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**Interregional Meeting**

**on**

**THE PUBLIC/PRIVATE MIX  
IN NATIONAL HEALTH SYSTEMS  
AND THE ROLE OF  
MINISTRIES OF HEALTH**

**Report**

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**Hacienda Cocoyoc, State of Morelos  
Mexico  
22-26 July 1991**

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Division of Strengthening of Health Services  
World Health Organization, Geneva

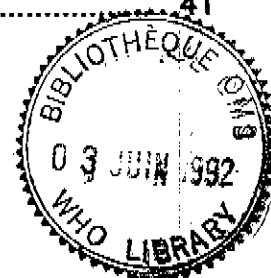
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## EXECUTIVE SUMMARY

The meeting on "The Public/Private Mix in National Health Systems and the Role of Ministries of Health" brought together Ministers of Health and senior decision-makers from 12 countries. The purpose of the meeting was to share countries' experiences in managing change in the public/private mix, and to review the role of ministries in harmonizing private sector activities with national health system objectives.

The meeting took place against a background of change. Participants emphasized changing epidemiological patterns, and an evolving political context which stresses improved government accountability and the role of the market in the allocation of resources and production of goods. Most important, however, were the economic difficulties in many countries and the subsequent resource shortage in the public health care sector. These factors had encouraged ministries to reassess the public/private mix for health.

In reviewing country experiences a distinction was drawn between the financing and the provision of health care. Any combination of public or private financing or provision is possible. The private sector was already involved, particularly in the provision of care, to a considerable extent. Countries had pursued a variety of policies to promote the private sector or increase efficiency and quality in the private sector. Often countries' experiences with these policies was too limited to draw firm conclusions about their success. But it was possible to make some tentative assessments in certain areas. For example, many countries had contracted out non-clinical services such as laundry, catering, cleaning, security and maintenance. Where the private sector had considerable capacity in this area, the policy had worked well. Even if services were slightly more expensive, they tended to be delivered more effectively. However, where investment costs were high and there were few private sector firms with the capacity to deliver the service, the policy of contracting out had proved problematic.

The existence of an effective regulatory capacity was felt to be essential to the success of any policies that encourage private sector participation. The background paper indicated that the main dimensions of regulation were the control of prices, quantity and quality. In addition, participants suggested that there were four main agents involved in the regulatory process: the government, insurance or financing agencies, professional associations, and consumers. Each of these groups had its own particular role to play in regulation. It was observed that in the past rigid legislation on what the private sector could and could not do had proved unsuccessful. Increasingly, countries were creating incentives, as well as disincentives, to encourage appropriate behaviour.

Although the private sector may bring additional resources and scarce skills into the health sector it was recognized that there was also scope for conflict

between public and private sectors. In particular, there was likely to be competition over resources such as manpower; and the narrower objectives of the private sector may have adverse effects on equity. Hence, the meeting concluded that policies to promote the private sector were only likely to be successful when they were implemented in the context of a strong government sector.

It was felt inappropriate to recommend specific approaches to managing the public/private mix given the complex nature of public/private interactions in health, and the variety of countries' circumstances. However, the need for more information and research was recognized and the involvement of private sector representatives in future discussions and policy-making was recommended. It was suggested that WHO may play an important role in helping countries to document and share their experiences and in disseminating research findings.

## 1. INTRODUCTION

Soon after the International Conference on Primary Health Care in Alma-Ata it was realized that the implementation of primary health care was often hampered by organizational constraints in the national health system. Ministries of health were frequently ill-equipped for the task ahead. To achieve the goals of Health For All, there was a need to reconsider the form of the health care system and perhaps to restructure the ministry of health.

WHO, in collaboration with the Danish International Development Agency (DANIDA), agreed to support a programme ("Strengthening Ministries of Health for Primary Health Care") to facilitate this process of change. The Programme supports several activities designed to improve the structure and functioning of ministries of health for implementation of health strategies. The meeting on the Public/Private Mix in National Health Systems was one component of the interregional and global activities of the Programme.

A WHO Expert Committee<sup>1</sup> in 1988 clarified the functions of health systems and ministries of health. It also identified major areas of weakness and recommended strategies for structuring ministries of health. More recently, a need was identified to develop some of the ideas discussed by the Expert Committee and, in particular, to consider changes in the respective roles of government, private for-profit and private not-for-profit agencies. In recent years, sociopolitical changes in many countries have affected the political orientation of national health and social service systems. An emphasis on liberalization, decentralization and privatization has become common. A wide range of policy options now exists, for countries at all levels of development, in the delivery and financing of health care.

In the light of these changes, the Interregional Meeting was held by WHO on the Public/Private Mix in National Health Systems and the Role of Ministries of Health at the Hacienda Cocoyoc, State of Morelos, Mexico, from 22 to 26 July 1991. The meeting brought together Ministers of Health, senior health officials and decision-makers from 11 countries from different regions (Nigeria, Tanzania, Zimbabwe, Mozambique, Chile, Mexico, Iran, Hungary, Indonesia, Sri Lanka, Malaysia; a full list of participants is attached as Annex A).

The participants were welcomed by Dr Carmen E. Galvan, Secretary of Health and Social Welfare, State of Morelos, on behalf of the Governor of Morelos. Dr Carlyle Guerra de Macedo, Regional Director PAHO/AMRO then gave a short

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<sup>1</sup> World Health Organization. Strengthening Ministries of Health for Primary Health Care, Report of a WHO Expert Committee, WHO Technical Report Series No. 766, 1988.

address on behalf of the Director-General of WHO. Dr de Macedo emphasized that WHO is concerned with promoting the Health For All goal, and not any particular structure or financing approach. He pointed to the need for creativity in combining public and private mechanisms for the delivery of health care, under the overall guidance of ministries of health. Dr Jesus Kumate, Secretary of Health of the United States of Mexico opened the meeting.

The objectives of the meeting were:

- (a) to share country experiences of the assessment of the organization and functions of ministries of health, focusing on the public/private mix;
- (b) to review and make comparative analyses of countries' experiences and approaches to changing the public/private mix;
- (c) to identify the respective roles of government, private for-profit and private not-for-profit sectors, organizational issues and areas for appropriate action;
- (d) to enumerate the essential functions of ministries of health in managing the public/private mix.

The programme of work for the meeting is contained in Annex B. This report provides a brief review of the background paper discussed at the meeting and then considers the experiences of participating countries in the light of this framework. Finally, some general themes emerging from the meeting are discussed and future needs identified by the participants are presented.

## 2. ECONOMIC PRINCIPLES AND POLITICAL RESPONSIBILITIES

The background document neither condemns the role of the private sector nor suggests that privatization is an appropriate solution to all problems. The paper's objectives were to explore the arguments, and the flaws in the arguments, about the role of the private sector in health care provision and financing, and to investigate countries' actual experiences. As section 2.5 shows, participants were skeptical about the ability of the private sector to promote national health system goals. In particular, private sector expansion in countries where there is a weak government health system and limited government capacity in planning, regulation and information, could be highly damaging.

Section 2.1 defines the terms used in this document. The arguments for the supposed efficiency of the private for-profit sector are then presented and examined. Policies to change the public/private mix and regulate the activities of the private health care sector are discussed. Finally, section 2.5 summarizes participants' discussion of the role of government *vis-à-vis* that of the private sector. The need for a strong public sector is stressed.

### 2.1 Definition of terms

The term "private sector" includes all those organizations and individuals working outside the direct control of the state, that is both for-profit private companies and individuals, and not-for-profit private organizations. The private sector, therefore, includes individuals and organizations with very different motivations, who cannot be treated as a homogenous group. In particular, there are likely to be considerable differences between for-profit and not-for-profit organizations. Economic arguments concerning the role of the private sector and the market are generally concerned solely with for-profit organizations. The category of not-for-profit organizations is diverse, including international organizations, national voluntary associations and community self-help groups.

The meeting was primarily concerned with the public/private mix in the health care system. There is little discussion in this paper of the health-related sectors such as water supply and sanitation, although it is recognized that these play a critical role in the achievement of Health For All. Moreover, the role of the private sector in the health care industry, such as in the manufacture and supply of pharmaceuticals and equipment, is not addressed.

It is important to distinguish between the financing and provision of services (see Table 1). Services may be publicly financed and publicly provided (for example, the national health services in many countries including Nigeria, Zimbabwe, Spain and Sri Lanka), or privately financed and provided (for example, private users of private services). However, private finance may coexist with public provision (e.g., with user fees for government services) or public finance with private provision (e.g., with government contracts for use of specific private sector

services). The terms "private sector" and "privatization" can apply to either financing or provision of health-related activities.

**Table 1**  
**A conceptual approach to the public/private mix**

		PROVISION	
		PUBLIC	PRIVATE*
F I N A N C I N G	PUBLIC	Government funding and provision, free at point of use: NHS services.	Services contracted to private providers.
	PRIVATE	Supplementary direct user charges. Private beds in public hospitals.	Private health care funded by private insurance. Health maintenance organizations.

\* See definition above.

## 2.2 The efficiency of the private for-profit sector

There is a widespread belief in the private for-profit market as an efficient means of organizing production and consumption. A for-profit market, given certain conditions, can be shown to achieve what is called Pareto-efficiency, that is a point where no one can be made better off without making someone else worse off. A crucial issue is whether the concept of Pareto-efficiency captures the goals of the health system, and whether the conditions necessary for efficiency are met in the health sector. The meeting agreed that three factors are particularly important in the context of the health sector in countries at all levels of development.

