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The role of government in health development

Governments play an important role in health development. The dramatic changes during the last four decades of the 20th century have greatly affected and led to a repositioning of the government's role in health as well as other social sectors. As market forces fail to address properly the health needs of populations, governments have an obligation to intervene in order to improve both equity and efficiency, to carry out public health functions and to produce vital public goods which have bearing on health development. The Regional Committee is invited to discuss ways in which to strengthen health systems functions with particular focus on governance, financing and service delivery, in order to protect the social role of government in health development.

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Executive summary

Governments, through ministries of health and other related ministries and agencies, play an important role in health development, through strengthening health systems and generation of human, financial and other resources. This allows health systems to achieve their goals of improving health, reducing health inequalities, securing equity in health care financing and responding to population needs. The role of governments in health development is well documented worldwide and is illustrated by the impressive growth of health systems, initiated and supported by governments and pursued through partnership with the private sector, nongovernmental organizations and charitable institutions.

The dramatic changes and challenges which took place during the last four decades of the 20th century have greatly affected and led to a repositioning of the government's role in health as well as other social sectors. However, the case of the health sector is distinctive from other sectors, as market forces fail to address properly the health needs of populations, for various reasons, leaving governments with special responsibilities in health development. As a consequence of market failures, governments have an obligation to intervene in order to improve both equity and efficiency, to carry out important public health functions and to produce vital public goods which have a lot of bearing on health development. Moreover, health is perceived in the Region and elsewhere, not merely as a market commodity, but as a basic human need and a social right, as stated in many constitutions and signed treaties. Such commitment entails significant roles and responsibilities for governments, despite changing political and social environments.

Governments in the Eastern Mediterranean Region receive conflicting messages with respect to their changing roles and responsibilities in the field of health, particularly in relation to privatization policies and moves towards market economy. This paper sheds some light on the role of government in health development and draws some lessons on the need to protect this role in view of increasing vulnerability in many countries of the region. Policy reforms should aim at adapting to new changes and challenges without eroding the social role of government bearing in mind the societal values and national, regional and international commitments and obligations. Efforts should be made to strengthen various health system functions with particular focus on governance, financing and service delivery.

1. Introduction

Governments, through ministries of health and other related ministries and agencies, play an important role in health development, through strengthening health systems and generation of human, financial and other resources. This allows health systems to achieve their goals of improving health, reducing health inequalities, securing equity in health care financing and responding to population needs [1]. Improved health outcomes are not attributable to health systems alone, as evidence has shown, but to social, economic, cultural and environmental determinants also, as reflected in the WHO conceptual framework of Health For All [2].

The role of governments in health development is well documented worldwide and is illustrated by the impressive growth of health systems, initiated and supported by governments and pursued through partnership with the private sector, nongovernmental organizations and charitable institutions. Governments, which levy taxes and benefit from natural resources, have social obligations to provide security and to facilitate socioeconomic development, including education and health development.

The dramatic changes and challenges which took place during the last four decades of the 20th century have greatly affected, and led to a repositioning of, the role of governments in health as well as other social sectors. Moves towards democracy, decentralization and a more active role for civil society in governance, and the growing importance of the private sector in socioeconomic development, have been accompanied by policy changes reflecting more privatization, a more restricted role of government in policy development, strategic planning and management, and greater reliance on market forces.

However, the case of the health sector is distinctive from other sectors, as market forces fail to address properly the health needs of populations, for various reasons, leaving governments with special responsibilities in health development. As a consequence of market failures, governments have an obligation to intervene in order to improve both equity and efficiency, to carry out important public health functions and to produce vital public goods which have a lot of bearing on health development.

Moreover health is perceived in the Region and elsewhere, not merely as a market commodity, but as a basic human need and a social right, as stated in many constitutions and signed treaties. Such commitment entails significant roles and responsibilities for governments, despite changing political and social environments.

Governments in the Eastern Mediterranean Region receive conflicting messages with respect to their changing roles and responsibilities in the field of health. On the one hand, market economy policies favour restricted government intervention in both health care financing and delivery of services. On the other hand there is evidence to show that poverty is increasing in the Region, coverage by social protection is not improving, and inequities in access to quality health care are on the increase. Such a situation calls for a more proactive role from governments in various areas, including governance, financing and service delivery, in order to protect equity and other societal values.

This discussion paper aims at shedding some light on the evolution of the role and responsibility of governments in health development and highlights the challenges facing them worldwide and in the Region. The paper describes the major trends emerging in the WHO Eastern Mediterranean Region in relation to the role of government in health development and suggests some directions for the future.

2. Evolution of the role of governments in health development

Human beings and communities throughout history have always strived to cater for their health needs by using indigenous medicines and the knowledge available from healers, either at home or in small facilities. Religious leaders have also played an important role in the provision of health care, the art of healing often being intertwined with religious belief. In ancient Egypt, the doctor was a priest [3]. In Europe, hospitals and health facilities were often built by churches and charitable institutions and some of them still bear the names of priests and religious scholars. In early Islamic society religious leaders developed health care facilities and hospitals, including *bimaristans*, sponsored well known

physicians and established medical schools to train health professionals. Local organizations, religious and endowment institutions contributed to the development of organized health care services during the colonial period, when coverage by the modern health system was limited to the rulers and to the privileged local elite in major cities. These services continue to be provided in some countries to supplement failing governmental facilities, focusing on the poor and deprived populations, particularly in slums and remote areas.

