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A telling phrase in David Southall and colleagues' Comment[1] is: "By offering better salaries and working conditions… international organisations prevent government-trained doctors and nurses from contributing to their NHS."

International organisations are not preventing health workers from being employed in public systems, but are providing what public health systems often neglect—good working conditions, on-time salaries, and recognition. From research on retention, we know that financial and non-financial factors affect health workers' choices about where they work and whether they stay.

In countries with weak health systems, non-state sectors might provide the bulk of health services. We cannot assume, therefore, that health workers employed by non-state sectors do not contribute to public health. Government health workers frustrated by poor working conditions might transfer to employers that provide salaries, equipment, and facilities, enabling them to perform well. Would they otherwise migrate externally and be lost as a resource to their countries?

The objective of WHO's guidelines[2] is to promote retention in underserved areas (especially remote and rural areas) to meet community needs, not retention in government facilities. Private organisations might be better at retention and support than governments. If the goal of quality health care is met, working in non-government settings should not be problematic.

We need more health workers everywhere. We need to make health workers' jobs attractive and give them the right to choose where they sell their skills. To avoid critical shortages, we should ramp up recruitment and retention, not remove choice.

We declare that we have no conflicts of interest.

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Authors' reply

We agree with Marko Kerac's experience from Malawi that health workers employed by international health organisations (IHOs) can effectively support public health services. The experience of our IHO, Maternal and Childhealth Advocacy International, in The Gambia and Pakistan, is that working in close partnership with the Ministry of Health is particularly supportive of the national health service (NHS).[1,2] It is our experience that funders of research find the added cost of supporting the NHS unacceptable.

We are not aware of evidence for Kerac's statement that employment outside the public sector helps staff trained by the state to remain in that country. If anything, our experience suggests that, especially for male health workers, the resulting experience can encourage and enable them to migrate.

The example we gave from The Gambia of conflict between research needs and the NHS is unfortunately continuing. Recently, a nurse managing a ward in a government hospital was directly approached by a doctor from the UK's Medical Research Council (MRC) and asked if he would like to work for them. Most unusually, he refused. As we reported, a significant proportion (around 30%) of government-trained nurses and midwives who could be working in the only public sector hospital for 250 000 poor people are working for the MRC.

We consider it an ethical duty of research organisations to either bring in their own international staff to do the research or else train additional new staff in-country to do so. Being in The Gambia for 60 years has given the MRC plenty of time to do the latter. Although effective delivery of existing health technologies is important, the reality in rural Gambia is that pregnant women are dying because of insufficient nurses and midwives to care for them in basic ways which do not require new technology.

We agree with Katherine Tulenko and Barbara Stilwell that public health systems in poorly resourced countries might neglect the working conditions and salaries of their staff. A key phrase in their letter is "If the goal of quality health care is met, working in non-government settings should not be problematic". In The Gambia, the quality of health care for 95% of the population is *not* being met, due predominantly to lack of resources rather than failure of government. The Gambian Government is doing its best to advance but is being significantly held back by a proportion of its trained staff working outside the public sector with IHOs, abroad and in the private sector, serving the rich, tiny minority. We agree that jobs must be made more attractive in the public sector, something being achieved in some Gambian hospitals, but realistically this is best supported by international actions to relieve poverty.

Our suggestion is that weaknesses in the public health sector in poorly resourced countries be addressed by IHOs working in partnership with Ministries of Health, rather than by setting up parallel systems.

We declare that we have no conflicts of interest.

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Corbis

Japan's health policy

In his Offline piece on Japan's health system (Sept 11, p 858),[1] Richard Horton criticises the fact that large vested interests dominate and that the voice of the academic community is almost silent in Japan. The Ministry of Health, Labour and Welfare (MHLW) was indeed formerly the only think tank involved in Japan's health policy, but the political power shift in 2009 enabled the public to participate in policy making.

Before the regime change, MHLW held absolute authority over policy decisions and some problems inevitably could be pointed out. First, MHLW bureaucrats exclusively selected members of policy board meetings.[2] Such a procedure tapped into a limited range of opinions, leading to biased policy making. Second, scientists and doctors could not express their opinion against MHLW's policy. They feared offending the bureaucrats since they had the power to shuffle personnel.

However, the regime change enabled patients, doctors, and scientists to convey their opinions to the government. Medical students appealed for an increase in the number of doctors on television and the newspapers, and I was provided with an opportunity to discuss the matter with several politicians. These actions contributed to an increase in medical school quotas after a 24-year stagnation. This public-led reform seems similar to that of the UK during the Blair administration.

We hope that this trend will continue; however, the government and bureaucrats could collude again. We should take note of whether the Democratic Party truly maintains public participation in policy making.

We declare that we have no conflicts of interest.

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Richard Horton[1] discusses Japan's endemic political crisis and the threats to its health-care system. However, he does not mention the ongoing drastic revision of health-care policy after regime change from the Liberal Democratic Party of Japan (LDP) to the Democratic Party of Japan (DPJ) in 2009. These changes in Japan are similar to the New Labour health reforms in the UK[2] in many respects: increases in medical expenditure and doctors' supply directed by political leadership.

Over the period 1961–2009 of the Japanese universal health insurance coverage, the LDP governed the Japanese health-care system. Under the initiative of the bureaucracy and its regulation, the LDP had reined in the total medical fee, which triggered medical facilities' closures. The collapse of regional health care has been caused by this flawed policy and by physician shortages.[3]

After the change of government in 2009, the DPJ took the political initiative and placed 100 political appointees in the ministries. For the first time in 10 years, the DPJ increased the total medical fee to 0·19%, adding 570 billion yen.[4] Moreover, greater remuneration was allocated to first-stage inpatient treatment in the departments of emergency medicine, obstetrics, paediatrics, and surgery, as well as to hospitals for complex operations. These strategies turned the trend of doctors' resignations and helped to prevent the further collapse of medical services. The education ministry now plans to establish new medical schools to cover a deepening shortage of doctors.[5]

Japan should learn from the British lessons on health reform[2]—DPJ's ability to make radical changes of health policy is tested.

We declare that we have no conflicts of interest.

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Post-MBBS exit test for doctors in India

I am writing in response to a *Times of India* article dated Sept 17, 2010, which describes a common post-MBBS examination—"an exit test before docs can practice".[1] Apparently the newly constituted board of governors at the Medical Council of India (MCI) has accepted the fact that not all fresh medical graduates are ready for serving in society, meaning that they agree about the deterioration of medical education in our country. The story of the tainted president of the MCI, Ketan Desai, who is still in custody, has already been covered in *The Lancet*.[2]