**Ignorance:** The efficiency of the private for-profit market depends on the existence of informed consumers: that is, consumers who are able to choose what health care they want and to judge its quality. These conditions may not be met in the health sector since consumers are in a poor position to judge what health care they require or its quality, and doctors or other health workers may have their own motivations which influence their decisions on what services to provide. For example, a doctor's income may depend directly on the number of services offered. If this is the case, then supply is no longer independent of demand. Free market proponents would argue that the solution is consumer education. However, even with a relatively well-informed population, consumers may not be able to make good judgements about the quality of the care they receive. Thus, recent health

care reforms in the United Kingdom have chosen to place the role of purchaser on the health authorities rather than the consumers, precisely because of this concern.

**Uncertainty:** The need for health care is uncertain. Markets in insurance can often protect individuals against uncertainty. However, private health insurance will not cover people whose probability of making a claim is high (for example, the chronically ill and elderly). It will, therefore, protect only a section of a population. Moreover, because health insurance lowers the price of health care at the point of use, inefficiently high levels of utilization may result (the problem known as moral hazard).

**Equity:** In a private market, access depends on ability to pay, either in direct payments or in insurance premiums. Obviously, without a shift of purchasing power, the poor will not have access to more than very basic private services. However, it has been argued that expansion of the private sector may be equitable if it permits the ministry of health to shift its resources to the most needy. Yet, it needs to be asked whether the ministry of health is able to implement this policy, and whether it may lead to the development of a "two tier" system of medical care - an expensive and high-quality service for the rich and a poorer service for others that is starved of resources. Moreover, Pareto-efficiency is not concerned with distributional issues: it takes as given the existing distribution of income and, thus, of purchasing power. Participants argued that societies are concerned that their members should have access to health care without regard to income status. Public finance and possibly provision can be a socially efficient way of embodying these preferences.

The failure to meet the conditions for efficiency of the private for-profit market does not necessarily mean that governments should provide all health care. Some of the problems discussed above are relevant also to the public sector. But, it is important to recognize that the private for-profit health care sector is not without its problems, even in theoretical terms. Moreover, a private market can operate efficiently only if it works within the environment of a well-functioning market system, which provides price signals that accurately reflect the social and financial costs of production. This environment is poorly developed in many countries.

The background paper for the meeting reviewed the empirical evidence on the efficiency of the private sector. Because of the limited amount of published material, it was not possible to identify clear general conclusions. In discussion, the meeting agreed that it is not apparent that the private for-profit sector will always offer services more efficiently than the public sector. The profit-making motive may lead to increased efficiency and greater courtesy and friendliness to the consumer. At the other extreme, it may induce over-supply of services and harmful cost-cutting.

Economic theory is not able to give a clear-cut answer to the appropriate mix between public and private sectors. This must be decided on a case-by-case

basis. In particular, factors such as the characteristics of the current health system and existing socioeconomic conditions must be taken into account, as these determine the feasibility of potential changes in the mix. Competitiveness may be more important than ownership in stimulating efficiency. Private ownership by no means guarantees competitiveness and it may be possible to stimulate competitive conditions within the public sector, thus improving its efficiency, rather than shifting responsibilities towards the private for-profit sector with its known problems.

The meeting emphasized that the private not-for-profit health sector, for example through the activities of many religious organizations, was an important and useful part of the private sector, with a different set of behavioural determinants than the for-profit sector. Government policy towards the not-for-profit private sector may need to differ substantially from its regulatory concerns with for-profit practice.

### **2.3 Privatization policies**

A number of countries are in the process of redefining the responsibilities of the public and private sectors through the adoption of "privatization" policies. Privatization of health services entails the use of government policies to generate or accelerate a shift to private sector provision and financing. Table 2 provides examples of policies that countries may adopt to change the public/private balance of either financing or provision. For example, private finance may be increased by raising user fees in public facilities, or encouraging private health insurance for those who can afford it. The role of the private sector in provision may be increased by contracting with the private sector to provide certain services in public hospitals (e.g., cleaning and catering), or offering those with social insurance the option of using private providers. The meeting agreed that such policies must be evaluated with regard to criteria such as equity, efficiency, cost containment, and cost of implementation.

A number of industrialized countries are attempting to incorporate the better aspects of market systems into their national health system in order to revitalize the public sector. Such reforms depend upon promoting some form of competition between health care providers so that there is a greater incentive for them to act efficiently or be more responsive to consumer preferences. A number of possible institutional arrangements exist including an internal market model (as adopted in the United Kingdom), where health authorities contract with both public and private providers for clinical services, or the public competition model (Sweden) where government funding follows consumers. The relevance of these reforms to the concerns of participating countries was a theme which was developed during the meeting.

**Table 2**  
**Table of policies to change the public/private mix**

FINANCE	PROVISION
<p><b>a. Promote supplementary private health insurance:</b> encourage better off people to take out extra private insurance in addition to coverage by public system.</p>	<p><b>h. Contracting out:</b> government retains responsibility for the service and continues to finance it but provision is undertaken privately. Clinical, non-clinical and management services could be contracted out.</p>
<p><b>b. Promote voluntary health insurance:</b> encourage population to take up health insurance, either publicly or privately.</p>	<p><b>i. Shift responsibilities to private sector:</b> certain services such as provision of drugs could be terminated or reduced. NGOs, mission sector could be encouraged to play a greater role.</p>
<p><b>c. Supplementary user charges:</b> increasing the level of non-tax financing of public health services through user fees.</p>	<p><b>j. Legislating for compulsory health insurance:</b> a statute ruling that all firms with a minimum number of employees should provide them with health insurance. This is likely to encourage use of private providers.</p>
<p><b>d. Financial arrangements to reduce risk of private insurance companies:</b> offering reinsurance or stop loss provisions to new private health insurance companies to reduce risk and encourage the establishment of such firms.</p>	<p><b>k. Enable choice of provider:</b> through, for example, provision of health care vouchers or reimbursement of private providers for certain sorts of care.</p>
<p><b>e. Tax relief:</b> provision of tax relief to all those who opt for private health insurance.</p>	<p><b>l. Increase competitiveness of public <u>vis-à-vis</u> private:</b> raise fees and quality in government sector to make public and private services compete on an equal basis.</p>
<p><b>f. Private provision in public facilities:</b> such as provision of pay beds or special clinics outside of working hours.</p>	<p><b>m. Legalizing private practice:</b> repeal of any legislation prohibiting private practice.</p>
<p><b>g. Opting-out:</b> permitting firms to opt out of compulsory social insurance if they provide a satisfactory alternative insurance scheme.</p>	<p><b>n. Support to private practitioners:</b> encourage practice of private practitioners through training courses, supply of essential drugs, etc.</p>

## **2.4 Regulation**

Regulation is considered here in a section of its own because of its importance in influencing the private sector to behave in the interests of national health goals.

Regulation may take the form of:

- controlling prices: for example, the fees of private doctors may be agreed nationally. This may be important in preventing excessive payments by those vulnerable to exploitation and in limiting the profits (and, hence, the attractiveness to health personnel) of the private sector. However, although fixing fees may have some attractions, it may be difficult to agree and implement and may distort competition, leading to inefficiency;
- controlling quantity and distribution: for example, controlling location to promote access to underserved areas; requiring payment mechanisms that discourage over-supply (e.g., capitation systems for paying the private health sector to treat insured patients); controlling the investment decisions of the private sector (e.g., construction of facilities and purchase of equipment);
- controlling quality: for example, strengthened licensing and inspection of personnel and facilities. Quality control is difficult and professional associations are often given monitoring responsibilities.

All of these may include controlling the allocation of money for health care. The ability to channel funding provides the opportunity to offer incentives, to implement priorities, and is often a more effective means of regulation than legal controls.

The background paper reviewed the sparse information on regulatory practices and concluded that this is an area which has received inadequate emphasis. Attempts at privatization are likely to encounter serious difficulties unless consideration has also been given to the development of appropriate incentive structures, ways to promote competitiveness, and ensure satisfactory quality in the private sector. It is considerably harder to regain control over an unrestricted private sector than it is to introduce controls as the scope for private providers and financing agencies is widened.

## **2.5 The functions of government**

Given current concerns over the relative roles of the public and private sectors and the problems that ministries of health are facing, how should governments respond? What should be the roles and responsibilities of the

ministry of health? Participants agreed that, whatever the proportions of public and private involvement in the financing and provision of health services, the public sector has special responsibilities.

Overall health policy, medium-term strategy, and short-term management of the public/private mix is at the initiative of the ministry of health. Strong information systems are necessary in order to generate the information upon which policy is built. In addition, the economic and legal authority of ministries of health often needs to be strengthened in order for them to coordinate and regulate the private sector.

The definition and implementation of national policies for health, as opposed to medical care, requires a perspective which embraces many aspects of life-style and environment, and several branches of government. The private for-profit sector concentrates on curative care. Therefore, the ministry of health must ensure that public health, preventive and promotive activities are not neglected. Private enterprises outside the health care sector may be able to contribute to these activities.

If a significant gap in quality of care between public and private sectors is allowed to develop then this may encourage the rapid development of the private sector and leave those who are unable to afford private sector charges without access to adequate health care. It was agreed that an appropriate public/private mix can be achieved only in the context of a strong public sector. Increasing the efficiency and quality of the public sector is thus vital.

Changes in public/private responsibilities, therefore, require a strengthened and expanded role for government, even if the ministry of health share of total health service provision is reduced. Because of the diversity of the private sector, ministries of health need to think separately about their relationships with the private for-profit sector and the private not-for profit sector. In the case of the former, regulation including quantity and quality controls are likely to be important. In the case of the latter, coordination and joint planning are likely to be more appropriate emphases.

