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Report on the

Report on the regional consultation on engaging the private health sector for accelerating progress towards universal health coverage

Cairo, Egypt
23–25 June 2014



World Health
Organization

Regional Office for the Eastern Mediterranean

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EXECUTIVE SUMMARY

A consultation on the private health sector was held by the WHO Regional Office for the Eastern Mediterranean in Cairo, Egypt from 23 to 25 June 2014 in collaboration with the International Development Research Centre. Participants included international and regional experts. The consultation also involved representatives from ministries of health, academia and the private sector from 14 countries of the Eastern Mediterranean Region as well as selected health system focal points from WHO country offices.

The objectives of the consultation were to: raise awareness among policy-makers and key stakeholders on the role and contribution of the private health sector in progressing towards universal health coverage; share experiences and results of analytical studies in selected countries of the Region on regulation of the private sector and its role in health service provision; develop a roadmap for private sector involvement in moving towards universal health coverage in the countries of the Region. The expected outcome was a country roadmap based on the regional framework for accelerating the role of the private health sector in universal health coverage.

In his opening message Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, highlighted the importance of engaging the private sector to support progress towards universal health coverage. The workshop would draw on international and regional experience on involving the private sector, including assessments of various aspects of the private health sector in countries of the Region. It was acknowledged that the role and contribution of the private health sector in universal health coverage is unclear despite the growth in the private health sector, increasing engagement in public–private partnerships, and community perception of a better quality of services in the private health sector in the Region. The importance of engaging with the private health sector as part of the efforts towards achieving universal health coverage was emphasized. In this regard, the significant gaps in information related to the private health sector need to be filled.

The workshop was facilitated by WHO staff from the Regional Office as well as international experts in public–private partnership from India, Thailand and the United States of America. Participants reviewed the regional framework of action for engaging the private sector, which includes seven commitments: building platforms for dialogue, policy and stewardship; mapping the private sectors; regulation and governance; purchasing and financing private sector services; leveraging quality and access; and patient information, engagement and satisfaction. Participants agreed on a set of recommendations organized around these seven areas of work and identified those requiring priority action within their own country.

At the end of the consultation, the participants welcomed the start of a regional dialogue on the role of the private health sector in moving towards universal health coverage, recognized the diversity in participation in the meeting, and looked forward to the next meeting. The participants emphasized the essential role WHO plays in advocating engaging with the private sector and guiding countries in the importance of linking public–private partnership with universal health coverage, bearing in mind the reasons for engaging the private health sector.

1. INTRODUCTION

A consultation on the private health sector was held by the WHO Regional Office for the Eastern Mediterranean in Cairo, Egypt from 23 to 25 June 2014 in collaboration with the International Development Research Centre. Participants included international and regional experts. The consultation also involved representatives from ministries of health, academia and the private sector from 14 countries of the Eastern Mediterranean Region as well as selected health system focal points from WHO country offices.

The consultation's objectives were to: raise awareness among policy-makers and key stakeholders on the role and contribution of the private health sector in progressing towards universal health coverage; share experiences and results of analytical studies in selected countries of the Region on regulation of the private sector and its role in health service provision; develop a roadmap for private sector involvement in moving towards universal health coverage in the countries of the Region. The expected outcome was a country roadmap based on the regional framework for accelerating the role of the private health sector in universal health coverage.

In his opening message Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, highlighted the importance of engaging the private sector in supporting progress towards universal health coverage. In some countries of the Region an estimated 70% of the population sought health care from private providers. The proportion of private sector services used by the poorest quintile ranged between 11% and 81%. Therefore, strengthening public-private partnerships for service provision could have a substantial impact on moving towards universal health coverage. The range of services provided by the private sector was, however, variable: standards were questionable, regulation was poor and there was insufficient information about the financial burden to the users of these services. Enforcement of quality standards for service delivery in the private sector was one of the biggest challenges faced by governments and ministries of health.

Dr Alwan noted that the importance of partnership with the private sector was increasingly being acknowledged by ministries of health, and policies for engaging with the private health sector were evolving across the Region. Despite this recognition, it had not been possible so far to formulate an evidence-based strategy on the role and contribution of the private health sector towards the achievement of public health goals in the Region. Mapping of the situation with regard to the private health sector in the Region was one of the first measures taken by WHO to better understand the challenges and opportunities for partnership and thus the contribution it could make towards universal health coverage. A preliminary analysis of the results had been presented to the 60th session of the Regional Committee in October 2013. This showed that the proportion of private sector outpatient services used by the population in some countries ranged from 33% to 86%. The proportion of private clinics in Group 1¹ countries ranged from 15% to 88%; the corresponding

¹ Group 1: These countries are where socioeconomic development has progressed considerably over the past several decades, supported by high incomes. Included in this group of countries are Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates. Group 2: This group of countries tends to be in the middle-income bracket. These countries have developed extensive public health service delivery infrastructure but face resource constraints.

figures were 5%–78% for Group 2 countries and 20%–90% for Group 3 countries. In Group 2 countries 7%–83% of hospital beds belonged to the private sector.

Dr Qamar Mahmood, Senior Programme Officer, International Development Research Centre (IDRC), provided a brief overview of the work of the Centre, a Canadian government agency that works with developing countries. He expressed the IDRC's keen interest in governance for equity in health systems and welcomed the opportunity to support the regional dialogue on involving the private health sector in supporting universal health coverage.

Dr Sameen Siddiqi, Director, Health System Development, WHO Regional Office for the Eastern Mediterranean, gave the keynote presentation on the private health sector in countries of the Eastern Mediterranean Region. He mentioned that over the last few decades there have been significant trends in privatization policies. However, the role and contribution of the private health sector in universal health coverage is unclear despite the growth in that sector, increasing engagement in public–private partnerships, and community perception of better quality of services in the private health sector in the Region. At the World Health Assembly in May 2012 and at the Regional Committee held in October 2012, Member States agreed on the need to engage with the private health sector as part of efforts to move towards universal health coverage. Dr Siddiqi then described efforts made by WHO to assess the private sector, including a quick assessment in 12 countries of the Region, an assessment of the regulation of the private health sector in Egypt and Yemen and a recent assessment of costing and quality of services provided by private sectors in 5 selected countries of the Region.

The findings from these efforts indicated that one-quarter of total health expenditure goes to the private health sector in Group 1 countries, half in Group 2 countries and as much as three-quarters in Group 3 countries; most of this expenditure is direct out-of-pocket payments. Private health insurance has limited scope in all three groups of countries. The Region has a diversity of private sector service provision, however some services (including health workforce development, primary health care delivery, pharmacies, and diagnostic facilities) are largely provided by the public sector. Service utilization by the different income groups also varies within countries.

Dr Siddiqi outlined the key issues for some of the main challenges to health workforce development in the Region; these include dual practice between the public and the private health sectors, the concentration of the private health workforce in urban areas and an unregulated expansion of programmes for the education of health professionals. The irrational use of biomedical devices and technologies and the weak medicine regulatory framework (including poor enforcement and limited control on promotion of medicines) also pose a challenge for the health systems of the Region. The limited capacity of Member States is one of the barriers to engagement between the

Included in this group of countries are Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestine territory, Syrian Arab Republic and Tunisia. Group 3: This group of countries tends to be in the low-income bracket. They face major constraints in improving population health outcomes as a result of lack of resources for health, political instability and other complex development challenges. Included in this group of countries are Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen.

public and private health sectors and to strengthening the regulatory framework for the private health sector.

In conclusion, Dr Siddiqi acknowledged the significant gaps in information regarding the private health sector and its engagement with the public sector in supporting universal health coverage. He identified the key priority areas of work, including the regulatory capacity of the ministries of health, partnership with the private health sector, reducing out-of-pocket payments incurred in the private sector, and improvement in quality of care. He encouraged the development of a regional strategy that could support countries to engage with the private sector towards achieving public health goals.

An extensive discussion took place following the presentation. It was acknowledged that public perception sees the private sector as providing better quality health care services, however, there was uncertainty as to whether there is evidence demonstrating any difference in clinical care. It was also noted that public sector officials often fail to understand the potential contribution made by the private sector to the health sector. Concern was also raised about whether or not the private sector is aware of their role in universal health coverage. It was recognized that often complex clinical cases are managed by the public health sector and the less-complex cases by the private health sector. Thus, participants emphasized the importance of regional discussions to address myths and misconceptions.

It was noted that a discussion about the private health sector is actually a discussion about the whole health sector. Countries need to consider where they see the health sector in 10 years and then determine the role of the private health sector to ensure universal health coverage. There is also a need to better understand how the private health sector can benefit from the public health sector. The issue of quality needs to be addressed; however, it needs to be linked to the system of governance in general and also to public perception of services.

