How African doctors make ends meet: an exploration

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Summary
This paper is an attempt to identify individual coping strategies of doctors in sub-Saharan Africa. It also provides some indication of the ‘effectiveness’ of these strategies in terms of income generation, and analyses their potential impact on the functioning of the health care system. It is based on semi-structured interviews of 21 doctors working in the public health sector in sub-Saharan Africa and attending in 1995 an international Master’s course in Public Health in Belgium or in Portugal.

This small sample of physicians yielded reports about 28 different types of individual strategies. Most of these potentially affect health service delivery more through reduced availability of staff than through the more blatant misappropriations. Activities related to the health field are mentioned most often. Allowances and per diems seem to be top regarding frequency and effectiveness, followed by secondary jobs, private practice or gifts from patients. None of the interviewees, however, admits using public resources for private purposes. Side activities may bring in very considerable amounts of income, out of proportion to the official salary, and can also be very time consuming. Nevertheless, all interviewees identify themselves in the first place as civil servants.

Individual coping strategies may lead to undesirable side-effects for health care delivery, through a net transfer of resources (qualified personnel-time and material resources) from the public to the private-for-profit sector. There may also be positive effects though, be it in terms of mobilization of additional resources, of stabilization of qualified personnel or of realization of professional goals. However, these emerging strategies call for innovative mechanisms, likely to shape coping strategies in such a way that they remain compatible with equity and quality of care to the population.

keywords medical doctors, public health services, sub-Saharan Africa, structural adjustment, ethics

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Introduction
Working in sub-Saharan Africa’s health sector, one cannot fail to note the time and endeavour many health workers, including medical doctors, invest in activities that are not, strictly speaking, part of their job. These ‘other activities’ can be considered as individual strategies to cope with the often extreme discrepancies between social, economic and professional expectations and real-life situation.

Health professionals’ expectations in terms of career perspectives and social status are shaped by social, political and institutional factors (Simmonds & Bennett-Jones 1989). The crisis and decline of sub-Saharan Africa’s public health services, the reform of the health sector and the emergence of
unregulated private practice profoundly affect what doctors hope to get from their professional life and the ways they try to achieve this.

Most actors in the health sector are aware that health workers’ reactions to the changing socio-economic and institutional environment often interfere with work performance and with the overall functioning of the health care system. Of particular relevance in this respect are those activities that are utilized to cope with the dramatic decline in purchasing power of health officials in public service. As early as the late seventies, per capita public spending for health dropped in real terms, whilst the personnel/population ratios increased (Van Lerberghe 1993).

This deterioration is clearly linked to the economic and political crises in the continent, compounded by the structural adjustment programmes externally imposed on African governments (Lowenson 1993; Igbedioh 1993; Tumwine 1992). Present attempts at reforming the health care sector do not generally offer solutions to this problem, at least not in the short term (Zaidi 1994). In the meantime salaries are paid months behind schedule, and health personnel feel that they are blatantly insufficient. For example, a doctor’s public sector salary in Guinea-Bissau barely pays house rent. In Angola it is equivalent to 12 kg of rice, 2–4 kg of beef or 2 litres of cooking oil. This is not a new or recent situation: in the early eighties, for example, a nurse’s monthly salary in Zaire could purchase only about 30 eggs.

Each health care provider reacts to the financial predicament pragmatically and in his own way. Taken together, however, these individual coping strategies are as important in shaping the health care system as are planned structures and actions. They can be considered as ‘emergent strategies’ (Mintzberg 1994) resulting from the aggregation of individual actions progressively evolving into an unforeseen structure or form, which must be taken into account when addressing the reform of the health sector in developing countries.

With the exception of some recent empirical work about economic regulation mechanisms of care provider behaviour (Bennet et al. 1994), the literature tends to address such health personnel attitudes and behaviour by generic and normative statements (WHO 1989) or in moralistic terms, from ‘lack of motivation’ to ‘corruption’. These issues can, however, also be addressed in terms of their functional aspects and their actual consequences (Cartier-Bresson 1992).

