Understanding the private health sector
in the Eastern Mediterranean Region

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WHO Library Cataloguing in Publication Data

Names: World Health Organization. Regional Office for the Eastern Mediterranean

Title: Understanding the private health sector in the Eastern Mediterranean Region / World Health Organization. Regional Office for the Eastern Mediterranean

Description: Cairo: World Health Organization. Regional Office for the Eastern Mediterranean, [2021] I Includes bibliographical references

Identifier: ISBN 978-92-9274-047-4 (pbk.) I ISBN 978-92-9274-048-1 (online)

Subjects: Private Sector I Workforce I Health Expenditures I Insurance, Health I Government Regulation I Eastern Mediterranean Region

Classification: NLM WA 540

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Contents

Foreword v

Acknowledgements vi

Executive summary 01

Introduction 07

Private health sector analysis and stakeholder perspectives 10

- **Private health sector resources** 11
  - A Facilities and infrastructure 12
  - B Growth determinants 14
  - C Human resources 16
  - D Resource generation 18
  - E Staff retention 18
- **Governance and regulation of the private health sector** 19
  - A Governance 20
  - B Private health sector legislation 22
  - C Registration and licensing 27
- **Private health sector financing modalities** 30
  - A Out-of-pocket payments 31
  - B Private health insurance 32
  - C Pricing schemes 35

- **Role of the private health sector in service delivery** 37
  - A Types of service 38
  - B Types of facility 41
  - C Intersectoral referral 41
  - D Use of private health sector services 42
  - E Distribution of private health sector services 44

Private sector health information systems 45

Quality and accreditation of the private health sector 48
- Quality perception 50
- Accreditation and service quality oversight 53

Public–private partnerships 56
- Definition and rationale of PPPs 58
- The legal and institutional environment 58
  for PPP and private sector engagement 65
- Public–private partnership examples in the Region 68
- Private sector engagement SWOT analysis 69

Policy directions and recommendations 70
- Adopt private sector engagement policies to assist in achieving universal health coverage 72
- Encourage private health sector investment
- Highlight the role of comprehensive health 74
  information in moving towards universal health coverage 76
- Emphasize the role of ensuring service quality in moving towards universal health coverage 77

References 79

Foreword

Universal health coverage (UHC) means that all people have access to essential, quality health services when and where they need them, without experiencing financial hardship. Reaching UHC is a key element of the Sustainable Development Goals and a strategic priority for the World Health Organization (WHO) both globally and as part of our vision of Health for All by All in the Eastern Mediterranean Region.

UHC cannot be achieved without the effective engagement and collaboration of all health actors including the private sector. Recognizing the significant contribution of the private sector to health service provision in the Eastern Mediterranean Region, Member States endorsed a framework for action on effective engagement with the private health sector for advancing UHC in the Region.

This regional report presents a snapshot of the operational environment of private providers in the health sector in 15 countries of the Region.

The report reveals that the effective engagement of the private health sector is hampered by significant challenges. These can be grouped into three broad categories. Firstly, many countries have reported governance challenges, with significant shortcomings related to the regulation and oversight of the private sector. These can be traced back to the fragmentation and limited capacities and resources of regulatory authorities. Secondly, there are challenges related to information. Many countries report that they lack sufficient evidence on the scope, scale and performance of private providers, restricting the ability of governments to make informed decisions from a health systems perspective and limiting opportunities for collaboration. Thirdly, a lack of formal and structured mechanisms for coordination with private providers limits knowledge transfer and effective collaboration, and promotes mistrust.

Despite the challenges, multiple opportunities for effective collaboration exist in the Region. There is political will, interest among donors, as well as some institutional capacities, frameworks and laws to underpin intersectoral partnerships.

WHO has pledged to support countries in addressing the identified challenges as part of its mandate and commitment to achieving UHC. I look forward to moving ahead with this important work.

Dr Ahmed Al-Mandhari
WHO Regional Director for the Eastern Mediterranean

Acknowledgements

This regional review was based on findings reported by a research team in 15 countries and territories of the WHO Eastern Mediterranean Region. We would like to recognize their individual work and the valuable contribution of their analysis and efforts in arriving at our regional understanding of the role of the private health sector in the Region.

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The authors express their gratitude to WHO partners for their support in the technical review of the report. Valuable contributions and support were provided at various stages by Dr Anirban Chatterjee, Regional Adviser, Health and Nutrition, Regional Office for the Middle East & North Africa, UNICEF; Dr Tomomi Kitamura, Child Survival & Development Specialist, Regional Office for the Middle East & North Africa, UNICEF; Dr Srihari Dutta, MBBS, MD, DIH, Health Specialist, Primary Health Care & Immunization, Regional Office for the Middle East & North Africa, UNICEF; Monica Villanueva, Health and Education Team Lead, Middle East Bureau, United States Agency for International Development (USAID); Amy Kay, Senior Health Advisor, Middle East Bureau, United States Agency for International Development (USAID); Dr Mohamed Afifi, Reproductive Health & Humanitarian Programme Specialist, Arab States Regional Office, UNFPA; Dr Walid Ibrahim, Country Manager, Egypt, UNAIDS; Dr Zinia Sultana, Public Health Officer, UNHCR; Dr Taghreed Farahat, President, Eastern Mediterranean Region, World Organization of Family Doctors (WONCA); Dr Nagwa Nashaat, General Secretary, Eastern Mediterranean Region, World Organization of Family Doctors (WONCA).

Executive summary

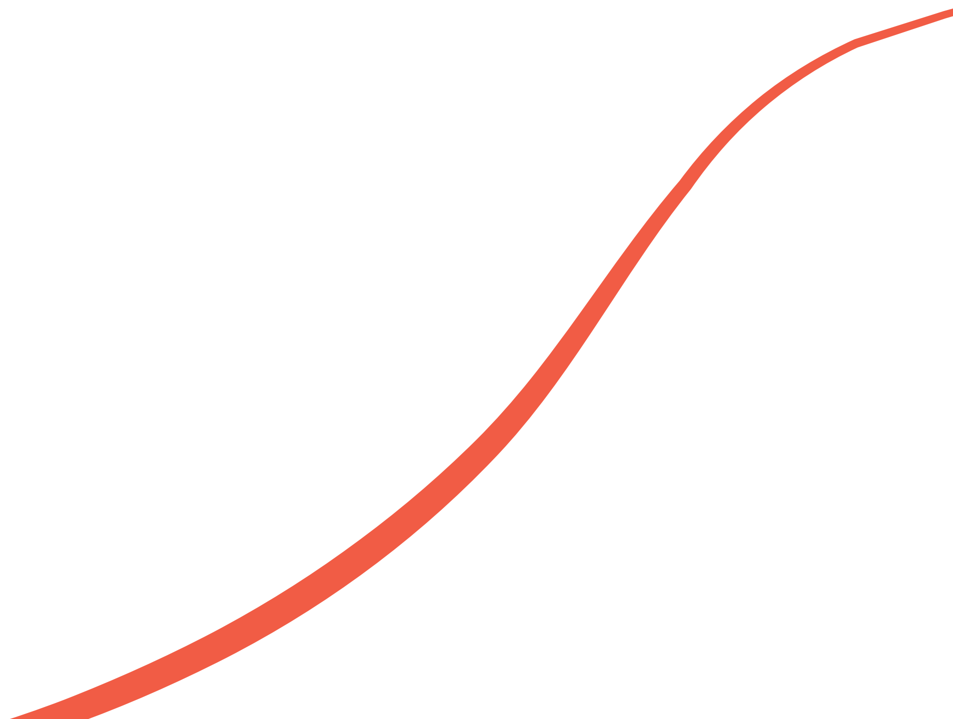
The private health sector (PHS) has grown rapidly over the past few years in the WHO Eastern Mediterranean Region and is expected to continue to grow as the public sector struggles to address the growing demand for health care. Low levels of health spending affect the quality of services in public facilities, which further drives patients to seek care in the private sector. This situation is exacerbated by lobbyists, dual practice among staff, limited enforcement of regulatory measures, and the growing adoption of neoliberal economic policies.

PHS services tend to be concentrated in urban areas, with a focus on revenue-generating secondary and tertiary curative care.

Among the main growth drivers are ambitious plans to include the PHS in national health insurance schemes, as observed in countries such as Oman and Qatar as part of their 2030/2040 health visions. Further growth drivers include investment laws that incentivize the growth of the private sector, the easing of bureaucratic processes, and the growth in purchasing power among people in some countries, such as Tunisia. The for-profit PHS is a key service provider in all countries and territories of the Region, except for Afghanistan, Djibouti and, to some extent, the occupied Palestinian territory, including East Jerusalem, where the not-for-profit sector plays a more prominent role. PHS services are more concentrated in urban areas, with a focus on revenue-generating secondary and tertiary curative care, a limited role in primary care and a virtual absence in promotive or rehabilitative care.

PHS facilities in the Islamic Republic of Iran, Iraq, Jordan, Lebanon, the occupied Palestinian territory, Oman and Qatar include private hospitals, private clinics, labs, and diagnostic and rehabilitative centres. Intersectoral referral processes range from being established to being poorly coordinated.

With a few exceptions, the use of PHS services in the Eastern Mediterranean Region is notably high. In Pakistan, the PHS provides services to nearly 70% of the population (outpatient and inpatient care). In Sudan, almost 50% of health services are accessed through private sector health facilities (for profit and not for profit). The use of private outpatient clinic services in the Islamic Republic of Iran and in Lebanon is estimated at 80% and 90%, respectively. It is further estimated that in the Islamic Republic of Iran 50.4% of patients seek health services from private outpatient clinics. In Sudan, almost 30% of patients make their first contact with the health system through a private facility. Similarly, in Jordan, private clinics are estimated to account for nearly 40% of all initial patient contacts. In Lebanon, private hospitals attract twice as many admissions as the public sector. This is contrary to the situation in the Islamic Republic of Iran, where 70% of inpatient admissions are at public hospitals.



The PHS is weakly regulated due to:

- fragmentation of regulatory authorities
- poor coordination among relevant agencies
- government leniency in enforcing laws and regulations
- weak institutional structure and capacity
- corruption
- lack of financial and human resources
- poor management
- bureaucratic bottlenecks

Private, for-profit facilities across the Region are highly concentrated in urban areas with relatively higher purchasing power. Not-for-profit facilities are typically present in rural and hard-to-reach areas. The urban bias of the formal, for-profit facilities may be due to the common unfavourable economic conditions in remote areas and the low purchasing power of the population, which decreases the demand for private services as well as revenues for private providers. Moreover, a lack of policies to incentivize PHS investments in rural areas or underserved areas, coupled with the underdeveloped infrastructure, presents challenges to PHS investors. This puts less-privileged areas and populations at a disadvantage and deprives them of a typically more equipped and advanced private sector.

Due to the legalization of dual practice in many countries of the Eastern Mediterranean Region, it is not possible to clearly distinguish health workers in the private sector from those in the public sector. The educational facilities that produce the health workforce in the Region are predominantly in the public sector. Across the Region, the PHS offers better salary and benefits to staff, resulting in brain drain in countries where dual practice is not permitted. The better staff retention rate in the PHS has been attributed to financial and nonfinancial incentives as well as the improved working environment.

In general, the PHS is weakly regulated, particularly in low- and middle-income countries of the Region. This may be due to the fragmentation of regulatory authorities and poor coordination among relevant agencies, as in Afghanistan, Sudan and Yemen. Other reasons include government leniency in enforcing laws and regulations, weak institutional structure and capacity, corruption, lack of financial and human resources, poor management and bureaucratic bottlenecks. However, self-regulation is increasingly being practiced by some private providers for the sake of maintaining reputation and sustaining business.

The stewardship of the Region's mixed health system is generally the responsibility of ministries of health. However, the role and authority of health ministries vary. In some countries, such as Oman, the Ministry of Health acts only as a policy-maker and high-level coordinator, while other governmental institutions act as its operational arm.

However, in other countries and territories, such as the Islamic Republic of Iran, Lebanon, the occupied Palestinian territory and Yemen, the role of the health ministry is not limited to governance but extends to cover regulations, including PHS regulations. Professional syndicates and orders play a complementary role in regulating the PHS and the health system as a whole in some countries, such as Lebanon and Yemen.

Three groups in terms of pricing and tariff control

1 Those without price or tariff control

Occupied Palestinian territory, Sudan and Yemen

2 Those where pricing schemes are set but not fully enforced

Djibouti, Jordan, Libya, Morocco and Tunisia

3 Those where prices are set and enforced

Islamic Republic of Iran

Laws that aim to encourage private investment in the health sector have been reported in Jordan, Morocco, Sudan, Tunisia and Yemen. These laws typically offer incentives or ease regulations on private investments in the health sector. Nonetheless, PHS investment is still legally restricted in some countries, such as Iraq. Some countries, such as Morocco and Tunisia, have laws that govern the physical standards for infrastructure and staffing requirements in health care facilities. However, the levels of detail of such specifications, as well as the requirements, are highly variable.

In terms of pricing and tariff control at private facilities, countries and territories in the Eastern Mediterranean Region can be classified into three groups: those without price or tariff control; those where pricing schemes are set but not fully enforced; and those where prices are set and enforced. The first group includes the occupied Palestinian territory, Sudan and Yemen. The second group includes Djibouti, Jordan, Libya, Morocco and Tunisia. The third group includes the Islamic Republic of Iran.

The licensing of private sector health care professionals is typically the responsibility of medical councils, as in Afghanistan, the Islamic Republic of Iran, Morocco and Pakistan; the responsibility of the syndicates, as in Iraq; or the joint responsibility of councils or syndicates and the health ministry, as in Jordan, Lebanon, Libya and Yemen. However, the registration and licensing of health care facilities is mostly the responsibility of the ministry of health, medical syndicates or separate regulatory bodies. Formal relicensing mechanisms of private health facilities are reported in the Islamic Republic of Iran, Sudan and Yemen. Oversight of private health facilities is commonly the responsibility of the ministry of health, as in Morocco, Qatar and Yemen. Challenges in the licensing process in the Region range from the overcomplexity of the process to its complete absence.

Most PHS facilities in the Eastern Mediterranean Region are funded by out-of-pocket payments and private health insurance. Direct payment at the point of care is the main revenue stream for private providers in Afghanistan, Djibouti, the Islamic Republic of Iran, Libya, Morocco, the occupied Palestinian territory and Yemen. Private facilities in Qatar, however, mainly generate profit through private health insurance, while in Lebanon, public agencies (public insurance) are major contributors to revenue generation in private hospitals.

Despite the significant contribution of the PHS to service delivery in the Region, it is more often than not excluded or minimally represented in assessments and evaluations of the health system. Accordingly, there is a lack of data and information on the size and characteristics of the PHS in the Region, very little information-sharing between the PHS and the public sector, and no comprehensive private sector assessment in countries and territories. Barriers to information-sharing include fear of heavy taxation by the government (which stands in the way of getting information about the size of business and sources of financing in the PHS), modest infrastructure, paper-based reporting, loss of data and lack of reporting accountability.

The PHS was perceived to provide better quality of care in most of the countries and territories within the scope of our review. However, the quality of services in the PHS is far from homogenous. Only respondents from Oman and Yemen mentioned that the quality of services is better in the public sector. In Afghanistan, the quality of services in both sectors was perceived to be equally poor. The accreditation process for private health care facilities in the Region is highly variable. It ranges from being nonexistent or in process, to being present but unenforced, to being present and enforced. In Afghanistan, Djibouti and Yemen, there is currently neither oversight of the quality of services nor an accreditation process in place for them.