Participants observed that there are at least 3 kinds of success stories depending on country grouping. As an example, Lebanon was presented as a country with great experience of a private health sector, however it may not be the best model for universal health coverage. At the same time, even within each income group there is great variability in the development of the private health sector, including general public perception of services as well as variability in the political and emergency situations. For instance, in some countries the private health sector has sufficient political power to influence regulation; in addition, in some countries public sector physicians also work in the private sector, a situation that could present a barrier to developing an appropriate regulatory framework. This variability needs to be acknowledged. At this stage, WHO needs to determine how to move forward in addressing this complex issue, including having a better understanding of the current situation, identifying some of the key gaps in our knowledge, and determining the key issues and concerns that require priority action.

2. TECHNICAL SESSIONS

2.1 Role of the private sector in universal health coverage

This session was chaired by Dr Hoda Rashad, Director, Social Research Centre, American University in Cairo, and started with a presentation by Dr Barbara O'Hanlon of O'Hanlon Health Consulting in the United States of America on the private health sector: challenges and opportunities, global perspectives. This opening presentation set the stage for participants to discuss how to leverage the private health sector to accelerate universal health coverage. The presentation offered a global perspective on the size of the private health sector in developing countries and their contribution to health systems. Private sector activities, challenges in partnering with the private sector, and core concepts related to the private health sector were also reviewed. Dr O'Hanlon identified challenges in working with the private sector from the public sector perspective, which included concerns about quality and regulation, rapid and uncontrolled growth on the informal market, and unbalanced geographic distribution of private facilities. There are also several challenges in working with the public sector from the private sector perspective; these include a lack of trust in the public sector, limited communication and dialogue, restricted access to important information, and the fact that the private sector is not invited to participate in strategic planning or policy reform efforts.

The presentation identified a number of steps to bridging the current gap between the public and private sectors: collect more data on the size and scope of the private health sector, report regularly to the Ministry of Health on private sector activities, acknowledge the contribution of the private sector, increase interactions and dialogue using data to inform discussions, involve the private sector in policy and planning, build a common vision on health sector priorities, and agree on roles and responsibilities to achieve them.

This was followed by a presentation via videoconference by Dr Shehla Zaidi, Aga Khan University, Pakistan, on the role and contribution of the private sector in moving towards universal health coverage in the Eastern Mediterranean Region. Dr Zaidi gave an overview of the private health sector in the Region in terms of composition, utilization and out-of-pocket expenditure. She also presented the key findings from recent research studies carried out in five countries of the region that assessed the quality and costing of care in the private health sector. Based on this assessment, Dr Zaidi proposed a framework of action for engaging the private sector in the move towards universal health coverage. This included seven commitments: building platforms for dialogue, policy and stewardship, mapping the private sector, regulation and governance, purchasing and financing private sector services, leveraging quality and access, and patient information, engagement and satisfaction.

Two presentations were then given to share country experiences. Dr Peerapol Sutiwisesak, National Security Officer for Policy and Financing, Thailand, presented the experience in Thailand. Thailand has just become an upper middle-income country, with a low level of poverty, moderate income inequity and fair health status. It has had universal health coverage since 2001. Six per cent (6%) of the gross domestic product (GDP), representing 14% of the national budget, is spent on

health. Out-of-pocket health expenditure fell from 75% in the early 1980s to less than 40% after implementing universal health coverage.

Health insurance in Thailand has continued to develop since 1975, when a low-income scheme was introduced. There are now three main government schemes, the Civil Servant Medical Benefit Scheme for civil servants and their dependents (7.69%), the Social Security Scheme for formal employees (15.99%), and the Universal Coverage Scheme for the remaining Thai citizens who are not covered under other government schemes (75.27%). One of key issues in achieving universal health coverage in Thailand was ensuring accessibility to quality comprehensive essential health services and technology without financial barriers. Most health providers in Thailand are governmental; only 6% of health facilities are private. However, the private sector play an important role in filling the gaps in the implementation of universal health coverage. This includes being service providers, especially in Bangkok, in urban areas and for specific services; being a member to the National Health Service Board; being product distributors, especially for drugs and medical equipment; and being producers of human resources for health. Some private services are provided for a limited number of cases depending on the available facilities, e.g. radiotherapy, heart surgery, and cardiac intervention (except haemodialysis), provided by private provision. Finally, some private organizations may be able to provide services for the public as part of corporate social responsibility to enhance their image. They also need to maintain the skills of their medical experts, especially in tertiary services.

Dr Alissar Rady, Technical Officer, WHO Lebanon, presented the experience in Lebanon. Lebanon has a turbulent history of political and security instabilities; it is a country with a mosaic of 19 different religious communities, all with specific social expectations. It has a liberal free economic system; the private sector has a prominent role in all aspects of society. In the health sector, nongovernmental organizations flourished before independence. Currently, the government largely purchases health services from the private sector (including nongovernmental organizations) and is progressively regaining a regulatory role. Although the system is known for providing a free choice of health providers and services for patients and having a good availability of services, concerns remain regarding the concentration of services in urban centres, social discrepancies in terms of affordability, poor government control of services and the high cost of service provision. Efforts are, however, being made to expand the primary health care network with a prepaid benefit pack of services, tariff unification, linking key providers and payers through an eHealth system, and the strengthening of public hospitals.

The presentation covered the four main objectives of the health system reforms: reinforcing the stewardship role of the Ministry of Health, rationalization of expenditure on health, reducing discrepancies in terms of access and affordability, and improving and monitoring quality of services. Dr Rady identified some of the challenges facing health insurance: political interference/territoriality, fragmentation of the health care services that leads to inefficiencies, fund collection issues, tariff unification, IT infrastructure and identification of the poor.

A brief discussion followed the four presentations. Concern was raised about the distinction being made between the for-profit and not-for-profit entities within the private health sector, when

in reality the differences are often minimal since they follow similar business models and behaviours. It was agreed that different countries may use different definitions for the private sector and public-private partnership.

It was noted that the public health sector seems to fail to appreciate the efficiency of the private health sector. On the other hand, it was recognized that the public sector needs to determine the direction of the private sector. It was agreed that a general discussion regarding universal health coverage would be useful to better understand the role the private sector and the programme was revised to include a separate presentation that would be added during Day 2.

2.2 Private sector regulation

This session was chaired by Dr Nizar Masalma, Director-General Health Insurance, Palestine. Dr Venkat Raman, Faculty of Management Studies, University of Delhi South Campus, India presented a global overview of private sector regulation. Faced with rapid expansion of non-state health care providers, regulating them is a major challenge for governments, particularly in low- and middle-income countries. While some countries are yet to formulate a regulatory (legal) framework, others are either ineffective or unable to implement their existing regulations effectively. There is limited empirical evidence to indicate the causes of regulatory failures (or successes).

Dr Raman presented the ten prerequisites for effective regulation of the private health sector:

- There is a need for enacting some basic legislation governing the entry (licensing and registration) of the private sector and their standards and quality (accreditation).
- Besides the legal (control) framework, a judicious mix of ‘incentives’ and ‘incentive regulation’ in the form of subsidies, contracts, purchase arrangements, etc. is equally important. But any such regulatory framework should consider the long-term effects on health care.
- Regulation should be appropriately timed (i.e. before the private sector becomes entrenched and commences regulatory capture), otherwise it becomes harder to enforce or implement. Experience from some countries suggests that it is virtually impossible to implement regulation once the industry is well established.
- ‘Incentives’ are likely to be more effective, if some form of relationship between the government and the private sector already exists, where governments still retain major roles in provision or financing.
- ‘Incentive regulation’ may be possible where governments have some form of input-based contracting/purchasing arrangements with the private sector. Governments may try to move towards performance- or output-based contracts.
- Effective implementation of regulations requires a strong organizational system, clarity of mandate and authority, adequate resources (competent staff), and institutional capacity.
- There is also a need to create a judicial subsystem that quickly responds to the regulatory challenges.

- Empowering consumers through awareness and legal facilitation can be a potent device against private sector coalitions or pressure groups. It may even elicit political support.
- There is a dire need to resolve the dilemma regarding informal providers in order to ensure patient safety. A significant proportion of the private sector in low- and middle-income countries comprises informal, indigenous or untrained providers, who cannot be completely abolished.
- There is also a need to facilitate regular communication between government (regulator), the private sector, consumer groups, and other key stakeholders.

Dr Raman emphasized that regulation in the health sector is a continually evolving process (not a one-time radical shift), and is not an alternative for better governance.

Dr Abdi Momin, Regional Adviser, Health Policy and Planning, gave a presentation on regulating the health sector: a key intervention towards universal health coverage. He noted that there has been very limited intelligence on the private health sector in health system development despite its growing role, especially in low- and middle-income countries, and more importantly, the sector remains largely unregulated. A comprehensive assessment conducted by WHO of private sector regulation in two countries shows that laws are outdated, enforcement is weak, and rules and regulations are vague. Dr Momin stated that the objectives of private sector regulation are to improve quality (safety); reduce inequality (geographic, economic); increase access (equity and justice); improve technical and allocative efficiency (economic); and constrain cost escalation (economic). He summarized the strategies and instruments for regulation of the private health sector into three groups: 1) control-based, a government's ability to mandate compliance with its decisions that is established through legal processes, executive/administrative and judicial processes; 2) incentive-based, which may be monetary or non-monetary rewards, for example, monetary rewards could be low interest loans, guarantees for borrowing and access to foreign currency while non-monetary awards could include creating an enabling environment (improving ease of entry to the market, improving regulatory processes and reducing bureaucratic controls, disseminating information on regulations and laws); 3) self-regulation, where the government delegates to the private sector with the role of each party and the rules for engagement clearly established.

