Center for Public Resources, with support from the Agency for International Development (AID) (Cooperative Agreement NEB-0150-A-00-2072-00), undertook an examination of current and potential private sector roles in health care provision in the Near East. This Report summarizes the results of that work, and emphasizes the very real, very immediate opportunities for development assistance leadership in blending public policy incentives with private and business resources to expand the availability, quality, and cost-effectiveness of health care in that region. This Report is not about AID; it is about publicly-mandated development assistance overall and the advantages to public agencies of closer private sector relations.

Business has a direct stake in cooperating actively with public leadership to resolve public problems. Indeed, as this Report illustrates in the health sector, the private sector often has initiated with its own resources and in the context of its own market interests programs to address public priorities. The private sector, therefore, houses both expertise and interests which can be pragmatically mobilized by public agencies to meet human needs more effectively and in ways that are consistent with and therefore sutainable by private sector motivations.

The result is not, as is so often claimed, a tainting of the purity of public objectives. Rather, it is mutual gain, a harnessing of public and private resources, a blending of public and private incentives, to meet human needs without the waste of confrontation and conflict. The strategy builds upon rather than tears down the individual strengths of public and private actors.

The Report emphasizes that there are very immediate and mutually beneficial opportunities for business (multinational and indigenous), government policy-makers, and development assistance agencies to cooperate more closely in resolving a range of health problems in the Middle East, using market mechanisms and incentives in ways that serve both public need and private concerns.

The catalyst for that cooperation will not come from business, however. Business is undertaking significant health activities, but there is little reason for it to become involved on its own initiative in the broader public health system concerns of public aid agencies. That is not "the business of business."

That leaves one alternative. A very bright, very obvious spotlight is shining on publicly-mandated development assistance agencies to take the lead, to offer their good offices to begin the public-private dialogue, and to provide their technical resources to move that dialogue to sustainable cooperation. Business often requires a much better perception of how it fits into the development process. Development professionals who understand this, as well as appreciate the dynamics of existing private sector roles and concerns, can improve that perception.

This Report does not suggest that the way ahead for that catalytic role is completely clear. Many barriers -- structural, attitudinal, and financial -- remain in many areas. We do argue, however, that the light at the health partnership intersection is amber, not red, and that public aid agencies can and should, therefore, proceed with caution.

The data and analyses in this Report are the products of many insightful business executives and public agency professionals. These individuals are too numerous to name, but we thank them all for their time and creativity. Special appreciation is extended to Pamela Johnson, AID's Project Officer for this effort, whose insights, patience, and sense of humor have often carried the day in this innovative project. Special appreciation is also extended to the research staff listed on the title page of this Report, for their often creative approaches to the very difficult data collection problems encountered along the project's way.

Finally, of course, nothing in this Report should be construed as presenting the official policy of the Agency for International Development or of the United States Government. Data analysis and conclusions, as well as all errors and inaccuracies, are thus solely our own.

Susan Ueber Raymond, Ph.D.
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BACKGROUND

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1. INTRODUCTION

"In a world where health care costs are soaring and where resources are woefully inadequate to meet health needs, we cannot fail to make the best possible use of all those who provide health services...private as well as public." M. Peter McPherson, Administrator, Agency for International Development.

The main problem facing development assistance (and developing countries) in the health sector is fairly simply stated. The public resources required to put in place and sustain a minimally-acceptable health infrastructure in the developing world are simply not currently available. Barring a budget-shaking display of political concern over the long-term future of health in the developing world, and thus a sustained increase in or diversion of tax dollars to radically expand health assistance efforts, it is also unlikely that those requisite public resources, from within or outside the developing world, will be available in the future. If the past ten years are any measure, that display of popular and thus financial outpouring for expanding health programs is unlikely. It is a reality which we may not like, but which we must face.

How, then, do we find new mechanisms to preserve, pursue, and maximize the essential functions of health sector financing performed by governments and publicly-mandated development assistance within public resource constraints?

The answer to that question is also fairly straightforward, i.e., by emphasizing public sector cooperation with private resources, not only those of private charity, but, perhaps more importantly, those of the private market-based sector (business and private providers). The rationale for such a strategy is clear. In the context of carrying out its regular business operations, the private sector (local business, private health service providers, and multinational corporations) generates or mobilizes resources -- financial and technical -- which are applied to a range of problems in the developing world, including

problems in the health sector. Public development assistance must find and optimize those private resources, and develop policy incentives for their expansion. In industrialized countries, we have pursued such collaborative strategies domestically (and for the last several years have done so with greater diligence); we must now do so internationally.

The answer for acquiring or encouraging new resources may be straightforward; the solution -- implementing that answer -- is more difficult. Development assistance professionals in the health sector seldom have the information, professional access, or cooperative mechanisms needed to identify relevant private, market-based resources; to apply those to public health problems; and/or to develop the policy incentives needed to attract private resources to development assistance projects. Furthermore, these professionals must overcome the history of conflict between public and private sectors which plagues the health sector.

Despite these constraints, development assistance professionals must seek out private resources. Unless public professionals are creative enough to explore the private, market sector options and partnership potential in order to leverage public resources in the private sector, the health sector must face and accept existing or increased limits on its programs. Resource leveraging, in every financial and technical sense of the word, is increasingly the only alternative to resource stagnation in social development sectors. The public health sector must establish both a baseline of information regarding the actual and potential activities and resources of the private sector, and a process for linking itself into these to the advantage of <u>both</u> private and public goals.

This Report is the first step toward such an information and process base for the health sector, with specific reference to the Middle East.

1.A. DEFINITIONS

Before proceeding, a few definitions are in order since the subject of this Report is not one normally addressed by those in the international public health and development assistance communities.

"Private sector" in this Report, unless otherwise qualified, refers to multinational business, domestic (indigenous) business within the countries at issue (including any major publicly-held corporations which often hold a monopoly on an economic sector but, although subsidized, operate as quasi-private companies), and indigenous private (full or part-time, personnel or facilities) providers of health services.

"The Near East" is used interchangeably with "the Middle East." The countries of special but not exclusive attention in the Report are Jordan, Egypt, Tunisia and, to a lesser extent, Morocco and Lebanon.

"Development assistance" refers to agencies, personnel, or funds which are targeted at economic and/or social development in the Third World and which are publicly-mandated and financed. The term also refers to the private, voluntary, non-profit vehicles for those publicly-financed programs.

"Health sector" refers to all aspects of the public health and curative medical establishments, as well as to family planning services and to demand-side nutrition programs (but not to supply-side agricultural production).

1.B. THE HISTORY OF CONFLICT

In the past, development assistance was regarded largely as a public function: the transfer of U.S. (or French or British or German) income to bolster or stimulate the public economic sectors of the less developed world. Government-to-government arrangements (at times, perhaps, carried out via private-non-profit pipelines) dominated the development scene. Project work was conceived in, investigated by, evaluated by, initiated under, implemented within, and managed by the public sector. With a few notable exceptions, development assistance agencies in the "North" were government bodies working with government or quasi-government bodies in the "South." The financial flow was largely one of public (tax) dollars. The assumption was that "made in the public sector" was not only a mark of quality, it was also the only mark available to ensure equitable distribution of project benefits to the poor. This tendency has been particularly dominant in the areas of social (i.e., not directly production-oriented) development projects such as those which dominate the health sector.

This emphasis on maximizing public roles has had two effects. First, it has tended to pit the public and private (business) sectors against one another. Both sides of the "government versus corporate" debate over Third World development became quite proficient at identifying the errors of each other's ways. Public accusations of corporate exploitation have been matched blow-for-blow with private sector lamentation of public sector inefficiency and waste. The pattern of confrontation continued to spiral ever upward. The result, from the mid-1960's through the late 1970's, was polarization and a dilution of both private and public expertise and resources targeted at economic and social development in the Third World.

The second effect of a development assistance emphasis on public/government roles in the Third World has been the obscuring of what has been, and increasingly is, the private sector's crucial role in both

the economic and the social development process in the developing world. In fact, and largely regardless of the level of development, a significant portion of the resources public agencies need to harness for economic growth and social development are privately owned, either by local businesses, by private service providers, or by international corporations.[1] Without a viable private sector (and what follows is an economic, not a political statement), governments have not and cannot (in the majority of instances) stimulate or sustain economic growth and development. In the shadow of the aforementioned development assistance debate, however, the actuality and potential of that private role have often been lost.

1.C. THE SHIFT IN PERSPECTIVE

In many quarters, the perception of the necessity for conflict between private resources and public policy has begun to be tempered. Thought is beginning to turn from confrontation to cooperation, though not in all public agencies or among all development assistance professionals. The reasons for this shift are at least four-fold.

First, the purely economic realities of the 1980's have set in. Oil-importing developing countries have been dealt a severe blow by the burden of energy costs. In the current market, even oil exporters in the developing world are feeling the pinch of trade deficits. Furthermore, the impact of energy events and a related recession in developed world economies have also served to suppress international trade and investment, and thus indirectly to dampen Third World economic growth. The resultant budget strain on public finance, indeed on the financial viability of many nations in the developing world, has resulted in public finance retrenchment, with public resources increasingly focused on production industries rather than on expanded social services.

Second, and due in large part to a recognition of those economic realities, government economic policy within Third World nations has begun to re-emphasize the mobilization of private business resources to finance economic growth. This re-emphasis on private roles has influenced the economic and service provision plans of even the more centrally-planned economies. Except in the most rigidly managed economies, the public sector has begun to re-emphasize its more traditional role, that of providing the environment and incentives necessary to direct private resources toward development goals, rather than its more recent role as the producer of resources for public achievement of those goals.

Third, and a point not unrelated to the first two, the public wells of development assistance financing have begun to run dry in the more developed nations. The result has been an expanded search on the part of some publicly-mandated development assistance organizations for ways to leverage their own decreasing, over-demanded resources via private cooperation.

Fourth, a political shift in some developed world countries has resulted in significant policy changes for bilateral development assistance. There is a new emphasis on encouraging entrepreneurial resources in all economic sectors of the developing world, rather than on expanding the roles of government agencies. As a result, a search is underway for improved methods of including private sector financing and technical expertise in the project portfolios of both bilateral and multilateral development assistance agencies.

The result of all of this ferment has been a renewed interest in defining public-private resource partnerships which serve the interests of all involved in development assistance: publicly-mandated agencies, the business world, national governments and their economic growth and equity goals, and the people of the developing world.

1.D. THE MEANING OF AND LIMITS TO PARTNERSHIPS

This renewed interest, however, has taken an incomplete turn. Increasingly, one hears development assistance pleas for "partnership" with the private sector that sound dangerously akin to "my agenda and your money," that seek private (particularly business) resources to pursue goals and programs determined purely in the public sector. This is not partnership; it is philanthropy. Such philanthropic approaches can be effective responses to some types of problems (see Case 38 regarding Lebanese reconstruction). 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 since these 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 should be acknowledged 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.[2] Drought, refugee relief, natural disaster, and epidemic disease control are all examples of areas in which almost exclusive public and philanthropic responsibility is indeed both appropriate and effective. It is

the public and philanthropic sectors which have so admirably responded to such needs for many, many years. It is also the spirit of that type of response that is one of the pillars of strength of the United States and other nations.

Moreover, for the very poorest nations, an early reliance on public finance and aid may be 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 only recourse for building the foundation. Once built, however, that foundation in nearly every sector -- social as well as productive -- can attract private capital.

Given the resource constraints faced by public programs in even these poorest countries (let alone in the Middle East), however, and the reality of private roles in the health sector, understanding of and cooperation with market-based, non-philanthropic private sector resources is a necessary, if not a sufficient, component for meeting the longer-term recurrent health development needs of the Third World. 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.

1.E. PROJECT RATIONALE

Within this general cooperative framework, this Report has two foci: geographically, the Middle East; substantively, the health sector.

The Middle East overall has one of the strongest private sector, entrepreneurial heritages in the developing world. It is thus an appropriate region in which to begin to analyze possible private sector-public development assistance linkages.

The health sector is another matter. The reality is that the private health delivery sector in the Middle East is relatively strong, with the majority of health services being delivered via businesses, private practitioners, and private facilities. Despite this reality, however, government policy in the region, both as regards service delivery and as regards the manufacture and supply of health services

products, has emphasized public responsibility for ensuring the availability, and indeed the actual delivery, of health services. This tendency to view the delivery of health services as a public mandate has stemmed both from national political concern for ensuring the adequate distribution of social goods, and from a definition in the broader international health community of health (and thus health care) as a "right" of every individual. From this assumption, health services and the product input to those services have come to represent public entitlement programs.

Despite these public policy and development assistance trends in the health sector, examination of possible development-private sector cooperation in health has many advantages. Most obviously, many services are, in fact, delivered in the private sector; e.g., the first point of health sector contact for the majority of needy in the Middle East is not the public clinic, but the private pharmacist. Yet the role of such pharmacists has long been ignored by public health planners and development projects. Providing incentives for the expansion of such private resources (see Chapter 12 for details on project potential in this area) is to the advantage of development assistance programs, since the results may be a broader availability of private services and thus a greater ability of development programs to target public services on the most needy.

Second, as described above, considerable expertise exists in private sector industries which, if considered as resources by development assistance professionals, would contribute to more effective public health programs and more viable health financing schemes. This is particularly true for the Middle East. As the economies of that region have advanced over the last ten years, health system problems have become more complex. While the private market sector may have limited resources or expertise to offer to the health problems of the most impoverished nations of the developing world, the health sector in the Middle East is different. The type of management, recurrent cost financing, and service provision problems of the health sector in that region are those to which the private market sector has something to bring. The region also has a degree of organized business activity in health-related areas sufficient to be a full partner in health sector development. The pieces are in place in the Middle East. The problems are appropriate. The partners are present. All that is needed is the catalyst.

1.F. ANALYTIC FRAMEWORK

To begin to understand the complexity of the interrelationships within the private sector on health issues, and between private and public agencies, one must have a framework of analysis upon which to trace the various actors and links. Page 9 contains the framework which will be used in this Report.

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET

INDIGENOUS BUSINESS

Manufacturing
- non-health products
- health products < pharmaceuticals / medical supplies

Extractive Industry

Banking

Insurance
- health
- non-health

Construction
- health projects
- non-health projects

Import/Export

Labor Contractor

Oil-surplus Arab Investment

INDIGENOUS SERVICE PROVISION

Private Delivery:

Hospitals/Clinics/Labs

MD's/Medical Associations

Nurses/Technicians

Pharmacies/Pharmacists

Emergency Medical Services

Public Delivery:

Hospitals/Clinics

Personnel

Financing

Emergency Medical Services

Central Administration

MULTINATIONAL CORPORATIONS

Manufacturing (Investor)
- non-health products
- health products < pharmaceuticals / medical supplies

Extractive Industry

Services - Health
- management
- evacuation

Commodities Supply
- pharmaceuticals
- medical and related supplies

Banking

Insurance
- health
- non-health

Construction/Engineering/ Infrastructure Development
- health projects
- non-health projects

Labor Contractor

Information/Communications

GOVERNMENT POLICY

Private Health Services Provision

Occupational Safety

Financing/Pricing

Education/Training

Private Investment

Patent/Trademark

DEVELOPMENT ASSISTANCE AGENCIES

Health Sector Projects

General Investment Finance

Export/Import Promotion

As the chart makes clear, the number of private groups and subgroups of actors actually or potentially involved in health-related issues and activities in the Middle East is large. The interdependencies among these groups and between private and public actors are complex. For simplicity's sake, but always recognizing that the disaggregation is artificial, this Report will untangle that interdependence and describe individually each set of actors in the framework. After the baseline of information is established, the analytic framework will be re-aggregated to trace, via the use of hypothetical cases,,the various interdependencies and development assistance opportunities in the system.

One limiting parameter on this Report should be acknowledged. This Report does not constitute a complete data base for the various partnership actors described. One could write a book on any one group (e.g., indigenous business), or any one set of actors within a group (e.g., the indigenous insurance industry) in the Middle East. Considerably more data has been collected than is presented here (a full bibliography is appended); considerably more remains to be collected. However, the profiles which are presented reflect available data and illustrate the pragmatic potential of the private groups of actors as self-interested partners for public development assistance.

SECTION II.

DATA BASE

2. DATA BASE SUMMARY

"In today's world, many Third World countries are undergoing a metamorphosis in the quality of their local health and medical care. As their economies improve and their public and private health resources join forces, the solutions to their health care needs can increasingly be found within rather than outside their national borders." Charles L. Whetstone, M.D., Manager, Medical Division, Conoco, Inc.

Chapters 3 through 10 present a lengthy analysis of the status and potential roles of the variety of private actors involved in the health sector in the Middle East. It is hoped that this summary chapter will both give the casual reader a meaningful overview of the extent of private involvement in Middle East health systems, and provide the more intense reader with a roadmap to the chapters and case material which follow. Included in this chapter are parenthetical references to case material contained throughout Section II which illustrates the private roles summarized here.

2.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.

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 largely a 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, virtually all of Lebanon's 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 structural 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 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 companies). In Egypt, private investment continues to be 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 to implement national economic goals. Thus, creating the right environment for private investment has become a priority for all countries concerned.

2.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.

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: 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 (Cases 1 and 2). 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 in 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 of 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 subsidization. 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 of the costs of such programs 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 MNC's (Cases 3 through 11).

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 occupational health 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 Egypt's 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 using a mix of public and private delivery systems (Case 12).

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.

2.C. INDIGENOUS PRIVATE PROVIDERS

In the Middle East, private providers are a fundamental part of the health systems of nearly all countries. In Jordan, approximately 50%-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 with 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, $18.4 million between 1978 and 1982. This amount of investment was nearly equal to that 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 domestic 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 (Case 13). 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. It has been estimated that there are 280 hospitals 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 (Cases 14-16). Of the 16,000 pharmacists registered in Egypt, 13,000 work in the private sector.

Overall assessment of the level of private services 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.

2.D. ROLE OF THE MULTINATIONAL CORPORATION

Multinational corporations (MNC's) play a variety of major roles affecting health and health care in the developing world.

1. Health-Related Products Industries:

The health role of the major medical supply 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 valued at $494 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 into Jordan. 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. The Tunisian private sector imports more than the public health delivery facilities. The total import bill was 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 production, except in Egypt, is not substantial in the focus countries of this Report. However, 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 (Case 20). 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 pharmaceuticals sales -- the major leaders spend 15% -- on research and development. The resultant new products and disease process knowledge can also pay a major role in the future effectiveness of health care systems (Cases 21-22).

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. 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 (Cases 23-28).

-- 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 (Case 29).

-- The viability of adequate occupational health and safety programs in the developing world is among the most 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 (Case 30).

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 (Cases 31-32).

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 (Cases 13 and 33) 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 product manufacturers, may offer project financial management expertise, and have themselves created unique financing facilities for local private sector development (Case 34).

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 in 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 (Cases 35-37).

2.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 (Case 39).

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 are beginning to build.

2.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.

2.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 planned 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 public and private sector priorities. These opportunities include 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 multinational and domestic private 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, impacting upon low profitability levels for public and private enterprises.

Tunisia's policy toward health products investment is the 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.

2.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 pages 23 and 24 outlines the roles of major development agencies in the region and indicates their private sector policy and experience.

As noted in the Table, few agencies have both 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 one that is certainly neither impossible nor unprecedented.

TABLE 2.I

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 2.I (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: indidgenous 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.

3. THE ECONOMIC ENVIRONMENT

"If government is inefficient and ineffective, or if it pursues policies that significantly distort private sector decision-making, both the private sector and the overall prospects for economic development suffer.... Public policy often has a decisive impact on the private sector, and the private sector usually has a decisive impact on the rate of economic growth."[1]
Barend de Vries, The World Bank.

3.A. INTRODUCTION

Questions regarding regional or national economies are not ones to which health professionals in development normally give much attention. Indeed, such questions are often viewed, at best, as ancillary to health sector concerns and, at worst, as irrelevant. However, the state of any country's economic environment is fundamental to decision-making in the private sector. Therefore, painful as it may be and unfamiliar though the territory is, health professionals in the public and development assistance communities must, from the outset, attend to national economic issues if they are to identify and forge mutually beneficial partnerships with their private sector colleagues.

This chapter does not pretend to present a full economic analysis of the region or of its individual nations. Rather, it is designed to provide health and development professionals with a sample of the questions which need to be raised in assessing the potential for success of private sector partnerships in each of the focus countries of this Report. The key areas of examination for this (and other) private sector assessment(s) are:

-- State of the economy;

-- Five-Year Development Plan, including the investment strategy and/or policy toward the private sector;

-- National budget analysis;

-- Future economic outlook.

Despite the many dissimilarities in the economic structures and priorities of these countries -- ranging from Jordan's relatively good performance in a free enterprise system to Tunisia's stable, tightly state-controlled economy -- there is one stark and fundamental similarity running through the published development plans, statements of government budget ministers, and analyses of the productive sectors of all five countries: a strong and urgent emphasis upon attracting private investment to attain national economic goals.

Although any broad comparison of these disparate economies runs the risk of simplicity and superficiality, these diverse countries are indeed plagued with similar constraints on their economic performance. The singular, most major constraint is a current or projected lack of government resources to finance ambitious development plans. All five economies maintain a solid dependence upon foreign aid and soft loans, not only to finance existing institutions, but to serve as a spur for attracing domestic and foreign private investment to existing and planned projects. Incentives designed to attract private sector capital range from a major policy stance and detailed regulations in Egypt to a general encouragement in Tunisia. Whatever the method, the necessity is clear and straightforward in all five economies: the ability to harness revenues to finance increasingly complex and costly development plans is dependent upon the ability to attract domestic and foreign private investment capital.

3.B. STATE OF THE ECONOMY

1. Jordan

With only 6% arable land and few significant exports except potash, Jordan's economic growth rate has been remarkably steady, averaging between 7% and 9% for the last eight years.[2] This growth in Gross Domestic Product (GDP) is due to a gradual increase in investment in the production sectors and a rapid expansion in banking and financial services. Moreover, the Jordanian economy, especially its export revenues, will receive a significant boost when its newly completed potash production facilities reach full production. In addition, Jordan enjoys the confidence of Western investors, who view it as one of the most well-managed of the developing economies, keeping development plans to schedule and usually under budget. The constraints on this growth have been both expanded import costs for energy and declines in markets for some of Jordan's primary exports (e.g., phosphates) due to the recent world recession.

Jordan's is essentially a free enterprise economy, with the Government creating the basic infrastructure and relying on public incentives to encourage private business. Although this policy is strong and enduring and regulations affecting private industry are modest, the Government's economic role is not insignificant. Nearly

one-half of the labor force is paid by the Government for either military or civil service. Price interventions are limited, but affect essential commodities such as drugs, food, and fuel. In addition, the Government has taken an investment role in infrastructure projects such as railroads, irrigation, and education. In some industrial projects, it has also contributed the initial equity capital which then leveraged private financing. In few cases, however, has this financial interest in industrial projects resulted in government control.

2. Egypt

Much attention has been given by economic and political scientists to the "Open Door Policy" begun by President Anwar Sadat in 1974. That policy is embodied in the June 1974 Law Number 43 "Concerning the Investment of Arab and Foreign Capital in the Free Zones" as amended by Law 32 in 1977, and is an attempt to open the Egyptian economy to Western and Arab direct investment in order to spur domestic savings and investment in almost every economic sector. The Open Door Policy aims to restructure the country's entire economic system, in the hopes that free trade will deal at least partially with the fundamental economic problems confronting the Egyptian people: high inflation (hidden by large government subsidies), population growth, the high import bill for food and consumer luxuries, and a strained agricultural system.

Despite these problems, the Egyptian economy has grown significantly in the past five years, averaging approximately 9% in real terms for that period, closing out 1980 with U.S. $24 billion in GDP and a per capita income of $650.[3] This growth was due in large part to the revenues of the petroleum and tourism industries. The Open Door contribution to that economic growth has had mixed reviews (discussed later). But despite government emphasis on private sector capital formation, the economic reality is that the public sector remains the backbone of the Egyptian economy, still accounting for 80% of all industrial output and 90% of investment.[4]

3. Tunisia

Tunisia's economy has been relatively strong in recent years, with an annual growth rate in 1980-81 of 6.5%, GDP of $8.45 billion, and per capita income totaling $1,200.[5] Yet, despite these positive indicators, concern over the country's long-term prospects remains. Most sectors of the economy remain under state control; the country's export line is limited; oil reserves are declining and revenue loss is predicted; agricultural sector productivity is declining; population is shifting to urban areas, but unemployment is growing. Indeed, the latter problem is acute. In 1980, 49% of the men under 25 were without

jobs, compared with 29% in 1966. A further 320,000 job seekers will enter the job market by 1986; according to optimistic assessments, the total number of jobs available then will be 300,000.[6] Price controls are also a severe constraint upon future economic productivity. The Government subsidizes key consumer products -- food, bread, milk, energy costs -- and maintains low interest rates. This system increases the purchasing power of poor consumers, but results in economic distortions and inefficient use of investment capital.

Estimated loss of future revenues from the petroleum industry has propelled planners to emphasize other economic sectors (e.g., tourism) and to encourage private sector investment to fill the gap.

4. Morocco

In contrast, Morocco's economic course has been rough of late. In 1981, the GDP declined by 1.6% to U.S. $16 billion; per capita income was $800.[7] This poor performance was due in part to an extensive and devastating drought which sharply curtailed growth in the country's agricultural sector; an extremely soft market for phosphates, the country's primary export; a 40% depreciation of the dollar relative to the Moroccan dirham; and a sharp rise in interest rates in Europe and the U.S. In addition, the war in the Western Sahara continues to drain government revenues. Morocco is also one of the few Arab countries almost totally dependent upon imported oil, with associated balance of payments deficit problems.

Due to this past year's poor performance and future problems, the Government is actively encouraging private sector investment, although both large-scale industries -- phosphates, utilities, rail -- and the social development sector remain under state control.

5. Lebanon

Under continued siege and strife for the past eight years, the Lebanese economy has been severely strained. What is remarkable is the fact that Lebanon has seen economic growth at all -- a fact due to the entrepreneurial resiliency of its citizens.

Until the 1975 civil war, Lebanon was the financial and commercial service center for the Middle East. Its liberal economic policies and central location in the region allowed the country to serve as a business and financial bridge between East and West. Its primary natural resource was and is its well-educated and multilingual population. The war has had contradictory effects on this resource. On the one hand, over 300,000 citizens have emigrated, at least temporarily, thus draining the country of vital resources upon which to

rebuild. On the other hand, remittances from these individuals have kept the country financially solvent. It is estimated that remittances total $150-$200 million per month.[8]

The war has had its effects not only on labor, but on all sectors and aspects of the economy. Estimated losses to the country at the end of 1980 were LL 21 billion ($5.1 billion), over 80% of which was in the private sector.[9] With the renewed fighting of 1981 and 1982, the economy came to a near standstill. Currently, the Council for Development and Reconstruction, charged by the Government with forming reconstruction priorities, is focusing on restoring the country's physical infrastructure and providing economic and monetary policy support to the private sector, the former backbone of the economy.

3.C. NATIONAL DEVELOPMENT PLANS: POLICY TOWARD PRIVATE INVESTMENT

1. Jordan

Jordan's Five-Year Development Plan (1981-1985) aims at increasing GDP by 64% over the five-year period to a total exceeding $3.2 billion.[10] Targeting an annual growth rate of 11%, the Plan calls for a total investment of about $10 billion to be contributed equally by the public and private sectors.[11] Special emphasis is placed on raising the commodity sectors' contributions to GDP from 38.8% in 1980 to 46% in 1985.[12]

Water, irrigation, manufacturing, and mining projects are projected to receive the greatest percentage of investment in the commodity-producing sectors. Health is allocated 3% of the planned investment budget.

The success of the Five-Year Plan is based upon three assumptions:

(1) Jordan will continue to pursue a policy of free enterprise with increased opportunities for private initiatives and closer cooperation between public and private sectors.

(2) The private sector will continue to respond favorably to development incentives and will assume an increasingly important role in attaining economic objectives.

(3) Where the Government has participated in large industrial projects, its interest will remain as a support to ensure adequate financing and a catalyst for mobilizing private investment.

There is reason for optimism regarding the validity of these assumptions and the attainment of Jordan's economic objectives. For the 1976-1980 Plan, private investment in all commodity-producing and tourism sectors was 66% of total investment. In the service industries, the private sector accounted for 53% of investment. Overall private investment in the previous Plan amounted to 59% of the total, a 9% increase in the projected level of private investment.

Projected allocations for the private sector in the current Plan are about 37% of the total, with 57% for productive sectors. Based upon previous figures, the actual amount of private investment should be greater than the projected level. The primary complaint from private enterprise about investment in the Plan stems from the lack of any central administrative structure to coordinate and channel these investments.

2. Egypt

Egypt's Five-Year Development Plan (1980-84) is designed to increase the country's economic self-sufficiency. The overall goals of the Plan are to increase production, maintain subsidy pricing, encourage private sector investment, provide vocational training, and reform the public sector. The Plan aims to achieve and sustain a 10% GDP growth rate during the 1980's.

The Government currently emphasizes "productive investment," with elimination of current expenditures on consumer luxuries. Thus the Government accords priority to industry, agriculture, and infrastructure to reduce dependence on foreign imports and luxuries. Of the total Plan's allocations, a projected public and private investment of $23.9 billion, agriculture is to receive 19.7% and communications and transport 14.7%.[13] Social services received 7.2% of the total allocation, with the health sector receiving 19% of this latter figure.[14]

The public sector continues to be the backbone of the economy, providing about two-thirds of the country's capital investment. The government is also attempting to cure the intractable structural and managerial problems in public sector industries, which were so severe last year that one-third of government-owned industries ran losses which together amounted to one-half of their total capital.

On the private investment side, investment has historically been channeled to light industry, with government funds dominating heavy industry. In fact, private funds account for over 50% of the total volume of manufacturing input in light industry.[15] For instance, in such light industries as leather, woodworking, wearing apparel, and engineering, there are over 4,000 private establishments employing two or more persons. In small-scale manufacturing enterprises, the private sector is the major employer, employing over 54% of all industry workers.[16]

Over the next five years, Egyptian planners are hoping for $5.9 billion in investment by the private sector, either independently by Egyptian entrepreneurs or in conjunction with foreign partners. To encourage local investment, the Government has recently promised Egyptian businessmen a five-year tax holiday if their funds are directed toward agricultural or industrial projects. Egyptian economists are optimistic about reaching the needed level of local private investment, basing that optimism on such positive economic indicators as a rise in the savings rate to 14% of national income, and an increase in the rate of investment to over 20% of national income.[17]

In the past, private sector spending on consumption exceeded spending on investment by a ten to one ratio. This trend caused critics of the Open Door Policy to contend that the policy contributed only to the widespread availability of luxury goods for the elite. Evidence indicates that this pattern is changing and that privately-held foreign exchange is being used to import investment goods. Recent estimates show that private foreign exchange bought 68% of capital goods and only 32% of consumable items.[18]

All of this activity is taking place within the regulations and incentives of the Open Door Policy, designed to replace centralized economic planning with a system that encourages an increased private sector role.

That policy allows for the transfer of Western capital and technology through joint ventures operating either in Egypt proper or in regional public or private free zones. While few sectors are explicitly excluded from the legislation, the Government has preferred to encourage public-private joint ventures rather than allow direct private sector competition with public sector firms. In addition to Law 43, Egypt has provided other incentives for private sector investment. These include the centralization of investment allocation authority and the creation of a national investment bank. The bank, which is represented in all the governorates, was established for the purpose of stimulating local financing and dispersing the Government's allocation of public sector investment funds. In addition, the bank serves as the country's development fund, managing and reviewing the financing of public sector investment projects.

The overall success of the Open Door Policy has not been without its problems. Since the inception of Law 43, 64% of all foreign investment projects undertaken have been in banking and finance. These projects, which usually invest abroad the locally generated revenues from Egyptian projects, create a foreign exchange drain, rather than recycle capital into new projects geared to the local economy and domestic production. A 1977 progress report admitted that the desired levels of investment flows had not developed. By the late 1970's, only 80 foreign firms had made equity investments in Egypt, usually in the form of real estate, tourism, and banking, but rarely in the productive sectors of the economy.[19]

Thus, new guidelines have been proposed to alter the direction of private investment and to take advantage of what is, nevertheless, a very real increase in the level of foreign private investment, which totaled $400 million in 1980, compared to $100 million in 1977.[20] These proposed guidelines include procedures for closer cooperation between the public and private sectors and, in the process, they direct private investment, both foreign and domestic, to those sectors which the Government considers most likely to produce long-term real growth, such as the food production industry. The Government intends to initiate joint venture companies with initial capital coming from the state-owned banks, relying on the private sector for loans and management assistance. Enterprises will be responsible to government-controlled equity owners for an initial five-year period, at which point ownership could be spun off to private investors. With this approach, the Government hopes to complete projects begun under earlier development plans and channel money into national development projects. It is interesting to note that, despite continued regional problems, Arab states have provided the bulk of foreign capital invested under Laws 43 and 32.

3. Tunisia

Tunisia's goals and objectives in the Sixth Plan (1982-1986), reflect the national concern over a future decrease in production of and demand for Tunisia's oil exports, as well as a failure to meet the growth rate goals of the previous Plan.[21] The annual growth rate was thus targeted at 6.7%, as compared to 7.5% in the previous Plan.[22] Investment goals in the 1982-86 period are set at $14 billion, representing 25.6% of GDP, a decrease in percentage of GDP from the Fifth Plan.[23]

To achieve this growth rate, the new Plan emphasizes increased investment in industrial sectors of the economy, particularly in the export industries and those industries which reduce dependence upon imported intermediate goods. In addition, emphasis has been placed upon employment-generating industries and on the tourism and agricultural sectors. The manufacturing sector will receive 20% of total investment, agriculture 18.9%, energy 17.9%, housing 15.7%, transportation and communications 13.4%, and tourism 5.5%.[24] Planned employment creation is targeted at 300,000 additional jobs.[25]

The Government will undertake a major portion of the planned investment, but the Government also realizes that the private sector must take a role in implementing the Plan's objectives. Thus, the Plan specifically makes note of private investment as a means to reduce government expenditures. It clearly states, "We must admit, without agonizing over it, that Tunisian socialism should make a larger role for the private sector and encourage it."

To encourage private sector participation in the Plan, several measures have been adopted:

(1) Law 80-59 to encourage private companies to create research departments.

(2) Law 81-56 to encourage private investment in manufacturing industries by providing exemptions from certain social insurance contributions, and employment subsidies.

(3) Creation of a national fund for private small business and an agricultural investment promotion agency.

For 1983, the projected level of private investment in the productive sectors is 40%.[26]

Also providing encouragement to private domestic and foreign investment has been the surge in the level of Arab funds invested in Tunisia. Saudi, Kuwaiti, Algerian and UAE joint development banks have been established to finance development projects and to spur joint project financing from the private sector.

In addition, to attract other foreign investment, the investment promotion law promulgated in 1981 was the most liberal in ten years. The law distinguishes between two types of investment, one for export and the other for domestic consumption. Funds for export industries can have 100% foreign ownership; internally targeted investments must be in the form of joint ventures, with the majority of capital held by Tunisians. The Investment Promotion Agency (API) coordinates and handles foreign investment opportunities, and is generally considered to be among the best in the region.

4. Morocco

The 1981-1985 Plan for Economic and Social Development is directed at mobilizing private savings, restoring public finances, tightening price controls, and improving the country's balance of payments.

Efforts to mobilize private savings will consist of restructuring the Caisse d'Epargne Nationale (National Savings Bank - CEN), increasing the amount of savings through the development of life insurance companies, and urging the participation of the banking sector in the financing of mortgages. Specific attempts to improve public finance include strengthened austerity measures in public sector and state businesses; reform of the tax system; a greater use of public bonds; and restructuring and standardization of price control policies. Efforts to restore the foreign trade balance consist of the promotion and development of export industries, and the readjustment of sectoral policies to achieve self-sufficiency.

The planned rate of growth for 1981-85 is 6.5% a year.[27] This objective presupposes an annual growth in investment of almost 8% per year in real terms.

Issued at the close of a disappointing economic year, the Plan relies heavily upon private domestic and foreign investment to finance its near-term objectives. The total sum of planned gross investment for 1981-85 is scheduled to reach $17 billion, which includes $5.3 billion in public monies, and $11.6 billion in private finance.[28] The Moroccan Development Plan considers public investment to include all investments except those of the Post and Telecommunications Administration (P&T), local collectives and the National Social Security Funds. Private investment is considered to include investment from the P&T Administration and from public and private companies in joint ventures. Thus, it is difficult to assess the true nature of private investment estimated for the current Development Plan.

It is interesting to note that the majority of private investment is earmarked for productive sectors. The Government's projected distribution of private sector investment reflects its desire to rely on private investment to increase production in those sectors where the marketing outlook is most promising, i.e., in the non-natural-resources production sectors. No domestic private funding is projected for the health sector, at least not in the Government's plans.

The Plan also contains policies designed to increase the level of private foreign investment. These policies include the creation of an administration to process and coordinate investment opportunities, establishment of industrial zones, and revision of the 1973 investment code. The revisions of the investment code include three fundamental changes:

(1) Foreign investors can hold up to 100% of assets in sectors where they are authorized to operate.

(2) Sectors open to foreign investors have been widened.

(3) Where private investment reaches MD 50 million ($7.65 million), a company can have the opportunity to renegotiate a contract agreement with the Government to improve its incentives for additional private investment.

These regulations and overall policy toward the private sector reflect the newly-stated policy of the Government that "private initiatives...must contribute, along with the public sectors, to the promotion of economic development."[29]

5. Lebanon

Development plans in Lebanon are directed toward rebuilding the economy and locating and targeting public and private revenues to finance reconstruction.

The Council for Development and Reconstruction has developed a list of priority projects, with reconstruction efforts in both the public and the private sectors. Financing is being sought from the Government of Lebanon, The World Bank, The Arab Fund for Economic and Social Development, and The Abu Dhabi Fund for Economic Development, although the latter Arab Fund contributions are contingent upon an acceptable settlement of the current dispute over the presence of foreign military troops in the country.

In the private sector, emphasis is being given to Lebanon's agricultural and tourism industries. Priorities in the public sector include reconstruction of destroyed housing, schools, and hospitals, and rebuilding of sea and airports.

The private sector has always been the foundation of the Lebanese economy. Statistics on past levels of private investment indicate private contributions to be the major source of revenue. The domestic private sector accounted for 82% of total national investment in 1977, 85% in 1978, and 88% in 1979.[30]

In addition, Lebanon has always encouraged foreign investment. Foreign investors are free to organize a Lebanese company, to participate in a joint venture with an existing Lebanese company, or to establish a branch or a subsidiary in the country. Other investment incentives are given to industries which produce a commodity not previously manufactured in Lebanon.

3.D. NATIONAL BUDGET AND BALANCE OF PAYMENTS ANALYSIS

1. Jordan

Jordan's 1982 budget of JD 765 billion ($2.14 billion) represented a 19.9% increase over 1981.[31] 51% of total budget expenditures are expected to be financed by foreign sources, largely via foreign economic aid, loans, and technical assistance which totaled an estimated $431 million in 1982.[32] The source of most of that assistance will be the Arab oil states.

The Jordanian economy is a study in petrodollars. 80% of the revenues financing Jordan's Development Plan originate in Jordan's exports to oil-producing countries and direct grants and remittances from these Arab countries. The drop in oil prices has, of course, affected the viability of that development strategy. Although Jordan

has relied on aid from Saudi Arabia to a greater extent as promised assistance from other Arab states has declined, Jordan nevertheless ended 1982 with a $300 million deficit. Consequently, $345 million in funds were cut from development projects in the country.[33]

Although exports increased in 1981, Jordan's trade deficit topped $24 billion, a one-third increase over the previous year. Moreover, the structure of Jordan's export portfolio has shifted over the years, with industrial goods increasing from 24.4% of the total market in 1975 to 33.7% in 1980.[34]

The value of commodity exports rose from $136.9 million in 1975 to $448 million in 1980, an average annual increase of 26.8%.[35] Exports during the first four months of 1982 rose by 21.6% compared to the same period in 1981.[36] Primary export commodities are vegetables, fruit, medicines, plastics, phosphates, and paint. Exports of phosphates and agricultural products increased by 29% in 1981. Most of Jordan's exports, with the exception of phosphates, go to the Arab world. Due to closer political ties, Jordanian exports to Iraq surged from $266 million in 1980 to $537.6 million in 1981. India, Rumania, and Poland are major buyers of Jordanian phosphates, with exports to those countries accounting for almost 40% of Jordanian exports.

However, Jordan has a very high import bill, especially for energy and food; imported crude oil from Saudi Arabia amounted to 95% of the value of its merchandise exports. Between 1975 and 1980, imports increased by 25.2%. In addition, imports rose by 25.7% during the first four months of 1982, compared to the same period in 1981.[37]

Despite a trade deficit, Jordan ended 1981 with an overall balance of payments surplus of $50 million. The surplus was due to the strong growth in remittances from Jordanian workers and, of course, the large amount of grant transfer payments from the oil-rich Arab states.

The United States is a major trading partner of Jordan, holding 23% of Jordan's import market. Jordan is the seventh largest market for U.S. goods among Arab states. U.S. exports to Jordan totaled $716 million in 1981, an increase of 7.5% over the previous year.

2. Egypt

According to the U.S. Commerce Department, the official budget deficit in Egypt was $1.2 billion in 1980-81, and was projected to rise to nearly $3 billion in 1981-82.[38] Any real improvement in this deficit is tied to the ability of the government to handle the country's serious structural problems, primarily high inflation masked by large government subsidies for commodities such as wheat, flour, sugar, oil, and tea. Cost/price distortions caused by subsidization have had a negative impact upon investment decisions, consumption patterns, and, of course, the government budget.

In addition to a national budget deficit, the Egyptian Governemtn must respond to a plunge in its balance of payments account for fiscal 1980-81. Imports in 1980-81 totaled $8.5 billion, 19% more than in 1979, of which 27% went for food and 25% for machinery and transportation equipment.[39] The high rate of population growth and subsidized prices for imported basic commodities have created strong demand pressure which cannot be absorbed by domestic production.

Of Egypt's extensive imports, over $2 billion worth were imported from the U.S., with food, machinery, and manufactured goods being the three main items. U.S. exports account for 24% of the total Egyptian import market. The U.S. is Egypt's major trading partner, although the European Community as a whole is approaching 50% of the total market in Egypt.

Law 118 of 1975 stipulated that importation rights be extended to the private as well as to the public sector, thereby allowing individuals to import directly for private use. In effect, the state monopoly and control over trade has been disbanded, at least in government policy.

Overall, Egypt's foreign exchange earnings for 1980-81 were 30% above 1979 figures, growth which was bolstered by earnings from oil exports, the service sectors, and capital inflow from foreign assistance. However, Egypt may not be able to depend on continued growth of foreign exchange. Tourism has slackened recently, and Suez Canal earnings, expected to reach $1.25 million in 1983, are high, but not as high as expected. In addition, Egypt has yet to develop a solid industrial export base in the country, nor has the Government been able to increase agricultural production to level off the large import bill for food.

In general, business is wary of the track record of Law 43 and Egypt's ability to get out from under its huge problems of balance of payments deficits, inflation, and the multitude of rules and regulations which hamper the free flow of trade and free enterprise within the country. Egypt is greatly dependent upon outside help. Foreign assistance amounts to $2.5 billion per year: $1.2 billion from the U.S., $600 million from Europe, $180 million from Japan, and $300 million from international financial institutions.[40]

3. Tunisia

Tunisia's $2.88 billion 1982 budget, a 17% increase over 1981, reflects the priorities of the country's Development Plan.[41] This increase results from the need to create jobs (10,000 jobs in the public sector alone), to finance an extended public payroll due to a general wage increase, to continue maintenance of government subsidies, and to fund Development Plan priorities.

The national trade unions, which have traditionally played a strong central role in the economy, recently were able to promote a 30% increase in the minimum wage. The amount is triple that of inflation. Price controls are also a drain, and Tunisia has not yet decided to raise the price of food products which are heavily subsidized.

Tunisia also expects a continuation of balance of payments deficits begun last year. In previous years, oil export earnings kept the deficits at a tolerable level, but, as stated previously, the Government can no longer depend on this foreign exchange earner. In addition, Tunisia faces a flattening in the world price for phosphates and a rise in the price of food commodities imported by the Government. The country's one foreign exchange bright spot is that income from remittances and from the tourism sector are growing, approaching $700 million in receipts last year.[42]

Commodities exports are primarily to Western Europe, with France the largest trading partner. Tunisian imports grew by nearly 30% in 1981, the bulk of which were machinery and raw materials, primarily food. Again, France is Tunisia's leading supplier, with 23% of the market, followed by Italy and West Germany. The U.S. is its fourth leading supplier, with 7% of the total market.[43] U.S. investment is minor, about $5 million in equity.

The Tunisian merchandise trade deficit is expected to increase to $1.52 billion in 1983. However, the country is relying on foreign capital infl[illegible] of approximately $400 million in direct investment as well as on expanded equity participation by the joint Arab banks.

4. Morocco

As might be expected from previous data in this Report, Morocco was faced with a significant budget deficit for 1981, approximately $2.5 billion. To cover the deficit, Morocco expects to obtain MD 9 billion ($1.4 billion) from foreign sources.[44] The IMF has agreed to supply the Government with Special Drawing Rights (SDR) financing to ease Morocco's trade deficit. In addition, France and Morocco have signed an agreement to provide $280 million in mixed credit for the Moroccan Government.[45] The Arab Monetary Fund, the Islamic Development Bank, and the Arab Fund for Economic and Social Development are also important donors. The World Bank recently approved three development loans with a total value of $57 million. France, the U.S., West Germany, and Spain also donated $60 million in mixed credits to Morocco. The Japanese plan to finance a $200 million sulphuric acid plant through low interest and long-term government credits.[46] Substantial support is also hoped for from Saudi Arabia and other Arab oil producers, who together provided about $1 billion in soft loans in 1981. Thus, despite the bad year, Morocco's fall has been cushioned by varied external aid packages.

Morocco's trade and current account deficits were also very high in 1981, with imports increasing by 33.7% and exports by only 25.9%.[47] Sharp increases in the price of food commodities accounted for part of the rise, although the major factor was Morocco's almost total dependence on imported oil (25% of its total imports). In turn, almost one-half of Morocco's export sales are in phosphates and phosphate products, a market which in 1981 recovered only partially from the particularly soft year of 1980. Export sales in food products fell because of bad weather, but exports of finished products, particularly textiles, increased.

Workers' remittances play an important part in Morocco's balance of payments. Over half a million Moroccans live and work abroad, mainly in France, and last year they remitted over $1 billion to their home country. This figure is 40% higher than the money earned from phosphates for that year.[48]

The U.S. accounted for only 6.5% of total Moroccan imports. This low level of trade is due to a variety of factors: the Moroccan propensity for European goods; more favorable financing packages with European countries; language problems; the appreciation of the dollar; and higher transport costs relative to European trading partners. To begin to alter this pattern, a U.S.-Moroccan Joint Committee on Economic Relations was inaugurated last year, and several trade missions (one in medical equipment) were organized by the U.S. Department of Commerce to begin to interest U.S. and Moroccan partners in closer trade relations.

5. Lebanon

Since 1976, the Government of Lebanon has been accumulating increasingly larger budget deficits as traditional sources of revenue shrink. Of the 1981 general budget of LL 4.484 billion ($1.4 billion), 23.6% was allocated to defense, 15.9% to education, 10.9% to public works, and 3% to health.[49] In 1982, the government budget was set at LL 7.55 billion ($1.60 billion), an increase of more than 40% over the 1981 level. It is conservatively estimated that Lebanon is losing approximately LL 200 million ($48.4 million) monthly in customs revenues because of smuggling through Lebanon's ports.

To finance the deficit, the Government has been forced to borrow from local banks. The government is also counting on financial assistance from other Arab states to help finance its current budget deficit. At the 1979 Tunis Arab Summit, Arab countries pledged to provide Lebanon with $2 billion over a five-year period for reconstruction and budget deficits. To date, the Government has only received $371 million of the promised financial aid. Thus, the Lebanese Government has had to finance some of its proposed development projects itself, further contributing to its deficit.

The Beirut Chamber of Industry estimates Lebanon's total exports for 1981 at approximately LL 5.40 billion ($1.3 billion).[50] 80% to 85% of Lebanon's exports go to Arab countries, with Iraq, Saudi Arabia, Jordan, and Syria being its principal clients. These exports represent Lebanon's own commodities plus a thriving re-export trade for products of other countries recycled through Lebanon's trading companies. 1981 Lebanese imports were estimated at about LL 11.5 billion ($2.7 billion), an increase of 15% over 1980.[51] Exports to Lebanon originated mainly in Western Europe, the U.S., and Japan. Figures on total foreign private sector investment in Lebanon are not available. Total U.S. private investment in 1980 did not exceed $40 million. In the early 1970's, more than 400 U.S. firms had offices in Beirut. When the war began, most of these firms closed their Beirut offices and relocated either elsewhere in the region or in Europe.

3.E. FUTURE OUTLOOK

As stated in the introduction to this chapter, all countries under consideration in this Report share similar opportunities for and constraints on their economic growth.

All countries (except Lebanon) have relied or plan to rely on a natural resource (oil in Egypt and Tunisia; phosphate and potash in Morocco and Jordan) to earn foreign exchange and spur industrial development. Most rely on remittances from their overseas work force to ease balance of payments deficits and to provide revenues for the economy. It is interesting to note that a need to create jobs to retain indigenous skilled labor is a priority in all countries, but a priority with mixed results if it will deprive these countries of the steady inflow of remittances.

All face the difficulties of underdeveloped agricultural systems and the need to import food, with a consequent creation of trade imbalances. One underlying factor in the ongoing difficulties in agriculture is the price/cost distortion of subsidies. Inflation is masked by government spending on subsidies for basic food items, which ultimately act as disincentives for the farmer or agricultural cooperative.