### 3. COUNTRY EXPERIENCES

#### 3.1 The public/private mix in participating countries

In describing the public/private mix prevailing in their country, many participants emphasized the recent deterioration in the economy which has influenced the pattern of public and private organizations. For example, in Mexico, the severe economic crisis not only reduced the resources available to the health sector but also provoked additional health care demands. The 1987 Ministry of Health budget represented in real terms just 53% of the 1981 budget. Health care services in Nigeria declined during the 1980s due to a combination of factors, including a reduced government allocation, rapid inflation reducing the purchasing power of the national currency and, ironically, privatization in other sectors such as electricity, telecommunications and water, which imposed higher costs upon the Ministry of Health. Other countries reported similar experiences. The effect of this economic crisis was to increase the resource gap; it became increasingly impossible to meet people's health care needs with the resources available to government.

In relation to **financing of services**, a number of countries have promoted private sources of finance to help meet this gap. Although most countries maintain that health is a government responsibility and should be provided free to those who cannot afford it, many have some form of user fee in place for government-provided services. There are generally exemptions for the poor. In addition, there are considerable out-of-pocket payments for private health care. Private health insurance tends to be far less common. Even in Malaysia, one of the richer countries present, private health insurance amounts to less than 3% of out-of-pocket payments for private health care (1983 data). A participant from Indonesia commented that for-profit private insurance was very slow to develop as people frequently did not feel at risk of incurring health care charges so high that they could not find some way to meet them. Nonetheless, some countries (Nigeria and Sri Lanka) have chosen to promote voluntary health insurance rather than legislate for compulsory national health insurance.

One country which has developed substantial private health insurance is Chile, where approximately 25% of the population have private health insurance, mainly through the State-initiated scheme, and through employer-based schemes. Private insurance schemes account for 44% of total health expenditure in Chile. Members of different socioeconomic groups tend to belong to different insurance schemes. Those belonging to the private insurance scheme have, on average, salaries over three times the minimum legal wage. Those covered by the standard government scheme who elect for top-up insurance have incomes one to two times the minimum legal wage. Zimbabwe also has considerable private insurance. Although the 27 medical aid societies cover only about 5.5% of the population they account for nearly 25% of total health expenditure.

Mexico, Chile, Hungary and Malaysia all operate some form of social security scheme covering health care services. After some debate it was concluded that social security should be considered part of the public, not the private, sector. Even if government makes only a small financial contribution to the scheme, it endows the social security agency with the power to tax, which is one of the defining characteristics of government.

In Hungary, a social security system has been in place for a number of years. However, as everyone has access to the same services regardless of whether or not they pay insurance premiums, it was not felt to be a proper insurance scheme. Moreover, although doctors are officially allowed to pursue private practice, the scope for this has been severely circumscribed by government. Thus, doctors extract "gratitude payments" from their public sector clients. Despite the fact that care is supposed to be free at point of service, considerable fees are often paid.

In relation to the provision of services, there is a surprising degree of private sector activity, as Table 3 indicates.

**Table 3**  
**Proportions of health sector expenditure**  
**by public and private sectors**

COUNTRY	PUBLIC	PRIVATE
Malaysia	77%	23%
Chile	56%	44%
Sri Lanka	53%	47%
Iran	63%	37%

NOTES: Dates of country data: Malaysia 1983, Chile 1990, Sri Lanka 1987, Iran 1991 estimates.

Unfortunately, the figures for Malaysia and Chile do not include out-of-pocket payments, due to difficulties in estimation. The significance of private provision is, therefore, likely to be considerably underestimated in these two countries. Percentages given for Sri Lanka include both modern and ayurvedic medicine but ayurvedic accounts for a very small proportion of total expenditure (less than 10%). Sri Lanka has managed to maintain and even increase government funding of health care; the government health budget more than doubled in real terms between 1978 and 1987. However, in the same period expenditure on the private health care sector increased nearly threefold. Although other countries did not

have data on the size of the private sector over time, many indicated that it has grown rapidly during recent years.

The activities engaged in by the private sector and the structure of the private sector vary significantly. On the whole, private provision is most widespread for primary care services. Several countries (Sri Lanka, Zimbabwe, Iran) allow public sector doctors to run their own private clinics after hours. This makes up a considerable proportion of private provision. Despite the fact that private health expenditure amounts to over 40% of the total in some countries, there were no countries where the private sector bed capacity reached one-third (Table 4). The significant investment costs associated with hospital care probably help to explain this. Data on bed capacity is frequently not available: of the countries omitted from Table 4, Hungary has virtually no private sector beds, and Mozambique and Tanzania have no private for-profit beds.

**Table 4**  
**Proportion of beds in public and private sectors**

COUNTRY	PUBLIC (No.)	PUBLIC (%)	PRIVATE (No.)	PRIVATE (%)
Chile	32 818	74	11 500	26
Malaysia	34 221	88	4 618	12
Mexico	59 000	78	17 000	22
Iran	70 000	83	14 000	17
Nigeria	72 265	69	32 467	31

NOTES: Public includes beds belonging to social security institutions. Private includes beds owned by NGOs.

Dates of country data: Chile 1990, Malaysia 1990, Mexico 1988, Iran 1991, Nigeria 1989.

Many participants observed that the private sector was more active in curative than in preventive care. It was stated that in Malaysia:

"The private sector concentrates on hospital care and treatment of simple ailments on an ambulatory basis, with little participation in less lucrative preventive care which is undertaken by the public sector."

Although most countries disliked this division of responsibilities, some seem to have accepted it as an inevitable feature of the private sector, and acted accordingly. For example, the explicit focus of insurance schemes in Chile is curative care whilst government remains responsible for preventive care.

Often the private sector has strengths in particular areas. In Mexico, it was observed that although the private sector accounts for only 2% of general consultations, it provides 15% of gynaecological and obstetric consultations. A concentration of private sector activity in these specialties is common elsewhere.

For-profit and not-for-profit elements in the private sector were distinguished in section 2. Mission facilities play an important role in most sub-Saharan African nations, even in those which otherwise have limited private sector activity, such as Tanzania. Mission facilities are often supported by government subsidies. A government subsidy of 7500 Tanzanian shillings per bed is provided to all eligible mission and NGO facilities in Tanzania. In Zimbabwe, it was estimated that total government subsidy to mission facilities amounted to Z\$ 35 million in 1990/1991. In return, the missions provide 35% of all institutional beds in the country and nearly 70% of beds in rural areas. The missions also play an active role in the training of health personnel, particularly nursing staff, and in the promotion of PHC and outreach services at the district level. In Nigeria, it was observed that although missions still receive subsidies both from government and abroad, those from overseas have declined in real terms and missions are increasingly dependent upon user fees. In other countries, the distinction between for-profit and not-for-profit seems not so clear cut. In Indonesia, some not-for-profit organizations have the same motivation as for-profits but plough accumulated revenues back into expensive technology for the hospital. This complicates Indonesia's policy of trying to limit for-profit health care.

NGOs often play an important role in specialized health care services. In Zimbabwe, for example, NGOs are active in the provision of services for the elderly (see Table 5). Sri Lanka's NGO providers, such as the Red Cross and the Sri Lanka National Association for the Prevention of Tuberculosis, are also active in specific areas.

Participants suggested that the bulk of the patients in the for-profit private sector are middle or upper class and relatively wealthy. However, it was also agreed that, on occasions, poor people would seek care from the private sector.

This relatively brief description of the public/private mix in participating countries does not adequately capture the complex relationships between public and private sectors which countries often described. As Table 1 indicated, any combination of public or private finance or provision is possible. Participants identified many different combinations of mix in their own countries. Table 5 shows the public/private mix in the provision and financing of health care in Zimbabwe. This table begins to capture some of the complexities. The complicated interrelationship between public and private sectors is explored further in section 3.2.

**Table 5\***  
**The public/private mix in the provision and financing of health care in Zimbabwe**

	PUBLIC PROVISION	PRIVATE PROVISION
PUBLIC FINANCING	<p>1. <b>Free government care:</b> all who present at a public institution have a right to appropriate, available treatment. Charges are waived for:</p> <ul style="list-style-type: none"> <li>* the poor (in receipt of less than US\$45 per month).</li> <li>* armed forces and police</li> <li>* health personnel</li> </ul>	<p>1. <b>Private provision for government responsibility patients:</b> a mine hospital treats government patients and bills MoH actual costs of care.</p> <p>2. <b>Contracting out:</b> instrument and electronic maintenance, laundry services and certain drug supplies contracted out. All contracted services are at least 60% more costly (487% in the case of laundry), but services are delivered more effectively.</p> <p>3. <b>Government subsidy to mission facilities:</b> provisions for salaries, drugs and consumables such as linen. Subventions for food, transport and maintenance. Major approved renovations carried out by government free of charge.</p>
PRIVATE FINANCING	<p>1. <b>Supplementary user fees:</b> income rated user fees for consultation, accommodation, maternity and surgical procedures.</p> <p>2. <b>Private beds in government hospitals:</b> two hospitals in urban centres have private wards. Unfortunately access to them remains restricted and costs are usually subsidized because of difficulty in keeping prices in line with inflation.</p>	<p>1. <b>Private insurance:</b> covers 5.5% of the population, yet accounts for 24.8% of total health expenditures. A simple consultation in the private sector costs 18 times as much as in the government sector. Despite this, enrolment into private schemes is increasing by 12% annually. The cost is mainly borne by the employer and higher-paid employees.</p> <p>2. <b>HMOs:</b> cover just 1.2% of the population, account for 8% of total health expenditure. Mines, agro-industry and multinationals all operate HMOs. Costs are heavily subsidized by the employer. Perquisites such as housing, private school and cars attract and retain health staff.</p> <p>3. <b>NGOs:</b> 94% of services for the elderly provided by NGOs.</p>

\* As at July 1991.