Only respondents from Oman and Yemen said that the quality of services is better in the public sector

We attempted to classify countries and territories into three categories

1
Those where PPP and/or PSE are recognized in national policies but supporting structures are missing

Djibouti, the occupied Palestinian territory, Qatar and Sudan

2
Those where PPP and/or PSE are not recognized in national policies and plans

Iraq and Yemen

3
Those where laws and structures are in place for PPP and/or PSE

Afghanistan, the Islamic Republic of Iran, Jordan, Lebanon, Libya, Morocco, Oman and Tunisia

Given the widespread growth of the PHS and the increasing demand for health care in the Region, engaging the PHS in the form of public–private partnerships (PPPs) is acknowledged as inevitable in achieving universal health coverage through risk-sharing and complementarity-based roles. Disparities were observed in the readiness of countries and territories for PPPs and for private sector engagement (PSE) in general. Accordingly, we attempted to classify countries and territories into three categories, as follows: those where PPP and/or PSE are recognized in national policies but supporting structures are missing; those where PPP and/or PSE are not recognized in national policies and plans; and those where laws and structures are in place for PPP and/or PSE. The first category includes Djibouti, the occupied Palestinian territory, Qatar and Sudan. The second category includes Iraq and Yemen. The third category includes Afghanistan, the Islamic Republic of Iran, Jordan, Lebanon, Libya, Morocco, Oman and Tunisia.

There are multiple examples of PPP across the Region. But most PPPs and PSEs are sporadic, ad hoc mechanisms rather than systematically planned and managed partnerships. Appropriate policy, legal and institutional frameworks and organizational structures are either absent or poorly developed. Our assessment has defined three priority areas for improvement: increased awareness of PPP and PSE modalities among policy-makers, development of health-sector-specific policies and legal frameworks for PPPs and PSE, and capacity-building in PPP and PSE project planning and risk assessment. In addition, development of a guiding framework for PSE and implementation of fair contractual arrangements with clear roles, responsibilities and payment mechanisms are critical.

1 Introduction

The WHO Eastern Mediterranean Region comprises 22 countries and territories that are home to almost 9% of the world's population. The Region is characterized by multiple complex health emergencies. At the end of 2018, 37 million people in the Region were affected by conflict, war and natural disaster, from a total of 80 million people globally. In 2018, there were nine graded health emergencies and 19 major outbreaks of emerging and epidemic-prone diseases in 12 countries and territories of the Region *(1)*.

More than half of countries in the Region do not meet the minimum density threshold of 44.5 doctors, nurses and midwives per 10 000 population

Despite the political instability in the Region, noticeable progress has been achieved across multiple health indicators. Between 1990 and 2017, the maternal mortality ratio declined by 50%, to 166 deaths per 100 000 live births, compared with a global average of 216. However, 31% of countries in the Region continue to witness over 70 maternal deaths per 100 000 live births, and the maternal mortality ratio in Afghanistan and Somalia continues to be among the highest worldwide *(2)*.

In 2017, almost 800 000 deaths of children under the age of five, of whom more than 50% were newborns, were recorded in the Region. Noncommunicable diseases have been identified as the main cause of death in all but one country of the Region. Life expectancy and healthy life expectancy in the Region have been estimated to be lower than the global averages by 2.9 and 3.6 years, respectively *(1)*.

The unstable political situation has also resulted in economic repercussions. According to WHO's 2019 *Health and well-being profile of the Eastern Mediterranean Region*, more than one fourth of the population is living below the international poverty line in five countries and territories. Coverage for essential health services is also less than the global average. In 2015, the regional average for the universal health coverage (UHC) index stood at 53, compared with a global average of 64. The Region is further characterized by low health care spending, which represents less than 2% of global health expenditure *(1)*.

The density of primary health care (PHC) facilities is inadequate: 12 countries have less than one PHC facility per 10 000 population, including four high-income countries. Moreover, there is a general shortage of health care workers. More than half of countries in the Region do not meet the minimum density threshold of 44.5 doctors, nurses and midwives per 10 000 population, which is required to advance UHC, and seven countries do not meet the minimum density threshold of 23 doctors, nurses and midwives per 10 000 population, which is needed for the delivery of basic health interventions *(1)*.

The health systems in countries of the Eastern Mediterranean Region are mixed, with a strong and growing private health sector (PHS) particularly in low- and middle-income countries. In a recent assessment, the for-profit PHS has been estimated to provide 53% of inpatient and 66% of outpatient services in the Region *(3, 4)*. Domestic private expenditure on health has been estimated at 61.4%, with stark variations between countries depending on their income levels *(4)*. In 2018, average out-of-pocket (OOP) expenditure in low-income countries of the Region was 72.3%,[1] compared with 13.9% in high-income countries *(5)*.

[1] Excluding Somalia, the Syrian Arab Republic and Yemen, for which data were not available.

The PHS has also been playing a significant role in countries that are experiencing protracted emergencies. The United Nations High Commissioner for Refugees notes that 64% of registered Syrian refugees in Egypt seek care in the PHS and close to 60% of Syrian refugees who seek medical care in Jordan go to a private facility first *(6, 7)*.

The PHS is thus considered a key partner in the realization of UHC in the Region. In October 2018, the 65th session of the WHO Regional Committee for the Eastern Mediterranean endorsed the Framework for Action on Effective Engagement with the Private Health Sector to Expand Service Coverage for Universal Health Coverage. The Regional Committee also adopted resolution EM/RC65/R.3(D), which urges Members States to engage with the PHS to deliver a UHC priority benefits package. The resolution further called on the WHO Regional Director for the Eastern Mediterranean to support country assessments that would identify challenges and opportunities related to the engagement of private care *(8, 9)*.

Based on this resolution, the WHO Regional Office for the Eastern Mediterranean developed a PHS assessment tool and used it to assess the PHS in 15 countries and territories. The tool has two main components: a desk review and qualitative expert interviews that cover five pillars pertinent to the PHS operational environment: governance, financing, access, quality control and public–private partnerships (PPPs).

This report aims to summarize the key findings from the 15 assessment reports, covering Afghanistan, Djibouti, the Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, the occupied Palestinian territory (including east Jerusalem), Oman, Pakistan, Qatar, Sudan, Tunisia and Yemen. The reports were developed between 2019 and 2020. Given the general lack of data on the PHS in the Eastern Mediterranean Region, we conducted qualitative expert interviews to address the gaps in information. Hence, some of the presented data are not linked to published resources. The data presented in this report have, however, been endorsed and validated by the ministries of health of the countries within the scope of this assessment.

2
Private health sector analysis and stakeholder perspectives

The PHS is defined by the World Bank as all actors outside of government including for-profit, nonprofit, formal and nonformal entities. This definition includes service providers, pharmacies and pharmaceutical companies, producers and suppliers, shopkeepers, and even traditional healers *(10)*. Unless otherwise stated, "private health sector" in this report refers to formal, for-profit service providers.

In the Eastern Mediterranean Region, the PHS is very active, providing ambulatory, hospital and medical educational services. It is also heavily involved in infrastructure development as well as in the production and supply of medicines and medical devices.

2.1 Private health sector resources

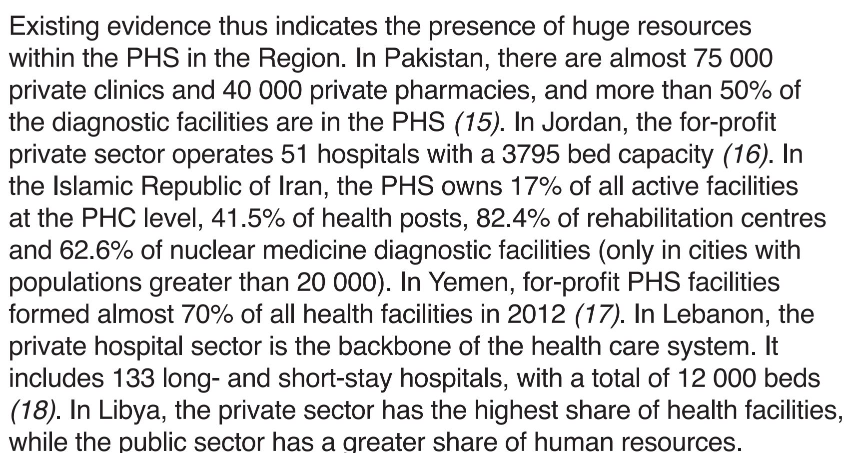
A Facilities and infrastructure
B Growth determinants
C Human resources
D Resource generation
E Staff retention

A

The private, for-profit health sector has seen consistent growth in recent decades across most of the Eastern Mediterranean Region

Facilities and infrastructure

The private, for-profit health sector has seen consistent growth in recent decades across most of the Eastern Mediterranean Region. In Tunisia, the number of private clinics has increased fourfold in the last 30 years *(11)*. Similarly, a fourfold increase has been noted in the number of private sector hospital beds in Oman between 2005 and 2017, compared with a 10% increase in the public sector *(12)*. In Iraq, the number of private pharmacies almost doubled between 2015 and 2019 *(13)*. In Jordan, a third of current private clinics have been established within the last five years *(14)*. This growth, however, is skewed towards urban areas. The pattern of private sector expansion has been mostly in the curative and secondary and not the preventive and primary health care areas.



Existing evidence thus indicates the presence of huge resources within the PHS in the Region. In Pakistan, there are almost 75 000 private clinics and 40 000 private pharmacies, and more than 50% of the diagnostic facilities are in the PHS *(15)*. In Jordan, the for-profit private sector operates 51 hospitals with a 3795 bed capacity *(16)*. In the Islamic Republic of Iran, the PHS owns 17% of all active facilities at the PHC level, 41.5% of health posts, 82.4% of rehabilitation centres and 62.6% of nuclear medicine diagnostic facilities (only in cities with populations greater than 20 000). In Yemen, for-profit PHS facilities formed almost 70% of all health facilities in 2012 *(17)*. In Lebanon, the private hospital sector is the backbone of the health care system. It includes 133 long- and short-stay hospitals, with a total of 12 000 beds *(18)*. In Libya, the private sector has the highest share of health facilities, while the public sector has a greater share of human resources.

Across most of the Region, the private sector owns most of the sophisticated equipment and advanced technologies. In 2016, the private sector owned 75% of CT scanners, 81% of MRI devices and 72% of cardiac catheterization rooms in Tunisia *(19)*. However, this ownership does not imply a homogenous distribution of equipment across PHS facilities. It has been observed that PHS facilities range from those that own the most sophisticated equipment to those lacking the basic tools for service provision. This diversity has also been noted in Pakistan, where many PHS facilities are built without following an internal design that would allow for the standard distances between different units. Facilities sometimes lack basic utilities, including power and water supply, sanitary installations, and sewage and solid waste management systems. The country's hospitals are also said to be either too big or too small for the number of patients they serve, specifically in the outpatient departments *(20)*. The availability of essential medicines is also generally higher in the PHS than in the public health sector, but supporting data are generally lacking in most of the Region.

Some countries have a limited for-profit private sector presence, as in Afghanistan and Djibouti. In Afghanistan, there are only around 400 licensed private hospitals and clinics, 800 labs, 100 diagnostic centres and 145 private mid-level training centres, compared with a total of 3300 public health facilities *(21)*. Similarly, in Djibouti, the public sector has more resources than the private sector, with public sector beds accounting for 92% of total beds *(22)*.

Facilities sometimes lack basic utilities, including power and water supply, sanitary installations, and sewage and solid waste management systems

The presence of the not-for-profit health sector is uneven across countries of the Region, and data on it are lacking in many countries

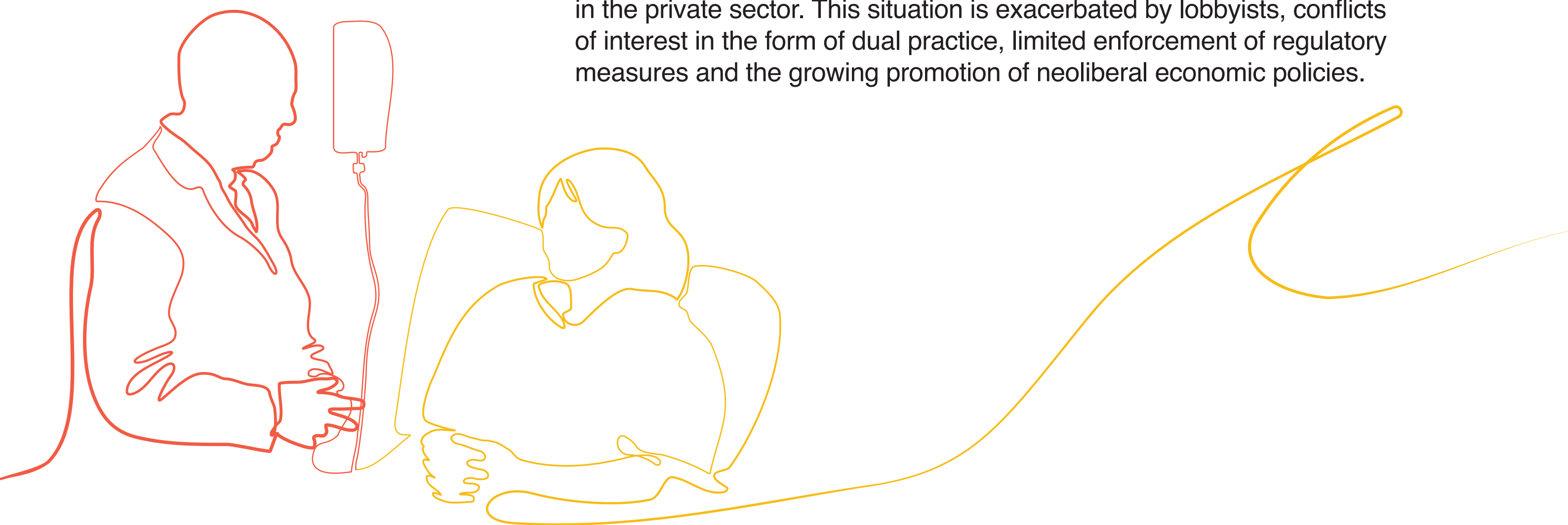
Data about the staffing, bed capacity, types and levels of services of the for-profit PHS are lacking in Afghanistan, the occupied Palestinian territory and Yemen, which makes it impossible to estimate the total resources of the sector and of the health system as a whole.

The presence of the not-for-profit health sector is uneven across countries of the Region, and data on it are lacking in many countries. In Iraq, there is not a regularly operating and sustainable not-for-profit PHS. The only noted activities are limited to mobile clinics that typically offer services during specified religious occasions, and to humanitarian relief operations conducted in collaboration with the public sector. However, the sector is very well established in Afghanistan and Pakistan and is considerable in Jordan. In Afghanistan, around 57 nongovernmental organizations signed memorandums of understanding on service delivery with the Ministry of Public Health in 2012 and delivered health projects. Accordingly, nongovernmental organizations have become prominent providers of health services in the country *(21).* In Pakistan, the not-for-profit sector owns more than 20 medium to large entities offering medical or specialty services. The emergency and response philanthropic networks are also said to have the highest outreach across most areas of Pakistan *(23)*. In Jordan, nongovernmental organizations run 98 clinics and eight medical laboratories as well as 15 hospitals with a total bed capacity of 1197 *(16)*.

B

Growth determinants

As mentioned earlier, the PHS has grown drastically over recent years in the Eastern Mediterranean Region and is expected to continue to grow as the public sector struggles to address the growing demand for health care. The low levels of spending on health reflect on the quality of services at public facilities, which further drives patients to seek care in the private sector. This situation is exacerbated by lobbyists, conflicts of interest in the form of dual practice, limited enforcement of regulatory measures and the growing promotion of neoliberal economic policies.