Based on the social and political value systems of each society, ethical decisions about ‘what is in the public interest’ are at the root of every public service. Like rules and regulations, these undoubtedly influence individual strategies (Crozier & Friedberg 1980). But they are clearly not sufficient to avoid undermining the delivery of quality care to the population. The management of health care systems implies dealing with individual coping strategies in a more rational way. This requires systematic, rather than anecdotal, knowledge of the nature and importance of these strategies, identification of the individual, social and institutional factors that shape them and of their impact on the health care system.

This paper is an attempt to make an inventory of some of the individual coping strategies of mid-level managers in sub-Saharan Africa. Based on semi-structured interviews, it reflects how these professionals themselves view these issues. The interviews also provide some indication of how ‘effective’ these strategies are perceived to be in terms of income generation, and of their potential impact on the functioning of the health care system.

Population and methods

During the first half of 1995, 21 medical doctors from sub-Saharan Africa were interviewed while attending an international post-graduate course in Public Health in Belgium or in Portugal.

Five doctors came from Angola, 4 from Cameroon, 3 from Benin, 2 from Guinea-Bissau, 2 from Congo, and one each from Guinea, Niger, Zaire, Chad and Burkina Faso. Their median age was 37 years; 15 were males and 6 females. Seventeen physicians worked in urban settings: 2 outside the hierarchy of the public health ministry, 1 at the university, 3 at the central ministry of health, 4 at regional level, 6 at district level and 1 at peripheral level. Among the 4 physicians working in rural settings, 1 worked at regional level and 3 at district level. Fourteen worked as government employees, but all the others also characterized their job as ‘public service’, be it in a university (1), in
non-governmental organizations (NGOs) (2), or as a public servant seconded to a foreign donor-funded project (4).

Semi-structured interviews were conducted by two European fellow students, well known to and trusted by the interviewees. The interview schedules started with questions on age, family environment, work setting and professional experience. More specific questions then addressed the individual economic situation, alternative sources of income, coping strategies, their financial effectiveness, and the beliefs associated with impact of these strategies on their tasks in their official capacity. Direct and indirect questioning addressed two motivational issues: why the interviewees deemed it necessary to develop coping strategies, and for what reason civil servants remained in public service. In some cases information was also elicited on other strategies used by other colleagues in their country, and on the reasons why the interviewees themselves did not want to or could not use them.

The interview questions did not systematically address discrepancies between the interviewees' professional role-image and their actual practice, or between their social status expectations and their present social position within the degrading socio-political climate. Although these would certainly provide an interesting perspective on the problem, the interviews were limited to the way health care providers most often frame the subject in a first analysis: in terms of economic survival. The basic question was: ‘How do you make ends meet in these difficult times?’

Results

Profile of coping strategies

Three of the 21 interviewed physicians reported that they lived entirely on their official salary. They either did not want to develop ways of earning more or did not need to do so. ‘I would rather not develop such strategies’, said one, ‘because they take up so much time they threaten family life. But I don’t know how long I’ll be able to stay out of it.’ The remaining 18 physicians talked freely about what they did to cope with economic difficulties in their countries. The type of strategies mentioned are summarized in Table 1 under three headings:

- Extra income from non-medical (commercial and agricultural) sources;
- Extra income directly related to professional medical activities, and
- Support by church or family.

Table 1 also indicates sources of income mentioned as being used by others in their environment, but not used by the interviewee himself. For instance, in the case of private practice and private drugstores, some of the interviewees said that, lacking investment money, they could not engage in these activities themselves, while others considered these sources of income unacceptable.

Non-medical income

Extra income from activities outside the professional field cannot be ignored, especially in rural settings where ‘the market for private practice is too small’. These activities come in all varieties of type and effectiveness—the additional income mentioned ranged from half a salary to 6 times the public salary. One interviewee mentioned that cultivating a piece of land given by local authorities ‘enables us to escape buying food on credit in local shops’. Another doctor explained that the parabolic antenna he had bought with his brother doubled his salary during the world football championships; the latter also ran a printing shop. These activities were said to interfere with professional work ‘only in terms of number of hours at work’.