### 3.2 Policies to change the balance of public and private sectors

Countries have implemented a variety of policies to shift the balance between public and private sectors. This section reviews the success of these policies in achieving their desired goal. We consider firstly those policies which focus upon the public/private mix in the financing of health care services and then turn to policies affecting the provision of health care.

Table 6 summarizes some of the **policies intended to alter the public/private mix in financing** in participant countries. This is not an exhaustive list but rather an illustration of the range of policies that countries have adopted. It is sometimes difficult to distinguish between policies primarily designed to change the public/private mix and those which have changes in the mix as a secondary or incidental result. For example, many countries have recently been reassessing their strategy for financing health care services. There has been considerable discussion of the advantages and disadvantages of insurance schemes and user fees, which has often been independent of concerns about changing the public/private mix. Many of the financing policies under consideration do, however, have an impact upon the public/private mix.

In Chile, as part of a package of privatization reforms, individuals were given the choice of paying their mandatory social security premiums either to the public or private sectors. A private health insurance scheme, ISAPRE, was established in Chile in 1981. ISAPRE is made up of a group of private institutions responsible for the administration of social security health funds on the basis of annual contracts and negotiation between interested parties on price and coverage of the individual health plans. Private health insurance has grown considerably since the establishment of ISAPRE, and a substantial proportion of the upper- and middle-income groups in Chile are now covered by ISAPRE. But there are a number of problems with the scheme. In particular, the paper from Chile noted the exclusion of certain persons and diseases from ISAPRE coverage, and problems of cost containment. The scenario described in Chile has striking similarities to the problems encountered for some time in the United States of America and Switzerland.

Hungary is contemplating a form of top-up insurance. People would be able to elect to pay an extra premium to a private health insurance company or eventually to the National Social Security Institute for luxury care. Several countries which do not have social security cover for health, are promoting voluntary health insurance schemes. These have remained relatively limited in size so far.

**Table 6**  
**Policies implemented by countries to change financing patterns**

POLICIES	IMPLEMENTATION
<p><b>a. Promoting private health insurance:</b></p>	<p><u>Chile</u>: ISAPRE private insurance developed some time ago. <u>Hungary</u>: a top-up scheme for luxury health care is proposed, to be administered by private insurance companies or in the future the National Social Security Institute.</p>
<p><b>b. Promote voluntary health insurance:</b></p>	<p><u>Nigeria, Indonesia and Sri Lanka</u>: all promoting voluntary health insurance.</p>
<p><b>c. Supplementary user charges:</b></p>	<p><u>Nigeria</u>: drug charges increased, further fee increases under consideration. <u>Zimbabwe</u>: proportion of population eligible to pay fees has increased as level of real income below which people are exempt has decreased with inflation. <u>Mozambique</u>: nominal fees to moderate service use.</p>
<p><b>d. Tax relief:</b></p>	<p><u>Malaysia</u>: exploring ways to encourage private health insurance in rural areas. <u>Nigeria, Indonesia, Zimbabwe</u>: tax relief for not-for-profit organizations. <u>Mexico</u>: tax relief to consumers on private health expenditures and tax relief on micro-businesses including private practice in rural areas. <u>Chile</u>: tax exemptions on mandatory social security contributions, as well as exemptions on sales tax for medical equipment. <u>Zimbabwe</u>: traditional practitioners are tax-exempt.</p>
<p><b>e. Private provision in public facilities:</b></p>	<p><u>Iran</u>: government doctors tend to private patients in afternoons in some pilot facilities. <u>Mozambique</u>: government medical staff run "special" clinics in urban government facilities outside of normal working hours. <u>Nigeria</u>: intramural private practice under consideration. <u>Zimbabwe, Tanzania, Mexico, Indonesia</u>: private pay beds in government hospitals.</p>

Countries acknowledged the potential benefits that health insurance offers in terms of spreading risk and transferring resources from the healthy to the sick. However, health insurance may also generate problems. Depending on the type of remuneration mechanism in place, insurance may induce over-utilization by patients and abuse by physicians. Problems associated with private insurance schemes tend to be greater than those in compulsory health insurance schemes, where government can control both the premiums paid and the care offered. In particular, the fact that private insurance companies relate premiums to risk was felt by participants to violate the principle of social solidarity. At the extreme, private insurance companies refuse to give coverage to certain individuals, such as those with chronic illnesses. Most compulsory health insurance schemes relate premiums to income rather than to individuals' health risk, and are, thus, assumed to be broadly progressive in financing and provide access to care for those in need.

As mentioned in section 3.1, a number of the participating countries have some type of out-of-pocket payment for public health care services. Frequently these fees have been introduced or increased recently. Generally, countries' experiences with user fees conform with that documented elsewhere.<sup>1</sup> Where evidence is available, it suggests that utilization drops immediately after the introduction of, or increase in, fees and, whilst attendances recover amongst some groups, they remain depressed amongst the poorest members of society. The importance of linking payment for services with improvements in the quality of those services was stressed by participants and there was some discussion of potential exemption mechanisms. Iran suggested that many patients believe that by paying for care they will receive a better service and, thus, feel in a stronger position to assert their rights. This was felt to be one of the positive effects of user fees.

More specific to the issue of the public/private mix is that of tax relief. Two types of policy appear to have been implemented in this area. The first provides tax relief to consumers on private health expenditures, as in Mexico and Chile, and the second offers certain tax relief to providers. Participants felt that the benefits of tax relief on premiums for health insurance schemes was debatable. Tax relief on insurance contributions has been used as an incentive to join social security schemes and help make the schemes more palatable to employers. However, such tax relief means that, in effect, government is subsidizing the health care of those in the scheme. All too often, such schemes cover a minority of relatively wealthy people within the country and, thus, the tax exemptions were viewed as highly inequitable.

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<sup>1</sup> Creese, A. User charges for health care: A review of recent experience, WHO, Geneva (unpublished document WHO/SHS/CC/90.1) 1990.

Tax relief for not-for-profit organizations often constitutes a direct subsidy to their activities: they may be exempt from import taxes and sales taxes on some items. Tax relief for for-profit companies may be used to encourage their development, but also as a means to influence factors such as their location or the services they offer. Both Mexico and Malaysia offer tax relief to encourage providers and insurers to locate in rural areas. Providing preferential access to foreign exchange reserves (as in Zimbabwe) is another potential means for encouraging private health care in countries with non-convertible currencies.

The complex network of tax relief and exemptions which may build up over time creates considerable difficulties for the measurement of government subsidies to the private sector and, more generally, resource flows between public and private sectors. Very few financing studies have been able to take into account the size and significance of implicit subsidies such as tax relief. There is a danger that these concessions disguise a substantial subsidy of the private sector by the public sector.

The meeting stressed the need to develop incentives which encourage the private sector to behave appropriately, rather than punitive measures. Some participants felt that tax exemptions were a good example of such incentives, although there is a danger that they will protect the interests of inefficient organizations.

The provision of private care in public facilities was reported to be widespread. It emerged during the meeting that one of the main reasons for contemplating such an arrangement was to help retain skilled staff in the public sector. Iran saw the harmonization of income for doctors working in the public and private sectors to be one of the principal challenges in handling the public/private mix. Although Iran has increased public sector salaries and taxed private sector earnings, these measures have not proved sufficient to retain personnel. The Government has taken steps, on a hospital-by-hospital basis, to encourage public physicians to work privately in government hospitals in the afternoon. This not only boosted the pay of medical staff but also increased bed occupancy. Workloads in the pilot hospitals have increased by two or three times. The scheme is now being extended throughout the country.

Mozambique has adopted a similar policy, under pressure from both the urban population and medical staff. Amongst the particular steps proposed, is the development of special clinics in public hospitals. These allow doctors and other health staff to attend private patients out of normal working hours. Special wards have also been set up, with improved conditions and higher prices. The Mozambican report notes that some negative aspects are already emerging; some "normal" patients are being discriminated against in terms of quality of treatment and access to diagnostic and therapeutic facilities, and there is a fear that health professionals are placing higher priority on their private sector work. On the other

hand, the policy appears to have been successful in motivating personnel and increasing revenues.

Another problem raised by Sri Lanka was that non-medical staff who work on the private wards, felt aggrieved that they did not receive salary top-up. Nurses in Iran have requested an extra fee for working on private wards, and Nigeria is already having problems negotiating with nurses over this issue. Zimbabwe has managed to avoid this problem: all nursing staff in Zimbabwe are paid on the same scale regardless of whether they work in the public or private sector.

As indicated in Table 6, many countries already have private pay beds in government hospitals and Nigeria is currently contemplating allowing private practice in its public facilities.

A large number of **policies to promote the private sector in the provision of care** have been pursued by participating countries. These policies are diverse in their form and objective. Some are designed to increase efficiency within the public sector (e.g., contracting out), some promote competition between providers in order to stimulate improvements in private sector standards (e.g., improving quality of public sector services), whilst others promote coordination (e.g., emphasizing the role of the private sector in particular areas). Finally, some policies provide general support to the private sector whether this be in the form of a more conducive legislative environment or material support and supplies. Examples are summarized in Table 7.

Although economic theory stresses the importance of the market in increasing efficiency, it is apparent that few countries have pursued policies to promote the private sector with efficiency, or responsiveness to consumers' needs, as their main objective. If the principal objective is to realize efficiency gains from privatization then competition between providers of health care should be promoted.