The presentation identified the main challenges facing the regulatory process: political constraints (inappropriate influence on the regulatory body and corruption of the regulatory body), administrative constraints (inadequate compliance with rules and regulations and lack of enforcement) and informational constraints (reliable and timely data for regulatory controls is not available).

Two presentations on the assessment of private sector regulations in countries of the Region in 2013 followed. Dr Sherine Shawky, Social Research Center, American University in Cairo, presented the findings from Egypt. The health sector in Egypt has been characterized in recent years by extensive private sector activity. Increasingly, experience with the private health sector has indicated problems with quality, pricing and role; consequently this led to a growing interest in government regulation. Extensive desk reviews were performed supplemented by in-depth interviews, focus group discussions and online surveys to define the private health sector, identify

the regulations and regulatory systems, and assess their effectiveness in Egypt. Dr Shawky reported that the existing regulatory framework appears to be fairly comprehensive, with rules and roles firmly established and covering almost all relevant, formal, private healthcare individuals and facilities. However, private health sector laws are outdated and the ministerial resolutions are fragmented. The regulations focus on entry and quality with little attention to pricing, quantity or distribution. The existing regulatory framework and the incomplete performance of regulatory functions has several gaps, which may lead to exploitation of healthcare beneficiaries and providers as well as cost escalation.

Based on the findings of the assessment, Dr Shawky proposed four key recommendations: strengthening the regulatory framework through updating private health sector regulations, filling in remaining gaps and regulating the semi-formal and informal sectors; reinforcing the regulatory system through building regulatory capacities and a potent information system, increasing resources and balancing government control by self-regulation; creating an enabling environment for healthcare professionals through setting up regulations for contractual arrangements, reviewing salary scales and contractual procedures, organizing multiple practices and working hours, providing a secure working environment and social security incentives; and raising the health-seeking awareness among beneficiaries through improving knowledge on rights and obligations and on risks from semi-formal and informal services.

Dr Rashad G. Sheikh, Focus Group International, Yemen, presented the findings of the assessment of private sector regulations conducted in Yemen. The assessment involved reviewing the relevant laws and regulations, carrying out interviews with 32 policy-makers, members of the public, nongovernmental and private health managers, members of academia and parliamentarians, conducting eight focus group discussions with 29 male and 26 female formal and informal health care users, and carrying out an online survey with 39 providers of care. The role of the private sector in health and that government is encouraging its expansion was recognized by all participants. The investment laws were deemed sufficient but political instability, poor security and corruption are major barriers to investment in public– private partnership.

On the other hand, Dr Sheikh noted that there are many regulatory bodies, including the Ministry of Health, which should be actively involved in streamlining the regulation of the private sector. The General Medical Council regulates the health professionals while the Higher Authority of Drugs and Medical Supplies regulates medical products. Professional syndicates are self-regulated, but their role is weak. Informal influences over policies are common. Market entry is highly regulated compared to quantity and distribution and regulation is especially weak in regard to quality and pricing. Dual practice and commercialized behaviour are common. There is also an informal sector which is not controlled. Enforcement of regulations is subjective and fragmented, with the different regulatory bodies having overlapping roles. All the stakeholders are aware of and frustrated by the weak enforcement, including both governmental and private professionals. Users of the health care services expressed dissatisfaction with the quality of public health care and the commercialized private health sector. Dr Sheikh concluded that the continuing expansion of the private sector, weak oversight and government interest in building an effective public–private

partnership calls for a redefinition of the role of the state and strengthening of the regulatory system.

Following the country presentations, Dr Adham Ismail, Regional Adviser, Health and Biomedical Devices, gave a presentation on regulation of the pharmaceutical sector and medical products. He expressed concern that the use of ineffective, poor quality, harmful products can result in therapeutic failure, exacerbation of disease, resistance to treatment and death. Thus, regulation of medical products is a public policy that restricts private sector activities in order to attain social goals set by the government.

Regulation – which covers the totality of legal, administrative and technical measures taken by government to ensure safety, efficacy and quality of medical products – is one of the government functions. The private sector may be competing with the public health sector, but the rules should be applied in both sectors. Therefore, effective regulatory measures are necessary for accelerating progress towards universal health coverage as they clearly affect cost, quality and coverage/access of the population. Regulatory activities are carried out by national regulatory authorities, which have a different scope and modus operandi in each country. To fulfil their mandate, they need to be competent, capable, and independent, with clear authority to enforce their regulations. Dr Ismail noted that there are several challenges in regard to regulation of medical products in the Region such as fragmentation and complexity of the legal/regulatory framework, weak implementation of regulatory functions, inadequate adaptation of guidelines and procedures, inappropriate organizational structure, conflicts of interest, and shortage of human and financial resources. Thus, actions by WHO, in collaboration with partners, are necessary to support regional and national initiatives for strengthening regulatory systems not only in developed but also in developing countries. These actions include the production of norms and standards, capacity-building of regulators and manufacturers, prequalification of essential medical products, development of post-marketing surveillance systems, and networking.

In his conclusion Dr Ismail highlighted three issues: strong regulatory measures should be in place and be effectively implemented, especially in Member States increasingly exposed to the threats of substandard/spurious/false-labelled/falsified/counterfeit (SSFFC) medical products; regulation of medical products involves several functions and its modus operandi may vary from country to country; effective regulation of medical products requires political and financial commitment, public adherence and interaction with various stakeholders (e.g. national regulatory authorities, manufacturers, consumers, professionals, researchers, customs, civil society).

A discussion followed the presentations. Participants noted that public–private partnership is a good initiative in health care but it is often seen as being competitive rather than complementary. Thus, they felt that significant lobbying and political support is required to move the agenda forward.

It was noted that regulatory agencies spend more time in enforcement of the private health sector than the public sector, and that the focus of regulations is only on the inputs. It was suggested that a paradigm shift is required so that the focus of regulation is on outputs such as quality,

efficiency and accessibility. Regulation is considered as a means not an end, and other approaches could be used to modify behaviour, e.g. incentives and contractual arrangements. In other words, providing an enabling environment and motivating individuals and institutions can complement enforcement measures. It was suggested that the more detailed a regulation, the more difficult it is to enforce; thus, regulations need to be developed keeping in mind enforceability and cost-effectiveness of enforcement.

Given the limited regulatory framework for medical devices in the Region, it was suggested that unified regional regulations should be developed for the manufacturers of medical devices. This has already been accomplished for vaccines, and other WHO regions are working on unified regulations for pharmaceuticals.

2.3 Role of the private sector in service delivery

Dr Hilda Harb, Ministry of Public Health, Lebanon, chaired the session and Dr Sameen Siddiqi presented a regional overview on universal health coverage. Dr Siddiqi defined universal health coverage as providing all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) that are of sufficient quality to be effective while ensuring that the use of these services does not expose the user to financial hardship. Monitoring progress towards universal health coverage involves three dimensions: direct cost (proportion of the costs covered), service coverage (which services are covered) and population coverage (who is covered).

In the Region, the share of out-of-pocket payment in total health expenditure has remained at 40% over the past decade; the amount has been relatively stable except for Group 3 countries, where it has increased from 59% to 69%. Service coverage for communicable diseases and reproductive health is generally high for Group 1 countries. For Group 2 countries, measles and DOTS (directly observed treatment, short-course) coverage is good, but there are variations and gaps for other areas, especially in terms of antenatal coverage and births attended by skilled birth attendants. For Group 3 countries, there are variations across countries in terms of coverage for essential services and in many the levels are unacceptable. In terms of providers and financing sources, for Group 1 countries, services are provided by ministries of health, other government agencies and private providers, and are predominantly financed from general government revenues. For Group 2 and 3 countries, services are provided by ministries of health and other ministries, social security, and private providers and they are paid for from general government revenues, social insurance organizations, donors, and households. Hence, the challenges are of different degrees for all three groups of countries. Financing modalities and mechanisms differ in the three groups of countries. For Group 1 countries, population coverage is high for nationals but there is concern regarding non-nationals. For Group 2 and 3 countries, population coverage varies significantly, and depth of coverage is a concern.

Following this overview of the situation of universal health coverage in the Region, Dr Siddiqi described the regulatory processes and approaches and presented the regional strategy towards universal health coverage. He concluded that the path to universal health coverage calls for reforming the entire health system, noting that a multisectoral approach is more likely to make

accelerated progress and that it should be well monitored and measured. He also noted that gaps towards universal health coverage exist in all three groups of countries, and that every country, irrespective of level of development, can progress towards universal health coverage through sustained political commitment.