Second job within public sector

Four doctors reported that, as a complement to their principal work in the public sector, they took extra ward, casualty or health centre duties. This possibility for extra income within the public sector is in some countries legally encouraged: one shift in casualty was the equivalent of one month’s salary. These activities were seen as a positive development for, while before it was difficult to get doctors for casualty duties, now they were readily available.

Allowances and per diems

Allowances and per diems seem to top all other extra income activities regarding frequency and
effectiveness. Commenting on the notion of ‘seminaritis’, one interviewee said he hoped ‘they will not abolish seminars, for life would be a lot tougher without the per diems they provide’. One physician said he earned a month’s salary by teaching at a 4-day workshop for a foreign agency. A number of interviewees actually presented these strategies as a very positive transfer of resources from the private and the NGO sector to the public sector by means of salary subsidy. Few negative effects were mentioned. Most of the interviewed physicians seem to think these premiums and per diems are for activities within their job description, and cannot have a negative influence.

However, three doctors who mentioned supervision allowances as an additional source of income immediately added that supervision calendars were fixed in advance, as if they wanted to underline that they did not take undue advantage from these opportunities. This could be an indication that they were aware of potential adverse effects of this premium on the functioning of local health services:

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**Table 1 Sources of extra income mentioned, and the number of times an interviewee mentions the strategy as being used by him/herself (direct) or by one of his colleagues (indirect)**

<table>
<thead>
<tr>
<th>Source of extra income</th>
<th>Mentioned as being used by interviewee</th>
<th>Mentioned as being used by others</th>
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<tbody>
<tr>
<td>Non-medical Agro-pastoral</td>
<td>Commercial farming 1</td>
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<td>Commercial Subsistence agriculture 6</td>
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<tr>
<td>Commercial Food 1</td>
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<tr>
<td>Commercial Manufactured products/cloths 4</td>
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<tr>
<td>Medical Secondary jobs Hospital ward 3</td>
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<tr>
<td>in public sector Health centre 2</td>
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<tr>
<td>Medical Casualty/Emergency 3</td>
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<td>Teaching in nursing colleges 1</td>
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<td>Punctual premiums Supervision 4</td>
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<td>and per diems Incentives from project/NGO 5</td>
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<td>Punctual premiums Teaching/attending workshops 12</td>
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<td>Punctual premiums Consultancies 3</td>
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<td>Punctual premiums Research 2</td>
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<td>Private practice Home visits 1</td>
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<tr>
<td>Private practice Private clinic 2</td>
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<tr>
<td>Private practice Private clinic and drugstore 2</td>
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<td></td>
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<tr>
<td>Private practice Clandestine abortions 2</td>
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<tr>
<td>Private practice Private clinic and laboratory 1</td>
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<tr>
<td>Private practice Private employment 3</td>
<td>2</td>
<td></td>
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<tr>
<td>Use of public resources Cars/petrol 5</td>
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<td>Use of public resources Administrative material 2</td>
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<td>Use of public resources Money 2</td>
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<tr>
<td>Use of public resources Accommodation/housing 5</td>
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<td>Use of public resources Medication and medical material 3</td>
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<td>Use of public resources Private practice within public facilities 1</td>
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<td>Use of public resources Presents from patients 5</td>
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<td>Social support Church 1</td>
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<td>Social support Family 5</td>
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supervisions being carried out more often than needed, or doctors fighting to go on supervision and neglecting other duties.

Private practice

Six interviewees said they developed a private practice, 5 in a formal private clinic, one limited to paying home visits. In addition, 3 had contracts with a private firm, with embassies or with a rich family to provide health care for its members, either for a fixed monthly allowance or on a fee-for-service basis.

Private practice in all its forms was said to be financially quite rewarding, although to various degrees. For instance, some interviewees reported that a doctor’s monthly income could be doubled with 15 days of private practice, whereas others estimated that this could be achieved with 10 hours—or even one hour—of private practice.