Among the main growth drivers are ambitious plans to include PHS in national health insurance schemes. This has been observed in multiple countries of the Region, such as Oman and Qatar as part of their 2030/2040 health visions. Further growth drivers include investment laws that incentivize the growth of the sector, the easing of bureaucratic processes that would otherwise hinder expansion, and the growth in purchasing power in some countries, such as Tunisia. **Table 1** includes some of the current PHS growth determinants in selected countries of the Region.

Barriers to growth include the unstable political situation in some countries, which reflects on corruption rates, reliability of infrastructure, devaluation of local currency, high inflation rates and general sovereignty concerns, all of which stand in the way of PHS investments. Difficulties in accessing bank credit with a low interest rate are a challenge in some countries, like Djibouti. Uncontrolled and sometimes exaggerated costs of services also limit the proportion of the population who can seek care at private facilities, as does the availability of qualified health care professionals.

Table 1: Examples of current PHS growth determinants in selected countries

Growth determinants	Country
Endorsement of the federal law for the establishment of private health facilities freed up capital for investment in the private sector, with no stipulations that the investor have a medical background.[a]	Iraq
A lack of entry barriers, along with the growing market for medical tourism, encouraged many investors to get into this sector. This in turn led to a significant increase in the number of private hospitals.	Jordan
Government promotion of voluntary retirement, which gave advantages to civil servants, including doctors, to retire before the set time for retirement, has led physicians to move their practice to the private sector after several years of working at the Ministry of Health.	Morocco
The new social health insurance project involves basic services package coverage by private health insurers. The insurance programme includes both public and private health care providers, which will be funded by private health insurers for the services specified. Additionally, the Ministry of Public Health has allocated funds that will cover services that do not fall within the package.	Qatar
• Relaxation of purchasing contributed to a surge in the number of large private clinics, in addition to the provision of tax exemptions and financial incentives to investors. • The reform of health insurance has made the private sector accessible through contractual arrangements that govern relations with the National Health Insurance Fund (CNAM). CNAM affiliates who have chosen the private scheme are able to access.	Tunisia

[a] Government of Iraq, Ministry of Health, Curative Services Department, Technical Affairs Directorate, personal communication.

C

Human resources

Due to the legalization of dual practice in many countries of the Eastern Mediterranean Region, it is not possible to obtain data that clearly demarcate the distribution of health workers between the private sector and the public sector. Countries of the Region allowing dual practice reportedly include Afghanistan, the Islamic Republic of Iran, Iraq, Morocco, Oman, Sudan, Tunisia and Yemen. Some data exist but remain incomplete. In Afghanistan, it has been estimated that there are 2795 doctors and 1832 nurses working in the private sector *(24)*. In Sudan, dual practice is so common that only 9.3% of all health workers work exclusively in the private sector *(25)*. In the Islamic Republic of Iran, government hospitals absorb 65% of all health workers, compared with 18% being employed in the for-profit PHS. In Tunisia, the PHS is estimated to employ 76% of pharmacists, 82% of dentists, 56% of doctors and 7% of paramedics. In Morocco, the number of medical doctors is almost the same in both sectors (12 142 in the private versus 11 848 in the public) *(26)*. In Oman, 67% of physicians and 71% of nurses were on the Ministry of Health payroll in 2019, compared with 27% and 20% in the private sector, respectively *(27)*. However, there is one exception to the dominance of the public sector provision of health services in Oman: dental services. According to the Ministry of Health, the number of dental clinics run by the private sector in 2019 was 299, compared with only 145 dentists who worked for the Ministry of Health *(27, 28)*.

Oman

67% of the physicians

71% of the nurses

were on the Ministry of Health payroll in 2019

Islamic Republic of Iran

65% of health workers work in government hospitals

Tunisia

the PHS is estimated to employ

76% of pharmacists

82% of dentists

56% of doctors

7% of paramedics

Sudan

9% of all health workers work exclusively in the private sector

Jordan
60%
of the 150 000 health workers in the country are employed by the private sector

Lebanon
70%
of the country's specialists work in the private sector

Qatar
most of the licensed practitioners work in governmental facilities

Djibouti
93%
of general practitioners work for the public sector

In countries where dual practice is not permitted, data are more widely available. In Jordan, it is estimated that 60% of the 150 000 health workers in the country are employed by the private sector *(29)*. In Lebanon, 70% of the country's specialists work in the private sector. This pattern is reversed in Djibouti and Qatar, where more health workers work in the public sector. In Qatar, most of the licensed practitioners work in governmental facilities *(30)*. In Djibouti, 92.77% of general practitioners work for the public sector.

D Resource generation

The educational facilities that produce the health workforce in the Eastern Mediterranean Region are predominantly in the public sector. In the Islamic Republic of Iran, less than 20% of the health workforce is produced by the private sector. However, when it comes to continuous medical education, the private sector makes a greater contribution. In Jordan, there are 44 medical schools, 19 of which are private and are responsible for producing 24% of all medical graduates *(31)*. Half of Jordanian medical students are studying outside the country *(32)*. However, in Yemen the split is skewed towards the private sector. In 2012, the private sector in Yemen ran 66 out of 113 medical colleges and institutions in the country, thus constituting 58% of medical and health science educational facilities. The public sector is mainly responsible for running medical and dentistry schools, whereas the private sector is responsible for the production of medical assistants, laboratory technicians, and so on *(17)*.

E Staff retention

Across countries of the Region, the PHS is said to offer better benefits to service providers, resulting in brain drain in countries where dual practice is not permitted. This has been observed in Libya, where the extensive loss of staff from the public sector to the PHS has led the Government to establish a committee to review the benefits of health professionals in the public sector in an attempt to address this critical issue.

The better staff retention rate in the PHS has been attributed to financial and nonfinancial incentives as well as the improved working environment. In Libya, the reasons for the attractiveness of the PHS to health providers are mainly related to perceived better workplace conditions, professionalism and financial incentives. In the Islamic Republic of Iran, the private sector culture of meritocracy and investment in personnel development is considered a benefit, in addition to staff recognition and growth opportunities. Those factors result in higher job satisfaction among health workers. The same has also been documented in Jordan, where nurses who work in private hospitals were found to be more satisfied and inclined to stay in their jobs than nurses in public hospitals *(33)*.

In countries where dual practice is permitted, health workers generally keep their public sector jobs as a safety net and as a source of patients for their private practice. They rely on their private practice for financial revenue. Thus, most physicians either work exclusively in the private sector or in addition to their job in the public sector. Dual practice is generally thought to affect the public sector negatively, since the public sector facilities are usually used as referral centres for the private clinics of the treating physicians rather than as treatment facilities, resulting in an obvious conflict of interest.

2.2 Governance and regulation of the private health sector

A Governance
B Private health sector legislation
B.1 Investment laws
B.2 Practice laws
B.3 Pricing laws
C Registration and licensing

A

Nurses, dentists and pharmacists also have professional orders, which clearly define their roles and regulate the respective professions

Governance

In the Eastern Mediterranean Region, the stewardship of the health system is generally the responsibility of ministries of health. However, the role and authority of ministries of health vary. In some countries, such as Oman, the Ministry of Health acts only as a policy-maker and high-level coordinator, while other government institutions – such as the Directorate General of Health Services – act as the operational arm for the Ministry. However, in other countries and territories the role of the health ministry is not limited to governance but extends to cover regulation, as in the Islamic Republic of Iran, Lebanon, the occupied Palestinian territory and Yemen. In the Islamic Republic of Iran, responsibility for supervision, regulation, governance, policy-making, production of health technologies, provision of health care services, research and education in medical sciences lies within the Ministry of Health and Medical Education. Similarly, in the occupied Palestinian territory, the Ministry of Health is mandated to regulate and monitor quality and standards in the private sector, to provide accreditation and licenses, and to maintain a registry of private health care facilities. In Lebanon, the Ministry of Public Health is responsible for the overall governance and regulation of the health sector, including in the purchasing and provision of some health services *(34)*.

Professional syndicates and orders play a complementary role in regulating the PHS and the health system as a whole in some countries, such as Lebanon and Yemen. In Lebanon, professional orders are the regulators of the PHS. Lebanon has two Orders of Physicians, as stipulated by Law 313 of 7 December 1946. The main role of these orders is "to unify the doctors practicing in the private sector, defend their rights, maintain their legitimate moral and material interests, raise the level of their profession, and ensure the ethics and dignity of the medical care" *(35)*. Nurses, dentists and pharmacists also have professional orders, which clearly define their roles and regulate the respective professions. Private hospitals are regulated by the Syndicate of Private Hospitals, which was established on 15 November 1965 as the official representative of all private hospitals through Ministerial Decree 1/523 *(36)*. In Yemen, syndicates were in charge of regulating health care professionals before this role was delegated to the General Medical Council.

However, when such governing policies are made, they are in many cases not comprehensive enough to ensure effective private sector engagement (PSE). When present, such policies are also usually unenforced due to limited capacities and resources or the absence of relevant implementation plans and supporting organizational structures. An example of this has been observed in Sudan, where some private sector regulatory structures exist at the national level, but most of them have no branches at the state level and lack sufficient financial and human resources. Accordingly, accountability is an immense challenge. In other countries of the Region, recognition of the role of the PHS in national policies is still absent altogether, as in Morocco and Yemen. In Morocco, PHS facilities are functioning as independent entities due to the absence of relevant policies.

In general, the PHS is weakly regulated, particularly in the low- and middle-income countries of the Region, for a myriad of reasons, such as the fragmentation of PHS regulatory authorities without proper coordination, as in Afghanistan, Sudan and Yemen. In Afghanistan, five agencies, other than the Ministry of Public Health, are responsible for regulating the private sector *(21)*. Unstable political situations can also cause core health system governance functions to deteriorate due to redirection of health system resources towards emergency response, as observed in Yemen *(37)*. Such deterioration leads the PHS to deviate from its planned complementary role and become a competitor to public health services *(38)*. Other reasons for weak regulation include the leniency of the government in enforcing laws and regulations, the absence or weakness of organizational structures, corruption, lack of financial and human resources, bureaucratic processes, and poor management. Nonetheless, self-regulation is increasingly being practiced by some private providers for the sake of maintaining reputation and sustaining business *(38)*.

In general, the PHS is weakly regulated, particularly in the low- and middle-incomes countries of the Region

B Private health sector legislation

Many pieces of legislation affect the PHS. Such legislation can be categorized as investment laws, practice laws or pricing laws, as follows.

B. 1 Investment laws

Laws that aim to encourage private investment in health have been reported in Jordan, Morocco, Sudan, Tunisia and Yemen. These laws typically offer incentives or ease regulations on private investments in the health sector.

In Tunisia, article 49 of the 1993 Investment Incentive Code specified tax incentives for investments in health establishments and hospitals and the Order of 16 December 1997 acts as a guide for private investors and developers in the health sector. Moreover, Law no. 2001-94 establishes the legal framework for health facilities that are exclusively directed towards nonresidents, with the aim of promoting health tourism. These facilities may provide services to residents within a maximum ceiling of 20%, except for in extremely urgent cases. However, no health facility has been established based on this legal framework to date. In Yemen, the 2002 and 2010 investment laws, coupled with the establishment of the Higher Investment Authority, created a pro-private-sector environment. Under those laws, investors were granted tax deductions and customs waivers, rights to land, and property ownership *(39)*. In Morocco, PHS investment flourished following the adoption of Law 113-13 in 2016, which gave the right to nonmedical doctors to invest in the PHS without specifying a geographical distribution. The law “Dahir n° 1-11-83 du 29 rejeb 1432 (2 juillet 2011) portant promulgation de la loi cadre n° 34-09 relative au système de santé et à l’offre de soins” considers the private sector a partner to the State in the provision of health system resources and services as well as the improvement of population health. Sudan developed several “investment encouragement acts”, with the aim of attracting more investments by streamlining investment procedures and facilitating privatization programmes.

Accordingly, multiple incentives have been offered to the private sector. These include complete exemption from customs fees on major projects; freedom of capital transfer; simplification of procedures; and tax exemption for five to 10 years on investment projects. In Jordan, the multisectoral investment laws (No. 16 of 1995 and No. 13 of 2000) and the Investment Law of 2014 granted investors incentives in the form of income, sales taxes and customs duties *(40)*. In Libya, Decrees 589 (1993) and 590 (1993) on PHS licensing and specialties have been noted to encourage investments in the PHS, and since their issuance the establishment of private health facilities has been on rise.

Nonetheless, PHS investment is still legally restricted in some countries: in Iraq, despite Federal Law 25 on the establishment of private sector facilities enabling the leveraging of PHS capital, the law is not free of shortcomings. This law enabled investors to establish private health projects after fulfilling Ministry of Health requirements, regardless of their professional background. However, mayoralty councils (local governmental councils) do not legally allow for such projects and are at the same time responsible for project evaluation.[2]

B. 2 Practice laws

Practice laws refer to the legislation pertinent to facility specifications, distribution, staffing and resources, in addition to the regulation of health workforce intersectoral mobility, ethics and dual practice.

Some countries of the Region noted the presence of laws that govern the infrastructure and staffing requirements of health care facilities, as in Morocco and Tunisia. However, the level of detail as well as the requirements of such specifications are highly variable between countries. In Morocco, the standards for establishing human resources are specified in Law n° 1-15-26 du 29 rabii 11 1436 (19 février 2015). This law details not only the staffing and infrastructure requirements but also the administrative procedures. In Tunisia, such regulations are more detailed and extend to include the reporting requirements to the Ministry of Health, and the organization and implementation of medical monitoring for health care activities, as noted by articles 40– 58 of Law no. 91-63. The standards and indicators of equipment by facility and the purchasing and distribution priorities for equipment, as well as the maintenance polices, are also guided by article 1 of Decree no. 92-1208 of 22 June 1992 by the National Council of Technical Medical Equipment. The operations of medical testing laboratories in Tunisia are further regulated by Law no. 2002-54.

[2] Government of Iraq, Ministry of Health, Curative Services Department, Technical Affairs Directorate, personal communication.

Some countries of the Region noted the presence of laws that govern the infrastructure and staffing requirements of health care facilities

The requirements for establishing private health care facilities do not apply to public health care facilities, which usually follow a less advanced criteria. This is contrary to the situation in Djibouti, where private health care facilities are granted licenses if they meet the requirements of public facilities. In Sudan, the Private Health Facilities Law has been developed but is yet to be passed by parliament. The law defines the types of private health facilities, the ownership and qualification requirements of facility managers, and the facility standards and licensing processes.

In Libya, the PHS was first recognized through Law no. (106) of 1973. This law has defined medical institutions and private clinics, outlined licensing mechanisms and specified the structure and other prerequisites for medical institutions *(41)*. The construction laws for health care facilities depend on the type of health facility. Law no. (09) of 1992, no. *(21)* of 2001 and no. *(1)* of 2004 on conducting economic activities have specifications regarding structural design, materials, construction, land area, and so on. In Afghanistan, the governing policies of the PHS have been articulated in several policy documents, such as Private Sector Policy and Strategy 2009–2014; Private Health Centre Regulation (2012); PPP Law and Regulation; Medicines Law; National Essential Medicines List and National Licensed Medicines List; and Private Sector Strategy.