The need for self-help in case of disease or injury was behind the development of health insurance in Europe and in other parts of the world [4]. Industrial workers developed the first sickness funds which later evolved into social health insurance under Bismarck in Germany, while tax-based health insurance was promoted by Lord Beveridge in the United Kingdom after the Second World War. In France, mutual aid and mutual societies evolved throughout the 19th and early 20th century into a social assistance system which covered only a limited population because of its voluntary nature [5]. The Beveridge Report influenced the development of a comprehensive social security system in France and in many Organisation for Economic Cooperation and Development (OECD) countries after the Second World War. In low-income countries, where the formal sector of the economy is weak and government coverage is usually limited, community health insurance schemes have been, and are still being initiated to provide social health protection. Sickness funds were developed to help workers in dealing with the social consequences of diseases and injuries for themselves and their families and to avoid catastrophic expenditures as a result of ill health. The efforts of individuals and communities to ensure they can access health care services now, as then, are justified by the unpredictable nature of diseases and injuries and their impact on life and well-being.

The evolution of modern health systems after the Second World War was facilitated by dramatic developments in biomedical technology and important discoveries, such as of antibiotics and other devices. The national government in France took control of religious hospitals, which became managed by local authorities as part of the policy of separation between the state and the Church [3]. National governments played a crucial role in the development of health systems, as part of the sovereign functions including governance, health system infrastructure and training of the necessary health workforce in all fields of medicine and public health. In most OECD countries, with the exception of the United States of America, medical schools and major hospitals were developed by governments and health personnel education was, and still is, heavily subsidized by governments, whether central or local. This situation is also reflected in the structure of health expenditure in high-income countries, where 70% or more of total health spending comes from public sources of financing. The high share of social and public health care financing is explained by the level of social protection which in many countries, apart from the United States of America, is almost universal.

The adoption of a market economy in many developed and developing economies has not been accompanied by a disengagement of governments from their social responsibilities in health development. Indeed, the role of health development in the formation of social capital and the protection of health as a human right have been accepted worldwide.

The global political developments following the First World War supported the move towards health as a human right. The Versailles treaty gave birth in 1919 to the International Labour Organisation (ILO) [3] based on the principle of “peace through social justice” and promoting social security against various hazards, including sickness and injury.

The United Nations adopted its Universal Declaration of Human Rights in 1948, which states that “every one has the right to a standard of living for the health and well being for himself and his family, including food, clothing, housing and medical care and necessary services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”.

The WHO Constitution, adopted in its First World Health Assembly in 1948, established as its objective the “attainment by all peoples of the highest possible level of health” and stated that “Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures”.

In 1968, the proclamation of Teheran provided for the protection of the family and children. In 1974, the Universal Declaration on the Eradication of Hunger and Malnutrition, called for the elimination every where of hunger and malnutrition. In 1975, the Declaration of the Rights of Disabled Persons affirmed the right of such persons to full rehabilitation. In 1978, the Alma-Ata Declaration [6] affirmed that "health is … a fundamental human right" and that "a main social target of governments, international organizations, and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".

These universal principles were supported by the United Nations Commissioner for Human Rights on many occasions. The former commissioner, Mary Robinson (1997–2002) stated that "A world of true security is only possible when the full range of human rights – civil and political, as well as economic, social and cultural – is guaranteed for all people. Governments from both the North and the South must expand their thinking and policies to encompass a broader understanding of security beyond the security of states." All these declarations and treaties have influenced the role of government in the field of health development and have helped shape health systems, particularly at the level of policy-making where political commitments made at national, regional and global levels are accommodated.

The landscape with respect to the role of government in developed economies is similar in many aspects to that of developing countries, particularly in the Eastern Mediterranean Region. In many countries that were formerly ruled by colonial powers, colonization has affected the development of health systems and has impacted on health development in several aspects, including organization of service delivery and training of human resources for health.

In the Eastern Mediterranean Region, health professionals were, and are still being, trained in different languages including English, French and Italian, affecting interpersonal communication between health care providers and served populations. The networks of hospitals and health facilities was tailored primarily to cater for the needs of the military and civil servants from colonial countries. In some countries hospitals were established for various communities, including French and Italian, and for indigenous Muslims, with varying standards in biomedical equipment and personnel. In some countries insurance systems were copied from those of the colonial rulers, in social and private health insurance.

On the eve of independence, the situation in most countries of the Region was marked by poor health indicators and by an acute scarcity of human resources for health that was worsened by the departure of qualified foreign professionals, leading to a high level of dependency of national health systems on the former colonial powers in the field of health personnel education and human resource development. The lack of human resources for health was and remains aggravated by imbalances in skill mixes, by inequitable distribution inside the countries, and by internal as well as external migration of professionals.

Real health system development in the Region started in the late 1950s and 1960s under the leadership of national governments. This development was made possible through the implementation of the national social and economic development agendas, where health was among the main priorities. In many constitutions health care and education were referred to as human rights and governments were entrusted to ensure their free provision. Most countries adopted a tax-based health system where most of the funding was from the government budget and health services were free at the point of use. Such a situation contributed to increasing coverage by health care, leading to improved health outcomes as reflected in increased life expectancy and overall reduction of morbidity and mortality. Governments contributed to the development of social protection for various categories of workers, building on existing employer-based insurance schemes and expanding their coverage gradually.