But the extra income was not the only reason provided for going private. One interviewee said he had started selling drugs at his private practice because it was ‘easier for patients’, and because it ‘favours continuity of treatment’. Others suggested that better quality of care for the communities was a positive impact of private practice. A number mentioned the problem of competition for working time, but none of the interviewed physicians expressed concerns about possible conflicts of interest resulting from involvement of public servants in private practice.

Private use of public resources

Private use of public resources ranged from using the services’ car for personal travel and taking pencils and paper home for the children, to taking ‘loans’ out of the hospital funds. Besides use of service vehicles and administrative material, which was generally accepted by the interviewees as part of the job, the loss of resources for the public health system resulting from appropriation by health workers of money, drugs and medical material was described in very negative terms.

None of the interviewees reported selling public drugs for their own benefit—a practice which is undoubtedly highly prevalent (Van der Geest 1982) and often referred to as being used by other doctors. This issue was apparently thought too reprehensible to be discussed openly. More generally, all interviewees denied using the public service for private purposes in any way: recruiting patients, changing patients to gain access to care, medication or laboratory tests, or using public material for private patients. Although reported anecdotes about such practices abound, interviewees do not describe them as sources of income for themselves.

Presents and social support

Gifts from patients—sometimes represented as a ‘petty form of corruption’ (Van der Geest 1982)—were said to provide an effective source of income by some doctors. Others said such presents are too irregular to consider them as a real source of extra income. Most interviewees, however, explicitly considered these gifts as an expression of appraisal or gratefulness rather than as a source of income, and certainly not as a barrier to access.

Besides gifts from patients, one interviewed doctor reported that the church supported him with accommodation and food, and 5 interviewees declared that they received regular food support from their families.

Perception of interference with public duties

Given the workload they imply, these various individual strategies can be expected to interfere with the official work of the physicians by diminishing the actual time they spend on the job. Indeed, most of the interviewees acknowledged the negative impact of extra work on public sector activities in terms of decreased personal availability, and consequences in terms of tiredness, lack of attention for their work in their official capacity, or increased waiting time for the patients. Some said they were present in their hospital or health centres only during mornings. Others, however, explained how they left the actual running of their secondary activities to relatives or employees and so worked the official number of hours in the public service.

Motivational issues

The explicit raison d’être of this effort to obtain an extra income was to try to maintain an acceptable
standard of living, despite salary cuts and rising cost of living. Reference was made to food, water and electricity bills to pay, to the need to support an extended family, to situations of stress and war, or to debts that were contracted in better times. An Angolan physician mentioned the need to support the professional development of fellow health workers. The bottom line, however, was coping with difficult economic circumstances and trying to maintain an acceptable standard of living.

Side activities brought in very considerable amounts of income, out of proportion to the official salary. For some, generating extra income was far more time consuming than their official job. Most acknowledged that their income from private activities was more important than their public servant salaries. Nevertheless, they all identified themselves professionally in the first place as civil servants. One interviewee, for instance, ran two private practices, a vegetable garden and a shop, but all the same continued working mornings in a public health facility. Salary was clearly not the main motivation: this interviewee explained that remaining a public servant ensured job security, credibility as a doctor and the social contacts public service grants. Other answers follow the same pattern: credibility and job security. Some added that public service gives access to power centres and resources through which other coping strategies can be developed.

Discussion

The medical doctors interviewed in this study certainly do not constitute a representative sample of African doctors, not even for West and Central Africa. Studying abroad is a much coveted privilege, and the interviewees probably have better access to decision centres and funding agencies than the average African physician. On the other hand, those who are highly successful in generating extra income, may be less likely to attend a public health course. These interviews nevertheless provide some insight into what may be happening amongst medical doctors in response to the inability of the public sector to sustain a credible system of health care delivery.

The lore on how health workers cope with the difficult economic situation most often focuses on those activities that are in obvious contradiction to the logic of a public service: appropriation of public resources for private means, ‘racketeering’ of patients and selling drugs for private profit (Melrose 1982) are activities which evidently hamper accessibility and jeopardize equity. What is highlighted in that perspective is, for example, that ‘patients go for days without seeing a doctor, unless bribes are paid or if there are family connections with those in authority.’ (Anonymous 1995).