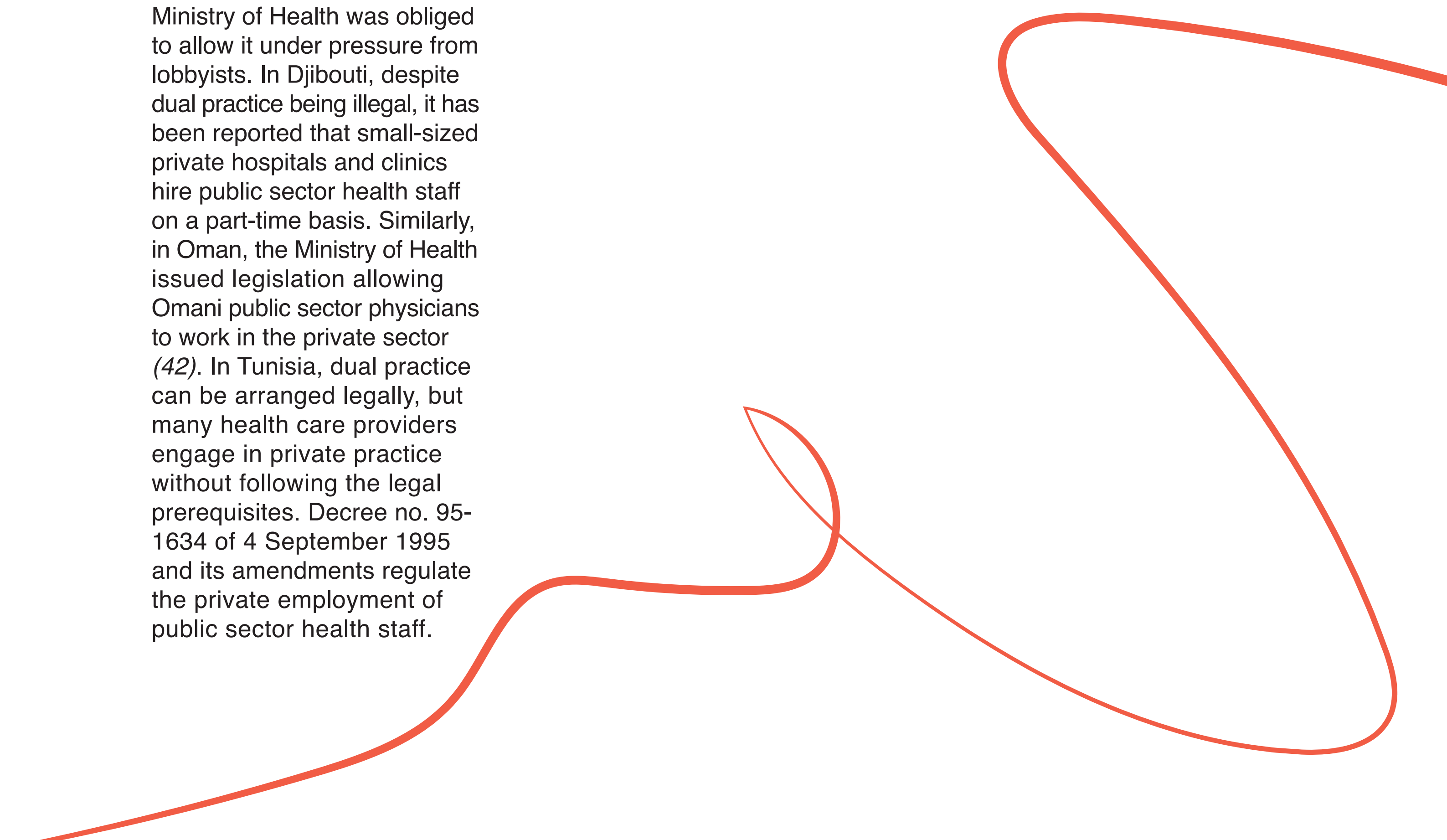
The 2012 Private Health Centre Regulation and its amendment are thought to be paving the way for quality improvement and clear oversight of private health facilities. In Yemen, two main laws are specific to the PHS: the Law of Private Health and Medical Institutions (1999, revised and reissued in 2004) and the Bill Regulating the In-Service Health Training Centres Work (2009). Furthermore, the Public Health Law (2009) outlined the rights of patients and the responsibilities of the public and private sectors in health. In Djibouti, there are no formal written documents available on licensing standards or quality control processes.

In Tunisia, the ethics of medical practice are regulated by articles 86–98 of the Code of Medical Ethics, while in Jordan, each health profession has a law or by-law that regulates all aspects of the profession (e.g. licensing, minimum education and certificates, categories, areas of practice, code of ethics). Regulations that organize health workforce mobility have been noted in Morocco, where public hospitals are allowed to contract private sector doctors.

Dual practice was not legal in Morocco until 2016, when the Ministry of Health was obliged to allow it under pressure from lobbyists. In Djibouti, despite dual practice being illegal, it has been reported that small-sized private hospitals and clinics hire public sector health staff on a part-time basis. Similarly, in Oman, the Ministry of Health issued legislation allowing Omani public sector physicians to work in the private sector *(42)*. In Tunisia, dual practice can be arranged legally, but many health care providers engage in private practice without following the legal prerequisites. Decree no. 95-1634 of 4 September 1995 and its amendments regulate the private employment of public sector health staff.

This decree allows professors with at least five years of experience in the public sector to have a complementary private practice, with the following conditions: (i) medical consultations are done in public facilities; (ii) hospitalization and medical acts are done in private facilities; (iii) the beneficiary doctor is entitled to practice in only one private institution; (iv) the right of practice at the private facility is limited to two afternoons per week and home visits are allowed through private facilities; and (vi) 30% of private consultation revenues are paid to the public facility in which the physician practices. These regulations are similar to those observed in the Islamic Republic of Iran, where health professionals who receive benefits for being full-time do not have permission to work in the private sector.

Some in-place regulations organize the distribution of health facilities, as noted in Tunisia, where Decree no. 76-233 of 16 March 1976 caps the number of pharmacies allowed per region and specifies the relevant work schedules.



B. 3 Pricing laws

Efforts to regulate the pricing of health services at private health care facilities have been observed in Djibouti, Jordan, Libya and Morocco.

In Djibouti, articles 85 and 86 of Law no. 63/AN/99/4th L consider clinics and private hospitals of a humanitarian nature as being of public utility, and they are accordingly subjected to the pricing rules applicable to public establishments. In Libya, the 2008 Decree no. 63 by the Ministry of Economic Affairs and Trade provided a comprehensive price list of medical and dental procedures as well as laboratory and pharmaceutical products. Furthermore, the Health Act 106, article 59, states that the minister of health should determine the price of all the services. However, despite the revision of the price list, it is not being strictly followed by the PHS. Of note, Law no. (106) of 1973 was the first law in the country that included the financing of health services in the definition of "medical institution" *(41)*. A similar situation was observed in Morocco, where overbilling is observed and the unified tariffs list for health insurance by provider type is not being followed. In Jordan, Private Hospitals By-law No. 54 of 2014 mandates all private hospitals to prepare an itemized listing of their fees (except for physician services). The fee list is then submitted to the Ministry of Health for approval. The approved list must then be made available to the public *(43)*.

C

Responsibility of medical councils

Afghanistan
Islamic Republic of Iran
Morocco
Pakistan

Responsibility of syndicates

Iraq

Joint responsibility of councils or syndicates and the health ministry

Jordan
Lebanon
Libya
Yemen

Registration and licensing

Variations between countries of the Region in the laws governing the PHS reflect on the registration and licensing procedures for both facilities and health professionals.

Licensing of health care professionals is typically the responsibility of medical councils, as in Afghanistan, the Islamic Republic of Iran, Morocco and Pakistan; the responsibility of the syndicates, as in Iraq; or the joint responsibility of councils or syndicates and the health ministry, as in Jordan, Lebanon, Libya and Yemen. In some countries, such as Oman, a medical board is granted that role. One-time licensing is required in Pakistan and Tunisia (with the exception of midwives, whose license needs to be renewed annually), while relicensing is required in Iraq, Jordan, Libya, Oman and Qatar *(44)*. The enforcement of licensing and relicensing requirements varies across the Eastern Mediterranean Region and ranges from being strict, as reported in Jordan, to being poor, as reported in Pakistan and Yemen *(38)*.

Registration and licensing of health care facilities are reportedly the responsibility of the health ministry, medical syndicates or separate regulatory bodies. In Afghanistan, the registration of private health care facilities, such as hospitals and laboratories, is the responsibility of the Afghanistan Investment Support Agency. In Iraq, public practice is licensed through the Ministry of Health and private practice is licensed through the corresponding syndicates, with the exception of private hospitals and diagnostic centres, which must be licensed through mayoralties and the Ministry of Health, respectively. Most facilities in urban areas comply with the licensing requirements, but compliance is lesser in rural areas, where fewer inspections take place. This is particularly apparent in rural outpatient clinics. In Morocco, the registration and licensing of PHS facilities is controlled by the Ministry of Health, the medical council and the secretary of government with inspection by a multi-stakeholder commission. In Sudan, licenses for PHS facilities are issued by the Private Health Facilities Directorate at the Ministry of Health. A license is issued in two stages: initial licensing to register the business, and final licensing after fulfilling the technical requirements for service delivery.

In Qatar, the Health Facilities Accreditation and Licensing Department of the Ministry of Public Health is responsible for health care facility licensing. In Jordan, licensing of private health care organizations is generally done by the Ministry of Health, except for radiology services. The licensing is based on the fulfilment of minimum requirements pertinent to location, physical infrastructure, equipment and human resources. Other government agencies and health professionals' organizations also participate in the process. In Oman, the licensing of private health facilities requires approvals by the Directorate General of Private Health Establishments, the Ministry of Manpower and the Ministry of Commerce and Industry, as well as by the municipality. The Ministry of Commerce and Industry and the municipality provide the commercial registration and authorization for the practice. The Ministry of Manpower authorizes personnel according to the "Omanization" policy: a national policy that aims to ensure a fixed proportion of Omanis to non-Omanis in the workforce. However, in the medical sector, this regulation is relaxed because there are not enough Omani medical staff *(45, 46)*. In Libya, the Ministry of Economic Affairs and Trade is responsible for issuing licenses for private health facilities. Licensing is, however, the responsibility of a multisectoral committee that assesses, studies and evaluates the renewal and issuance of applications for licenses of any health facility. After getting Ministry of Health endorsement, the Ministry of Economic Affairs usually grants the license. In the Islamic Republic of Iran, outpatient clinics, diagnostic labs and hospitals are licensed by the Curative Affairs Vice of the Ministry of Health and Medical Education.

Formal relicensing mechanisms for private health facilities are reported in the Islamic Republic of Iran, Sudan and Yemen. In Yemen, their level of enforcement is not known. In Sudan, facility licenses should be renewed, but the interval for renewal varies from annually up to every three years, depending on the state. Lack of compliance with the relicensing mandate has been noted, despite the commonly associated penalties.

Oversight of private health facilities is typically the responsibility of the health ministry, as in Morocco, Qatar and Yemen. In Qatar, the Department of Healthcare Professions is responsible for defining the specifications for accrediting health facilities, issuing and revoking the licenses for practicing health and medical professions, and issuing and revoking practice licenses, in addition to receiving complaints. In Morocco, despite the processes for inspection by the Ministry of Health and the regulations on the geographical distribution of health facilities, regulation of the PHS continues to be problematic. This is due to the observed inequity in the distribution of PHS facilities as well as the incomplete reflection of the distribution of such facilities in the 2015 health distribution map, which points to suboptimal enforcement of the geographical distribution parameters. In Jordan, the Ministry of Health exercises considerable powers in determining adherence to various

Challenges in the licensing process in the Region range from the overcomplexity of the process to its complete absence

licensing rules and regulations; however, strict coordination between the Ministry of Health and the professional organizations is needed to effectively carry out these responsibilities *(47)*. Nevertheless, in some countries of the Region, such as Pakistan, legislation for health care facility accreditation and quality assurance mechanisms remains absent. Similarly, in Jordan and Tunisia, the criteria for quality of care at PHS facilities are not usually identified.

Challenges in the licensing process in the Region range from the overcomplexity of the process to its complete absence. In Afghanistan, the licensing process includes 13 steps. In addition, there is no standard digital application form and little guidance on how to process the application *(48)*. Similarly, in Iraq, the licensing process suffers from bureaucratic red tape and poor administrative systems, which typically prolong the process *(49)*. However, in Djibouti, there is no written document clearly explaining the authorization process or the accreditation process. At the time of writing this report, the Inspector General and the Inspector General's staff determine the conditions and the list of documents to be provided for the granting of the license. The General Health Inspectorate of the Ministry of Health is the only body responsible for issuing licenses for private health facilities, while the Medical Association Council is responsible for registering health care professionals. Similarly, in Pakistan, no licensing mechanisms were required to establish or operate a health care institution until recently, when the provinces established health care commissions with the mandate of registering, licensing and accrediting public and private health entities, but data are not available on the existing level of enforcement. In Sudan, the licensing process in some states has been criticized for being focused on the associated fees rather than on assuring the fulfilment of the required standards. In the occupied Palestinian territory, reported reasons behind the perceived ease of the licensing process included the absence of any regulations or standards that consider population needs and demands as well as sound quality standards.

2.3 Private health sector financing modalities

Most PHS facilities in the Eastern Mediterranean Region are funded by two main funding streams: OOP payments and private health insurance (PHI).

A Out-of-pocket payments
B Private health insurance
C Pricing schemes

A

OOP expenditure:

72.3%

low-income countries of the Region

13.9%

high-income countries of the Region

Out-of-pocket payments

In 2018, the average OOP expenditure, as a percentage of current health expenditure, in low-income countries of the Region was 72.3%,[3] compared with 13.9% in high-income countries *(5)*. Direct (OOP) payments at the point of care are the main revenue streams for private providers in Afghanistan, Djibouti, the Islamic Republic of Iran, Libya, Morocco, the occupied Palestinian territory and Yemen. In Afghanistan, 61.8% of OOP payments (which represents 76% of total health expenditure according to the 2011 National Health Accounts) were made to private health care facilities; public health services received 38.2% of the total OOP expenditure. Similarly, in Yemen, direct payment is the largest financing source in private health facilities. Employer reimbursement and capitation payment in informal agreements with government authorities may cover 5–10% of the clientele in a few facilities. In Morocco, private practices are estimated to absorb 36.3% of OOP payments, followed by private hospitals at 14.4%. In Jordan, PHS hospitals absorb 36% of household health expenditures, and other private facilities absorb 29% *(50)*. In Djibouti, almost 99% of private facility revenue comes from the direct payment of patients. Similarly, in Libya, the largest financing source of the private, for-profit sector is direct payment for services by patients. Other sources of financing include health insurance reimbursement and personal investments. This is also observed in the Islamic Republic of Iran, where OOP payments constitute 35% of the service price, and the remaining amount is paid by private insurance if the patient is covered. Otherwise, the patient bears 100% of the cost in the form of OOP payments. OOP payments constitute the largest share of the revenue of PHS facilities. In the occupied Palestinian territory, OOP payments make up the main source of revenue, followed by the services outsourced by the Ministry of Health. In Tunisia, OOP payments, which are spurred by medical tourism, are the main sources of revenue. Despite National Health Insurance Fund coverage of the health services offered by private providers, households bear 65% of the cost of health care in the private sector, followed by National Health Insurance Fund with 29% and private insurance companies with just 6%. Medical tourism accounts for 36% of the total revenue generated by private clinics.

However, private facilities in Qatar mainly generate profit through PHI, while in Lebanon, public agencies are major contributors to r evenue generation in private hospitals. In Lebanon, it is estimated that 64% of the private hospital budget comes from public financing, 30% of which is provided by the Ministry of Public Health.

[3] Excluding Somalia, the Syrian Arab Republic and Yemen, for which data were not available.