A discussion regarding universal health coverage followed the presentation. Concern was raised that universal health coverage overlooks some key principles of primary health care such as social accessibility and medical, but not service, quality. Concern was also raised that by pushing universal health coverage, countries would focus on quantity and forget quality. It was noted that in the World Health Report 2008 on primary health care, universal health coverage was seen to be at the heart of primary health care. Thus, social justice is at the heart of universal health coverage and is an approach towards meeting the goals of primary health care. Its focus is on ensuring 100% population coverage, a package of essential services of acceptable quality and out-of-pocket expenditure less than 20%. Concerns were also raised about the ability of the financing system to maintain coverage. It was noted that although countries need resources, between 20% and 40% of funds are wasted through abuse, corruption and wastage. Thus, it is not so much resources that are of concern, but more about how to spend money. It was agreed that the Ministry of Health has the stewardship role, therefore, it is the Ministry of Health that has to bring together all health players to develop a national vision for universal health coverage.

This discussion was followed by a presentation given by Dr Barbara O'Hanlon on the process of assessing the private health care sector. She noted that there are several methodologies available to do this and presented the new web-based private sector assessment (PSA) tool. Dr O'Hanlon gave a description of the PSA methodology and elaborated on the range of information and analysis of five elements covered in a PSA: demand for health services, supply of products, service provision, health financing and policy environment. Dr O'Hanlon noted that the biggest achievement from her experience in conducting these assessments was to get all the information/data in one place; the data shape the dialogue. The outcomes are concrete, strategic recommendations such as: formalize the dialogue, organize the private health care sector, and/or strengthen contract service.

It was noted during the discussion that followed a distinction needs to be made between assessment and mapping. Mapping requires gathering itemized information, which is done by the government to document what is happening in the private sector and is a long-term strategy. The challenge in a PSA is actually gathering the primary data. It is, therefore, important to engage the private health care sector, to develop formal agreements and to be transparent. It was also noted that mapping of the private health care sector is critical; it can provide information that is helpful in negotiations and in making decisions for the benefit of patients.

Following the discussion, presentations were made on a rapid assessment of the role and contribution of the private sector in health care delivery and the costing of services in four countries of the Region, Jordan, Lebanon, Pakistan, and Saudi Arabia. Dr Shadi Saleh, Associate Professor and Chairman, Department of Health Management and Policy, American University of Beirut, presented the methodology for the rapid assessment and the findings from Lebanon. The assessment

attempted to evaluate two common procedures/conditions: caesarean section (C-section) and diabetes care. Data were collected from obstetrics and gynaecology hospital departments, speciality clinics and general practitioner/primary care clinics. For each facility, an assessment tool was completed and medical records ($n = 10/\text{facility}$) for patients reviewed based on a structured survey. Patient interviews were conducted to enquire about patient perspectives on quality and expenditure. The total patient population comprised 100 C-section patients and 141 patients with diabetes (49 patients treated by endocrinologists (specialists) and 92 patients treated by general practitioners/primary care physicians). The findings revealed that all facilities had updated treatment protocols; 71.4% of examined facilities had an in-house laboratory for diabetes-related tests (all hospitals did) with 67% having laboratory guidelines for performing tests. Whereas all facilities kept records for diabetes patients, only eight out of ten kept records of patients' diagnostic tests. The records were mostly used for financial audit (80%) and clinical and management review (70%). The results for C-section showed that almost all facilities examined had a solid infrastructure with fully functional maternity wards, nurseries and neonatal intensive care units (NICUs). Three in five facilities had computerized medical records, with 80% having a mix between computerized and paper-based records. Dr Saleh concluded by highlighting five findings; private health facilities are well equipped, treatment protocols and diagnostic guidelines are updated, variations in care between general practitioners and specialists, perceptions of patients vis-à-vis the role of the physician, and inefficiencies in the system for C-section care.

Dr Mohamed Tarawneh, Director, Noncommunicable Diseases, Ministry of Health, Jordan, presented the findings from Jordan. Three randomly selected hospitals from Amman were surveyed and 120 patients with diabetes mellitus attending GP clinics and a further 50 diabetic patients attending specialists were interviewed. Additionally, 100 patients who had undergone C-section were interviewed. The cost was estimated for each vignette according to the cost/pricing of the recommended visits and complementary exams required for appropriate follow-up. All main diagnostic tests for confirming the diagnosis of diabetes are performed. The overall performance score for the three hospitals across domains was between 50% and 70%. Difficulty controlling blood sugar levels was reported by 85% of those with diabetes. More than half (54.2%) the patients were unsure whether the practice helped them to understand their health problems. The attitude of the clinical staff was reported as being very helpful by 48% of patients in specialist clinics compared with 40% in GP clinics. The total cost for diabetic patients under the care of specialists in both sectors was acceptable, with an average total cost/pricing of management in public health facilities at GP clinics of 10–12 Jordanian dinars. The cost in the private sector was almost double this. The infrastructure for carrying out C-sections was available in the three hospitals. None of these hospitals had service delivery guidelines for C-section. A majority of patients (76%) reported being highly satisfied with the communications they received from the doctors and staff. The nursing care was rated as excellent by 67%, and 73% described their experience of care at the hospitals as excellent. Charges were incurred by 85% of patients during hospitalization for C-section; this charge was self-payment for 33% of the patients.

Dr Tarawneh listed three main challenges faced during the study: the process of collecting data from the private sector institutions was difficult and the researchers were pressed to search for innovative channels of communication to obtain the required data; communicating and

collaborating with the patients in the private sector was also difficult for the interviewers—some patients were sensitive and cautious of providing information on their own health status or issues; and there were problems in making a cost analysis and computing the economic burden on patients in all groups since the concepts of cost and price is different. In conclusion, Dr Tarawneh reported that the overall performance score for the three private hospitals across domains was good. The total cost/price for diabetes patients under the care of specialists in both sectors was acceptable, but the gap in pricing was too great. He noted that the private health sector does not collaborate with the public sector in exchanging information. In comparing the cost/price for C-section in both sectors, it was evident that the gap is great.

Dr Abdulelah AlHawsawi, Central Board for Accreditation of Health Care Institutions, presented the findings from Saudi Arabia. Three private health facilities providing diabetes care and C-section were surveyed. In-depth interviews were conducted addressing pricing and quality of care with a number of private care providers (7 general practitioners, 3 gynaecologists), 150 patients with diabetes mellitus attending diabetes clinics and 100 C-section patients. Overall the hospital performance for diabetes management services and C-section was good. Although a majority of the patients were aware of the signs and symptoms of hypo/hyperglycaemia, had the ability to perform self-monitoring, were satisfied with the services received, achieved desirable glycaemic control and continued treatment at three facilities, different criteria for diagnosing and management protocols were used for patients who suffered severe symptoms. All patients said that charges were being incurred for diabetes care although most were covered by health insurance. However, 35 of the 150 patients paid out-of-pocket. The majority of the C-sections were planned (90%), only 10% were emergency procedures. Position of the fetus (breech presentation) and previous C-section were the most common indications for elective C-section. Labour failing to progress and fetal hypoxia were the most common indications for emergency C-section. In the post-operative period for mothers of the last 10 C-section cases, the following actions were undertaken: monitoring of pulse, blood pressure and temperature; pain management; and observation for post-partum haemorrhage. None of the three hospitals reported maternal complications. Out of 100 patients interviewed, 98% said that charges were being incurred for C-section care and 90% were paying under private insurance. Out of 100 patients, 90 said that the medical services mentioned above were covered by their insurance, while 10 patients were paying out of their own budget.

Dr Assad Hafeez, Dean and Executive Director, Health Services Academy, presented the findings from Pakistan. The assessment involved private healthcare service providers in four metropolitan cities (Islamabad, Lahore, Peshawar, Rawalpindi). Thirteen diabetes clinics and four specialist clinics for C-section were included. Only 60% of the facilities were licensed by the authorities, although 92% were run by qualified staff. Only 30% of facilities maintained patient records. The facilities providing services for C-section scored better than the diabetes clinics. Patient satisfaction level (for using the same facility again) was high. Average expenditure for consultation at diabetes clinics was estimated at US\$ 28 and average expenditure for C-section was US\$ 360. A majority of patients (90%) were paying out of pocket. Dr Hafeez stressed that this study had a small sample size and there were also other potential limitations; however it was a step forward in determining the quality and cost issues of private health care in Pakistan. He recommended that a full-scale study be conducted in Pakistan to discover collaborative

opportunities for involving the private sector in providing standardized, evidenced-based, quality health care to the community. Dr Hafez also recommended key action points for the government, the private sector, professional bodies and patients.