The national commitment is also reflected in educational policies aimed at securing self-sufficiency in human resources development. Important investments were made to develop medical schools, schools of pharmacy, and schools of nursing and allied personnel throughout the Region. Needless to say, analysis of time series data has shown a positive correlation between the increase in human resources for health and the improvement of health outcomes. Training institutions were also used to support

research activities in the various fields of health, to raise public health standards and to control endemic diseases which were prevalent in most countries of the Region.

Governments, utilizing public resources, continue to make most of the investments in health system infrastructure including health personnel and physical facilities. The number of medical schools in the the Eastern Mediterranean Region increased from 18 in 1950 to 252 by end of 2005 [7] and most schools were built by governments. However since the 1980s, there has been a steady increase in private human resources education and in private investment in health facilities in most countries of the Region.

The growth of the private sector in service delivery and in health personnel education was made possible through the direct and indirect involvement of governments. Incentives were given to private investors by governments in several countries in the form of tax credits and other facilities. Legislative support, norms and standards were developed by ministries of health and higher education with a view to improved regulation of the development of the private sector.

3. Domains of government role in health development

Ministries of health are responsible for leading health development through the implementation and improvement of main health system functions [1], including leadership and governance, health care financing, provision of health services, and generation of inputs for health development, including human resources for health and biomedical technology. Efforts are coordinated with other related ministries and departments.

Leadership and governance

Governments are the guardians of social commitments and values such as solidarity, social justice and equity, which are stated in their constitutions, signed treaties and conventions. In many constitutions worldwide, and in the Eastern Mediterranean Region, the rights to health care and education are clearly indicated and governments are responsible for providing access to these services without financial barriers and for ensuring that the value of health as a basic human right of all is protected [3].

Ministries of health oversee the overall development of health systems using their governance function, which includes policy analysis and formulation, regulating service delivery between partners, developing norms and standards for quality assurance and ensuring the implementation of agreed upon policies and strategies. The governance function is supported by a routine information system, supplemented by population-based surveys and by health legislation in line with national ethical values. The governance role is becoming of paramount importance in view of the increasing complexity of health systems and changing epidemiological and demographic scenarios. Ministries of health are mandated to assess the performance of health systems in terms of equity, quality improvement, and efficiency and population satisfaction with health services. Several analytical tools have been developed by WHO to help ministries of health in carrying out periodic performance assessment exercises and to develop their strategies based on evidence.

The need for government intervention in health care is explained by the peculiarity of health services which cannot be left to market forces only for generation and distribution. Evidence shows that market forces have failed to work in the health sector for several reasons including *inter alia* the asymmetry of information between patients and health care providers, the existence of public goods with positive externalities, adverse selection and moral hazard. Patients, who are not knowledgeable about their health problems, rely on health care professionals to make health and medical decisions on their behalf. Patients are ill-equipped to assess the adequacy of physicians' decisions and actions and focus on the environmental and interpersonal aspects of clinical services, the elements that they are best able to evaluate [8]. Some important health services, called public goods, such as mass immunization, environmental health activities, health education and promotion, surveillance, control for communicable diseases at borders, etc., are not profitable for private providers and are mainly provided by governments.

Over-consumption of health services or “moral hazard”, occurs when these services are free at the point of use and is also caused by over-production of services by providers when no costs are incurred to patients, particularly those who are insured. Such behaviour escalates the cost of health care and calls for cost-containment strategies and programmes which are usually initiated by governments.

Adverse selection is practised by private insurers not willing to enrol the old, the chronically ill and some vulnerable groups who are in greater need of social protection. Governments usually intervene to compensate for the market’s reluctance to ensure inclusion of the most vulnerable groups [8]. Also, in view of the unpredictable nature of diseases and risk of impoverishment during sickness, governments are major players in developing pre-payment and insurance schemes, whether social, private or a mix of both.

Health service delivery

In most OECD countries, while health care financing is socialized, delivery of health care services is secured by both public and private providers and nongovernmental organizations. The role of government is often to steer the overall health development by designing health policies and programmes, securing essential public health functions and regulating the delivery of health services. In most OECD countries, governments provide health care services, including public goods such as promotive and preventive services and hospital care. While the role of private hospitals in service delivery is growing in these countries, public hospitals remain the reference for quality standards, prices of services, training of quality health professionals and health and medical research in various aspects.

Ministries of health are responsible for health protection and undertake that responsibility by implementing the essential public health functions, including surveillance systems and provision of public goods such as programmes for mass immunization, environmental protection, food fortification, food safety, etc. The delivery of essential public health functions is becoming complicated in view of increased globalization and its impact on changing lifestyles, including eating habits and the rapid increases in international travel and communication technology.

In order to fulfil its public health functions and to protect national health security, governments, through ministries of health, are responsible for the provision of necessary medicines and vaccines and supporting laboratory networks. Access to quality and affordable vaccines used in national immunization programmes faces several challenges, including limited financial resources, inappropriate supply systems and lack of effective national regulatory authorities to implement quality and safety standards. Strategic decisions have to be made by governments in terms of national investment in developing self-reliance and self-sufficiency in medical technology, including medicines and vaccines.

Governments are also involved in the provision of clinical services at primary, secondary and tertiary levels of health systems. These services are provided in communities, work settings and public institutions including health centres, investigation networks and hospitals. In most countries health services are provided to the military, security forces and to their dependents in special settings.

The role of government in service delivery contributes to increasing equity in access to health care, particularly in rural and remote areas where qualified private providers, concerned about their income, are in limited supply. The direct provision of health services by governments contributes to market regulation for both pricing and quantity of services.