All countries (for the time being, except Lebanon) also place considerable emphasis on the further development of one of their chief foreign exchange earners, the tourism sector; plans target this sector's revenue growth for as much as 40% over the upcoming five years. The achievement of growth in that sector, of course, can be set back considerably by disease outbreaks or serious health problems in the country. Thus, health sector development is closely related to this key economic development industry.

As mentioned earlier, all countries, in varying degrees and with varying economic incentives and regulations, are looking toward the private sector, both domestic and international, to inject capital into the economy and participate in economic development. All five-year plans have projected private sector investment in all areas of the economy, ranging from approximately 50% in Jordan to 35% in Egypt, and 40% in Tunisia.

Jordan's primary emphasis for private sector investment is in mining and manufacturing. Egypt targets private sector participation in light industries and housing and construction; Morocco in agriculture and fisheries; Tunisia in agriculture and manufacturing. In Lebanon, where 80% of the business is done by the private sector, the emphasis is on reconstruction of the country and the economy.

The future outlook for the Jordanian, Moroccan, and Tunisian economies appears relatively optimistic. Despite Moroccan and Jordanian dependence on oil imports and Morocco's poor economic performance in 1980-81, the economies are stable and can, in the long term, rely on their natural resources to earn foreign exchange. Despite Tunisia's more problematic outlook (due to decreasing oil supplies and chronic unemployment), the economy appears strong in the near term. It has solid exports in textiles and olive oil and a good foundation in industrial development. The future economic outlooks for Egypt and Lebanon, however, are more questionable. Certainly, Lebanon's situation is dependent upon the cessation of hostilities and the injection of stability and security into the country. Egypt's economy, although steady because of oil, tourism, and remittance revenues, is strained and complex, and must overcome many obstacles, including high budget deficits and a complex bureaucracy which impedes the needed injection of foreign private capital. The future outlook is dependent upon the country's ability to overcome its long-term structural difficulties.

The future outlook for all these countries is also dependent upon a continued influx of foreign aid and soft loans. The loss of revenues to the oil-exporting Arab world may mean a decrease in Arab assistance to these economies, and, in turn, may force these states to provide additional incentives and structures for foreign and domestic private investment.

4. INDIGENOUS PRIVATE BUSINESS

"In the Arab culture, the local merchant has a time-honored place in the delivery of goods and services. This is no less so in the area of health care. The roles of private business, as well as those of the individual medical practitioner, are essential parts of the overall provision of health care in the Middle East and thus should be factored into any public planning for health care improvement." Mohamed A. Baghal, Executive Director, The U.S. - Arab Chamber of Commerce.

4.A. INTRODUCTION

Little prior investigation has been carried out to specify the health sector roles of indigenous businesses in the Middle East. Yet, the fact that little prior research had been conducted in this area does not negate the existence of opportunities for a health-related partnership with indigenous private business. Local business does provide or interact with a variety of health care system components and thus there are a variety of incentives for closer cooperation among local business, national governments, and development assistance agencies to improve standards of health in the area.

This chapter describes the level and types of indigenous private business health activity and areas where realistic opportunities exist to expand or create such a business health role. Appropriate case studies illustrate existing health activities or limitations on their expansion. It should be noted from the outset, however, that there is a great deal of interdependence between public and private, indigenous and international business and agencies on many of these health care issues. These interactions will be highlighted and analyzed in Chapter 11, but the reader will find many references to this interdependence in the materials in this chapter. For the purpose of general description, this chapter organizes local business into the following four types:

-- health products companies, primarily pharmaceutical manufacturers and local importers of health equipment;

-- manufacturers of non-health products, as regards their occupational and health safety programs and expanded health care programs;

-- banking and finance, as regards its potential for joint financing of health product industries or private health care provider systems;

-- insurance industry, as regards health insurance and social security. Although social security programs are publicly-managed and financed, this Report will treat them as private enterprises in keeping with the definitions previously set out in Chapter 1.

4.B. GENERAL BACKGROUND

As stated and illustrated in Chapter 3, the private sector in much of the Middle East, and certainly in all countries under consideration in this Report, has been encouraged to assume a larger and more important role in furthering national development priorities. For many similar reasons, from tightly controlled state economies like Tunisia to the relatively laissez-faire economy of Lebanon, financial managers are providing various incentives to private business to participate in economic development plans. Planners are depending upon private capital and entrepreneurial activity to improve and broaden domestic manufacturing and mining industries as well as export, agriculture, and finance sectors. This trend only reflects a reality that has long characterized economies in the region. In Egypt, although the purely private sector has been virtually excluded from intermediate and capital goods industries, the country's 4,000 private light industry establishments account for over 50% of total investment in such industries as leather, woodworking, wearing apparel, and engineering. Over 54% of all industry workers are employed in the small-scale manufacturing enterprises of the private sector.

In Jordan, between 1976 and 1980, 670 new private factories were licensed, 30% in the chemicals industry. During that period, over $160 million in private capital was invested in private enterprises in the mining/manufacturing sector. Another $673 million of investment in that sector was mixed private and public finance.

In Lebanon, 88% of total industrial investment is private. Nearly all of the country's manufacturing operations are in private hands. In Tunisia, 40% of the investment in productive sectors in 1983 is projected to be private capital.

As will be made clear in this chapter, however, the presence of this level of private business in the economies of the four focus countries does not necessarily mean that the health roles of these private employers are well developed. Indeed, in many cases those roles are more potential than actual, and thus provide ample opportunity for improvement and/or expansion via the development of public policy incentives or the encouragement of public-development assistance-corporate partnerships.

4.C. HEALTH PRODUCTS INDUSTRY

The degree to which the private sector is involved in the indigenous health products industry in the Middle East varies significantly from country to country. In general, however, one can say that where private investment is allowed, the resultant manufacturing industry:

- -- Is not research based;
- -- Focuses on the formulation and packaging end of the manufacturing scale (the exception is Egypt);
- -- Is import-substitution oriented rather than export-based (the exceptions here are Jordan and Lebanon);
- -- Relies on licenses from the major multinational corporations for expansion of its product lines;
- -- Almost exclusively focuses on the production of prescription pharmaceuticals and over-the-counter preparations, without diversification into medical equipment and supplies (the exception, to some extent, is Egypt).

In two of the five focus countries -- Jordan and Egypt -- the indigenous health products industry is very well developed and a good deal is known about its operation. This section summarizes relevant studies on this subject available through other sources and supplements these with new material collected for this Report. Interested readers wishing further detail should consult the end notes and bibliography of this Report for other references.

In addition to the national industries described in this section, however, note should be taken of the effort of states in the region to establish regional self-sufficiency in health product industries.

Case 1: ARAB COMPANY FOR DRUG INDUSTRIES AND MEDICAL APPLIANCES

After nearly ten years of planning and discussion, the Arab League's Unity Council in March of 1976 established in Cairo the Arab Company for Drug Industries and Medical Appliances (ACDIMA). The purpose of ACDIMA was to increase the region's self-sufficiency in the manufacture of pharmaceuticals and medical supplies, a market which was then projected to total $2.8 billion by 1985.

ACDIMA has $213 million in capital, held by Iraq and Saudi Arabia (each with 18% of the company's 6,000 shares), Syria, Libya, Qatar, the United Arab Emirates, and Kuwait (about 8% each), and minor shares held by Jordan, the Yemens, Sudan, Tunisia, and the Palestine Liberation Organization.

When the signing of the 1978 Camp David accords resulted in Egypt's expulsion from the Arab League, ACDIMA moved its headquarters from Cairo to Amman. As a consequence, nearly a third of its capital was frozen in Egyptian banks. Moreover, many of its technical personnel and managers remained in Cairo where an Egyptian ACDIMA now operates.[1]

Despite this financial and human resources loss, ACDIMA has continued to be a major force in the region's drug and medical supply investments, finding and promoting investments and putting together financing packages. ACDIMA's five-year plan (1981-1985) commits $300 million to the start-up of new projects in the health care field. In any project, ACDIMA can hold no more than 25% of the capital. The company tries to obtain 30%-40% private capital for the project, with the remainder of the financing coming from Arab investment companies, government loans, or public subscriptions.[2]

Among ACDIMA's recent projects is construction of a $140 million antibiotics plant in Iraq, the first of its kind in the Arab world, to supply raw materials to the region's formulation factories. The plant is able to produce annually 250 tons of penicillin and derivatives, 100 tons of tetracyclin, and 20 tons of erythromycin.[3]

In addition, ACDIMA is undertaking the construction of a $67 million glass container factory in Syria to help overcome the region's lack of quality glass containers for drug packaging, as well as assuming a 15% share in an infusion solutions plant to be constructed in Saudi Arabia.[4]

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1. Jordan

Market Size and Structure: Domestic sales of pharmaceuticals in 1981 were JD 16.9 million ($47.2 million), averaging JD 7.5 per person. Of this total, just over 24% was supplied by local producers, up from 14.9% in 1976, but a decrease from the domestic industry's largest market share -- 27.3% in 1980.[5]

In 1981, 62% of domestic sales were in the private market and 38% were accounted for by government tenders. This domestic procurement represents nearly 30% of the Government's pharmaceuticals purchases.[6]

The Jordanian domestic industry is also a major exporter of pharmaceuticals, mostly to the rest of the Arab world. In 1981, Jordanian companies exported nearly $15 million worth of drugs, representing just under 3% of total Jordanian exports for that year.[7]

Major Companies: There are four major indigenous pharmaceutical producers in Jordan, two of which (Dar al Dawa and The Arab Pharmaceutical Manufacturing Company) are public corporations. All four companies import their basic chemicals as well as capsule and packaging materials, and are thus limited to pharmaceutical processing and packaging functions.

° The Arab Pharmaceutical Manufacturing Company, Ltd. (APM), Jordan's oldest and largest domestic drug company, is capitalized at JD 4 million as of 1982. This is twenty times its capital at the time of its 1962 registration. The public sector owns only 5.5% of APM's shares; the remainder are spread among 22,000 shareholders. The company is governed by a nine-member board of directors, with public sector representation from the Ministry of Health and the Armed Forces (one member each).

In 1982, the company's sales volume totaled $17.4 million, up 13% from 1981. This total sales volume was distributed as follows:

-- Sales to Government: 1.4% of total 1982 sales, an increase of 12.6% over 1981;

-- Sales to the private local market: 17.2% of total, up 17.8% over 1981;

-- Exports: 71.4% of total sales.

The company's export market is largely in the Peninsula and East Africa. However, export expansion to West Africa is planned after the completion of a new factory in mid-1983. This new facility, to be called the Al-Buheira Pharmaceutical Manufacturing Company, Ltd., will have twelve times the production capacity of APM's current factory. The factory is being built by a British company with a total construction and equipment cost of nearly JD 9 million.

Currently APM manufactures 17 product groups and over 100 individual products. The new factory will expand that product group line to 47.

APM employs a labor force of over 400, exclusive of managers and technicians. That number will more than double with the 1983 opening of the new plant. The company operates two shifts per day to satisfy product demand.

° Dar al Dawa Development and Investment Company, Ltd. had 1982 pharmaceutical sales of JD 1.2 million ($3.4 million), an increase of 60% over 1981. The domestic market accounted for 60% of those sales. However, Dar al Dawa is paying increasing attention to its export market where sales increased by 189% between 1975 and 1981. The major markets for the company are Syria and Saudi Arabia.

Dar al Dawa is capitalized at just over JD 1 million and employs 100 non-management personnel.

° Al-Hikma Pharmaceuticals Company, Ltd., formerly an Italian subsidiary trading under the name Life Pharma, is a privately-held company with total sales of JD 1.25 million ($3.5 million). Of this total, 72% is exported to Iraq, Syria, Kuwait, and the United Arab Emirates. The company also expects to be registered in Saudi Arabia and Libya by the end of 1983. Domestic sales were almost entirely to the Jordan private sector.

Al-Hikma is capitalized at JD 500,000 and employs 75 non-managerial personnel. Its product line is limited to 23 items. Expansion of the company's operations is hindered by Jordanian law limiting the capitalization of privately-held companies to JD 500,000.

Case 2: AL-HIKMA PHARMACEUTICALS COMPANY AND HEALTH EDUCATION, JORDAN

Most pharmaceutical companies in the Middle East are small and have limited technical capability. It is, therefore, rare to find them engaged in non-sales or production activities such as those described in Chapter 6 for multinational pharmaceutical firms. One such case is that of Al-Hikma. In 1981, Al-Hikma Pharmaceuticals Company, whose product line includes a limited number of anti-tussives, developed a combined advertising/public health education brochure on the causes and treatment of coughs and their possible indication of serious bronchial disease. The short brochure is written in Arabic in layman's language. Developed under the company's former name (Life Pharma), however, it is not widely distributed by the company. Nevertheless, it does represent at least one possibly replicable local corporate effort to serve both public need and company interest.

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° Jordan Pharmaceutical and Medical Equipment Company, Ltd. (JPM) is the newest of the four producers, having begun production early in 1981. JPM is also privately-held and so has limited growth capability under Jordanian law.

JPM is capitalized at the maximum allowable JD 500,000 and employs 70 persons. Its total 1982 sales were JD 580,000 ($1.6 million), an increase of 29% over 1981. Most of that growth was in export sales, which comprised 38% of JPM's sales in 1982, compared to 15% in 1981. JPM's local sales of JD 360,000 ($1 million) in 1982 were almost exclusively in Iraq and the Arabian Peninsula.

Domestic Products: Although in 1981 there were 1,664 basic kinds of drugs registered on the Jordanian market, less than 10% were produced by the four domestic companies described above. However, even this limited product line represents most of the categories needed for a primary care system. None of the companies, however, produce oral rehydration salts, contraceptives, or weaning foods. Only APM produces intravenous fluids, and that under license to the Swiss company, Viofor. Intravenous fluids are also one of APM's chief export products to Saudi Arabia.

Vaccines are produced exclusively by the Jordanian Corporation for Serums and Vaccines (the former Jordan Vaccine Institute). In 1981, the Corporation produced 197,900 doses of tetanus vaccine (4,000 of which were donated to Lebanon), 144,200 doses of cholera vaccine, 55,000 doses of typhoid vaccine, and 664,400 cm^3 of typhoid test antigen.[8] All other vaccines and serums are imported by the Ministry of Health.

2. Egypt

A number of extensive studies are available regarding Egypt's pharmaceutical market and industry, thanks largely to the size and historical strength of that market. This section will present only that information directly related to Egypt's domestic industry. Sources cited in this Report's end notes and bibliography should be consulted for more detail on government policy and the process of pharmaceuticals provision in Egypt.

Market Size and Structure: In 1980, sales of pharmaceutical products in Egypt were valued at $304.5 million; 80% of the products sold were locally-produced. This expenditure represents an annual rate of growth of 20%-25% in the Egyptian drug market.[9] However, estimates are that the value of local production will need to triple in the next 15 years if the country's growing needs are to continue to be met by domestic production.[10]

Of this total consumption, 17% derives directly from government expenditures. The remainder represents private pharmaceutical purchases through the nation's system of over 5,000 private pharmacies described in the next chapter of this Report.[11]

Approximately 3,200 pharmaceutical products are registered and sold in the Egyptian market, of which about 700 are imported and about 2,500 are manufactured locally. Between 90% and 100% (by sales volume) of such products as antidiarrheals, antihistamines, chemobiotics, cathartics, sulfonamides, vitamins, dermatologicals, and antitussives are locally produced. However, Egypt imports nearly a quarter of its endocrine system drugs, including contraceptives.[12] About 70% of all locally produced drugs are manufactured by state-owned companies.

The medical equipment and supply market in Egypt has also grown at an annual rate of 20% over the last five years. Expenditures in that market, however, are overwhelmingly those of the Government in the context of its health care system. Moreover, most medical equipment and supplies are imported. In 1980, medical equipment and supplies imports totaled nearly $40.4 million.

Major Companies: The history of the indigenous health products industry in Egypt dates back to 1939 when the Misr Bank created the first "modern" company, the Misr Pharmaceutical Company. The founding of two more private companies soon followed: the Memphis Chemical Company in 1940 and the Alexandria Company, a small private laboratory, in 1941. Over the next 20 years, many small laboratories formulating basic over-the-counter drugs were created. In 1961-62, however, the Egyptian Government nationalized the pharmaceutical industry, closing many small laboratories and consolidating the larger ones into a limited number of public companies. Although the Government has made some attempt over the last five years to open the indigenous pharmaceutical sector to greater private investment, the structure of the local industry still reflects the years of nationalization.

There are two types of private or quasi-private companies involved in Egypt's health products industry: producers of drugs and supplies, and large distributors of imported medical products. It should be noted that a major part of the business of domestic production companies is carried out under license to multinational pharmaceutical companies. Over the last 20 years the benefits to multinationals of these licenses have been considerably eroded. In 1957, Egyptian firms paid foreign producers 10% royalties on all products manufactured, whether under license or not. Royalties are now only 5%, payable for five years instead of ten, and applicable only to drugs for which a license is held. Since foreign manufacturers are only allowed to import large quantities of a pharmaceutical if local producers are unable to fulfill demand, there is some additional protection for licensed drugs. Once local firms are in a position to fill this demand, however, foreign companies are given two years to phase their product out.

It should be noted as well that the quasi-private firms operating in the domestic pharmaceuticals market are heavily subsidized. Government subsidies to the industry totaled LE 6 million in 1979 and 1980, while LE 37 million in public funds was spent for the renovation and expansion of state-owned drug plants under the current Five-Year Plan.[13]

Manufacturers: All purely indigenous pharmaceutical companies in Egypt (i.e., those without foreign participation) are technically public companies. Of the eight public companies manufacturing dosage forms, one (El Nasr Pharmaceutical Chemical Company) is predominantly a producer of chemicals and active ingredients to be used by other pharmaceutical manufacturers. The remaining seven companies are as follows:[14]

° The El Nil Company for Pharmaceuticals and Chemical Industries was formed in 1962 via the nationalization and consolidation of several small private laboratories. If measured by sales, El Nil is the second largest of the public drug manufacturers, with 1981 sales totaling $33.6 million, an increase of 41% over 1980.

El Nil is the licensed manufacturer for a range of multinational companies including Upjohn, Merck, Wyeth, Parke Davis, Abbott, and Le Petit (a division of Dow Chemical). Its product line includes cosmetics and skin creams as well as ethical pharmaceuticals. In the latter categories, it focuses on antibiotics and intravenous solutions (which it has sold at a loss for several years). It is also Egypt's only producer of "cat-gut" sutures.

The company has one of the only corporate research and development operations among indigenous producers, focusing on sulfa drugs and antacids. It has also undertaken research programs regarding the therapeutic effects of local herbs on liver and skin diseases and on diabetes.

° The Chemical Industries Development Company (CID) is the only one of the seven major companies to have been founded (in 1946) as a public sector company. It is also the largest, with $37.8 million in sales in 1981. This represents a 35% increase in sales over 1980.

CID produces drugs under license for such major companies as Bristol Myers, Schering AG, Boehringer Ingelheim, Astra and Takeda. Its product line is broad, but for several years, it has specialized in antibiotics and insulin. CID is also UNICEF's local producer of oral rehydration salts for government purposes.

° Al Kahira Pharmaceuticals and Chemicals Industries Company was founded in 1962 via the nationalization and consolidation of four private companies. The total volume of its 1981 sales was $30.8 million. Al Kahira's non-licensed production is limited to hard and soft gelatin capsules and a series of veterinary drugs, which it hopes to expand through future licensing arrangements. It is Egypt's only producer of gelatin capsules, and has considerable potential for expansion of this product line since the entire Egyptian market for this type of capsule is valued at $20 million per year.

Currently, Al Kahira's licensing arrangements are solely for medicines for human use, and are with such major companies as Merck, Eli Lilly, Morton Norwich, Smith Kline, Searle, Boots, and ICI.

° The Misr Company for Pharmaceuticals is the nationalized version of the oldest pharmaceutical company in Egypt. Currently, it is capitalized at LE 3 million and has 200 non-management employees. Misr's 1981 sales were $30.8 million, and its product line is limited to 25 therapeutic categories scattered over a wide range of medical needs. It also has only four major licensing arrangements, and generally makes its money via the sale to the Government of injectable and oral dosage forms of antibiotics.

° The Memphis Chemical Company is also the nationalized form of the earlier, private corporation. Its sales are small ($16.8 million in 1981), but it is expected to grow considerably when a new plant comes fully into operation in late 1983. Memphis has a broad line of pharmaceuticals and holds 25 product licenses with major U.S. and European firms

° The Alexandria Company for Pharmaceutical and Chemical Industries is also one of the smallest of the local producers $16 million in sales in 1981), but is one of the more diversified of these companies. Alexandria not only manufactures a broad line of human pharmaceuticals, it also is a major producer of rubber surgical gloves and medical adhesive. Factory expansion focused on these operations is expected to meet an increasing portion of the Government's needs in this area. However, although local production of gloves can serve 75% of the market, poor quality has resulted in the company's product being used only in public sector hospitals. Similarly, although Alexandria's adhesive production could meet 30% of Egypt's requirements, quality problems have resulted in private sector reliance on imported products.

° The Arab Drug Company was founded in 1963 and had 1981 sales of $16 million, nearly a 50% increase over 1980. The company compensates for its limited licensing arrangements by marketing an extensive line of veterinary medicines as well as by specializing in injectable drugs.

Distributors:[15] Until four years ago when Egypt's "Open Door" economic policy was instituted, two public companies held a monopoly on medical products import and distribution for both the public and private sector health care provision systems. Recently, several smaller companies have been created which have been allowed to compete with the public sector and now control about 30% of the import market.

° The Egyptian Company for Trade and Distribution of Pharmaceuticals ("Egydrug") is the public company responsible for the import of drugs in finished dosage forms and for the wholesale distribution both of drugs produced locally and those imported. Egydrug has a distribution network of 43 warehouses and also operates 23 pharmacies of its own.

Egydrug is required by law to distribute up to 50% of the production of public sector companies. Its clientele thus is comprised of all government pharmacies and about 5,600 private pharmacies. All pharmacies have access to Egydrug, but the company's role is primarily a passive one. It neither actively markets nor presents information on the drugs it distributes, but merely takes import orders from its user pharmacies.

The total annual value of imports distributed by Egydrug hovers around $50 million, covering about 800 items. Egydrug handles both ethical pharmaceuticals and such health-related products as baby foods and infant formulae.

Despite the breadth of its import role, Egydrug's own financial picture is often dim. The company is allowed a wholesale mark-up of 7% by government policy. Acquisition prices on the international market, however, have been consistently rising. Moreover, Egydrug also must absorb shipping charges to its supply centers and, until recently, an import duty of 23.5%. Although the retail price of imported drugs is allowed to rise (locally-produced products are strictly controlled and are often held below cost via a complex pricing system), approval for increases is required from the Ministry of Health's Tariffication Committee. The time lag between any approval of price increase and the importer's petition often leaves Egydrug bridging the financial gap between high international costs and low domestic market prices.

° The El Gomhouria Company for Trading Pharmaceuticals, Chemicals and Medicinal Appliances was responsible until recently for all imported health care supplies except finished dose drugs. This includes both raw materials needed to produce bulk pharmaceuticals and the fine chemicals used by the above seven public companies. Total sales via El Gomhouria in 1980-81 were about $125 million, of which $35 million was for medical equipment. 95% of these sales were imports. This represents about 70% of the non-drug health product import market. El Gomhouria also is the exclusive representative for many major foreign firms in the Egyptian market. Its third role is that of purchasing agent for the Government's large international tenders.

El Gomhouria has a unique advantage over its new private sector competitors in that, as a public sector company, it can obtain the foreign currency required for imports at the official rate plus a 10% surcharge. The private companies must purchase foreign currency on the free market at a rate as much as a third above the total price paid by El Gomhouria.

The four leading private sector companies which have become newly involved in the health products import/distribution market largely service private sector facilities. These import companies cover both pharmaceuticals and medical equipment, and include:

° Alkan Company, sales volume $4 million;

° SSC, sales volume $2.5 million;

° Chemipharm, sales volume $2.5 million;

° Nile Stores of Egypt, sales volume $2.5 million.

3. Tunisia

Market Size and Structure: Total pharmaceutical sales in Tunisia in 1981 were just under $120 million, 80% of which represented imports.[16] Medical equipment and instrument sales totaled another $6 million, 90% of which was accounted for by government purchases.[17]

Major Companies: Unlike the other focus countries in this Report, Tunisia's indigenous pharmaceutical production is centralized in the Central Pharmacy of Tunisia (PCT), which is also responsible for all drug and chemical imports and distribution. While other companies may manufacture dose-form drugs, they must import the manufacturing inputs from PCT. Moreover, royalty payments on licenses are strictly limited, thus reducing the product line of any independent local producers. The result has been that the PCT has a dominant position in the local production as well as the importation of pharmaceuticals.

Prior to 1962, nearly all drugs in Tunisia were imported. Some simple formulations of over-the-counter external-use products were carried out by private pharmacists in small laboratories, but the activity was marginal compared to imports. An industry training program with Czechoslovakia started that year and the construction of PCT's own production facilities (completed in 1972) positioned the PCT as the major local producer.

In 1980, the total value of production at the PCT factory was $8.7 million, 17% of PCT's 1980 turnover. 46% of this local production was sold to the public sector, 43% to private pharmacies and facilities, and 10% was exported, mostly to Algeria under the cooperation agreement between the countries described in Chapter 9.[18]

The production of the PCT factory meets 75% of the product needs of public hospitals and clinics, but only 25% of the needs of private pharmacies, since the latter are the main distribution sites for prescription drugs.[19]

Three primary problems face the PCT factory. First, its manufacturing capability is becoming outdated; as new equipment is procured, new facilities are required. The Tunisian Sixth Five-Year Plan contains a project for construction of a new factory, but outside financing will be necessary.

Second, integrating PCT production with its distribution function has proved complex. Indeed, in 1980 there was a virtual crisis in public health institutions when the drug supply all but stopped due to a mismatch between local production, international tender, public institution demand, and the frozen stock of the extensive private pharmacy system. Since then, the PCT has reduced

its stock level to a four-month supply and adjusted its production and ordering process accordingly to meet consumption projections that are targeted at narrower time frames.

Third, unlike its Egyptian public sector company counterparts, the majority of PCT production is not under license. In 1978, it negotiated its first license and royalty arrangement with a French firm. However, PCT's director has publicly expressed dissatisfaction with the payment of royalty fees for multinational licenses and the general ties in those licenses to the purchase of imports from the home company. Although the PCT seems to recognize that the most efficient way to broaden its production base and to assimilate technological advances is via licensing arrangements, it has not determined how it will achieve that goal without compromising its unwillingness to adhere to process patents and to pay production royalties. This difficulty is described further in Chapter. 9.

4. Morocco

Approximately 80% of the pharmaceuticals in Morocco are locally formulated and manufactured by the 17 different drug manufacturing companies in the country.[20] However, about 95% of the locally-produced medicines are manufactured under license from foreign multinational corporations. All raw materials for this local production are imported. The total value of locally-produced drugs is approximately $120 million per year.

All sales prices of the 2,500 products (local and imported) licensed in the country are regulated by the Government. The sales price structure allows the retailer a mark-up of 30% and the wholesaler a margin of 10%. The rigidity of the pricing structure and the costs of investment in the local industry have acted to minimize company profits and thus discourage investment expansion.

The top three companies, in rank order, in the Moroccan market are as follows:[21]

° Polymedic, with 16% of the Moroccan market, was created in 1953 as a wholly-owned subsidiary. It now is a government joint venture and employs 300 persons. It is capitalized at MD 6.5 million and its primary products are antibiotics and drugs for gastrointestinal disease. Polymedic produces 250 products, some of which are drugs of its own product line, and some of which are products of other companies such as Merck, Sharp & Dohme and Schering Plough. The company imports 90% of its raw materials, and has an annual product turnover valued at MD 90 million ($13.8 million).

° Maphar is a wholly-owned subsidiary of France's Clin-Midy and was created in 1970 with MD 30 million in capitalization. The major portion of its 200 products are antibiotics. Maphar employs 200 persons, accounts for 13% of the local market, and has MD 85 million ($13 million) in turnover per year.

° Laprophan is a state-owned company created in 1949 with MD 3 million in assets. It has a product line of 200 items and also produces, under license, 26 other brand names. The company employs 300 persons and has an annual turnover of MD 70 million ($10.7 million). Laprophan accounts for 13% of the Moroccan market and has seen sales grow by 20% per year for the last five years.

4.D. NON-HEALTH PRODUCTS MANUFACTURERS

As noted earlier in this chapter and in Chapter 3, the manufacturing sector, both private and quasi-private, is a major part of most Middle Eastern economies. As compared to those of their multinational colleagues, however, the health-related activities of these domestic firms are generally not as well organized or as central to corporate activity. This is generally not for lack of intent or interest, but is simply a function of size and economics. With the exception of the major public sector companies, most indigenous business is relatively small and does not have the economic resources, either overall or on a per employee basis, to devote to employee health care programs. Furthermore, local private companies cannot call on parent company technical resources, as can multinational subsidiaries, to address service provision, equipment, or training program design needs. Even if financing were not a problem, this lack of domestic technical resources would inhibit health programs.

Given these limitations, two types of health-related activities on the part of indigenous business have been identified: integrated health services provision, and occupational health and safety programs. The cases presented below are illustrative of the responses of local companies, from the largest to the relatively small, in reacting to employee needs and/or national regulation. In both types of programs, ample opportunity exists for publicly-mandated development assistance agencies and/or governments themselves to provide incentives for expanded programs; linkages between indigenous businesses and those multinationals with experience in the relevant health issues; and/or joint resources to overcome the health services bottlenecks in local firms. More detailed discussion of these opportunities is contained in the final chapters of this Report.

1. Provision of General Health Services

In most cases, again for a combination of lack of resources in domestic private business and lack of initiatives from the public health system's side, no general health services are provided by local employers. In some cases, national regulation requires that pre-employment physicals be carried out, with particular emphasis on communicable disease control, but these regulations only apply to larger firms and then are poorly enforced (see Chapter 9 on national policy). There are few if any incentives developed by governments to encourage any other type of primary health care activity. By and large, business relies on the quasi-private insurance systems and public health facilities, discussed later in this chapter, to meet the health needs of employees.

It may be useful, however, to examine the case of what can happen when corporate resources and creativity are available in the region and are encouraged by government policy to assume a significant health provider role.

Case 3: KUWAIT OIL COMPANY

Begun in 1947 with an 80-bed hospital for Kuwait Oil employees, Kuwait Oil's health services currently provide health care to over 60,000 employees and members of the communities surrounding the company's facilities. The extent of the services offered by Kuwait Oil Company have increased gradually over the past 35 years, but the Ahmadi Hospital, built by Kuwait Oil in 1960, is now a major provider of health care in the country. The hospital began to offer its services to non-employees of the company when the Minister of Health asked that a number of beds be used for the acutely ill and for acute emergency cases from the surrounding area.

Ahmadi Hospital, with a 1982-83 budget of $17.2 million, offers the following services to its patients:

- -- medical services, including pediatrics, intensive care, pharmaceuticals;
- -- surgical services;
- -- dental care;
- -- preventive health, both public and occupational.

There are 627 people on staff and more than half are employed in nursing services. Emphasis is on hiring staff from the Middle East and in-service training is provided where necessary to better the credentials of the Middle East staff.

Although the Government owns Kuwait Oil Company, its health services are considered private and run from the Ministry of Oil, rather than from the Ministry of Health.

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Case 4: HEALTH SERVICES IN STATE-OWNED CORPORATIONS, MOROCCO

In Morocco, the country's physical infrastructure and chief natural resources are managed and operated by large state-owned corporations. These corporations and their workers are often self-contained agencies, financing and providing many of their own services outside the normal ministerial or social welfare structures. The provision of health services is no exception.

The Office Chérifien des Phosphates is the state-owned corporation responsible for the production, processing, and marketing of Morocco's main export. The company annually spends nearly $5 million on social services for its 23,000 employees. It finances and operates two multi-service hospitals with a total of 464 beds. Over 40 physicians are employed by the company to serve these facilities as well as the outpatient clinics operated at its mines and processing plants. Services in these facilities are provided to all employees and their families.

The Office National des Chemins de Fer, the national railroad company, also operates a set of its own clinics for all employees at a total annual cost of $4.5 million. Oversight of these facilities is outside the authority of the Ministry of Health.

The other two state-owned infrastructure companies, the Office National des Transports and the Bureau de Recherches et de Participation Minière, also provide their own health services to employees, but do so via contract arrangements with private sector facilities and physicians. The total health budget costs to these two companies approach a quarter of a million dollars annually.

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Case 5: MISR SPINNING AND WEAVING COMPANY MELHALLA ELKUBRA, EGYPT

Misr Spinning and Weaving is a state-owned corporation employing 35,000, with textile facilities located halfway between Cairo and Alexandria. The company operates a 200+-bed hospital for its employees and their dependents.

The 23 outpatient examining and treatment rooms see 1,500 to 2,000 outpatients per day. Between 30 and 40 company and company-contracted doctors staff this operation. The company hospital provides nearly all types of medical, surgical, and obstetrics/gynecology services. Its annual patient load is between 7,500 and 20,000 persons.

The Misr Spinning medical operation is the main provider of health services in Mehalla Elkubra, and thus has all the problems of Egypt's public health system. Patient flows and management are often disorganized. Equipment is outdated and inadequate; maintenance and repair is sporadic at best because the company, just as the public health system, suffers from the country's general lack of technical personnel.

Nevertheless, the company has made a considerable effort to meet the needs of its workers and their families. The company facility offers medical, dental and ophthamological services not only to its workers and their families, but also to the surrounding community. Its outpatient clinics also offer a wide variety of medical, child-care, nutrition, and some family planning services to women workers as well as to those in the community.

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2. Occupational Health and Safety

The health problems of workers in the Middle East, as in most developing regions, are more complex than in industrialized countries due to the general health conditions in the countries, the level of worker training, the availability of safety equipment, and even the mismatch between the dimensions and layout of imported equipment compared to the physical proportions of the local work force. Solving these problems is not only a matter of developing workable national policies (see Chapter 9). It is also a matter of economics (much, often all, safety equipment must be imported, requiring foreign currency which is in short supply in private local business); the age of most machinery in private factories, not easily adaptable to modern concepts of protection from air pollution, noise, and heat (in many cases, substantial investment would be needed to replace basic machinery even before safety equipment could be added); and the level of technical knowledge among (or the sheer lack of) specialists in occupational safety within the individual countries or companies.

In these circumstances, nearly the only way indigenous business can respond to its OHS needs is via cooperative partnerships, relying on (1) public/government policy systems, which focus on incentives rather than on public threats; (2) development assistance for equipment, training, and technical skills; and (3) multinational corporate leaders for technical guidance on the ground as to how to set up internal, sustainable reporting, training, and warning systems.

The following six examples illustrate the successes (and the serious problems) of delivering occupational health and safety services in the private industrial sector of the Middle East. The examples also illustrate the potential of existing OHS programs for expansion particularly as the private sector grows and expands with new public economic policies. In many cases, OHS programs offer many employees their only avenue for consulting with a physician and engaging in disease prevention programs. Limited OHS programs already in existence may, with the right approach, be broadened to cover a whole range of public health programs, including nutrition education, hygiene education, and disease control.

Case 6: CAIRO COMPANY FOR BEVERAGES

The Cairo Company for Beverages is a private company established in 1980, employing 1,350 workers. In accordance with Egyptian law (see Chapter 9), the company has instituted a Health and Safety Committee to ensure implementation of safety regulations and train members in occupational safety procedures. Spokesmen of the company state that these OHS requirements are not difficult to maintain. The company provides a medical check-up prior to employment and medical check-ups are administered to all workers on a regular basis for early detection of occupational or other diseases.

The company's largest problem reportedly is in the reliability of the required Health and Safety Committee itself. Egyptian law mandates that a quorum, 50% of the members, is required for a Committee meeting. However, 50% of the Committee members are also required to be factory workers. Given the pressures of time and lack of worker understanding of OHS issues, factory workers often fail to attend meetings. The result is that few meetings officially take place and thus the company has problems with reporting statistics to the Government and thus risks being viewed as not complying with the law.

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This problem of the on-the-job implementability of government regulations, developed almost exclusively by public or international regulators and without business input, plagues most private sector management.

Case 7: NASR COMPANY FOR MANUFACTURING TELEVISIONS

Nasr TV is a publicly-owned company which was licensed in 1979 to produce television reception sets and general electronic equipment. The company operates several small factories and is responsible to the Ministry of Industry.

Since the company is relatively new, OHS conditions are fairly good and the company provides the following health and safety services to its workers:

-- Free first aid services;

-- Periodical medical check-up and referral to the hospital of the worker's choice as necessary;

-- On-the-job training in OHS procedures by company personnel and experts from the Ministry of Industry.

Payment for worker services, beyond on-the-job first aid, is handled via the public worker insurance systems described later in this chapter. Since these insurance schemes only apply to public facilities, however, the policy of the company seldom involves the local private delivery sector.

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Case 8: HELWAN IRON AND STEEL FACTORY, EGYPT

The Helwan factory is one of the largest of Egypt's publicly-owned companies and employs over 16,000 workers. In keeping with government regulations, it too has developed an OHS Committee which meets every two months. Helwan also has had problems with the practicality of this mechanism for identifying and dealing with OHS needs.

In addition to supplying workers with the necessary safety equipment, the company attempts to provide a range of preventive occupational safety measures in such areas as air purification, materials storage, and continuous cleaning of equipment. However, the expense of these procedures, the company's reliance on public finance, and the aging equipment in the factory make these procedures increasingly difficult.

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Case 9: NASR PAINT AND CHEMICAL COMPANY

Nasr Paint and Chemical is responsible to the Ministry of Industry for production of a range of paints and varnishes as well as for the manufacture of charcoal and printing inks. Clearly, work environment and materials represent potentially serious chemical hazards for workers. Required OHS programs have been largely ineffective in the opinion of company management.

The company does have an OHS Committee, but conditions are poor, primarily because of limited and poor technology in the factory. Hazards of chemicals, animal dust and bacteria remain problems. The managers complain that they do not have sufficient means to deal with the many problems.

There are no periodic health check-ups to detect or prevent the occurrence of occupational diseases. If diseases do occur, workers are referred to public sector hospitals for treatment. The company states that it requires substantial investment to modernize machines for increased safety and additional finances to provide training for specialized staff to ensure early detection and treatment of OHS problems.

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Case 10: THE JORDAN ELECTRICITY COMPANY, AMMAN

The Jordan Electricty Company devotes great attention and care to the subject of occupational health and safety due to the great danger involved in the nature of the company's work.

The company has formed "The Labour Safety Committee," which is solely responsible for ensuring worker safety. This Committee consists of representatives from the Electricity Labour Union, the Company's Board of Directors, and the Jordanian Labour Union. All foremen or heads of workshops or superintendents, site engineers or company inspectors, submit monthly reports to the Committee on any work accidents, safety violations, or any other safety incidents that occur. The Committee members discuss these reports and develop new safety instructions, solutions, and recommendations accordingly. The company's Department of Labour Safety, directly responsible for informing workers of all safety procedures and instructions and ensuring that such instructions are strictly followed, takes the Committee's report and distributes it to all work sites. In addition, every six months a periodical bulletin is published on all work accidents that have occurred during that period, showing the causes of such accidents and ways to avoid them.

The Department of Labour Safety also has a specialized staff of inspectors who make regular rounds to examine to what extent both the laborers and their supervisors are following the company's safety instructions, e.g., using safety helmets, rubber boots, etc., and to comment on any violations.

Both the Committee of Labour Safety and the Department of Labour Safety cooperate in conducting training courses for new workers, and in providing safety upgrading lectures to all staff.

The Department of Labour Safety is also responsible for the distribution of all instructions issued by the Ministry of Labour regarding occupational safety.

The Jordan Electricity Company has published a booklet about safety instructions for those working on networks and installations of low, high, and very high voltages. The booklet was designed by the head of the company's Technical Department and it is distributed to each and every worker. It describes, in lay terms, the nature of electricity and its dangers, gives comprehensive and detailed instructions on safety procedures, and specifies how and when all safety equipment should be used. A special chapter is devoted to instructions on electric shock and its treatment since most accidents that occur involve this problem. This chapter informs the workers of the effects of electric shock on the human body and of the different ways of treating it, e.g., how to administer artificial resuscitation, etc. Usually the workers are shown live demonstrations of such procedures so that they are well prepared in case of emergency.

The Department of Labour Safety also has sub-committees that are mainly concerned with the cleanliness of the work environment, before, during and after execution of work, in order to avoid hazardous conditions such as water leakage onto underground cables.

In spite of the company's efforts, accidents are common and are often fatal. The accident reports indicate that most of the occurrences are avoidable and are due to the failure to use safety equipment.

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Case 11: THE JORDAN PHOSPHATE COMPANY, LTD.

The Jordan Phosphate Company has designed a special program for ensuring occupational health and safety. This program is carried out in all of the company's three mines.

In each mine the "Department of Labour Safety" is responsible for ensuring that the company's safety program is being followed with minimum violations. The heads of these departments are appointed by

the company and are regularly sent abroad to skill upgrading courses to ensure that they are fully aware of new mine safety procedures.

These safety departments distribute written instructions to all workers in the company's mines. Instructions are also developed in the form of circulars which are displayed on all bulletin boards in the mines. In addition, the heads of the safety departments are responsible for holding group meetings with workers to inform them of the content of any new notices. Posters and explanatory diagrams are also developed by the departments and widely distributed in the mines. All workers receive practical training before starting work. The safety departments also circulate the safety instructions and regulations issued by Jordan's Ministry of Labour and are required to submit to the Ministry monthly reports of all work accidents, showing the causes and the period the worker was off work.

During their rounds, the heads of the safety departments record and make notes on the extent to which the workers are abiding by the program's insturctions. They provide in situ instruction to any workers violating safety procedures.

Besides the safety departments, each mine has its own clinic with a staff physician and nurse on duty to treat work accidents. In the case of serious accidents, each mine has an ambulance which transports the worker to the nearest hospital. In addition, free medical check-ups are provided every six months to all workers to examine general worker health and provide early identification of occupational illnesses.

Management feels that the chief barrier to improved safety is the worker's failure to follow the safety and health instructions given. Almost all accident reports filed at the Ministry of Labour indicate a failure to adhere properly to safety instructions.

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4.E. BANKING AND FINANCE

As noted earlier, examples and potential for indigenous financing of health services can be found and illustrated in the chapters on OPEC financing and indigenous private providers. A brief description of indigenous commercial banking in certain select countries is included here to highlight the level of this activity and to pinpoint the countries (Jordan, Lebanon, and Egypt) where there may be opportunities for local financing and management linkages with development assistance.

An interesting aspect of Middle East banking should be noted here -- that of Islamic banking. A number of large banks in the Middle East, including the Feisal Islamic Bank in Egypt, the Jordan Islamic Bank, the Jordan Finance House, the Islam Development Bank in Saudi Arabia, and the Kuwait Finance House in Kuwait, operate according to Koranic principles. They must find ways of interpreting the Koran's prohibition of "riba" (charging interest) in financially reliable ways. Islamic banks do not charge interest on deposits or loans; rather, they seek ways in which the deposits or loans can "earn money" in productive ways. The return on a bank's investment would thus be passed on to the bank's customer in a profit-sharing way.

Thus, loans and deposits take on different forms in Islamic banking. One cannot collect interest at a fixed rate on a loan, but one is entitled to a return on loaned capital where it has been provided to an entrepreneur on the basis that the lender will receive a proportionate share in the profits of the enterprise. Because the loaned capital is productively employed and the lender is sharing in the risks of the enterprise, any profit that he makes is earned. Of course, since he also bears the risk of losses, he may be unable, under Koranic principles, to recover even his initial capital. A bank depositor is not entitled to any fixed return on his deposit, but he may receive any return from investments for which he allows the bank to employ his deposit, although he subjects himself to the risk of any losses incurred in such investments.

1. Jordan

In Jordan there are 19 indigenous banks, five of which are wholly-owned. The remainder are joint ventures. The most well-known of Jordanian banks is the Arab Bank of Jordan. In existence for 50 years, it has assets of over $7.26 billion and a growth rate of 15% per year. The Arab Bank has branches worldwide (a branch was recently opened in the U.S.), yet Jordanian accounts entail 31% of its lending and the Arab Bank handles 45% of all Jordanian commercial banking business.[22]

Like so many other private businesses in the Middle East, the Arab Bank is family-owned and managed. The bank's operations are sophisticated and international; yet, it is viewed by the local population as a traditional family-run business, receptive to the "small man" and to various development initiatives.

The Central Bank of Jordan has been encouraging a stronger lending role by Jordanian commercial banks for individual development projects.[23] The most important vehicle for channeling funds to local projects and industry has been the locally-syndicated loan. This process has become a valuable source of finance for local industrial and development projects. Although the traditional recipients of loans have been the construction, real estate, and trading sectors,

there are opportunities, given the availability of private capital, government encouragement and direction, and expertise from development assistance, to channel local bank financing toward the health sector. Of concern to Jordan's banking system is a shortage of trained personnel, capable of efficiently and effectively evaluating the credit risk of loans for development projects. This concern over the shortage of trained personnel may present an opportunity for development assistance to offer its expertise and training capabilities to Jordanian banks for channeling loans to health-related industries and/or private providers.

2. Egypt

As mentioned earlier in this Report, the astounding growth of the banking sector in Egypt -- 65 banks in eight years -- created great expectations of capital flows for development projects which just were not realized. The majority of the newly-established banks concentrated their business in short-term credit for trade.

Since financing for development projects has not been forthcoming, the Central Bank has initiated several regulations which will have the effect of channeling more money into domestic development. Again, the encouragement, support, and incentives of the Government for directing private finance to development may provide the right environment for linkages and encouragement from development assistance.

3. Lebanon

Despite the five years of civil war and turmoil which have severely disrupted the economy and the quantity of commercial transactions in Lebanon, one cannot describe private banking in the Middle East without briefly mentioning this country. Banking and finance were the lifeblood of Lebanon's development, and, to a large extent, still are. Surprisingly, since 1975, commercial banking business has grown. The number of licensed banks in the country is 130, and 69 banks are actually operating. Deposits in local and foreign currencies have risen and loans have increased. It appears that the future economic stability and development of the country will rely as well upon the continued durability of the private banking sector.[24]

4.F. INSURANCE

Growth in the private indigenous insurance industry (outside Lebanon) is a recent phenomenon in the Middle East. However, an increase in demand for marine, construction, automobile, and life insurance has stimulated an expansion in this indigenous industry serving both the home country and wider international markets.

The General Arab Insurance Federation (GAIF) is the trade association for the insurance industry in the region. The overall GAIF goal is the creation of a single Arab insurance and reinsurance common market. However, a multitude of diverse regulations in this highly-controlled field is a major obstacle to the formation of a structured Middle East system.

Of particular interest to this Report, the health insurance industry in most countries is dominated by government agencies, particularly those responsible for government and industrial worker casualty and disability finance.

In general, the participation of private insurers in the health insurance industry is still in an embryonic stage, its growth stunted by a range of government policies which seek to maintain public control over the industry. As will be indicated in this chapter, this public control frequently results in limiting health services to the overall population by removing many insurance financing options and by limiting the aggregation of capital by the private sector in these countries.

This section will briefly cover the status and role of the private indigenous insurance industry and will also focus on key public social security and health systems responsible for providing health insurance.

1. Egypt

Egypt's delivery of health insurance is highly-structured and relatively sophisticated.

Every permanent salaried employee above the age of 18, with the exception of construction, shipyard and domestic workers, is socially insured by Law 79/1975, amended by Law 25/1977. This social insurance includes old age, disability and death, occupational injury insurance, health and unemployment. It is also obligatory and is paid by both the employer and the employee. The private sector employer withholds 3% of employee monthly wage for occupational injury, 15% for pension, 4% for health insurance, and 2% for unemployment. Although the General Organization for Social Insurance is the government agency responsible for claims settlement under Egypt's social insurance laws, the health aspects of those laws are implemented by the General Organization of Health Insurance (GOHI).

There are three main systems for health insurance provision in Egypt:

(1) Law No. 75 (1964) specifies that 1% of the monthly wage of an employee is to be paid by the employee and 3% of the monthly wage of the employee by the employer to the GOHI health insurance fund, with services to be provided by GOHI.

(2) Law No. 32 (1975) establishes the possibility of partial coverage. An employee may choose to pay 0.5% of his monthly wage and have 1.5% paid by the employer to the GOHI for health insurance. GOHI then provides health services, but these are only partially funded, and the beneficiary must assume some service costs, not to exceed 50%.

(3) There is also a nascent private health insurance industry in Egypt, provided by private carriers who serve employers who decide not to use the GOHI systems. These employers, however, must still pay employee health coverage to GOHI. (This double burden of payment obviously deters many companies from utilizing a private system of health insurance.)

GOHI began its operations in 1964 in Alexandria, where the majority of beneficiaries are still located. At its creation, GOHI was a public sector enterprise subject to control by the Ministry of Health. However, in 1979, as an outgrowth of the Open Door Policy, GOHI was converted to an "open enterprise." Re-categorized as an "economic authority," GOHI was given greater flexibility, independence and autonomy over its own management decisions. It is able to set rates of remuneration to its salaried employees at levels exceeding those admissible for public service government employees, and is able to finance investment projects from operating surpluses or from foreign donors. Nevertheless, the GOHI retains significant public agency ties. All medical posts in GOHI must be authorized by the Ministry of Health; its service provision activities are closely monitored by the Government; and, of course, its finances are derived from government-authorized and controlled social security schemes.

GOHI currently covers about 2.5 million people. It operates 20 hospitals, comprising 3,526 beds in addition to bed space leased from Ministry of Health facilities on a contractual basis. The bed/population ratio for GOHI beneficiaries is 2.2:1,000. Established staffing ratios are generally adhered to with difficulty. Each general practitioner is expected to handle 20 patients. The prescribed ratio is 1:4. One nutrition specialist is provided for every 100 beds, one laboratory and one X-ray technician for every 50 beds and a social worker and public relations person for every 100 beds.

General practitioner clinics are located within each firm employing 300 workers or more -- otherwise, these clinics are centrally located to service several smaller firms.

The medical staff of GOHI are employed either on contractual or salaried bases. Salaried physicians receive higher payments than those received for government services, but they are not permitted to engage in private practice.