Only two countries, Hungary and Chile, are firmly following policies to enable greater choice of provider. In Hungary, the National Social Security Scheme will be adapted so that it covers both public and private sectors at the same reimbursement rate. It is hoped that this will make the private sector a more feasible choice for consumers. Pharmaceutical bills incurred in the private sector in Hungary can already be reimbursed by the social security agency at the same rate as in the public sector. In Chile, the national social security scheme is designed to cover both public and private providers, so that insured persons may choose the provider they believe to offer the best quality of care. Private providers have been actively promoted, and public primary health care establishments have been decentralized and now operate as part of Municipal Health Corporations. There has been considerable restructuring of the Ministry of Health in order to support these reforms. Planning, financing, and services delivery roles have been separated in order to facilitate decentralization and potential further privatization.

**Table 7**  
**Policies Implemented by countries to change provision**

POLICY	IMPLEMENTATION
<b>a. Contracting out:</b>	<p>Widely implemented:  <u>Sri Lanka</u>: security, laundry.  <u>Mexico</u>: non-clinical services.  <u>Chile</u>: contracts for clinical services in private sector where government does not have capacity.  <u>Iran</u>: non-clinical services and MoH contracts with private sector for some clinical services.  <u>Malaysia</u>: laundry, catering, security and rubbish disposal all contracted out; use of private sector facilities where public facilities absent (radiotherapy, CT scan, X-ray).  <u>Nigeria</u>: contracting out laboratory services.  <u>Zimbabwe</u>: equipment maintenance, laundry services, invoicing for care of insured patients, contracted to private sector; mining hospital reimbursed for care of general population.</p>
<b>b. Increase responsibilities of private sector:</b>	<p><b>For-profit</b>  <u>Zimbabwe</u>: emphasizes private sector role in provision of non-essential drugs, traditional practitioner role in mental health and terminal care.  <b>Not-for-profit</b>  <u>Zimbabwe</u>: increasing district responsibilities of mission facilities, increasing use of NGOs for certain services such as care of the elderly, family planning.  <u>Mexico</u>: use of Health Foundation to tap private sector resources to promote research and support health sector activities.</p>
<b>c. Enabling choice of provider:</b>	<p><u>Chile, Hungary</u>: promoting health insurance with choice of public or private provider.</p>
<b>d. Increase competitiveness of public sector <i>vis-à-vis</i> private sector:</b>	<p><u>Nigeria</u>: increased pay to government doctors to attract back to public sector.  <u>Iran</u>: increased revenue from private care in public facilities is used to improve quality.</p>
<b>e. Legalizing private practice:</b>	<p><u>Tanzania</u>: repealing legislation prohibiting private practice.  <u>Mozambique</u>: legislating to allow private not-for-profit organizations to establish clinics and hospitals, and to allow private enterprise to establish clinics for their employees.</p>
<b>f. Promoting preventive care within the private sector</b>	<p><u>Nigeria</u>: provision of vaccines and condoms to private sector.  <u>Iran</u>: provision of cold chain facilities and free vaccines to private sector.  <u>Zimbabwe</u>: promote condom availability in bars and other private enterprises.  <u>Sri Lanka</u>: integrated family planning and immunization campaigns.</p>
<b>g. Support to private practitioners:</b>	<p><u>Iran</u>: regular refresher courses for private sector practitioners.  <u>Nigeria</u>: training in specialties for private sector in return for trainee services in government facilities.  <u>Hungary</u>: loans at special rates under consideration.</p>

As the reforms in Hungary have yet to be implemented, and no complete evaluation has been carried out in Chile, it is difficult to say how successful the competition approach has been.

In contrast, many countries are seeking to coordinate public and private sectors rather than encouraging them to compete. This is reflected in the efforts countries have made to ensure that private sector activities are complementary to those in the government sector. For example, the policies cited in category (b) of Table 7 attempt to entice the private sector into areas where government provision is limited. In Zimbabwe, certain clearly-defined tasks, such as care of the elderly and family planning, have been promoted within the private not-for-profit sector. This has happened to a lesser extent with for-profit providers. Traditional practitioners play an important role in mental health, the care of the terminally ill and in home delivery. Tanzania also stresses the importance of traditional practitioners, particularly in a large, sparsely-populated country where providing good access to modern government care for everyone is a huge challenge. With some of the identified functions such as family planning, it was useful for an NGO, unconstrained by government policy, to play an active role. The Mexican Health Foundation, a not-for-profit organization, acts as an effective fund raiser for research and other health sector needs. The Mozambican Congress recognizes the need to preserve the existing national health system, but has recently encouraged the development of nongovernmental organizations in order to bring extra resources into the health sector.

Many of the participating countries view the management of the public/private mix as a potential means for generating more resources for the health sector in a time of acute resource shortages. This explains the emphasis that countries place upon collaboration, coordination and complementarity, rather than competition.

Despite this, countries did not want to allow the gap in quality of care between public and private sectors to become too great. A number of countries have taken specific measures to prevent the gap from widening, and virtually all express commitment to publicly-provided services of a reasonable quality and at an affordable price. Countries recognize the inherent competition for resources between public and private sectors and act upon the belief that a strong public sector is needed to keep the private sector in check.

Sometimes policies directed at one part of the health system have unforeseen effects on other parts. For example, in Nigeria, salaries for government physicians have been increased in order to make them more comparable with the private for-profit sector. However, this has created pressure for salary increases in the mission sector, and church groups have requested increased subsidies to enable them to pay competitive salaries. This demonstrates the complexity of government policy-making in health sectors which are highly fragmented, and which have diverse ownership. The lack of a clear-cut formula or

even policy for state subsidies to the mission sector in Nigeria complicates the issue further.

Many governments are unhappy with the apparent focus of the private for-profit sector on curative care and have introduced policies to promote more preventive care within the private sector. The most common of such policies is the provision of certain supplies, such as vaccines, condoms and other contraceptives.

In Tanzania and Mozambique, private practice has been effectively banned for many years. In both countries, legislative changes are in progress which will allow greater private sector involvement. The speed with which the private sector responds requires monitoring.

If practitioners are working wholly in the private sector, there is a danger that they become isolated and out of touch with the latest medical developments. Although several countries have a good supportive relationship with traditional practitioners, relationships with private sector personnel in modern medicine tend to be less developed. Iran is an exception. It has instituted a system of refresher courses for doctors every five years, regardless of whether they work in public or private sectors. Nigeria will provide specialist training for private providers in exchange for the trainees' services for a period of time. Although Zimbabwe does not have a formal system of refresher training for private sector practitioners, it is common for people working in the private sector to provide support to public services when shortages arise. This encourages a shared body of knowledge amongst the medical community. Similarly, Tanzania recognizes that private sector providers are commonly not given the opportunity of attending meetings and conferences which they might find of interest. This situation is being redressed.

A number of countries also mentioned the need for management training as a result of the changing public/private mix. For example, the Hungarian paper, after reviewing the proposed reforms, concluded that:

"All above mentioned plans can be fulfilled only by leaders and personnel who have appropriate managerial education and skills. Hence one of our first tasks is to organize managerial courses on a broad scale."

Of all the policies to promote the private sector, contracting out has been the most commonly tried. The results of the policy differed according to the service which has been contracted. On the whole, the provision of catering, security, cleaning and laundry services by private firms appears to be relatively successful. Iran has experienced lower costs after contracting out certain services. In Zimbabwe, the costs have increased (by over 400% in the case of laundry) but the service has been delivered more effectively. For example, responsibility for billing insurance companies for care provided in government hospitals has been removed from the Treasury, and contracted to a private company. This has raised costs significantly but has also raised reimbursement levels by a higher factor.

For contracting out to be a feasible option, the public sector must have the managerial capacity to handle the contracting process and, equally importantly, there must be adequate capacity in the private sector to fulfil the contract. It is desirable for there to be a number of potential contractors who compete against each other. In Zimbabwe, the least successful contract has been for medical equipment maintenance. Costs have doubled and it was felt that the service was not as good as when carried out by government. This was partly because the Ministry of Health could no longer set priorities, but also because a few engineering firms monopolized the maintenance industry. In Malaysia, the contracting out of rubbish disposal has not worked particularly well because the large capital investment required limited the number of firms willing to tender.

Few countries have experience of contracting out clinical services. In the Latin American countries, contracting between government and social security health systems is common, but this is really between different public sector institutions. Malaysia contracts out certain clinical services to private sector providers where public facilities are lacking. In particular, services such as radiotherapy, CT scans and X-rays are contracted out. The purchase of high technology equipment frequently appears to initiate public and private sector negotiations. There is a common interest here: the owner wishes to encourage full utilization of the equipment and the other providers of care desire access. In Tanzania, the purchase of a CT scanner by the Aga Khan hospital has led to negotiations to permit public sector access.

In addition to the policies designed specifically to affect the mix of public and private health care, there are a number of other policy changes which affect the public/private mix. For example, in Sri Lanka:

"Overcrowding and service deficiencies in Government hospitals have resulted in a growth of private hospitals in urban areas during the past decade. Resumption of private practice for Government doctors, liberalization of drug imports, introduction of health insurance and medical benefit schemes, and the liberalised economic policy of Government encouraged people to invest liberally in the private health sector."

Frequently, one of the driving forces behind private sector growth is the decline of public sector services. In Chile, it appears that this has been part of the privatization strategy: the public sector has been restricted to those activities which involve those who cannot afford private care, and many responsibilities have been directly delegated to the private sector. For the majority of countries, however, decline in the quality of public sector care has resulted from severe financial difficulties and there remains a firm commitment to publicly-provided services.

### 3.3 Regulating the private sector

A number of countries are in a transition phase as regards private sector regulation. Previously, relationships with the private sector have been very much in the control and command mode. Regulations have been issued defining exactly what the private sector could and could not do. On the whole, such a relationship has proved unsuccessful. For example, the paper on Tanzania notes:

"In 1967 the government passed a law to stop private practice by individuals. ... The effect was dramatic. The morale of the doctors dropped as they could no longer charge fees or engage in private practice openly ... Owing to the difficulties in opening up private clinics the country experienced brain drain of its doctors to neighbouring countries, for greener pastures. Altogether over 170 doctors left the country to go and work elsewhere."