Government-owned health and hospital facilities are the reference places for training of human resources and are often the most appropriate sites for research activities in the field of health, public health and medicine. The development of bio-medical and health research is totally indebted to the support of government institutions in design, funding, protection of ethical values and in monitoring the impact of research activities on health outcomes.

Governments are becoming increasingly concerned about managing the public–private mix in health service delivery, the result of the many active privatization policies initiated in welfare-oriented health

systems and aimed at increasing the supply of private services. The last two decades of the 20th century witnessed waves of health policy and sector reforms aimed at improving the efficiency of health systems and increasing equity in relation to access to health care. For example, reforms have been designed to introduce private practice in publicly owned hospitals in the United Kingdom, Australia and some developing countries as part of public-private partnership. Business-oriented rules for management have been introduced in publicly dominated service delivery systems in OECD countries and elsewhere. The main stakeholders, which include professional associations and unions, have different attitudes towards these reforms, ranging from active support to total disapproval. Governments and researchers are equally interested to assess the impact of privatization policies in equally the financing and health delivery systems.

In USA, when for-profit hospitals were compared with not-for-profit hospitals, the performance was found to be similar [3]. Extensive study of immunization programmes in Canada has shown that public institutions offer advantages over private institutions with respect to accountability, standardization of procedures, vaccine handling practices, human resource use, records management, cost, etc. [3]. In California, seven local county governments turned their public hospitals over to private management in the late 1970s in the hope of achieving greater efficiency. After several years of trial, five of the seven “private management contracts” were terminated as no evidence of reduced unit operating costs or improved efficiency could be found [3].

In Cuba, after the revolution of 1959, the abrupt transformation of the health system from being dominated by the private sector to one of almost wholly public character, and its association with a vast increase in service delivery, and spectacular improvement in Cubans’ health status and a number of social determinants including literacy, is well documented [3]. In Chile, the military dictatorship of the 1970s reduced government involvement in service delivery and encouraged privatization of health care with negative impact on access for the poor segments of the population although life expectancy for the population as a whole did not decrease as a consequence.

In 1989, a general review of health service privatization throughout the world was published [8] which concluded that while the main objective of privatization was to widen individual choice, “the luxury of truly having free choice in the health care field remained confined to a small group of privileged consumers in industrialized societies”. It predicted that the pendulum will gradually shift to more state control, as the conceptual and methodological lessons of health services privatization are learned, but that the timing of such a shift will depend on larger political forces in a turbulent world.

Health care financing

Governments play a major role in health care financing by mobilizing the necessary resources through public budgets and other contributive mechanisms, pooling resources allocated to health development, guiding the process of resource allocation and purchasing health services from various providers. Ministries of health are entrusted to protect equity in access by improving financial risk protection, by reducing financial barriers to access particularly to the poor and to vulnerable populations, and by ensuring that health care financing by all income groups is fair. Health care financing is becoming an important function in health systems as inequities inside and between countries with respect to access increase because of financial barriers and lack of appropriate social protection.

Human resource development

As human resources constitute the main inputs and assets in health systems, governments are responsible for designing appropriate policies for human resource development aimed at meeting the real needs of populations, securing appropriate skills mix, improving equity in distribution of human resources, managing them properly, and monitoring and evaluation of the national health workforce. Governments set national standards for health personnel education and develop systems for accreditation of training institutions.

Appropriate policies and strategies for human resources development depend on the degree of intersectoral collaboration between ministries of health and ministries of education and other related

departments. Often the lack of coordination among various stakeholders leads to duplication and inefficient production of the health workforce.

Promotion of the centrality of health in socioeconomic development

Governments play a crucial advocacy role in promoting the central role of health in overall social and economic development. Several studies, including the report of the Commission on Macroeconomics and Health, have shown the interplay between health and economic development and have concluded that intersectoral collaboration should be developed in order to harness the important synergies between health and development.

The focus on the social determinants of health gained momentum following the Declaration of Alma-Ata, which targeted the achievement of health for all through primary health care, and this focus was further affirmed in the UN strategies for comprehensive socioeconomic development following the World Summits for Social Development in 1995 and 2000. Several initiatives were taken by ministries of health and other related ministries of the Region to improve health outcomes through promoting the social and economic determinants of health, such as a sustainable environment, literacy, female education and empowerment, and poverty reduction.

4. Key challenges facing governments in health development

The changes and challenges which evolved globally, regionally and nationally during the last half of the 20th century have had significant impact on health systems, on the pace of their development and on health outcomes. In the political field, democratization with more participation of civil society in governance and focus on local and decentralized government has affected the configuration of health systems worldwide and in the Region. Policy development is becoming more participatory, and organization and management of health services delivery is being further decentralized to provinces and even to communities. This trend was strengthened following the Alma-Ata Declaration.

The main challenge since the early 1980s is represented by the move towards market economies and the reduction in interest in central planning in social and economic development. In many developing economies, macroeconomic reforms including structural adjustment and stabilization programmes, were implemented under pressure from the International Monetary Fund and the World Bank and were often accompanied by cuts in public spending on social sectors including health and education. Cost-sharing policies were implemented in order to compensate for diminishing government budgets allocated to health. Macroeconomic reforms led to restrictions in recruitment of new health professionals and replacement of retirees as part of public sector downsizing policies and programmes. The reduction in government health spending contributed to passive privatization, as public institutions increasingly lacked the necessary medicines and motivated human resources, encouraging those users of the public sector who could afford it to shift to private providers.