B

Private health insurance

In general, PHI plays a limited role in risk pooling and total health expenditure in the Eastern Mediterranean Region

In general, PHI plays a limited role in risk pooling and total health expenditure in the Eastern Mediterranean Region. In Tunisia, even though the PHS accounts for 55% of current health expenditure, PHI only represents 3.3% of total health expenditure. Similarly, in Pakistan and Yemen, PHS insurance offers minimal contribution to total health expenditure. It mainly covers private sector employees, a few public sector employees and a minority of self-insured individuals. Together, they represent around 1% of the total health expenditure in Yemen and 0.9% in Pakistan (2016). In Jordan, 12.4% of all insured residents are covered by PHI plans, which is equivalent to around 648 000 beneficiaries. The beneficiaries are mostly middle- and upper-class professionals who are ineligible for the public insurance programme, interested in withdrawing from a public insurance programme, or seeking supplemental or additional coverage. In Lebanon, 6.5% of the population is covered by private insurance, of whom 2.6% are self-insured and 3.9% are insured by their employer, a syndicate or an institution *(51)*. In the Islamic Republic of Iran, about 20 million people (25% of the country's population) have a form of PHI. In Libya, the PHI sector is relatively small, with about 250 000 beneficiaries from oil companies, banks, social security funds, civil aviation and telecommunication. PHI currently covers only about 4% of the Libyan population. In the occupied Palestinian territory, PHI covered 2.6% of the population in 2017, representing around 2.5% of total health expenditure *(52)*.

Oman and Qatar have ambitious plans to expand coverage by PHI.

In Qatar, around 22% of the total population have PHI *(53)*. A new health insurance law is currently under development and is envisaged to include the whole population. According to this draft law, the average private insurance policy is planned to cover inpatient, outpatient and emergency services. Insurance exclusions are mainly cosmetic interventions and pharmaceutical products of a non-therapeutic nature. In Oman, private insurance companies provide health insurance for almost 43% of the expatriate population. There are also ongoing plans by the Capital Market Authority of Oman to mandate health insurance for the private sector and expatriates as part of a unified health insurance plan *(54, 55)*. This plan, once finalized, is expected to boost the PHI market.

The service coverage by private health insurers is considered limited in Jordan, Libya, the occupied Palestinian territory, Oman and Qatar. In Jordan, of the 28 companies licensed to provide health insurance, only one offers full-package coverage. This is attributed to the high cost of the comprehensive package, which constitutes about 56% of the average Jordanian's annual income; thus, only a small percentage of the population can afford it *(56)*.

In Lebanon, there are two types of insured individual:

- individuals who are covered by the National Social Security Fund, have complementary private insurance and have access to hospitalization only or to additional ambulatory care (9.7% and 26.1%, respectively), with an average premium of US$ 228 annually; and
- individuals who are covered solely by private insurance and have access to hospital care and a variety of outpatient care, with an average premium of US$ 464 annually (57).

In Jordan, of the 28 companies licensed to provide health insurance, only one offers full-package coverage

In Libya, PHI does not cover the following medical conditions:

disaster (natural or human-made)

epidemic and endemic disease

AIDS

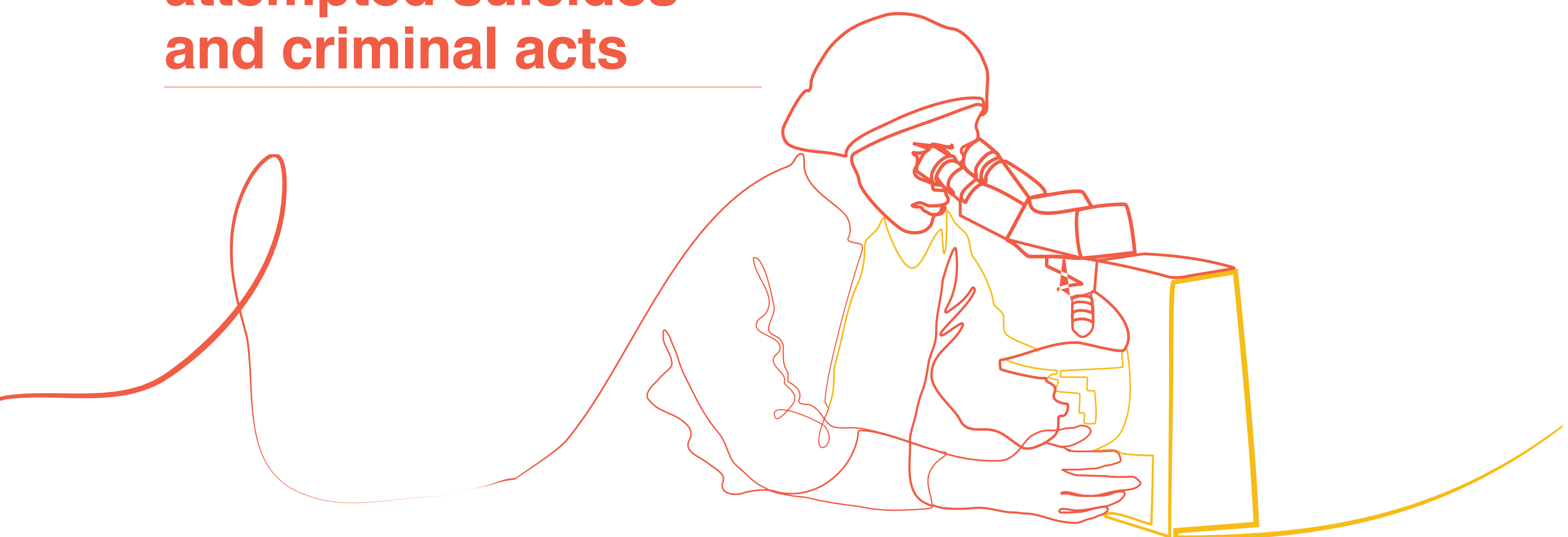
drug addiction and drug abuse

war injuries

injuries due to attempted suicides and criminal acts

In the occupied Palestinian territory, the private benefit packages exclude many pre-existing conditions and chronic illnesses, while other services, such as pre- and postnatal care, can be covered upon payment of additional premiums. Nonetheless, a maximum ceiling for claims is imposed. In Oman, major insurance providers cover outpatient services, laboratory and investigation services, pharmacy services, as well as inpatient and surgical services. However, HIV, AIDS and family planning are not usually covered unless agreed with the beneficiary.[4]

Commercial insurers may function in two ways: as insurers or as third-party administrators, whereby firms may contract with third parties to administer their health plans to reduce the associated costs. In Qatar, most private insurance companies outsource their operations to a third-party administrator. An analysis of third-party payments by health insurance organizations in Morocco estimates that public hospitals receive only 10.3% of all direct payments from insurance funds, compared with 65% received by private clinics and hospitals. The remaining funds are directed towards self-medication in the private sector. Accordingly, almost 90% of the resources of the health insurance funds are received by the private sector.



[4] Faiza Al Busaidy, AXA Insurance Company, personal communication, 2018.

In most cases, payments are made in the form of a fee-for-service model, with some less disease-oriented flat rates

The payment mechanism of health insurance is mainly based on negotiated tariffs within the national conventions that define the billing procedures. In most of cases, payments are made in the form of a fee-for-service model, with some less disease-oriented flat rates (in Morocco). The services provided and premiums vary according to the policy type. In Libya, premiums must be paid annually in advance. Monthly payments can be arranged only if the beneficiary is able to arrange for a relevant loan, repayments of which are then collected monthly.

In Qatar, PHI is co-regulated by the Qatar Central Bank, the Qatar Financial Centre Regulatory Authority, and the Ministry of Public Health. In Jordan, the Insurance Directorate in the Ministry of Industry and Trade is responsible for regulating and supervising the local insurance sector, including the PHI sector. However, insurance companies in Jordan are thought to attract the young and healthy and to shift unwanted risk onto the public sector. This because legislation is too broad to effectively shape this growing market and regulate its contribution towards national health policy goals *(56)*. Similar challenges were noted in Libya, where the limited understanding of insurance foundations among PHS providers has led to more focus on revenue maximization at the expense of the efficiency, equity and sustainability of health care financing.

C Pricing schemes

In terms of having defined pricing schemes at private facilities, countries and territories of the Region can be classified into three groups:

- those without price control;
- those where pricing schemes are set but not fully enforced; and
- those where prices are set and enforced.

The first group includes the occupied Palestinian territory, Sudan and Yemen. The second group includes Djibouti, Jordan, Libya, Morocco and Tunisia, while the third group includes the Islamic Republic of Iran. In Sudan, pricing regulations are lacking, which allows service providers to decide on their pricing list without any control. Price regulation efforts are under way in the occupied Palestinian territory and Yemen. In the occupied Palestinian territory, corrective measures to reinforce regulatory compliance (e.g. setting price lists and quality standards procedures) are being taken by the Ministry of Health, while in Yemen, the Ministry of Health initiated a classification and costing exercise targeting the private hospitals, in which representatives of the private hospitals were invited to participate in December 2018.

In Tunisia, the prices of health care services are set either by the national boards of doctors (and dentists), by the Ministry of Commerce for hotel services or, in a less regulated way, by paramedics and clinics. Paramedics and clinics may set the prices of services related to accommodation and more technical services, which creates pricing disparities. In Jordan, the charged hospital fees must follow the Private Hospital Association's voluntary fee schedule. However, the doctors' fees schedule has not been updated since 2008 due to opposition by consumers and other stakeholders. Most physicians, especially consultants, charge self-insured patients more than the maximum fee level *(59)*. Similarly, in Libya, the tariffs for PHS services were determined 11 years ago and never got revised, which made them outdated and irrelevant to the actual cost of care. This lack of relevance is one of the reasons behind the current lack of compliance by the PHS. The same was also noted in Djibouti, where the last revision of the price list occurred in 2009.

In contrast is the systematic update and enforcement of price lists in the Islamic Republic of Iran: each year the Government assesses the total inflation rates and the purchasing power of the population and uses them to revise the set tariffs.

The new tariffs are communicated by the cabinet and are then followed by the public, private and charity sectors.

2.4 Role of the private health sector in service delivery

A Types of service
B Types of facility
C Intersectoral referral
D Use of private health sector services
D.1 First contact with the health system and outpatient care
D.2 Inpatient care
E Distribution of private health sector services

A

Types of service

Across the Eastern Mediterranean Region, the PHS aims to fill the gaps in the public sector in terms of the availability and quality of services. However, its activities are seldom guided by a framework that ensures complementarity. The for-profit PHS is a key service provider in all countries and territories of the Region except for Afghanistan, Djibouti and, to some extent, the occupied Palestinian territory, where the not-for-profit sector plays a more prominent role. PHS services are more concentrated in urban areas, with a focus on revenue-generating secondary, curative care and a limited or absent role in primary and promotive or rehabilitative care.

Afghanistan

In Afghanistan, health services are primarily delivered by nongovernmental organizations through the Basic Package of Health Services and the Essential Package of Hospital Services. The Basic Package provides primary care, and the Essential Package provides secondary-level care. Basic Package services are offered in health facilities at provincial, regional and national levels. The package is implemented in 31 provinces by nongovernmental organizations and in three provinces by the Ministry of Public Health.

Afghanistan's Essential Package was established in 2005 and is delivered through 15 hospitals. The Essential Package encompasses a standardized package of services at different hospital levels.

Furthermore, it is used as a guide for estimating the needed staffing, equipment and supplies. The Essential Package further promotes a health referral system that integrates the PHC system with the hospital system *(60)*.

Occupied Palestinian territory

In the occupied Palestinian territory, the Ministry of Health remains the largest health care provider and employer, particularly at the primary and secondary health care levels. The public sector runs 65% of PHC facilities (2018); not-for-profit, private providers make up the next largest percentage, owning 36% of the total hospital beds, compared with the 25% owned by the private, for-profit sector. The private, for-profit health sector contributes to the provision of health services mainly at the secondary and tertiary health care levels *(61)*.

Lebanon

Similarly, in Lebanon, a network of around 229 PHC centres is mostly run by nongovernmental organizations, which own 67% of such centres. The services provided by the private, for-profit sector include primary, secondary and tertiary care and can be found throughout the country, but these services are neither homogeneous nor provided at the same level.

Iraq

In Iraq, the public sector is the dominant provider of health services. The PHS is mainly concerned with the provision of primary care services, elective surgical procedures, and obstetrics and gynaecology services *(62)*.[5] The private sector is thus providing diagnostic and curative services, but no preventive services and limited rehabilitative services.

This selectivity in health service provision in the private sector is due to security (i.e. emergency health services present a potential source of problems for private sector personnel) and to the high cost of services such as neonatal care and long-term inpatient care.[6]

Jordan

In Jordan, the Ministry of Health is the major provider of PHC, with small contributions from other health care providers.

Libya

In Libya, the highest volume of health services delivered by the PHS is within dental care, followed closely by maternal, newborn and child health, in addition to reproductive and child health services, and other outpatient services. Gynaecology and paediatric consultative services are the most commonly sought in the outpatient setting, while ophthalmology and cardiology services are less commonly utilized. No services are provided for some communicable diseases, such as tuberculosis and HIV *(63)*.

[5] Sources of information also include Government of Iraq, Ministry of Health, Curative Services Department, Technical Affairs Directorate, personal communication; Iraqi private sector hospitals owners, personal communication.

[6] Government of Iraq, Ministry of Health, Curative Services Department, Technical Affairs Directorate, personal communication.

Islamic Republic of Iran

In the Islamic Republic of Iran, the private sector has little role in the provision of PHC services *(64–66)*. PHC is mainly provided by the public sector and to a lesser extent by the private sector in urban areas. The role of PHS in PHC is part of the Iranian Health Transformation Plan, through which the private sector has been contracted to deliver primary care services to specified populations on behalf of the Government in selected urban areas in the form of PPPs. The main scope of work of for-profit health care providers is in outpatient care, diagnostic services, rehabilitation, consultation, mental health and nutrition.

Oman

In Oman, most private facilities provide basic health care services, including some PHC services such as maternity and childcare services, while a small number provide hospital care. In general, the contribution of the private sector in terms of outpatient visits, surgeries and procedures is limited.

Yemen

In Yemen, the PHS provides lucrative health care services, such as simple surgical operations, as well as diagnostic health services; inpatient services are still primarily sought in the public health sector. Several health services are provided solely in the private sector, such as assisted reproductive technology and karyotyping

Sudan

In Sudan, private sector facilities provide most of the health services, with varying levels of comprehensiveness. Some facilities offer curative, preventive and promotive services, while others provide only curative services (mainly private facilities at the secondary and tertiary levels). However, most private providers do not offer preventive services. This is because private providers are always striving to recover operational costs and generate profits to ensure business sustainability. Furthermore, no incentives are provided for them to provide preventive services.

B Types of facility

PHS facilities in the Islamic Republic of Iran, Iraq, Jordan, Lebanon, the occupied Palestinian territory, Oman and Qatar include private hospitals, private clinics, labs, and diagnostic and rehabilitative centres *(67)*. In Iraq, there are no private physiotherapy centres due to high cost of equipment and the long-term nature of the rehabilitation process, which can result in financial hardship for patients. Group practice is increasing in Jordan due to the associated cost savings and the desire of health care professionals to work in a collegial professional environment. In Pakistan, the PHS at the primary level includes general practitioners ranging from certified physicians to homeopaths and Ayurveda practitioners, in addition to traditional birth attendants. Secondary-level facilities include maternity homes, group-owned clinics and small hospitals; and tertiary-level facilities include teaching hospitals affiliated with medical colleges. In Sudan, primary care at the community level is mainly provided by village midwives and traditional healers in addition to PHC centres. At the secondary level, private clinics, medical laboratories and pharmacies are either organized in the form of polyclinics or stand-alone facilities. At the tertiary level, many specialized hospitals and advanced diagnostic centres are established in the capital and large cities.