Following the four presentations, there was a discussion on the findings, which focused largely on regulations and information systems. It was noted that regulation, commitment and control is not the way to handle the private health sector. Rather, the private sector should be seen as equal partners and regulation seen as facilitation. Participants agreed that health information systems are important and should be encouraged, however, it was noted that the private health sector is concerned about the negative aspects of information-gathering and the taxes involved. The main cause of mistrust is the misrepresentation and misunderstanding of the data. In addition, private sector facilities are often solicited for information but need to be convinced of the importance of providing data because they have their own limitations and priorities. It was agreed that non-threatening health information systems that could pool information could be developed to protect confidentiality of information.

2.4 Country experiences with private sector self-regulation

This session was chaired by Dr Salem Abdullah Alwahabi, Saudi Central Board for Accreditation of Health Care Institutions, Saudi Arabia, and involved presentations on the role of the medical association/syndicates in self-regulation of the private sector from three countries.

Dr Sleiman Haroun, President, Syndicate of Hospitals, Lebanon, gave a presentation on the Lebanese private sector, which plays an essential role in serving the population and constitutes around 90% of the entire health sector. Professional associations and syndicates support the government in regulating the private institutions and providers and in acting as a health system steward. The Syndicate of Hospitals in Lebanon was established in 1965 as the official representative of all private hospitals. It includes 117 short- and medium-stay hospitals (10 045 beds) and 19 long-stay hospitals (3496 beds). The syndicate plays a major role with policy-makers in Lebanon, mainly the Ministry of Public Health, and with third party payers; its major functions are advocacy, capacity-building, networking and knowledge sharing. Furthermore, the syndicate works constantly with all its members and through its internal committees to enable the development and implementation of an environment that satisfies community expectations of healthcare quality and safety. In this regard, many quality and research projects have been initiated, e.g. the benchmarking of nursing-specific performance indicators and a national database for all hospitals in Lebanon. The syndicate also collaborates actively with the Ministry of Public Health in the national accreditation system, which started in 2000, and conducts, in collaboration with the WHO, a series of training workshops on critical topics, e.g. disaster management, infection control and patient safety. It collaborates with universities, governmental institutions, international organizations and other stakeholders to support the growth of health professions and institutions in Lebanon to ensure that the Lebanese population has access to safe, high quality health care. Dr Haroun proposed four recommendations: involve the syndicate in regional activities because Lebanon is the only country in the Region where the private sector dominates; work to develop a shared governance accreditation programme; broaden the National Hospital Database and update it

on a regular basis; and establish “best practices” for syndicate members to ensure that all citizens have access to safe, high-quality health practitioners and services.

Dr Khairy Abd Al Dayem, Head of the Medical Syndicate, Egypt, gave a presentation on the role of the Medical Syndicate in Egypt. He summarized the six roles of the syndicate: regulating registration of health providers, regulation of quality of medical services, acting as a disciplinary authority, pricing medical services, overseeing labour relationships within the private sector and legislation.

Medical schools are licensed by the Ministry of Higher Education. There are 2 private medical schools, 10 private schools of pharmacy, 10 private schools of physiotherapy, in addition to nursing schools and schools for medical technicians. Graduates must be accepted by the syndicate in order to be registered in the General Registry and obtain a license to legally practise medicine. The Egyptian Medical Syndicate is also entitled to evaluate and accredit the degrees offered by educational institutions that do not belong to official medical schools such as the Diploma of Infection Control offered by the Union of Arab Doctors and the Diploma in Nutrition offered by the American University in Cairo. The syndicate is part of the official process of licensing clinics, diagnostic centres, hospitals and other facilities. They must be inspected by the syndicate before proceeding with the licensing steps of the Ministry of Health and Population. However, the Egyptian Medical Syndicate has no role in the continuous supervision of facilities to ensure they maintain the standards required, nor for the upgrading and updating of equipment or physical structure in order to remain acceptable as international criteria of good medical practice evolve. This duty is the responsibility of the Private Practice Authority of the Ministry of Health and Population. In terms of quality of medical services, the role of the Egyptian Medical Syndicate is to ensure that guidelines are developed and updated regularly as medical practice changes worldwide, and that these are not influenced by the interests of the industry and that the updates are implemented. Part of quality assurance is the enforcement of the Code of Ethics of Medical Practice, as required by law. The syndicate, in conjunction with the Egyptian legal system, applies disciplinary action on its members, including investigating alleged deviations from proper medical conduct or violation of the Code of Ethics and referring cases to the first order disciplinary court. Penalties range from giving notice of unacceptable behaviour to permanent removal from the registry of doctors, hence terminating the member’s right to practice medicine.

Dr Yasmin Rashid, Central Executive Counsellor, Pakistan Medical Association, gave a presentation on the role of medical associations in Pakistan following a brief overview of the health system in Pakistan. She reported that the private sector caters for approximately 80% of medical service provision. The private health care sector itself is divided into a number of segments, ranging from 300-bed hospitals to small, single-room clinics in congested parts areas. The industry is regulated mainly through market competition, where practitioners thrive according to reputation, quality of service and affordability. This is also true for medical colleges, pharmacies and dispensaries. The Pakistan Medical Association is a registered volunteer organization made up of reputable doctors trying to regulate the private sector through awareness-raising seminars, educational programmes and individual counselling. Although the association does not have the legal capacity to censure unethical acts, they have performed an important role as watchdogs in self-

regulation by creating media awareness and conducting protests against people involved in wrongdoing. However given the size of the country and its population, the private health sector in general remains unchecked and unregulated.

The Pakistan Medical Association can further enhance its role by helping doctors in developing quality management systems, developing standard operating procedures and conducting educational sessions to disseminate these standards and encourage their implementation. They can also organize audit teams/committees for quality checking of practitioners. In her recap, Dr Rashid highlighted several issues: political turmoil and corruption has hampered public sector development in Pakistan; the private health sector caters for ~80% of health services and is largely unregulated in terms of standards of practice and quality of service; the private sector is regulated mainly through market competition—good organizations seek a competitive edge by focusing on quality and equity of services.

The panel discussion recognized the long legacy of both the Lebanese and the Egyptian experience and their country-specific roles in self-regulation. Concern was raised about the conflict of interest when peer groups regulate their own members. In Egypt, for example, the syndicate is part of the process but not the final body to give licenses; accreditation is through the Ministry of Health and Population. In Lebanon, good governance demands an independent body but the review requires peer review. Thus, Lebanon has a mixed system; however, they do have a degree of independence. It was noted that the different functions performed by medical associations and syndicates need to be recognized and clarified, especially as the private sector gets more complex.

Following the lunch break Dr Eduardo Banzon, Regional Adviser, Health Economics and Financing, presented global experiences in contracting out as a means of public–private partnership. He discussed how different contracting arrangements in health care have led to the development of different public–private partnership arrangements. Contracting in health care is defined as the development and implementation of a documented agreement between a purchaser (principal), who will be providing compensation, and an agent, who will provide a defined set of services for a defined target population. Contracts that have been implemented globally include concession, co-location, private finance initiative, lease agreement, management contracts and service contracts. Another type of contract that has evolved is the contract between social health insurance agencies and health care providers. Public–private partnerships are essentially a type of contract and there are various categorizations of such partnerships. In general, efforts should be made to ensure that contracting with the private sector supports the move towards universal health coverage.

During the panel discussion it was noted that moving towards universal health coverage will have an impact on the burden of the private health sector in service provision. Accreditation is not the only way to ensure standards of care: these can be included in any insurance programme. In fact, the evidence is mixed regarding the impact of accreditation. It was agreed that contracting is important and governments need to build the capacity to develop and manage contracts with the private sector. It was noted that long-term concession agreements require a number of skills which many ministries of health do not have. Thus, it may be wiser to work on simpler contracts which can be managed by the ministries.

Following the discussion, Dr Hassan Salah presented outlines for working groups to review the draft regional framework for accelerating the role of the private sector in universal health coverage. Four working groups were identified, based on socioeconomic status and health system priorities in each group. Two tasks were set: 1) review the framework for engaging the private sector in accelerating progress towards universal health coverage and identifying key actions that can be taken in the coming 12 months in your country, and 2) what is the role of the WHO in complementing these actions?