Attempts to proscribe private practice by law and to limit income in the private sector have been found unworkable. Instead, ministries of health are exploring ways to create incentives, such as offering tax holidays to private providers in underserved areas. Participants felt that regulation needs to be more of a "two-way street" and means must be found to involve the private sector itself in regulatory activities.

The regulatory mechanisms that countries have adopted are set out in Table 8. Policies were considered under the dimensions of price, quantity and quality. However, it soon became obvious that these three objectives of regulatory activity are closely interdependent. If the prices a doctor can charge are circumscribed, then there is a temptation to over-provide services in order to maintain income. Similarly, the quality of care is likely to be affected by other constraints placed upon providers, such as how much they can pay medical staff.

Participants stressed the complex nature of quality of care. Quality is not a one-dimensional characteristic. A service may be courteous but of clinically low quality. A hospital may provide luxury hotel features but have inadequate medical equipment. In general, care provided by the private sector will be of high quality in those aspects that are easily discerned by the average consumer, such as hotel features and politeness of staff. On the other hand, participants felt that government services often offered higher standards of clinical care. Participants added that the quality of the health care system as a whole does not depend solely on the quality within individual provider units. The referral system and relationship between units is equally important. Consideration of quality of care issues is complicated by difficulties in measuring quality of care. **Input indicators** (measuring the quantity and quality of resources put into the service) or **process indicators** (measuring the actual process of care) are most common. But **output indicators** (measuring the impact of care on health status) are of greatest value, but are particularly difficult to develop and measure.

**Table 8**  
**Regulatory mechanisms employed by countries**

MECHANISM	APPLICATION
<b>Controlling prices</b>	
a. Fixing private sector charges	<u>Iran</u> : MoH fixes prices for services and laboratory examinations. <u>Hungary</u> : prices paid to public and private sectors to be equal under new insurance arrangement. <u>Tanzania</u> : plans to set guidelines on fees.
b. Negotiation of salary scales	<u>Zimbabwe</u> : nurse salaries in both public and private sectors are fixed by the government and professional association.
<b>Controlling quantity and distribution</b>	
c. Through the payment mechanism	<u>Nigeria</u> : using capitation payment for health insurance scheme combined with co-payments to reduce incentives to over-treat. <u>Hungary</u> : using capitation combined with incentive payments in new health insurance scheme.
d. Location of private facilities	<u>Tanzania</u> : new private sector facilities must receive licence from MoH, location of facility is criterion used in considering application. <u>Malaysia</u> : currently considering legislation on location. <u>Iran</u> : issues permits for private sector and approves location.
e. Doctors drug prescriptions	<u>Zimbabwe</u> : legislation to restrict dispensing by private practitioners.
f. Investment	<u>Malaysia</u> : legislation on investment in equipment and buildings is under consideration.
g. Number of procedures	<u>Iran</u> : regulation of the number of procedures which can be carried out per day under consideration.
h. Supply of physicians	<u>Iran</u> : initial bonding period of 5 years for doctors.

MECHANISM	APPLICATION
Quality	
i. Inspection and licensing	<p>Many countries insist on the licensing of private facilities and have the authority to inspect such facilities. Countries with this arrangement include Chile, Malaysia, Nigeria, Mozambique, Zimbabwe, and Tanzania.</p> <p><u>Tanzania</u>: issues guidelines on size of hospital and type of personnel to be employed.</p>
j. Quality monitoring	<p><u>Nigeria</u>: quality monitoring by professional body.</p> <p><u>Zimbabwe</u>: anonymous peer review by Health Professional Councils.</p> <p><u>Sri Lanka</u>: quality monitoring by General Medical Council and drug review committees.</p> <p><u>Iran</u>: drug review committees.</p> <p><u>Malaysia</u>: medical audit under consideration.</p>
k. Complaints	<p><u>Zimbabwe</u>: complaints about treatment are widely publicized, legal facilities for prosecution over malpractice exist.</p> <p><u>Nigeria</u>: complaints publicized and possibility of prosecuting over malpractice.</p>
l. Accessibility	<p><u>Iran</u>: 3% of beds in private hospitals have to be reserved for poor patients.</p> <p><u>Indonesia</u>: 25% of beds in private hospitals have to be reserved for poor patients.</p> <p><u>Mexico</u>: all hospitals are legally obliged to accept emergency cases regardless of financial status of patient.</p>
m. Drugs	<p><u>Nigeria</u>: essential drugs licence used to control imports of drugs; drug quality monitoring.</p> <p><u>Zimbabwe</u>: drug quality monitoring.</p>
n. Training	<p>Many governments control training curricula for both public and private sector staff.</p> <p><u>Malaysia</u>: now negotiating with private sector over training responsibilities and curricula.</p>

Some discussion of the need to control investment or place a "maximum standard" upon quality of care took place. Developing countries need to prevent excessive use of high technology care. Once some patients have access to such care then through a demonstration effect others will want the same treatment. Malaysia is considering legislation controlling investment in buildings and equipment. In some countries such as Mexico, the framework of a liberal market economy gives few possibilities for controlling the acquisitions of the private sector.

Countries agreed that essential drugs lists helped to control extravagant prescription practices. The sale of expensive and unnecessary drugs has proved to be a considerable problem:

"For years the Nigerian drug market was flooded by thousands of different brands of drugs. Many newly developed and expensive drugs were introduced to compete with already established cheaper ones that were in no way inferior to the new product. The same active generic drug was being offered in several different proprietary names, and were intensively promoted in advertisements without any indication to the unsuspecting public that they were old wines in new bottles."

The Federal Ministry of Health tried to impose order through legislation. The Essential Drugs Law was passed, which prohibits any drugs except those on the essential drugs list being brought into Nigeria, and which also states that advertisements for proprietary products must give equal prominence to their generic identity.

Despite the fact that manpower was one of the critical resources for which public and private sectors compete, little is being done to influence private sector behaviour in this area. Some countries already rely heavily on the private mission sector for training of certain cadres. Malaysia has started negotiations with the private sector, encouraging them to establish their own training facilities. Participants from Mexico observed that in their own country, private medical schools had created problems. Firstly, the teaching tended to be of a low quality and it was difficult for the government to enforce standards. Secondly, the schools often socialized doctors into private care and neglected certain aspects of their education, such as community health.

It was stressed that information was the basis of all regulation. Without knowing the behaviour of private providers (e.g., the prices charged, and the quality and types of services offered) it is impossible to regulate properly. Although the private sector in many countries is legally bound to provide information, data are often late and incomplete. Participants felt that compulsory information collecting, particularly on information relating to income, would be extremely difficult

to implement. However, as far as possible, information on the private sector should be improved and integrated into regular health information systems.

It was recognized that a number of agencies play an essential role in contributing information to the regulatory process. Participants suggested that there were four key groups involved in regulation: the government, professional bodies, the financing or insurance agency, and consumers. Different agencies have access to different information and have different relationships with providers. Table 9 summarizes the role these different groups play in the participating countries, by type of regulatory objective.

**Table 9**  
**Role of agencies by regulatory objective:**  
**Some examples from participating countries**

<b>Agency Object</b>	<b>Government</b>	<b>Professional body</b>	<b>Financial agency</b>	<b>Consumer</b>
<b>Price</b>	Control of level of charges.	Negotiation of salary/fee scale.	Fixing of reimbursement rates.	Consumption decision.
<b>Quantity and distribution</b>	Location of private facilities. Control over drug prescription, investment, procedures, supply of physicians.	Supply of physicians.	Design of payment mechanism. Review of claims for over-billing.	Pressure group lobbying, consumer groups.
<b>Quality</b>	Inspection and licensing. Accessibility. Drug quality. Training curricula.	Quality monitoring/ peer review.	Inspection of facilities. Review of drug prescriptions.	Complaints procedures and legal action. Consumption decision.

The ministry of health is able to control easily measurable variables such as the number of procedures carried out each day, or the number of beds per square metre. From the experience of participating countries, it appeared that governments are most

active in controlling the quantity and distribution of services. In addition, governments may help set the framework within which the private sector operates, for example by regulating whether or not private physicians are allowed to dispense drugs as well as prescribe them. However, participants thought that it was both inappropriate and unfeasible for the ministry of health to play a major role in monitoring process and output indicators of the quality of care. There was a feeling that the ministry should not act as a judge of the private sector; this was better left to professional associations, through a peer review process. Many countries use professional committees to review the services offered in the private sector, and the drugs prescribed. Such a peer review process can be used to influence quality of care in both public and private sectors.

Regulatory responsibility is organized differently in different countries. Most ministries of health have a licensing and inspection division. In Chile, where a number of health sub-systems exist, each has its own regulatory authorities. In Hungary, the main government monitoring responsibility will lie with a network of public health officers. In addition, the social security organization will have responsibility for monitoring. There was some concern that duplication of regulatory activity would occur in such environments. Countries often felt that although they have the authority to monitor, they do not have the capacity. The paper from Sri Lanka states:

"There is adequate provision in the legislation to take regulatory action whenever the need arises. The monitoring mechanisms need further strengthening, the constraint being inadequate funding and personnel."

The lack of cohesiveness in the private sector is another potential obstacle to effective regulation. Malaysia noted that:

"There is no one body representing the private sector, making it difficult for the MoH to discuss meaningfully and obtain consensus."

Chile has established a National Council on Private Health, including representatives from both public and private sectors, which is supposed to resolve problems concerning the private sector.

Both Zimbabwe and Chile mentioned the tax system as a useful way of disciplining the private sector. Higher financial penalties are imposed for inaccurate tax returns than the ministry of health could ever impose.