GOHI has been able to maintain an excellent system of record keeping for monitoring utilization and cost rates, due to a beneficiary passbook system, the passbook containing name, code number, picture, and medical record.

It is interesting to note that there are substantial differences in utilization rates between co-payment (sharing costs of services) and non co-payment beneficiaries.

Utilization Rates of Co-Payment and Non Co-Payment System in Alexandria - 1981

	Co-Payment	Non Co-Payment
Average Annual Visits/GP	4.0	6.0
Average Annual Visits/Specialist	1.0	1.5
Average Annual Prescription rate	3.0	6.0
Average Annual X-ray	100	150
Average Annual Lab Visits	400	750

Although there is not a substantial difference in visits as between general practitioners and specialists, the use of additional GOHI services -- lab, X-ray, drugs -- appears to be dependent upon whether the beneficiary perceives such services to be free. It may also be a reflection of a lack of beneficiary understanding of the importance of these treatment and diagnostic tools to overall health care. "Seeing the doctor" may be considered sufficient in itself to treat the illness.

Costs in the GOHI system in 1982 were estimated at LE 20 per beneficiary. There are various interpretations concerning the financial solvency of the system. Some reports maintain that the system is under-financed and over-extended. Other reports maintain that the system is currently breaking even, yet expects problems in the future if wages do not increase to cover the rising costs of health services. In addition, GOHI would like to expand its services to include dependents, pensioners, and agricultural workers. It is doubtful that this expansion would allow the system to maintain the level of management

and per unit cost with the reduction in per unit revenue of members added. Thus, the future viability of the public health insurance system in covering a wider proportion of the population appears to be in some question.

Private health insurance, possibly with cooperation from development assistance, could play a more significant role than is currently allowed in supplementing hard-pressed government health insurance systems. Of course, the private health insurers could also serve populations not covered by the GOHI system.

In 1980, there were 144 active private insurance funds in Egypt. Most of these are internal programs of agencies, companies, syndicates, or associations wishing to increase benefits and health services to their members. In 1980, these funds distributed the following benefits:

Function	Amount in LE '000
Death	706
Disability (members')	166
Marriage of Daughter	14
Illness and Treatment	652
Birth	12
Pensions	2,990
Investment	84,000
Return on Investment	5,712

All insurance companies in Egypt, of whatever type, must be owned by Egyptian citizens, and all insurance activities in Egypt must be covered by Egyptian insurance companies. The insurance industry in Egypt is regulated by Law 10/1981 and controlled by the Egyptian Agency for Insurance Control (EAIC). Insurance activities include fire, transportation, life, capital formation, marine, and accident. The three largest public insurance companies in Egypt are El Sharq, National Insurance, and Misr Insurance. The three largest private indigenous companies are El Mohandes, El Delta, and El Suez. Two recently created joint venture companies are the Egyptian American Insurance and Arab International Insurance. The Egyptian American Insurance is held equally by the El Sharq Insurance Company and the American International Insurance Agency. The Arab International

Insurance Company is held by Egyptian, English, German, French, Italian, Japanese, Swiss, Iraqi, and Kuwaiti insurance companies.

The three private sector insurance companies do not cover any health insurance. Their coverage extends only to marine, property, car, and life.

2. Tunisia

Health insurance was first introduced in Tunisia in 1952, for the benefit of civil service employees only. In 1960, a National Health Insurance Fund, "Caisse Nationale de Sécurité Sociale" (CNSS), was created to provide health insurance coverage to private sector employees.

The civil service health insurance was modified in 1958. Two funds were then established: the "Caisse Nationale des Retraites" (CNR) and the "Caisse de Prévoyance Sociale." In 1976, they were merged into the present fund, the CNRPS.

In addition to CNSS and CNRPS, a number of "Mutual Health Insurance Schemes" (for government employees) and "Group Insurance Contracts" (for private sector employees) are negotiated annually with private insurance companies to provide added coverage.

Three major nationalized companies -- The Electric Power Supply Company, The Railways Company, and The Hauling and Public Transportation Company -- are exempted from participation in CNRPS or CNSS. They have been legally authorized to operate their own health insurance schemes as well as to provide medical services to their employees, with a stipulation that these services must be at least equal to those provided in the public health sector. Approximately 30,000 employees benefit from this system.

Membership in the CNRPS is estimated to be 300,000 for a total population coverage of 1.5 million. Participation in this fund is obligatory. Civil service employees are required to contribute 1% of their salaries, with the Government contributing an equal amount. Under this fund, members have free access to public health facilities upon presentation of their card, and are reimbursed for medical expenses incurred in the case of illnesses which necessitate over six months of treatment. Reimbursement is made according to the following percentages:

80%	physician honoraria
100%	drugs
100%	hospitalization cost (in the public sector)
75%	hospitalization cost (in the private sector)

Membership in the CNSS is estimated at 350,000 members for a total population coverage of 1.7 million. Participation in this fund is also obligatory. The total contribution is 19.25% of salary with 6% being contributed by the employee and the remainder by the employer. This contribution covers illness, death and child benefits. The main insurance share is estimated at 6% of the total 19.25%.

The CNSS health insurance scheme provides coverage for ambulatory care and hospital treatment in the public sector only. It does not allow a free choice of physician and treatment in private hospitals. The CNSS also operates three major outpatient centers in the cities of Tunis, Sousse, and Sfax.

With some 650,000 members, the two major national health insurance funds cover a total population of 3.5 million, approximately half the entire population of the country. As health services financed under these two funds are almost exclusively restricted to a public health sector already overburdened by service provision demands of the non-insured population, there is often no real difference in access to care as between the insured and non-insured population. Thus, a variety of private health insurance schemes and group insurance contracts have arisen to compensate for the lack of services provided under the obligatory systems. In order to gain access to private health care and to have a free choice of hospital and physician, employees and employers are constrained (similar to Egypt) to double up their coverage under the health insurance funds by entering health insurance agreements with private insurance companies. The volume of this activity is estimated to be $20 million for 1982.

3. Jordan

Revenues for Jordanian insurance companies have risen from JD 269,000 in 1972 to JD 3 million in 1980, a substantial increase, which reflects the increase in the number of companies and in the quality and quantity of their investments.

Jordan's Social Security Corporation is financed by subscription from employer and employee and from the return on its investments. Although a public agency, it maintains administrative and financial independence from the Government. The Social Security Corporation covers health, disability, old age, and unemployment insurance. Its 1982 revenues totaled $65.8 million, more than double its 1981 revenues of $32 million. Yet, in the first half of 1982, the Social Security Corporation paid out only $294,000 for medical treatment.

Case 12: JORDANIAN INSURANCE, A MOVE TOWARD THE PRIVATE SECTOR

In April 1983, a conference was held in Jordan involving both government health officials and private health insurers and providers to discuss methods for establishing a comprehensive medical insurance scheme in cooperation with the Pharmacists Syndicate. Leaders of the Pharmacists Syndicate lent support to this conference in order to increase the pharmaceutical profession's interest in and contribution to a comprehensive medical insurance scheme.

The aims of a comprehensive medical insurance scheme were agreed upon as follows:

-- The provision of medical services to cover all citizens;

-- Beneficiary freedom of choice of hospital, physician, or pharmacy, thereby stimulating competition and better services among providers;

-- Implementation of a pre-financing scheme with a fixed percentage deducted from individual income as payment, and thus with higher-income employees absorbing more of the insurance bill;

-- Utilization of all services and capabilities including those of the private health sector in order to reduce duplication and provide for maximum availability of services;

-- Support for competitive atmosphere among all service providers to create most cost-efficient services.

The conference also supported the establishment of an independent institution to manage the comprehensive medical insurance scheme and recommended the allotment of 10% of wages and salaries to be divided between the Government, employer, and employee to fund the scheme initially.

The final recommendations and processes for implementation of this scheme have not at this writing been made public. However, the program, as it appears on paper, would provide for a competitive and cooperative mix among the public and private health care providers. It would thus be relatively unique among the existing insurance systems in the region in placing the insurance function into an institution independent of the Government and using both private and public delivery systems to provide services.

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4. Lebanon

Whereas other countries in the Middle East have only recently experienced growth in their domestic private insurance industries, Lebanon has historically served as the insurance center for the region. Business has only increased since the civil war. In fact indigenous insurance companies are comp ining that there are now too many insurance companies operating in the country, too much unstructured competition, yet too few well-qualified and conscientious personnel.

Prior to 1968, twelve indigenous and 83 foreign insurance corporations were operating in Lebanon. At the end of 1982, those numbers were 40 and 64 respectively. The withdrawal from the market of foreign companies has been more than compensated by the establishment of local companies.

The presence of so many companies in the Lebanese market has reduced insurance rates, but has also resulted in low profits, and thus some subscribers have difficulty collecting on claims. At distinct variance with private domestic insurance in other Middle East countries, the Lebanese insurance industry is attempting to introduce more, not less, control and regulation into the system to create stability in the insurance sector.

The social security health insurance system in Lebanon is also fairly sophisticated and comprehensive. The first social security law was approved by Parliament in 1963 and became operational in 1964. Initially, coverage was limited to child support and to pension financing. In 1971, a form of medicare was added to the social security system, covering both illness and maternity costs. To date, workmen's compensation for accidents and occupational diseases is not a part of the system, although these aspects are planned for the future. By law, all Lebanese must be members of the National Social Security Foundation (NSSF) if they work in any sector of the economy, with the exception of people working in agriculture, government, army ,and police forces. In 1975, the total number of insured was 290,000 which, if the beneficiary rate of 3.8 as a factor is applied, gives approximately 900,000 total beneficiaries.

The NSSF is an independent institution, government-controlled, with financial participation of the Government of 25% to cover the medicare cost. The insured employee pays 8.5% of his gross salary for indemnity and 7.5% of his gross salary for the child support insurance up to a total monthly income of 2,000 Lebanese pounds. For medicare a charge of 7% is levied -- 5.5% is paid by the employer and 1.5% by the employee, up to a monthly salary of LL 750. Since the intake of monies into the Fund is not sufficient, the Fund has proposed raising the monthly contributory salary rate to LL 1,450.

From the medicare costs, the NSSF pays 70% of the drug cost, 70% of doctors' fees, 70% of laboratory and X-ray charges, 85% of hospital charges in specified hospitals, including payment for some lab work and X-rays. NSSF also pays 100% of maternity costs. The tariff between the NSSF and the service institutions is being negotiated by a medical committee composed of the American University of Beirut, the St. Joseph's Medical Faculty, the Ministry of Health, the doctors' syndicate of Beirut, and the doctors' syndicate of Tripoli. All proposals are submitted to a board of trustees of the NSSF, which has 11 members, four of whom are employees and four of whom are employer representatives, three government representatives, and one from the Ministry of Health. In theory, the NSSF pays 80% of hospital costs. In reality, 50% of the money paid by the NSSF covers the cost and the patient pays the balance.

Since neither the Government nor the NSSF can offer much in the way of alternative hospitalization and polyclinic facilities, the private health care suppliers enjoy something of a monopoly position. The NSSF has, therefore, suggested that, in addition to the privately-operated hospitals, a group of hospitals with adequate technical facilities, but cheaper "hotel" facilities should be established and run by joint boards from the Government, NSSF, and private groups. These facilities would then be the primary inpatient sites for NSSF-financed services. However, the NSSF is of the opinion that purely government-run hospitals are in no way capable of competing with the private services and would not contribute to altering the existing situation.

5. INDIGENOUS PRIVATE HEALTH SERVICE PROVIDERS

"The relationship between private and public health leaders has too often been one of suspicion rather than of cooperation. Private and public providers have seldom collaborated to ensure the access of the entire medical community to the best available means of medical care. Yet, if our health aspirations are to make financial sense, we together must now begin to see our individual roles as inextricably linked, to ensure better relationships among health providers and to promote the development of total health systems for our nations and our peoples."
Doctor Hamouda Ben Slama, General Secretary of the Arab Medical Union. Former Deputy President of the Tunisian Medical Council.

5.A. INTRODUCTION

In general, little specific data is available about private delivery of health care in the developing world. The assumption in development assistance has usually been that health services are more equitably available to poor populations if these services are managed, regulated, and actually provided by the public sector.

In the Middle East, however, private providers are a fundamental part of the health system, often even the first point of contact between that system and the public.

This chapter will set out some basic data regarding the size and distribution of private delivery and providers in the specific countries of interest in this Report. Chapter 9 will address national government policies toward this private sector. General discussions of the health problems and the public health service in each country are to be found in other documents and are discussed here only when relevant to issues facing the private provider sector.

5.B. JORDAN

Private health care has traditionally been the norm in Jordan. While the number of private facilities and personnel differ as between government and medical syndicate statistics, approximately

a third of inpatient beds, over a quarter of inpatient admittances, and half the country's health personnel are accounted for in the private sector. In addition, in 1979, approximately JD 11.6 million ($32.5 million) was spent on private hospital and physician services, nearly the same amount as that spent on health services by the Ministry of Health.

Facilities: Currently, there are 26 private hospitals in Jordan, with a total of 1,045 beds.[1] Most such facilities are fairly small, with seven having between 40 and 90 beds and only two, both in Amman, having 100 or more beds. Nevertheless, this number represents nearly a 60% increase in private beds since 1971.[2] Table I below indicates the geographic and public-private distribution of hospital beds throughout Jordan.

TABLE 5.I

Distribution of Hospital Beds of Government & Semi-Government & Private Hospitals in the Different Districts of Jordan for 1981

District	No. of Gov't. & Semi-Gov't. Beds[a/]	No. of Private Beds[b/]	TOTAL
1. Amman Governorate	2052	850	2682
a. Amman	1692	735	2203
b. Zarqa	310	115	429
c. Madaba	50	-	50
2. Balka Governorate	114	-	114
3. Irbid Governorate	571	170	718
a. Irbid	400	80	475
b. Jerash	50	-	50
c. Mafraq	55	40	95
d. Ramtha	56	-	56
e. Ajloun	-	50	50
f. Northern Jordan Valley (Ghor)	10	-	10
4. Kerak Governorate	181	25	217
a. Kerak	139	25	175
b. Tafilah	42	-	42
5. Ma'an Governorate	156	-	156
a. Ma'an	86	-	86
b. Aqaba	70	-	70
TOTAL	3074	1045	3887

[a/] Includes hospital beds of the Ministry of Health, The Jordan University and The Royal Medical Services (armed forces). The Annual Statistical Report for 1981 (published by The Directorate of Planning/Ministry of Health).
[b/] 1983 statistics of the Medical Syndicate.

There are also 1,250 private outpatient clinics in Jordan, but details of their geographic distribution are unavailable.

Expansion of these private facilities can be expected in the future. For example, the Jordan Medical Corporation (JMC) has plans to build a 150-bed private hospital in Amman with an attached office block for the practices of 28 consultant physicians. The JMC is a private company with 24,500 shareholders, all Jordanian.

In terms of the service performance of these institutions, private hospitals in 1981 accounted for 25.6% of hospital admittances in the country, 26% of surgical operations, and 28% of maternity cases. Table II below compares these figures for the various categories of providers in Jordan.

TABLE 5.II

Percentage Distribution of Hospital Services According to the Different Health Sectors During 1981

Services	Ministry of Health	Royal Medical Services	Jordan Univ. Hospital	Private Sector	TOTAL
Admittances	44.2	21.8	8.6	25.6	194942
Surgical Operations	41.2	24.2	8.6	26.3	69258
Birth Cases	45.7	22.6	3.6	28.2	54312

Source: The Annual Statistical Report for 1981 (published by The Directorate of Planning, The Ministry of Health).

Private hospitals in Jordan in 1981 had the lowest occupancy rates of the above provider categories (55.2%, compared to 68.3% for Ministry of Health facilities), but also the lowest average length of stay (3.3 days) of any provider category. Comparable ALOS for other sectors were 4.1 days for MOH facilities, 5.8 days for Royal Medical Service facilities, and 6.8 days for the Jordan University Hospital. This combination of fairly low occupancy plus low ALOS in the private sector indicates that, although there may be utilization problems, the private sector continues to move patients through its facilities in a fairly efficient manner and does not hold them over to boost occupancy rates and therefore patient bills.

Private hospitals in Jordan operate under a minimum/maximum fee structure established by the Joint Hospitals Committee of the Ministry of Health and Medical Syndicate. Hospital rooms are classified by floor area and degree of privacy, and fees, including all non-medical services, are set as follows:

	Minimum (JD)	Maximum JD)
a. Suite	30	40
b. First Class/Deluxe	18	25
c. First Class	15	20
d. Second Class	10	15
e. Third Class	7	10

Accompanying relatives are charged half the room fee. Costs of medical services are calculated separately and are also regulated by detailed minimum/maximum standards.

Fee disputes between hospital (or physician) and patients are mediated by the Joint Hospitals Committee and, if necessary, submitted to a disciplinary council of MOH and Medical Syndicate officials.

Personnel: In many health personnel categories the number of private providers rivals or exceeds those in the public sector. Table III below contains summary figures for the main personnel categories by sector.

TABLE 5.III

1981 Statistics on the Number of Physicians, Dentists, Pharmacists, Nurses & Midwives in Jordan

SECTOR[a]	THE PUBLIC SECTOR			TOTAL		
CATEGORY	Ministry of Health	Jordan Univ. Hospital	Royal Medical Services	PUBLIC SECTOR	PRIVATE SECTOR	TOTAL
Physicians	858[b]	147	451	1456	1302[b]	2758
Dentists	68	-	66	134	366	500
Pharmacists	32	2	31	65	613	678
Nurses	262	197	312	771	120	891
Midwives	155	7	22	184	40	224

[a] The Annual Statistical Report for 1981 (published by The Directorate of Planning, The Ministry of Health).
[b] Data from the Medical Syndicate and the Nurses and Midwives Syndicate, 1983.

The above data should be qualified on three points. First, they do not include some 300 unemployed physicians, mainly trained in Eastern bloc countries, who are unable to take and/or pass the locally required Medical Board examination. This problem is serious in Jordan, but its scope is difficult to determine. Second, the data introduce something of a false impression overall, since it is not uncommon for publicly-employed medical personnel to supply medical services privately on a part-time basis in their off-hours. Third, the data mask some fairly serious medical care personnel distribution problems. 90% of the country's physicians are located in Amman, Zarqa, and Irbid,[3] which together have 45% of the population.

One of the main personnel problems in Jordan, in both the private and public sectors, is the nursing shortage. The Government estimates that shortage to be 35% of current requirements,[4] mostly due to the drain of nurses out of the country and into the oil-producing nations.

No fee scales are set by the Government for private nursing and midwife services. Physicians' fees are regulated by Article 57 of the General Health Law, amended in 1979, effective October 1, 1982. This law specified minimum/maximum physician fees by type of activity (clinic examination, house call, consulting fee, specialist attendance at hospital), by type of physician, and by type of service rendered.[5] In brief, the fee structure is as follows:

Clinic Examination Fees:

	Minimum (JD)	Maximum (JD)
a. General Practitioner	1.5	3.5
b. Specialist		

c. Second visits (re-examination) fee should not exceed half the first examination fee.

House Call Fees:

a. Day-time visits arranged by the physician himself: the fee should not exceed double the maximum of the clinic examination fee.

b. Night visits and emergency calls: the fee should not exceed triple the maximum of the clinic examination fee.

Consulting Fee:

a. If requested by the attending physician, the fee is JD 10/ Physician.

b. If requested by the patient or his family, the fee is JD 20/ Physician.

Specialist Attending Patient in Hospital Fee:

a. The daily supervision fee of the specialist is calculated on the basis of the class of the room the patient is occupying (this is only in cases when surgery is not required):

1.	Third Class	JD 6
2.	Second Class	JD 8
3.	First Class & Suite	JD 12

b. In cases of surgery, the specialist's supervision fee is considered as part of the operation cost and should not be added as separate daily supervision fees.

Nevertheless, the monthly income of private specialized physicians can be over double that of physicians in government service, which is one of the reasons for private sector growth over the last ten years.

Pharmacists/Pharmacies: In 1981, there were 678 pharmacists working in Jordan, 613 (90%) of whom were in the private sector.[6] A very minor portion of this private number are employed in the pharmaceutical manufacturing sector;[7] the remainder operate distribution and retail pharmacies. In 1980, there were 266 private pharmacies in Jordan, predominantly in urban areas. Amman, Zarqa, and Irbid together contain 72% of the nation's pharmacies but only 45% of the population.[8] The result is that the ratio of pharmacists to population in these three largest cities is 1:5,000, while the same ratio for the rest of the country is 1:16,666.[9] While a licensing system has been developed to attempt to encourage pharmacy development in rural areas, it thus far has not succeeded. The waiting list for urban applications is over 400 pharmacists; in 1980, of the 40 new pharmacies opened, 24 were in the above three urban areas and 16 were in smaller towns.[10] However, some 80% of the rural population has daily access to urban centers.

The Government pricing regulations for pharmaceuticals sold in the private sector have been addressed in detail elsewhere.[11] In brief, drug prices are established by a public-private Tariffication Committee and are set at both the wholesale and retail levels. At the wholesale level, a series of "drugstores," which are the wholesale distributors to retail outlets of imported and local products, are permitted a 19.5% gross margin to cover import and handling costs, and derive a net profit of about 5%. The retail pharmacy is allowed a 26% margin on the wholesaler's price, with a net profit of about 10%.

5.C. TUNISIA

In contrast to the Jordanian system, Tunisia's private medical sector is a much less obvious force in health care provision. An underlying private sector does exist, however, and represents a significant physical and financial resource in the country's health system.

Facilities: The majority of hospitals in Tunisia are operated in the public sector, with the total number of hospital beds in the country being just over 13,000. Although not designated as "hospitals," there are 35 "medical centers," essentially clinics with 10-15 inpatient beds per facility, in Tunisia. These centers have a total of 441 beds. Of these 35, 27 are private and account for 353 of Tunisia's medical center beds. These centers are nearly all located in Tunis.

While, in terms of facility and bed numbers, this private presence is small, the investment of resources it represents is not, even when compared to public, Ministry of Health capital investment. As Table IV below indicates, private investment in medical centers/clinics totaled over $5 million in 1982, and over $18.5 million for the five-year period 1978-1982.

TABLE 5.IV

Private Tunisian Finance in Medical Clinics
1978-1982

('000 Tunisian Dinars)

	1978	1979	1980	1981	1982	TOTAL
Number of Facilities	2	8	3	5	5	23
Total Investment Source	556	3230.7	3443	1527	3218	11974.7

Source: Agency for Investment Promotion, Tunis.

While it is always difficult to compare public investment based on national plans to private investment, since much of the former is often not realized, this nearly TD 12 million ($18.4 million) in private sector investment in health infrastructure compares well to that of the Government, if one examines public investment actually achieved. In the Fourth Plan, TD 74.1 million ($113.4 million) was planned for health infrastructure and TD 13.4 million ($20.5 million), 18% was realized. While 1978-81 plan achievements

are not available, only TD 5.8 million ($8.9 million) additional investment was planned over that carried forward from the Fourth Plan, of which TD 3.5 million ($5.4 million) was allocated to equipment. If one assumes that the Tunisian public sector health investment realization rate rose to 25% in the Fifth Plan, then approximately TD 15.4 million ($23.6 million) was invested in new and carryover health infrastructure projects in 1978-81, to which the private sector investment of TD 12 million ($18.4 million) compares quite favorably.

In sum, the private finances flowing into health infrastructure investments in Tunisia are significant both in terms of objective level and in terms of government investment. While comparable data is not available for all countries in the region, the presence of such a level of investment in Tunisia (and, as will be seen later, in Egypt -- both with strong public delivery sectors), implies at least an equal level of private investment in countries like Jordan and Lebanon, with frequently stronger private provider sectors.

Personnel: Approximately 27% (400) of the physicians in Tunisia are employed in the private sector, 50% of those with practices in Tunis. This medical concentration reflects the general medical maldistribution problem in the health service overall; 78% of the country's physicians are located in Tunis, which has a population/physician ratio of 1,300:1, compared to a 8,333:1 ratio for the rest of Tunisia.

This concentration in Tunis together with an increasing rate of production of physicians, dentists, and pharmacists by Tunisian Universities, and thus the relative youth of the medical profession, has recently raised fears of a medical surplus in Tunis on the part of the professional associations representing these three groups. For example, 70% of the physicians in Tunisia are under 40 years of age and only 6% are over 60. 80% of the physicians in the country have been certified in the last ten years. Recently, the various associations met together to examine their options for dealing with this surplus over the next five to ten years. Among the likely results of any "surplus," of course, will be the availability of greater numbers of physicians for the Government's public health institutions. However, there is also considerable interest within private sector associations for developing methods (see Jordan discussion above) to encourage movement of private practices out of Tunis to smaller, underserved towns.

The proportions of Tunisia's nursing and technical personnel employed in the private sector are less easily specified. The Ministry of Health does not keep full registries of these categories of personnel, and no professional associations represent them. Moreover, many nurses and midwives employed in the public sector provide services to private individuals or institutions in their

off-duty hours. Comparing 1980 numbers of specialized and general nurses available and who had graduated from Tunisian nursing schools since 1960, assuming a 2% attrition rate of total nurses available in any given year, and subtracting the known nursing employees of the public health system, it appears that approximatley 14% of Tunisian-trained nurses (general and specialized) were employed in the private sector.

Ceilings on the 1962 law (No. 69-2) regulating service fees for private medical personnel and facilities were revised in April 1982. Fee structures in the regulations are fairly complex. Orders of magnitude of service fees are illustrated by the following:

Clinic or Home Consultation Fees:

a. Surgeon-dentist:

Consultation	3 D 500
Home visit	4 D 500

b. General Practitioner:

Consultation	3 D 500
Home visit	4 D 500

c. Specialized Physician

Consultation	5 D 000
Home visit	6 D 000

For night and Sunday visits, 1 Dinar is added to the base -- Night fees are applicable between 9:00 p.m. and 7:00 a.m.

Fees for Medical Procedures:

Common medical procedure	0 D 400
Surgery or specialized procedure	0 D 700
Dental Surgery	0 D 750
Midwifery procedure	0 D 300
Nursing procedure	0 D 250

Lump Sum Fees for:

Normal childbirth, attended by a physician	40 D

Lump Sum Fees (cont.)

Multiple childbirth, attended by a physician	50 D
Simple childbirth, attended by a midwife	20 D

Consultation Fees for University Hospital Personnel:

Private consultation by a Professor or 'Maître de conférence agregé'	7 D 000

Pharmacists/Pharmacies: Nearly 40 million dinars ($61 million) worth of medicines are consumed each year in Tunisia. One of the key outlets in this consumption is the system of private pharmacies throughout the country. Tablve V below indicates the relative dominance of the private sector in the pharmaceutical profession.

TABLE 5.V

Pharmacists in Tunisia - 1981

Category		Number
Private		651
of which in	private pharmacies	612
	private laboratories/medical facilities	30
	industry	9
Public		134
of which in	hospitals	105
	hospital laboratories	29
Licensed, but not yet in practice		160

In addition, another 1,224 Tunisians are in the process of pharmaceutical studies, 594 in France and 630 in Tunisia. The Pharmacists Syndicate estimates that approximately 1,000 will enter mostly private practices in the next five years, with a resultant saturation of the pharmacist market.

40% of the private pharmacists are located in Tunis. While all governorates increased their numbers of practicing pharmacists between 1980 and 1981, interestingly, the greatest rate of increase

did not take place in Tunis. While Tunis expanded its number of pharmacists by 11%, Bizerte increased its number of 61%, Zaghouan by 57%, Mahdi by 60%, Monastir by 50%, and Gabes by 47%. These growth rates are, to some extent, a product of national policy, since pharmacist licenses are given on the basis of pharmacist/population ratios in the applicant's projected area of practice. Nevertheless, objective numbers of private pharmacists in the governorates remain small. The Tunis pharmacist/population ratio is approximately 1:4,300, while that of Bizerte is 1:9,459, Mahdi, 1:13,750, and Siliana and Jendouba governorates tie for the country's lowest ratio, each having one pharmacist per 33,000 persons.

Pharmacists throughout the country are organized into a Pharmacists' Association which makes recommendations to the Government in such areas as training curriculum and the pharmacist's role in broader health care. This commercial versus health professional tension in the pharmacist's role is one of increasing concern to the Association. In addition, many pharmacists are associated with one or both of two joint-Arab associations, the Union of Arab Pharmacists and the Federation of Arab Maghreb Pharmacists. Both have membership across the Arab world and/or the Maghreb specifically, and are focused on standardizing pharmaceutical laws, encouraging scientific research, and generally encouraging Arabization of the pharmaceutical industry in the Middle East.

5.D. LEBANON

Traditionally, the private sector in Lebanon has provided approximately 80% of the care for the country's non-refugee population. The current service delivery pattern in the country is more than a bit confused due to the continued presence of foreign military operations in Lebanon. For example, in the South of Lebanon, the Israeli Defense Force provides a variety of outpatient health services, has conducted extensive immunization programs, especially among children, and provides a referral service to specialized private hospitals in Israel. While a limited private medical sector continues to operate in the South of Lebanon, the extent and nature of its activities are difficult to specify since so many of the area's health facilities were damaged in the 1982 hostilities. Of course, the nature and extent of private or foreign military health services in the Bekaa Valley and the western regions of Lebanon are unknown.

Thus, the information presented here must be limited, to some extent, to what is currently known about private delivery in and around Beirut.

Personnel: There are approximately 2,000 physicians in Lebanon, the vast majority located in Beirut and practicing in private sector facilities. Due to eight years of war and the overall personnel drain to oil-producing countries of the region, both the public, non-profit and for-profit health sectors have a severe shortage of qualified nursing

and paramedical personnel. The vast majority of personnel in these categories in the private sector are expatriate, largely from other developing countries, mostly Asian.

Physicians in the private sector have been trained in a wide range of countries, this diversity creating professional standard-setting problems for the Ordre des Médecins, the national physicians' association. Over 400 physicians in Lebanon, graduated from Soviet and Eastern bloc medical schools, have thus far not been able to pass the required national licensing examinations.

Facilities: Estimates, even among units of the Ministry of Health, regarding the numbers and distribution of private health facilities in Lebanon vary widely, especially since the damage incurred from the June-October 1982 conflict. There are approximately 100 private for-profit hospitals in Lebanon with approximately 3,000 beds. This is about the same number of beds provided by Government plus private voluntary hospitals.

Half of the private/profit facilities and about a third of the private beds are located in Beirut. The operational status of the remaining facilities outside Beirut is unclear since many were heavily damaged in recent fighting.

Outpatient dispensaries in the private sector number about 150. However, the services provided by these facilities are usually few and periodic. Many have been set up by individuals to provide for only their own extended families; many others are sponsored and financed by political groups to serve and/or attract political members or recruits.

Private for-profit facilities provide services to their own independent patients; to refugee patients, usually tertiary referral, via contract with the United Nations Refugee Works Agency (UNRWA); and to the general population in emergencies. Quality of services provided in the latter two circumstances has been a problem.

Theoretically, service quality standards in private sector facilities are set by the national private hospital syndicate, a dues-paying organization whose main task is to collect monies owed to private facilities by the Ministry of Health, the National Social Security Fund, and various other worker and medical insurance groups. Many private hospitals have not joined the syndicate so private quality standards across the country vary widely.

Given that variation, it is perhaps misleading to present a profile of a private facility in Beirut. Nevertheless, the operations of one of Beirut's best for-profit hospitals may give a view of the size and problems of such institutions.

Case 13: NAJJAR HOSPITAL, BEIRUT

The Najjar Hospital is a private, for-profit facility located near the American University of Beirut hospital (AUB), the country's preeminent facility. It is owned by two private Lebanese physicians, has 70 beds, and has been open for two years. Occupancy is usually about 90% with an average length of stay of 7.1 days, about the same as the AUB facility. All medical and surgical services, except cardiac and vascular surgery, are possible.

The hospital is staffed by 65 physicians, 6 medical residents and 6 surgical residents, one X-ray resident, three permanent anesthesiologists, and one laboratory doctor. All physician staff members of AUB have attending rights at the facility, as do 18 local private practitioners who do not belong to AUB. The teaching aspects of the hospital are also affiliated with AUB. Total staff, excluding physicians, is 120, for a staff/bed ratio of 1.7:1, considerably less than AUB's 3.6:1.

The hospital's entire administrative system, including discharge procedures, budgets, and personnel management, is carried out via a computer system developed by Data General. To avoid service interruption due to the frequent public power failures, the hospital has its own generating facilities.

The hospital's primary problems are three-fold. Keeping a full complement of staff is extremely difficult and time-consuming, especially for nursing categories. The 60 nurses currently employed are all Asian since no local nurses are available. This problem creates its own subsidiary difficulties of patient communication. Second, hospital costs have been difficult to control since small facilities must purchase drugs and supplies on the local market, which has itself fluctuated widely over the last two years, rather than directly on the foreign market as does AUB. Najjar's owners are hoping to forge a purchasing cooperative with several other local facilities to place bulk orders on larger markets and thus obtain lower prices. Finally, the facility lost LL 1.9 million ($0.5 million) over the last year treating emergency cases from the Beirut hostilities.

Financing: As private sector facilities expanded to fill health services demand over the last ten years, there has emerged a serious financing problem between public and private sectors. The Ministry of Health estimates that a total of LL 1.1 billion ($266 million) is spent each year on health care, of which it dispenses LL 130 million ($31.5 million) in hospitalization; LL 500 million ($121 million) are hospitalization costs in the private sector; and LL 500 million ($121 million) are direct private payouts for physician services and pharmaceuticals.

Much of the financing of these costs has come via public monies. Since the public sector lacks its own facilities, it contracts services to the private sector. Over the last eight years, reimbursement for those services has risen from 10% of the Ministry of Health budget to a level greater than the budget itself. Similar reimbursement mechanisms, without cost control mechanisms, operate in various other public ministries and agencies. The result is a hemorrhage of public funds for medical care. The problem is less the focus of provision of services than the lack of auditing, fiscal accountability, and cost analysis standards and capabilities within public reimbursement agencies. This problem is one whose solution is essential, but which solution can be filled either with confrontation between public and private sectors or with cooperative problem-solving. Chapter 12 below presents these options in more detail.

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5.E. EGYPT

Of the various countries in the region, the most is known about the nature and extent of the Egyptian private health sector, thanks largely to in-depth work carried out by the U.S. Agency for International Development. That work will be summarized here, and supplemented where necessary. However, given the complexity of the Egyptian system, these field studies should be consulted for more detail.

Personnel: Estimates from the Ministry of Health indicate that there are now about 12,000 private physicians in practice in Egypt, of whom some 4,000 are in rural areas. Comparisons to the number of publicly-employed physicians are misleading, since many of these "private" practitioners are government-employed with part-time private practices. In rural areas, this process of "privatization" has been speeded not only by economic need, but also by changes in government regulations which now officially allow government physicians to carry on private practices. This regulatory change, combined with the medical saturation of the urban market and high start-up costs of urban practices, have resulted in upwards of 50% of young physicians, after completing their one-year required rural service tour, choosing to remain in rural systems.

The prevalence of non-physician private health personnel is thought to be widespread. However, since they neither are publicly-registered, nor have a professional association, nor work in facilities (e.g., private hospitals) which must file personnel records with a central government bureau, there are no accurate estimates of their numbers.

Outlets for the services of private physicians are severalfold, and include:

-- Independent/individual practices, usually via a small clinic or one-room examining/treatment office;

-- Via affiliation with larger, curative institutions (see below);

-- Contract arrangements for services with the Cairo and Alexandria Curative Organization, a quasi-public agency which was created to manage, maintain, and administer 14 of the 40 formerly private hospitals and clinics nationalized in the mid-1960's. Curative Organization facilities now number 12 and are permitted a profit, but that profit must be plowed back into facility and equipment investments and improvements;

-- Contracts with health facilities of private voluntary, charitable, or group-supported organization.

While most private physician fees are not publicly-regulated, the Curative Organization operates on a set fee schedule, half of which goes to the hospital and half to the physician. Private charitable facilities also usually charge fees, which are split with the physician, but these vary by facility and are also unregulated.

Services provided by private practitioners are almost wholly curative in nature, although some preventive and health education programs appear to be carried out in rural areas.

Case 14: SUEZ CANAL UNIVERSITY GROUP PRACTICE, ISMAILIA

The full economic and social infrastructure development of the area surrounding the Suez Canal has been one of Egypt's development priorities since the re-opening of the Canal in the late 1970's. As part of that effort the Suez Canal University was inaugurated and its School of Medicine opened in October 1981. Planning for the medical school had quickly identified one of the the prime barriers to successful operation of the facility, i.e., in order to attract and retain senior clinical faculty to the school in Ismailia and to ensure that a substantial portion of their time was spent on University activities, a way would need to be found to enable faculty members to earn an income comparable to what they could otherwise earn in private practice. A solution to this problem, however, would have to be integrated into Ismailia's larger need for quality primary health services.

To address these barriers, the U.S. Agency for International Development, Boston University, the Egyptian Government, and the Dean of the School of Medicine joined forces to develop a quasi-private delivery solution to the compensation/quality problem. On December 5, 1982 the Group Practice of the Suez Canal University School of Medicine opened its doors. The "Group Practice" is, essentially, a private practice clinic whose members are also members of the Faculty of the medical school. The Group Practice allows a substantial number of faculty to integrate private clinical activities with their teaching/service/research responsibilities by establishing a fee-for-service formula in the private clinic which divides the group's revenues between the practitioners' or specialists' operating units and the Faculty of Medicine. Funds distributed to the Faculty of Medicine are used to support the school's educational programs. Funds allocated to the practice units generating the revenues pay for salaries, equipment, supplies, funded depreciation, and services purchased among revenue-generating units of the Faculty of Medicine. Because revenues are distributed to practices on a percentage basis with built-in productivity bonuses, productivity is expected to increase, revenue to expand and, therefore, the amount of funding available for education programs also to increase.

At its inception, the Group Practice was subsidized by a grant from the Agency for International Development. Currently, the proportion of revenues versus grants in the Practice is shifting, and the need for subsidization is expected to be eliminated in the near-term.

Thus, in addition to providing practitioners in a public institution with official additional income, and thereby both attracting quality personnel and ensuring that their priorities remain with the institution, the Group Practice also:

-- Improves medical services for the Suez area population;

-- Provides a subsidy for the educational institution from practice income;

-- Establishes a model practice environment for students and area providers;

-- Integrates and improves private and governmental health services.

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Facilities: As with personnel, there is no central count of the number of for-profit private health facilities in Egypt. Once again, "facility" is a term which must be interpreted liberally, as it covers everything from the newly-planned $20.3 million, 266-bed Agouza Medical Center to one-room offices of part-time practices. Moreover, even the largest private hospitals, although required to be licensed by the Ministry of Health, are not required to report statistics on their size or level of operations. Smaller private clinics neither register with nor report to the Government. A registration law for these small clinics was passed in late 1981, but has not yet been implemented.

With these cautions in mind, it has been estimated that there are approximately 280 hospitals (37% of which are in Cairo and Alexandria), 478 licensed poly-clinics (59% of which are in Cairo and Alexandria), and 12,210 clinics (60% in Cairo and Alexandria) in the private sector in Egypt. Ministry of Health statistics place the number of beds in these facilities at 7,005; other sources have estimated that figure to be 5,000. Approximately two-thirds of these facilities are located in Cairo and Alexandria governorates. Ministry of Health data also document 363 private laboratories in Egypt, 80% of which are located in Cairo, Alexandria, and Port Said.

It has been estimated that between 30% and 45% of Egypt's outpatient visits are accounted for in the private sector, exclusive of visits to private pharmacies.[12] The Ministry of Health estimates that 70% of these visits were for general medical services, although the majority of private physicians have specialist training.

Whatever the exact number of personnel and facilities and the level of utilization, it is clear that the private health sector in Egypt is growing rapidly. Some estimates place the annual private investment in health facilities, equipment, and space at LE 50 million ($60.5 million), almost double the annual rate of public sector investment in health.

Who, then, does this private sector serve? The obvious and easiest answer is "the wealthy." That is part, but not all of the answer. The private sector, exclusive of private pharmacies which will be discussed below, is increasingly the medical route of choice of the middle and emerging blue-collar class. A Health Maintenance Organization (HMO)-type approach has emerged in which small cooperatives of neighbors, members of a profession, or company workers, have come together to hire, on a salaried basis at a fixed fee for service, one or more local physicians to serve the group. Even for more conventional fee-for-service medical practices, growth in working-class neighborhoods has been the norm. A 1981 study of the neighborhoods around the Helwan industrial zone in Egypt found that, in an area of approximately 600,000 people, with ceiling incomes of LE 50 per family of five, 309 physicians are now conducting private fee-for-service practices.[13]

Even the larger, newer private sector hospitals have a diversified clientele, serve as tertiary care referral facilities from public hospitals, and are beginning to develop their own insurance schemes to supplement the Government health insurance system and help defray service costs in traditional risk-spreading insurance fashion. Not all such facilities have been successful; some are in serious financial trouble, having overbedded for current demand. Some, however, are becoming successful parts of the national health care system, as is illustrated by the following case.

Case 15: ALSALAM HOSPITAL, CAIRO

Opened in October 1982, the 100-bed Alsalam Hospital was conceived and executed by a small group of private Egyptian physicians. In addition to serving the individual patients of its staff physicians, the Hospital:

- -- Has contracts with 24 companies (local and foreign) to cover employee health services; a total of 9,000 employees are thus covered;
- -- Has an agreement with the Ministry of Health to provide fixed rate services to patients referred from the public system for kidney disorders;
- -- Provides fixed-rate services for employees of the General Agency for Land Reclamation/Ministry of Agriculture.

Hospital administrators and owners are currently developing, but have not yet received Government approval for, a flat rate, HMO-type system to cover health services for local industries. In essence, the system would cover all inpatient and outpatient services (with the exception of such specialized procedures as dialysis or chronic diseases) at an annual flat fee of LE 200 per employee if a minimum of 20 employees are registered. It is currently unclear as to whether the plan will be approved since its marketability would be as a company alternative, not addition, to current government worker insurance.

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Pharmacies/Pharmacists:[14] According to the Egyptian Syndicate of Pharmacists, there were approximately 16,000 pharmacists registered in Egypt at the end of 1981. Of these, about 13,000 were working in private pharmacies or in manufacturing. Overall, this represented a 30% increase in the number of Egyptian pharmacists since 1978.

At the end of 1981, 5,378 pharmacies were registered in Egypt, 49% of which were in Cairo and Alexandria. Distribution of services in rural areas is particularly inadequate, with many village areas completely unserved by pharmacies.[15] As a result, and given the rates of increase of pharmaceutical manpower, there is considerable danger of urban market saturation and, conversely, considerable opportunity for the development of public incentives to encourage pharmacy expansion in rural areas. The latter opportunities, and the potential roles of public and private sectors, are discussed later in this Report but can be illustrated by Case 16 below.

Case 16: PRIVATE PHARMACIES AND FAMILY PLANNING IN EGYPT

In an effort to seek more effective outlets for family planning materials and thereby reduce its rate of population growth, the Government of Egypt, through its Ministry of Social Affairs, commissioned a private organization, "Family of the Future," to promote family planning and modern contraceptives through private physicians and commercial outlets. The primary objective of the effort has been to increase the demand for and the commercial viability of contraceptives in urban areas, and the secondary goal has been to recover at least part of program costs to minimize financial drains on government or donor resources.

Technical assistance to the Family of the Future organization is provided by the U.S. management consulting firm, The Triton Corporation. In addition, the project has undertaken, with the assistance of the U.S. advertising firm Porter Novelli and Associates, an extensive broadcast and print media campaign to reach consumers at retail outlets, to advertise products to the general public, and to educate medical personnel. These advertising campaigns are carried out using Egyptian advertising agents and free-lance ad specialists.

Family of the Future products are promoted directly to physicians and pharmacists by medical representatives, and are sold to pharmacies by distributors. Products are also promoted to potential customers via rallies and face-to-face contacts established through sales volunteers. Originally, Family of the Future pursued a mixed distribution system, handling some product distribution itself and contracting some distribution out to private or state-owned companies. Mixed distribution was not found to be cost-effective, and Family of the Future now handles all product distribution through its own employees and logistics system.

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5.F. MOROCCO[16]

Personnel: Nearly 50% of the physicians registered in Morocco are in private practice. Of these 900 physicians, 57% are general practitioners and 43% are specialists. 35% of the 900 private physicians are foreign; the majority of these are medical specialists. Of the private medical sector, 60% are practicing in the Casablanca-Rabat-Kenitra-Tanger axis, which contains only 25% of the country's population.

In addition, the private medical sector includes an estimated 300 nursing personnel (14% of the country's nurses) and 120 dentists (nearly all the country's dental personnel),[17] 500 pharmacists owning private pharmacies, and 50 pharmacists practicing in industrial settings.

An additional 100 physicians are employed by public corporations, but outside of the public health system (see below).

Facilities: If over half of Morocco's physicians, virtually all of its pharmacists, and 15%-20% of its non-physician health personnel are officially engaged in private practice, the same is not true of the country's health care infrastructure. Most private personnel practice in small office settings. There are only 79 private clinics in Morocco, with an estimated 2,400 inpatient beds, just under 10% of the country's hospital beds. In contrast, the public health system manages over 70 general and specialist hospitals, some 250 rural and urban health centers, and over 800 rural and urban dispensaries.[18]

Every government hospital operates its own pharmacy, but only an estimated 20% of the nation's drug distribution takes place through this channel. The remaining 80% is carried out via private retail pharmacies. Total pharmaceutical sales in 1980 were estimated at $157 million, with an average annual consumption valued at $8 per capita.

Recently, a series of complex negotiations were successfully completed for a new private medical complex which will increase considerably the presence and profile of private health care in Morocco.

Case 17: INTERNATIONAL MEDICAL CENTER, RABAT

In 1980, two private Moroccan physicians (Dr. Abderhaman Alaoui, trained in the United States, and Dr. Mohamed Sentici, with a supplementary doctorate in public health obtained from a university in Canada) surveyed the Moroccan medical scene and determined that the country needed improved private health care services and a health care institution

which could be a quality leader for the rest of the Moroccan health system. These two physicians joined with U.S. partners, Theodore F. Mariani and Gerald Stevens, to form International Medical Enterprises, S.A., a joint Moroccan-American corporation. The sponsors of IME began to develop plans and investigated financing for a medical center comprised of a 204-bed hospital, polyclinic, and guest quarters for visiting staff, to be located on a 10-acre campus in Souissi, a suburb of the capital city of Rabat.

A draft prospectus for the project was prepared and submitted to the Ministry of Finance and local banks for reaction before proceeding further. After receiving positive signals at that step, a full market and financial feasibility study was carried out by a U.S. management consulting company, Moore-Johnson, Inc. That study indicated that there was a potential underserved private market and the proposal for the Medical Center development was financially sound, even if only a fraction of the possible user population was actually served.

At that point, negotiations were opened with a group of Moroccan banks to provide approximately 60% of the estimated $28 million needed to finance the project. The remaining 40% of the financing was to be raised from equity partners such as private persons and multinational corporate investors within and outside Morocco. Financing the Center's equipment from the U.S. Exim Bank was considered to be an option open to the sponsors. The Center is being designed by a U.S. architect/engineer firm, Mariani and Associates, Inc., in cooperation with a local firm in Rabat, Morocco.

In Morocco, projects involving external capital require clearance and approval from the Ministry of Economics as well as from the Ministry of Finance. This also involves negotiations on project exoneration from tax and other regulatory aspects of Morocco's investment code. With the Moroccan bank financing proceeding smoothly, the assurance of equity funds from private investors and over 550 new jobs to be created, clearance by the Government was fairly well assured.

In terms of the patient base for the Medical Center services, six categories are considered to be the major users:

- The approximately 2% of the Moroccan population which can afford the facilities per diem costs and fee-for-service rates;

- Foreign nationals living in Morocco, visitors and tourists;

- The Government Social Security System which proposes to process cases through the Center which it would normally have to send abroad, thereby saving considerable money in its payouts;

-- Private clients holding health insurance through the country's private insurance system;

-- Group-financed arrangements with large industrial companies;

-- Neighboring countries in West Africa and the Middle East.

In addition, the Medical Center has established a foundation to finance clinical research by Center physicians, to sponsor public programs, to provide training and education to staff, and to work with local universities. Moreover, the facility planned by the IME investment group will also be a teaching hospital for the public medical and nursing education system.

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5.G. SUMMARY

The private health provider sector in all five countries -- and in the Middle East in general -- is strong and growing. In Jordan, 50% to 60% of health care delivery is in the private sector. In Tunisia and in Egypt (and thus probabaly also in Jordan and in Lebanon), the level of private health sector investment approaches or equals that achieved by public institutions. In Lebanon, 80% of the health facilities are private. In Egypt, the private delivery sector is growing rapidly, both as a spontaneous response to demand and investment and as a result of changing government policy.

In many ways, therefore, the private service provider sector already is a functional "partner" of public sector policy and delivery, via the level of its annual investment, the extent of its utilization, and the role it plays in the national medical referral system. In many ways as well, the public sector de facto provides a setting conducive to successful private ventures, for example, by providing free medical schools, controlling the prices of drugs used in private (as well as public) institutions, and allowing mixed employment in the public and private medical sectors.

In sum, a strong basis for further, more explicit cooperation between public and private providers is already in place in the Middle East. The potential role of development assistance in catalyzing and channeling this cooperation is discussed later in this Report.

6. THE ROLE OF THE MULTINATIONAL CORPORATION

"Multinationals face many challenges even as their power grows. If (they) seem to extend the economic and political power of a nation, this is seen as a threat. If they transcend nations and urge a world without borders, this is wrong. If they admit to running branches tightly from a central headquarters, this is wrong. Now they must reach out to be more responsible for the impact of their actions across the whole range of social, cultural and environmental systems.... This will bring multinationals into more power, and subject them to more criticism, but it will also further generate and spread social and cultural change, and promote the ongoing evolution of society and polity."[1] L. P. Gerlach.