C Intersectoral referral

Intersectoral referral processes range from being established to being poorly coordinated. In Iraq, public health care providers are not supposed to refer patients to private health care facilities, but private health care providers can refer patients to public facilities *(68)*. The latter is usually sought for the provision of services that are unavailable in the private sector or when the patient does not have the financial means to seek care at private facilities. This referral is typically facilitated when the provider is serving in both sectors. In Sudan, weak coordination between private sector providers is heightened by the absence of a referral system. This is mainly attributed to lack of clear regulations to guide the referral process between private sector facilities and between public and private facilities. Accordingly, patients directly access most of the secondary- and tertiary-level private facilities without any PHC gatekeeping procedure, which affects the efficiency of the health system. Conversely, an established intersectoral referral system has been observed in Lebanon.

D Use of private health sector services

With a few exceptions, the use of PHS services in the Eastern Mediterranean Region is notably high. In Pakistan, the PHS provides services to nearly 70% of the population (outpatient and hospitalized) *(69)* and in Sudan, almost 50% of health services in the country are available through private sector health facilities (for profit and not for profit). However, only 23.6% of total services are being provided by the private sector due to the inequitable geographical distribution of the private facilities and the relatively high cost of private health services compared with public services.

In conflict areas, the private sector (mainly not for profit) is a principal provider of health services. For example, out of 149 working health centres in South Darfur state, Sudan, 51 are operated by not-for-profit nongovernmental organizations. A similar situation is observed in Afghanistan, where around 80% of health care is provided by nongovernmental organizations, and in Lebanon, where faith-based and some sectarian organizations provide 43% of PHC services *(70)*. The Lebanese PHC network provided 165 000 patients with medicine in 2017 and was able to reach poor populations, including Syrian refugees amid the crisis *(71)*. In the occupied Palestinian territory, approximately 15% of the population in the Gaza Strip seek health care from the private sector, compared with 60% in the West Bank. Nongovernmental organizations own about 52% of PHC facilities in the West Bank, and around 20% of health care services in the Gaza Strip are provided by the for-profit and not-for profit private sector.

D. 1 First contact with the health system and outpatient care

The use of private outpatient clinics in the Islamic Republic of Iran and in Lebanon is estimated at 80% and 90%, respectively *(72, 73)*. It is further estimated that in the Islamic Republic of Iran, 50.4% of patients seek health services from private outpatient clinics.

In 2019, Oman recorded 4 345 865 visits to private sector outpatient clinics. In Sudan, almost 30% of patients make their first contact with the health system through a private facility. Similarly, in Jordan, private clinics are estimated to account for nearly 40% of all initial patient contacts (26% for-profit clinics, 5% not-for-profit clinics and 9% private pharmacies), compared with 49% by the Ministry of Health *(74, 75)*. The private sector also plays an important role in the provision of family planning services and is estimated to serve 55.4% of users of modern methods *(76)*.

D. 2 Inpatient care

In Lebanon, the use of private hospitals is considerably higher than that of public hospitals. In 2011, the number of short- and average-stay beds in public hospitals was 2550, compared with 12 648 short- and long-term-stay beds in the private sector *(77)*. Private hospitals also attract more than twice as many admissions as the public sector (162 513 and 67 016 admissions, respectively). Furthermore, around 29.2% of patients seek diagnostic and surgery-based services in the private sector.

Conversely, in the Islamic Republic of Iran, 70% of inpatient admissions were at public hospitals in 2017. The admission rate is estimated to be 31.85 and 23.85 patients per bed in public and private hospitals, respectively. According to Health Services Utilization Survey data in 2015, only 15% of patients in the Islamic Republic of Iran sought health services from private hospitals.

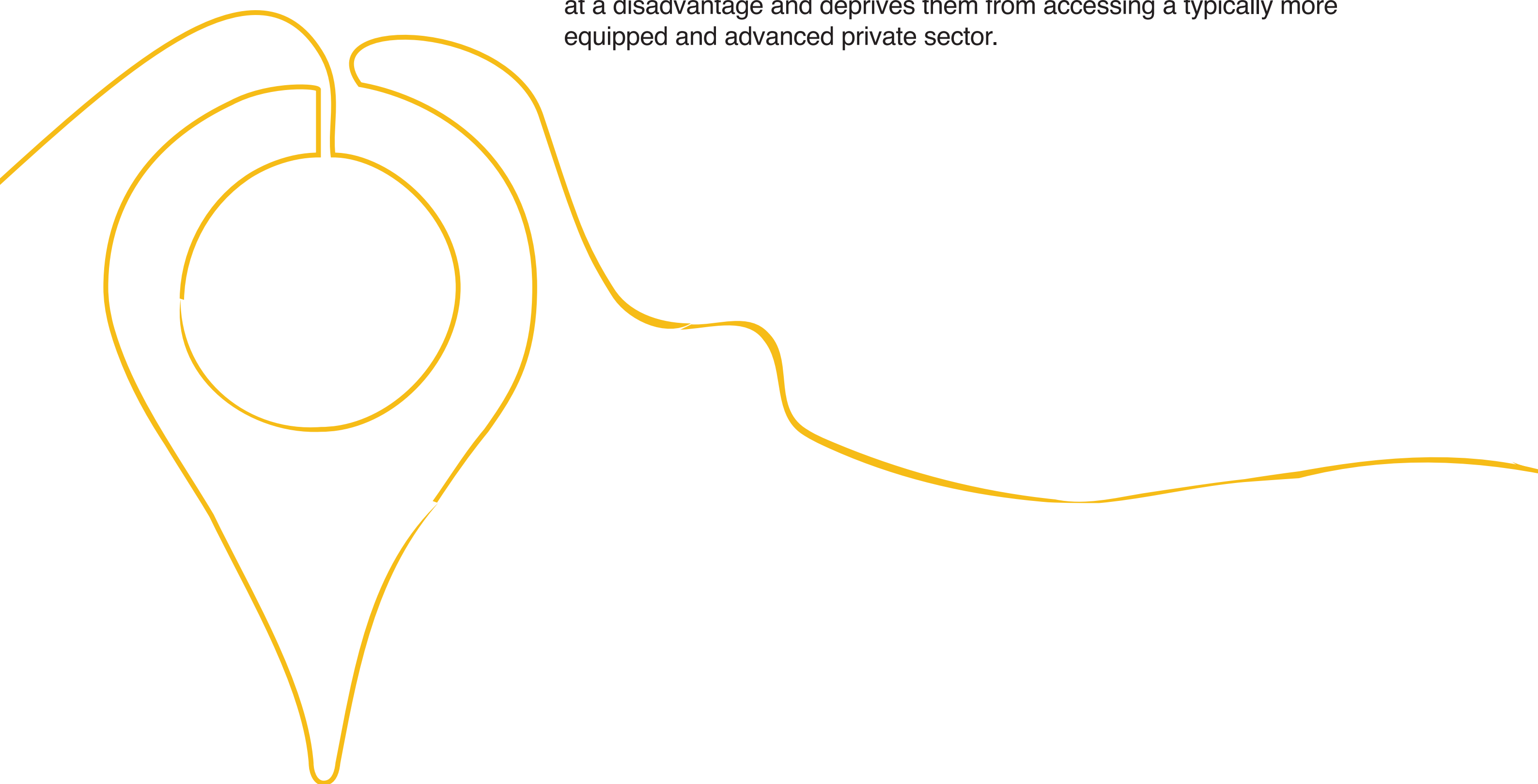
E

Distribution of private health sector services

As stated earlier, across the Eastern Mediterranean Region, private, for-profit facilities are highly concentrated in urban areas, which have relatively high purchasing power. Not-for-profit facilities are typically present in rural and hard-to-reach areas.

In Jordan, 36% of private, for-profit clinics are located in Amman *(74, 78)*. Similarly, in the Islamic Republic of Iran, about 30% of hospitals and 40% of private hospital beds are concentrated in Tehran. In Tunisia, more than 40% of the private clinics in 2018 were located in Tunis, leaving five governorates without any clinics at all. The same pattern is noted in Lebanon and the occupied Palestinian territory: in Lebanon, the highest number of private hospitals is in Beirut and the Metn area, and the lowest in Kesrouan–Jbeil *(79)*.

The urban bias of the for-profit facilities is due to the unfavourable economic conditions in remote areas and the low purchasing power of these populations, which decreases the demand for private services as well as revenues for private providers in these areas. The lack of incentives and encouraging investment environment in these areas, coupled with the weak infrastructure, presents further challenges to PHS investors. This, however, puts less-privileged areas and populations at a disadvantage and deprives them from accessing a typically more equipped and advanced private sector.



3 Private sector health information systems

Despite the major contribution of the PHS to service delivery in the Eastern Mediterranean Region, it is more often than not excluded or minimally represented in assessments and evaluations of the health system. Accordingly, there is a dearth of data on the presence, extent, form and comprehensiveness of record-keeping and information-sharing from the PHS in the Region.

In Sudan, the health information system is primarily based on health facility reporting, supplemented by surveys. The main challenges in gathering information include fragmentation and low reporting rates, especially at PHC facilities, where the reporting rate is only 30%, compared with 85% at hospitals. Systems for data management and analysis are largely manual and focus on the public sector; data from the private sector are rarely reflected. Although the Ministry of Health instructs PHS providers to submit integrated reports that include indicators for all programmes, data collection from private facilities is patchy and is typically done as part of vertical health projects, and the data are then compiled with other reports or, on rare occasions, included in public sector health information systems. Integration of reports takes place during the monthly and annual notifiable diseases reports and in the annual Ministry of Health statistical report. Currently, the National Health Insurance Fund receives regular and detailed data from the private sector, linked with financial claims.

Although the Ministry of Health instructs PHS providers to submit integrated reports that include indicators for all programmes, data collection from private facilities is patchy

However, those reports are usually not integrated or shared with the Ministry of Health, and indicators generated from the reports are not usually used for planning for the private sector's role in the country's health system.

This integration typically worsens at the lower (facility and locality) levels and improves at state and federal levels, where information generated from annual reports is used as evidence for planning initiatives.

Some countries of the Region reported a plan to improve their health information systems

Similarly, in our country assessment of the PHS in Yemen, it was estimated that only one fifth of the pharmacies and diagnostic facilities submitted regular reports to the Ministry of Public Health and Population. In the not-for-profit facilities, reports are communicated to the Government or funding agencies on a regular basis, which is usually required by the funding institutions. Reports from the different private sector actors are usually administrative, with a focus on service output indicators such as the number of patients, services or diagnoses. In the Islamic Republic of Iran, private hospitals are required to report diagnoses and quality indicators to the general public. This information is typically compiled at universities by the vice chancellor in treatment affairs and then gets sent to the Ministry of Health and Medical Education's treatment deputy. However, the collected information is usually outdated, especially when it comes to outpatient care. Furthermore, data about the extent and performance of the private sector are considered to be widely lacking. Conversely, in Oman the health information system comprises programme and quality indicators of the private sector, such as number of institutions, beds, laboratories, pharmacies, human resources, visits and medical procedures *(80)*. However, only a third of the private health establishment is fully compliant with the reporting requirements, according to the Department of Statistics and Information, Ministry of Health *(28)*.

Barriers to information-sharing include fear of heavy taxation by the government (which stands in the way of getting information about the size of business and the sources of financing in the PHS), modest infrastructure, paper-based reporting, loss of data and lack of accountability for reporting.

Some countries of the Region reported a plan to improve their health information systems, such as Qatar, where the Qatar Health Information Exchange hub is expected to be launched in the coming years. The hub is set to be managed by the Ministry of Public Health to support evidence-based decision-making by creating digitally connected patient-centric health care services. Its main objective is having a central data repository that allows for information exchange between patients, providers, payers, government and third parties.

4

Quality and accreditation of the private health sector

4.1 Quality perception

4.2 Accreditation and service quality oversight

4.1 Quality perception

The PHS was perceived to provide better quality of care in most of the countries and territories within the scope of our review. However, the quality of services in the PHS is far from being homogenous in most countries of the Region, and although some facilities provide superior quality, others are poorly equipped and do not cater to patient needs. The main drivers for seeking care in the PHS are outlined in **Table 2.** Only respondents in Oman and Yemen mentioned that the public sector is of superior quality. In Afghanistan, the quality of services in both sectors was perceived to be equally poor. In Yemen, government officials believed that health care professionals are more experienced in the public sector and that the delivered services in the PHS are substandard *(39, 81)*. A study assessing patient satisfaction with the PHS in Oman showed that only 34% of those who used the PHS were satisfied. The main reasons behind the poor perception of the PHS were related to the high cost of services (83%) and the suboptimal quality of care (55.1%), whereas Ministry of Health clinics and hospitals were perceived to be more advanced and equipped to deal with complicated cases.

Table 2: Drivers for seeking care in the private health sector as reported by countries and territories

Category	Countries and territories	Driver
Nonclinical attributes	Iran (Islamic Republic of) Tunisia	Responsiveness
	Lebanon Tunisia	Confidentiality/ trust
	Lebanon Occupied Palestinian territory Oman Qatar Tunisia Yemen	Less waiting time
	Djibouti Lebanon Oman Qatar Tunisia Yemen	Empathy/ friendliness/ personalized care
	Lebanon Pakistan Tunisia	Better facilities/ technologies
	Oman Qatar	Ease of access
	Lebanon Oman Sudan (not for profit)	Geographical proximity
Clinical attributes	Iran (Islamic Republic of) Iraq Lebanon Occupied Palestinian territory Sudan	Better treatment outcomes
	Iraq Lebanon Occupied Palestinian territory	Availability of specialized services

For all countries and territories, there was no evidence supporting the perception of quality, either better or worse, due to limited data on the quality of services and patient experience in both sectors. As regards diagnostics, a study done by the WHO Regional Office for the Eastern Mediterranean in 2013 in five countries showed that most private outpatient facilities had basic equipment for patient examination and maintained patient records. The commonly cited weaknesses of the PHS are largely attributed to limited or nonexistent regulatory standards, poor enforcement of quality measures, unaccountability, limited monitoring capacity on the government's side, absence of laws that safeguard patients' rights and safety, and lack of capacity to deliver quality care. Moreover, the absence of standardized clinical practice protocols results in the notion that the quality of care is dependent on the technical expertise of each individual physician rather than being institutionalized. The for-profit nature of the PHS in the absence of strong oversight further results in mistrust by government officials and suspicion by patients related to provider-induced demand for services, overuse of diagnostic and therapeutic procedures, overbilling, and inaccessibility by the poor due to the high cost of services.

Other causes of dissatisfaction that were reported in Jordan included case skimming, poor communication with patients, limited post-discharge instructions, and the absence of case records for future reference *(82)*.

A study by WHO in 2013 in five countries showed that most private outpatient facilities had basic equipment for patient examination and maintained patient records

The for-profit nature of the PHS in the absence of strong oversight further results in mistrust among government officials and suspicion among patients

4.2 Accreditation and service quality oversight

Accreditation processes are being planned in Afghanistan, Jordan, Libya, Morocco, Sudan and Tunisia

The accreditation process for private health care facilities is highly variable in the Eastern Mediterranean Region. It ranges from being nonexistent or in process, to being present but unenforced, to being present and enforced. Table 3 on page 62 illustrates the status of accreditation in countries and territories of the Region.