2.5 Public–private partnership

This session was chaired by Dr Sameen Siddiqi, Director, Health System Development. It began with an introduction to public–private partnership in health by Dr Barbara O’Hanlon. This presentation gave participants a working definition of public–private partnership in health, discussed the policy and institutional frameworks required by the ministries of health to implement public–private partnerships, and provided a typology of the most common categories in the health sector in developing countries. After this, Dr Venkat Raman presented experiences from India in public–private partnerships. Despite its vast network of health facilities, systemic deficiencies have steadily eroded the ability of the public health system in India to meet the burgeoning demand for health services effectively. Consequently, a substantial proportion of people, including the poor, are ‘forced’ to seek services from the private sector, which have expanded remarkably during the past two decades. The private sector is not only expensive, but is ineffectively regulated. In the absence of widespread health coverage, a substantial proportion of health expenditure is out-of-pocket, which is debilitating, particularly for the poor and under-served sections. Dr Raman reported that many provincial governments across India are exploring partnerships with the private sector to address the challenge of equitable access to affordable health care services for the poor. He then provided models of ongoing health public–private partnerships across India and highlighted the operational and policy-level challenges in engaging the private sector for health service delivery. He reported that if well-designed and implemented in stages, public–private partnerships offer contextually appropriate, innovative solutions that may ensure equitable access to health services for the underserved sections of the population. Although formal collaboration between the public and the private sectors is increasingly advocated as a policy option across several countries, including India, the benefits of public–private partnerships can be optimized when government provides leadership with sector-specific policy support, creates an organizational structure within the Ministry of Health, develops institutional capacity to manage partnerships, and complements it with an effective regulatory structure.

A panel discussion on public–private partnership followed. Participants recognized that it was important that access is addressed in innovative ways as demonstrated by the case studies from India (i.e. mobile units and telemedicine) because they can increase quality and efficiency. It was noted that telemedicine in particular is especially useful in helping organize the private health sector, which is often largely formal solo practitioners. It was suggested that there may be similar success stories in the Region but this may not be known by central-level health officials. It was also suggested that conducting an inventory to determine whether the different types of public–private partnership existing in a country would be useful for starting a dialogue with the private health

sector and developing a country-level understanding of public–private partnership. There was also an understanding that the private sector needs to be better organized to facilitate such dialogue.

Concern was raised that having a high-level, dedicated, public–private partnership unit will then entail the programme taking a vertical approach, which can be a challenge to coordinating with other programmes. It was agreed that the location of the unit is not important, rather it is imperative that all relevant stakeholders are involved; being at a high level in the Ministry of Health often facilitates such collaboration and ensures an institution-wide approach. More broadly speaking, the government usually has a cell for public–private partnership which does not necessarily involve the health sector. Therefore, a dedicated unit within the Ministry of Health is needed to handle procurement and contracting. Although the Ministry of Health has the leadership role, the negotiating should be done on an equal footing.

Participants felt that the meeting had allowed only limited discussion about what is required at the policy level regarding the private healthcare sector. It was suggested that an Arabic language document that could guide the discussion would be useful so that there is informed debate beyond the health sector. This should include both the formal and the informal private health sector. Some segmentation to make it easier to understand the private health sector may be helpful. It was noted that India has a wealth of examples that include the benefits of health public–private partnerships, but a more in-depth look at the cost–benefits would be useful. This is a major challenge for donors since they are not yet convinced of using this approach.

The working groups provided feedback on the draft regional framework for accelerating the role of the private sector in universal health coverage (see Annex 3). Some groups provided detailed comments on the draft while others adapted the framework to their specific context.

3. CLOSING SESSION

Dr Siddiqi led the closing session by reviewing the recommendations from the meeting and requesting participants' feedback on the recommendations. Participants identified the priority areas of work for their own country (see Annex 4). They emphasized the essential role WHO plays in advocating and guiding countries in engagement with the private sector and the importance of linking public–private partnership with universal health coverage to keep in mind the reasons for involving the private health sector. The challenge is how to leverage the private sector towards addressing vulnerable groups in ensuring universal health coverage.

The participants welcomed the start of the regional dialogue on the private health sector, recognized the diversity in participation in the meeting and looked forward to the next meeting.

4. RECOMMENDED ACTIONS

To Member States

1. Ensure political commitment from policy-makers in the countries of the Region to engage with private health sector partners.
2. Translate commitment into a specific policy that spells out the strategy for engagement with the private sector, including the role of public-private partnership.
3. Establish a multistakeholder task force involving the different constituencies within the private health sector to initiate a public-private dialogue that will enhance mutual trust between the public and the private sectors.
4. Document the physical and financial size and scope of the range of services provided by the private sector.
5. Undertake rapid assessment of the private health sector, taking a snapshot of its current status as a basis for informing on size, scope and range of activities.
6. Develop means to continually map the private health sector in order to inform policies and plans and tap its potential roles and contribution in the implementation of priority health programmes.
7. Strengthen the institutional capacity of ministries of health to engage with the private sector.
8. Establish/strengthen a private sector cell or directorate in the Ministry of Health and allocate the required resources, financial and technical, to support assessment/mapping studies, update legislation and regulation, and incorporate public-private partnership in national health policies, plans, and commitments in moving towards universal health coverage.
9. Strengthen the grants and contract management unit in the Ministry of Health so that it can design contracts, technically and financially, and adopt an open and competitive bidding process, and which has the capacity to monitor and evaluate outputs/outcomes.
10. Ensure fair distribution of private health care providers with incentives that encourage them to function in the disadvantaged areas with a defined package of services that ensure good quality, comprehensive and affordable health care services.
11. Allocate a budget line that allows for analytical work and advocacy which promotes the increased engagement of the private health sector.
12. Transform perceptions regarding regulation from being a 'coercive' to a 'facilitating' instrument for increased private sector engagement.
13. Develop evidence-informed policy papers and briefs that emphasize the importance of regulation as a means towards behaviour change among providers and which advise on moving away from the 'command and control' type to 'incentive based' regulation.
14. Build the capacity of regulators as well as providers and associations in regard to the different approaches to regulation and the potential benefits and limitations.
15. Inform the general population of the potential role of the private health sector in realizing public health goals.
16. Draft a communication strategy that promotes an environment of a friendly private health sector and supports partnership-building between the public and the private sectors in the move towards universal health coverage.

17. Develop national health plans that respond to the needs and priorities of the public and private health sectors, particularly in the development of national human resources plans.
18. Strengthen the capacity of the planning units in the Ministry of Health to develop plans that are responsive to the challenges and priorities of the private health sector, and respond to these by developing appropriate strategies.
19. Build stronger interaction with the private sector associations and syndicates and be more open in terms of sharing mutual interests, mandates, capacities and activities in moving towards universal health coverage.

To Member States and WHO

20. Support research activities at country level to build evidence on strengthening the role of the private sector.

To WHO

21. Advocate with Member States by presenting evidence and drawing attention to the importance of the private health sector in high-level regional policy forums.
22. Provide tools and mechanisms for rapid assessment of the scope and size of the private sector.
23. Assist Member States in institutional capacity-building activities to facilitate the sharing of experiences and to document good practices and lessons learnt.
24. Align and harmonize actions with those of other United Nations agencies, global and regional partners and donors in promoting the role of the private sector in service provision.
25. Assist Member States to assess, review and set standards for the regulations for active engagement of the private sector in moving towards universal health coverage.
26. Assist Member States to develop their national health plans and to incorporate these in their respective collaborative workplans as strategies for improving service provision.
27. Invite representatives of the private sector associations and syndicates to relevant regional and local meetings, events and seminars.

Annex 1**PROGRAMME****Monday, 23 June 2014**

08:30–09:00	Registration	
09:00–09:15	Address by Dr Ala Alwan, Regional Director, WHO Eastern Mediterranean Regional Office	
09:15–09:20	Remarks by the International Development Research Center (IDRC)	<i>Dr Qmar Mahmood</i>
09:20–09:25	Objectives and expected outcomes	<i>Dr Hassan Salah, WHO</i>
09:25–09:35	Introduction of participants	
09:35–10:00	Private health sector in countries of the Eastern Mediterranean Region: exploring unfamiliar territory	<i>Dr Sameen Siddiqi, WHO</i>
10:00–10:30	Discussion	
<i>Technical session 1: Role of private sector in universal health coverage</i>		
<i>Chairperson: Dr Hoda Rashad, Social Research Center, American University in Cairo</i>		
11:00–11:20	Private health sector: Challenges and opportunities; global prospective	<i>Dr Barbara O'Hanlon, United States of America</i>
11:20–11:40	Role and contribution of the private sector in moving towards universal health coverage in the Eastern Mediterranean Region	<i>Dr Shehla Zaidi, Pakistan [through VC]</i>
11:40–12:10	Country experience: Thailand, Lebanon	<i>Dr Peerapol Sutiwisesak, Thailand Dr Alissar Rady, WHO Lebanon</i>
12:10–13:00	Discussion	
<i>Technical session 2: Private sector regulation</i>		
<i>Chairperson: Dr Nizar Masalma, Director-General Health Insurance, Palestine</i>		
14:00–14:20	Global overview of private sector regulation	<i>Dr Venkat Raman, India</i>
14:20–14:35	Regulating the health sector: A key intervention towards universal health coverage	<i>Dr Abdi Momin, WHO</i>
14:35–15:10	Status of private sector regulation in: Egypt, Yemen	<i>Dr Sherine Shawky, Cairo Dr Rashad G. Sheikh, Yemen</i>
15:10–15:25	Regulation of pharmaceutical sector and medical products	<i>Dr Adham Ismail, WHO</i>
15:25–16:00	Discussion	
16:30–16:45	Assessment private health sector: Tanzania experience	<i>Dr Barbara O'Hanlon</i>