6.A. INTRODUCTION

Much has been written about multinational corporations (MNC's) in the developing world. Much of that has been normative rather than empirical, portraying MNC's and their operations as either the worst or the best things that ever happened to developing countries. That polarization of views is present at its most extreme on health issues, with the most vocal element in the debate being the critics who portray MNC's of all types as the antithesis of the social organization required to address the health needs of the vast majority of developing country populations.[2] Some of that opinion may be right; most is probably wrong. Taking sides in this long-standing and, in its generality, insoluble debate is not the point of this chapter.

Whatever the balance of good and ill in any particular case, the striking fact remains that, overall, MNC's play a variety of significant roles affecting health and health care in the developing world. Multinational corporations have an indirect but important impact on health as a result of the local income and employment generated by their investments. MNC's have also developed excellent and highly relevant health-related service systems and house significant reservoirs of expertise on a wide variety of health-related problems, both representing resources that can be applied to Third

World concerns. Moreover, the multinational investment also implies the transfer to a developing country of capital, management skills, organizational expertise, tax payments, and the creation of a secondary market for local inputs to new business. All these valuable resources might, with directed creativity, be utilized for needed improvements in the local health and health management sector.

There are many types of MNC industries and roles relevant to this Report. To some extent, any effort to organize these roles by type of industrial actor is misleading, since most companies today are highly diversified in their operations. Nevertheless, for purposes of this examination of private sector actors, some categorization method is necessary. Thus, discussion of industrial roles will be organized as follows:

- -- Health products industry, both as producers of health inputs, and as investors in local manufacturing plant operations with health-related activity in such areas as occupational safety and worker health delivery;
- -- Non-health products manufacturers, as regards their arrangements for worker and/or community disease control, health education, occupational safety, nutrition, etc.;
- -- Health management industry, as a reservoir of systems and personnel management expertise;
- -- Information/communications industry, as a provider of information management and public communications services;
- -- Finance and banking industry, as financier of both major health industries and small business operations in the health sector;
- -- Insurance industry, including life, health, property, and casualty roles in personal, group, and facility insurance provisions, as well as the industry's role as a source of investment finance in the Middle East;
- -- Construction/engineering industry, both its roles in worker/community health services and its role in the physical development of health infrastructure.

This chapter will discuss the extent of these roles in the Middle East, and present case examples of how these roles are actually implemented. The general discussion and specific cases in this chapter are illustrative, but certainly not exhaustive, of the types of health roles MNC's assume in the developing world and for which development assistance agencies and countries themselves can provide both positive

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incentives and partnership opportunities. Incentives for mobilizing such roles, in both the public and private sectors, and development assistance strategies for working with and maximizing those roles are presented later in this Report.

6.B. GENERAL BACKGROUND

Before addressing the health-related initiatives of specific industrial categories, a bit of background on the overall type and level of MNC activities in the Middle East might prove useful. It should be noted that many MNC's have been involved in the Middle East for 40 or 50 years. The ties of these companies to the region are historical and strong, and greatly contribute to the level and nature of MNC roles in the region.

MNC's pursue three categories of economic activity in the Middle East. They trade; they invest; and they finance.

For the first, export sales of equipment, services, technology and consumer goods by multinationals[3] to the Middle East will amount to over $100 billion per year during the decade of the 1980's.[4] This trade has outdistanced the more traditional view that the MNC-Middle East relationship is one solely of natural resources exploitation.

As for the role of investor, although direct investment by MNC's in the developing world experienced a sharp downward trend between 1968 and 1973, real rates of investment from 1973-1981 were even higher than during the peak period of 1960-1968.[5] However, the year 1981 itself saw limited multinational capital expenditures on overseas operations due to the worldwide recession, with plans to increase foreign spending up only 8% in 1981 over 1980, compared to a 23% increase in 1980 over 1979.[6] It is important to note, especially for purposes of this Report, that a major exception to this pattern has been the drug and health-care industry, which has continued to expand overseas operations in response to recession-insulated burgeoning demand.[7]

In the developing world, the nature of foreign corporate investment has also changed for virtually all industries over the last ten years. Headquarters-controlled private investment, as typified by the wholly-owned subsidiary operating as an appendage to the local economic environment, has often been replaced by turnkey operations, international subcontracting, licensing and technical assistance, joint ventures, and trilateral cooperation, which are now the more common vehicles for MNC involvement in Third World economies.[8] At the same time, this diversification of investment forms has introduced new actors to the investment process -- international financial institutions (private and multilateral), local private business, and a variety of local government agencies -- spreading both the financial and political investment risk across a number of actors.

For two reasons, the above change in strategy is important to remember in this Report. First, it has often imposed differences on MNC's in the ways in which they react to the health-related activities associated with their manufacturing or natural resource extraction projects. Investments involving government partners have often dictated more formal health programs, in turn more highly regulated by government policy. Second, because they expand the number and nature of actors brought into the MNC investment process, new investment forms also provide potential opportunities for development assistance agencies to become partners in many aspects of the investment process, thereby both leveraging development resources and providing incentives for the provision of improved peripheral public services associated with the investment. These issues will be addressed in more detail in this chapter and in other sections of this Report.

As for the MNC financial role, loans of private international banks and financial institutions to the developing world account for 37% of the international banks' assets, and the Third World's deposits account for 29% of the banks' liabilities.[9] The non-oil-surplus Arab states of the Middle East (including North Africa) account for only 7% of the total $277.6 billion borrowed by non-oil developing countries in 1981, down from 9% in 1978.[10] Nevertheless, according to the Bank for International Settlements, of the focus countries in this Report, only Jordan is considered a small debtor. As of 1981, Egypt, Morocco, and Tunisia owed between $1 and $4 billion each to international banks.[11]

In the past, such borrowing in the developing world has represented the actions of public entities, while borrowing in the industrialized world results from private interactions with the capital market. Increasingly, however, this distinction is becoming blurred, with a significant proportion of LDC transactions accounted for in the private sector and many industrial countries supplementing capital-attractive policies with direct public borrowing.[12]

6.C. HEALTH-RELATED PRODUCTS INDUSTRIES

The health role of the major international medical products and pharmaceuticals corporations is a crucial one virtually anywhere in the developing world. This is no less true in the Middle East. Such firms play three major health roles in that region:

-- Traders in medical products and pharmaceuticals;

-- Investors in manufacturing operations and, thereby, local producers of health-related products;

-- Researchers of tropical diseases and tropical disease products.

1. Health Care Products Trade

Background: Worldwide, the pharmaceuticals market is valued at over $76 billion per year,[13] 18% of that in the developing world.[14] Developing country demand is expected to increase by 15% annually for the next decade.[15] While there are between 2,000 and 3,000 broadly-competitive, medical supply/pharmaceutical companies in the world, 110 manufacture 90% of the market's pharmaceuticals.[16] Even with this reduction in numbers, however, the world market remains extremely fractionated. In no country is any one company's market share much more than 6%; indeed, in the 22 countries whose combined market amounts to 80% of the world total, the share accounted for by the 36 most important international firms has been dropping.[17]

Middle East: The market in the region for medical products overall (drugs, medical supplies, and medical equipment) is estimated at $5 billion per year.[18] The pharmaceuticals market accounts for $1.5 billion of that figure, and is growing rapidly due in part to the region's rapid economic development and in part to the rise in purchasing power and expansion of health systems in the oil-exporting states.[19]

The import share of this regional market varies considerably by country,* as does the country of origin of the major supplier MNC's. Table 6.I and 6.II below summarize the import data for the focus countries of this Report. The percentage share for the largest trading partners is also given. It is interesting to note that in only one case is the U.S. the major health products trading partner of any of the focus countries.

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*Note that local production by MNC's is addressed in the next section of this chapter.

TABLE 6.I.
1980 Medicinal/Pharmaceutical Products
($ '000 U.S.)

	U.S.	Belg.	France	Ger.	Italy	Neth.	U.K.	Swe.	Jap.	Total of 14[a/]
Egypt	9251	1335	11318	22470 (23.2%)	7473	8421	18911	485	222	96722
Tunisia	1495	225	52314 (84.2%)	575	2911	621	1181	NA	NA	62165
Lebanon	5103	3155	9406	12990 (22.6%)	4405	1849	10859	233	197	57529
Jordan[b/]	1982	1492	887	3216	3552	537	6537	49	NA	22360
Morocco[b/]	232	133	27804 (77.4%)	2685	1168	1971	994	11	NA	35945
TOTAL	18063	6340	101729 (37.0%)	41936	19509	13399	38482	778	419	274721

TABLE 6.II.
1980 Medical Instruments[c/]
($ '000 U.S.)

	U.S.	Belg.	France	Ger.	Italy	Neth.	U.K.	Swe.	Jap.	Total of 14[a/]
Egypt	2642	439	1869	4949	7492 (27.9%)	442	5035	368	2821	26806
Tunisia	458	197	2254 (38.1%)	1362	376	172	132	NA	339	5917
Lebanon	4620 (35.3%)	518	1300	2029	1536	78	1915	143	1253	13808
Jordan	999	NA	261	818	525	113	1485 (27.1%)	69	544	5481
Morocco	78	93	4340	2312	219	16	138	35	360	NA
TOTAL	8797	1247	10024	11470	10148	821	8705	615	5317	

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a/ 14 principal exporting countries in the world.
b/ 1979 figures.
c/ includes medical, optical and dental equipment categories.

Egypt: The total market for pharmaceuticals and medical equipment in Egypt in 1981 was over $430 million, $383 million of which was expended on pharmaceuticals,[20] and $41 million of which was for medical equipment.[21] Approximately 75%[22] of the pharmaceuticals in the Egyptian market are manufactured in Egypt (albeit often under license to non-Egyptian corporations). Practically no medical equipment is manufactured in the country. Simple tables, beds and chairs are produced locally, but even the more sophisticated equipment of this type, as well as all electromedical equipment, is imported.

The major non-investor foreign companies supplying the Egyptian market do so via three types of arrangements:

- -- 127 multinational health products companies have registered medical representative offices in Egypt which market and sell products to both private physicians/facilities and to the Government's purchasing agent, El Gomhouria. Among such companies are Cyanamid International Scientific, Dupont de Nemours, and Hospital Corporation of America, Ltd.

- -- El Gomhouria itself, previously described in Chapter 4, is also the exclusive representative of several MNC's (e.g., Bausch and Lomb, Siemens, Ugo Basile, Nippon Medical Supply Company).

- -- Since initiation of the Egyptian Government's economic Open Door Policy, El Gomhouria's role in the pharmaceutical/medical supply market has dropped from a monopoly position to a 70% market share position. Although this figure still represents $125 million per year, a variety of new local private sector companies have emerged to handle the imports of many of the major MNC producers. The four largest are the Alkan Company, SSC, Chemipharm Ltd., and Nile Stores of Egypt, with total sales volume of $11.5 million.

All major suppliers of medical equipment have their own service teams in Egypt, but service contract costs are often quite high. This is particularly true for firms, including most U.S. corporations, for which the relatively little amount of sophisticated medical equipment sold makes costs per serviced unit high. In some cases, a service agreement can cost as much as the piece of equipment purchased, or even twice the purchase price if a resident maintenance technician is to be supplied.

Jordan: Imports account for approximately 75% of the Jordanian pharmaceutical market, down from 85% in the mid-1970's.[23] The major MNC suppliers are British, Swiss, and German, together accounting for 56% of drug imports in 1981.[24] However, of the top three firms in

pharmaceutical trade, two are American (Bristol Myers/Mead Johnson and Merck, Sharp and Dohme/Frosst). As described in Chapter 4, the indigenous production sector, although still largely concentrated on packaging, is becoming increasingly competitive.

Virtually all medical equipment is imported, with British and U.S. firms accounting for 45% of the market.

The process by which foreign corporations involved in this trade operate in Jordan is quite different from the Egyptian case and has been well explained in other documents.[25] In brief, foreign drug companies are required by law to have a Jordanian representative acting as distributor. A network of "drugstores" has thus emerged which act as agents for the 187 foreign companies present in Jordan. These "drugstores" supply both private pharmacies and small (less than JD 1000) government purchases, and are responsible for all logistics, customs, storage, promotion (via approved channels such as medical journals), and marketing of the drugs of their client companies. Over 92% of the private Jordanian market is accounted for by this corporate-"drugstore" agent-pharmacy system.

Larger purchases by the Jordanian public sector, both the Ministry of Health and the Army, are handled via public tender. As will be noted later, some preference is given to local producers, but the latter are expected to submit price estimates 10%-20% below those of their foreign competitors.[26] Since all local companies import their primary products and thus are tied to the same international market as their international competitors, this preferential treatment does not always result in a local tender award.

It should be noted that the variety of foreign companies and imported drugs in the Jordanian market has been greatly reduced in recent years. Ten years ago there were over 15,000 preparations available in Jordan and 300 companies were represented.[27] Today there are about 1,500 trade names and just under 200 companies represented.

Lebanon: The level of pharmaceutical imports into Lebanon can only be approximated since eight years of war have compromised the reliability and validity of almost any measure of trade for the country. Thus, nearly all data for Lebanon must be viewed guardedly.

The value of pharmaceuticals imports into Lebanon in 1980 was nearly $60 million, with the major suppliers being British and German firms. Virtually all medical equipment in Lebanon is imported from the U.S. and Europe, with U.S. firms having over 35% of the market share. Prior to the most recent hostilities, virtually every major MNC drug manufacturer had a local representative in Beirut.

Approximately 15,000 different pharmaceutical formulations are all being imported into the Lebanese market, both for local use and for re-export to the rest of the Arab world.[28] Another 2,000 products have found their way onto the market although they have not yet been licensed as to effectiveness. This latter situation is, to some extent, a result of the general disruption due to the years of conflict. According to Lebanese law, if the Ministry of Health (MOH) has not responded to a licensing application for a particular drug within three months of its submission, regulatory statute permits the importer and supplier of the drug to market the product pending a later MOH licensing decision. Delays in government approval machinery caused by the years of war have made this procedure commonplace.

The most pressing recent issue for multinational pharmaceutical firms in Lebanon has been a rampant problem of drug counterfeiting. While, to some extent, multinational corporate executives have found counterfeits of their products in other countries of the region, the problem is of major proportions in Lebanon. Recently, the Ministry of Health listed 57 counterfeit drugs in the country, many used for life-threatening conditions. In many cases, the counterfeit packaging was indistinguishable from that of the genuine drug. Companies with serious problems in this area are Beecham, Boots, ICI, Burroughs Wellcome and Hoechst. Late in 1982, Hoechst publicly warned Lebanese doctors and pharmacists about the counterfeiting of its products, noting the differences in logo and package size between the genuine and the fake drugs. Beecham's quality assurance laboratories found that batches of ampicillin products being sold under its name in Lebanon -- with exact batch numbers and manufacture and expiration dates -- were completely useless counterfeits.[29] Since there is no effective public quality control authority in Lebanon at this point, many multinational companies which are major traders in Lebanon are now examining their own packaging or quality control options to resolve the counterfeiting problems.

Tunisia: Approximately 80% of the Tunisian pharmaceutical market is supplied via imports, although this average percentage masks a considerable difference between the source of supply of the public and private sectors. Hospitals and other health facilities in the public system import only 25% of their pharmaceutical needs, while 90% of the pharmaceuticals in the private pharmacy and service delivery system are imported.

Total Tunisian imports in 1982 for pharmaceutical and related medical supplies were just over $103 million, or 4% of the country's overall import bill. As is to be expected, the major drug suppliers for Tunisia are French firms. The U.S. supplies just over 2% of the Tunisian pharmaceutical market.

Tunisia does not manufacture medical equipment or disposables. All health care equipment, laboratory instrumentation and products are imported, again, largely from French companies which supply over 50% of its medical products, the only two medical supply corporate offices of U.S. companies in Tunis being those of Dow and an Eli Lilly subsidiary.

In terms of trade process, the Tunisian Central Pharmacy (PCT) holds a monopoly on representation of all pharmaceutical suppliers in the country and an import monopoly for all drugs. Both government procurement and private sector purchases are carried out via the Central Pharmacy.

MNC trade in medical equipment is managed through a variety of channels, both public and private. On the public side, the Ministry of Health, which is the end-user of 90% of imported medical equipment, purchases equipment either directly from manufacturers via international tender or through private local sales agents. These private importers also act as the sales agents for equipment to private clinics in Tunisia.

Summary: Multinational pharmaceutical/medical supply companies are thus major actors in Middle East health care systems on three levels.

First, in most cases, local pharmaceuticals production capability is limited. Thus, trade in pharmaceuticals is the major supply route for both public and private health systems. Even where that capability is significant, however, the MNC tie is strong since much local production is carried out under license to larger international companies.

Second, multinational supplier companies also provide technical services to the local service provider community, as illustrated by Case 18 below.

Case 18: MONTEDISON-FARMITALIA/CARLO ERBA: TRAINING IN THE MIDDLE EAST

Montedison is a Milan-headquartered diversified manufacturer of bulk petrochemicals and plastics, with subsidiary service corporations in engineering, telecommunications, and oil and gas exploration. Its associated pharmaceuticals company, Farmitalia/Carlo Erba, is a major trader with several Middle East countries in a range of proprietary specialities such as antibiotics, amebicides, trichomonacides, and antirheumatics. All commercial activities are carried out by resident agents, specifically in Egypt, Saudi Arabia, Syria, Kuwait, the UAE, North Yemen, and Jordan. Many of the company's products are produced in the region by local companies under license arrangements.

In 1979, Farmitalia/Carlo Erba instituted a series of top-level roundtables and conferences in the Middle East targeted at improving the flow of recent diagnosis, research, and therapy information to private physicians and hospitals and to public health administrators. Internationally reputed lecturers and presenters from around the world are brought to the region at company expense. Roundtable subject matter is chosen by Montedison/Milan and by its Middle East staff. In all cases, the topics and presentations are not tied promotionally to specific Farmitalia/Carlo Erba products, although the company may manufacture product lines relevant to the diseases under discussion. Thus far, symposia, roundtables and conferences have been sponsored in Syria, Egypt, Lebanon, and Jordan. In addition, the company is financing a series of clinical cancer chemotherapy courses at the Cairo University's Faculty of Medicine. Although to date the topics of these efforts have focused on the diagnosis and treatment of such diseases as diabetes, cancer, and rheumatism, the presence in the region of the company's operations and symposia system, and its broad range of expertise, make these efforts an immediate partnership opportunity for development assistance to co-organize professional symposia aimed at the region's communicable endemic disease problems.

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Third, in some cases entire companies have been created within an MNC to supply the specific health-medical needs of markets in the Middle East and other parts of the developing world. For example, Seward Surgical (Case 19), part of the highly diversified Unilever Corporation, has shifted its focus to the manufacture of medical supplies and equipment that are both durable in and affordable to the developing world.

Case 19: SEWARD SURGICAL

A sub-group of Unilever's Medical Division, Seward Surgical in recent years has focused on research and development that has led to production of medical supplies, equipment, and pharmaceuticals suitable for use in developing countries. Disposable caps, gowns, masks, and gloves have been developed for circumstances where adequate re-cycling facilities do not exist. An operating table has been designed to be economical, reliable, simple to handle and transport, maintenance-free, and yet flexible enough to meet the needs of most operations performed in developing country rural health clinics. Currently, that table is used under such diverse circumstances as North Sea oil rigs, Nigerian health centers, and Iraqi health units.

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The relationship between the multinational pharmaceutical/ medical supply companies, public health policy, and local health delivery is thus a significant one from the point of view of both corporations and the local health system. All parties to the relationship, therefore, have considerable motivation to seek improved, mutually beneficial means for development of the region's health systems.

2. Health Care Products Investment

The international health care products industry has made only limited investments in the Middle East overall, and specifically in the countries focused on in this Report. For the most part, foreign investment in health care industries in the region is heavily regulated and, except in Egypt, is not a major economic development or health system force. However, the technical expertise, quality control, and manufacturing resources of the industry in its investment capacity make it an important potential actor in national health systems, especially where a skilled labor force is available.

Egypt: There are four subsidiaries of major MNC's in Egypt, three of which are joint ventures with Egyptian firms.

The one wholly-owned subsidiary is that of Squibb, which was established under the investment statutes of Public Law 43. Production at the Squibb plant began in 1979, but 1980 was the first full year of operation. Squibb's market share in Egypt in 1980/81 was 2.1%, smallest of all the top dozen local and foreign joint venture firms.[30] Squibb's situation is a case in point of MNC investment problems in the fairly delicate economics of the Middle East. As a result of Egypt's expanded need for foreign exchange in the recent international recession, the cost to international firms of doing business in Egypt has escalated. Foreign firms, like Squibb, have had to pay 30% above the official rate for the foreign exchange necessary to buy raw materials from their parent corporations,[31] seriously impairing their operations in the country.[32]

Three multinational corporate joint ventures with Egypt have also been established. These are:

-- Pfizer Egypt, owned 50%-50% by Pfizer and the Egyptian Government, with $14.7 million in sales (3.6% of the market) in 1980/81 and 450 employees.

-- Hoechst-Orient, owned 60% by Hoechst and 40% by the Egyptian Government, with $23.7 million in sales (5.7% of the market) in 1980/81. Hoechst employs about 500 Egyptians in the country.

-- Swisspharma, owned 47% by Ciba-Geigy, 13% by Sandoz, and 40% by the Egyptian Government, with $34.4 million in sales (8.3% of the market) in 1980/81 and 500 employees.

Problems which limit the production levels of these joint ventures include:

-- Pricing regulations and controls. Products now produced locally, but which were on the Egyptian market before the price liberalizations of 1977, are still controlled by pre-1977 price allowances, thus making them financial losses on the Egyptian market;

-- Inability to use local input products (e.g., packaging bottles) due to poor quality, therefore leaving the companies dependent upon the availability of sufficient imported input products;

-- Import duties and foreign exchange requirements for such products.

Despite these problems and limitations, the health sector role of such corporate enterprises is both major and positive. These firms not only supply health products to the local market, but are also health system leaders in such areas as product quality and personnel training. The nature and importance of these roles is discussed in more detail later in this chapter.

Lebanon: The largest foreign producer of pharmaceuticals in Lebanon is the Charles E. Frosst Company, an affiliate of Merck, Sharp and Dohme, USA (MSD). One of the company's major activities in Lebanon has been to formulate products for export to other parts of the Arab world, especially to Saudi Arabia. When the counterfeiting problems cited above resulted in a blanket closure by Saudi Arabia of its market to products originating in Lebanon, the Merck/Frosst operation suffered significantly, despite its rigorous quality control procedures.

Case 20: MERCK/FROSST QUALITY CONTROL IN LEBANON

The MSD/Frosst plant implements a series of quality control procedures which are typical of the way in which an MNC pharmaceutical subsidiary operates in the developing world. All key plant personnel are trained by the headquarters company in quality control procedures. The product formulation and testing procedures are supplied by MSD.

Virtually all raw materials are imported. These raw materials are checked upon arrival by the Frosst plant quality control department, and random batches are sent to the MSD home plant in Rahway, New Jersey for independent quality checks. The plant water used in the formulation process comes from the local supply but is monitored by the quality control department. Manufacturing waste water is treated before it is allowed to enter the ocean. U.S. manufacturing quality standards are used in the production process. The finished products are sent in random batches to the home plant. Only after approval has been given from that plant are the drugs sold on the local market.

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Health Sector Role of MNC Health Product Investments: Beyond the production and supply of health-related goods, the MNC investments, such as those described above for Egypt and Lebanon, represent both transfers to the Middle East of technical expertise and management capability and industry leadership on such issues as quality control. The training of quality control, laboratory, and maintenance technicians and the basic and in-service education of facility managers is not of benefit to the production facility alone. In the experience of some MNC's, as much as 20% of these trained personnel are lost to the MNC operation each year, attracted away by local private enterprises or public health sector opportunities.[33]

MNC health-product investments also have put in place a system of product quality procedures and precedents which could be mobilized by public or development assistance programs to assist in developing means to raise overall drug quality among local producers, or develop joint public-private quality control mechanisms. In the Lebanese case, for example, with export markets so extensively damaged by current quality issues, Government and the major private producers have the incentives and the resources to address cooperatively the quality control system.

Finally, the presence of international health products investments in the health sector also raises the opportunity for improved cooperative training and in-service education on new drug and treatment developments of importance to the region as well as on health management and public health issues.[34] The transfer of this medical knowledge, to both private and public personnel, is of current and potential benefit to development of the overall health services of the region.

To the extent that public agencies can provide incentives for and cooperate with these roles, cost-effective resource leveraging can result.

3. Research

The third role of the research-based pharmaceutical corporation is that of basic research and product innovation. Corporate research efforts of importance to the health problems of the Middle East are many, but are not easily cataloged within companies. This is in part because basic research can seldom be categorized as disease specific; as Lewis Sarett, former research vice president at Merck, has pointed out, the interdependence of research fields is fundamental to cost-effective drug development: "The great amount of work that is being done on infectious diseases alone, while its prime target is bacterial illness, does lead to agents that are useful against such diseases as malaria, leprosy and tuberculosis. Moreover, basic studies in many laboratories intended to elicit better understanding of disease processes and drug actions have application across the board in all areas of therapy."[35]

Moreover, the difficulty in determining what portions of multinational corporate research and development costs address the Middle East's specific health needs is a function of the problem in defining those needs themselves. Corporate research projects on trachoma, amebiasis, and venereal diseases all are of relevance to improved health in the Middle East, although the diseases attacked are not regionally specific. The point is that major corporations spend 5% to 8% of annual pharmaceutical sales -- the leaders spend closer to 15% -- on basic research and development.[36] The resultant new products and disease-process knowledge can play a major role in the future of health care systems in the Middle East and elsewhere.

One example of how such internal corporate research can reach public health programs via a public-private partnership effort can be illustrated as follows.

Case 21: ALLIED CHEMICAL CORPORATION AND VACCINE TECHNOLOGY

In the context of its wide-ranging internal research and development programs, the Allied Chemical Corporation happened upon a cnemical, called 2, 4-hexadiene-1, 6-(p-toluenosulfonate), known as PTS. Exposure to heat causes PTS to polymerize, a shifting of molecules that results in its changing color, from red to brownish-black. The higher the temperature, the more rapid the change.

If applied to a self-adhesive sticker, then, this chemical could indicate both the time-span of a product's exposure to heat and the temperature of that heat. Such stickers might have a range

of health applications for products which are heat-sensitive. However, in the industrialized world, where the availability of refrigeration is seldom a problem, the market for such a product is small. Allied estimated it would cost the company between $4 and $5 million, above the initial research cost already incurred, to develop the indicator for mass production. Allied's management decided that, while there was an insufficient corporate market to recover the costs of the resultant product, the technology would be extremely useful in vaccination programs in the developing world. The company thus approached the World Health Organization (WHO) with the chemical and its ideas for vaccine applications.

No one knows exactly how many useless vaccinations are given each year due to vaccine spoiled by heat. For measles vaccine alone, however, estimates range from 10 million to 16 million. Given the prevalence of measles and its mortality rate, this would mean that, by conservative estimates, 300,000 deaths occur annually among vaccinated children due to spoiled vaccine.

Recognizing the potential for reducing the number of such deaths, Allied's research product was picked up by WHO and a small Seattle-based firm, the Program for Appropriate Technology in Health (PATH). Financed by the New York-based Edna McConnell Clark Foundation, the Canadian International Development Research Center, and OXFAM of the United Kingdom, PATH is now in the process of testing the Allied vaccine indicator idea. These tests are being carried out with the technical cooperation of a Canadian vaccine manufacturer, the Institut Armand Frappier. If all goes well, mass production of the vaccine stickers could begin in late 1983.

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The research activities of benefit to the health systems in the Middle East include not only laboratory studies, but also the field efforts of multinationals undertaken in the process of drug evaluation and disease investigation. These often lead not only to better pharmaceutical products, but also to better understanding of the process of specific disease control options within the test country. Extensive analysis of this role has been carried out for Brazil and Madagascar.[37] In the Middle East, examples of these activities are fewer but no less important.

Case 22: CIBA-GEIGY IN EGYPT

Ciba-Geigy, headquartered in Basle, Switzerland, is one of the largest and most diversified chemical/pharmaceutical companies in the world, with sales in pharmaceuticals alone in 1982 topping 4 billion Swiss francs. Ciba-Geigy's involvement with development is multifaceted,

with its unifying theme being the company's 1974 corporate policy guidelines on the Third World. These guidelines set out the specific types of technical, research, and financial contributions which are to underpin the company's relations -- business and philanthropic -- with the developing world. These activities have been carried out directly by Ciba-Geigy's business units (e.g., staff experts teaching disease control and treatment in local universities and medical schools, the secondment of experts to Swiss Government projects abroad, the initiation of new R and D programs on tropical diseases); by its own Special Staff for Relations with the Third World, created in 1974; by a separate institution, The Basle Foundation, established by several Swiss firms to carry out developing country projects (e.g., establishment of the Ifakara, Tanzania school for medical assistants); or by joint resource-pooling arrangements with other Swiss firms for specific project design and management.

Ciba-Geigy has begun to focus its developing world project activities on pilot control projects targeted at specific diseases. Based on its past experience with broadly defined health projects, the company feels that it can make a more successful contribution to projects which are defined and focused on disease control activities.

For two years, Ciba-Geigy has been involved with the Egyptian health authorities in a Dermatological Survey for the Detection and Treatment of Skin Affections in Gharbia Governorate, with a total population of 3 million, located in the Nile Delta area of Egypt. In the late 1970's, Egyptian public health officials were aware of endemic foci of leprosy in this Governorate, which could reflect a national problem, but had no specific data on the extent of the disease's prevalence. At about the same time, Ciba-Geigy officials were searching for an appropriate leprosy/skin diseases project to support in the developing world. When Ciba-Geigy/Basle officials learned (via their local representative) of the concern of the Egyptian Government health authorities, the company stepped forward and suggested a joint project.

The detection and treatment pilot project that resulted focuses on establishing the incidence and prevalence of all types of skin diseases in Gharbia Governorate, and exploring means of improving their diagnosis and treatment using the Governorate's existing primary health care system. Ciba-Geigy is a technical resource and equal partner in the Project, but takes its lead from the Egyptian health authorities which remain in firm control of all Project decisions. The company's functional role has been to help design the project, establish the records system, design the project management and evaluation systems, produce training materials, and, to the extent possible, assist with planning, budgeting, and follow-up. The company also supplies some pharmaceuticals to the Project at privileged prices (if the Project was truly to be replicable, both partners agreed early on that to supply it with free drugs was not desirable), and some financial

assistance to defray ancillary costs essential for progress of the Project. The World Health Organization also gives some financial and technical support to the Project.

The initial Project phase was set for three years to determine the incidence of various skin diseases and thus the size of the problem and the investment needed to address it adequately. The length of a larger second phase is to be determined at that point.

Although the Survey is not yet complete after 15 months, in a total of three rural and one urban areas in Gharbia, the Project has found that 2.5 percent of those treated at the primary care centers had skin diseases of one form or another. The average incidence of leprosy is 1.97 per 1,000, ranging from a high of 4.8 in one rural area to a low of 0.17 in the urban site. If this incidence rate is statistically concluded at the end of the Survey, it would highlight a potential leprosy problem which might necessitate consideration of a major control program. An additional benefit from the therapeutic aspect of the Survey will be the evaluation of the effectiveness and suitability of the World Health Organization recommended regimens for the treatment of leprosy in the Egyptian population.

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6.D. NON-HEALTH PRODUCTS MANUFACTURERS

The health sector roles of MNC manufacturers of non-health products in the Middle East are often significant. The existence of these health-related activities and technical resources in the manufacturing sector provides ample opportunity for public and development agencies to join with and provide incentives for such initiatives in improving and expanding local health services.

This section presents an explanation and case illustration of the direct health services and disease control activities carried out by manufacturing and extractive industries in the Middle East. The similar activities of construction/engineering industries are discussed separately later in this chapter.

Health-related roles of manufacturers and extractive industries in the region include:

-- the provision of general health care services to employees, families, and surrounding communities, including such services as vaccination and nutrition programs;

-- disease and vector control for communicable diseases;

-- occupational health and safety programs, both preventive and emergency.

The following profile of services provision is derived from a wide range of corporate interviews. Specific case illustrations follow this discussion.

1. Provision of General Health Services

Responsibility for determining the general health care needs associated with any foreign investment and developing a strategy for responding to those needs is usually, but not always, the responsibility of the Corporate Medical Director. Before presenting several cases of extensive MNC involvement in health services delivery in the region, it is useful to understand the process by which health services are provided under normal investment circumstances. A distinction is important here. Where investments are wholly- or majority-owned by the foreign corporation, or are turnkey operations, the corporation has greater involvement in health services decisions and actual service provision. Joint-ventures with local governments usually, again not always, involve the delivery of worker and/or family/community health services in the context of the government's public health system, and are normally developed and overseen by the government entity participating in the investment.

In the former types of circumstances, the manufacturing investor, early in the investment planning process, undertakes an inventory of the public and private health services available in the investment area, including water supply, and conducts a general epidemiological review of worker and community health status. In most cases, this leads to a strategy for meeting expected corporate health care needs and the investment proceeds on schedule. In some cases, however, the paucity of local health services in the context of severe disease and water supply problems in a potential investment area has been one of the crucial factors in an MNC decision not to pursue an investment opportunity.

The field health services which generally result from the more common health sector assessments are general in nature and serve, as a priority, employees and their families, and, in exceptional circumstances, surrounding populations. The following activities/arrangements are usually included.

a. Disease Screening:

-- Expatriate personnel are processed by the MNC or its contractor for medical problems prior to arrival at the investment site.

-- Local personnel are normally screened for a range of communicable diseases at the job site by the locally-contracted health staff. In some cases this screening also includes such health problems as nutritional deficiencies. It was in this area of local disease screening that the greatest number of medical directors interviewed expressed dissatisfaction with the performance of their local corporate health services. Logistics problems, laboratory quality,

an ill-defined work force, problems of worker identity, the quality of health worker training all have combined to impede the provision of early disease screening for employees, with consequent problems of disease control within the investment area. This has been particularly true in large, labor-intensive, geographically dispersed investments.

b. General Care:

-- Arrangements for health services provision are made, usually using the local private providers. Physicians and/or facilities receiving contracts are selected on the basis of local/international reputation, origin of training, and quality of equipment.

-- Alternatively, but more rarely, expatriate physicians and other health personnel are hired (many of whom are former medics in the military services) to provide care in company-owned and built facilities. In these instances, company facilities are nearly always turned over to the local public health system if the multinational role in the investment is phased out.

-- And/or, MNC's sponsor and finance improved training for one or more local paramedical personnel who then provide general outpatient care in company clinics, with inpatient care provided at local private hospitals by company-contracted physicians.

c. Preventive Care:

-- MNC's usually undertake worker health education programs within their plants, especially as regards water and sanitation behavior. This is particularly true for industries in which the quality of the production process is directly related to maintaining a sanitary environment (e.g., pharmaceuticals or chemicals). Safety aspects of these education programs are discussed separately below.

-- In many, perhaps the majority of circumstances, the investing company also provides the water supply infrastructure for the physical plant and any surrounding worker community.

d. Emergency Care:

-- Clinics on the investment premises, staffed as described above, are available for minor emergency cases.

-- Major emergencies, defined in various ways depending on the quality of care in the local environment, are handled either in contracted local facilities or via the MNC investors' own contracts

with an international "med-vac" company. The latter company, with its own aircraft, is retained on a 24-hour/7-day basis to fly the seriously injured to the nearest acceptable hospital.

The coverage of these health services varies depending on the company, the physical environment within which the investment takes place, and the point of evolution of the corporate investment itself in terms of its relationship to any surrounding community. In general, all four of the above service categories are available to both local and expatriate employees for all health problems acquired at or brought to the job site. In a small number of cases, all in circumstances in which the MNC actually has built and manages on-site health facilities and personnel, disease screening, general health and emergency services, often including maternal-child health care, are provided to worker families. These cases usually do not include preventive health services. In a third, much less common set of cases, usually in remote areas and where the corporate investment is projected to be of several years standing, all four types of services are provided to workers, their families, surrounding communities, and any mobile population passing through the investment area. Normally, such extensive coverage is not actually planned prior to the actual investment, but evolves out of the dynamics of health care supply and demand and only after the community has gained confidence in the MNC's health operations.[38]

In no situation did the interviews conducted for this Report identify significant cooperation between multinational services and the public health care system. In many cases, this was due to the virtual lack of such services in the relevant geographic area; in many, however, this division of services resulted from MNC concern with the quality of local, public services. Whatever the reason, the result was the same, the expenditure by the MNC investor of often major levels of resources to assess, provide, and maintain a wide variety of health services. The existence of this expenditure and the internal corporate expertise overseeing it, as well as the corporate incentive for finding more efficient, less costly means for meeting the health care needs of its workers and other community groups, represents an opportunity for a partnership role with public agencies. The potential catalyst role of development assistance in brokering such partnerships is discussed later in this Report.

In some situations, as described above, the corporate role in health services has extended far beyond the provision of general and emergency care to meet the needs of a broad section of the community in a variety of medical areas. In the Middle East, due to the length of historical involvement and the geographic remoteness of investment operations, many of these examples are from the petroleum industry. While these examples often are not within the countries of specific interest to this Report, they are included here as illustrations of in-depth corporate health care involvement in the region.

Case 23: CONOCO IN THE UNITED ARAB EMIRATES

One of the most extensive examples of medical care in the context of multinational investments in the Middle East is that of the Continental Oil Company (Conoco) in the United Arab Emirates (UAE).

Worldwide, Conoco employs over 42,000 people in over twenty countries. Its business areas include coal and minerals mining and chemical production, but 70% of its investment is in petroleum operations in the U.S. and abroad.

In the UAE, Conoco's medical services have been undertaken as part of its petroleum exploration and investment agreements with the national oil companies of the various individual Emirates. To aid this Report on private sector health roles, Conoco officials aggregated extensive information regarding the health problems and facilities of the individual states of the United Arab Emirates, and Conoco's own role in these health systems. This brief profile summarizes Conoco's own comprehensive data.

In Dubai, an extensive network of private hospitals and physicians is being increasingly supplemented by a stronger government presence in health service regulation and delivery. Conoco's affiliate, the Dubai Petroleum Company (DPC), operates the most modern and well-equipped outpatient clinic in the State. Opened in 1978, the clinic provides consultation, examination, treatment, X-ray and laboratory services. The clinic's 8,000 patient visits per year are comprised of both DPC staff and their familes, and a broad spectrum of employees/families affiliated with nearly 220 other private and government companies in the area.

The primary indigenous health problems are respiratory ailments, mainly allergic in origin, as little is known of the pollens of the desert flora; intestinal infections; fungal infections; urinary infections; and, metabolic diseases, particularly diabetes of the late onset type. Injuries from traffic accidents are the most common emergency cases seen at the clinic, occurring much more frequently than industrial accidents. Corporate medical personnel also deal regularly with schistosomiasis, typhoid, amebiasis, and malaria, all of which are imported into Dubai by employees from India, Oman, East Africa, Southeast Asia, Yemen, and Egypt.

In Abu Dhabi, Conoco and its national affiliate operate the largest and best-equipped outpatient facility in the State. Known as the ADCO clinic, it serves employees and families of a number of petroleum and natural gas operations, a total of 20,000 persons. The clinic is staffed by six physicians, three nurses, a physiotherapist, a lab/X-ray technician, and a pharmacist. The clinic

sees 100-150 patients daily. In addition, its personnel pay weekly field visits to subsidiary primary care clinics located in the oil fields.

In Sharjah and Ajman, the petroleum company clinics provide virtually the only outpatient care in the remote areas of those States.

Conoco finances its health care system using a capitation reimbursement mechanism. The oil company builds and equips the facilities. For its own employees using the system, the company pays a lump sum to the provider regardless of the number of service units required. Others using the services pay on a fee-for-service basis. For its own employees, pharmaceuticals used in treatment are included in the lump sum payment.

In sum, then, Conoco houses one of the most sophisticated reservoirs of corporate experience and expertise in the financing and delivery of health services not only to employees, but also to remote areas and communities surrounding natural resources investments.

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Case 24: EXXON IN LIBYA

The Exxon Corporation is the largest industrial company in the United States, with diverse operations in nearly every aspect of energy, from research to exploration, to production and processing, to related industries such as petrochemicals. From 1957 until December 1, 1981, Esso Standard Libya, Inc. was one of Exxon's Middle East operations, coming under a joint ownership with the Libyan National Oil Company from 1973 onward. It had employees assigned in three principal locations -- Tripoli, Benghazi, and the company-developed town of Brega, a desert town with approximately 5,000 inhabitants.

In 1968, Esso Libya met with the Ministry of Health to discuss the health needs of the petroleum operation and the surrounding community. Given the nearly total lack of health services present at the time, Esso Libya proceeded to provide, via a network of clinics, both industrial and community health care for expatriates, its 1,500 Libyan employees, and their families. In addition, corporate funds were donated for the construction of a 25-bed Adventist hospital in Benghazi; somewhat later the company guaranteed a capital improvements loan for them. At the same time, Exxon contributed financially to the jointly-managed Oil Clinic in Tripoli, and provided medical advice and backup services upon request.

The staff of Esso Libya's Brega clinic included four physicians, a dentist, several nurses, and a full laboratory with X-ray facilities. A community medical center facility provided a community innoculation service, particularly for children, and a preventive medicine/health education program. Emergency care was provided to all victims of accidents in the community and to nomadic populations which regularly passed outside the gates of the Esso Libya Brega operations.

Major health problems encountered in the area were respiratory diseases, gastrointestinal diseases, typhoid fever, and trachoma.

In 1980, a year or so before Exxon withdrew from the overall Libya investment, the medical program was mandated to continue under a government-appointed (but Esso-paid) Libyan medical director.

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Case 25: SHELL INTERNATIONAL PETROLEUM COMPANY LTD.

The Medical Division of Shell International Petroleum Company, together with the Medical Division of Shell Internationale Petroleum Maatschappij in The Hague, is responsible for providing medical advice and services to all operating companies of the Royal Dutch Shell Group. Where operating companies employ medical personnel or provide medical services, they call upon these Medical Divisions for assistance and advice as necessary. The two Divisions are also responsible for ensuring that the required standard of service is maintained in all company facilities.

Royal Dutch Shell companies employ over 100 physicians and hundreds of other health personnel worldwide, although many of these focus exclusively on occupational medicine rather than on general health services. In a wide variety of settings, however, Royal Dutch Shell medical clinics provide both inpatient and outpatient services to employees and surrounding communities. In the past, this health services network was much more extensive and intensive. In about a dozen settings, Shell even built and operated fully-equipped hospitals. In some instances, these were turned over to local oil companies or governments as petroleum production was nationalized. In other instances, the local Shell Company has donated its hospital to the local government health services when these have developed adequately (usually with the aid of oil income in that country).

In the Middle East, the company has two types of medical services. In Egypt, Jordan, Tunisia, Morocco, and the Yemen Arab Republic, Shell's Operating Companies rely entirely on local medical services. In such situations the company identifies and appoints a suitable doctor

who can provide limited, part-time services. For clinical medical services a small group of local doctors is identified to whom employees and dependents may turn. It is also the practice of full-time senior Shell Medical Advisers in The Hague and London to maintain a continuing monitoring activity on such local medical services so as to assist Operating Company managements in identifying suitable family doctors, hospitals, and nursing homes to whom their employees (both regional and expatriate) may turn.

Medical operations in Oman are more comprehensive. Petroleum Development (Oman) has a fully-integrated medical service in Oman with seven full-time medical officers and three scattered clinics with inpatient facilities. In this situation, total medical care is provided, including family medicine, occupational medicine, some hospital-type medicine and public health (or environmental health) services. These services are provided to company employees (both local and expatriate) and to their families. A small number of closely-associated local suppliers are also served by the facility, but medical services have not been extended to surrounding communities.

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Case 26: GOODYEAR TIRE AND RUBBER IN MOROCCO

Goodyear, one of the largest manufacturers of rubber products in the world, is deeply involved in many areas of the developing world, both in terms of plantations for cultivation of the raw material, and in terms of local product manufacture. In Morocco, Goodyear operates a small manufacturing plant outside Casablanca, whose health services are typical of smaller multinational investments in the Middle East.

Goodyear operates a limited health care program in its plant for all local employees. The service provides some general health education and first-aid, and serves as a clearing station for work accidents.

As with all companies in Morocco, Goodyear is bound both by law and by its individual labor agreement with the strong and well-organized national labor unions to cover employee accidents and general health. A local doctor is under contract to be in attendance regularly at the clinic to handle first-aid and to refer patients to other public or private services for additional treatment. Emergencies involving accidents are treated on-site and then referred to the employee's physician of choice. Pharmaceuticals and related supplies used in the clinic are bought over-the-counter at local private pharmacies.

In terms of the financing of health services, Goodyear itself pays for the local physician and all materials. It also contributes per employee to the Caisse Nationale de Sécurité Sociale (CNSS), a semi-public insurance system which covers 1.5 million persons, about 10% of Morocco's labor force. If further medical consultation is needed after an employee is treated at the Goodyear plant site, the employee pays for his or her further treatment and is reimbursed by the CNSS. The CNSS has a tariff agreement with the local physicians' syndicate to set rates of payment. To qualify for reimbursement, the employee is permitted to receive further care either from the new CNSS hospital in Casablanca or from private physicians.

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Case 27: STANDARD OIL COMPANY (INDIANA) IN EGYPT

The varied health delivery arrangements of Standard Oil (Indiana), better known as Amoco, are illustrative of the impact of changing investment organization on health service provision. Where Amoco has sole ownership of resource exploration or production, decisions on health service provision are made and implemented by the corporate Medical Director. Normally, this involves contracting with local, private physicians and health facilities to provide occupational, emergency, and general health care to employees and their families. Without exception, these arrangements are known to the government, but Amoco has never seen any public or development assistance interest in the nature of its services or the resources they represent.

When an MNC enters into an investment arrangement with a government, however, the process of decision-making on health services changes. In Egypt, for example, Amoco has invested in a joint venture with the Egyptian Government to establish and operate the Gulf of Suez Oil Company (GUPCO). In this situation, the government reserves for itself the determination of health service requirements and regulations for its national employees; Amoco's expatriate GUPCO employees are served by the same medical personnel and facilities established for the company's wholly-owned subsidiary, Amoco Egypt. For example, the government has set medical/personnel standards per offshore rig to which GUPCO must adhere. GUPCO managers are responsible to the Egyptian investment partner for conformance to these requirements, not to Amoco. As a consequence, the nature and quality of services are neither set nor monitored by the investing foreign corporation.

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Case 28: UNILEVER IN THE DISTRICT OF ETAH, INDIA

Unilever is the largest consumer products company in the world. Although not extensively involved in manufacturing in the Middle East, it is one of the most sophisticated multinational developers of health and community services in the context of its overseas manufacturing investments. The resultant programs have been both essential to the company's business, and major local development catalysts. This is especially so in some of the poorest states in Africa (e.g., Zaire and Zimbabwe) where Unilever has major business operations.

Thus, though not specifically in the Middle East, a case summary of one of Unilever's partnerships is a useful example both of the health activities of the company and of the way in which it has joined with local public resources to address barriers to developing its own and community health services.

In 1963, Hindustan Lever, one of Unilever's subsidiaries, established a milk dairy in the district of Etah, with a population of 1.1 million and tucked into the State of Uttar Pradesh in India. The district's 1,600 villages boasted 700,000 head of cattle, and company surveys indicated that a milk products plant would be commercially viable if built there. By 1968 it was clear that something was amiss with the investment. The modern dairy, designed to process 30,000 tons of milk a year, was operating at barely a third of capacity. For the next five years, the company approached the under-utilization problem from various angles, including lending half of the dairy's capital to local farmers to obtain better breeds of cattle from neighboring states and thus add to the milk supply. Nothing worked, and Indian Government price controls prevented the company from raising milk prices to compensate for under-production. The milk plant thus remained a financial loss to the company. Plans were made to sell off the dairy.

In 1973, however, a deal was struck between the company, the Government of Uttar Pradesh, and the plant's employees. The plan would overhaul operations and attempt to convince local farmers that raising milk production was in their interest. Studies were undertaken which clearly indicated that poor agricultural and animal husbandry practices, as well as the general economic stagnation of the area, were the fundamental causes of the dairy supply problem. In 1976, therefore, the company undertook an Integrated Rural Development Programme (IRDP) for the district, focused on agricultural and animal husbandry improvements, but also on expanding the health, education, and local finance services available to village farmers.

Parts of the IRDP were co-financed with foundations set up by Indian industries. The company also worked hand-in-hand with the Government's public welfare programs, extension services, and irrigation projects.

Two medical vans were equipped and staffed and each village was visited fortnightly. Unilever trained local women in paramedical skills and sent them out to organize preventive health programs for children, to chlorinate drinking wells, and to establish family planning programs.

The IRDP now covers 35 villages. The quality of agriculture and milk-producing cattle has soared and the dairy is making a profit. Moreover, the Programme has given the company the experience necessary to operate successfully in other districts, as it certainly will have to do, since current government policy deliberately targets industrial location toward backward regions of the country.

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2. Disease and Vector Control

Communicable disease control is of obvious concern to multinational manufacturing and extractive industries in the developing world. Corporate medical operations often undertake, independently or jointly with university or government agencies, disease and/or vector control campaigns to limit the spread of various diseases in communities surrounding the investment area, and therefore within its labor force. The most common targets of such disease control efforts have been malaria, tuberculosis, schistosomiasis, and eye diseases such as trachoma.

Many of the most comprehensive examples of such programs are not in the Middle East, but rather in Africa and Asia, where extractive and plantation industries operate in more remote, humid areas subject to more varied and complex vector-borne diseases.

In the Middle East, the Ciba-Geigy case described earlier is an example of disease control programs sponsored or managed by multinational firms. The various corporate interests in disease control are ones that can and have been enlisted in often widespread public programs targeted at communicable diseases.

Case 29: ARAMCO IN SAUDI ARABIA

The Arabian American Oil Company (ARAMCO), during the many years in which it was the corporate aggregate entity controlling the major oil exploration and production concessions in Saudi Arabia, provided extensive, and nearly exclusive, health and medical care to the Eastern Province of Saudi Arabia, notably in Dhahran, Ras Tanura, and Abquiq. By the terms of its concession, ARAMCO was responsible for providing medical care to its ultimately 127,000 employees and their families. De facto, services were also provided to nomadic populations passing through ARAMCO concession lands. A 363-bed hospital and ten clinics were built and staffed by a total of over 1,600 physicians, nurses, technicians, and other medical personnel.