However, this small sample of physicians identified no less than 28 different types of individual strategies. Most of these potentially affect health service delivery, more through reduced availability of personnel than through blatant misappropriations. More detailed investigation of the different coping strategies should lead to a typology based on documented rather than assumed impact. This would give a better basis for tackling the problem.

Interviews such as these cannot document actual practice or its effects. What they provide is information about the way medical doctors mentally reconstruct the phenomenon of coping strategies, about their beliefs and experience related to various strategies, their views on compatibility of other activities with their public servant identity, their perception of what is more or less socially acceptable.

Socially constructed views on coping strategies

Two major tracks for interpretation can be drawn from the interviews: coping strategies are viewed by the doctors themselves primarily in economic terms, and are spontaneously categorized according to their perceived degree of social legitimacy.

Economic interpretation of coping strategies

Actors in any organization develop strategies in order to pursue their own interests (Crozier & Friedberg 1980)—economic, intellectual, affective, power or prestige. In the interviews conducted in this study, individual strategies are looked upon as ways to cope with a difficult economic environment. Obviously the design of the interviews induced this economic interpretation. But it is noteworthy that none of the interviewees proposed other explanations, whether in terms of job satisfaction or of career expectations. The explicit motives put
forward consisted in the search for a decent standard of living.

The definition of acceptable standards of living for physicians, however, is by no means universal, and very heterogeneous among the interviewees. There were doctors in rural settings who lived in houses which had no electricity or running water. Others rented houses with running water and electricity big enough to house 20 persons. Some had no personal or professional means of transportation, while one had 5 personal cars. All nevertheless engaged in extra income-generating activities. This indicates that the relation between income, actual living standard and coping strategies is not as straightforward as one might assume.

Various social, political and organizational factors probably contribute to shape the complexity of professional identities. Professional role-images of medical doctors are classically based on technical competence and service rather than self-interest orientation (Parsons 1951), but also include expectations related to high social status, leading to value conflicts for doctors practising in environments characterized by scarcity (Ogoh Alubo 1990). Foreign doctors working in these countries, and often earning as much as 50 times the salary of a local doctor, may contribute to a status image that African doctors try to emulate. The insistence on overall economic deterioration helps legitimize practices which, while aiming at improving social and economic status, remain marginal, irrelevant or even contradictory to the more classic role image of the medical profession.

Perceived legitimacy of various coping strategies

Not all strategies were presented as equally acceptable. It was possible to clarify somewhat the line separating legitimate activities from illegimate ones on the basis of what interviewees acknowledged to do themselves, and on the basis of their relative ease to speak openly about specific strategies.

During the interviews a number of strategies were mentioned as being used, not by the interviewee himself but by other colleagues: private practice within public services and selling drugs that belong to the public service. Finding out whether the interviewed physicians actually use these kinds of strategy but hesitated in admitting so is not the point here. The point is, is that in these doctors’ views, keeping private practice and public service separate seems to be important. In a context where structural adjustment is contributing to make private practice more legitimate, this explicit ethical standpoint is noteworthy. It may, however, result from a selection bias: all interviewees were involved in public-oriented service, and moreover attending a course in public health.

It appeared also that, the more individual coping strategies are dissociated from the public servant role, the more easily are they discussed openly. Recognition that the logic of individual coping strategies clashes with the logic of a public service would touch what still appears to be the core of the professional identity of these doctors: the role image of the doctor as public servant. This is supported by the reasons interviewees put forward for continuing public service work, and particularly the notion that civil servant status enhances professional and social credibility.

A frank discussion of these very delicate issues would have been quite impossible a few years ago. One interviewee commented about a colleague who sells the drugs belonging to his hospital: ‘A few years ago I would have condemned him severely. Now, I understand’.