Active privatization policies were also adopted in most health systems through incentives provided to private investors in the form of subsidized loans and tax credits, particularly in poor and deprived regions. Incentives were also developed in many health systems of the Region allowing government health workers to practise privately inside and outside the public facilities.

In the social field, the main challenges are represented by growing poverty, widening disparities within and between countries and increasing social exclusion. Almost 3 billion people are living on less than US$ 2 per day, despite rising per capita income in many developing countries. The average income ratio at global level of the richest 20% of the population to the poorest 20% is 82 to 1, compared to 30 to 1 in 1960 [9]. The increase in social, economic and environmental vulnerability is associated with a deterioration of health status among deprived communities and calls for a more proactive role from governments.

Globalization has also had an impact on health systems, and particularly on access to health care. The conflict over acquisition of affordable antiretroviral treatment for poor AIDS patients in South Africa and other developing countries illustrates some of the threats posed by the implementation of TRIPS agreements. The migration of scarce human resources from countries of the South will further weaken

health systems as a result of GATS (General Agreement on Trade in Services), as is being witnessed in some regions including Africa.

5. Changing role of government in health development in the Eastern Mediterranean Region

In the Eastern Mediterranean Region, Member States have pledged to protect the values of equity and social justice and reaffirmed them through signing of the Alma-Ata Declaration and adoption of Health for All for the 21st century, which highlights the importance of health as human right and in the context of human security [10]. Health development is high on the political and social agendas of Member States as reflected in the programmes of political parties involved in recent presidential and parliamentary elections which took place in the Region, and in many reform programmes aimed at improving health system performance. However, analysis of some of the trends shows new developments which are influenced by the changes and challenges facing health development in the Region.

National health accounts analysis has shown that in most middle-income and low-income countries, government spending, as a percentage of total health expenditure, is decreasing over time. The new financing profile is characterized by the imposition of an increasing burden of health care costs on households and communities and decreasing equity and fairness in health care financing. Some studies carried out in middle-income countries have found that 2% of households face catastrophic expenditures due to ill health, being forced to spend between 30% and 40% of their disposable income on medical treatment and risk impoverishment because of sickness events. Apart from high-income and oil producing countries, which represent only 8% of the total population of the Region, the level of social protection is quite limited [11].

In low-income countries, which constitute half of the population of the Region, the government share of total health care spending is diminishing and represents only 20%–30% which raises serious concerns about equity. The financial gap in health care financing, based on the recommendations of the Commission on Macroeconomics and Health with regard to securing basic health services, is so large that the UN Millennium Development Goals are unlikely to be achieved without concrete efforts to generate regional and international solidarity for health development.

In high-income countries, where access is almost universal and through the government budget, efforts are being made to reduce public spending in health by implementing user charges for publicly provided services and by designing contributive policies through pre-payment schemes for the expatriate population. The dual practice of professionals working in the public sector has contributed to blurring of the boundaries between the public and private sectors and to a form of passive privatization.

In some countries, public services are outsourced to private providers particularly for ancillary and non-clinical services, including security, catering, laundry, etc. Some costly imaging and dentistry services are also contracted out to private providers as part of the policies of active privatization. Ministries of health are not well equipped to manage the new public–private mix in health delivery. The management of the public–private mix in health systems is becoming difficult owing to some institutional weaknesses of ministries of health, particularly in relation to governance and appropriate regulatory tools and instruments. The functions of policy analysis and formulation are not strong enough to allow for development of policies and strategies based on evidence and for appropriate priority-setting targeting cost-effective interventions and programmes. Standard-setting and development of norms for quality assurance and improvement are also weak.

The private sector is playing a growing role in provision of medical services and in training of human resources for health. However, the private sector growth in service delivery is often uncoordinated, leading to duplication of government and social insurance facilities and to increased inequities in access to quality health care services.

The increasing role of the private sector in health personnel education has not been supported by a stronger role of government in setting appropriate norms and standards for the production of human resources. This raises concerns about the quality of new professionals trained in private institutions and security of employment for new graduates from private schools.

As part of the opportunities offered by globalization, several private investors are looking for niches in the areas of medical and health tourism in some countries and are planning to expand their hospital facilities with state-of-the-art medical technology. The risk of uncoordinated development could lead to saturated markets for hospital care in the Region, and calls for an active role for governments in regulating the supply of services.

6. The way forward

The report of the Commission on Macroeconomics and Health [12] provided additional evidence of the importance of investing in health and also of the importance of the role of governments and international institutions to generate the necessary financial resources for health using national resources, supporting poverty reduction strategies aimed at improving economic growth and seeking regional and international solidarity. Some ministries of health from the Region, using the evidence of the high economic return on investment in health and of the synergy between health and development, have been instrumental in convincing ministers of finance to allocate reasonable public sources to health development. The national efforts to raise public spending from government budgets has not been matched by an increase in official development assistance (ODA) despite the political commitment expressed at the highest levels to achieve the Millennium Development Goals. Only a few Nordic countries have reached the agreed target of 0.7% of GDP allocated to official development assistance. In order to improve social development including health, the World Summit for Social Development (1995) adopted the 20/20 initiative which recommended that 20% of ODA support go to social development provided that governments commit themselves to allocating 20% of their national budgets to these social sectors.