In Afghanistan, Djibouti and Yemen, there are currently neither oversight of the quality of services, nor an accreditation process, nor official service quality standards. There are no databases for tracking either the activity or the performance of the PHS. In the occupied Palestinian territory, although some regulations and standards are in place to ensure quality and safety, the absence of transparent or objective standards and of regular inspections by the Ministry of Health make these regulations and standards ineffective. This has been attributed to the lack of regular coordination and information-sharing between the public and private sectors, weak technical and managerial capacities, and the lack of sovereignty of the Ministry of Health over some geographical areas (Jerusalem and Area C). There are, however, accreditation processes being planned in Afghanistan, Jordan, Libya, Morocco, Sudan and Tunisia. The planned Afghanistan National Healthcare Accreditation Organization is a national organization that will be responsible for developing health care standards and training as well as assessing and awarding accreditation certificates to eligible health facilities. Similarly, in Tunisia, L’Instance Nationale de l’Evaluation et de l’Accréditation en Santé is in the process of developing good practice standards, and a national accreditation system is being put in place for both public and private health care facilities, whereby facilities will be required to produce and publish their data on the quality of health services provided. In Morocco, the systematic accreditation of the PHS is not yet operational, and oversight is typically practiced through some Ministry of Health inspections but with little effect on regulating the

private sector. Furthermore, the conventions signed relating to health insurance do not include mechanisms for enforcing improvement or compliance with the accreditation norms and standards. However, the Moroccan Ministry of Health has recently developed a self-accreditation system at PHS hospitals. The system was piloted in several hospitals but has not yet been integrated into the routine of hospital management. In Sudan, an accreditation programme has been initiated in some states. The programme involves standardized monitoring of specific parameters that are required to license health facilities. In Jordan, the quality and safety of health care services are mainly regulated through initial one-time licensing procedures that ensure the presence of baseline requirements for operating health care facilities. However, a law that came into force in late 2018 stipulates some basic medico-legal standards that health providers should adhere to that are directly related to quality of health care and health outcomes. Furthermore, the Health Care Accreditation Council was founded in 2007 following the adoption of a national programme for health services accreditation. Since its inception, the Council has accredited and reaccredited 11 private hospitals, 13 Ministry of Health hospitals, eight Royal Medical Services hospitals, two university hospitals and 100 Ministry of Health PHC centres *(83)*. However, the absence of economic, professional or regulatory incentives for health care organizations to seek accreditation may pose a challenge to the sustainability of the national accreditation programme. In Libya, a new centre for health facilities accreditation was established in 2018 to accredit public and private health facilities. The centre developed accreditation standards and methodologies for the accreditation of health facilities.

The Health Care Accreditation Council in Jordan has accredited:

11
Private hospitals

13
Ministry of Health hospitals

8
Royal Medical Services hospitals

2
University hospitals

100
Ministry of Health PHC centres

An accreditation programme has been in place since 1983 in Lebanon and was further revamped in 1999. The new accreditation system was developed per international standards and was drafted to incentivize hospitals to continually improve quality. Between 2001 and 2002, the accreditation process for hospitals was implemented by the Ministry of Public Health. By the end of 2016, the accreditation rate reached 69.53% *(71)*. To improve and update the existing hospital accreditation system in Lebanon and to comply with International Society for Quality in Health Care requirements, this system was revised in 2019 by the Ministry of Public Health with the development of new Lebanese hospital accreditation standards, which had a focus on achieving optimum clinical measurable outcomes for the patient *(84)*. The Ministry of Public Health now has a database for monitoring service provision in public and private health facilities. In the Islamic Republic of Iran, the Evaluation and Accreditation Office of the Ministry of Health and Medical Education is responsible for visiting all covered hospitals and other health centres to ensure their compliance with quality and patient safety standards. Each university has an accreditation office that performs related duties at the provincial level on behalf of the Ministry of Health and Medical Education's accreditation office. Accreditation and assessment are performed by a team consisting of representatives of providers, purchasers (health insurance) and supervision entities. Quality of services is usually assessed by the same team annually, following accreditation, except in cases where issues are reported. Then, the complaints are assessed by the Islamic Republic of Iran Medical Council, which is the inspection unit at the medical universities and the Ministry of Health and Medical Education.

In Iraq, according to the national health strategic plan, a process of acquiring accreditation is in place; however, our review revealed that no health facility has been accredited yet in either sector. Currently, the process of acquiring accreditation is active at the primary care level *(85)*. Legally, the Department of Inspection of Private Health Institutes is responsible for monitoring the quality of services in private hospitals, diagnostic centres and labs. Accordingly, quality issues generally do not stem from the structure of the governing body, but rather from poor implementation due to corruption and the lack of standards *(49)*.

Table 3: Status of accreditation process of health care facilities in the Region

Accreditation process for private facilities	Countries and territories
Nonexistent or in process	Afghanistan, Djibouti, Jordan, Libya, Morocco, occupied Palestinian territory, Sudan, Tunisia and Yemen
Present but not enforced	Iraq
Present and enforced	Islamic Republic of Iran and Lebanon

5

Public–private partnerships

5.1 Definition of rationale for PPPs

5.2 The legal and institutional environment for PPPs and private sector engagement

5.3 Examples of public–private partnership in the Region

5.4 Private sector engagement SWOT analysis

5.1 Definition of rationale for PPPs

PPPs are complex contractual arrangements that involve the provision of different types of services by the private sector under the umbrella of the public sector. PPPs can take many forms. The contracted services could include infrastructure development, service delivery or financial protection, the latter of which entails service delivery coverage through vouchers and insurance payments. Moreover, the private sector can be contracted to provide specific service streams, such as telemedicine, social marketing, or research and development *(86)*.

Successful PPPs typically require strong political will, effective intersectoral communication, effective governance, advocacy, and capacity-building within the public sector. PPPs can be a tool for the provision of quality health care, health sector efficiency improvement and acceleration in achieving UHC *(87)*. This stems from the entrenched performance-based culture in the PHS, which can make it more responsive to patient needs, as well as more flexible, efficient, innovative and managerially competent than the public sector.

Given the widespread growth of the PHS and the increasing demand for health care in the Region, PPPs are increasingly seen as inevitable in achieving UHC through risk-sharing and complementarity-based partnerships.

5.2 The legal and institutional environment for PPPs and private sector engagement

The role of the private sector is increasingly being acknowledged and incorporated in health policies and reform plans. In Afghanistan, the vision and objectives of PSE were defined by the Ministry of Public Health in 2009. In Sudan, PSE was noted in the national health policy (2017–2030). In Qatar, the private sector is seen as a partner in shaping the new model of care, as per Qatar National Vision 2030, the Qatar Second National Development Strategy 2018–2022, and the National Health Strategy 2018–2022.

In some countries of the Eastern Mediterranean Region, specific departments and units are concerned with overseeing PPPs and work on ensuring collaboration with the PHS, as in Afghanistan, where the Directorate of Private Sector Coordination acts as the main coordination platform between the public and private sectors.

Disparities in the readiness of countries and territories for PPPs and for PSE in general were observed. Accordingly, we attempted to classify countries and territories into three categories, as follows: those where PPPs and/or PSE are recognized in national policies but supporting structures are missing; those where PPPs and/or PSE are not recognized in national policies and plans; and those where laws and structures are in place for PPPs and/or PSE. The first category includes Djibouti, the occupied Palestinian territory, Qatar and Sudan. The second category includes Iraq and Yemen. The third category includes Afghanistan, the Islamic Republic of Iran, Jordan, Lebanon, Libya, Morocco, Oman and Tunisia.

Disparities in the readiness of countries and territories for PPPs and for PSE in general were observed.

Category 1

Those where PPPs and/or PSE are recognized in national policies but supporting structures are missing

Djibouti, the occupied Palestinian territory, Qatar and Sudan

Category 2

Those where PPPs and/or PSE are not recognized in national policies and plans

Iraq and Yemen

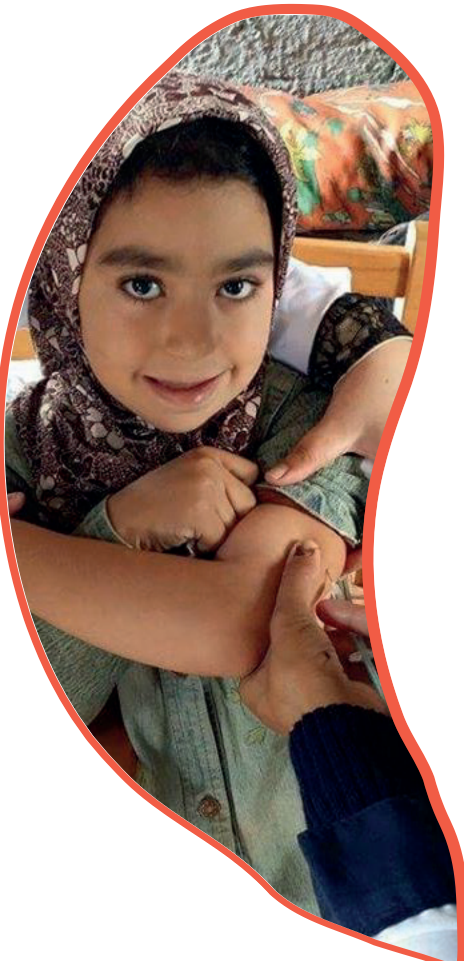
Category 3

Those where laws and structures are in place for PPPs and/or PSE

Afghanistan, the Islamic Republic of Iran, Jordan, Lebanon, Libya, Morocco, Oman and Tunisia

Occupied Palestinian territory

In the occupied Palestinian territory, the 2017–2022 National Health Strategy and related plans have underscored the need to develop long-term partnerships between the public and private health sectors to achieve UHC. The participatory approach used to develop the latest national health plan (2017–2022) is viewed as promising, yet still inadequate, due to the lack of detailed micro-level data on PHS activities and the reliance on a small sample of key stakeholders.



Qatar

In line with Qatar National Vision 2030, the Government introduced Law no. 12 of 2020. This law regulates PPP activities in the country by stipulating the guidelines for collaboration. The law defined the partnership between the two sectors as an agreement between the Government and the private sector to implement and finance works or provide services involving the allocation of lands through leasing or usufruct use (commonly referred to as "concession"), to be developed by the private sector through one of the following modalities:

- **build, operate and transfer;**
- **build and transfer ownership and operation;**
- **build, own, operate and transfer ownership; or**
- **operate and maintain.**

The law also necessitates the formation of a separate committee for each project that includes representatives from the contracting authority, the experienced department and the Audit Bureau.

Sudan

The policy stated that the private sector may be contracted by the public sector

Similarly, the 2009 National Policy for Private Health Sector in Sudan defined the roles and responsibilities of the State vis-à-vis the PHS in the overall context of health system PPPs. The policy stated that the private sector may be contracted by the public sector to provide supporting services like laundry, catering or gardening. Moreover, the policy stated that private providers may be contracted to organize and manage health services using, as well as providing, a defined health services package. However, the implementation of the PPP model is still very limited, and only one example of PPP has been reported, in which the Ministry of Health co-financed a private, not-for-profit facility with an Italian NGO.

Djibouti

The law also established an institutional framework for PPPs

In Djibouti, the Government developed a PPP policy in 2017 in line with Vision Djibouti 2035. The PPP policy defines the country's PPP strategy and general policy. This was followed by Law no. 186/AN/17/7th L of 29 May 2017 on PPPs. The law defines the term "public–private partnership" as a form of cooperation between public authorities and the for-profit, private sector to provide financing, construction, renovation, management or maintenance of public infrastructure or to provide a public service. It also describes the different forms of contract and specifies the obligations of the contracting parties. The law also established an institutional framework for PPPs, in which each function (e.g. financing, service provision, quality assurance) is managed independently.

Iraq

There are no existing PPP or PSE laws

In Iraq, there are no existing PPP or PSE laws. Moreover, Iraqi Public Health Law number 89 of 1981 is considered an obstacle to effective PPP and PSE. This law states that the mental, physical and social well-being of citizens is the responsibility of the State and that the Ministry of Health is the sole responsible entity for the organization of health services to achieve this goal.

Yemen

The political commitment to PPP is not reflected in national plans

In Yemen, the political commitment to PPP is not reflected in the national plans. Accordingly, the ecosystem for the establishment and facilitation of PPPs requires further development. Currently, there is neither an established PPP body within the health authorities nor a dedicated budget for this.

Morocco

Private health establishments are able to complementarily participate in public health actions

In 2008, the Ministry of Health in Morocco defined the partnership framework for both the for-profit and not-for-profit private sectors. Morocco's action plan for 2012–2016 also included steps for reinforcing collaboration with the private sector within a PPP framework. Those steps included defining a framework for collaboration between the Ministry of Health and medical associations, developing new forms of health investment PPP and developing private financing initiatives for public hospitals. Furthermore, according to Law 34-09, private health establishments are able to complementarily participate in public health actions. A division has been established within the Ministry of Health to regulate long-term partnerships with the private sector. This unit is responsible for following PPP projects and initiating others and for advising the Ministry of Health about the legal components of potential partnerships.

Tunisia

Projects subject to partnership contracts must have clear objectives

In Tunisia, Law no. 2015-49 provides a general framework for public–private contracts. This law states that projects subject to partnership contracts must have clear objectives and address a prespecified need by the public entity that is aligned with national and local priorities. The law further authorizes the establishment of a strategic council responsible for developing national PPP strategies and setting priorities in accordance with the guidelines in development plans. Article 38 of the same law allows the creation of a general PPP body within the presidency. This body provides technical support to decision-makers related to the preparation and implementation of PPP contracts.

The framework and policy for a PPP have not yet been implemented

Lebanon

The Lebanese Ministry of Public Health has also been able to develop a model of collaborative governance based on inclusive and negotiation-based leadership that brought together public and private stakeholders in consensus-oriented networks. However, our interviews revealed that the framework and policy for a PPP between the Ministry of Public Health and the private sector have not yet been implemented.

Oman

Two royal decrees on PPP were issued in 2019

In Oman, the Ministry of Health led an initiative in 2014 to develop plans for the health sector up to 2050, as part of Vision 2050, which puts special emphasis on the role of the private sector in the country's health system *(88)*. In 2017, the Omani Chamber of Commerce established a temporary committee to serve as a platform for intersectoral dialogue and for creation of a channel of communication and coordination *(89)*. Moreover, two royal decrees on PPP were issued in 2019. Royal Decree 52/2019 included a PPP law that outlined provisions related to the allocation of projects, contractual agreements, and the commitments and responsibilities of each party, as well as oversight and monitoring *(90)*. Royal Decree 54/2019 authorized the establishment of a general authority for privatization and PPP *(91)*.

Islamic Republic of Iran

The Ministry of Health and Medical Education's Economic Partnership Constituency was established in 2015

In the Islamic Republic of Iran, the Ministry of Health and Medical Education's Economic Partnership Constituency was established in 2015, and stipulations for PPPs have been enforced in recent years. The existing PPP models include concession contracts (build, own and operate; build, operate and transfer), clinical and nonclinical service contracts, management contracts, leasing contracts, outsourcing contracts for clinical and nonclinical activities, private finance initiative contracts, and public sector divestment or full privatization (divesture) contracts. Currently, the medical university of each province is free to decide on the form of PPP.

A PPP council has been established to facilitate and support PPP

Jordan

In Jordan, a PPP council has been established to facilitate and support PPP, headed by the prime minister and a PPP unit linked to the finance minister.

The PHS was formally organized in March 2014 through a business council for inpatient clinics

Libya

In Libya, the political commitment towards engaging the private sector was first highlighted by Law no. (9) of 1992, which consists of 18 articles concerned with the conduct of economic activities. Article 2 of this law allows PSE in many sectors, including health. This was re-emphasized in Law no. (1) of 2004 on conducting economic activities. The PHS was formally organized in March 2014 through a business council for inpatient clinics known as the General Federation of Inpatient Clinics. The priorities of the Federation are to collaborate with the Government in revising and updating the regulation, licensing mechanisms and accreditation mechanisms, and in achieving UHC through PPP. Unfortunately, the Federation is receptive to neither the public health programmes nor the exchange of information with the Government. Furthermore, there is no programme for continuous medical education in the Federation.