Insurance agencies have also proved useful in exercising control over the private sector. In particular, the records kept by insurance agencies have proved extremely helpful. For example, in Zimbabwe, the Medical Aid Societies have a complaints committee which reviews bills. Practitioners who are over-billing will be cautioned and, if necessary, prosecuted. This has made doctors very cautious about over-charging.

Insurance schemes can also influence the behaviour of providers through the payment mechanism adopted. In Iran, bills for services covered by reimbursable insurance were compared with those where the insurance company made a direct payment to the provider. It was found that where the consumer had initially to pay out of pocket, the bills were much less. However, such a method of insurance has high administrative costs, and may also reduce accessibility. Also in Iran, many providers are paid on a capitation basis for those patients who have insurance coverage. As capitation payment tends to be less remunerative than fee-for-service payment, providers stopped accepting insured persons. The Iranian government has attempted to circumvent this problem by legislating that a certain proportion of patients treated by a particular provider must be insured persons. However, this is proving difficult to implement.

Hungary is also reforming its remuneration system, as part of the overall reform of the health care system. The new system will be mixed, combining a capitation payment (at a variable rate according to local demography and professional qualifications), with fee-for-service reimbursement. This system attempts to capture both the incentive effects of a fee-for-service system and the cost containment effects of a capitation system.

Finally, consumers were felt to be an important but often neglected group in the regulatory process. Participants noted that consumers have become increasingly active in asserting their rights. Governments have taken measures to encourage this, including publicizing cases of malpractice in local newspapers, and ensuring the establishment of proper complaints procedures. Ministries of health can also commission and publish research into the services offered by private providers. In Zimbabwe, a study is under way to compare rates of Caesarian section in public and private sectors. Such consumer information helps patients to "vote with their feet" and take their demand to reputable providers where the quality of care delivered by some providers is poor. Zimbabwe, and also Sri Lanka, felt that campaigns to inform consumers about the true benefits of drugs have been successful, and increasingly consumers were resisting injections or the prescription of many drugs.

Consumer information appears to be a relatively unexplored area which offers considerable potential in influencing the behaviour of both private and public providers. One participant commented that now that people had experience of the private sector, they were more ready to question the quality of care they received in the public sector. The consumer information approach conforms with the precepts and principles set out in the Alma-Ata Declaration; however, it can never be more than a partial solution. The dissemination of information will allow consumers to make better choices of provider in certain situations, but for some services consumers may not have the incentive (for example, if the service is rarely used) or the time (e.g., emergency services) to acquire and use information. A clearer understanding of the areas in which a consumer information approach is effective would enable better policy-making.

#### 4. GENERAL CONCLUSIONS AND FUTURE NEEDS

In the course of the meeting, the complexity of private sector regulations became evident. In particular, there is a high degree of heterogeneity within the private sector. The difference between for-profit and not-for-profit organizations was felt to be especially important. Frequently not-for-profit organizations share similar goals to the government. Moreover, it was pointed out that public and private should not be thought of as completely distinct: the same physician may work in both sectors but will act rather differently according to the incentive structures he or she faces.

Notwithstanding these complexities, participants were able to draw some general conclusions from the discussion. It was felt that the characteristics of the private sector make it potentially a force which both conflicts with and complements government health objectives. Conflict potential lies in the fact that:

- there is frequently competition between public and private sectors for the same resources. This is particularly acute for human resources, but may also affect other inputs;
- the private sector's objectives, particularly those of the for-profit sector, whilst not necessarily purely financial, are narrower than those of the public sector. In many cases, the private sector provides only the more remunerative services which tend to be easier to provide and most in demand ("skimming the cream"), leaving responsibility for the poor, for emergency care and for training to government;
- with the primary criterion for determining access to the private for-profit sector being willingness and ability to pay for care, it is likely that private sector expansion will create increasing inequity in the health care system unless carefully controlled;
- government may have little control over some aspects of private sector activity, e.g., cost and price trends, which affect public sector operations;
- without careful planning and monitoring, the private sector may lead to duplication and waste.

Potential complementarities lie in:

- the additional resources which the private sector can mobilize, including finance and certain skills in management. Sizeable traditional sectors in many countries constitute actual and potential complements to public sector services;

- providing choice for some health care consumers and offering a high standard of hotel services and continuity in dealing with patients;
- the greater flexibility in the private sector, both in for-profit and not-for-profit organizations. The private sector may frequently play an innovatory role and be active in areas where government has not yet developed capacity or is unable for political reasons to become involved.

It was evident from the meeting that ministries of health are beginning to re-assess the public/private mix, and to rethink government policy directions on this issue. A number of influences have brought about such a reconsideration. Participants mentioned the epidemiological transition, from communicable diseases to an increasing level of non-communicable diseases and injuries. A political transition was also mentioned: pressure for greater governmental accountability both from within and outside the country has mounted, with a global shift to philosophies favouring a more market-oriented economy. Perhaps most important of all, however, for many of the countries represented, are current economic difficulties and the severe shortage of resources available to ministries of health.

Policies to increase the role of the private sector have often been initiated as a result of financial stresses and strains. Yet there is an inherent tension in this approach: successful promotion of private sector providers depends upon people having adequate incomes to seek private health care. Private sectors flourish mainly during resource rich times - or at least among the resource rich section of communities. Two countries represented at the meeting, Chile and Malaysia, were distinctive in that they had not promoted privatization measures as a response to financial crises. Chile had started to privatize in 1973, before the start of economic decline and as a result of political changes rather than economic ones. It was felt that a closer examination of Chile's experience would be extremely useful to countries now contemplating similar policies. Malaysia retains the belief that health is a government responsibility and should be provided free to all those who cannot afford it, but it also believes in a free market system and, despite a well-respected public health care system, is actively promoting the private sector. Moreover, it is doing this in resource rich times: GNP growth has remained strong during the past few years.

Some participants felt that poor countries with inadequate government infrastructure should not be promoting the private sector, particularly for-profit private providers. Yet it is commonly these countries which have the greatest need of additional resources. Unlike in countries such as Malaysia, minimum standards of health services can frequently not be provided from the government purse. Thus, promotion of the private sector is a pragmatic response to pressing needs.

Participants debated whether or not payment by the better-off for private care actually brings more resources into the health sector, or simply results in a

transfer of resources from public to private sectors, or increases costs for both sectors. It is likely that elements of each of these scenarios occur; for example, the private sector may bring extra financial resources into health care but this may still create damaging competition for limited scarce resources, which will raise the prices of these resources. A clearer understanding of the dynamics of competition for resources is required. It is also clear that the government must have adequate capacity to control the development of the private sector, in order to ensure that the resulting competition is not harmful to the interests of the whole health system.

In Western Europe and the United States, the appropriate roles of the public and private sectors are also under debate. Here, however, the principal type of reform is seen as moving towards a **managed competition** or an **internal market** solution. This notion, originally proposed by Enthoven,<sup>1</sup> seeks to define the parameters of a health care market which will generate true competition and consumer choice, whilst retaining the advantages of the public sector in terms of universal access and free care at point of service. Reforms being implemented in Western European countries need to be closely monitored, using criteria such as equity, efficiency, cost containment and cost of implementation, to see what relevance they may have for other countries.

The goals that countries are pursuing through changing the public/private mix differ. Some countries (e.g., Hungary) appear to draw upon the notion of managed competition and place emphasis upon giving greater rein to the market system and creating more competition in order to improve efficiency. This does not necessarily involve privatization; competition may be promoted between different public sector organizations. However, many of the participating countries were principally concerned with generating extra resources for health and, thus, stressed the need for improved collaboration and coordination.

The differing objectives which countries are pursuing imply considerable differences in policies and management of the mix. To generate competition it is essential that consumers have a number of health facilities and/or health insurance plans to choose between. On the other hand, collaboration implies a careful planning of facilities in order to ensure maximum coverage and minimum duplication. For many countries, the principles of managed competition are of interest, but remain remote. Managed competition is concerned principally with increasing the efficiency with which resources are allocated between providers. In many ways, this can be seen as a fine tuning of the system. There are many other routes to be pursued to improve efficiency.

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<sup>1</sup> Enthoven, A. C. Managed competition of alternative delivery systems, Journal of Health Politics, Policy and Law, 13(2): 305-321, 1988.

Economic theory shows that there is no "correct" mix of public and private sectors. This conclusion was reinforced by the country experiences described during the meeting. It was felt inappropriate to recommend specific approaches given the complex nature of public/private interactions in health, and the variety of countries' circumstances. Given the diversity of existing systems and the different policy objectives and political orientation of governments, one must question the notion of a "well-balanced" or "appropriate" public/private mix. What is, or is not, appropriate depends largely upon the existing health system structure, and the political judgement and freedom of manoeuvre of government. This does not imply that there are no alternatives facing particular countries: all countries face choices on the ingredients of the "mix", and these choices will perform better or worse in terms of criteria such as efficiency and equity.

Participants stressed that we must not become so lost in the details of the public/private mix that we ignore the overarching objectives of the ministry of health. Ministries of health continue to promote the goal of Health for All, which includes not only the provision of health care services, but also takes into account a variety of other factors which affect the health status of the population such as sanitation, health education, women's literacy, etc. Similarly, the political feasibility of various options needs to be considered. The private sector presents a major challenge for government. But it is clear that the public sector needs to be considerably strengthened to respond to this challenge.

One of the principal needs identified before coherent policies towards the private sector can be developed is improved information. This includes both basic data for each country and more research, the results of which could be shared between countries. Amongst the suggestions made were private sector censuses and periodic surveys of the private sector. None of the countries present had experience of this, but most felt that the data gathered through such an exercise would be valuable.