16:45–17:15 Discussion

Tuesday, 24 June 2014

Technical session 3: Role of the private sector in service delivery

Chairperson: Dr Hilda Harb, Ministry of Public Health, Lebanon

- | | | |
|-------------|--|--|
| 08:15–09:00 | Universal health coverage – regional overview | <i>Dr Sameen Siddiqi</i> |
| 09:00–09:30 | Assessment of private health sector; Tanzania experience | <i>Dr Barbara O'Hanlon</i> |
| 09:30–10:45 | Role and contribution of private sector in health care delivery in 4 countries followed by discussion: Lebanon, Jordan, Saudi Arabia, Pakistan | <i>Dr Shadi Saleh, Lebanon</i>
<i>Dr Mohamed Tarawneh, Jordan</i>
<i>Dr Abdulallah AlHawsawi, Saudi Arabia</i>
<i>Dr Asad Hafeez, Pakistan [VC]</i> |

Chairperson: Dr Salem Abdullah Alwahabi, Saudi Central Board for Accreditation of Health Care Institutions, Saudi Arabia (CBAHI)

- | | | |
|-------------|--|---|
| 11:15–12:00 | Role of the medical association/syndicates in self-regulation of private sector: Lebanon, Egypt, Pakistan | <i>Mr Sleiman Haroun, Lebanon</i>
<i>Dr Khairy Abd Al Dayem, Egypt</i>
<i>Dr Yasmin Rashid, Pakistan [VC]</i> |
| 12:00–13:00 | Panel discussion: Role of medical association/syndicates in self-regulation of private sector | <i>Mr Sleiman Haroun, Dr Khairy Abd Al Dayem, Dr Mukhtar Shahab El Deen</i> |
| 14:00–14:30 | Contracting out as a means of public–private partnership: Global experiences | <i>Dr Eduardo Banzon, WHO</i> |
| 14:30–14:40 | Group work: Accelerating the role of private sectors in universal health coverage | <i>Dr Hassan Salah, WHO</i> |
| 14:40–17:00 | Review of the draft regional framework for accelerating the role of the private sectors in universal health coverage | |

Wednesday, 25 June 2014

Technical session 4: Public–private partnership

Chairperson: Dr Sameen Siddiqi, Director, Health System Development, WHO/EMRO

- | | | |
|-------------|--|----------------------------|
| 08:30–09:00 | Introduction to public–private partnership in health | <i>Dr Barbara O'Hanlon</i> |
| 09:00–09:30 | Public–private partnership: Experience from India | <i>Dr Venkat Raman</i> |
| 09:30–10:00 | Panel discussion: Public–private partnership | |
| 11:00–12:30 | Working group presentations and discussion | |
| 12:30–13:00 | Closing session | |

Annex 2

LIST OF PARTICIPANTS

AFGHANISTAN

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Annex 3**GROUP WORK RESULTS****Group 1. Low-income countries (Afghanistan, Somalia, Sudan and Yemen)**

Goal in 12 months: build the relationship and increase trust between public and private sectors

Commitments	Actions for countries	WHO support
1. Build PPD	<ul style="list-style-type: none"> • Landscape actors • Encourage public and private organizations/stakeholders to join PPD initiative • Identify existing PPD mechanism and build on them for PPD platform • Define purpose of and focus of PPD platform • Identify initial (not politically risky) activities that the public and private sectors can work on together to build trust 	<ul style="list-style-type: none"> • Recommend and encourage MOH to form PPD platform • Provide guidelines/tools from other country experience in PPDs in health • Organize capacity-building workshop for stakeholders participating in PPD platform • Facilitate (or help secure finances to support) PPD initiative
2. Map private sector (situation analysis)	<ul style="list-style-type: none"> • Define terms of references for situation (rapid) analysis (private sector activities for health, public health PPP, and role in achieving universal health coverage) • Conduct analysis • Disseminate findings and recommendations of analysis 	<ul style="list-style-type: none"> • Technical support (or help secure finances) to conduct private sector mapping/situation analysis and dissemination of findings in consultative workshops
3. Policy and stewardship	<ul style="list-style-type: none"> • Raise awareness among public and private sector stakeholder groups on benefits of health PPPs and their role in achieving universal health coverage • Increase government and private sector groups' commitment to health PPPs • MOH draft/issue policy statement (public communication) recognizing private sector contribution, outlining guiding principles on how public and private sector will work together, and quoting existing policies/regulations supporting public-private cooperation (health PPPs) 	<ul style="list-style-type: none"> • Recommend and persuade MOH to engage the private sector • Proactively encourage MOH to interact and cooperate with the private health sector • Provide guidelines/templates from other country examples on health PPP policy
4. Deliverables	<ul style="list-style-type: none"> • Develop roadmap outline next steps for how public health private sector will work together to achieve universal health coverage goals 	<ul style="list-style-type: none"> • Develop measurable indicators for private sector engagement • Provide and sustain momentum with MOHs to engage private sector

PPD = public-private dialogue; PPP = public-private partnership; MOH = Ministry of Health

Group 2. Middle-income countries (Egypt, Iraq and Palestine)

Commitments	Actions for countries	WHO support	Comments
1. Building platforms for dialogue	<ul style="list-style-type: none"> • Setting up taskforces for communication and dialogue between state and private sector • Inclusion of private 	<ul style="list-style-type: none"> • Assist Member States to develop roadmap on "engaging the private health sector for accelerating progress 	<ul style="list-style-type: none"> • How should we respond to the frequent turnover of MOH? • How can syndicate facilitate the

Commitments	Actions for countries	WHO support	Comments
	<ul style="list-style-type: none"> sector in setting national health policies, strategies and health sector reform process • Joint setting up of targets for PPPs and process of measurements 	<ul style="list-style-type: none"> towards universal health coverage”. • Organize capacity-building workshops for national focal points on “strategies for private sector engagement in service provision and PPP” • Develop measurable indicators for measurement of PPP 	<ul style="list-style-type: none"> establishment of PPP? • How should we make the private sector see the benefits of PPP? • How can we create an atmosphere in which different stakeholders are willing to buy in? “Nobody can win all the pieces of the pie.” • Therefore, suggest including new point for action for Member States: strengthen and enhance the role of health council which should engage health care providers, health care users and MOH • Also, additional point for WHO support: set up plan for monitoring and evaluation
2. Policy and stewardship	<ul style="list-style-type: none"> • Building coherence of PPPs in health as part of larger public sector economic and reform measures, through joint forums involving related line departments: finance, planning and legal • Development of strategy to shift public health sector responsibilities from direct service provision to a strategic oversight involving both public and private health providers 	<ul style="list-style-type: none"> • Support research activities at the country level to build evidence on strengthening role of the private sector relevant policies 	Wording change: public sector should be responsible for providing the service on the public side and for overseeing the providers on both the public and private sides
3. Mapping private sector	<ul style="list-style-type: none"> • Identification of licensed and unlicensed providers and geographical distribution • Differentiation of ‘pure private sector’ from those in dual practice • Assessment of basic organizational capacity, individual practitioners versus institutions • Identification of services (preventive, screening, curative and 	<ul style="list-style-type: none"> • Technical support in mapping private health care providers and facilities to document and disseminate good practices related to utilization, quality, pricing and financing 	<ul style="list-style-type: none"> • More detailed data on human resource information is needed, including quantity, demographic, etc. • Shared and functional database should be established, improved and updated so as to provide the landscape of private sector and facilitate further research • For WHO, help with

Commitments	Actions for countries	WHO support	Comments
	rehabilitative) provided, areas of overlap and complementarity with public sector		reaching funding sources and opportunities
4. Regulation and governance	<ul style="list-style-type: none"> • Development of regulatory framework for private and public providers • Enactment of laws for entry, distribution, quality and price control of health providers • Setting up regulatory bodies, within or outside the MOH with budgetary and human resource support • Undertaking accreditation and providing capacity building through trainings and protocols • Piloting of self-regulation innovations backed by incentives 	<ul style="list-style-type: none"> • Develop and share instruments for assessment of private health sector regulations 	<ul style="list-style-type: none"> • Change commitment to just governance • In some countries, the accreditation system is available but not functioning therefore wording should be “moving towards mandatory accreditation” • Add/develop regulations on the rights of health care users, providers and employers • For WHO, provide case studies of success stories
5. Purchasing and financing private sector services	<ul style="list-style-type: none"> • Identify package of health services for purchasing from private sector, geographical areas for purchasing and target recipients • Determine unit costs of services, identify performance targets and contractual safeguards • Set up purchasing bodies in ministries of health, distinct from supplies procurement • Establish speedy fund flow systems for timely disbursements and working out of payment modalities (volume based/capitation/block grant) 	<ul style="list-style-type: none"> • Develop guidelines for cost assessment of health services delivered by the private sector • Build capacity in contracting mechanisms and facilitate exchange of experiences 	<ul style="list-style-type: none"> • Develop a service pack building upon both public and private providers • Assess the reasons behind the delay in the social health insurance mechanism (referring to the successful model in the Region: Palestine)
6. Leveraging quality and access	<ul style="list-style-type: none"> • Set standards for quality of care, recording and reporting mechanism by the private care providers • Periodic surveys of private and public sector on health care 	<ul style="list-style-type: none"> • Develop quality standards for service delivery (inpatient and outpatient). • Assist in assessing and improving quality of care at all levels 	<ul style="list-style-type: none"> • Health outcome should also be included in the periodic surveys • For WHO, facilitate the activation and implementation of the survey