Preventive medicine specialists administered a pest and insect control program. Water and sewage treatment was also a focus of attention to minimize water-borne diseases, especially intestinal infections, in the investment area.

Three specific communicable disease control programs became large-scale operations for ARAMCO's medical service. Malaria eradication was a focus of effort until 1956 when the Saudi Government assumed responsibility for the work. ARAMCO was also one of the chief actors in smallpox eradication in Saudi Arabia during the years of the worldwide smallpox control program sponsored by the World Health Organization. Finally, from 1954 to the mid 1970's, ARAMCO supported a trachoma and eye disease research and control program carried out by scientists of the Harvard School of Public Health. In clinical diagnosis, trachoma is often confused with other eye diseases, such as adenoviral or bacterial infections, and thus errors in diagnosis make the evaluation of trachoma vaccine effectiveness difficult. The project was undertaken to develop a microbiological test to supplement clinical diagnosis in the evaluation of these vaccines. ARAMCO gave both financial and technical support to the research. In addition, many of the research sites were ARAMCO-constructed towns. The ultimate product of the research was a demonstration of the effectiveness of trachoma vaccinations among young children, as well as the actual vaccination of over 1,000 children under the age of three in the Eastern Province.

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3. Occupational Health and Safety

Previous case descriptions have alluded to the level of occupational health and safety (OHS) concerns and programs among MNC investors in the developing world. Critics of multinational OHS policies do abound. Their work is focused particularly on international mining industries, but the analyses seldom describe the specific OHS programs multinationals do put in place to protect local workers.[39]

Historically, multinational companies use the safety regulations and OHS standards of their home country, rather than local safety regulations, in their developing country plants. The major overseas problems have been ones of compliance with those regulations, both for managers and for workers.[40] The incentives for using such standards are many. The human cost of industrial accidents is of prime concern, as is the corporate investment those workers represent. Moreover, major health and safety inefficiencies imply lost productivity and higher production costs. Furthermore, the industrial hygiene aspects of OHS can have significant product quality implications. For example, a chemical company wishing to sell its product as input to other industries needs to ensure the hygienic quality of its production process if that product is to be accepted.

Yet, the range of industrial hazards is broad; the difficulties in preventing them, especially in a poorly educated, poorly trained work force, are often overwhelming. OHS is a difficult enough proposition in the U.S.;[41] it is often a frustratingly complex proposition in the developing world.

Some multinational corporations implement their OHS programs in the Middle East on a plant-by-plant basis, using centrally determined standards, but leaving safety monitoring solely to local managers. In most MNC's, however, OHS planning and implementation is centrally-controlled by a highly trained headquarters staff.

Case 30: WARNER-LAMBERT IN EGYPT

Warner-Lambert Company is a worldwide manufacturer of health care and consumer products, employing more than 45,000 people and operating more than 140 manufacturing facilities and three major research centers worldwide. The company just this year began operations in its new gum manufacturing plant in Egypt, and will apply its international OHS training and oversight system to that plant's operations. That system is one of the most sophisticated in the business world.

As in any complex manufacturing operation, Warner-Lambert's OHS program involves three basic components:

-- Safety engineering to prevent accidents;

-- Industrial hygiene, i.e., the maintenance of worker health, in the work environment;

-- Fire protection.

The Corporate Safety Services Department is responsible for determining the risks associated with any particular plant or operation and then developing programs for protecting workers from those risks. Warner-Lambert's policy is to rely on U.S. standards for determining risk, but to use local standards in any situation in which the latter are more stringent than those in the U.S.

Once the standards are set, Warner-Lambert enforces them at local plants via two strategies. First, the company trains its own safety coordinator from among its local staff. This individual's OHS skills are then upgraded in the company's own in-service training program via annual training courses and regional OHS corporate meetings. Warner-Lambert's is one of the most intensive and comprehensive internal OHS training programs in the world.

Second, the central Warner-Lambert safety staff is responsible for overseeing all plant safety coordinators, and, just as importantly, for creating within plant management a commitment to safety and to specific training programs. Central corporate staff conducts periodic local safety audits of the company's plants in the developing world, whether or not the central headquarters has received any reports of safety problems. These audits serve both to spot potential OHS problems and to emphasize to safety coordinators and plant managers the seriousness with which the company views worker safety and health operations.

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6.E. HEALTH MANAGEMENT INDUSTRY

One of the fastest growing categories of multinational business is that of health care and facilities management. The overseas revenues of U.S. health management companies more than doubled between 1978 and 1981.[42] While, to date, the Middle East has represented a major growth center for this industry, due mostly to the presence of oil wealth, most such companies are beginning to expand to other markets. In Brazil, for example, the Hospital Corporation of America operates a Health Maintenance Organization (HMO) which covers 650,000 employees of 1,400 private companies.[43]

For the most part, the major health management companies own or manage urban inpatient facilities in the Middle East. Where the facilities are not privately owned, they are usually parts of a public universal entitlement program of health care, and thus serve all income groups. In some cases, described below, the companies have also been responsible for service delivery in more dififcult, remote areas. While not involved to date in projects sponsored by development assistance, such companies house significant resources (technical expertise, personnel and facility management systems, and financial analysis capabilities) which are of relevance to the health programs of development assistance agencies and national governments in the Middle East.

Indeed, in some private health management multinational companies (especially those in Britain), there is a growing interest in and experimentation with expansion into public joint-venture or technical assistance relationships. This has been particularly demonstrated by health services management arrangements between the health services companies and indigenous manufacturing, construction, and natural resources companies in the Middle East. There is thus some overlap between cases presented here and information in Chapter 4 of this Report.

Case 31: UNITED MEDICAL ENTERPRISES LTD. IN ABU DHABI

United Medical Enterprises, Ltd. (UME) is a British health management and equipment holding company, owned by a consortium of British banking, investment and insurance corporations and the British Government's National Enterprise Board (the majority shareholder). The UME Group is comprised of two principal operating companies, Allied Medical Group, Ltd. (AMG), the company's health planning and management arm, and United Medical Company International, Ltd. (UMEDCO), the building and equipment arm.

AMG is Britain's largest health management corporation and is involved in projects in Africa, Latin America, and Asia as well as in the Middle East. AMG acts both as consulting firm (e.g., to develop administrative systems for the Osman Ahmed Osman and Co. hospital in Egypt) and as a facility management/personnel recruitment company.

While much of AMG's involvement in the latter type of operations is in hospitals in central urban areas, it has begun to develop experience in more remote, community situations. Under contract to the Abu Dhabi National Oil Company, AMG manages and delivers services in the company's 200-bed Ruwais Hospital, Ruwais Housing Clinic, and three primary care clinics in outlying desert areas of Abu Dhabi. Ruwais is approximately 15 kms. inland from Jebel Dhanna, the tanker-loading terminal for the entire output of Abu Dhabi's oil fields. Ruwais itself is the gas terminal where a refinery, LPG plant, and some 500 houses have been built by GASCO, the national gas company.

The hospital and clinics serve all members of the Ruwais community, as well as all surrounding villages. The hospital is also the referral center for oil field emergencies of the ADCO clinics mentioned in Case 23 above.

The hospital and clinics specialize in the provision of medical and surgical care for accidents and emergencies, and operate one of the only available obstetrical/gynecological emergency units in the area.

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Case 32: WHITTAKER CORPORATION IN THE YEMEN ARAB REPUBLIC

The Whittaker Corporation is a diversified corporation with interests in life sciences, as well as in a variety of other technology areas. Whittaker's Life Sciences Group houses both international and domestic programs, which functionally are involved in a variety of businesses including management, equipment supply and facility staffing.

The international health systems management portion of Whittaker's business is predominantly in the Middle East, where the company manages eight hospitals (six in Saudi Arabia, and one each in the U.A.E. and in North Yemen) and employs 5,500 health personnel Whittaker's management and personnel services are carried out not in the private sector, but for public health institutions in situations of national universal entitlement.

While most of Whittaker's work is in large, wealthy institutions in the oil-rich states, the company's involvement in the Yemen Arab Republic (YAR) is quite different and offers insights into the type of role a health management firm could assume in smaller-scale, poorer development assistance areas.

Sa'adah Governorate is the YAR's northernmost area on the border with Saudi Arabia. It is relatively arid, compared to the country's central agricultural mainstays, and sparsely populated with 3.4% of the YAR's population. In the mid-1970's, only one hospital with 21 beds and three rural health units served the governorate's 154,000 people. In the same year, the area was estimated to have only three physicians, one pharmacist, eleven medical assistants, three nurses, and three midwives.

In 1975, the Government of Saudi Arabia, attentive to its southern border and generally close relationship with the YAR, constructed in Sa'adah the Al-Salam Hospital as a donation to the YAR Ministry of Health. Since the latter faced serious personnel and equipment difficulties of its own, the hospital lay idle until 1980 when Whittaker was asked by the Saudi Ministry of Defense and Aviation to evaluate the resources necessary to operate the facility. Based on those recommendations, Whittaker contracted with the Saudi-Yemen Coordination Council to open and operate the facility.

Currently the facility, nearly the only available health care in the northern region of the YAR, is operating beyond capacity. Its 55 beds are usually filled and its outpatient clinics in such areas as maternal-child care, immunization, and dentistry are seeing 800 outpatients per day, rather than the previously anticipated 250. Whittaker has responded to this service demand by supplementing the hospital's facilities with mobile surgical tents which it uses to

bring outpatient and minor surgery services to the outlying areas of the governorate. The Coordination Council has recently approved the expansion of the hospital's primary care facilities to meet the governorate's medical care demands.

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6.F. INFORMATION/COMMUNICATIONS INDUSTRY

Important contributions to health systems and public health management in the developing world are also represented by the information/communications industry, including both companies focused on information dissemination and those focused on information processing.

The Egyptian family planning case described in Chapter 5 of this Report is illustrative of the technical resources that a private advertising agency can bring to bear on the education of the public regarding a variety of health problems. In industrialized countries, it is common for the advertising industry to become involved in public health issues through either of two methods. Advertising firms are often responsible for designing the communications strategies for the public education campaigns sponsored by health products companies. Alternatively, companies become involved in public health issues by rendering pro bono advice to public agencies initiating public education programs on particular disease or health problems. This advice can be given either directly or through industry organizations (e.g., the U.S. Advertising Council) which aggregate public agency or non-profit organization requests for assistance and approach the appropriate member companies for technical and resource assistance in designing and implementing communications strategies.

A second arm of the communications industry is that involved in data management, processing and distribution. Many data management companies have developed a variety of information systems and data bases used in health care facilities and public health systems in industrialized countries to improve health system management. Applications of these capabilities to developing country health systems are, to date, few in number. One such application was described in Chapter 5 for Beirut's Najjar Hospital.

Information processing companies are also moving beyond the information needs of individual health facilities to the design of products to serve the needs of the broader area of economic development and development aid. The data collection and distribution products of these efforts take the form of both subscription printed materials and computerized data retrieval systems, both of which are designed to assist development professionals and public agencies in tracking, cataloging, and accessing the plethora of project and program experience derived from the thousands of ongoing and completed

development assistance projects and relevant business products around the world. While the health sector is only a small part of the substantive material covered by these information products, the state-of-the-art information management tools being developed now in this industry are examples of market responses to development assistance and public agency needs.

Case 33: CONTROL DATA CORPORATION AND THE 'DEVELOP' DATA BASE

Control Data Corporation is one of the largest computer and information processing companies in the world. Control Data's corporate philosophy is also on the cutting edge of corporate involvement with social needs. As Control Data's Chairman, William C. Norris, recently noted, "Simply stated, corporations must use their vast resources more efficiently by taking the initiative, in cooperation with other sectors of society, to address major unmet needs as profitable business opportunities."[44] Control Data has followed its own philosophy and has developed many of its product lines to meet social needs through the marketplace. Among the company's many such products are education tools, vocational training centers, small business data management tools, and rural venture capital firms.

In the international arena, Control Data has designed the computerized DEVELOP Data Base which provides subscribers with on-line access to detailed descriptions of technologies, processes, technical networks, organizational profiles, published literature, marketed products, and research in progress in a wide variety of developing country economic sectors. Among those sectors are agriculture, education, health, industry, banking, finance, energy and power, housing, and infrastructure. The data base allows the user to access information of any type for any sector or combination of sectors for persons, projects, products, laws, and literature around the world. Control Data's goal has been to develop a marketable information and management tool which, at the same time, will make the process of development assistance and economic and social planning more cost-efficient and thus more effective.

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6.G. BANKING AND FINANCE

International capital flows between developed and developing countries have fueled economic progress for most of the last two centuries. Of the many channels for this flow, commercial bank lending has been particularly important for the last ten years. Indeed, from the early sixties to the late seventies, commercial

lending (exclusive of export credits) increased by eleven times in real terms, swelling from one-fourteenth to one-fourth of the total flow of capital to developing countries.[45] With the oil price increases of the early 1970's, most of that borrowing took place to ensure the viability of development programs.[46] All major international commercial banks were involved. So were most minor ones; as banking analyst Peter Kenan has noted, during the 1970's, "banks from strange places began to lend to even stranger places."[47]

Yet even during this period, and certainly now that growing developing country debt has introduced more caution into the foreign operations of commercial banks, mobilizing that commercial resource for specific development projects in the Middle East has often been difficult. More difficult has been mobilizing commercial lending for small to medium scale business undertakings, which have neither the size to attract development assistance finance nor the assurance of success to attract major commercial banking investment.

The experience of Egypt in this area is illustrative of the problem. The banking and financial liberalization undertaken in the last ten years in Egypt, it was hoped, would attract foreign commercial banks to major investments underlying Egypt's development plans. Some 40-odd foreign-owned banks did indeed open up operations in Egypt, but their emphasis quickly became not long-term investment finance but the financing of short-term needs such as consumer imports. The result has been renewed Egyptian Government restrictions on foreign banks and on the foreign currency deposit market.

The problem -- and opportunity -- of foreign commercial banking has relevance for the health sector priorities of development assistance. It is commercial banks which can provide the capital for expanded private sector health product manufacture. Moreover, it is commercial banking which may offer the financial management expertise so often missing in health sector programs. Finally, at least one international commercial bank initiative offers a model for more creative thinking about the potent resource role of commercial banking in the health sector.

Case 34: BARCLAYS BANK INTERNATIONAL LTD. INTERNATIONAL DEVELOPMENT FUND

Barclays Bank International has offices and operations in 84 countries around the world, and has for many years struggled with what is often a difference between projects which are commercially viable and those which may be economically desirable. In the belief that a commercial bank can contribute to bridging the gap between commercial finance and development assistance, the Bank, in 1970, established the Barclay's Development Fund. That Fund, which now totals over £3 million, is made up of contributions from the Bank's after-tax profits.

The larger part of the Fund's money is intended for "support of practical development projects involved in increasing production and improving services in agricultural, industrial, and commercial projects." In many cases, it is expected that as such projects move toward commercial soundness, they will turn increasingly to ordinary banking facilities, hopefully those of Barclays itself. It is possible that some projects may effectively use a mixture of Development Fund money and commercial funds from the Bank, but Development Fund support is not conditional on a continuing relationship with the Barclays Group. The Fund also supports projects which involve novel research or training related to economic/commercial development.

Geographically, the Fund has been most active in Africa and the Caribbean, areas with which Barclays has a long banking association. Project finance from the Fund has been in amounts varying from £1,000 to £50,000, but the Fund has now built its resources to a point that it is in a position to contemplate larger amounts for suitable projects. Where necessary, these larger amounts may be disbursed over a period of years.

The major financing criterion for the Fund is that projects be those where financing on a conventional commercial basis is difficult. This implies that lack of tangible security, or an irregular or uncertain cash flow in initial project phases, will not necessarily eliminate projects from consideration. Support for development projects is favored where the Fund's initial financial contribution might reasonably be expected to generate continuing development, leading in due course to a healthy cash flow and normal finance arrangements.

Financial support is tailored to suit the needs of each project and to blend, if necessary, with other sources of finance. A mixture of financial methods can be used. Assistance may be arranged as: interest-bearing loans (for varying lengths of time and at varying rates of interest); interest-free loans (for varying periods); guarantees (to cover bank borrowings); equity (where suitable); and grants.

The Fund naturally hopes that projects supported will prove economically and commercially sound, but accepts the risk of failure and financial loss.

Examples of Fund loans include:

-- Equity for a small holder's sugar company in Zambia;

-- A loan fund for on-lending to small firms in Malawi;

-- A loan fund for on-lending to blind persons running farms and small businesses in Barbados.

While health sector projects have not been specifically supported by the Fund -- and are unlikely to be supported in the near future -- the Fund is a model for bridging commercial and development finance which could be replicated, using both development assistance and commercial bank funds to capitalize such banking mechanisms for health sector lending. This option is discussed in more detail in Chapter 12 of this Report.

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6.H. INSURANCE

The dimensions of the insurance industry relevant to the health sector of the developing world, and specifically the Middle East, are many. However, the actual involvement of the U.S. and, to some extent, the European insurance industry, in some areas of that market has been minimal, largely due to regulatory and financial disincentives.

Since the insurance industry is so diverse, some discussion about what it is, what it does, and how it is subdivided is in order here. Insurance is a service industry which provides protection against financial losses arising from unexpected events. These losses can be:

-- Commercial (fire, marine, product liability insurance);

-- Personal injury (workmen's compensation insurance);

-- Life;

-- Personal health and disability.

Insurance is in essence a financial industry; it spreads individual risk across large numbers of people, then aggregates and invests the individual financial payments for that risk-spreading service. This process of protecting individuals against risk results in the accumulation of large reservoirs of assets which, in turn, supply significant levels of investment capital to an economy. In the U.S., for example, domestic life insurers supplied $34.5 billion out of a total of $419 billion of new funds to the U.S. money and capital markets in 1980.[48]

Although the insurance industry is inherently an international one,[49] the overseas activities of most companies are extremely limited because the industry's financial nature places it at the heart of a country's economic concerns. It is thus highly regulated, extremely so in the capital-poor developing world. This regulatory factor,

combined with the poor availability in the developing world of the statistics upon which the industry must rely for its risk decisions and with the general difficulty in serving poorer populations, has served as a strong disincentive to Third World involvement by the large insurance companies around the world.

The insurance functions of specific importance to the health sector are of four types: property insurance, as it relates to investments in health products plants and facilities; casualty insurance, as it relates to worker compensation; life insurance; and health insurance. The roles of indigenous insurance companies in these services are discussed in Chapter 4. On the international corporate side, especially in the Middle East, multinational insurers have been involved only in the first set of activities. Property insurance for health-product investment in the Middle East is handled by local companies (in Egypt, by the national monopoly). Multinational companies are re-insurers to these businesses. The problems of stabilizing and encouraging this sector of the insurance industry in the Middle East are being handled within the industry itself, with considerable help from the major London and New York brokers. Indeed, in 1978 alone, direct insurance premiums retained in 18 Arab countries (excluding Saudi Arabia and Lebanon) totaled $1.5 billion.[50]

Workmen's compensation is handled via national social security schemes, as described in Chapters 5 and 9 of this Report.

Setting aside for the moment the cultural and religious barriers to life insurance in the Middle East, this type of insurance is generally publicly-held, since it can be a major aggregator of investment capital. Egypt does not permit foreign life insurance companies; Jordan, as of 1982, no longer issues new licenses to foreign life insurance companies; Morocco and Tunisia have virtual government monopolies of the industries; Lebanon as a life insurance market is in chaos.

The use of private health insurance, either individual or group, as a means of financing health care as well as of spreading risk and accumulating capital, is in its infancy in the Middle East. No major health insurers from the industrialized countries are major actors in the provision of local health insurance in the region. The nature and extent of locally-provided health insurance in the Middle East are discussed in Chapters 4 and 5 of this Report.

Despite the lack of an international industry presence in the Middle East, interviews conducted with industry executives in preparation for this Report identified a variety of ideas for insurance financing options appropriate to the countries of the region. Industry representatives were also impressed with the potential for a development assistance role in creating the information base and policy framework which would provide the incentive for such private financing schemes,

to the advantage of both the local health systems and the insurers. As one executive noted, "Insurance is a very powerful way to push the health system the way you want it to go. With a combined finance/delivery system, properly constructed and driven by the financial plan, there is no reason the health system, even in an LDC setting, could not both serve the middle class and save the children of the poor."

Options for such insurance activities, and opportunities for accessing multinational corporate expertise on their design, are discussed in the final chapters of this Report.

6.I. CONSTRUCTION AND ENGINEERING INDUSTRY

The development boom throughout much of the Middle East has meant a similar boom in heavy construction, power plants, infrastructure, and housing. The MNC construction and engineering companies carrying out that work thus are major employers in the region and thus are both providers of a wide variety of health services and, at project's end, suppliers of health care facilities. In most cases, however, these facilities are turned over not to the public health care system, but rather to the national company operating the project at issue. They thus remain separately-staffed and managed, and are financed outside the national health budgets.

As compared to an investor, a construction firm is a contractor, carrying out a piece of work for a client, usually the national government. Thus, the health care activities undertaken, and the finances spent in their provision, must be approved by the client, resulting in considerably less innovation on the part of the contracting firm.

In general, the same sets of health care options described for multinational manufacturing investors apply to major construction firms. Most contract with local private physicians or facilities to provide health care for employees and their families. Emergency evacuation services for serious injuries are provided via plane or helicopter using "med-vac" contractors. If the project is two or three years in duration, companies hire expatriate medical professionals and usually provide their own basic medical services.

In some cases, however, the involvement of the contracted engineering firm in health services may be less than even the above level of activity. One company noted that it seldom hires local labor on its projects in the region. Rather, it hires, through labor contractors, workers from such countries as the Philippines or Korea. These workers usually bring their own physicians with them, thereby eliminating the need for the central contractor to provide health services.

In all cases, safety standards applied in these construction projects are those of the company's home country. A senior corporate expert attached to the project is in charge of local safety training. Given the relatively unskilled labor force, safety and hazard prevention are of great concern to the MNC's interviewed, and have proved extremely difficult to ensure. In one instance in Africa, an executive noted that their OHS training was as basic as educating the labor force in the importance of wearing shoes on the job site.

Moreover, many engineering and construction companies are increasingly concerned about environmental health and safety, especially regarding worker exposure to dangerous chemicals, as they become involved in rebuilding old energy plants. Methods for protecting unskilled workers from such dangers were often considered currently unsatisfactory.

As with their counterparts from investment industries, medical directors of construction firms were often dissatisfied with disease screening of workers. In construction projects the MNC usually does not hire its own labor, but relies on a local or international labor contractor who, in turn, is responsible for communicable disease screening and normal physical examinations prior to employment. The MNC firms' experience has been that this function does not receive the emphasis appropriate to its importance.

Although the solutions to health services needs in construction projects tend to be more ad hoc than in investment projects, in large part because the MNC role is transient, cases of extensive health system involvement are present. These have often been a function of a project's geographic isolation, the nature of the project itself (e.g., construction of new towns), or the onset of natural disaster.

Case 35: FLUOR CORPORATION IN ALGERIA

The Fluor Corporation is one of the largest energy drilling, mining, engineering, and construction firms in the U.S. Fluor is involved not only in direct energy production projects, but also in mining, petrochemical industry development, and infrastructure projects involving both community and industrial support facilities.

In Algeria, a Fluor gas-processing project is being undertaken in the southern Sahara, an area without even the beginnings of a health infrastructure. In this setting, Fluor began with the basics. Water reservoirs were explored and deep wells drilled. Along with all housing for the work camp and managers, Fluor is building a series of medical clinics, hiring physicians and nurses, and arranging for medical supplies and for emergency evacuation services. All health services are available to the company's hundreds of employees and their families, as well as to the nomadic population in the area.

As in other Fluor projects, all health facilities are turned over to the government client for community use at project completion.

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Case 36: BALLAST-NEDAM IN SAUDI ARABIA

The Ballast-Nedam Groep N.V. is one of Europe's largest dredging and construction companies. The company was one of the first foreign contractors to undertake major construction work in Saudi Arabia -- construction in 1963 of the Al Khobar and Dammam water and sewage systems with financing arranged by ARAMCO.

Between 1975 and 1977, Ballast-Nedam contracted to build eleven complete and fully-equipped towns in various areas throughout Saudi Arabia. At work sites which were "empty areas of desert where even fencing off a construction site was, in itself, quite a job," the company had to provide accommodations and health services which not only met basic needs but which would ensure labor satisfaction under trying desert conditions, and thus ensure high performance.

A referral hospital was built, and a series of clinics outfitted with X-ray facilities, pharmacies, and sophisticated laboratories. The company drilled its own water wells and set up its own water quality control program, later found to be a key factor in reducing absenteeism due to illness.

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Case 37: DAVY MCKEE

Davy McKee Corporation is an engineering and construction firm with extensive operations in the developing world. While the health services provided in its construction projects vary somewhat by country or area need, its standard approach to health services provisions is quite comprehensive in remote project areas. Of predominant concern is the establishment of adequate emergency services. Vaccination programs are universally carried out, especially immunization against communicable diseases and venemous snake bite. Sewage systems and/ or sewerage treatment facilities are established for both project site and housing/camp locations. An internal consultant or professional dietician undertakes a nutritional survey to determine required foods and/or food supplements, and these are made available to all employees and their families. Where community health practices are particularly low, the company undertakes community health education programs.

While the availability of all of these services is normally limited to employees and their families, the system is planned with community emergency in mind. In 1976, for example, the Guatemala earthquake completely cut off all supply routes to the company's rural work site and surrounding communities. The company health service undertook to vaccinate all employees and community members and to supply medical care until access was again established.

In the company's experience, the most difficult health needs for corporate programs to meet in remote areas are those of anxiety and depression, particularly in surrounding communities. The social and cultural dimensions of psychological problems are extremely complex and difficult for companies to confront. Davy McKee's most successful option has been to open its employee recreational activities to surrounding communities and to organize various community-project events to establish community trust and communication.

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6.J. A PARENTHETICAL ON PHILANTHROPY

One parenthetical is appropriate here. A great many pages have been and will be spent in this Report emphasizing the potential of the private sector in the Middle East on the basis of that sector's experience, and economic and market stake in the region. The private sector's economic ties bind many corporations, multinational and indigenous, large and small, to the peaceful development of Middle Eastern nations. But for the Middle East, perhaps more than for many regions of the world, the ties are much deeper. The many private sector interviews conducted over the past year in preparation for this Report have revealed a unique concern among private sector executives with the social and broad economic development of the region and with its peace and stability. As noted earlier in this chapter, Middle East operations are not new to most of these corporations; many have been involved in the area for 40 or 50 years. Those years of close observation, of participation in the region's triumphs and traumas, have developed among corporate executives almost an ethos of admiration that ties corporate concern to the region's development in ways that even the greatest levels of current trade and investment cannot.

For this reason, in addition to the obvious increasing pressure of market incentives and forces in the region, development assistance has a very clear opportunity to interest private sector executives in development problems in the Middle East. The corporate economic/market interest combined with long years of regional experience and concern can leverage both market and philanthropic resources. An illustrative case is perhaps appropriate here of how those factors have coalesced in the past in response to, admittedly crisis, development needs.

Case 38: THE CORPORATE RESPONSE TO LEBANON'S RECONSTRUCTION[51]

The response evoked by the 1982 war in Lebanon from the multinational corporate sector is an interesting case of the intertwining of corporate economic and philanthropic initiatives in the Middle East.

When calm -- if not peace -- had returned to Lebanon in the autumn of 1982, after the hostilities of the summer, corporations with long economic ties in the region began to mobilize, singly and in groups, to meet the country's reconstruction needs.

The major petroleum companies, whose communications systems with the region are among the best in the world, were the first to come forward with reconstruction contributions of finance and in-kind materials. Among these were Amerada Hess, Arabian Petroleum Investments, ARAMCO, Ashland, Conoco, Esso Middle East, Gulf Oil, Mobil, Texaco, and Standard Oil of California.

Other individual corporations, often through explicit and direct action of their Boards of Directors, began making reconstruction contributions even before the fighting had ceased. Among these were Arthur D. Little, Bechtel, Gulf & Western Industries, Fluor, Ford, Johnson International Publishing, NCR, The Olayan Group, Pepsico, Riggs National Bank of Washington, Western Geophysical, Westinghouse, and Whittaker Corporation.

Soon after the 1982 invasion began, the Chairman of the Board of Time, Inc., chaired a group of executives, chartered as the non-profit American Corporate Aid for Lebanon, Inc., to raise $2 million for Lebanon's reconstruction from the Fortune 500 companies. Before the guns had even cooled, they had received more than that amount in cash and in-kind materials from 23 companies. Those contributions were then subdivided into quarter-of-a-million-dollar packages and given to institutions with proven track records in the country, with a primary focus on meeting the country's health needs. The American University of Beirut Hospital, Save The Children Fund, and the Red Cross were major recipients.

Finally, the Lilly Endowment, the foundation arm of Eli Lilly and Company, despite its explicit policy to focus on Indiana institutions, came forward with an unsolicited grant of $100,000 to the American University of Beirut, one of the largest single grants made for use in Lebanon.

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6.K. JAPANESE CORPORATE ACTIVITY

A separate section on Japanese international business activity is included here because of its unique and distinctive nature.

There is no doubt that foreign trade has sustained the economic well-being of Japan. The overriding need to acquire the foreign exchange necessary to purchase vital raw materials propelled the nation to develop a sophisticated, highly complex system of promoting foreign trade. Because this system exists in no other nation, the way in which governments or development assistance determines appropriate linkages with the Japanese is dependent upon understanding the international business institution known as "soga shosha."

Established in 19th century Japan as trading companies, soga shosha have evolved into enormous institutions with extensive business ventures, a multitude of functions, worldwide offices, and information networks. A New York-based representative for a major soga shosha summed up their activities by saying, "Wherever there is business, there is a soga shosha."

Soga shosha are not only trade intermediaries, but also the creators of trade flows. The basic rationale of soga shosha differs from that of multinational manufacturers. They are not "user-oriented," but instead are "supply-demand oriented." Or, to describe their aim in another way, the main approach of a soga shosha is to look for problems in trade flows or industrial development and try to solve them. Some of their activities include: investment in resources; assistance in industrial growth; organization of industrial projects; finance; provision of extensive information on everything from markets to weather. This multitude of activities makes them one of the most important centers for business information in the world.

The purpose of all these activities is to stimulate trade flows to and from Japan. Thus, they take part in every kind of commercial transaction to ensure the continued growth of trade.

Soga shosha have an extensive network of worldwide offices with highly trained staff, usually creamed from the top echelon of business graduates. The six largest soga shosha each have more than 100 offices overseas. The nine largest soga shosha are:

1. Mitsubishi
2. Mitsui
3. Marubeni
4. C. Itoh
5. Sumitomo Shoji Kaisha
6. Nissho-Iwai
7. Tomen
8. Kanematsu-Gosho
9. Nichimen

The combined sales of these companies for 1976 were $199.7 billion.[52]

Japanese trade with the Middle East totaled $15.152 billion in 1980, representing 12% of total Japanese trade with the world.[53] The main Japanese export items include machinery, equipment, textiles, and metals. Japan's exports of pharmaceuticals to the Middle East are minor. Although Japanese exports of pharmaceuticals worldwide increased 8.7% in 1981,[54] international sales of pharmaceuticals account for only 3% of total Japanese drug revenues.[55] Pharmaceuticals are not a major export commodity of Japan.

Interestingly, there has been a recent shift in Japan's international business strategy, a shift away from trade toward a greater level of investment abroad. A variety of external factors prompted Japanese business, with encouragement and support from the Government, to begin to alter their econmic strategy. These factors range from the protectionism reaction among industrial nations to the influx of Japanese exports, to developing countries' international policies for domestic processing and production of their natural resources. Thus, investment has become the alternative to being locked out of profitable markets and denied access to raw materials. The level of Japanese investment overseas is clearly growing. In 1970, the total investment was $3.6 billion; in 1978, it was $4.6 billion.[56]

Soga shosha have become the leaders in this new direction. In addition to their other business functions, soga shosha currently have heavy investments in manufacturing and resource extraction. They have also acquired the recent function of organizing business investment projects, which entails developing a consortium for the project, financing, marketing, procuring materials, and developing local industries to support the project.

Although this new Japanese investment strategy is targeted toward the industrial world, direct Japanese investment in the Middle East is expected to continue to grow. There is OPEC money available for joint and trilateral investment, and Japan's deep dependence on imported Arab oil requires it to be receptive to investment opportunities in Arab countries. In 1980, the level of Japanese investment in the Middle East was $158 million.[57] Investments were primarily in manufacturing, commerce, and chemical projects.

The delivery of health services or general health activities stemming from the operations of soga shosha have yet to be determined. Representatives of these institutions have maintained, however, that there is not a strong likelihood that these companies will address the social service side of their operations in any extensive way.

Yet, since the Japanese have only recently begun to invest heavily abroad in manufacturing activities and since these capital flows are expected to increase, new business incentives and international competition for government contracts may require the Japanese to address the health-related issues of their indigenous employees in

a more systematic way. The potential benefits of government or development assistance cooperation with these benefits may enhance the health-related aspects of the investments and thereby bring new resources to bear on the region's health problems.

6.L. SUMMARY

Multinationals are major actors in the provision of quality health care to communities in developing countries. The wealth of expertise, range of activities, and accumulated experience of these corporations are too valuable to be ignored by public health administrators and like-minded development assistance agencies. On the contrary, these roles should be exploited and offered incentives for improving and expanding the level of private health capabilities in these countries.

As the size of their effort and expenditure on health care indicates, MNC's feel they have a vested interest in the health and welfare of the people who comprise both their labor pool and a market for their products. MNC health and safety standards are usually set according to those of the MNC's home country, and their facilities often expand beyond employee care into the servicing of families and local communities. In some cases, MNC's are the only providers of modern health care in a given region and in some countries, the largest and most sophisticated outpatient facilities are those set up by MNC's. Indeed, it is a multinational company which houses one of the most intensive internal OHS training programs in the world.

In addition, the extensive role of the health products industry in the health care systems of these countries offers development assistance many long-range opportunities for improving the delivery and quality control of products, and training of personnel.

Similarly, the banking, finance, and insurance industries, although not currently major actors in the health systems of these countries, present promising potential for involvement as investors in health, industries, and services. The way in which development assistance can leverage its way into these ongoing or potential activities will be explored in Section III of this Report.

7. THE OPEC CONNECTION

"Government planners and private entrepreneurs (in the Middle East) are now reminding themselves of all the ways in which the potential for regional cooperation had already been present but has not been implemented. And for many Arabs, economic unity looks like... an historic opportunity for the Arab nation to act in concert to raise the living standards of all of its 140 million people."[1] Malcolm H. Kerr, University of California, Los Angeles.

When reviewing the possible solutions for virtually any development problem in the Middle East, thoughts immediately turn to the financial role -- current and potential -- of the oil-surplus countries of the region. This chapter will review the nature and level of private investment and mixed private/government financing in the region, and, to the extent available, its health sector role. Chapter 10 will include a similar discussion of the various Arab formal development assistance funds.

7.A. MAGNITUDE OF THE CAPITAL SURPLUS

At the end of 1979, the net external assets of all OPEC countries totaled approximately $200 billion.[2] By the end of 1980, that capital accumulation was $343 billion.[3] To gain a sense of the magnitude of these figures, this surplus accumulation can be compared to total U.S. exports worldwide of $220 billion in 1980.

78% of the OPEC capital accumulation was held by Saudi Arabia, Kuwait, Iraq, and the UAE, with another 19% by Iran, Libya, and Qatar.[4] It is estimated that between 1974 and 1980, Arab oil-surplus countries exported $691 billion worth of resources while their imports amounted to $225 billion.[5]

The recession and consequent softening of energy demand in the last two years have, of course, resulted in recent price declines. Therefore, projections of the future for this capital surplus are more conservative. Indeed, OPEC's oil output has been more than

halved since 1979. Saudi Arabia's real oil revenues have dropped to one-quarter of their 1980 peak.[6] Moreover, non-OPEC producers now supply more than 50% of the free world's oil.[7]

Although projections of the stability of price reductions and consequent earnings and capital surpluses vary, the general assessment is that, barring both an extremely strong international economic recovery over the next three years and an abandonment of government and industrial conservation policies in the West (since 1978 the industrialized nations have reduced their overall oil demand by 20%[8]), continuation of these excessive accumulations is unlikely. Indeed, ongoing commitments to such capital intensive projects as the Jubail and Yanbu industrial areas in Saudi Arabia will likely result in the need to begin applying the existing surplus to internal development requirements.[9]

7.B. INVESTING THE SURPLUS/GOVERNMENT

Of the above capital surplus in the Arab oil-surplus countries, probably no more than 15% constitutes private sector money.[10] The remaining 85% has been recycled by government or quasi-government entities.

Addressing the former portion of that surplus first, the preference of government investors has clearly been for secure, stable investments. This has attracted government monetary authorities to the short-term obligations of Western governments. Since 1979, the annual distribution of the government-controlled surplus of the oil-exporting Arab countries has favored direct bank deposits (49% of investments; of course, some of these funds find their way back to the Middle East via commercial banking loans to non-surplus governments); government securities (fluctuating between 8% and 15% of investments), mostly in the U.S., U.K., Germany, and Japan; portfolio and direct investment in OECD countries (between 19% and 24%); and loans to the International Monetary Fund and The World Bank (between 3% and 6%). Direct loans to Arab and other developing countries have represented only between 12% and 16% of government surplus capital flows.[11]

This pattern has satisfied the conservative investment tendencies of the national bankers responsible for investment portfolios. It has also put large portions of capital out of the reach of regional development projects. Moreover, it has yielded an average rate of return on official assets of only 7.5% between 1974 and 1980.[12]

Given that poor earnings performance, the likely slowdown in capital accumulation due to price and production declines, and the governments' desire to develop alternative sources of food and manufactured goods, banking and finance leaders in the region are beginning

to recommend adjustment in that portfolio pattern. They suggest keeping only 40% of assets in financial instruments and seeking higher rates of return via direct corporate investment. Indeed, the banking manager for the Industrial Bank of Kuwait has recommended that 70% of its direct investment be placed in projects in Arab and Third World nations that guarantee the investments against nationalization.[13]

Within the portion of public capital which has not been invested in financial instruments, and has been used in Arab and other developing countries, the tendency has been to carry out investments either via multilateral Arab organizations or via quasi-governmental investment companies. In either case, however, the overriding concern continues to be monetary stability and protection against inflation and monetary devaluation.[14]

Multilateral Channels: Multilateral institutions have been modeled, to some extent, on the International Finance Corporation arm of The World Bank. For example, the Arab Investment Company (TAIC) was founded in 1972 as a joint stock company to help fund Arab development. It is capitalized at $290.5 million, has assets of $500 million and is owned by 15 Arab countries (Kuwait, Saudi Arabia, and the UAE are the largest contributors at $45 million each). The company must earn a commercial return (a $21 million profit in 1980 has been its highest), and its goals is to stimulate private sector development under the "triangular investment" strategy (Arab capital plus Western technology plus local resources). Since 1975, TAIC has disbursed over $150 million in loans and has taken up over $100 million in equity. More than half of its portfolio is in the private sector. Loans range from $5 million to $30 million, with a preference for small to medium-sized projects. Although agri-business has been a major recipient, TAIC has also been involved in insurance, banking, and service industries. While the health sector, either in its manufacturing or in its service provision aspects, has not been a project area, the creative potential for such investments may be quite real, as evidenced by the precedent of the Kuwait Real Estate Investment Consortium case described below.

Quasi-Government Channels: The vehicles for much direct oil-surplus government investment in the Arab world and other developing countries have been quasi-government investment institutions within individual countries. These organizations, while not technically government agencies, trace a majority of their capital back to government monetary authorities. However, these institutions take joint-venture equity positions in development projects, with both public and private partners. The focus of these projects has generally been in the housing, real estate, and tourism industries. The investment institutions normally seek a commercial return on the investment, although their public/government partners may be (and

sometimes have been) more concerned with political impact. The resultant near incompatibility of objectives has put more than one such joint venture at risk.[15]

Case 39: THE KUWAIT REAL ESTATE INVESTMENT CONSORTIUM AND THE TAWFIQ CLINIC, TUNISIA

Essentially a joint venture between private sector agencies and individuals, the Tawfiq Clinic in Tunis was conceived to provide "state-of-the-art" health services in the private health sector in Tunisia. The diversity of participants in the $6.3 million investment is a classic example of why it is difficult to classify such public/private sector projects in the region.

The idea for the clinic was originally developed by a group of private Tunisian physicians. The financial package needed to build, equip, and operate the clinic is 70% held by non-Tunisian oil-surplus investors (government, development assistance, and individual); 20% by the Kuwait Real Estate Investment Consortium; 30% by the Islamic Development Bank; and 20% by the Saudi Arabian business investor, Salah Kamel. The remaining 30% is Tunisian-held, with an equally diverse set of investors: both public and private, Tunisian banks as well as individuals, the latter mostly physicians. Moreover, the multinational corporate connection is also present in the deal, with Britain's International Hospitals Group Ltd. providing the technical and managerial project assessment for the investors.

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7.C. INVESTING THE SURPLUS/PRIVATE INVESTORS

As regards the 15% of surplus capital (some $50 billion) in private hands, investment interests and activities are extremely diverse. In general, however, it can be said that most investment of this type is undertaken outside of the Arab world Egypt has been the main recipient of private Arab investment within the Middle East, and that largely in tourism and construction projects. Overall the investment pattern is conservative, although the "new money" (private individuals whose wealth stems from recent boom years, as compared to the "old money" of royalty) is more entrepreneurial.[16]

The primary areas of private investment focus outside of the Middle East have been, in order of priority, bank deposits and their financial instruments, real estate, and the short-term bond market. Recently, there has been greater interest in stocks, particularly those of electronics and petrochemicals companies, and, interestingly, the pharmaceutical and health care industry.[17]

Geographically, this investment interest has focused on Germany, the U.S., and the U.K. New markets, such as Japan, Brazil, Argentina, Peru, Indonesia, and Malaysia, however, have increasingly become sites of private Arab investment.

The actors on the private investment scene are many and varied. Most are royalty, former government officials, businessmen who made their wealth via the trading boom, or bankers. The involvement of royal personages in regional investment and health systems is widespread. Although not from an OPEC country per se, the activities of Oman's Sultan Qaboos Ibn Sa'id are typical of the quiet, behind-the-scenes roles of Arab royalty in regional health development.

Case 40: QUEEN ALIA HEART INSTITUTE, JORDAN

In April 1983, while on a state visit to Jordan, Sultan Qaboos Ibn Sa'id of Oman joined Jordan's King Hussein in inaugurating the Queen Alia Heart Institute and the Royal Rehabilitation Center of the King Hussein Medical Center in Amman. The 100-bed Heart Institute was a personal gift from Sultan Qaboos to Jordan and was built at a cost of $19.6 million.

Since its opening in March of 1982, the Institute has provided services to 12,000 persons and has become the major heart center for the region. Opened earlier this year, the affiliated Royal Rehabilitation Center serves the needs of the physically handicapped. Built at a cost of $25.2 million, the 147-bed facility, which was not externally financed, includes a burn treatment unit, as well as departments for orthopedic, prosthetic and psycho-therapeutic treatment.

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Interestingly, perhaps especially so for the health sector, some of the region's wealthiest, most powerful private investors are women. The most important of them is Sheikha Badria al-Saudi al-Sabah, a member of the Kuwaiti royal family and an officer and controlling owner of a variety of investment groups with interests ranging from precious metals to French steel mills. Three other Kuwaiti businesswomen are among the 66 Arab millionaire members of the Sharjah Group, which has assets of over $400 million and is the most active of such companies, investing nearly totally in the Arab world.

While the presence of private Arab capital in health systems in the Middle East per se may be small, experience with and sensitivity to health sector opportunities is beginning to build. Indeed, in the last two years, there have been two examples of major Arab

private investment in health care provision outside the Middle East, both in Britain. Both have focused on the provision of quality services outside Britain's National Health Services system for prices just below those of the country's teaching hospitals.

7.D. SUMMARY

In sum, then, the role of investment in Middle East health by the various channels of oil-surplus Arab countries has been a fairly small one. Expanding that role, given the impact that oil price and economic factors will have on asset growth, may prove difficult. However, precedents for such investment do exist, both in the Middle East and in the West. This is particularly so for the multilateral investment institutions and for individual private entrepreneurs.

Despite these precedents, however, the development sector will have to do more than sit back and wait for its project phone to ring. Appropriate projects in the health sector will need to be viewed and marketed as productive, secure investments with potential for furthering regional economic cohesion and establishing regional self-sufficiency in basic health care products and services. Making that point, even within solely private investment schemes outside the health sector, has proved difficult.[18] Successfully mixing public finance with private investment and development assistance, and placing its focus on the health sector, will be a long and complex process. In short, turning past experience into future opportunity is likely to require considerable effort and an entrepreneurial spirit on the part of development assistance officials.

8. IMPACT OF DEVELOPED COUNTRY POLICIES

8.A. INTRODUCTION

So as not to lose perspective, one must remain aware that development assistance or other public efforts to foster the growth of private health roles or resources in the Middle East may be impeded by barriers that have neither to do with any lack of resources or skills available in the region, nor with any incompatibility between private motive and public/government health goals, nor with any lack of interest or willingness on the part of development assistance to act as a catalyst for these private partnerships. Rather, these barriers may exist as a result of the government policies or regulatory structures of industrialized countries that exist to serve their own domestic economic goals. As a spinoff effect, these policies may also serve to create disincentives to multinational corporate or indigenous health-related investments and research of potential benefit in the developing world.

Examples of the effects of domestic policy on international trade and investment in the Third World are many. The point of this chapter is not to develop a dissertation on that issue, but rather to provide two illustrations of this barriers/incentives relationship between developed country policy and private roles in the developing world. In many cases, the barriers raised by these policies cannot be resolved by the corporations involved, by LDC governments or by development assistance professionals. However, it is hoped that the two illustrations which follow will keep the health and development professional attuned to the potential barriers to expanded private roles which, although outside his/her own realm of responsibility, may affect the way in which private executives evaluate public opportunities for cooperation. Forewarned about the complexity of the policy environment within which private corporations must make decisions in their foreign operations, the public sector professionals may be able to design more effective approaches to potential private corporate partners headquartered in the industrialized world.

8.B. TAX DISINCENTIVES TO FOREIGN INVESTMENT

In order to avoid inflicting double taxation on a firm that is incorporated in America but operating abroad, the U.S. Government grants foreign tax credits for the full amount of the tax paid by a multinational corporate branch to its host government. If this amount is greater than the normal U.S. tax, no payment to the U.S. Government is required. If, as is more often the case in developing countries, the tax paid to the foreign government is less than what would correspond to the U.S. rate, the firm pays the difference to the U.S. Treasury. The lower the tax rate in the host country, the greater the sum received by the U.S. Government. The effect of this policy is to partially neutralize any tax incentives put in place by LDC governments attempting to attract foreign investment, since whatever money is foregone by the LDC government is paid to the U.S.[1]

In the 1950's and early 1960's, treaties which included "tax-sparing" provisions were negotiated between the U.S. and several developing countries. These provisions would have conferred credits on the full amount of tax that would have been paid to a foreign government in the absence of a tax incentive program. However, these treaties were never ratified by the U.S. Senate. Other treaties are today in various stages of negotiation, but their conclusion is thought to be unlikely due to current economic conditions in the United States.[2] It should be noted that most other industrialized countries have "increasingly wider networks of treaties with developing countries," in contrast to the American example.[3] (European countries, however, are stricter in their co trol of foreign exchange.[4])

On the other hand, some tax provisions in industrialized countries actually encourage the retention of corporate profits in the foreign host country. One provision on the U.S. books known as "deferral" grants a waiver on income earned abroad by foreign subsidiaries (as opposed to foreign branches) of U.S. companies until that income is sent home in the form of dividends to stockholders. In cases where the foreign tax rate is lower than the U.S. rate, the repatriation of profits is discouraged and reinvestment abroad encouraged.

Given the employment impact of these provisions in the U.S., there are periodic calls for elimination of deferral. Should deferral be repealed, the effect on U.S. MNC's in developing countries would be serious. It was estimated in 1977 that the average effective tax burden on both the distributed and undistributed (i.e., eligible for deferral) income of foreign subsidiaries was 41%, compared to the 48% U.S. statutory tax rate (reduced to 46% in 1979).[5] While many developed countries have already adopted treaties with "tax-sparing" provisions (e.g., Canada, Denmark, Finland, West Germany, Italy, Japan,

Norway, Sweden, and the U.K.), with no tax-sparing policy of its own in the U.S., the repeal of deferral could put U.S. multinationals at a serious disadvantage vis-a-vis their international competitors in host countries.

An example of the application of this problem as an investment barrier can be seen in Tunisia. The double taxation issue involves a conflict of views between the U.S. and the Government of Tunisia on the taxation of U.S. companies expatriating income from joint venture or wholly-owned operations in Tunisia. Tunisian law governing foreign investment exempts corporate income from taxation for periods of up to 20 years. Tunisia will not allow U.S. companies to take advantage of these investment incentives because income earned in Tunisia, but not taxed in Tunisia, will be taxed in the U.S. when expatriated. Tunisia's position is that U.S. taxation of this income is a real cost to Tunisia. Therefore, the Tunisian position is that Tunisia should also tax this income, the source of which is Tunisia. At this time there appears to be no prospect for resolution of this issue. Although, in any case, a large U.S. investment flow to Tunisia is not foreseen, this issue could remain one of the stumbling blocks to U.S. investment in that country.

8.C. REGULATORY DISINCENTIVES TO THE DEVELOPMENT OF TROPICAL DISEASE PHARMACEUTICALS

In many ways, the regulatory environment in a more developed country, such as the U.S., is inseparable from the availability of a drug therapy for a disease in the developing world. To the extent that this environment discourages either general drug R&D or the structures and data needed to support tropical diseases research, developing world drug availability is impaired.