Despite the financial constraints facing most countries of the Region, the commitment to secure equity in access to health care is still present, at least in the political discourse. The commitment needs, however, to be translated into reality by securing a fair share of health spending from public sources and by improving social protection. More efforts are needed by countries to expand coverage by social, private and community health insurance and to reduce the share of out-of-pocket expenditure in total health expenditure. In doing so, technical support from WHO and the International Labour Organisation is necessary to help in developing evidence-based policies and strategies for equitable health care financing.

The use of analytical tools developed by WHO to refine the measurement of fairness and equity in health care financing should provide solid evidence to decision-makers in engaging policy debate around health care financing options and the role of government. It is essential that the important partners in health development, including the private sector, nongovernmental organizations and professional associations, contribute to policy dialogue and efforts should be made to reach out to bilateral and multilateral partners and to regional and international development banks involved in health.

Privatization in the health sector will continue, indeed the pace is expected to increase in view of changing political and economic scenarios and the impact of globalization. Therefore, ministries of health need to be well equipped to manage the new policy directions, particularly through improving of standard-setting and regulatory functions. It is clear that unless governance is strengthened, privatization policies may lead to unregulated development of the private sector resulting in negative impacts on equity, quality of services and overall health system efficiency. The national vision for health development, designed under the leadership of government, should encompass all partners, including the private sector and other nongovernmental players in order to avoid duplication, misunderstanding and conflict of interests.

Ministries of health need to develop legislation and regulatory tools to improve management of the public–private mix, particularly in contracting in and contracting out of clinical and non-clinical health care services. A recent consultation organized by the WHO Regional Office for the Eastern Mediterranean to assess country experiences in contracting in health systems [13] highlighted the limited capabilities in most ministries of health in negotiation and the limited legal support in organizing contracting arrangements, in implementing agreed contracts and in monitoring the impact of these contractual relationships. More research is needed to share the lessons learned from best practices inside and outside the Region in this important field. An ongoing WHO Regional Office study on the size and magnitude of the private sector in the Region is expected to shed more light on the issues related to coordination between all partners in health development in the Region, and ways and means of improving such coordination.

In view of market failures in health and the social responsibilities of government in provision of quality and affordable services and taking into consideration the important public investments in health system infrastructure in most countries of the Region, governments, in addition to their governance function, still have a role to play in service delivery in collaboration with other partners. In order to secure equity in access to health care, public facilities in remote and rural areas, which remain the main providers of services for millions in the Region, need to be further strengthened. The provision of necessary public human and financial resources to these facilities will allow them to produce accessible and affordable health care services. A transparent system of accountability should be developed in order to assess and monitor the effective and efficient use of public resources in health development.

Ministries of health need to raise the issue of improving civil servants' salaries as public institutions cannot operate effectively and efficiently with a low paid and unmotivated workforce. Although the issue is not related to ministries of health only but to the whole public sector, ministries of health can argue their specific case for favourable treatment based on the specific and life-saving nature of health services. Reforms initiated in some countries of the Region, including tax credits and some fringe benefits including housing allowances, have generated incentives for health professionals working full time in public facilities without changing the salary scale of all civil servants. Some of the reforms aimed at allowing civil servants to practise privately in order to improve their income are distorting the whole service delivery system, creating unnecessary inequities and generating abuse of both public facilities and patients.

7. Conclusions

Governments have an important role in health development in both developed and developing economies in view of their social mandate and the peculiar nature of the health care market. The efforts initiated by governments to build modern health systems must be continued and adapted to the new changes and challenges in the political, economic, social and cultural fields.

Despite the pressures facing governments in managing the social sectors, ministries of health should continue to play their leadership role in health development and should advocate for the importance of investing in health and of protecting the social values of equity, solidarity and fairness.

Health development should be coordinated between all concerned government ministries and agencies and with all stakeholders, including academia, professional associations, the private sector and civil society organizations. Efforts must be made to promote the centrality of health in comprehensive socioeconomic development.

The private sector is assuming a growing role in both financing and delivery of health care. However, care must be taken to ensure that such developments are not at the expense of an effective and efficient public sector and to ensure that they are implemented under strong leadership and governance from the government. Privatization of health service delivery must be well designed and guided by ministries of health and other related departments, taking into consideration the social obligations of governments in health development and the main health system goals.

WHO will provide the necessary technical support to help ministries of health in better implementing their roles in health development through its normative and technical cooperation functions, and by promoting networking and exchange of experiences and good working models in various fields. WHO will also promote a culture of policy and strategy development based on evidence and will promote national and regional health policy forums where important issues are debated and where agendas for further research-to-policy activities are developed. WHO will continue to remind governments of their global commitments to the inspirational and noble goal of health for all and to implement effective strategies to achieve the health-related Millennium Development Goals.

WHO will continue to support Member States in owning and in using its analytical tools to assess equity, efficiency and overall health system performance through capacity-building, institutional development and provision of technical expertise. Particular interest will be paid to supporting governance, financing and human resources functions. The WHO regional observatory on health systems will help in assessing health development in the Region and in networking among policy-makers and health professionals in order to address the challenges facing health systems in achieving their goals. Monitoring and evaluation of the role of governments in health development will be among the tasks of the regional observatory.