With regard to research, a large number of issues arose during the meeting about which participants felt there was inadequate information; only a small number of the proposed topics are mentioned here. There was felt to be an inadequate understanding about the relationship between government policy/practice and private sector behaviour. Some countries claim to be committed to maintaining very strong public services yet have virtually no controls on the private sector. Can strong public services favourably influence the quality and price of private sector care? It was also felt that before stimulating growth in the private sector there should be better analysis of what resources are scarce and how government can regulate their use. Finally, there was a need for documentation of country experiences, particularly in those countries which had pursued innovative policies. It was suggested that the privatization experiences of Chile should be investigated and documented.

There is commonly adequate legislative provision to take regulatory action whenever the need arises. More problematic is the institutional capacity within the ministry of health to monitor the private sector, and to determine when government intervention is required. Participants felt that this task may warrant a higher level of funding and better staffing. Greater involvement of funding agencies, consumers and

professional associations was felt highly desirable. In particular, participants identified the lack of management skills in the health sector as a key problem for both public and private sectors. Several countries were hoping to strengthen their health management capacity through training courses.

The participants in the meeting were principally government officials. It was felt that a closer and more active involvement of representatives of the private sector, including not-for-profit agencies, was highly desirable. Private sector representatives should be involved in the evaluation, regulation and policy-making process and their guidance should be sought on information-gathering.

Further opportunities to structure the comparison of countries' experiences were considered valuable. WHO has the potential to play an important role in supporting ministries of health to document the experiences of national health systems in managing the public/private mix, encouraging research, and disseminating the findings.

ANNEX A

**LIST OF PARTICIPANTS**

**Country participants**

**AFRO**

- Dr José Maria de Igrejas Campos, Vice-Minister of Health, Maputo, Mozambique  
Dr Abdul Razak Noormohamed, National Director of Planning and International Cooperation Departments, Maputo, Mozambique  
Dr S. K. Gyoh, Director-General, Federal Ministry of Health, Lagos, Nigeria  
Dr K. A. Mmuni, Chief Medical Officer, Ministry of Health, Dar-es-Salaam, United Republic of Tanzania  
Dr T. J. Stamps, Minister of Health, Harare, Zimbabwe  
Dr S. C. Mundawarara, President, Zimbabwe Medical Association

**AMRO**

- Dr J. Jimenez de la Jara, Minister of Health, Santiago, Chile<sup>a</sup>  
Dr Jesus Kumate Rodriguez, Secretary of Health, Mexico DF, Mexico  
Dr Federico Chavez Peon, Director of International Affairs, Ministry of Health, Mexico  
Dr Enrique Wolpert, Under-Secretary of Health Services, Ministry of Health, Mexico  
Dr Martha Barquin, Chief, Public Relations, International Affairs, Ministry of Health, Mexico  
Dr Jaime Sepulveda, Under-Secretary of Organization and Development, Ministry of Health, Mexico  
Dr Carmen E. Galvan, Secretary of Health and Social Welfare, State of Morelos, Mexico  
Dr Julio Frenk, Director-General, National Institute of Public Health, Cuernavaca, Mexico

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<sup>a</sup> Unable to attend but paper presented at meeting.

Annex A

EMRO

Dr R. Malekzadeh, Minister of Health and Medical Education, Teheran,  
Islamic Republic of Iran  
Dr B. Sadrizadeh, Under-Secretary for Public Health, Teheran, Islamic  
Republic of Iran  
Dr I. Fazel, Chairman of the Council of Sciences, Teheran, Islamic  
Republic of Iran

EURO

Dr Gyula Pulay, Deputy Secretary of State, Ministry of Welfare of the  
Republic of Hungary, Budapest, Hungary

SEARO

Dr Mohammad Isa, Inspector-General, Ministry of Health, Jakarta,  
Indonesia  
Dr Suwarna, Secretary, Directorate-General Community Health, Ministry  
of Health, Jakarta, Indonesia  
Dr George Fernando, Director-General of Health Services, Government  
of the Democratic Socialist Republic of Sri Lanka, Colombo,  
Sri Lanka

WPRO

Dato' Dr Abdullah bin Abdul Rahman, Director-General of Health,  
Ministry of Health, Kuala Lumpur, Malaysia

WHO

Dr C. Guerra de Macedo, Regional Director, WHO Regional Office for  
the Americas/Pan American Sanitary Bureau, Washington, D.C., USA  
Dr Luis Arcila, DHS, Office of the WHO Representative, Mexico  
Dr Jorge Castellanos, Regional Programme of Health Policies  
Development, WHO Regional Office for the Americas/Pan American  
Health Sanitary Bureau, Washington, D.C., USA  
Dr P. C. Y. Chen, Regional Adviser, Human Resources for Health,  
WHO Regional Office for South-East Asia, New Delhi, India  
Dr H. Nakatani, Human Resources Policy Analysis, Division of  
Development of Human Resources for Health, WHO headquarters,  
Geneva, Switzerland

Annex A

WHO (continued)

Professor G. Soberon, Temporary Adviser, WHO headquarters, Geneva  
Dr Juan Manuel Sotelo, The WHO Representative, Mexico  
Professor Milton Roemer, Consultant/Observer, WHO Regional Office  
for the Americas/Pan American Sanitary Bureau, Washington, D.C.,  
USA  
Dr E. Tarimo, Director, Strengthening of Health Services, WHO  
headquarters, Geneva, Switzerland

Secretariat

Dr Sarah Bennett, Health Economics and Financing Programme,  
Department of Public Health and Policy, London School of Hygiene  
and Tropical Medicine, London, UK (Temporary Adviser)  
Mr Andrew Creese, Responsible Officer, National Health Systems and  
Policies, Division of Strengthening of Health Services, WHO  
headquarters, Geneva, Switzerland  
Dr Ann Mills, Health Economics and Financing Programme, Department  
of Public Health and Policy, London School of Hygiene and Tropical  
Medicine, London, UK (Temporary Adviser)  
Mrs Carole Riley, District Health Systems, Division of Strengthening  
of Health Services, WHO headquarters, Geneva, Switzerland  
Dr I. Tabibzadeh, Responsible Officer, District Health Systems,  
Division of Strengthening of Health Services, WHO headquarters,  
Geneva, Switzerland

Observers

Dr Ascobat Gani, Adviser, Ministry of Health, Jakarta, Indonesia  
Professor A. P. R. Aluwihare, Chairman, University Grants Commission,  
Colombo, Sri Lanka  
Professor Ruth Roemer, Adjunct Professor of Health Law, School of  
Public Health, University of California, Los Angeles, California  
USA  
Professor Charas Suwanwela, President, Chulalongkorn University,  
Bangkok, Thailand

**PROGRAMME OF WORK**

**Monday, 22 July 1991**

09.00-09.45      **INAUGURATION SESSION**

Welcome by Dr Carmen E. Galvan, Minister of Health and Social Welfare, State of Morelos, Mexico, on behalf of Mr Antonio Rivapalacio, Constitutional Governor, State of Morelos, Mexico

Welcome on behalf of the Director-General and WHO by Dr Carlyle Guerra de Macedo, Regional Director, AMRO/PAHO

Opening of the Meeting by Dr Jesus Kumate, Minister of Health of Mexico

09.45-10.30      Introduction of participants and appointment of officers

10.30-11.00      **COFFEE BREAK**

11.00-12.30      Adoption of Programme of Work  
Presentation of the Background Document and discussion

12.30-14.30      **LUNCH**

14.30-16.00      Presentation of country papers and discussion

**AMRO**  
Mexico  
Chile

16.00-16.30      **COFFEE BREAK**

16.30-18.00      Presentation of country papers and discussion (continued)

**EMRO**  
Islamic Republic of Iran  
**EURO**  
Hungary  
**SEARO**  
Indonesia  
Sri Lanka  
**WPRO**  
Malaysia

Annex B

**Tuesday, 23 July 1991**

09.00-10.30            Presentation of country papers and discussion (continued)

                          AFRO  
                          Mozambique  
                          Nigeria  
                          United Republic of Tanzania  
                          Zimbabwe

10.30-11.00            COFFEE BREAK

11.00-12.00            Summary of principal themes on country experiences  
                          General discussion  
                          Adjournment

Highest official from each participating country

12.00                    Departure to Mexico City

14.00                    Visit to Mr Carlos Salinas de Gortari, Constitutional President of  
                          the United States of Mexico

15.00                    LUNCH (given by the Minister of Health of Mexico at Hacienda  
                          San Angel Inn Restaurant)

17.00                    Departure from Mexico City to Hacienda Cocoyoc

Remaining participants

12.00-14.30            LUNCH

14.30-16.00            General discussion (continued)

16.00-16.30            COFFEE BREAK

16.30-18.00            General discussion (continued)

Annex B

**Wednesday, 24 July 1991**

09.00-10.30	Working Groups
10.30-11.00	COFFEE BREAK
11.00-12.30	Working Groups
12.30-14.30	LUNCH
14.30-16.00	Working Groups
16.00-16.30	COFFEE BREAK
16.30-18.00	Working Groups

**Thursday, 25 July 1991**

08.00-12.30	FIELD VISIT
12.30-14.30	LUNCH
14.30-16.00	Report of Working Groups and discussion (plenary)
16.00-16.30	COFFEE BREAK
16.30-18.00	Report of Working Groups and discussion (continued) (plenary)

**Friday, 26 July 1991**

09.00-10.30	Presentation of the report, recommendations, discussion
10.30-11.00	COFFEE BREAK
11.00-12.30	Recommendations, discussion (continued)
12.30	CLOSURE OF THE MEETING
12.30-14.00	LUNCH
15.00	Return to Mexico City