As Pedro Cuatrecasas of the Burroughs Wellcome Company, long involved in research and development programs which address developing country diseases, has pointed out, "The resources and requirements for discovering drugs for diseases of developing countries are... inseparable from those of drug discovery in general.... New therapies for parasitic diseases, for example, are as likely to result from a program initially directed to the discovery of an antimetabolite, or antibacterial, or even an anti-hypertensive as from a deliberate, rational program for a specific parasitic disease.... (Thus) If American industry is to contribute, it must do so within the same framework of...regulatory...constraints that restrict all of its other, current innovative pursuits.... This is the extreme paradox of today: at a time when the potentials of science and technology are at their greatest, so are the man-made restrictions, disincentives, frustrations and discouragements."[6]

Some innovations have come into force since Cuatrecasas' 1979 remarks to address regulatory barriers affecting drug research and development. Early in 1983, for example, the U.S. Congress passed the Orphan Drug Law allowing a total deduction of 73% from expenses for clinical testing related to finding a cure for diseases with a low incidence among Americans. In addition, the law provides for federal grants of up to $4 million for smaller companies and individual researchers working on such diseases. While not specifically targeted at resolving developing world health problems, the Law's definitions would appear to cover most tropical diseases. Appearances, however, can be deceiving. In May of 1983, questions regarding the potential for application of the Act to tropical diseases remained. In developing interim guidelines for the Act, the U.S. Food and Drug Administration noted that it had considered whether infectious diseases widely prevalent in the developing world would be considered "orphans" under the U.S. Act. The results were mixed: "We have...decided to apply the provisions judiciously. Whereas a firm would have no trouble establishing that it could not recoup its development and distribution costs from sales in the U.S. of an exotic antiparasitic drug, it is readily apparent that such a drug can be quite profitable when there is a potential worldwide population of millions. In order not to, in essence, subvert the Act, we have decided not to designate such a drug an orphan unless a reasonable number of U.S. patients will benefit, e.g., 500 or more per year."[7]

Thus, even though many developed country regulatory structures are beginning to encourage rather than inhibit new drug research and development, specific application to many diseases of the developing world remains a problem. Furthermore, there are specific regulatory inhibitions (e.g., in the U.S., the difficulty of using clinical trial data from foreign sites in support of drug applications) which add another layer of regulatory barriers to private corporate involvement in Third World diseases. These barriers remain despite the fact that it is the corporate world which houses the most cost-effective drug R&D and production capability.

Finally, regulatory dictates in the developed world can affect the cost-efficiency of the relations of development assistance itself with the private sector. A case in point is the inability of the U.S. development agency to procure oral rehydration sales (ORS) from manufacturers abroad, themselves supported by UNICEF, because of the U.S. regulatory inability to decide if ORS is a food or a drug. Given that indecision, warning labeling was required, to adhere to U.S. law if the ORS were procured by a U.S. agency. Yet, operating under different regulatory structures, foreign manufacturers did not include the necessary labeling. Thus, the development agency was forced to finance an entirely new ORS production operation within the U.S., with appropriate labeling, so that the product could be procured for U.S.-supported programs. All this when ORS itself is a simple mixture of salt, sugar, potassium, and sodium bicarbonate.

9. NATIONAL GOVERNMENT POLICY

"If I consider the consequences of a continuing lack of business-government communication and cooperation -- of a clinging to stereotypical attitudes which blind us to opportunities for development -- I can see these consequences clearly as disastrous. Poverty is the enemy!"[1]
Daniel Parker, Former Chairman, Parker Pen Company.

9.A. INTRODUCTION

The practical viability of any private sector strategy or initiative -- multinational or indigenous -- is fundamentally affected by a wide range of policies of the host national government. This is no less so on matters relating to the health sector. Everything from exchange rate policies to project review policies to service or product pricing regulations can affect, directly or indirectly, a private sector decision to become involved with or to expand in a given economy.

A full country-by-country treatment of the entire web of national policy which provides incentives and barriers to private roles in the Middle East is beyond the scope of this Report. This chapter will focus on national government policies with immediate impact on private health industries or providers. It is within this policy context that development assistance and private actors will need to analyze their own potential roles and recommend, as needed, policy revision. The policy areas covered in this chapter are:

-- Private provision of health services;

-- Private investment in health products manufacture;

-- Occupational health and safety;

-- Patent protection.

9.B. PRIVATE PROVISION OF SERVICES

As has been described in Chapter 5 the private provision of health services is permitted in all Middle East countries of special focus in this Report. In few instances, however, are incentives for expansion of these services deliberately provided by the government. Rather, government policy and regulations usually focus on the structure and level of fees charged for private services. There is only limited policy or regulatory oversight of quality in the private sector.

Lebanon: In Lebanon the policy incentives to private sector health provision and expansion have largely been the absence of both private sector regulation and public sector delivery systems. Indeed, the lack of close public management of its relationship with private providers, who are contracted to deliver many services, has created significant financial problems for the national public health budget. Public payments for these contracted services have often forced the national health budget into deficit. Without improved fiscal control, or new reimbursement procedures, the Ministry of Health will continue to face an uncontrolled hemorrhage of its funds into blanket support of private services with users bearing little of the financial burden.

Faced with this situation, Lebanon's public policy is beginning to shift toward more -- some would say too much more -- public authority in the health sector. The Ministry of Health is beginning to assume responsibility not only for the quality and, as necessary, reimbursement financing of health services, but also for the actual delivery of those services. Among the key premises in the Ministry of Health's post-war policy development is that "the State is committed to provide personal and non-personal, curative and preventive, promotive and rehabilitative health services to the Lebanese population -- irrespective of one's ability to pay for such services..." The recently developed organizational model for the Ministry "assumes and promotes the concept that the new and reorganized Ministry of Health... is the primary and most important manager of health services in Lebanon and has the greatest authority and responsibility in the health care delivery system...."[2] Opportunity for a "partnership" with the private sector is left open.[3] However, based on a painful memory of private service reimbursement problems and of a system spinning out of control during eight years of war, the current public policy preference in Lebanon is to emphasize greater public regulation of private health services and expansion of active public service provision.

Jordan: Of the three focus countries with a history of private sector regulation, Jordan is on the most liberal end of the scale. While ceilings for both personnel and facility fees have been established, there is little additional government interference in private service delivery. Indeed, many senior public health managers are former private

practitioners and view Jordan's health needs largely in private sector terms. While unlikely to abandon the delivery of some health services in the public sector, the Jordanian Government remains supportive of private sector service provision. The exception in Jordan, of course, is health services provision for Palestinian refugees, most of which is, and is likely to remain, in public or United Nations hands.

One of the key issues outstanding in government policy is that of finance. As noted in Chapter 4, the health insurance system in Jordan, is currently under evaluation. A proposed comprehensive medical insurance scheme has been designed which would allow for medical coverage of all citizens, a system of pre-financing, and a cooperative mix among public and private health care providers in an independent insurance scheme. This approach to utilizing private providers would be one of the first in the Middle East.

Egypt: In the middle of the policy spectrum is Egypt, which continues to require service in the public system for all health personnel in the country, but which has instituted new policies allowing those public personnel assigned to rural posts also to engage in limited private practices. This experimentation with active encouragement of private sector roles derives both from the Government's limited financing capabilities in the health sector, and thus de facto limited services, and from increased demand and ability to pay for private services on the part of Egypt's rising urban commercial and agricultural middle classes.

This initial policy experiment with private sector delivery of health services as a complement to hard-pressed public institutions is, however, only the first of several internal policy decisions Egypt faces in its private sector relations. Currently, the Egyptian public health system is, to a large degree, horizontally integrated, trying to be all things to all people at all points in the health delivery chain, from personnel training to health product provision, from illness diagnosis to treatment to prevention. The Government has yet to determine in which types of services it wishes to maximize or expand existing private roles. However, such a comprehensive view of the desired public-private interface is essential for the development of policies which will promote long-range incentives for the private sector. After years of public delivery dominance in national health policy, Egypt will need to develop clear, consistent policy signals to the private sector if the actions of the latter are to be channeled to serve both private goals and public needs.

Among the service delivery areas requiring policy attention are:

-- The coordination of facility and personnel planning and location with private sector investment plans;

-- Review of salary and allowance systems for public sector, mixed public-private, and private sector personnel;

-- Development of capacity-to-pay criteria and evaluation systems, both as regards service provision to the truly indigent and as regards controlled-cost systems for public and private rural systems;

-- Review and specification of the public service requirements for health personnel;

-- Development of incentives for financing schemes to broaden the income-group coverage of private facilities.

In addition to its own internal dynamics, the Egyptian health system faces private sector policy decisions created by the flow of external capital into the system. The desire to provide an alternative to European health services has attracted significant levels of Arab capital to Egypt to develop private centers of care. While the Government has not determined how, if at all, these new investments can be given incentives, or otherwise be used, by the public sector to serve other than wealthy patrons, Government officials are not unaware of the level of financial and technical investments represented by these new institutions and their potential for helping to meet the nation's health care needs.

Changes in government insurance policy might be the beginnings of an answer to the problem of expanding the catchment area and clientele of private facilities. As described in Chapters 4 and 5, currently health insurance is virtually a government monopoly. Nevertheless, ad hoc "insurance" arrangements, similar to Health Maintenance Organizations, are springing up in even the middle class neighborhoods of Cairo. These arrangements charge an annual membership fee, pool these finances, and hire a physician to provide, for a set payment, all services required by members. By establishing stable membership and spreading utilization risk across the user group, the individual costs of health services can be reduced. Such arrangements remain ad hoc, however. Requests for formal approval of similar schemes for private facilities have not been resolved. Government policy in this area has yet to be developed, and immediate opportunities exist for development assistance technical support to the Government to determine its financing alternatives.

Thus, Egyptian Government policy on private service provision has begun to shift from strict regulation to positive reinforcement. The need now is for comprehensive policy evaluation and design to ensure that the health system which ultimately evolves from this internal process satisfies both private and public needs.

Tunisia: Private service delivery in Tunisia remains a separate and autonomous stream of activity, largely outside the public health system. With the exception of fee regulation, set out in Chapter 5, the Tunisian Ministry of Health seldom concerns itself with private service delivery. Standards of quality and service provision for private medical facilities and personnel are set out in a variety of national laws,[4] but, as with most regulatory structures, enforcement is sporadic. The distinct public planning emphasis is on the expansion of the public delivery system.

On the other hand, as Chapter 5 has described, the Tunisian private sector is not only an increasingly significant financial and service provider force, but is also itself facing a set of distribution and financing problems which mirror the problems and priorities of the public sector. The Tunisian Government has recent experience in taking advantage of these private sector roles and concerns, specifically in developing incentives to expand private pharmacy services. Two other immediate opportunities are present for the creation of additional incentives which respond both to Ministerial concerns and to private sector priorities.

One of the Ministry of Health's prime public concerns is the maldistribution of health personnel and facilities in the country. Balancing the dominance of Tunis with other geographic poles of medical/health system growth is a chief goal of public sector policy. To date, however, this goal has not taken cognizance of the fact that maldistribution is also a primary concern of the private medical and pharmacists' associations. As the private Tunis health care market becomes saturated with services, private sector leaders are searching for ways to move private practices out of central Tunis to other urban and semi-urban areas. Thus, instead of (or, in addition to) the current focus on public investments to solve the distribution problem, Tunisian policy-makers have a unique opportunity to develop incentives packages to encourage the private sector to reach out to underserviced areas with the concurrence and perhaps even cooperation of private sector leadership. For example, financing systems could be developed to reimburse private sector delivery of certain types of services to the general population, with reimbursement differentials for underserved regions. Alternatively, a health sector equivalent of an agricultural development bank could be established which would provide soft loans (with low interest rates, long maturity, and a repayment grace period) to private physicians to finance start-up costs of private practices, if such practices were located and operated for at least ten years outside Tunis. (Chapter 11 describes this option in more detail.) Another possibility would be for the Government to leverage its resources by co-financing with private investors the establishment of private or mixed-service health facilities, if these were located in the Ministry's target provinces, with provision for either partner to offer to buy the other out when the facility becomes sufficiently well-established.

The second area in which public policy and private providers share concern is service finance. The Government is already on record as favoring increases in the level and coverage of hospital service charges in public sector facilities, with adequate protection for the truly indigent,[5] in order to meet increased service costs. Encouraging the private insurance system to expand and thus more efficiently spread service risks at reasonable rates would provide a partial answer to the payment dilemma that such service fee increases create for the Government. Thus, a public finance problem would be submitted for at least partial resolution to private, market mechanisms.

9.C. PRIVATE INVESTMENT IN HEALTH PRODUCTS INDUSTRIES

Chapter 3 of this Report emphasized the degree to which all four focus countries have begun to search for private investment to help finance economic development. The degree to which those policies extend to the local manufacture of pharmaceuticals and other health products, however, varies considerably among the countries.

Lebanon: Once again, Lebanon's policy is the most laissez-faire of the four focus countries. While Lebanon is not a major manufacturer or packaging site for health products, both private multinational and private local investment in such products is welcomed. Even with current public policy concern over product quality and counterfeiting, there has been no indication that the resolution of those problems will imply government assumption of the means of production.

Lebanon's public policy in the area of health products is also notable for its lack of drug quality review or enforcement mechanics or, to date, for its lack of any national pharmacopeia. The manufacturer of a product is responsible for providing proof of drug safety and effectiveness via use of a Ministry of Health questionnaire. If Government policy regarding pharmaceuticals is likely to be strengthened in any area, it is this one regarding product quality. The Ministry's Task Force on Pharmaceuticals is of the general consensus that manufacturer self-regulation on this issue is insufficient and that a government or independent institution should be established to take responsibility on this issue. At present, however, the public sector has available neither adequate personnel nor a non-interested institution to implement any policy change.

Jordan: The Jordanian Government's health products policy has emphasized and attempted to aid the growth of domestic production of pharmaceuticals and medical supplies, albeit for local rather than multinational business. The Government's goal is to have local companies supply over 40% of both public and private pharmaceutical needs by the

mid-1980's. Indeed an aspirin and paracetamol production project is among the 41 industry profiles compiled by the National Planning Council for priority investment implementation.[6]

Despite these supportive policies, the Government has not fully opened the health products industry to expanded private investment. Although two of the four firms in Jordan are privately-held, they are subject to Jordanian law which requires that privately-held companies limit capitalization to no more than JD 500,000 ($1.4 million) and 50 employees. This seriously inhibits production or product line expansion for these companies.

Moreover, as described in Chapter 4, Jordanian companies import all of their basic compounds and thus their costs are tied to the international chemicals market. However, they are given little pricing advantage in government tenders for pharmaceutical products and so have difficulty competing with Jordan's major foreign suppliers. Limitations on product lines and capital investment, as well as existing government procurement policies mean that domestic companies increasingly compete with one another, not outside firms, for a limited market share.

The most important policy incentives available to Jordan to encourage private roles in drug and medical supply production, therefore, are those which would allow greater amounts of capital into the privately-held companies or those which would allow joint ventures with larger, multinational corporations. The result of either effort would be the expansion of both product lines (to meet a greater percentage of Jordanian needs) and production levels. Economies of scale might then be achieved, thereby lowering unit costs and making locally-produced products more competitive in public tenders. This combination of product line diversification and lowered costs might then help to break the cycle of purely domestic firm competition on public tenders.

Egypt: Emerging from a period of public sector monopoly over health products manufacture, Egypt now actively encourages both multinational and domestic investment in both the pharmaceutical and medical supply industries, either as wholly-owned private companies or as joint ventures with existing public companies. The opportunities for specific investments in the health sector, as well as the limitations of those opportunities, are described in detail elsewhere.[7]

In terms of government health policy impact, the most important policy implications for health products investments have to do not with the investment itself (which is handled by the Ministries of Industry and Finance) but with the distribution and pricing of the product manufactured. In these areas, Egyptian policy is one of stringent regulation, and has changed little despite the advent of Public Law 43 and the liberalization of private investment.

For example, the prices of pharmaceuticals are closely regulated. While prices for many essential drugs are pegged (often at mid-1960's levels, with one 30% across-the-board increase in 1973 which returned most drugs only to their 1961 price levels), raw materials and production costs have skyrocketed. As a result, even public sector companies would require a 20% to 30% across-the-board price increase to restore profitability.[8] Indeed, in 1981 public sector pharmaceutical and medical supply companies failed to make a profit[9] and the Government stepped forward to fill the gap in their balance sheets with a subsidy of LE 13 million.[10] In a further effort to cut production costs, customs duties of 5% to 10% for the pharmaceutical industry raw materials were eliminated in late 1982. Exemptions apply to products or articles which represent 90% of the ingredients generally imported for pharmaceutical production.[11]

These stringent pricing policies create not only significant disincentives for private drug investment, but also, therefore, a serious problem in meeting Egypt's drug demand. Taken together, Egyptian Government subsidies on basic goods, including subsidies directly on drugs and to the pharmaceutical industry, are estimated to total at least 11% of gross domestic product.[12] Until significant alterations are made in Egypt's approach to pharmaceutical pricing, the health sector contribution to this national drain will continue and will probably grow larger. At this point, such alterations appear to be unlikely.

Tunisia: Of the four focus countries, Tunisia's approach to health products investment continues to be the most centralized. Indeed, little of the country's recent overture to private investment appears to apply to an expansion of private investment in health products either for export or for the domestic market. This will probably continue to be the case in the near term, since the Ministry of Health is not represented on any of the major private investment commissions or investment review councils in Tunisia, although both the agricultural and housing ministries are usually represented.[13]

Tunisia's health products and investment policy revolves around the Central Pharmacy, which holds a monopoly on pharmaceuticals and basic chemicals imports and also operates a drug manufacturing plant. While other companies are permitted to formulate and package drugs, they are not permitted to import either basic ingredients or bulk drugs. This role is held solely by the Central Pharmacy. Moreover, the Government's view is that any new pharmaceutical companies must complement one another rather than compete.[14] Therefore, private investors also face regulation of their product lines.

Another key thrust of Tunisian policy regarding health products manufacture emphasizes regional integration of pharmaceuticals production and purchasing. A joint structure -- Comité Mixte d'Achat en Commun (CMAC) -- was established with Algeria in 1980 for the joint purchase of

drugs and raw materials. CMAC is also planning to establish a joint production plant to meet Algerian and Tunisian needs and to compete in the regional market.

Thus, while private sector health products industry investments are not at all ruled out by Tunisian health policy, centralized control over chemical inputs and product lines, reluctance to grant royalties or patents (see below), and emphasis on the priority of regional development for the industry all work to limit the expansion of private roles in this industrial sector.

9.D. OCCUPATIONAL HEALTH AND SAFETY

Most countries in the Middle East are parties to the major international conventions regarding occupational health and safety (OHS) and have enacted legislation to specify implementation procedures for those standards. Enforcement is usually another matter for at least three reasons.

As in so many other technical fields, most countries in the region lack trained OHS personnel, both within local private companies and within public inspection agencies. Most local companies and agencies rely on general paramedical and auxiliary medical personnel whose skills are not sufficiently specific to recognize OHS problems before they become crises. The exceptions to this pattern usually are the personnel working in multinational corporate investments, in large part because of availability of special training and support programs in these larger corporations.

Second, OHS equipment is expensive and usually only available if imported. For many indigenous or public companies, this effectively rules out any major OHS programs, whatever the public policy, because the requisite foreign exchange is either unavailable or allocated to other priorities.

Finally, OHS legislation and policy generally is spread out across a variety of government agencies including Ministries of Health, Labor, Industry and Interior. The result is that enforcement responsibility becomes too dispersed to be effective. Moreover, OHS legislation and policy is normally developed solely by public agencies without private sector input or consultation. As a result, there develops a natural antagonism between public regulators and private business over OHS issues.

Three examples of the OHS regulations, loci of responsibility and enforcement barriers in Middle East countries will illustrate regional OHS policies and problems.

Egypt: Employment Law No. 173/1981 is the OHS legislation applicable to all employment conditions except private domestic services or small family enterprises. A special committee comprised of local representatives of the Ministries of Housing, Labor, Health, and Industry issues licenses for new establishments and ensures that they satisfy OHS regulations. The Ministry of Housing and Reconstruction also enforces Decree No. 380/1975 which specifies the OHS standards for industrial and commercial establishments. The General Directorate for Industrial Safety at the Ministry of Labor Force and Training is the agency responsible for inspection, supervision, and sanctions, the latter including criminal prosecution.

Every establishment must form an Occupational Health and Safety Committee to ensure compliance with OHS regulations. The company is solely responsible for training committee members in OHS. Industrial companies must assign an OHS specialist for every 500 employees. If the firm has fewer than 500 employees, it must assign an OHS technician. Non-industrial companies may train any workers for OHS responsibilities.

Companies are responsible for medical tests prior to and during the period a worker is employed. They must notify the Governorate Industry Safety Office of the Labor Force and Training Directorate within 24 hours of any accident or discovery of a disease. Every six months, any establishment employing more than 50 persons must supply statistics on accidents and occupational diseases to its Industrial Safety Office (ISO). These statistics are compiled and published annually.

Industry Safety Inspectors from the responsible ISO are required to pay inspection visits to all regulated establishments every six months. However, there are only 12 such offices in the Cairo Governorate and 51 in Egypt overall.

All establishments must provide emergency health services to their workers. If a company has over 50 workers, the establishment should provide a trained nurse and doctor on site as well as ensure the availability of all medication. If the company employs over 300 workers, it is required to provide primary health care, specialized care, minor surgery, and any necessary medication for all employees.

Companies are required to conduct periodic medical check-ups for employees, performed by the General Organization of Health Insurance for its specified fee.

Despite the specificity of these regulations, indeed perhaps because of it, enforcement has been less than effective. All of the personnel, financial, and technical problems cited earlier are present in the Egyptian OHS system. As a result, the 1979 annual inspection visits revealed that only 55% of all establishments were complying with OHS requirements.

Tunisia: Tunisia has a firmly established framework of worker protection via legislation; a strong, independent labor union; and comprehensive collective bargaining between the labor union -- the Federation of Trade Unions (UGATT) -- and employers from various sectors of the economy via their Employers' Organization (UTICA). In this framework, the Government plays the role of legislator and mediator, but individual or collective worker disputes or benefits are handled directly between the UGATT and company representatives.

The general regulatory framework relating to labor affairs, including OHS, is the 1966 Labor Code (Law 66-27, April 30, 1966). Responsibility for enforcement of OHS regulations which are not contract-specific rests with the Ministry of Social Affairs.

In all establishments of at least 20 employees, a Joint Consultative Committee of employers and employees is required to be organized. Its responsibilities are varied, but include some aspects of worker safety. In certain industries, especially heavy equipment manufacture, chemical and mining industries, a specific Works Safety Committee is also required to negotiate and take action on all types of health and safety matters.

All employers of over 20 persons are required to make available basic first aid medicines and materials for emergencies, as well as to provide for worker hygiene. The employer is liable for any failure to comply with basic safety provisions determined by the Works Safety Committee.

In addition, a medical unit must be set up in all establishments (except agricultural) employing a minimum of 40. If there are 300 or more employees, the establishment must have its own medical unit. When the number of employees is between 100 and 300, the unit may be either separate or common to several firms.

As mentioned above, the employer is fully liable for industrial disease or accidents. There is no requirement that a disabled worker prove employer negligence; the latter is always liable to make good the damages suffered by an employee, and is required to carry insurance for that purpose.

Compensation for industrial accidents includes lump sum payments to cover the loss or damage sustained by the victim or other parties. The applicable benefits are:

- -- Treatment throughout the period of disability until such time as the injured person is completely recovered;
- -- Cash payments to make up for the wages lost as a result of the cessation of work and the decrease in vocational capabilities;

-- Where necessary, provision of artifical limbs, etc., and orthopaedic aids to correct physical disabilities resulting from the accident;

-- Priority placement in vocational retraining programs and upgrading within the company to a job consistent with the worker's remaining capabilities;

-- Maintenance of eligibility for family allowances in the case of permanent disablement.

If the accident should prove to be fatal, the employer or the insurance company is required to make a lump sum reimbursement for funeral expenses. Pensions to victims of industrial accidents are based on the degree of disability and the worker's annual wage.[15]

It is certainly true that compliance with health and safety regulations is spotty, despite the specificity and strength of these liability laws. The technical capabilities of OHS personnel as well as the costs of equipment are significant factors undermining compliance. Nevertheless, the strength of the country's labor organization and precedents for large employee suits against employers,[16] ensure that the OHS regulations are taken more seriously in large industrial organizations in Tunisia than might otherwise be the case. Indeed, in some analyses, the stringency and enforcement of these and other labor regulations have become serious deterrents to expanded private investment in the country.[17]

Jordan: Occupational health and safety regulations in Jordan are covered by Labor Law No. 21 of 1960, as amended by Labor Laws 2 (1965), 25 (1972), and 7 (1976). The responsible agency is the Ministry of Social Welfare and Labor. Essentially the same regulations regarding the maintenance of OHS on the job apply to both private and public (government) institutions. These regulations include specifications for worker hygiene facilities, first aid and medical aid requirements, and procedures for government notification of worker injuries.

Regulations regarding compensation for such injuries differ, however, between private and public establishments. The private sector does not pay social insurance taxes. Thus the regulations of Social Security Law No. 6 (1966), which established the Social Security Fund, do not apply to private companies.

Employees of government or public establishments, on the other hand, are covered by detailed regulations on their financial compensation in the event of injury at the job site or family compensation in the event of their job-related death.

9.E. PATENT AND TRADEMARK POLICY

A final example of national policy specifically affecting the expansion of private, especially multinational corporate, health roles is the nature of a country's patent policy.

The issue of intellectual property protection has always been a divisive one for multinational corporations and developing countries, with the latter concerned about access to technical knowledge and the former concerned about both the protection of that knowledge and the relationship between that knowledge and the recovery of extensive product research and development costs.

The current basis for international patent protection is the Paris Convention of 1883, to which most developing countries have not chosen to be signatories. All of the focus countries of this Report, however, do subscribe to the 1883 convention.

Each subscribing country has developed its own list of specific products or processes that are eligible to be patented and those that are not. Of the four focus countries, only Jordan has no specific exclusions. Egypt, Lebanon, and Tunisia all exclude pharmaceuticals from patentability, thereby limiting local manufacture of drugs patented in other countries but also limiting multinational interest in investing in that industry and/or limiting the MNC product line manufactured in the context of an investment.

In Egypt, inventions related to substances prepared or produced by chemical processes and intended for food or medicine are not patentable; but special chemical processes to make such products are patentable. The Ministry of Health's Pharmaceuticals Affairs Section is responsible for policy implementation in this area.

In Tunisia, historically, pharmaceuticals have not been patentable, but special processes relating to their manufacture have been eligible for patents. Recently, however, leadership in the Tunisian pharmaceutical sector, concerned with the country's continued reliance on imports, have urged a change in this government policy. Their position is that if local producers are to expand their product lines, they must have access to both the products and production methods of large, multinational corporations. In 1978, the Central Pharmacy (PCT) manufacturing facility signed its first licensing contract with a large French firm to manufacture its product line. Although continuing to pursue such licenses, the PCT has found a number of constraints in implementing this expansion of its production line, including:

-- Obligation to purchase raw materials from the supplier of the license;

-- Territorial and export restrictions;

-- Restriction on use of technology after expiration of the contract;

-- Restriction on disclosure of technology on the national level;

-- Royalty payments.[18]

Thus, the Government is being encouraged to revise its patent laws to deny patents on pharmaceutical processes as well as products so that the production processes for licensed drugs can be absorbed by PCT factories, in turn promoting the self-sufficiency of the Tunisian market.

10. DEVELOPMENT ASSISTANCE AND PRIVATE RESOURCES

"When we talk about private sector involvement in development, we are actually talking about managing resources, how we get them and how we use them. Today, most underdeveloped countries recognize that the public sector is not able to carry out necessary development activities unassisted. More and more, multilateral institutions recognize that entrepreneurial participation in development is required. We must use business people whose management skills, willingness to take risks, profit motivations, and free-market attitudes make them prime movers in stimulating economic development." W. Antoinette Ford, Assistant Administrator, Bureau for Near East, U.S. Agency for International Development.

10.A. INTRODUCTION

The role of public development assistance agencies in the Middle East has been a major and a varied one. Forms of assistance supplied by those agencies have ranged from specific project support, to trade credits, to commodities support, and, more recently, to the acceptance of equity positions in major public investments.

Increasingly, as in other geographic areas, the distinction between grant aid, public commercial aid and private commercial support in the Middle East has begun to blur. The development assistance relations of many "donor" countries with Middle East "recipient" governments have evolved into intermeshed packages of project grant aid, tied commodities financing, and commercial and trade credits.[1]

This chapter is intended to outline some of the major development assistance actors in the health sector in the Middle East, the nature of their relations with countries in the region, and their policies, if any, toward the private sector -- multinational or recipient country -- in carrying out their development assistance programs. This chapter's goal is not to catalog the health projects

of every development agency in every country in the Middle East, but rather to sketch the roles of some of the major agencies in the region and to assess their policy and program potential as partners in the types of private sector-development assistance cooperative projects described in subsequent chapters of this Report.

A résumé table of the aid organizations described here is contained in Chapter 2, Data Base Summary.

10.B. REGIONAL OVERVIEW

In 1981, the Middle East/North Africa region received $6.84 billion in official development assistance (ODA) from Arab oil-surplus nations and member nations of the Organization for Economic Cooperation and Development (OECD).[2] This figure is exclusive of non-concessional resource flows (e.g., export credits, direct investment, etc.) and grants by private voluntary agencies, but includes both bilateral and multilateral financing. The Middle East total represents 21% of the total ODA received by the developing world, by far surpassing the region's 8% share of developing world population.[3]

Within the region, Egypt, Jordan, Morocco, and Tunisia account for nearly half of the ODA receipts. In 1981, Egypt received $1.35 billion in ODA; Jordan, $1.02 billion; Morocco, $0.6 billion; and Tunisia, on the verge of "graduating" from the grant-assistance programs of many donors, $0.21 billion.[4]

The nature of these resource flows differs widely by country and by donor group. For example, the 1980 aid from Development Assistance Committee (DAC)* member countries to Jordan had only a 67% grant element, while that of the OPEC countries was 93% grant. DAC flows to Lebanon for the same year had a 57% grant element, while OPEC flows were 100% grant. On the other hand, 60% of Tunisia's DAC receipts were grants, while its OPEC aid had only 45% grant component.

Sectorally, over 50% of the ODA to the region is for general balance-of-payments and debt support. Project finance is concentrated in the agricultural, utilities, and education sectors.

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*DAC is a specialized committee of the Organization for Economic Cooperation and Development. DAC members are Australia, Austria, Belgium, Canada, Denmark, Finland, France, the Federal Republic of Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, the United States, and the Commission of the European Economic Communities. DAC members have agreed to secure an expansion of the aggregate volume of resources made available to developing countries and to improve the effectiveness of those resources.

10.C. THE ARAB DEVELOPMENT FUNDS

In 1981, the Gulf states of Kuwait, Qatar, Saudi Arabia, and the United Arab Emirates disbursed $7.457 billion in official concessional assistance, 95% of the aid disbursed by all OPEC countries.[5] Of that amount, these four countries disbursed approximately $1.4 billion (18% of the total) to Morocco, Tunisia, Jordan, and Lebanon combined. This amount is exclusive of the harder-to-trace personal or government-to-government assistance which often is negotiated on an ad hoc basis between leaders of the region.

Until the recent round of oil price reductions and production cutbacks, total OPEC development assistance contributions annually averaged between 2.5% and 5% of their combined Gross Domestic Product (GDP).[6] The signals are mixed as to the future level of ODA to be expected out of the OPEC, largely Arab, funds. In the UAE, the fiscal 1982-83 budget slashed aid spending by nearly 60%.[7] On the other hand, the budget of Saudi Arabia for fiscal 1982-83 maintained foreign aid expenditures at the $5 billion average of the past few years.[8] The resource levels available to the region for development programs may dip over the next years, as the petroleum fortunes of surplus countries ebb and flow. Nevertheless, even in the context of an aid reduction on the part of Arab oil producers, it seems unlikely that, out of the 80-odd countries receiving Arab OPEC assistance, Arab aid states will be chosen to bear the major burden of those reductions.

Thus, the questions become: who are these "Arab Funds"?; what are their major sectoral interests?; and, who are the major Middle East recipients of their largesse?

The main, permanent institutions established within the Arab world to channel OPEC (mainly Arab) surplus funds into development programs are both bilateral and multilateral. In all cases, the flow is one of currency rather than of products (the latter characterizing DAC assistance programs) since the Arab nations have few industrial goods to offer their neighbors.

1. Bilateral: Bilateral programs dominate Arab aid, handling about 80% of all their development assistance commitments and 92% of all disbursements in 1981.[9] The main government-run bilateral actors are four in number:

The Kuwait Fund for Arab Economic Development (KFAED) is the oldest of the Arab Funds. Established in December 1961 with capital of $350 million, KFAED was originally created to provide assistance only to the Arab world. By February 1981, its capitalization had grown to $7.4 billion, its lending capability increased to about $21 billion, and its scope of operations expanded to include the rest of the developing world. KFAED is also authorized to borrow up to twice its capitalization for re-lending on concessional terms.

Recipients eligible for KFAED project finance are government and public bodies, development institutions, and mixed or private enterprises "whose activities have a development impact and which are not geared exclusively to profit-making."[10] Eligible private institutions are required to be under the control of nationals of one or more developing countries. The Fund participates neither in equity financing nor in balance-of-payments support.

Fund assistance is packaged in many forms: loans, grants-in-aid, advisory services, and joint financing with other development institutions. Financing for technical assistance is made on a grant basis for project feasibility and pre-investment studies. The amount of the grant is repayable only if the Fund later finances the project under study.

The guiding principle for Fund decisions is economic, although not necessarily financial, return. Thus, while the Fund is highly supportive of private commercial enterprises, the project criterion for support is macro-economic impact, not micro-economic financial return. As one KFAED official has noted: "As long as the project substitutes for imports and as long as there is a heavy demand (for the product), why shouldn't the company make a good profit...? The profit is irrelevant to us."[11]

In 1982, the Fund approved 40 projects with a total value of $769.5 million.[12] This represented just under a quarter of the funds expended in that year by the major bilateral Arab Funds.*

Sectorally, most KFAED funds go to the infrastructure (transport and power) and agricultural sectors, with the latter more favored in recent years. Just under a quarter of KFAED loans have been made in support of industrial projects. Although these have not to date been in health products industries, the latter certainly fit the Fund's lending criteria and so are eligible for support. At this point the closest KFAED has come to health sector support has been lending for water and sewerage projects, although even this is a very small part of KFAED portfolio.

In terms of recipient countries in the Arab world, until recently, Egypt had been KFAED's biggest borrower. At the end of 1978, Egypt accounted for 13.1% of the total value of the Fund's loans.[13] More recently, however, Tunisia has attracted a major

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*Note that Kuwait has decided not to record as official development assistance payments to the "Confrontation States" under the Baghdad Agreement. This has reduced its bilateral aid disbursement figures by almost $500 million annually since 1979. Other Arab States continue to include in their aid statements payments under the Baghdad Agreement.

share of Kuwaiti (and other Arab) aid. Gulf aid and investment in Tunisia in 1981 totaled some $500 million, nearly half of Tunisia's $1.2 billion in foreign aid and capital for that year.[14] Since 1979, Kuwait alone is estimated to have financed between $800 million and $1 billion of Tunisia's development needs, coming from a combination of KFAED and private investment.[15] Indeed, the Tunisia-Kuwait linkage is a two-way street. In 1981, the two countries entered into a joint-venture pharmaceuticals plant project to be built in Kuwait. Financed by Kuwait, the project would use Tunisian technicians in plant design and operation. In addition, Tunisia has proposed to set up an associated medical training center in Kuwait to train pharmacists and laboratory assistants.

In sum, then, the KFAED has played and continues to play a major role in regional development. While its project focus has been considerably outside the health sector, as traditionally defined by development assistance agencies, its size, its geographic priorities, and its encouragement of private sector efforts make it a possible health sector partner for medical products industries projects in the region, as well, perhaps, as for more complex "investment bank" project options as described in later sections of this Report.

The Abu Dhabi Fund for Economic Development: The Abu Dhabi Fund was established in 1971 and has current authorized capital of just over half a billion dollars. However, its potential lending resources are considerably greater, since it is allowed to borrow, issue bonds, and give guarantees up to twice the amount of its authorized capital and reserves.[16] Nevertheless, it is the smallest of the three major bilateral funds.

The Abu Dhabi Fund focuses on industrial development. It is the only bilateral fund with authorization to take equity in projects, but has preferred not to act on this capacity because of the long-term commitment inherent in an equity agreement as compared to a project loan. However, recent oil revenue declines have seriously buffeted Fund resources. In 1980, the Fund committed to 12 loans and grants totaling $202.69 million. In 1982, the number of loans was cut to four and the total commitment to new projects was just $34.7 million.

The Saudi Fund for Development: Established in 1974, the Saudi Fund is capitalized at $3 billion. Between 1975 and 1980, it financed 173 projects in 55 countries, expending $3.9 billion in the process, and signed an additional 101 loan agreements providing a further $2.6 billion in development project finance. In 1982, the Saudi Fund committed another $609.5 million to new development projects.

The Saudi Fund reaches out to a much broader range of countries than its Arab counterparts. In fiscal 1979-80, only 4 of the Fund's 18 loans were made to Arab countries (recipients were Morocco, Jordan, and North Yemen), lending which amounted to only 16% of total Fund loans for the year. In the same period, the Fund made 23 grants, seven of which were in the Arab world, most to North Yemen.

The Fund, by its Charter, is restricted to direct government lending, primarily to co-finance development projects. It, therefore, cannot work directly with private sector institutions if the latter are to be loan recipients.[17] Private sector presence in a co-financed project, however, does not rule out Fund participation, provided the Fund loan remains in the public sector.

Parenthetically, Saudi Arabia maintains a strong interest in strengthening the private sector in development. The Saudi Government, in January 1983, signed an agreement with the International Finance Corporation (IFC), the World Bank's private sector support affiliate, to provide $100 million to the IFC for joint equity investments in IFC member countries. The purpose of this partnership is to provide Saudi risk capital, in parallel with the IFC and up to the same amounts as the IFC itself invests, for sound business ventures.

Sectorally, the Saudi Fund devotes 60% of its funding to infrastructure projects. Of the major Arab Funds, the Saudi Fund is the only one with any "social investment" portfolio. The Fund has financed both education and health projects, mostly at the university and hospital level of service provision. As with its other bilateral counterparts, however, the Fund has significant industrial loan interests and a small water and sewerage loan portfolio. The latter activity includes a recent loan of $50 million to Tunisia for water supply and exploration, bringing total SFD lending in Tunisia as of 1982 to $153 million.[18]

2. Multilateral: There are three major multilateral Funds dominated by Arab oil-surplus capital.

The Arab Fund for Social and Economic Development, established in 1971, began operations in 1973 and lends exclusively to the Arab world. The largest shareholder in the Arab Fund is Kuwait (20.25%), followed by Saudi Arabia (19.98%) and Libya (12.89%).

In 1982, the Arab Fund approved loans and grants totaling $237.2 million. The Fund lends to both public and private organizations, although relationships of the latter type must carry a government guarantee. The Fund prides itself on its creative approach to project finance, which has enabled successful leveraging of its own resources in the private sector (e.g., in private investment companies) and in other development funds. For example, in financing Egypt's Talkha II fertilizer plant, the Arab Fund

loaned $22.4 million of its own; procured $24.1 million from the Kuwait Fund, and $10.35 million from the Abu Dhabi Fund; and gained a total of $13.45 million from the Government of Qatar and the Libyan Arab Foreign Bank in the form of bond purchases whose proceeds were used by the Fund (as the project's executing agency for finance) to purchase goods and services.[19]

While the Fund wishes to focus its resources on the poorest Arab states (e.g., the Yemens, Somalia, Sudan), absorptive capacity in those countries has limited the achievement of this goal. Egypt, Morocco, Jordan, and Tunisia thus have all received significant resources from the Fund.

Sectorally, high priorty is given to projects involving two or more Arab states or which promote import-export relationships among states in the region (e.g., in manufacturing pharmaceuticals and basic medical supplies, although no such project has yet been forwarded to the Fund). Projects within individual countries have focused on infrastructure, industry, and water supply.

The OPEC Fund for International Development, formerly known as the OPEC Special Fund, has, until recently, been one of the most active of the Arab Funds. Created in 1976 with $1.6 billion in subscribed capital from a variety of OPEC nations (led by Saudi Arabia, Venezuela, Iran, and Nigeria), the OPEC Fund's capital base at the end of 1980 totaled $4 billion.[20] A third replenishment of $1.6 billion was approved in February of 1981, but by mid-1982, the Fund's cash position had become precarious due both to reduced oil revenues and to political differences stemming from the Iran-Iraq war. Both Venezuela and Iran balked on scheduled 1982 donations, leaving a shortfall of $625 million.

In 1982, the OPEC Fund approved over 50 loans and grants totaling $366.4 million. Financing is available not only for project work, but, unique among the Funds, for balance-of-payments support.

In operation, the OPEC Fund also differs significantly from its counterparts. The Fund is not actually owned by OPEC; it is a special account collectively owned by contributing OPEC members whose commitments are paid in when and as needed to support lending commitments.[21] Moreover, the Fund does not have its own specialized projects staff, but relies on other development assistance agencies for evaluation and approval of specific projects, balance-of-payments needs, or the financial needs of multilateral aid agencies such as the International Fund for Agricultural Development. Finally, the Fund tends to emphasize swift decision-making. Between May 10, 1976 when the Fund became effective, and the end of August of that year, more than three-quarters of the Fund's resources had been committed in principle.[22]

Geographically, the Fund concentrates on the poorest LDC's. Indeed, in 1980, only 39% of the Fund's resources went to Arab nations; 32% went to finance Asian projects and 29% to other LDC's.[23] Within its project lending, the agricultural sector dominates, with industrial development as the second priority area. However, nearly a fifth of its project funds have been spent in the social sector for education, housing, and health projects.

The Islamic Development Bank (IDB) is a development assistance institution attempting to carry out development finance in accordance with Islamic law. Although funded by the governments of 33 countries with dominant Islamic populations, the IDB's voting power is concentrated in the hands of Arab subscribers who, as a group, control over 82% of the institution's voting power. The authorized capital of the Bank is denominated in "Islamic dinars," units of account established by the Bank with a value equivalent to the Special Drawing Rights (SDR's) of the International Monetary Fund.

In 1980, the highest rate of loans of all Arab Funds was granted by the IDB, 41 loans and grants with a value of $429.08 million.[24] In 1982, that financing total rose to $527.8 million. The sectoral focus of this activity was foreign trade financing and petroleum-related investments and purchases.

The IDB operates by lending, issuing loan guarantees, and taking equity. The latter is preferred as it poses no problems of conformance to Islamic law which prohibits the payment of interest. The primary project criterion at the IDB is financial return. With this emphasis, the IDB has a very strong and direct working relationship with the private sector in recipient countries, and, indeed, does not require a government guarantee of equity investments in either the public or private sectors.[25]

Geographic priority at the IDB is given to the most needy Islamic countries (e.g., Bangladesh). Sectoral preference is for industrial, energy, and agribusiness projects. The IDB is also unique among the Arab Funds in providing credits tied to the import of specific goods essential to member economies, e.g., petroleum and fertilizer.

10.D. AGENCY FOR INTERNATIONAL DEVELOPMENT

As with other of the more industrialized countries, U.S. policies and programs affecting economic and social development in the Middle East are spread across a number of U.S. agencies, from the Department of Commerce, to the Export-Import Bank, to the Department of Defense. Unlike many of its European counterparts, however, U.S. development aid is much less tightly packaged with or contingent on the commercial relationship.

The focus of responsibility for non-commercial U.S. development assistance relationships with the Third World, and specifically with the Middle East, is the Agency for International Development (AID). Housed (physically and institutionally) in the Department of State, AID is responsible for most of the U.S. Government's development project grants, commodity support, soft loans, and technical assistance.

1. Middle East Policy and Priorities: The Middle East remains a priority region for AID, although the improved economic positions of countries such as Tunisia are "graduating" some countries out of its concessional aid program. In fiscal 1982, AID's total commitments to the Middle East were $20.6 billion, of which the health sector was allocated $5.5 million. In fiscal 1983, total regional support was $21.3 billion and the health sector received $7.2 million for project and commodities work.

Egypt: Egypt is clearly the priority Arab state in the AID Middle East portfolio. Since 1979, AID's economic assistance program in Egypt has ranged between $1.0 and $1.2 billion per year, including P.L. 480 programs.* In fiscal 1983 alone, AID's assistance to Egypt totaled just under $1 billion. Of this, $300 million was allocated to the commodity import program, which covers the expenses of basic Egyptian imports not connected to AID development projects and $400 million was reserved for specific project support. An additional $262 million was allocated P.L. 480 commodities procurement.

The project substantive emphasis in AID's Egypt program has been on transportation industries and commerce development; improvement in Egypt's agricultural productivity; and social services provision, with a significant emphasis on health services and disease control. Between the fiscal years 1976 and 1982, AID's health/population direct project portfolio totaled over $146 million in grants.

Other countries focused on in this Report are also AID priorities in the region.

Tunisia: Since Tunisia's independence in 1956, the U.S. has made available nearly a billion dollars in direct bilateral

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"P.L. 480" is development assistance shorthand for an agricultural commodities finance program established via Public Law 480. A complex program, legally and administratively, it in essence channels surplus U.S. agricultural commodities to developing countries either via grants to private voluntary organizations or via soft-currency payment programs for the countries themselves. This latter soft-currency is then retained in the commodity recipient country to be used by AID for development programs.

assistance. Of this, $508 million has been allocated in the form of P.L. 480 agricultural commodities financed by both grants and loans; over $237 million has gone to project loans and $186 million for project grants.

A decision was taken by the Administration several years ago to phase out U.S. bilateral assistance to Tunisia, given that country's economic growth. Fiscal year 1981 was the last year of new development assistance obligations. U.S. economic assistance to Tunisia in fiscal year 1982 was approximately $19 million, $12 million of which was P.L. 480 funded food commodities support.

Although the AID program currently is in a "phase-out" mode in Tunisia, a pipeline of approximately $50 million of projects remains to be implemented over the next five years. These projects support Tunisian efforts in rural development, health, family planning, agriculture, nutrition, housing, and the transfer of science and technology.

AID's plans for fiscal years 1983 and 1984 included both the provision of just over $10 million of P.L. 480 commodities (in each year) and miscellaneous small activities funded out of AID's central (non-regional) budgets. However, on its own initiative, the U.S. Congress earmarked an additional $5 million of economic support funds for Tunisia for fiscal 1983 in the 1982-83 Authorization. Of that 1983 addition, $1.75 million will be used to assist the Tunisian Government in responding to the housing needs of the victims of the October-November floods. The remaining $3.25 million is being used for private sector development and technology transfer.

Lebanon: The AID assistance program to Lebanon is focused on the country's reconstruction efforts after eight years of internal conflict. To date, AID has allocated $112 million in Lebanon for humanitarian aid. In addition, a further request has been made to Congress for a fiscal 1983 supplemental increase of $150 million in economic assistance for Lebanon, to be used in such areas as water supply rehabilitation, health services improvement, and repair of telecommunications installations.

AID has also worked closely with Lebanon's Council on Development and Reconstruction (CDR) to improve the latter's reconstruction coordination and management capabilities.

Jordan: AID's presence in Jordan has been a minor one compared to the main development actors in that country, the Arab Funds. While AID's annual economic assistance to Jordan has declined from $93 million in 1979 to $15 million in 1982, the Arab grants and loans have totaled between $200 million and $230 million per annum since 1979.

Sectorally, AID's program in Jordan focuses on agriculture and water supply. Health is a relatively small part of AID's activities in Jordan. Within the health sector, AID projects have emphasized training of paramedical personnel, primary health care services, and health education. A recent examination of the role of private pharmacies and pharmacists in health care delivery promises to lead to interesting project development.

2. Private Sector Policy: In order to extend the impact of its limited public development assistance funds, AID has begun to reemphasize vigorously the importance of private sector resources -- local and international -- in development programs. Rather than only providing developing country governments with publicly-generated money for large public projects, AID's recent emphasis is to apply leverage -- to provide enough public aid or credit to attract larger amounts of resources from private channels, hopefully for enterprises that will eventually be self-financing.[26]

While this private sector approach is a new policy emphasis at AID, it reflects an economic reality of U.S. private sector linkages to the developing world which have evolved over the last 20 years. Currently, U.S. exports to developing countries constitute 40% of all U.S. exports. About 6% of all American jobs in manufacturing produce exports to the Third World, and 25% of the U.S. agricultural harvest is shipped to developing countries.[27]

Moreover, the foundations of the new emphasis extend back to Section 601 of the Foreign Assistance Act of 1962, which explicitly recognized "the vital role of free enterprise in achieving rising levels of production" and "standards of living essential to economic progress and development." Section 601 further declared that it is the policy of the United States "...to encourage the efforts of other countries to increase the flow of international trade, to foster private initiative and competition, to encourage the development and use of cooperatives, credit unions, and savings and loan associations, to discourage monopolistic practices, to improve the technical efficiency of their industry, agriculture, and commerce, and to strengthen free labor unions...." Finally, Congress also declared it to be United States policy: "...To encourage the contribution of United States enterprise toward economic strength of less developed friendly countries, through private trade and investment abroad, private participation in programs carried out under this Act (including the use of private trade channels to the maximum extent practicable in carrying out such programs), and exchange of ideas and technical information on the matters covered by this subsection."

Renewed application of this policy in the health sector was recently urged in AID's own health policy paper: "A.I.D. will support feasibility studies to assess the potential for private sector involvement in LDC's, and is prepared to provide seed capital for experimental

private sector programs."[28] The renewed emphasis on private sector roles in development has several foci in the U.S. Government. Within AID, there are two major sets of actors responsible for implementing the private sector policy, the new Bureau for Private Enterprise, and the regional project bureaus themselves.