8. Recommendations

1. Governments should promote investment in health development as having important economic return and should advocate the centrality of health in all development initiatives.
2. Governments should continue to play their leadership role in health development in order to protect societal values of equity, solidarity and fairness in line with health for all policies and strategies which consider health as a human right and not as a market commodity.
3. Governments should strengthen their governance capabilities, particularly in policy development, regulation and public/private mix management. The role of government in service delivery should be protected in order to secure access for the poor, vulnerable groups and rural and remote populations. Particular interest should be paid to improving working conditions for professionals working full time in government facilities.
4. Governments should promote the development of national health system observatories aimed at developing forums to assess equity and health system performance and to better adapt policy reforms to the evolving changes in the political, economic and social fields.

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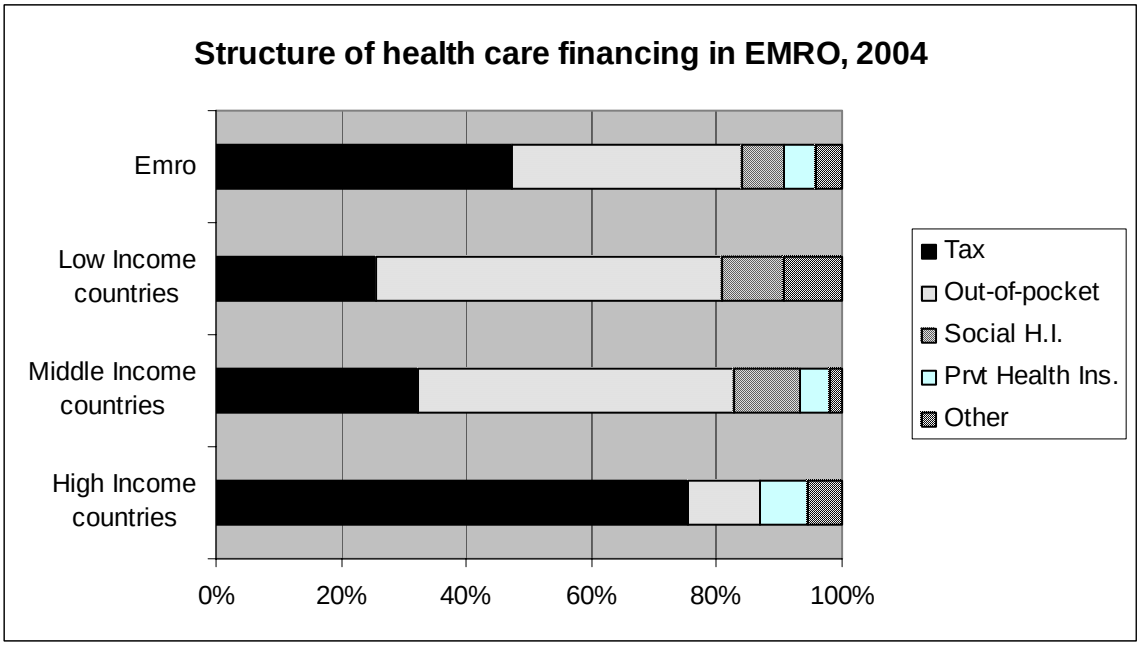
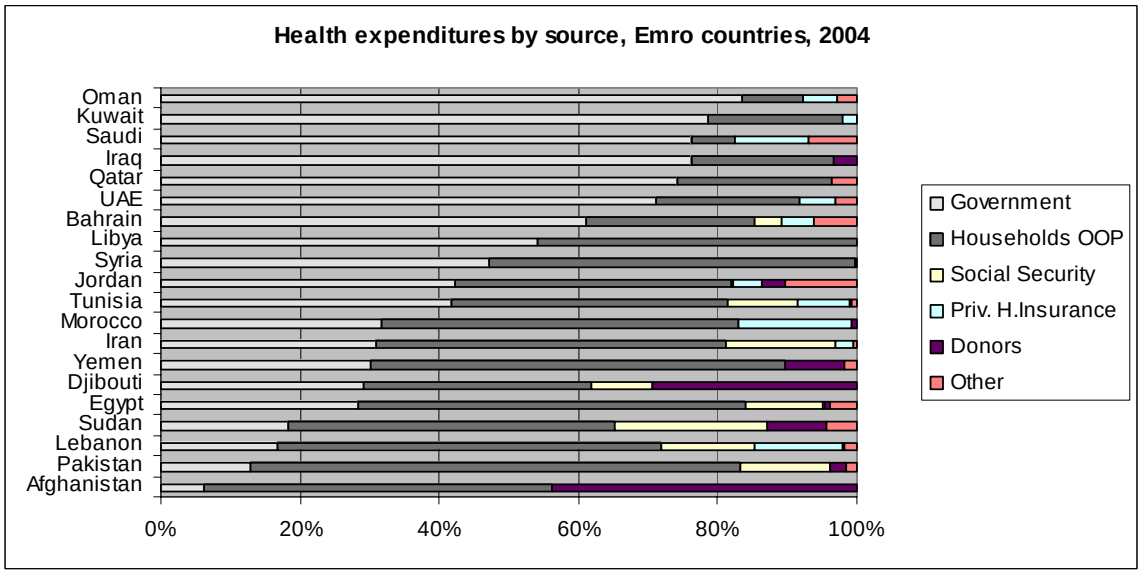
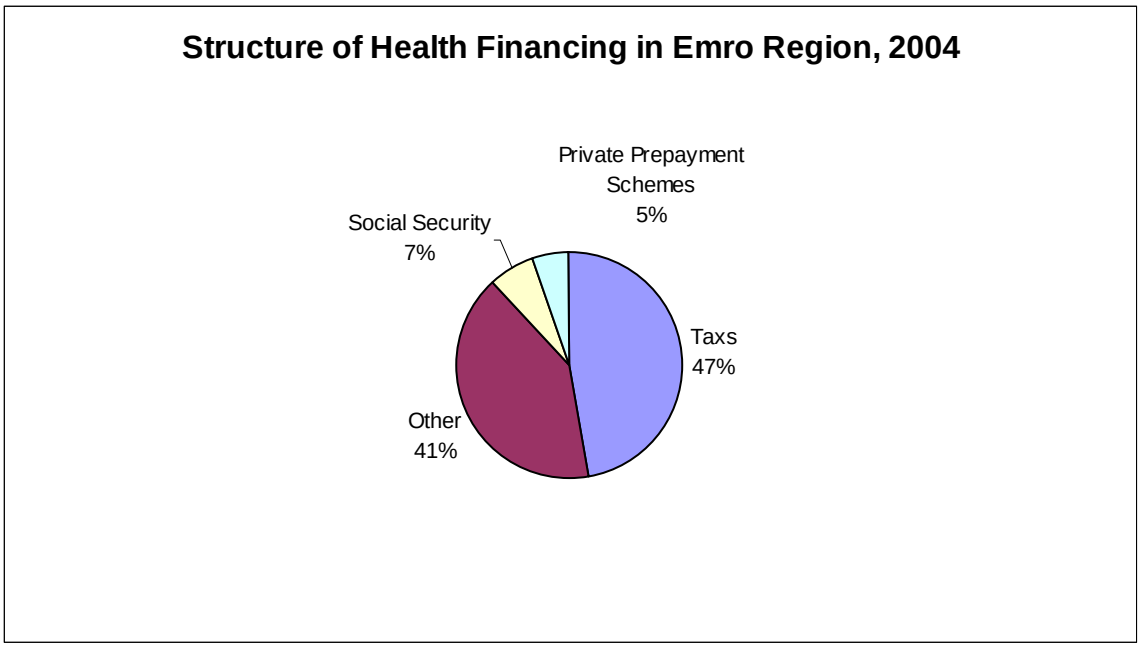
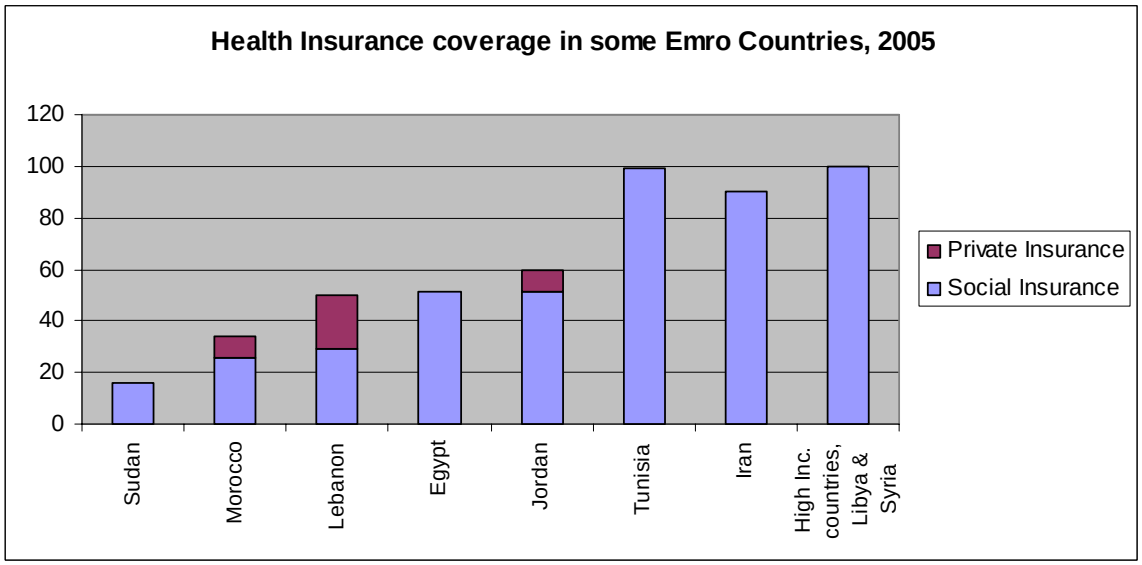

Structure of health care financing in EMRO, 2004
Emro
Low Income countries
Middle Income countries
High Income countries
0%
20%
40%
60%
80%
100%
Tax
Out-of-pocket
Social H.I.
Prvt Health Ins.
Other


Health expenditures by source, Emro countries, 2004
Oman
Kuwait
Saudi
Iraq
Qatar
UAE
Bahrain
Libya
Syria
Jordan
Tunisia
Morocco
Iran
Yemen
Djibouti
Egypt
Sudan
Lebanon
Pakistan
Afghanistan
0%
20%
40%
60%
80%
100%
Government
Households OOP
Social Security
Priv. H.Insurance
Donors
Other


Structure of Health Financing in Emro Region, 2004
Private Prepayment Schemes 5%
Social Security 7%
Taxs 47%
Other 41%


Health Insurance coverage in some Emro Countries, 2005
120
100
80
60
40
20
0
Sudan
Morocco
Lebanon
Egypt
Jordan
Tunisia
Iran
High Inc. countries, Libya & Syria
Private Insurance
Social Insurance