In summary, coping strategies were seen as legitimate as long as, in principle, they were kept out of the public sector. In three circumstances however the overlap was seen as justified: when coping strategies ‘make it easier for patients’, when they brought extra resources into the public sector; and when they supported the development of fellow health workers.

Implications

Extra income-generating activities can be considered as ‘emergent strategies’ (Mintzberg 1994) that, left unchecked, lead to uncontrollable and undesirable side-effects for health care delivery, through a net transfer of resources (qualified personnel-time and material resources) from the public to the private-for-profit sector.

The balance, though, is not wholly negative. There may be compensation effects in terms of mobilization of additional resources where public funds are
scarce. Some individual coping strategies can also have a stabilizing effect on qualified personnel by allowing them to attain a standard of living which is closer to what they expected. The amount of time invested in private practices, even the not very profitable ones, may also permit the realization of professional goals which are blocked in public service because of deteriorating working conditions.

The response from the side of most Ministries of Health is one of laissez faire, laissez aller. This permissivity can be explained in 3 ways. First, if the economic effectiveness of individual coping strategies indicated by the interviewees is even a bit close to reality, most African countries do not have the financial capacity to increase salaries enough to compete with them in an effective way (Chernikovski & Bayulken 1995). Second, allowing the development of secondary activities is seen as a way to stop the brain-drain from the public health services. And last but not least, very powerful pressure groups, such as pharmaceutical companies, the urban elite, and health workers themselves, obtain advantages from the existing system.

Potentialized by and enhancing the effects of structural adjustment programmes and the reigning economic theory they carry, all these factors are rapidly undermining the capacity of the State in providing, organizing and controlling the health system. The problem is that, in countries where the health system was until recently purely public, no other organization, be it of professionals, representatives of the population or patients, has emerged which is strong enough to replace the State in assuring accessibility, equity and quality of health care.

Foreign agencies further stimulate coping strategies through allowances and per diems, which seem to enjoy an unquestioned legitimacy. However competitive and effective they may be in the short run, they may also run counter to public interest. This form of incentive is indeed designed to have operational staff perform those tasks and activities that are on the priority list of international organizations, bilateral cooperation agencies and NGOs. These priorities not only change too fast and too frequently to be absorbed by the countries (Justice 1987), they also reflect the values, interests and philosophies of the West, instead of being tuned to local interests and grassroots priorities (Stone 1992). Besides being ethically questionable (Olweny 1994), this potentially has counter-productive effects: from total failure of programmes due to lack of adjustment to local situations (Banerji 1990; Foster 1987; Justice 1987; Zaidi 1994), to disruption of basic health services as health personnel spend their time attending various seminars and workshops.

The question is whether a purely economic response to coping strategies makes sense. The rationale of doctors developing side-activities probably extends far beyond the sole economic interpretations usually provided. The presence and influence of role models and ethical rules can be felt throughout these interviews. In the climate of permissivity presently reigning in public health services in Africa, it makes sense to speculate that ethical rules and the idea physicians have about what is socially acceptable for a doctor remain important to keep health worker behaviour from degenerating into a purely commercial market approach. This should be capitalized upon, strengthening the public interest role model of physicians and privileging coping strategies that are not in conflict with public service goals and the delivery of quality care to the population.

It would, however, be an illusion to expect the tenuous barriers of ethics to hold against increasing economic hardship in the absence of mechanisms ensuring that practitioners’ behaviours remain in line with wider societal interests. Neither the state, nor professional associations, nor consumer organizations seem to be able to play that role satisfactorily for the time being.

Studying coping strategies more closely implies understanding them from the point of view of health professionals, but also to identify structural conditions which, in the organization of the health care system, affect these strategies. The methodology of first choice for exploring the feasibility and effects of various organizational responses to coping strategies is that of action research at local level. The underlying hypothesis is that, even in an adverse socioeconomic environment, it is feasible to create conditions that allow individual providers’ strategies to remain compatible with equity and quality, while responding to their aspirations for survival, social status and professional satisfaction.
This, in turn, should feed policy-based mechanisms of control, which have to be documented and evaluated.

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References