Afghanistan

PPP constitutes a separate unit at the Ministry of Public Health

Finally, in Afghanistan, PPP constitutes a separate unit at the Ministry of Public Health. This unit is the key government body for coordinating the collaboration between the public and private health sectors. The existing laws and regulations for PPP are the National Policy on Public–Private Partnerships, 2016, which provides guidance on how to apply PPPs in Afghanistan *(92)*; the Public–Private Partnership Law, 2016, which is the principal governing legislation for the implementation of PPPs; and a cabinet resolution approving the establishment of the High Economic Council and outlining its role in approving PPPs.

5.3 Examples of public–private partnership in the Region

There are multiple examples of PPPs across the Eastern Mediterranean Region. The reported engagements are mostly ad hoc and sporadic rather than organized and systematic.

Example 1 People's Primary Healthcare Initiative in Pakistan

Through this initiative, the management of government-run basic health units was contracted out across all four provinces to a national NGO that managed 48% of all PHC facilities in the country *(93)*. Additionally, from 2003 to 2008 extensive contracting -out of HIV control services was undertaken, with the Government purchasing services from nongovernmental organizations through performance-based contracts *(94)*. A similar project was conducted in the Islamic Republic of Iran, with the Tabriz Health Cooperatives being a model of a PPP to provide PHC to a defined population based on an identified integrated service package.

Example 2 Participatory Health Posts in Tehran Medical Sciences University in 2005

In this project, all PHC services were contracted out to the private sector to increase service coverage and improve the quality of delivered care. More than 20 million people were covered by the PPP and received PHC services from the private sector, especially within the marginalized areas of Tabriz and Tehran. Such PPPs have created jobs for almost 19 000 graduates of medical and paramedical sciences in towns and suburban areas and increased the access and availability of the primary health services up to 100% in urban areas.

Example 3

Qatar megaprojects

In Qatar, the Ministry of Public Health planned around 10 megaprojects to be implemented by the private sector through tendering processes in 2018. These projects are based on the principles of the build, own, operate and transfer model and include building hospitals and health centres on land allocated by the Government. Approximately 1280 beds are expected to be created from the 10 projects, which have an estimated value of around US$ 1 billion.

More examples

In the Islamic Republic of Iran, Iraq, Jordan, Libya, Morocco and Oman, the health ministries have been outsourcing specific health services to the PHS. In Morocco, a partnership framework between the public and private sectors has begun to take shape since 2005. This started with outsourcing dialysis services for the poor to the private sector at an estimated national budget of DH 200 million. The Jordanian Ministry of Health has also outsourced renal dialysis services based on leasing kidney dialysis machines in the private hospitals at a discounted rate per patient (JD 25), while the Ministry provided the consumables and medical supervision *(95)*. Similarly, Oman recently started outsourcing renal dialysis to reduce waiting times *(96, 97)*. Libya has reported other examples of purchasing specialized clinical services, such as cardiology, cardiac surgery, orthopaedic surgery and neurosurgery. In the Islamic Republic of Iran, the outsourcing process is more extensive, with almost all public hospitals contracting the PHS for the operation of pharmacies, medical imaging and diagnostic tests, and emergency departments. In Iraq, one private hospital – located in Baghdad – is offering dialysis services subsidized by the Government. Moreover, there is a cardiology centre in Erbil with public and private sector staff, public infrastructure, and government subsidization of service provision.

The health ministries in Jordan, Libya and Oman have been outsourcing the management of hospital general services such as catering, housekeeping, laundry, control, transport and security to private contractors for years *(98)*. The most significant reasons for outsourcing these services are to reduce costs, enable hospital management to focus on core services, and improve patient satisfaction. In Libya, such arrangements have extended to maintenance of hospital equipment, sanitation and other services in an attempt to move from outsourcing to concrete partnership within the PPP framework.

In Iraq, an insurance modality covers services for the employees of the Ministries of Oil, Interior and Electricity at private facilities

Vouchers were used by the Jordanian Ministry of Health to buy family planning services and women's health services from private sector practitioners in partnership with international donors in the following projects: the Private Sector Project for Women's Health; Jordan Health Communication Partnerships Project; Jordan Communication, Advocacy and Policy Project; Health Policy Project; and Sustaining Health Outcomes through the Private Sector Plus. The last two of these projects are funded by the US Agency for International Development *(99, 100)*. In Iraq, an insurance modality covers services for the employees of the Ministries of Oil, Interior and Electricity at private facilities. Under this modality, employees from these ministries receive services in specific private sector facilities and the services are covered by the appropriate ministry's insurance account.

Other examples from the Region include the operation of three hospitals by the private sector in Afghanistan under contracts sought by the Ministry of Public Health, and the construction of an HIV/AIDS prevention and communication centre in the capital of Djibouti in cooperation with the US Agency for International Development–FHI; UNICEF; the operating company of Djibouti Port, DP World; the Ministry of Health; and the Ministry of Budget.

Lebanon was the only country of the Region reporting PPP and PSE examples in setting health policy, health information systems, disease surveillance and monitoring, emergency preparedness, and quality assurance and accreditation.

Conversely, in Yemen – even though PPP was put on the agenda of the development programme in the transitional period 2012–2014 – collaboration between the public and private health sectors exists in a limited and sporadic manner that is usually reactive to immediate needs such as treatment of war casualties, vaccination campaigns and outbreak control. This collaboration is not formalized throught contract, and there are no clear criteria for the selection of cases or hospitals. Similarly, only a minority of laboratories and radiology centres provide services in collaboration with the Government, and slightly more than a quarter of laboratories act as referral centres within the health system. In the few cases where contracts exist, they are usually in the form of bilateral agreements between the service provider and a revenue-generating public authority, such as the Ministry of Oil, to provide services for their employees and dependents. However, a number of non-for-profit health centres have contracts with the Government to provide PHC and limited specialized care for people with disabilities and other vulnerable groups.

5.4 Private sector engagement SWOT analysis

S Strengths

- There are existing PSE projects in many countries.
- Strong political will for strengthening PSE has been noted in many countries.
- Some countries have been engaged with the PHS for decades in the provision of health care support services, such as catering, cleaning, pest control and laundry, through service agreements.
- Some health authorities in the Region have functional PPP laws and dedicated teams or units to manage them.
- Private sector stakeholders are represented in the health policy and regulating bodies of some countries.

W Weaknesses

- There is inadequate coordination between the public private sectors, and among private sector organizations.
- Gaps exist in the regulatory laws of the PHS and related enforcement mechanisms in most countries.
- Many countries do not have the resources or capacity, or a framework, strategy or vision, for effective PSE to achieve public health goals.
- There is limited evidence of the effectiveness of existing PPPs in health care in the Region.
- Laws in some countries explicitly limit PSE engagement opportunities in health.
- Many health authorities have limited capacity to manage PPPs and draft effective contractual arrangements.
- There is often inadequate internal resource allocation to support PSE in the development of national programmes.
- Most countries lack accurate data on the size, distribution and performance of the PHS; these data are needed for planning PSE and for decision-making.
- Long bureaucratic processes in the public sector hinder effective engagement.
- The PHS is perceived to be less technically competent than the public sector in some countries, such as Djibouti, Oman and Yemen.
- There is often limited corporate governance at private health facilities.
- The urban bias of the for-profit PHS limits the scope of partnership in increasing the access of rural communities to health care services.
- Poor compliance of the PHS with existing regulations and national reporting mandates supported by the one-time licensing of health care professionals and health facilities is an issue in some countries.
- Collaboration (if it exists) is usually part of ad hoc initiatives rather than systematic engagement and partnership.
- The short duration of PPP does not allow for both sides to reap the fruits of collaboration through long-term efficiencies and process refinement.

O

Opportunities

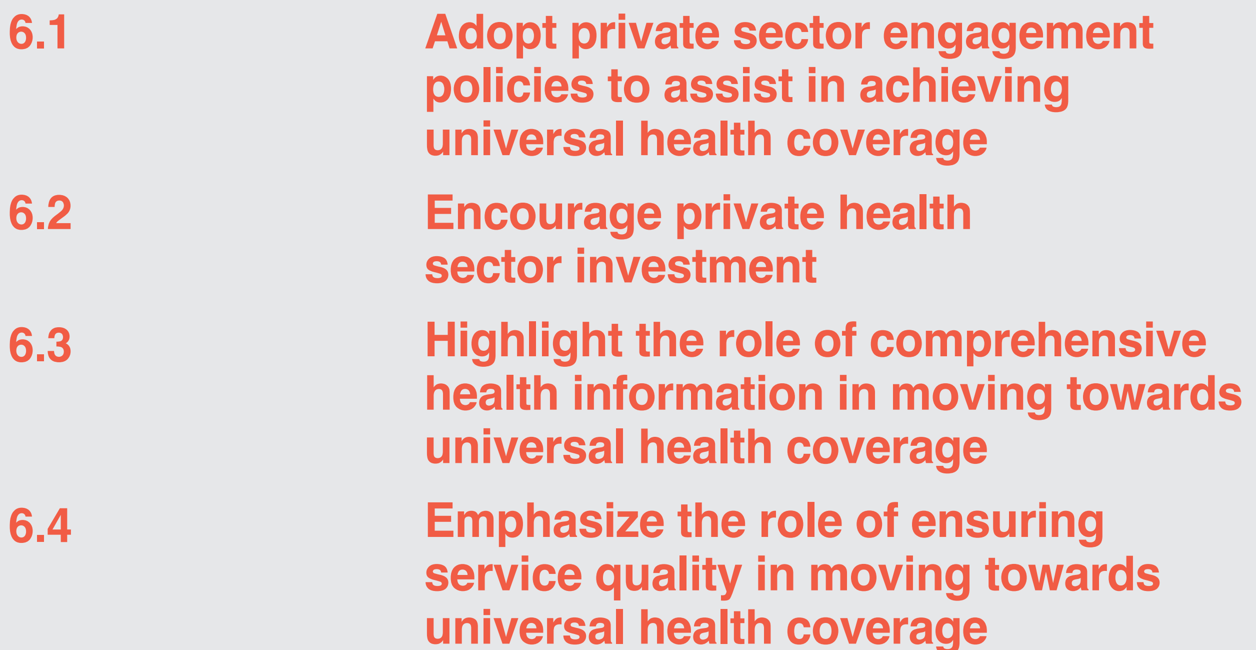
- Multiple global health partners and donors are interested in promoting PSE in support of the regional commitment to UHC.
- The PHS can fill many service provision gaps due to:
  - its ability to offer technologically advanced and specialized services that the public sector cannot provide;
  - smaller caseloads, enabling patients to receive more personalized care;
  - more flexible resource deployment and working hours; and
  - its efficiency, innovation and performance-based management.
- Strengthening the national health system by collaborating with the PHS can reduce the brain drain, help reduce the economic cost of indigenous patients seeking services abroad, and redirect funds from government-supported “treatment abroad” programmes to national economies.
- The public generally perceives the PHS to be better than the public health sector, and thus collaboration could improve health service utilization.
- The collaboration could offer the PHS the benefits of operating at scale and decrease the burden on the struggling public sector in many countries.
- The private sector and PSE are at the heart of health sector reforms and UHC plans in many countries in the Region.
- There is strong movement at the international level to include the private sector as a partner and not as a threat in moving towards UHC.

T

Threats

- Operational challenges hinder the expansion and growth of the PHS in some countries due to lack of flexible financing, poor security, sovereignty challenges and political instability.
- Dual practice in many countries presents a huge conflict of interest in PSE for UHC.
- There is a perception of poor alignment between the PHS and national health goals and preventive health care services.
- There is a lack of trust between some public and private actors within the health sector.
- There is often an unequal power dynamic between the private and public sectors.
- The increased access that would come with PPP could be associated with increased costs of health care services if efficient cost-containment measures are not in place.
- Most of the high-income countries have insufficient market size to achieve economies of scale for specialized and complex care.
- Many countries have unsustainable and fluctuating public health sector financing.
- Some countries have unstable macroeconomic policies and legislation.
- The continuous deferral of payment release and other contract obligations to the contracted PHS facilities and services by some governments threatens the sustainability of the model and could reverse the achieved PPP gains.
- A competitive attitude between private and public sectors in high-income countries with strong public sectors may hinder intersectoral collaboration.
- A systematic, policy-driven approach is often lacking, and the capacity of the Ministry of Health is often insufficient to conceive, design and manage professional PPP contracts.

6
Policy directions and recommendations



6.1 Adopt private sector engagement policies to assist in achieving universal health coverage

6.2 Encourage private health sector investment

6.3 Highlight the role of comprehensive health information in moving towards universal health coverage

6.4 Emphasize the role of ensuring service quality in moving towards universal health coverage

6.1 Adopt private sector engagement policies to assist in achieving universal health coverage

1

ORGANIZE
a leadership capacity-building programme for health officials and managers on the ways of engaging effectively with the PHS for UHC, with a focus on insurers and providers.

2

ENGAGE
with the PHS in a national policy dialogue to develop PPP strategies and define a common ground for joint work towards a common objective.

3

INSTITUTIONALIZE
regular communication and involvement of the private sector in national health policy and/or public health sector planning by establishing a dedicated PPP unit within the Ministry of Health.

4

EXPLORE
the feasibility of developing a representative body for PHS stakeholders for easier engagement in public–private collaboration.

5

SET
strategic purchasing plans for the collective mobilization of stakeholder resources to implement the developed strategies.

6

STRENGTHEN
governments' capacity to carry out core stewardship functions, such as identifying priorities, setting goals, and regulating, monitoring and incentivizing the PHS.

7

ESTABLISH
a multi-stakeholder commission to set relevant and accurate reference costs of health services, supported by updated data and using international standard classifications of diseases and procedures.

8

REVISIT
existing health legislation to ensure its alignment with national PPP goals and plans.

6.2 Encourage private health sector investment

1

FACILITATE
market entry through enhanced access to capital for investors. This can be done by encouraging larger and more flexible contributions of banks and/or microfinancing institutions.

2

STREAMLINE
the registration and licensing procedures by adopting a “one-stop shop” model.

3

ADOPT
a transparent regular relicensing approach for facilities and providers.

4

CONSIDER
In the absence of national health insurance, consider applying a policy of benefits for employers that provides comprehensive health insurance for their employees and their dependents.

5

SUPPORT
compliant PHS stakeholders with tax exemptions and reduced costs for utilities.

6

ENCOURAGE
private providers to engage in corporate partnerships for the provision of supporting services, such as laundry, catering, medical waste disposal, and maintenance, to leverage economies of scale for small- or medium-sized enterprises.

6.3 Highlight the role of comprehensive health information in moving towards universal health coverage

1

SET
investment plans to strengthen national health information systems that include timely gathering, processing and generating of information on the PHS for evidence-based decision-making.

2

INCLUDE
indicators of service quality, human resources, patient safety and treatment outcomes in health system performance monitoring.

3

CREATE
a live registry of all PHS information for better coordination, monitoring and partnerships.

6.4 Emphasize the role of ensuring service quality in moving towards universal health coverage

1

ENSURE
the presence and enforcement of a medical liability law as a key to service quality and equity.

2

DEVELOP
standardized clinical practice guidelines for both sectors in partnership with professional bodies.

3

STRENGTHEN
the referral process between public and private facilities, as well as between ministry of health facilities.

4

DEVELOP
binding intersectoral continuous medical education programmes for service providers.

5

CREATE OR EXPAND
accreditation programmes for private clinics, laboratories and other medical and health facilities, and use purchasing or insurance as leverage to promote voluntary accreditation and quality improvement.

6

DESIGN
a national incentive package to reward private facilities and professionals who voluntarily seek accreditation, adhere to national treatment protocols, and improve performance indicators.

7

SHARE
service quality ratings of private and public facilities with the public.

8

IMPROVE
transparency and accountability by promoting the public disclosure of private-sector-related information, including partnership arrangements.

7

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