The Bureau for Private Enterprise (PRE) was created in 1981 to provide a central AID locus of responsibility for stimulating free enterprise in Third World countries and, where possible, to involve the U.S. private sector in that process. In pursuit of these goals, PRE has initiated a range of activities to encourage developing country governments to provide a climate supportive of private investment, domestic and foreign. The Bureau particularly encourages the improvement of capital markets and other financial structures that generate savings and direct them into private investments; provides direct capital, at near market rates, to local banks, venture capital firms, leasing companies, insurance companies and other intermediaries that lend directly to local private enterprises; and has plans to lend directly to local business enterprises.[29] While the Bureau is not authorized to take equity in local enterprises, it does have the authority to take convertible debentures in foreign enterprises. If it does so, it would sell these to private investors once the local enterprise is operational.

Geographically, PRE is authorized to operate across the spectrum of developing countries. In practice, it has established a set of ten priority countries, only one of which (Egypt) is in the Near East. Sectorally, the Bureau's emphasis to date has been on venture capital operations and on agribusiness.

The Regional Bureaus are responsible for implementing aid programs in individual developing countries. These Bureaus group together in a central administrative structure the AID Field Missions in each country. The latter Missions have the direct decision-making responsibility for determining, together with the relevant local government units, what projects will actively be carried out within the individual countries.

The Near East Regional Bureau has been among the most active in exploring such roles, particularly regarding the health sector. In Egypt and Jordan, AID has completed several baseline studies on private pharmacists and pharmacies and on private health services provision in general. In Lebanon, one of the key questions being raised in health sector reconstruction is the establishement of complementary roles between government agencies and what has become the nearly exclusive source of health care, the private sector.

3. Activities of Related Agencies: Although strictly speaking not development assistance programs, the related activities of two other U.S. Government agencies are essential components of U.S. private sector policy in the developing world. While both are commercial agencies attempting to expand U.S. business trade with and investment in Third World countries, both, de facto, affect Third World economic development. It should be noted that the commercial-development assistance relationship between these trade/investment agencies' activities and AID is not nearly as tightly linked as in the European and Japanese cases described subsequently in this chapter.

Export-Import Bank: The "Exim" Bank was created 45 years ago to provide financial assistance (direct loans, guarantees, insurance) to U.S. exporters. In fiscal year 1981, Exim authorized nearly $12.9 billion in loans, guarantees and insurance to assist export contracts concluded during the year. A self-sustaining agency, Exim has paid over $1 billion in dividends to the U.S. Treasury.

Exim programs are available to exporters in over 120 countries. Among these programs are assistance to exporters in making market contacts in Third World countries, provision of export financing (to make U.S. exporters competitive with foreign companies which benefit from officially supported export credits), and guarantees for a variety of loan types, including those denominated in foreign currencies.

Fiscal year 1981 Exim authorizations (loans, guarantees and insurance) in the Middle East countries of central focus to this Report totaled $151.7 million, the largest recipient being Egypt ($64.9 million), followed by Tunisia ($60.6 million), Morocco ($23.9 million), and Jordan ($12.3 million).

Overseas Private Investment Corporation: OPIC was created 13 years ago primarily to provide political risk insurance to corporations investing abroad. Recently, it has come to play a significantly larger role in U.S. economic and development relations with the Third World due to current U.S. policy emphasizing the role of private capital in economic development.

In 1981, OPIC assisted 113 projects involving insurance commitments of nearly $1.5 billion and direct loans and loan guarantee commitments of $101 million. These projects involve an aggregate of approximately $4.5 billion in investment in the Third World, of which 42% is provided by U.S. investors; 47% by host countries and private sectors; 12% by third party countries, and the remainder by multilateral lending institutions. 62 of the 113 projects involve local ownership, most of those with local joint venture partners owning 50% or more of the enterprise. Like Exim, OPIC is a self-sustaining government institution, with 1981 income of $76.2 million and approximately $800 million in reserves to cover insurance claims settlements.

As it has expanded in size, OPIC has also broadened its programs. These now include not only an extended variety of political risk insurance and financial programs (loans to small business and commercial bank credit guarantees), but also a renewed stress on the financing of investment feasibility studies and the financial support of local management training and education programs related to the acquisition of U.S. technology.[30]

Sectorally, OPIC's efforts are heavily targeted on four industries: agribusiness; energy and minerals (especially oil and and gas exploration and production as well as coal and alternative energy sources); health care products and services; and construction materials. Geographically, the OPIC focus has been on the People's Republic of China and the Caribbean. In 1981 alone, OPIC issued $308 million in political risk insurance and committed over $55 million in financing for 30 projects in 11 Caribbean Basin nations. While OPIC has been active in providing insurance to projects in almost all countries in the Middle East, financial support and investment promotion have been concentrated on projects in Egypt and, more recently, in Lebanon. Indeed, in 1982 at the request of the White House, OPIC co-sponsored a mission to Lebanon with the Association of General Contractors of America, to bring 18 construction executives to Beirut to explore ways in which the U.S. construction industry could help in rebuilding that war-torn city.

In short, the OPIC message is that expanded capital flows to the developing countries are advantageous both to the recipient countries in terms of local private capital stimulation, technology transfer and job creation, and to the U.S. in terms of economic and export growth.

10.E. BRITISH OVERSEAS DEVELOPMENT ADMINISTRATION

British development assistance has undergone a series of structural and financial changes over the last five years. Organizationally, aid administration has been downgraded by the Thatcher Government from ministerial status to a section of the Commonwealth Office. In addition, British assistance to the Third World is gradually being shifted from bilateral relationships to funding through the Economic Development Fund of the EEC (see below).

In 1981, official bilateral development assistance of the British ODA totaled nearly $1 billion, down from $1.5 billion in 1980. Contributions to multilateral institutions for that year totaled another $1 billion. Total bilateral plus multilateral assistance declined from $2.5 billion in 1980, to just under $2 billion in 1981.

Geographically, British bilateral aid is concentrated in Asia and Africa. The Middle East accounts for only about 4% of British ODA aid. Key recipient countries in that region are Egypt, the Yemen Arab Republic, and Jordan. Sectorally, British aid is wide-ranging. Over a quarter of project aid in 1981 was concentrated in education, followed by industry, agriculture and public utilities (each with between 8% and 10%), and then by health and social welfare categories, with 3% to 5% each. This percentage represents a growth for the health sector, which captured only 1.7% of British project aid in 1977.[31] However, in the Middle East, British aid is heavily concentrated in the manufacturing and energy sectors.

Although British private voluntary organizations are deeply involved in Third World development and health in particular, British official aid has no specific private sector/business policy. By and large, private sector contact in British aid is largely a product-purchaser relationship between the aid agency and British business.

It should be noted that, in the Middle East health sector, two exceptions to this pattern have occurred, one related to development assistance and one related to commercial development. For the first, the British Overseas Development Administration undertook in 1982 an extensive study of private and quasi-private health insurance options for the Government of Jordan. While not yet released in Jordan, this report reflects the concerns of both parties for private financing mechanisms in the Jordanian health sector. In addition, in 1981 the U.K. and Egypt signed a health cooperation agreement to provide for British business and technical assistance to Egypt in the design, construction, equipping, and administration of Egyptian hospitals, and in the provision of screening and pharmacology services within Egyptian health sector institutions.[32]

10.F. CANADIAN INTERNATIONAL DEVELOPMENT AGENCY

In 1981, official development assistance of Canada totaled nearly $1.5 billion. $1 billion of that was bilateral assistance administered by the Canadian International Development Agency (CIDA). This represented nearly a doubling of Canada's bilateral assistance between 1980 and 1981.[33] Approximately 69% of that bilateral total was sector-allocable aid, the vast majority (71%) in the agriculture and public utilities sectors. The health sector is the smallest of all CIDA sectoral programs, a mere half a million dollars in project finance in 1981.[34]

Geographically, CIDA programs are focused on Asia and East Africa. In the Middle East, CIDA's activities are concentrated in Egypt, which, since 1980, has been considered one of CIDA's priority countries. CIDA's Egypt portfolio includes hydroelectricity, agriculture, transportation, and education projects, as well as significant

commodities import support. In addition, in 1981 CIDA provided a total of Cdn $1.2 million to over 40 Canadian companies interested in joint ventures in Egypt through the Industrial Cooperation Program described below.

Canada operates two specific programs supportive of the private sector via CIDA's activities:

The Management for Change Program seconds senior managers and executives from corporations and public agencies in Canada to governmental agencies and mixed public-private business organizations in developing countries as technical advisors on the resolution of specific management problems. Requesting agencies pay for local accommodations and travel; the corporation or agency sending the personnel pay the executives' usual salaries; and CIDA assumes the international travel and related costs.

CIDA's Industrial Cooperation Program (ICP) carries out a number of activities which are analogous to the U.S./OPIC functions described above. However, the ICP is an integral part of CIDA and its sectoral and geographic priorities and policies, in contrast to the clear agency distinctions between OPIC and AID. The ICP is designed to be a link between Canadian businesses, especially small and medium-sized companies, and their developing country counterparts to promote trade, investment, and private capital development in Canada and the Third World. The ICP conducts five sets of activities:

(1) Information dissemination, to provide information in readily usable form to the Canadian private sector and to developing countries about each other's potential for cooperation;

(2) Technical assistance, to link Canadian technical capabilities to the needs of Third World private sectors;

(3) Financing of feasibility studies, (up to $10,000 per project) to reduce the front-end costs for Canadian companies investigating LDC opportunities for joint ventures, direct investments, licensing agreements, co-production arrangements, etc.;

(4) Operation of the Canadian Technology Transfer Facility, which finances Canadian firms to test and adapt their technology in developing countries as a lead-in to long-term cooperation with LDC private sector counterparts;

(5) Operation of the Canadian Project Preparation Facility, which provides post-feasibility but pre-investment financing for detailed Canadian investment preparation in developing countries.

Countries in which private sector industrial cooperation activities are supported become eligible for regular CIDA project financing even if they are not already part of CIDA's development assistance program.

10.G. EUROPEAN ECONOMIC COMMUNITY

The EEC, in 1981, disbursed nearly $1.7 billion in development assistance, an increase of 68% over 1980 if measured in European currency units. This increase is largely attributable to the value of food aid disbursements, a result of the rising price of food commodities and a special hunger program initiated in 1981 by the Council of Ministers.[35]

In the Middle East, EEC aid is largely in the form of food import subsidies and trade preference agreements. In addition, EEC assistance is given to link European companies to Middle East government projects as suppliers and contractors, and to local private business for purposes of trade and investment. Thus, EEC aid packages overall represent vehicles for significant private sector promotion in Europe and in recipient countries. EEC aid in the Middle East provides one of the most salient examples of closely linked commercial and development strategies in aid packages.

In June of 1982, the EEC signed a five-year agreement with Egypt to provide $284 million in aid in the form of European Investment Bank (EIB) loans at market rates ($154.2 million), $51.4 million in soft loans, and $78 million in grants from the EEC budget. In addition, EEC project aid, largely via EIB loans, has been made available for a variety of energy and agricultural projects in Egypt.

In Jordan, the EEC aid package is targeted at expanding European-Jordanian trade via grant support for Jordanian exhibitions in international trade fairs and technical assistance to the government for the promotion of Jordanian trade.

In Tunisia, EEC grant aid in 1981 totaled $1.175 million, over half of which was allocated to urban health care projects, with the remainder split among export promotion programs with the EEC, food aid, and education projects.

10.H. JAPANESE DEVELOPMENT ASSISTANCE

Japanese bilateral development assistance increased in 1981 to nearly $2.6 billion, 72% of which was focused on Asia. Sectorally, 45% of Japan's bilateral aid was allocated to public utilities projects and another 36% to agricultural and industrial development. The health sector garnered only 7% of Japan's bilateral aid.[36]

In the Middle East, the chief recipient of Japanese aid has been Egypt. Other Middle East countries receiving Japanese aid are Jordan (mostly tied loans for communications system improvements), Morocco (tied loans for rail system improvements), and Tunisia (a combination of tied loans and grant aid for industrial projects).

Between 1973 and January 1983, Japan's aid to Egypt has included $1.013 billion in soft loans, both project and commodity, with the latter being fully untied since 1979; $67 million in grants; and $29.1 million in technical assistance. These amounts are exclusive of the long-term export credit facility Japan operates with Egypt. Sectorally, loan aid has been focused on the transportation sector (largely rehabilitation of the Suez Canal); housing; water supply; agriculture; and public utilities.

In Japan's grant program for Egypt, the health sector has played a fairly strong role. In 1979, $1.6 million in Japanese commodity aid was donated for a nutrition improvement project in Cairo. In 1980, $18 million was allocated to construction of and equipment for a pediatric hospital as part of a rebuilding effort for the Kasr el Aini Hospital in central Cairo. In 1982, another $4.5 million was allocated for the purchase of equipment and supplies for the Rift Valley Fever Control project. The total allocations to these projects represent nearly a third of all Japanese grant aid in Egypt.

Japan's technical assistance programs are also carried out on a grant basis, and include the provision of trainers, advisors, and equipment to Egypt as well as the training of Egyptian personnel in Japan. Again, the health sector has been one focus of attention, both in terms of medical equipment supply and maintenance and in terms of nursing training associated with medical and nursing equipment supplied to Egyptian medical facilities.

As in many other areas of Japan's domestic and international economic affairs, public sector activities are promotive of and often overlap with those of the private sector. Indeed, Japan's Ministry of Trade and Industry considers the placement of Japanese private investment in the developing world to be just as much a part of aid as the allocation of public development assistance grants. The emphasis in Japan's aid policy is the development of economic cooperation directly between local and Japanese private sectors through direct investment and trade. This commercial relationship, rather than direct government grant aid, is the priority in Japanese policy.[37]

Organizationally, Japanese aid is coordinated through the Economic Cooperation Bureau of the Ministry of Foreign Affairs. The main operational agencies are:

-- Overseas Economic Cooperation Fund, within Japan's Economic Planning Agency, which manages direct government grant and loan flows for official development assistance;

-- Japanese International Cooperation Agency, within the Ministry of Foreign Affairs, which implements all technical assistance programs, in terms of personnel, training, and commodities;

-- Export-Import Bank, within the Ministry of Finance, which administers the trade credit program.

Japan's government development assistance programs thus often promote the development of the local private sector, as well as strengthen the ties between local companies and Japanese business. For example, this year Japan allocated $156.5 million of its development assistance funds in Egypt to an integrated steel mill project which was in essence a joint venture of Japanese Government funds, a number of Egyptian private companies, a consortium of Japanese businesses, and the International Finance Corporation. Moreover, of the IFC share of $102.4 million, $64 million is actually in the form of participation by a group of Japanese banks led by the Fugi Bank Ltd.

10.I. THE WORLD BANK

Over the last year, The World Bank has begun to reemphasize its role as "one of the most important sources of foreign finance for private enterprise in the developing world."[38]

1. IBRD/IDA: In fiscal 1982, lending commitments by the International Bank for Reconstruction and Development (IBRD, The World Bank's lending window) and the International Development Association (IDA, the "soft-loan" or credit window) totaled $19.139 billion. IDA commitments during the year were in support of 97 projects in 42 countries; IBRD loans were made for 150 projects in 43 countries.[39] The health/population/nutrition sector represented just 1% of total IBRD/IDA project financing; the Middle East accounted for just over 12% of total project financing.

The Bank's general operations involve and strengthen local private sector resources directly via loans to small and medium-scale enterprises and indirectly via loans to sources that improve the public provision of materials and services required by private business. In the health sector, it has been only the latter, indirect function that the Bank has pursued in its worldwide lending/credit programs.

The Bank has also recently reemphasized the importance of private capital in project finance, largely from international commercial banks. In fiscal 1982, private commercial co-financing was a record $3.3 billion (13% of total project costs), compared to $1.1 billion in 1981.[40]

2. International Finance Corporation: By far the most important private sector role at The World Bank, however, is carried out by the International Finance Corporation (IFC). The IFC is a Bank affiliate charged with furthering economic development by encouraging the growth of private sector enterprises in the Third World. Begun in 1956 with 31 member countries and authorized capital of $100 million, the IFC today has 122 members and a capitalization totaling $1.2 billion.

In fiscal 1982, the IFC approved 65 projects in 31 countries with a total project cost of $2.9 billion and an IFC investment of $611.8 million. The IFC is authorized both to make loans and to take equity in the private sector, although the latter accounts for only 15% of its investment activities.

The IFC applies three criteria to its operations. It invests "only in those ventures which contribute to the development of the country involved, only those which can provide an adequate financial return, and only those which, without IFC's assistance, would not, as... proposed, be able to attract adequate financing on reasonable terms and in a timely fashion."[41]

Geographically, the Middle East is a relatively small part of IFC's operations. In fiscal 1982, only 15% of IFC projects and 9% of its funds were in Middle Eastern countries. Of this investment, the majority was located in Egypt and Tunisia.

Recently, the IFC has made an effort to diversify the sectors in which it is involved, moving away from traditional areas of manufacturing and into such areas as agribusiness and commercialized research and development. In fiscal 1982, the IFC for the first time undertook an investment in a health-related field by helping to finance $16 million of a $64.3 million project to construct an 800-bed addition to a physical rehabilitation hospital in Yugoslavia, serving East Europe and the Middle East. This is IFC's first health sector experience. However, the IFC's efforts to diversify its activities, the extent of private health sector development in the Middle East, and the precedent represented by the Yugoslavia investment could lead to future consideration of participation in health product and service provision investments.

10.J. THE UNITED NATIONS GROUP

A variety of U.N. agencies are involved in the health, industry, and/or private sector issues of relevance to this Report. Few, however, address or impact in any major way the private provision of health services or products. Those which are actually or potentially relevant to that intersection of private roles in the health sector are abstracted below.

1. The Center on Transnational Corporations (CTC) was established in 1976 as an autonomous body within the U.N. Secretariat to further an understanding of the nature of transnational corporations and their effects on home and host countries; to secure arrangements to enhance their positive effects and control their negative effects; and to strengthen host country abilities to negotiate with such corporations. In essence, then, UNCTC is a research and coordinating, rather than an operational, agency.

For the past several years, one of the UNCTC's main areas of research focus has been the role of pharmaceutical multinationals in the world market and their impact on developing country economies, industries, and health care. The interpretation of this research has been a point of some controversy between the international industry and UNCTC, especially as regards the level of international market concentration, the capabilities of local industry in the Third World, and the role of patents and trademarks in Third World settings.

2. The United Nations Development Program (UNDP) is a diversified U.N. agency providing technical assistance, project finance, and policy guidance to developing countries in a wide range of economic sectors. In 1981, 4.6% of its project expenditures were in the health sector, and 11.9% in the Arab states of the Middle East.

Nearly all of UNDP's pilot projects, investment feasibility studies, and technical assistance activities are carried out in the public sector. However, these upstream investment services do have significant private sector links, which UNDP is trying to expand, via subsequent private sector investment in UNDP-designed projects. In 1981, 20% of the follow-up financing to UNDP projects was supplied by private sector companies and financial institutions, a third of that by private institutions within the project country. In UNDP's health project feasibility work, however, no follow-up financing was obtained from private sources.

3. The United Nations Industrial Development Organization (UNIDO) was formed in 1967 to promote and accelerate industrialization of developing countries. UNIDO is an "executing agency" for UNDP, i.e., UNDP finances UNIDO's provision of technical advice, equipment, feasibility studies, research, etc. in developing countries. In addition to providing technical advice within countries, UNIDO acts as an investment

middleman, sponsoring meetings of financial and business executives from the developed world and their developing country counterparts to promote project investment.

UNIDO's one foray into the health sector has been related to the pharmaceutical industry in the Third World and its relations to the multinational industry. A series of studies and national and international meetings have resulted in recommendations to developing countries to emphasize public regulation and control of drug provision and pricing and to expand indigenous private production of pharmaceuticals.

4. The United Nations Children's Fund (UNICEF) works closely with developing country governments, bilateral and multilateral development assistance agencies, and, especially, private voluntary organizations to design and supply family and child health programs targeted at the world's lowest income groups. UNICEF's recent emphasis has been on combining the use of growth charts, oral rehydration, breast-feeding, universal immunization, and pre- and post-natal health care into comprehensive, national campaigns to improve child health worldwide.[42]

The private (provider and business) sector has not been a traditional focus of UNICEF concern. Recently, however, UNICEF has initiated an effort to involve private business resources and expertise more directly in one area of the above UNICEF concerns, oral rehydration. UNICEF has established a consultative group of multinational corporate executives to discuss and advise UNICEF on the possible business opportunities for producing and marketing oral rehydration products in the developing world. In the words of UNICEF's Executive Director:

> "There is every reason to believe that proper marketing (of oral rehydration therapies) can produce a considerable demand for the product. There are, after all, hundreds of millions of cases of diarrhoea annually, and tens of millions of families who would buy low cost ORS (oral rehydration salts) packets if they were readily available. Hence, the marketing of an item like ORS by the private sector so that the packet is available in every village and urban slum along with matches, batteries and other low cost consumer essentials is not only a desperately needed public service, but potentially a profitable enterprise in its own right."[43]

5. The World Health Organization's (WHO) private sector interests have also been almost totally related to the issue of drug and vaccine provision.

WHO's Special Programme for Research and Training in Tropical Diseases includes a series of cooperative laboratory research programs with multinational pharmaceutical companies in the U.S. and Europe. There is a general recognition in the TDR programs that it is the private pharmaceutical manufacturing sector which has the production capability necessary to turn laboratory discovery into marketable product. However, this recognition of private roles has been seen to have some limitations. Earlier this year, the gene splicing company, Genentech, withdrew from a proposed venture to produce a malaria vaccine with New York University (NYU), eliminating the possibility of rapid vaccine development in this area, because WHO exercised a contractual claim to the patent in the public interest on the basis of its previous support for NYU's research. The result will be a delay in the development of a usable product from NYU's research work, and, perhaps, a greater private sector hesitancy to become involved in drug development and marketing arrangements with WHO.

WHO and the multinational pharmaceutical industry have also recently reached preliminary agreement on cooperation in the Essential Drugs Programme. The industry has agreed to fill bulk orders for some essential drugs at below market prices, but details of the arrangement have yet to be completed.

10.K. SUMMARY

In sum, then, a variety of development assistance actors involved in the Middle East have explicit policies supportive of private sector involvement in project development, finance and implementation. Few agencies, however, have both private business/provider policies and experience with implementing those policies in the health sector. Thus, building project partnerships between groups of development assistance actors and the private sector will be a challenging, but certainly not impossible or unprecedented, undertaking.

SECTION III.

PROCESS OF INTERACTION

11. THE PROCESS OF INTERACTION AMONG PUBLIC AND PRIVATE HEALTH SERVICES IN THE MIDDLE EAST

"A company's proactive concern for the health of its employees in any less developed country translates very quickly into a series of positive consequences. First, the ripple effect yields better care for an employee's dependents and the setting of higher quality standards as to what health care is acceptable for them. Secondly, this concern for quality influences the doctors/clinics/hospitals with whom we deal, helping and encouraging them to upgrade their level of medical care, not only for our employees and dependents, but also for others of the community who use them. Third, the evident 'human' concern of companies practicing health care thus translates into good will and a positive environment from which the company, employee and community all profit." C. Eugene Moore, M.D., Exxon Corporation.

11.A. INTRODUCTION

Section II of this Report has set out in some detail the nature and level of private sector involvement in health care in the Middle East, as well as the government policies affecting that involvement. The conclusions are strikingly clear. Nearly all types of private sector health roles are present in significant degrees, or have significant potential for expansion, in the Middle East. Moreover, in most cases, those roles, and their expansion, are consistent with existing government policy.

The preceding chapters, however, are an insufficient foundation upon which to examine the possible roles of publicly-mandated development assistance agencies in creating partnerships with and incentives for private sector health activities, for they poorly convey the interdependency among the various private and public actors in the health system. Strategizing a useful future development assistance role assumes a full understanding of the ways in which the various private actors currently interact with and

depend upon one another. If development assistance wishes to create for itself a public health niche in existing private systems, so as to leverage its own and other public resources and to provide incentives for improvements in private services and products, then it must understand not only the individual actors but also the web of relationships and interdependencies that ties them closely together. It can then assess and match its own strengths, resources, and priorities to the process of health care provision as it exists in the private sector, and understand where and when development assistance can have the greatest impact.

The previous section of this Report has stressed the importance of this web of interrelationships in individual cases and for individual actors. Since the detail of that web may have been lost in the amount of data in Section II, this chapter will focus on the process of interdependency that currently exists among the various private sector actors.

11.B. HYPOTHETICAL SITUATIONS IN AL-BILAD

It will be recalled that Chapter 1 of this Report set out the various actors to be described in Section II's data base. We will now return to that analytic framework, overlaying the lines of interdependency upon the categories of actors we have analyzed. The result will be a composite picture of who is linked to whom, how, and on what issues in the production and delivery of health services.

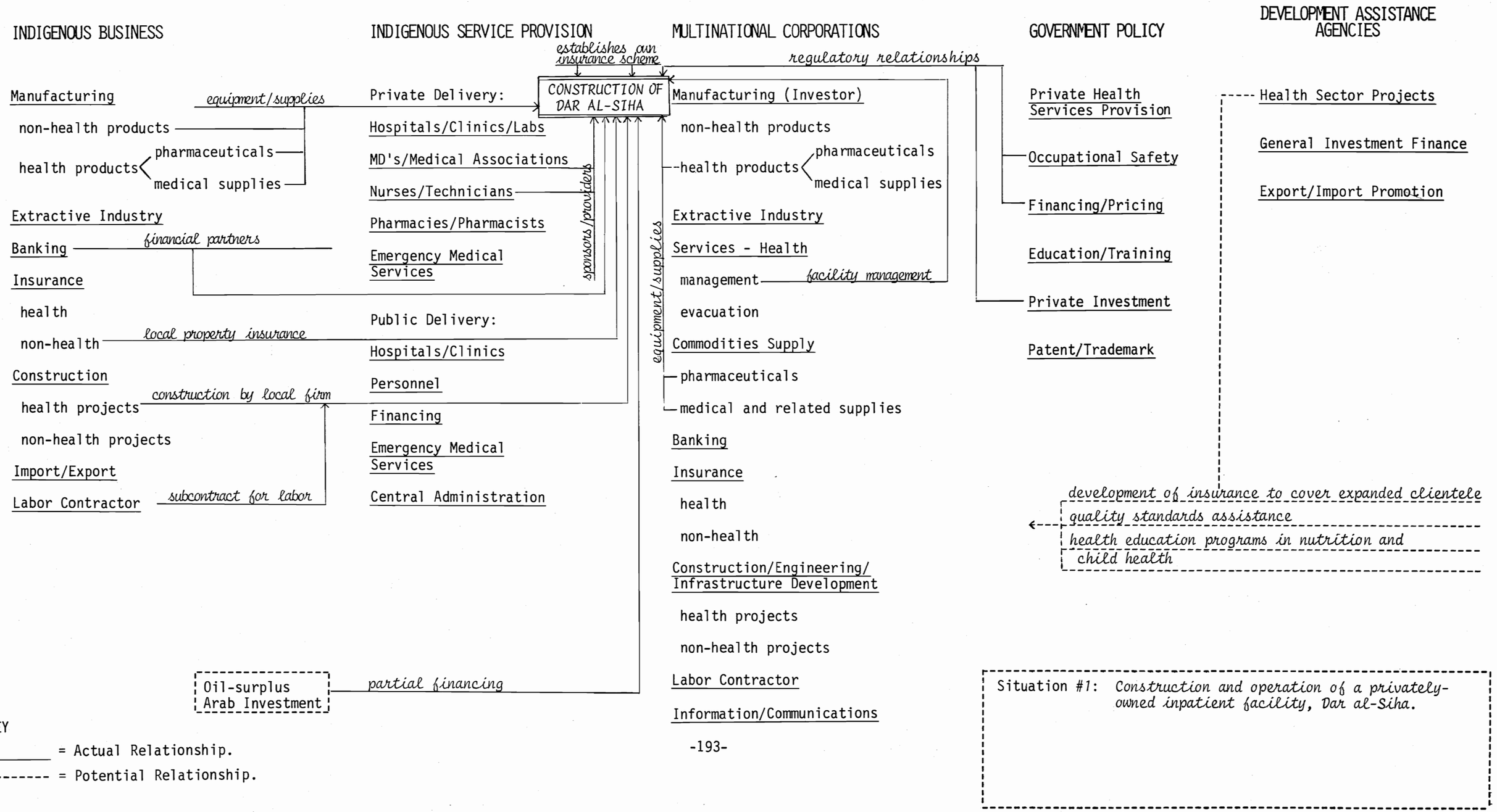
This composite will be presented for nine hypothetical situations in a country called Al-Bilad. These hypotheticals are drawn from both actual case material and the general information gathered through the process of research for this Report. As such, the hypotheticals represent no one company or instance, but rather are aggregate profiles of how the system works in the private sector and of where public health and development assistance linkages might be structured. The schemata displaying the health linkages in the situations described are presented on the page immediately following the beginning of each hypothetical situation.

Situation 1: DAR AL-SIHA HOSPITAL

A group of private physicians has decided to build a 100-bed private, inpatient facility, Dar al-Siha, on the outskirts of the capital city of Al-Bilad on land purchased from a large land owner. An Italian architectural firm is hired to design the facility and to draw up construction specifications. Financing has been aggregated from the personal resources of the physicians, private Arab investors

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET



KEY

_____ = Actual Relationship.

-------- = Potential Relationship.

from the oil-surplus countries of the region, and a consortium of local banks.

Investment clearance has been received from the Ministries of Finance and Plan, and the Ministry of the Interior has approved the land purchase. Fee schedules, interior plans, and staffing plans for the facility have been approved at the Ministry of Health.

A local firm, Mahmoud Construction Company, is contracted to build the facility. It, in turn, subcontracts to a local company for the provision of unskilled labor on the job site. While the requisite occupational safety and health activities and structures are part of the construction plan approved by the government, compliance is more in the letter than in the spirit of the law. No safety instruction or equipment is provided to laborers. However, an emergency clinic to treat accidents is set up at the work site, and a local private physician is contracted to be on call for serious accidents.

Upon completion, the facility will serve individual patients as well as establish a group membership self-insurance scheme. The latter would resemble a Health Maintenance Organization, with "members" (e.g., local companies) paying a flat annual fee for unlimited, non-specialist services for employees treated at the facility. The scheme requires approval by the government's insurance organization. That approval has not yet been received.

A range of development assistance links are possible in such a private project. Since private resources have already borne the investment costs in the facility, its equipment, and personnel, any linkage which public health/development assistance can forge will represent a fairly cost-effective method of service provision for the public sector. Three possibilities for such links are as follows:

(1) Development agencies could approach government agencies, private sponsors, and corporate users (see Situation 2 below), regarding the possibility of capitalizing an insurance fund that would cover specific lower income groups in the facility's geographic catchment area to receive specific services, including maternity, emergency, and pediatric care, and such preventive services as immunizations.

(2) Development agencies could work with government agencies and private providers to establish quality standards in the private facility; to utilize the professional capability in the facility to train the management and providers employed in public facilities; and, reciprocally, to assist the facility with its own personnel training problems.

(3) It has been regularly observed in Al-Bilad that problems involving nutrition and child health are common among not only the very poor, but also among the newly rising worker and middle class. Parents

in these groups have only recently acquired relatively significant incomes and thus still retain some traditional, possibly harmful, misperceptions of appropriate family health practices. Development assistance and public representatives could approach the facility's management about setting up regular, joint health education campaigns in the facility's outpatient clinics in such areas as nutrition-education, family planning, and child health. This would allow the facility to expand the kinds of services it offers its clientele, and also would give public health development professionals a low investment outlet for health education materials and services.

Situation 2: W. A. SMITH WIDGET CORPORATION (CHICAGO)

After lengthy and often painful negotiations, the W. A. Smith Widget Corporation, headquartered in Chicago, has finally reached agreement with the Government of Al-Bilad on the construction and operation of a widget manufacturing and packaging plant 20 km. outside the capital city in a new, but currently empty industrial park. The W. A. Smith investment will be 49%/51% joint venture, with the Government partner being the Al-Bilad Investment Agency. However, Smith is responsible for all construction and operation decisions.

The company's health-related activities in the context of the investment are diverse. In terms of construction, Smith has contracted with a German firm to design and manage the actual building of the plant since widget technology is complex and requires fairly specialized facilities. The German company, in turn, has subcontracted to an international labor contractor who will provide Korean labor to the project. The Korean agreement specifies, by Korean request, that the contractor provide all project medical services from Korean sources. However, occupational health and safety regulations, both during construction and during operation, are those of the U.S. All OHS equipment is imported; local OHS managers are trained at Smith's Gary, Indiana plant.

A basic dispensary is maintained at the plant site to handle emergencies as well as primary care for local and expatriate employees. Drugs and materials are purchased from a local pharmacy. The dispensary is staffed by a local paramedic who was trained at Al-Bilad's Health Institute and sent by Smith to East Kansas University for further training prior to the opening of the plant. In addition, the company provides health and hospitalization insurance for all local employees. Depending on the illness, between 8% and 10% of services are paid by the company. Smith/Bilad has contracted with the new Al-Siha hospital to provide both in- and outpatient services to company employees and their families. A major U.S. carrier provides health and accident insurance for expatriate employees.

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET

INDIGENOUS BUSINESS

Manufacturing
- non-health products
- health products < pharmaceuticals / medical supplies

Extractive Industry

Banking

Insurance
- health
- non-health

Construction
- health projects
- non-health projects

Import/Export — *OHS equipment*

Labor Contractor

INDIGENOUS SERVICE PROVISION

Private Delivery:

Hospitals/Clinics/Labs — *provision of employee/family services with own finance scheme*

MD's/Medical Associations — *provision of employee/family services with own finance scheme*

Nurses/Technicians

Pharmacies/Pharmacists — *provision of employee/family services with own finance scheme*

Emergency Medical Services

Public Delivery:

Hospitals/Clinics

Personnel

Financing

Emergency Medical Services

Central Administration

MULTINATIONAL CORPORATIONS

Manufacturing (Investor) — *provision of employee/family services with own finance scheme*
- non-health products
- health products < pharmaceuticals / medical supplies

Extractive Industry

Services - Health
- management
- evacuation

Commodities Supply
- pharmaceuticals
- medical and related supplies

Banking

Insurance
- health
- non-health

Construction/Engineering/Infrastructure Development
- health projects
- non-health projects

Labor Contractor — *provides construction health services*

Information/Communications

W. A. SMITH WIDGET

GOVERNMENT POLICY

Private Health Services Provision

Occupational Safety

Financing/Pricing

Education/Training

Private Investment

Patent/Trademark

DEVELOPMENT ASSISTANCE AGENCIES

Health Sector Projects

General Investment Finance

Export/Import Promotion

health/nutrition education

OHS training and policy

family health

Oil-surplus Arab Investment

KEY

_____ = Actual Relationship

-------- = Potential Relationship

Situation #2: *W. A. Smith Widget Corporation of Chicago enters a joint venture with the Government of Al-Bilad on a 49%/51% basis to build and operate a widget manufacturing and packaging plant in Al-Bilad's new industrial park.*

The presence of the Smith joint venture on the Al-Bilad scene provides development assistance professionals in Al-Bilad with a number of opportunities. Smith, as an employer of 4,000 people, could be enlisted in a variety of public health education campaigns, combining development assistance materials with company outlet facilities (bulletin boards, news sheets, worker meetings, etc.). One key area of attention, of interest both to the company and to public health professionals in the Government, might be family nutrition, since the company provides all employees with a midday meal.

Another potential linkage is family health. Since Smith is providing some insurance coverage for health services for the families of its employees, it has a bottom-line concern with disease prevention. It might be prevailed upon to contribute financing, materials, or the time of its paramedic to a local health project designed to improve maternal/child health in nearby areas.

Occupational health is, of course, a third possible area of collaboration, since Smith's corporate headquarters prides itself on its international safety record. A public-private seminar or task force on the subject bringing together local and multinational business and government agencies to discuss options for improved worker or manager OHS training, as well as in-service training for government regulators, might be held using the good offices of the development assistance agency. Indeed, Smith's Chicago executives might be prevailed upon to co-sponsor the meeting and/or provide technical materials to support the meeting agenda.

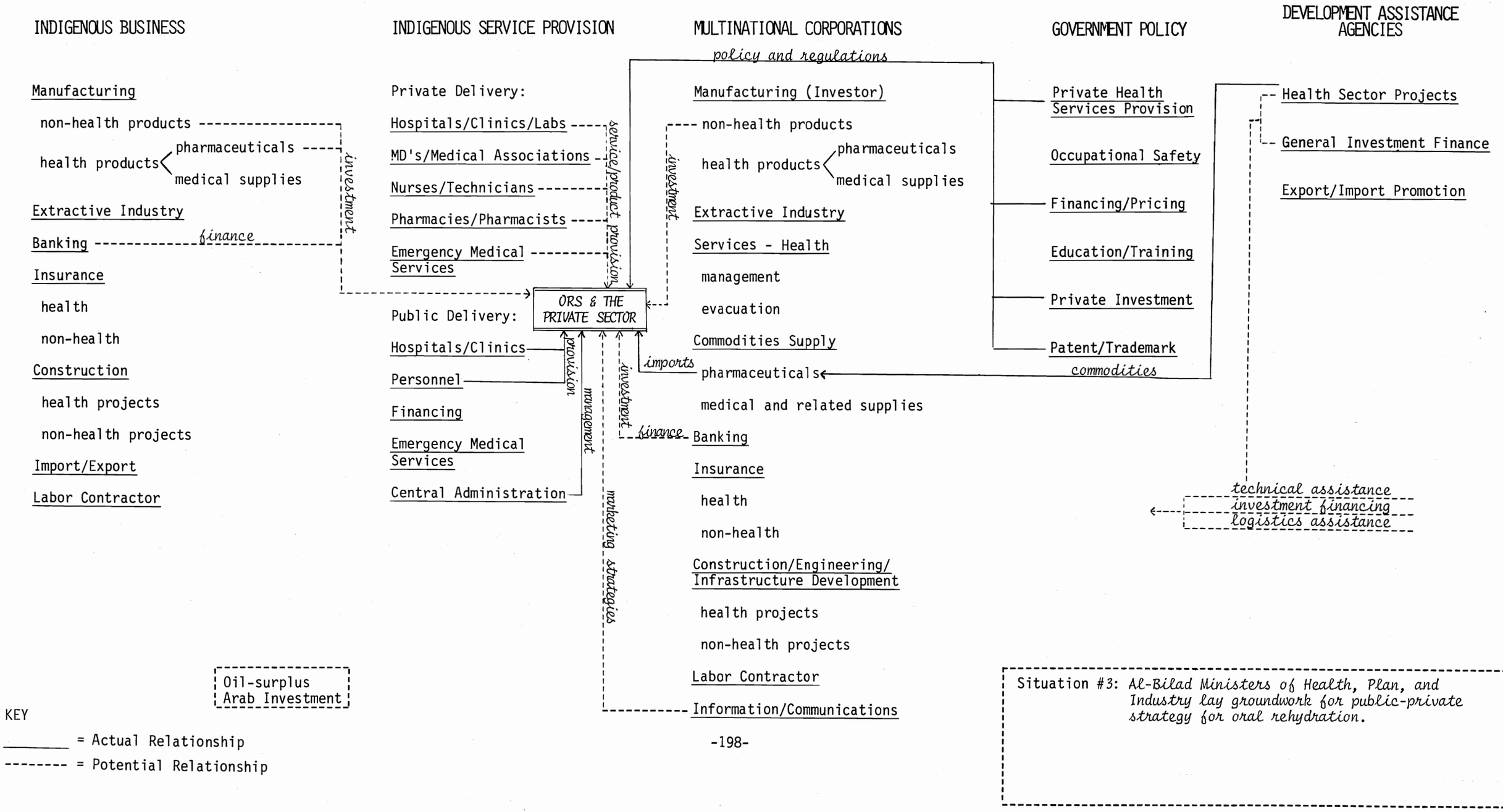
Situation 3: THE PRIVATE SECTOR AND ORAL REHYDRATION

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.

The method of 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

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET



Situation #3: *Al-Bilad Ministers of Health, Plan, and Industry lay groundwork for public-private strategy for oral rehydration.*

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 Ministry 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 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.

Situation 4: LES PETITS BONBONS CONSTRUCTION COMPANY

Concerned about recent unrest in a province 100 km. from the capital, Al-Bilad's Government has decided to move forward with the long-planned construction of a power plant in that province. A neighboring oil-surplus government has been prevailed upon to finance the extensive project since the province is also on the latter's border.

Les Petits Bonbons Construction Company of Paris, a specialist in the energy field, has been hired to build the plant, but operations will be totally managed by Al-Bilad since this is considered, in part, a defense-related facility. Bonbons, therefore, is a temporary fixture on the Al-Bilad scene. This suits the preference of Bonbons' management, since five years ago the company's joint venture power facility in the South of Al-Bilad was nationalized by the current government. Bonbons is happy to have the current business, but its executives in Paris have no desire to make a corporate capital commitment of any type to Al-Bilad.

Familiar with the Al-Bilad scene, Bonbons' manager for the project knows that the new plant's location is a difficult one. A relatively rugged, mountainous region, the area has no paved roads or public facilities. The four- (probably five-) year project will need to develop its own water source, housing, and health facilities, and other services. Before a road can be built, the only easy access to the project site will be via helicopter. Bonbons' manager, with immediate concurrence from Paris, decides that health services and disease control responsibilities will be totally subcontracted to Health Services, Inc., a diversified health management company headquartered in Alabama with 20 years of health facility management experience in the Middle East. Health Services will assume all water, health and medical responsibilities (design, management and provision) during project construction and see to it that the facilities and personnel turned over to Al-Bilad at the end of the project are adequate.

Wishing to minimize the project resources spent on what Bonbons considers to be ancillary services, Bonbons' management has specified that Health Services' contract be a fixed cost one, requiring that cost increases be reviewed in Paris. Health Services, therefore, has

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET

INDIGENOUS BUSINESS

Manufacturing
- non-health products
- health products < pharmaceuticals / medical supplies

Extractive Industry

Banking

Insurance
- health
- non-health

Construction
- health projects
- non-health projects

Import/Export

Labor Contractor

INDIGENOUS SERVICE PROVISION

Private Delivery:

Hospitals/Clinics/Labs

MD's/Medical Associations

Nurses/Technicians

Pharmacies/Pharmacists

Emergency Medical Services

Public Delivery:

Hospitals/Clinics

Personnel

Financing

Emergency Medical Services

Central Administration

MULTINATIONAL CORPORATIONS

Manufacturing (Investor)
- non-health products
- health products < pharmaceuticals / medical supplies

Extractive Industry

Services - Health
- management
- evacuation

Commodities Supply
- pharmaceuticals
- medical and related supplies

Banking

Insurance
- health
- non-health

Construction/Engineering/Infrastructure Development
- health projects
- non-health projects

Labor Contractor

Information/Communications

GOVERNMENT POLICY

Private Health Services Provision

Occupational Safety

Financing/Pricing

Education/Training

Private Investment

Patent/Trademark

DEVELOPMENT ASSISTANCE AGENCIES

Health Sector Projects

General Investment Finance

Export/Import Promotion

personnel

commodities

services

commodities

finance

labor

financing for service area expansion

BONBONS

Oil-surplus Arab Investment

KEY

_____ = Actual Relationship

-------- = Potential Relationship

Situation #4: *Les Petits Bonbons Construction Company of Paris is hired by the Government of Al-Bilad to build a power plant and related distribution grid in a rugged province 100 km. from the capital city.*

limited ability to extend services during construction outside the project perimeter unless a cost-effective means of doing so can be found. This concerns Health Services' management on a number of counts. The company is used to, indeed prides itself on providing services in as large a catchment area as is needed to control disease and health problems effectively. The company has always used health, not financial, standards to measure its effectiveness. By limiting its broader community contact due to the financial limits, communicable disease control will be difficult, as will triage decisions in dealing with expected community requests for services.

This is obviously a difficult situation for development assistance and the public health sector in general. Paris is decidedly not in a partnership mood. Health Services is used to working more broadly in communities in the context of its facilities management, but is under severe contractual limitations. On the other hand, the province at issue is one on which development assistance has long had an eye since formal health services are virtually non-existent there. Working out from the power plant's health facility to establish a broader disease control and services system could ensure more cost-effective health projects in the region in the future, particularly since the Government will operate the facility anyway once constructed. Moreover, local development assistance professionals will also benefit if collaboration can be arranged, since entry into the province will give them a possible project pipeline, with implications for solidifying their own health project budget at the headquarters agency.

The possible links for development assistance to ensure an adequate health systems base are threefold: (1) in the Government, since Al-Bilad will be the plant's operator over the long term. The Government thus should have a strong interest in seeing that Health Services is free to do an adequate job; (2) the project's Arab financing partners, since adequate health and other services over the longer term may help to calm what has long been a politically restless area; (3) its own project funds, allowing it to complement Health Services' health provision base at no immediate cost to either Health Services or to Bonbons, with the hope that as the project proceeds, its project seed money will help Health Services attract more Bonbons/Al-Bilad health financing to the project.

Health Services is likely to be receptive to any or all of these overtures, since it has hopes of ultimately cooperating with several development assistance agencies on health project management in the region.

Situation 5: 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 clinic. 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.

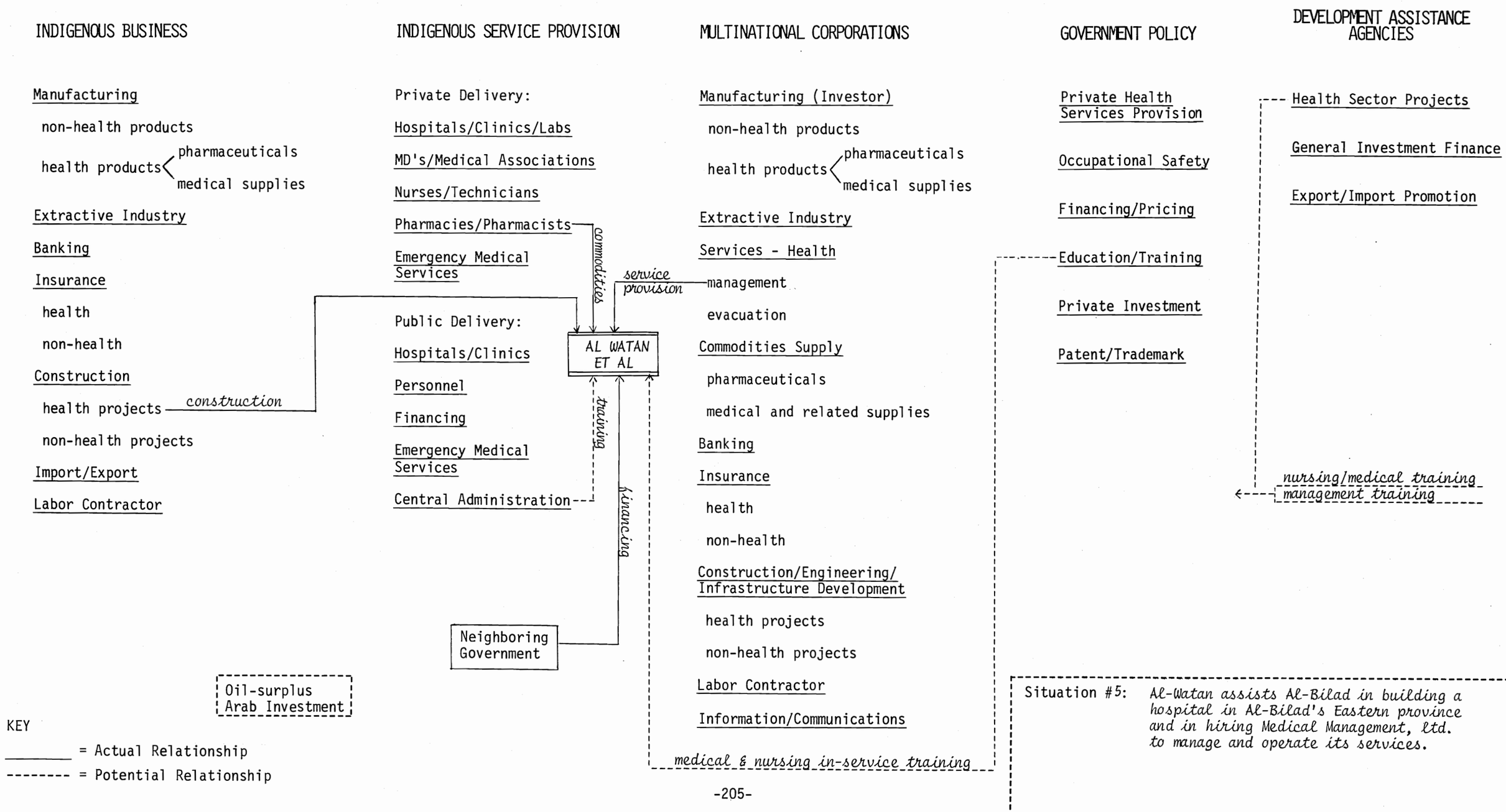
In this, as in all of its projects, Medical Management has taken particular concern with quality control and in-service personnel training. The hospital has a small library, which contains up-to-date copies of all key professional journals. Both physicians and nurses are regularly given skill up-grading 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.

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

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET



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.

Situation 6: SAHARA TEXTILE COMPANY

The Sahara Textile Company of Al-Bilad is a privately-owned and operated textile spinning and weaving company located in the heart of Al-Bilad's capital, with an additional plant in the country's only port city. Sahara is one of Al-Bilad's oldest companies, a family-owned venture with a long and proud history in the national economy.

Sahara has always done business as a family affair and has stayed out of the political arena. Even at the height of Al-Bilad's romance with socialist economic ways, the company remained insulated from the roving eye of public takeover simply by attending solely to its own business. Sahara neither seeks nor welcomes outside questions about its facilities, operations or finances. Public "partnership" is very close to the opposite of its philosophy. "My company," its current chairman once remarked, "has always taken care of itself and its own. Others are invited to do likewise."