Commitments	Actions for countries	WHO support	Comments
	utilization, differentials in utilization by various socioeconomic groups and quality of care, using independent monitors where possible <ul style="list-style-type: none"> • Establish separate monitoring and evaluation cells within MOH for execution, collation and synthesis of in-house monitoring and independent surveys 		
7. Patient information, engagement and satisfaction	<ul style="list-style-type: none"> • Introduce checks on unrestricted advertisement of health services and medical products • Public dissemination of information on accredited providers • Setting up of client feedback mechanisms for hospitals • Review and redress of laws for medical negligence • Periodic assessment surveys of clients satisfaction for public and private sectors 	<ul style="list-style-type: none"> • Technical support to develop national accreditation bodies • Develop tools and standards to assess patient satisfaction 	
8. Provider information, engagement and satisfaction	<ul style="list-style-type: none"> • Conduct survey to get the opinion of the providers on: salary schedule, incentive scheme, contract arrangement, working hours and workload, working environment and safety, capacity building, health insurance, pension schedule and overall satisfaction 		An additional commitment is required.

MOH = Ministry of Health; PPP = public-private partnership

Group 2 (cont'd). Middle-income countries (Islamic Republic of Iran, Jordan, Lebanon, Morocco and Tunisia)

Commitments	Actions for countries	WHO support	Remarks
1. Building platforms for dialogue	<ul style="list-style-type: none"> Establishing a joint taskforce between the public and the private sectors 	<ul style="list-style-type: none"> Prepare generic terms of reference Capacity-building 	<ul style="list-style-type: none"> Countries of the group are at different levels of the platform establishment and need different WHO engagement
2. Policy and stewardship	<ul style="list-style-type: none"> Convening a multistakeholder meeting for priority-setting Generating evidence for policy decisions 	<ul style="list-style-type: none"> Support building evidence for priority setting 	<ul style="list-style-type: none"> Different activities are needed for each country (research, data collection, etc.)
3. Mapping private sectors	<ul style="list-style-type: none"> Mapping exercise in countries who have not yet done it 	<ul style="list-style-type: none"> Technical and financial support in the mapping exercise of private health care providers and facilities 	<ul style="list-style-type: none"> Countries are at different levels of information availability
4. Regulation and governance	<ul style="list-style-type: none"> Undertaking accreditation and providing capacity building through trainings and protocols Piloting of self-regulation innovations 	<ul style="list-style-type: none"> Develop and share instruments for assessing private health sector regulations 	<ul style="list-style-type: none"> Some countries have already started accreditation
5. Purchasing and financing private sector services	<ul style="list-style-type: none"> Identify package of health services for purchasing from private sector, geographical areas for purchasing and target recipients Revise/update unit costs of services, identify performance targets, and contractual safeguards Initiate revision of purchasing supplies and services and fund flow systems 	<ul style="list-style-type: none"> Building capacity and facilitate exchange of experiences 	
6. Leveraging quality and access	<ul style="list-style-type: none"> Set standards for quality of care recording and reporting mechanism for the private care providers Establish separate monitoring and evaluation cells within MOH 	<ul style="list-style-type: none"> Develop generic quality standards for service delivery (inpatient and outpatient) Develop generic TORs for medical education units 	
7. Patient information, engagement and satisfaction	<ul style="list-style-type: none"> Restrict the advertisement of health services and medical products Public dissemination of information on accredited providers 	<ul style="list-style-type: none"> Technical support to develop national accreditation bodies. Develop tools and standards to assess patient satisfaction 	<ul style="list-style-type: none"> Some countries have already done some of the activities with the help of WHO and other international organizations

MOH = Ministry of Health; TORs = terms of reference

Group 3. High-income countries (Oman and Saudi Arabia)

Commitments	Actions for countries	Action plan	WHO support
1. Building platforms for dialogue	<ul style="list-style-type: none"> Set up a coordination committee for dialogue between state and private sector 	<ul style="list-style-type: none"> Decide membership including cross section of types of private providers from various regions Decide objectives and terms of reference (mandate to be involved in setting health policies/strategies and PPP options) 	<ul style="list-style-type: none"> Organize capacity building workshops for national focal points on “strategies for private sector engagement in service provision and public private partnership” Develop tools for implementation of PPP
2. Policy and stewardship	<ul style="list-style-type: none"> Develop a health sector specific PPP policy clearly defining scope for public and private health sector collaboration Develop operational guidelines for PPP 	<ul style="list-style-type: none"> Review current policies related to PPP Update policies to better define scope of public and private health sector collaboration 	
3. Mapping private sectors	<ul style="list-style-type: none"> Strengthen provider database to including GIS mapping Private health sector assessment 	<ul style="list-style-type: none"> Obtain GIS information for all providers Plan and conduct private health sector assessment 	<ul style="list-style-type: none"> Technical support in conducting private health sector assessment
4. Regulation and governance	<ul style="list-style-type: none"> Regulatory framework currently under review Dissemination of new regulatory framework Develop a proposal to establish an independent accreditation body 	<ul style="list-style-type: none"> Dissemination new regulations once approved Negotiate with concerned stakeholders concerning the proposal Develop proposal for review by the coordination committee 	
5. Purchasing and financing private sector services	<ul style="list-style-type: none"> Train 2–3 experts in the MOH tender board on purchase and contract design 		<ul style="list-style-type: none"> Building capacity in contracting mechanisms and facilitating exchange of experience
6. Leveraging quality and access	<ul style="list-style-type: none"> Monitoring adherence to quality standards to be facilitated by a monitoring specialist in the PPP unit 		<ul style="list-style-type: none"> Technical support in conducting periodic surveys
7. Patient information, engagement and satisfaction	<ul style="list-style-type: none"> Assessment of patient satisfaction of the public and private sector 		<ul style="list-style-type: none"> Develop tools and standards to assess patient satisfaction

PPP = public–private partnership; MOH = Ministry of Health; GIS = geographic information systems

Annex 4

**COUNTRY PRIORITIES FOR IMPLEMENTING THE SEVEN MAJOR
RECOMMENDATION AREAS**

Country	Ensure political commitment	Conduct mapping	Build institutional capacity	Transform perception	Friendly environment	National health plans	Interaction with PS syndicates
Afghanistan			♦			♦	♦
Egypt		♦					
Iran, Islamic Republic of	♦	♦				♦	
Iraq							♦
Jordan	♦	♦	♦				♦
Lebanon			♦	♦		♦	♦
Morocco		♦		♦			♦
Oman	♦	♦	♦				
Palestine			♦	♦		♦	
Somalia	♦	♦	♦				
Sudan	♦		♦		♦		♦
Tunisia	♦				♦	♦	
Yemen	♦		♦		(
TOTAL	7	6	8	3	3	5	6

Annex 5

MINUTES OF THE FOLLOW-UP MEETING

Agenda

- General feedback on the 3-day meeting
- Recommended actions to strengthen private sector for accelerating progress towards universal health coverage

Participants

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Discussion

Overall, the participants found the consultation valuable, informative and a good start to a discussion on the private health sector. Many expressed the need for close follow-up. Two main concerns raised were the limited time for discussion beyond questions related to the presentations and the need for greater representation from the private health sector. Concern was also raised that some topics (e.g. health financing, provider payments) were missing; however, many agreed that adding more topics would have made the agenda too heavy. It was also noted that WHO has held separate meetings on health financing and quality assurance. There was an extensive discussion regarding the immediate action agenda for the next 6 months, noting countries expressed interest in extensive WHO support.

1. Adapt available assessment/mapping tool to obtain basic information about the private health sector.
2. Use the tool to train a team of 3–4 experts from 6–7 countries of the Region on rapid assessment of the private health sector.
3. Conduct a brainstorming session with experts regarding the results from the assessment of regulations in 5 countries of the EMR (Egypt, Lebanon, Saudi Arabia, Sudan and Yemen); this could also include an assessment of quality and pricing.

4. Develop policy trigger/brief (2–4 pages) to assist in building a national platform for a policy dialogue. This would describe private–public partnership in the context of universal health coverage and outline a few action points for Member States.
5. Widen networking and core group of champions and private health sector partners.
6. Enhance policy dialogue (initiated in Sudan).

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