Unfortunately, the past few years have made Sahara's life considerably more complex and raised its public profile. In its port plant, which employs 10,000 people, the company installed the newest in weaving machinery, imported from the U.S. but installed and operated by local staff. Three weeks later, seven workers were killed and ten maimed when a large piece of machinery came loose and smashed into a work station. In traditional fashion, families of the dead were given a financial gift by the company and the maimed sent to a company-sponsored rehabilitation center. As far as anyone knows, no operating changes were made or safety equipment ordered.

Sahara's health services are limited. Its employees are part of the government labor insurance scheme which operates fairly efficiently. Most workers obtain health services at public clinics. Emergencies, such as those described above, are treated at the company dispensary by the company male nurse and then sent to public hospitals. Aside from the government insurance plan, the company operates no formal disability insurance or compensation program. No health education or worker nutrition programs are carried out in any of Sahara's facilities.

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET

INDIGENOUS BUSINESS

Manufacturing
- non-health products
- health products < pharmaceuticals / medical supplies

Extractive Industry

Banking

Insurance
- health
- non-health

Construction
- health projects
- non-health projects

Import/Export

Labor Contractor

SAHARA TEXTILE

INDIGENOUS SERVICE PROVISION

Private Delivery:

Hospitals/Clinics/Labs

MD's/Medical Associations

Nurses/Technicians

Pharmacies/Pharmacists

Emergency Medical Services

Public Delivery:

Hospitals/Clinics

Personnel

Financing

Emergency Medical Services

Central Administration

employee services

technical regulation

MULTINATIONAL CORPORATIONS

Manufacturing (Investor)
- non-health products
- health products < pharmaceuticals / medical supplies

Extractive Industry

Services - Health
- management
- evacuation

Commodities Supply
- pharmaceuticals
- medical and related supplies

Banking

Insurance
- health
- non-health

Construction/Engineering/ Infrastructure Development
- health projects
- non-health projects

Labor Contractor

Information/Communications

GOVERNMENT POLICY

Private Health Services Provision

Occupational Safety

Financing/Pricing

Education/Training

Private Investment

Patent/Trademark

DEVELOPMENT ASSISTANCE AGENCIES

Health Sector Projects

General Investment Finance

Export/Import Promotion

occupational safety/health;
insurance;
health services provision;
health education

Oil-surplus Arab Investment

KEY

_____ = Actual Relationship

-------- = Potential Relationship

Situation #6: *Sahara Textile Company is a privately-owned and operated spinning and weaving company employing 15,000 hourly wage personnel.*

The opportunities for development assistance and public agencies to develop health-related incentives for major employers like Sahara are clear, and range from health education programs to finance to improved on-site care to accident and disease prevention. The prerequisite is that such incentives be cooperatively determined and be structured as parts of the broader portfolio of activities of public agencies, rather than as "command and control" regulations targeted at specific companies or industries. Section III which follows will present such potential activities.

Situation 7: 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.

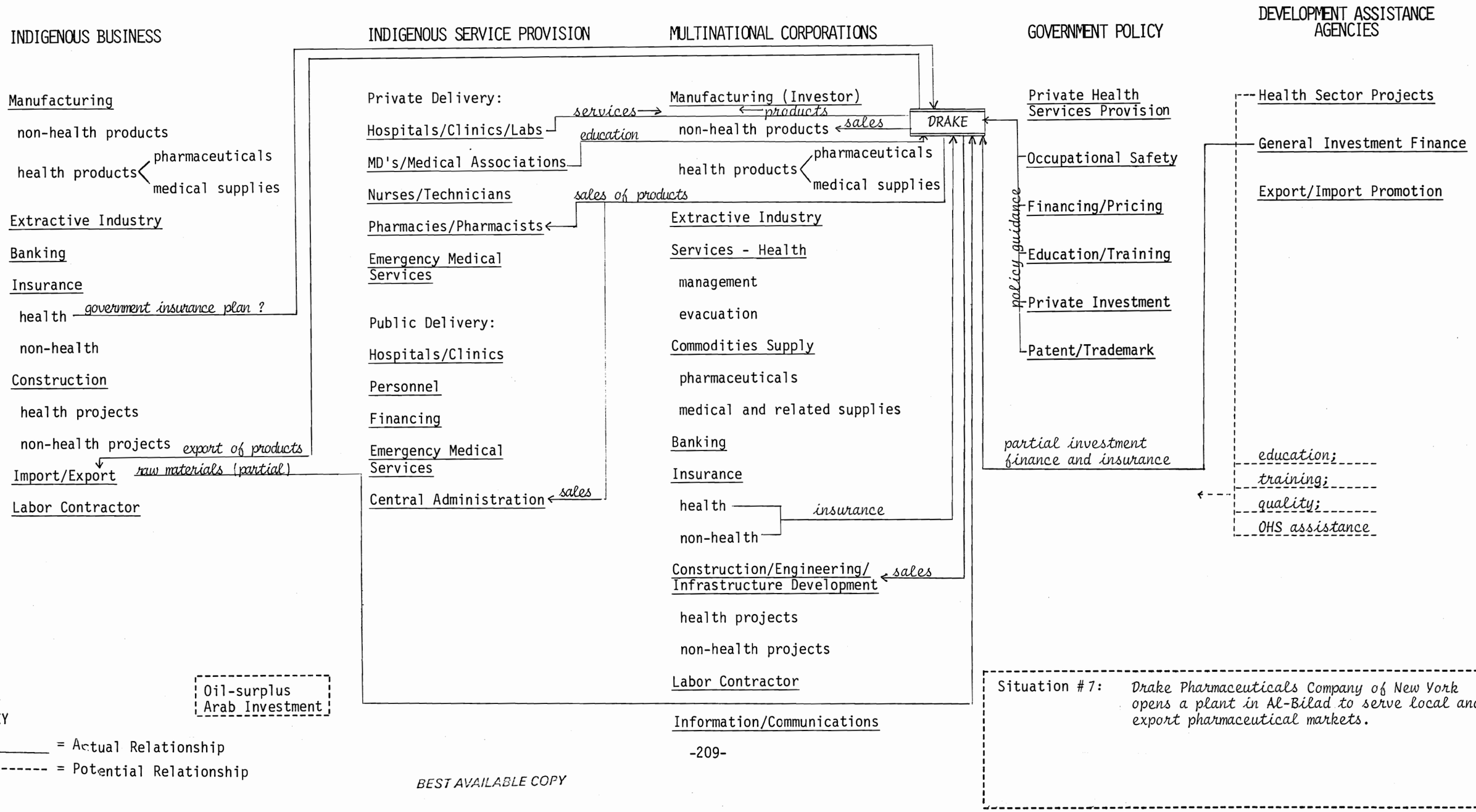
Given the importance of sanitary practices to product quality control, Drake's Al-Bilad management is particularly concerned about worker hygiene. Drake maintains a health and hygiene office at the plant staffed by three public health/sanitation specialists, one of whom is a U.S. citizen and two of whom are nationals of Al-Bilad whose skills were upgraded 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.

Occupational safety and health 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

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET



Situation #7: *Drake Pharmaceuticals Company of New York opens a plant in Al-Bilad to serve local and export pharmaceutical markets.*

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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-upgrading 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.

Situation 8: BILLINGS PETROLEUM CORPORATION

Things are beginning to look up for the Al-Bilad economy. Two years ago, a geological survey indicated possible petroleum and natural gas reserves in the deserts in the country's southern region. Last year, Al-Bilad negotiated an exploration agreement with Billings Drilling and Petroleum Corporation of Laredo, Texas, in which Billings gained exclusive exploration rights in the area plus a guarantee of a limited-term government joint venture for production of any reserves. An old hand in the region's oil business, Billings' President, Billie Ray Billings, is well known for his ability to strike such lucrative bargains.

Billings Petroleum recently made a significant find in the far southern desert and has begun to build up the facilities and personnel needed to exploit the find and develop the pipeline necessary to carry the crude to port terminals. In the process, it has developed a health systems plan for the project area. Since the likely wellheads will be 500 km. from the nearest major town, the company will build a twenty-bed inpatient facility as well as provide all outpatient services to its employees and their families. The health services will be staffed by an expatriate physician and three paramedics, all veterans of the Vietnam War. Billings has also signed a 24-hour contract with an international evacuation company to handle serious disease or accident problems. Non-critical emergencies will be stabilized at the camp facility and flown by helicopter to the capital, to private hospitals with which Billings has negotiated service agreements.

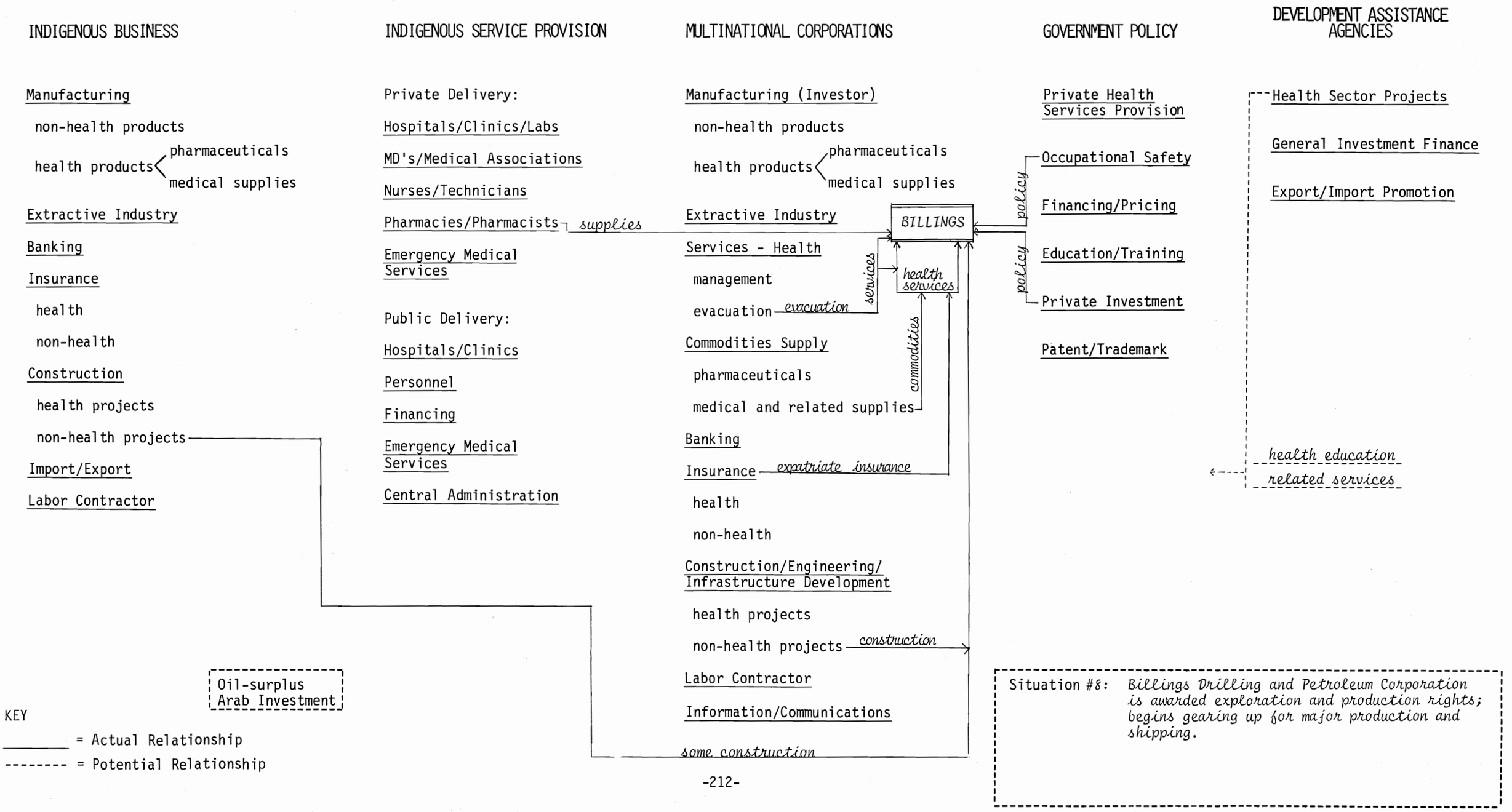
Billings' previous experience in the region and elsewhere in the developing world is that the multi-year effort will attract not only local labor but also their families and other local service entrepreneurs. In addition, the southern province is a prime route of movement for nomadic populations which crisscross the national borders of Al-Bilad and its two southern neighbors. In keeping with its corporate policy, Billings will provide emergency medical care to all of these non-employee groups, as well as conduct regular out-patient clinics, particularly for child health and vaccinations. The company will also allow free community access to its water supply and sanitation systems.

Costs for all these services will be absorbed by the company in the context of its investment. Several previous experiments with co-payment schemes or other forms of employee cost-sharing have not proved successful, given the isolated circumstances of the company's operations and the lack of employee alternatives for care.

In this situation, there are many areas of corporate activity which relate to public and development assistance interests, but there are probably few opportunities for active linkages or incentives.

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET



Possibilities include providing Billings medical staff with health and water-use education materials to use as part of their clinic programs and providing, for example, family planning or food commodities if Billings would add family planning or nutrition education activities to its health programs. However, the project site is so remote that opportunities for supervision or evaluation of these public roles may be few.

Indeed, the company and its long experience in the region is more a resource for development assistance than vice versa. Closer communication between public/development assistance health staffs and the Billings medical staff might assist public projects in other remote areas of the country in management of such problems as emergency care, water supply, and community disease control.

Situation 9: THE AL-BILAD MINISTRY OF HEALTH

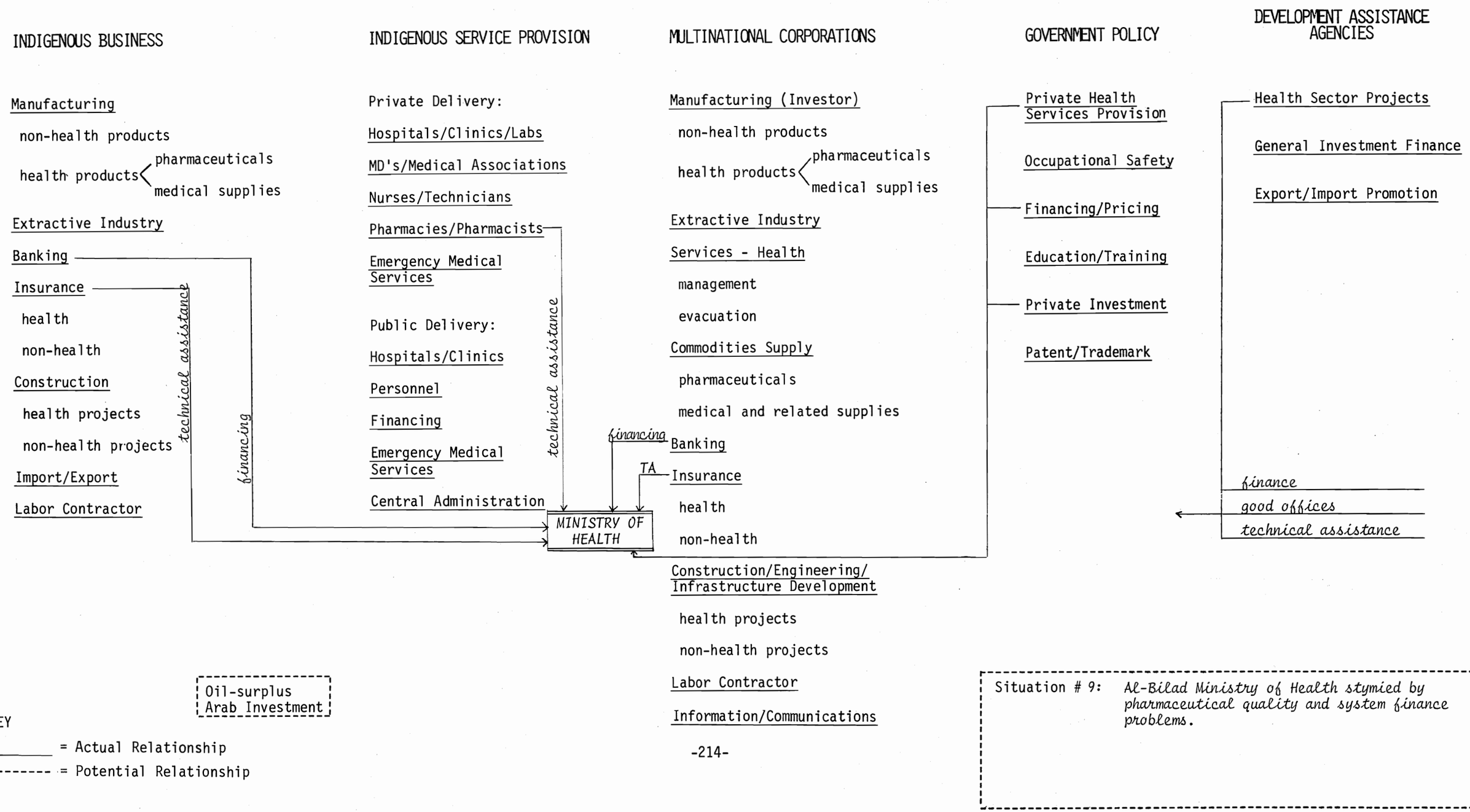
Al-Bilad's publicly-financed health system has worked closely for many years with a range of Western development assistance agencies to improve public health services in the country. Virtually all of this activity has involved only Ministry and agency resources. The public lines of communication are thus well established. The problems of the public health system, however, remain significant, and Al-Bilad's public options are limited. The country's President has three times in the last two years publicly pronounced the right of Al-Bilad's people to health care. Nevertheless, the operating budget of the Ministry of Health has continued to lag behind those of other national sectors. Its investment budget has fared even less well; 70% of the physical plant in the public system is at least 25 years old.

The country's traditional approach to the provision of free service and drugs to all its users is becoming increasingly untenable, both in financial terms and in terms of the absorptive capacity of the health infrastructure. Although there is significant private capital in the country's private medical system, a major privatization turn to solve the public finance dilemma is politically unfeasible, given the President's recent remarks.

The financing situation has recently been joined at the top of the Minister's worry list by an increasing quality problem in the nation's drug supply. Three years ago, in an effort to bring down costs, the Ministry changed its import suppliers from major Western firms to those of smaller Eastern bloc and developing countries. In addition, it expanded the product lines of the two state-owned packaging plants in the country. Recently, however, serious quality problems have arisen in the products from both types of sources. Indeed, several deaths at the country's teaching hospital have been rumored to be attributable to the problem. While no conclusive evidence

PRIVATE - PUBLIC SECTOR INTERRELATIONSHIPS FOR HEALTH CARE SERVICES

ANALYTIC FRAMEWORK DISPLAY SHEET



has been found to support that rumor, public perception is beginning to overwhelm the facts. Moreover, a rash of instances of drug counterfeiting has been discovered in over-the-counter medicines at a half dozen major pharmacies in the capital city. As a result, three regional importers of Al-Bilad-produced drugs have barred all Al-Bilad products from their markets until the quality issues are resolved.

Both the public and private sectors are upset about the situation, both as it involves the local market and as it affects Al-Bilad exports. The financing and recurrent cost implications of a major public quality control system are beyond the Ministry's foreseeable capabilities.

The Minister has called in his prime development assistance contact, a personal friend of long standing as well as a professional colleague, to discuss the Ministry's options in dealing with the two sets of problems. Attuned to the technical resources of a variety of private sector organizations, the agency representative could suggest two approaches. On the financing side, the agency and its Western headquarters could sponsor a technical assistance meeting of experts from major financial and insurance companies to help the Ministry think through its insurance financing options and the managerial prerequisites for their viability. The agency could then assist in the capitalization of broad insurance systems as well as the training, perhaps with the pro bono assistance of relevant local and international companies, of Ministry personnel.

On the quality control side, the agency could suggest that some combination of private and public finance be offered to the private sector to establish a quality control laboratory with standards set by the Ministry. Alternatively, the Government could build, with development assistance help, and lease to the private sector a quality control facility, so that operation and costs were absorbed by the private sector (lessees and private companies), but with close Ministry supervision of work quality.

Preliminary meetings with the pharmaceutical industry, local banks, and/or local branches of major international banks could be scheduled to explore financial and technical options and interests in such a solution to the quality problem. The attraction of the proposal to the banker is the loan, subsequent letters of credit for materials, etc., and contacts in a new area, thereby expanding his competitive position vis-a-vis other banks. Development assistance money could be offered as the catalyst for the process, either to finance the feasibility work or as a partner in the financing. In the former case, the assistance could be structured as a loan, repayable with interest if the deal is made. The development agency could also serve as a bridge for the technical work to be done by providing technical assistance to the feasibility study from the drug regulatory authority in its home country.

If the private sector option comes to fruition, the Al-Bilad Ministry could confer a certificate on drugs passing quality standards at the laboratory, although avoiding giving the laboratory monopoly position by requiring the certificate for all drugs. This would help both the local market and importers of Al-Bilad's products ensure that they receive quality products, and thus rebuild consumer confidence.

SECTION IV.

PROJECT IMPLICATIONS

12. PROJECT OPTIONS FOR DEVELOPMENT ASSISTANCE

"Health needs have become a main component in social and economic development plans in the Middle East, and large investments have been allocated for that purpose. Yet, the diversity of these investments and the rapid growth anticipated will require the technical know-how and entrepreneurial creativity of the private sector. There are joint opportunities available and entrepreneurs welcome the potential for partnerships with public development programs in the spirit of free enterprise."
Ali T. Dajani, Director, Amman Chamber of Industry.

12.A. INTRODUCTION

If all, or even some portion, of this Report is viewed as accurately portraying the existing and potential private roles in the health sector in the Middle East, what can or should be done to ensure that those roles are maximized? If development assistance agencies are the necessary catalysts to realize closer public-private collaboration to resolve health sector structural and service provision barriers, how can those agencies realistically alter their project portfolios to take greater account and advantage of the private sector resources, expertise, and opportunities that already exist? What are the project portfolio options that are, on the one hand, pragmatically possible and, on the other, consistent with the public service mandates of those agencies?

This Report cannot supply all of the answers to those questions. Project solutions to the collaboration dilemma are a function of the specific structures, professional skills, legislative constraints and policy directions of individual agencies. What this chapter can and will contribute, however, is a general framework for the project options all agencies face, and specify within each option the structural/professional/financial prerequisites, advantages and disadvantages public aid agenices recognize if the option area is pursued.

Project identification and development is a long and painstaking process in most development assistance agencies. The project options areas discussed here are not meant in and of themselves to short-circuit that process. As will be seen, however, that issue of lengthy project

approval processes is important and will need to be dealt with by agency management, since it is a major disincentives for private sector relationships. Rather, the options described here are offered as examples of the paths which specific project development might take as aid agencies seek ways to cooperate with and contribute to the maximization of private resources in the health sector.

One caveat is needed. The project area options described here are rarely issues in which the private sector requires assistance. For the most part, private sector health systems work well enough to meet private sector needs. Rather, the options represent areas in which, with development assistance leadership, private resources/networks/expertise could be matched with and therefore expand upon the availability and cost-effectiveness of aid resources in the interests of the former's market concern and the latter's public mandate.

There are four general categories of project options open to aid agency initiatives:

-- Expansion of existing agency project portfolios in those traditional project areas which are inherently supportive of both private services and public needs;

-- Initiation of new project areas which, while innovative, simply represent variations on traditional aid agency project themes;

-- Significant, creative departures from traditional project areas, as adjuncts to, but not replacements for, traditional projects;

-- Significant, creative departures from traditional project approaches which would require, for most agencies, changes in their legislative or public mandates.

12.B. 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" 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 option would need to be largely aid-financed, but could expect varying degrees of private sector technical assistance and in-kind contributions. Examples of these activities and the ways in which they build on existing private and public systems include:

(1) In-service training for private pharmacists to improve their diagnostic skills, since they are often, in fact, the first point of contact between the population and the health care system. Such training would, of course, be in cooperation with private pharmacists' organizations, could use private facilities, could be developed using innovative pharmacist diagnostic training materials already being developed in several multinational pharmaceutical companies, and could, for simplicity's sake, be begun within the geographic confines of an existing primary health care or rural development project of the aid agency.

(2) Financing for physical infrastructure as well as management training funds could be included in existing or planned primary health care projects to establish more efficient national logistics and warehousing systems. Such systems would support both private and public sector providers. Moreover, their operation might be contracted or licensed to the private sector to reduce the operating cost load on public budgets. Design of such project components could make use of the logistics expertise in a variety of private, multinational corporations, either in the form of pro bono technical assistance or the contribution of in-kind materials. The resultant logistics systems would benefit not only public provider health systems, but also private pharmacies, facilities, and providers. By improving the movement of products through the health system, the systems would benefit private suppliers (local and international) of health products as well.

(3) In the normal course of their government relations, development assistance professionals could provide expanded policy advice to national governments on the impact of various policies as barriers to or incentives for private capital and service flows in the health sector. Such an advisory role would include, on request, provision of technical assistance to develop policy options or alternatives for government-private sector relations.

(4) The site of recruitment for health sector positions in national ministries is the medical school, not the business school. Yet, if government personnel are to strike partnerships with their private sector colleagues, they will need basic familiarity with the economic and financial considerations important to businessmen and which structure their decisions. Development aid agencies could provide short-term training funds, perhaps jointly with corporate assistance, to government health sector decision-makers or project managers (as well as to, perhaps, those of the aid agency itself) to gain these basic business skills and knowledge. Training might even take place in the sophisticated centers which exist for this purpose within various corporations. Areas of training focus, with specific reference to their health sector and private partnership relevance, might include trade economics, project finance, business management, and health economics with emphasis on fee-for-service and insurance scheme alternatives. The goals of the training

would be to assist public managers to administer their own health programs in a more cost-effective manner, and to improve communication and understanding between public policy makers and private business/providers on partnership options.

From the 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, nor 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 hinge not on what this option accomplishes, but on what it does not accomplish. The point has been made consistently throughout this Report that the levels of private resources and expertise are significant in the health sector, 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 opportunities of aid agencies and national governments.

12.C. 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 agency's 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. Such new project areas would be subjected to the same agency project review process as are existing projects. As new initiatives, however,

these would involve, from the first review step, the views, expertise, and resources of the private sector partners. Examples of such project areas are fourfold:

(1) A new area of project work might be the creation of a private sector-government partnership to develop and implement sustainable, enforceable, occupational health and safety standards and systems, perhaps with an initial focus on certain types of industries or workers. Aid agency roles would be not only those of training and commodities financing, but, perhaps more importantly, the provision of the agency's good offices to bring the various local actors together on what can often be antagonistic issues. The agency would also represent an arm's length vehicle for channeling specific multinational corporate expertise to both industry and government actors to improve OHS programs.

(2) Recurrent cost financing is a crucial problem in nearly all developing country health systems. Public finance is increasingly unable to meet the needs of broadly available health services. Aid agencies could provide policy advice and support pilot project initiatives for the design, capitalization and operation of private or quasi-private insurance scheme alternatives to public finance. These could be targeted projects, limited to specific categories of health services or groups of service users such as agricultural cooperatives, specific industries, or urban neighborhoods.

A fundamental component of such projects would need to be improvement in the data collection capabilities of the various levels of local government in the project's areas. Reliable actuarial and demographic data is the base upon which viable insurance schemes are built. The lack of such data would need to be overcome, since it is a major disincentive to the broad commercialization of health and life insurance in the Middle East, as well as in other developing regions.

If an arms' length technical assistance mechanism could be established through which the advice could flow, one of the aid agency's primary technical resources to select and design such projects is located in the multinational insurance industry. Although large firms in that industry currently have no significant interest in the health insurance market in the Middle East, they do house very sophisticated expertise in all aspects of health insurance design and provision. Moreover, by focusing on the development of the local industry, aid agencies may contribute to establishing the fundamental industry underpinnings which will ultimately attract large companies to health sector finance in the region, a point that should be lost neither on those companies nor on planners concerned about the region's health finance system over the next 20 years.

(3) Turning internally for a moment, development aid agenices themselves need to expand their own line-staff capability to understand and communicate with private business and providers. "Doing business with business" will require an understanding within aid professionals of business concepts and structures, and among business of development assistance goals and conerns. What is required of development professionals is not so much an academic grasp of business administration as a pragmatic, operational understanding, for each relevant industry or issue, of business structures, resources, constraints, and concerns. To achieve that end, and to provide a forum for business executives to meet and exchange views with their development aid technical counterparts, an internal training project could be organized to provide health, population, and nutrition technical staff with a working project-related knowledge of such areas as:

-- basic business economics;

-- project finance in the private sector;

-- international banking and its health sector role;

-- the insurance industry and the constraints and incentives to its involvement in Third World health sectors;

-- the international pharmaceuticals industry, its diversity, organization, and technical resources;

-- health product quality control concerns and resources in the private sector;

-- the communications/advertising industry and its public consumer education resources;

-- occupational safety and health expertise and industry models;

-- how various companies organize themselves to manage and respond to Third World issues;

-- construction, architecture, and engineering resources in the private sector;

-- the management industry's view of health facility and system design and management.

This training project could be effectively co-financed with private business, if the latter were to provide the facilities and seminar leaders for each subject area. Indeed, offers to co-sponsor such seminars, at corporate expense, have been made to this

project over the last year by executives in a variety of health-relevant industries in this country and in Europe. Thus, while such a project might be independently organized and chaired, it would deeply involve business executives themselves, with obvious advantages for maximizing the operational utility of the materials presented as well as for communicating development aid goals to business itself.

(4) Finding ways for development agencies to work with private business and providers in the health sector also implies finding ways for local governments to work with their own private sectors as well as with multinational business of all types. In contrast to some areas of economic development, the relationship between public and private sectors (international or local) on issues of health, population, and nutrition has not always been an easy one. Indeed, it is more often fraught with hidden or overt confrontation than with cooperation. Clearly, this situation must be altered considerably if the seeds of cooperation are to fall on other than extremely barren ground.

Many developing country public health officials interviewed in the context of this Report have expressed a desire to develop closer private sector linkages, and to manage public-private disputes in a more constructive, creative fashion. As has been noted in Chapter 9 above, national government policies in the Middle East reflect that desire as they begin to develop incentives for expanded private sector roles. Many models of and processes for dispute management and collaborative decision-making between the public and private sectors exist.[1] These processes have emerged from the recent regulatory experience of governments and businesses in the industrialized world. As the desire for maximizing both economic efficiency and social goals expands, these cost-effective processes are beginning to dominate regulatory relationships between the public and private sectors in those regions. The opportunity to learn how to apply them in the health sector in developing country settings, and the access to technical assistance for their implementation could be a crucial element in providing national governments in the Middle East with the tools to work more effectively and optimally with their own private sectors in such areas as:

- -- pharmaceuticals delivery;
- -- health product quality control;
- -- occupational safety and health;
- -- health-service financing and coverage;
- -- worker nutrition;
- -- major projects where the natural or social environment is at risk and thus puts health or nutrition at risk as well.

Development aid agencies could sponsor training for national government officials (and their own agency staffs) in the newly emerging but rapidly growing discipline of dispute resolution. Such training could take advantage of the sophisticated resources being developed in corporations and regulatory agencies in the U.S. and Europe as these groups attempt to break with past confrontational tradition and find more rapid cost-effective means for dispute avoidance and resolution.

The advantages for aid agencies in initiating new project areas such as those illustrating 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 disadvanges to Option 2 are at least two-fold. 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.

12.D. NEW, INNOVATIVE PROJECT DIRECTIONS

Striking out on a new course, public aid agencies could begin to get involved in project activities directed at leveraging private resources in the heart of health system problems, i.e., investment and recurrent finance. Staying within the limits imposed by their own authorizing legislation or bylaws, public development assistance agencies could begin to work with local and international financial institutions to attract greater investment capital to the health sector. Two examples of such projects or aid roles will illustrate this financial broker role. A third will illustrate new project endeavors which would position aid agencies more directly as immediate non-equity investors in health industries.

(1) Building on the Barclays Bank case described in Chapter 6, aid agencies could approach major international or local financial institutions to join with them in capitalizing a health sector equivalent of a Development Bank. This bank could finance two basic kinds of activity.

First, it could offer small loans, with a grace period on payback and long maturity but at near market interest rates, to private health service providers to assist in the startup of individual or group private practices (purchase of equipment, rent, etc.) if those practices were established and remained for a minimum number of years in underserved rural or small urban areas. Beyond established national regulations, fee structures would be left to the economics of supply and demand; overcharging would result in reduced provider income (and thus inability to meet loan payments) since families would not be able to meet excessive fees. Furthermore, competition in the form of greater number of practices located in given areas could be encouraged by, for example, a conscious policy of balanced geographic allocation of loans.

Second, the bank could also provide financing for plant expansion and equipment of private health products industries. If necessary, limits could be placed on the types of drugs and medical supplies to be produced. As in the Barclays case, these loans would only be considered in cases where traditional banking channels were unable to respond to industry needs.

Such a project would not only meet public aid goals of expanding the availability of health services and materials to larger portions of a nation's population, it might also attract new capital to the health sector from other financial institutions and, particularly, from regional aid agencies. Furthermore, by focusing on repayable loans, not grants, the approach would begin to introduce the discipline of market finance into investment decisions in the health sector.

(2) Public aid agencies could also begin to actively seek out private finance alternatives for health sector projects rather than accepting the more easily investigated public aid option. An example of how this might be done, in the area of drug quality control testing, was described in the hypothetical situation 9 in the previous chapter. In such cases, the public aid agency becomes a technical and, if necessary, a financial bridge between, on the one hand, public and private health sector projects and, on the other, private finance. The aid role is to provide project technical design assistance and to finance the early feasibility studies required by the private financial institutions.

(3) Public aid agencies could provide direct capital finance for private and quasi-private plant and equipment in the health services and products industries. Direct financing of, for example, health products plant expansion or modernization could be tied to the production of certain needed medical supplies or pharmaceuticals. This type of project work would be extremely complex. In most instances, this aid role would entail complex negotiations between aid agency and

the national government over such issues as pricing policies and industry subsidies. It would also involve the agency directly in the entire web of production problems from labor availability to quality control. Despite these problems, at least one publicly-mandated aid agency is currently actively examining its industrial finance options in just this area.

The advantages of projects such as those illustrating Option 3 involve both their use of leveraging (using limited public finance to attract multiples of private finance to health sector investments) 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 reassurance. Four additional disadvantages also make Option 3 difficult to implement.

First, these potential projects require staff professional capabilities (project finance, banking, etc.) which are normally at least in short supply and often non-existent 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. Again, for most public agencies, direct monitoring of and at least some control over project implementation is built into the project system.

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 but 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.

12.E. DIRECT INVESTMENT

The fourth option available to the health sector of public development assistance is to begin to take direct investment or equity positions, perhaps together with relevant multinational corporations, in local health product or finance industries. The investment would be focused on those areas or products where development assistance finance would provide the final lift to a project being considered in the private sector or would motivate that private sector interest. This would imply, specifically in the health sector, a development finance role similar to that of the International Finance Corporation affiliate of The World Bank, described in Chapter 10.

For example, when faced with problems of population growth and its economic and maternal/child health impacts, public aid agencies and governments normally respond by developing primary care and maternal/child health programs centered in public clinics and hospitals, and by emphasizing the use of simple oral contraceptives. The products needed to support these programs are imported via the commodities finance programs of the aid agency. While such project activities may address the immediate family planning program needs of the health sector and the economy, they often do not develop within the recipient country the long-term local capability to support and supply those public programs, or to extend them to either private facilities or the general marketplace.

Few local firms in the Middle East produce the very product that those public and private health programs need -- oral contraceptives. So, what has an aid response, focused on near-term needs accomplished? It has indeed assisted in establishing public programs for dissemination of knowledge and products regarding family planning and maternal/child health. That role is essential, especially in

situations of very rapid population growth. Leaving aside the recurrent cost financing question regarding those programs, however, it has not placed those programs at the center of consumer attention, the marketplace. Furthermore, by distributing products which are imported, it has either tied the country to a higher medium-term import bill or resigned itself to medium- or long-term commodities support for the country. This is hardly an advisable solution, given the data in Chapter 3 on economic environments.

An aid agency and government team, recognizing these factors and attuned to the market and production capability of the private sector, has a clear option: invest directly in the expansion of the product line of local production industries and/or encourage multinational corporations with relevant products in the industrialized world to establish operations in the country at issue to manufacture and market the products needed for local family planning programs. The aid agency then can assist the government by (1) determining the likely companies to produce the products (local and MNC); (2) financing the necessary industrial feasibility studies; (3) developing with the corporate partners the marketing and distribution approach; (4) providing direct investment for the project, probably jointly with private financial institutions or the corporation itself; and (5) assisting the national government to develop methods for using the privately produced contraceptives extensively in the national health system, public and private.

The aid agency and government benefit because the needed input to solve the population/health problem becomes more readily available, and is made available in such a way as to minimize administrative or financial drain on the public management sector. The private company(ies) benefits because of product or investment expansion and because public incentives structures minimized their upstream investment design and evaluation costs. The public benefits because a range of contraceptive products are available both in the health system and as consumer products in the marketplace. The economy benefits not only because imports are reduced, but because investment is increased, tax revenues are expanded, employment is created, and a new industry is developed.

It is this type of project thinking which most comprehensively taps the technical and financial resources of the market sector to meet both market and public needs. It is also this type of project thinking which is most difficult to find among health professionals in public aid agencies. The option entails all of the disadvantages of Option 3 above. In addition, it may require, in some countries, alterations in the authorization legislation for the agency itself, a formidable lobbying job in many circumstances.

However, it is this type of integrated project development -- combining the individual strengths of public and market forces to meet public needs -- which best fits the true meaning of "partnership" among the sectors and most optimally will meet many of the long-term health needs in the Middle East.

13. TAKING ADVANTAGE OF THE OPPORTUNITY: A PROGRAM OF ACTION

"The relationship between the socially responsible and innovative enterprise and the government must be a cooperative one.... The responsible enterprise does not...accept the inevitability of an adversary relationship between government, corporation, and working force.... Nothing in the age of organization is as certain as that in the end there will have to be negotiation, conciliation, and compromise.[1]
John Kenneth Galbraith.

13.A. INTRODUCTION

The significant level of private sector activity in the health sectors of the Near East, and the extraordinary potential for development assistance and government agencies to expand and direct this activity, create a wide range of opportunities for leadership on the part of the latter two groups as they seek to create more effective, sustainable health programs. This range of opportunity need not appear overwhelming to the already overburdened development or public health professional. That there are many things that can be done does not imply that they all need to be done at once. The program options which public and development professionals face can instead be grouped into four potential next steps:

- -- No response;
- -- Immediate initiation of the internal project identification/appraisal process of aid agencies to investigate one or more specific project areas for subsequent aid/private sector support;
- -- National seminars or conferences in individual countries targeted at the specific health issues of greatest concern and interest to government agencies, indigenous business, multinational corporations, private health service providers, and development assistance organizations involved in those countries;

-- Development of a regional constituency for the more effective use of public and private resources in meeting the health needs of the region, and for creating national momentum in individual countries to facilitate closer private/public cooperation.

13.B. THE "NO RESPONSE" OPTION

A decision on the part of public or aid agencies to make no private sector additions or alterations to development assistance or public health project portfolios, despite the potential described throughout this Report, is certainly one option. It is also, in the short-term, the easiest option to pursue for it removes the necessary mantle of leadership from the shoulders of development professionals. Such a decision, however, foregoes significant medium- and long-term opportunities both for more effective/sustainable projects and for resource leveraging. Ignoring the existence of and/or potential for private sector health activities effectively reduces the amount of resources, both financial and technical, which could be applied by development assistance to improve standards of health in the Middle East.

13.C. IMMEDIATE DEVELOPMENT OF SPECIFIC PROJECTS

A second option for aid agencies is to move directly to project identification and design, using their own internal project approval process and based on their own program priorities. This option certainly would allow agencies to take advantage of immediate opportunities for private sector linkages in Middle East health systems. However, it risks leaving in the private sector an impression of not being equal, valued partners in the project development process.

Development of partnership projects entails the development of long-term partnership interests in seeing that the project succeeds. That long-term interest is a function not only of a private economic market stake in the project, but also of the interest and commitment of private sector professionals in the technical aspects of the project's design and application. In turn, that professional and personal stake in the success of the project will only occur if representatives from both public agencies and private business are involved in the project idea from the beginning. Resources and technical expertise from both public and private sources must be utilized at the birth of the project idea, not just at the time of its financing. Certainly, creative and effective projects can be developed at aid agencies without the counseling of private business leaders. Yet, if these agencies are serious about using their funds to catalyze an expanded health role for the private sector, then the private sector must be given a serious role in project formulation and must be viewed as a working partner,

both in style and in substance. To develop such roles and long-term commitments, a constituency-building effort may be needed to create, on the part of all actors, an understanding of the responsibility, need, professional justification, and benefits of cooperation. In this innovative approach to development assistance, the process of building a partnership approach may be just as important to the agency as the end-product project itself.

13.D. CREATING NATIONAL CONSTITUENCIES

As noted in several sections of this Report, 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 individual national seminars or conferences is an option for both identifying the key substantive issues between public and private actors involved in an individual country's health sector and catalyzing the various interests of the government, development assistance, and business into a constituency for a partnership solution to those problems.

The goals of such national seminars or conferences would be fivefold:

(1) To begin the process of establishing a local network of private and public sector leaders involved in the health problems and the possible resolution of these problems;

(2) To examine the status of the specific health areas and issues which provide opportunities in the country for closer public/private cooperation and the leveraging of public resources;

(3) To specify and assess the major barriers and incentives to closer cooperation in those areas, from the perspectives of all sectors represented;

(4) To identify and develop, with some degree of detail, specific opportunities for forging closer cooperation in those areas, with particular reference to possible catalyst roles for development assistance agencies;

(5) To develop follow-up procedures for implementing recommendations of the conference.

Sponsorship of the seminars could be retained within the development assistance or government agency, or, perhaps more advisedly, could be shared by a business and a public third party. In the latter approach, no individual group or organization would be in the spotlight to implement the recommendations for action that would be forthcoming from the meeting. Implementation could then also be jointly determined.

Participants would include representatives from the local government, development assistance (regional and international), local business (manufacturers of pharmaceuticals, manufacturers of non-health products, banking, and insurance), private providers, and multinational corporations (including, as relevant, pharmaceutical companies, manufacturers of non-health products, construction, banking, communications, and insurance).

The achievement of the above goals, however, implies a conference which focuses not on speeches but on a serious result-oriented discussion. The agenda, therefore, would need to be highly structured and would require a mix of plenary meetings to set conference ground-rules and review final recommendations for follow-up action, and working groups which divide participants into small discussion/decision groups to grapple pragmatically with various substantive issue areas and to design specific recommendations for resolution of the problems.

13.E. CREATING A REGIONAL PROFILE

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 partnership 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? There exists a wealth of experience on these subjects within multinational corporations, indigenous business, and government agency partners in countries of the region both covered and not covered in this Report.

Moreover, a history of public-private conflict may inhibit immediate, pragmatic dialogue within some countries. If placed within a precedent, region-wide concern with health cooperation, however, such national meetings might become more viable.

Creating a regional forum for discussion and analysis of both the precedents for and the potential of public-private health partnerships would provide the opportunity for representatives from government, multinational and indigenous business, private providers, and development assistance to learn about the track record of prior public-private cooperation; to utilize the expertise of those involved in the partnerships experience to chart a course for development assistance participation in partnership efforts; and to create regional momentum for cooperative problem-solving approaches in the health sectors of the Middle East.

Thus, a regional meeting or conference would have six goals:

(1) To begin the process of personal networking for public and development assistance professionals to identify resources and expertise among their corporate counterparts;

(2) To provide national governments, indigenous business and private service providers from countries in the region with the catalyst and network necessary to begin to seek their own national or corporate cooperative strategies;

(3) To expand both corporate, government, and development assistance knowledge regarding the barriers to and incentives for partnerships, based on the more sophisticated case studies of cooperation in the region and surrounding areas;

(4) To apply that partnership experience to new areas of concern to development assistance professionals working in the health sector and to assess the incentives for and barriers to partnerships in each general area (e.g., occupational safety, health care financing);

(5) To develop, to the extent possible, specific suggestions for project cooperation, to identify the development assistance catalyst role in each, and to assess the private sector resources which might be brought to the partnership;

(6) To publish the proceedings of the conference, including models of successful working partnerships and summary findings of the conference, to be utilized in pursuing follow-up meetings or project recommendations.

To achieve the dual goals of constituency-building and pragmatic opportunity assessment, the conference could be divided into two sections. During the first day, a series of case studies of cooperation could be presented to and examined by the plenary. Presenters would be the business executives and, where possible, the government officials involved in forging and implementing a partnership to address health problems of

concern to both business and public leadership. Each case presentation would address, from both business and government perspectives:

(1) The problem faced;

(2) The incentives/barriers to action;

(3) The process by which a partnership was forged;

(4) The nature of the resulting project;

(5) Evaluation of its effectiveness and the success/failure of the partnership strategy;

(6) Potential for duplication in other areas of the region.

The second period of the meeting could then be organized around working groups which would apply the lessons of partnership-building to specific regional health concerns, such as occupational safety and health, the development of cost-recovery financing schemes, or specific aspects of disease control in remote areas. These groups would develop the framework of problems, incentives, and barriers to cooperation which could then be used as the agenda for subsequent national problem-solving meetings.

13.F. CONCLUSION

All that has been written in this Report can be summarized in three statements:

(1) Maximizing all available resources is crucial in the under-financed 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 promising prospects 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.

COUNTRY DATA SUMMARY

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 registered in Morocco are in private practice. 35% of this group of 900 physicians 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.

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COUNTRY INDEX

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END NOTES

Chapter 1 End Notes

[1]Barend A. de Vries, "Public Policy and the Private Sector," Finance and Development, September 1981, pp. 1-5.

[2]It should be recognized that some who have provided the intellectual underpinnings to the "private initiatives" emphasis in the United States would argue (and have) that virtually all "public" programs can be privatized with more cost-effective and equitable results. That is not the view taken by this Report.

[3]Donald Gordon, "Private Enterprise and Development," Development Digest 20 (January 1982): 117-18.

Chapter 3 End Notes

[1]Barend A. de Vries, "Public Policy and the Private Sector," Economic Development and the Private Sector (Washington: The World Bank, September 1981), pp. 2 and 5.

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International subcontracting: a principal based in a developed country places orders with a sub-contractor in a developing country to produce components or assemble finished products with inputs provided by the principal and with finished products sold by the principal.

Licensing Agreement: licensor provides the licensee with access to a particular technology in return for value -- an initial lump-sum fee, a percentage of sales, royalties, share of equity or goods produced.

Joint Venture: sharing of assets, risk and profits, and participation in the ownership of a particular enterprise or investment project by more than one firm or economic group.

Trilateral Cooperation: at least three firms or organizations, one or more domiciled in a centrally-planned economy of Eastern Europe, at least one in the OECD, and one or more in the South join to carry out common activities in the host developing country.

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NOTE ON METHODOLOGY

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GOALS

The Project upon which this Report is based was initiated in September of 1982. Its goals were three-fold:

(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 begin to identify a private sector constituency for health issues in the Middle East, and the private foci of resources and expertise to which development assistance professionals might turn in the future for further development of private health partnerships; and to create within that private constituency a greater knowledge and appreciation of, and enthusiasm for, the policies and priorities of development assistance as regards private sector linkages.

METHODOLOGY

At the outset, the data collection aspects of the Project faced a nearly total lack (at least within the development assistance community) of baseline information on private sector roles in health. With a few notable exceptions, the resources, expertise, level of activity, and perceptions of relevant multinational industries, indigenous businesses, and private service providers were unknown. Moreover, little computed information was available regarding local national government policies as they affected, discouraged, or even encouraged private roles, or regarding the similar policies of the major development assistance actors.

Complicating the matter, it soon became clear that an approach which emphasized data regarding individual private or public sector actors was insufficient because the numerous actors in the private sector -- indigenous business, delivery, and multinational corporate -- were highly interrelated. For example, the delivery of health care in a local private hospital might involve U.S.-syndicated financing of partial OPEC-based private investment, with U.S. architects, Korean construction firms, French insurance schemes, British facilities standards, and cost-recovery methods developed by the U.S. health management industry. An integrated view of the existing private sector process was thus necessary if development assistance agencies are to (a) determine the appropriateness of a private sector partnership in existing health delivery systems, and (b) identify their own specific role in such a partnership.

Thus, the Project faced two methodology problems: first, how to identify and collect the baseline private sector data; and, second, how to trace and express, in ways useful to publicly-mandated agencies, they dynamics of the interrelationships within that private sector.

Regarding the first, the following activities were undertaken:

(1) A full literature search was carried out, with an emphasis on business documents not normally accessed by development assistance health professionals;

(2) Field work regarding indigenous business and service delivery in each of the subject countries was carried out by a senior consultant with former experience as a medical director of private extractive industries in Africa;

(3) Local researchers in each country were contracted to pursue detailed business, service delivery, and government policy data collection. CPR provided detailed terms of reference; the senior consultant provided monitoring and quality control;

(4) With assistance from the commercial offices of all the major developed countries, a complete list of major multinational corporations (MNC) and investors (U.S., European, and Japanese) in the subject countries was developed. A letter-survey was then conducted to identify those with health product or services activities in the region;

(5) Personal or telephone interviews were conducted to gather MNC background and case study information regarding the roles of various companies and industries in health services in the region;

(6) Letter-survey and follow-up interviews were conducted with all major development assistance agencies involved in the region to identify current private sector policies and projects regarding health services.

Regarding the process of interaction among private sector actors on health issues, a four-step methodology was employed:

(1) Based on case study research and interviews, a schematic was developed arraying the full range of public and private actors involved in health care products and service provision in the Middle East.

(2) Hypothetical situations were then developed, based on actual cases and general interview materials, illustrating the interrelationships among these actors. These interrelationships were then traced on the schematic, with specific indication of (a) the context of the relationship and (b) the status (actual or potential) of the relationship.

(3) These hypothetical cases were then submitted to a group of multinational corporate executives who had previously volunteered to review and amend the cases and the process analysis on the basis of their first-hand field experience.

(4) The process analysis was revised accordingly.

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