Analysis of the private health sector in countries of the Eastern Mediterranean

Exploring unfamiliar territory

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Regional Office for the Eastern Mediterranean

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Contents

Executive summary 5

Introduction 8

Approach and analytical framework 8

Geopolitical, socioeconomic and demographic characteristics of countries of the Region 11

Trends in privatization and implications for the private health sector 14

Trade in health services in the Region 15

Rationale for the expansion of the private sector 15

Current status of the private health sector in countries of the Region 16

Private health sector financing 16

Service provision in the private health sector 18

Health workforce in the private sector 24

Private medical and allied institutions 26

Medicines and medical devices in the private health sector 27

Governance 29

Accreditation, quality and safety of private health care facilities 30

Experience with public–private partnerships and contractual arrangements 31

Challenges and gaps in relation to the private health sector 34

Conclusions and next steps 35

References 36

Executive summary

The importance of the private health sector in most countries of the WHO Eastern Mediterranean Region is increasingly being acknowledged by the ministries of health in the Region. Despite this recognition, it has not been possible 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.

Despite limitations, a systematic effort has been made to put together the best available information on the private health sector in the Region in order to facilitate a dialogue on the subject and eventually lead to the development of a regional strategy. The private sector has been defined to include all formal service providers working for profit and/or not-for-profit. The focus of this study has largely been on the for-profit private sector in the countries of the Region.

The privatization policies in the countries of the Region have followed three main trends—free market–driven towards privatization generally; natural growth in the private sector leading to a mixed public and private health sectors; and maintaining the traditional role of the state where the public sector remains in control. Based on analysis of the 12 reports, the major factors that underlie the (ir)rational expansion of the private sector are the poor image of and reduced quality of care offered by the public health sector; better perception of the private sector and higher level of satisfaction among communities; absence of public facilities in underserved areas and incentives from governments to encourage the expansion of the private sector; urban migration and inability of the public sector to cope with increasing populations; low government spending on health; and an increasing tendency among populations to turn to the private sector.

As a whole approximately US$ 125 billion were spent on health in 2011 in the Region. The share of out of pocket spending varies between 32% and 79% in Group 3 countries, 19% and 58% in Group 2 countries, and 11% and 18% in Group 1 countries. The trend of out-of-pocket spending on health over the last two decades has fluctuated around 50% for Group 2 countries, and has increased from 59% to 69% for Group 3 countries. The few equity studies carried out in Group 2 countries have shown that almost 5% of the households face a financial catastrophe following ill health and that a significant number of households are pushed into poverty, nearly 1%–1.5%.

The use rates for private sector outpatient services ranges in some Group 2 and 3 countries from 33% to 86%. The percentage of private sector services used by the poorest quintile ranges between 11% and 81%. Generally, the role of the private health sector is not well defined, its capacities are poorly understood, and practices are not monitored. The range of services provided is variable, standards are questionable, regulation is poor and there is insufficient information about financial burden to the users of these services.

The government continues to be a major provider of hospital services in all Group 1 countries; however the private sector is growing. Of these the proportion of private hospital beds ranges from 6% to 22%, the highest being in Saudi Arabia. In Group 2 countries, 7% to 83% of hospital beds are in the private sector, the highest being Lebanon. The proportion of private clinics in Group 1 countries ranges from 15% to 88%. In Group 2 countries, the proportion of private clinics varies from 5% to 78%. In Group 3 countries, the percentage of private clinics varies between 20% and 90% of all the primary care facilities. There are almost 50 000 private clinics in Egypt and 75 000 general practitioners in Pakistan that do not fall under any proper regulatory regime. Private care providers are reluctant to invest in preventive care and in remote or deprived areas. Absent and/or weak regulatory systems in addition to absent and/or weak formal mechanisms to monitor the quality of health care services offered by various private providers are among the major challenges.

On average more than 60% of pharmacies in countries of the Region are in the private sector. Between 27% and 90% of pharmacies in Group 1 countries are owned and managed within the private sector. In Group 2 countries, 60% to nearly 100% of pharmacies are privately owned. In Group 3 countries the range is between 22% and 98%. Anecdotal evidence shows high levels of irrational prescriptions with possible adverse consequences within the private pharmaceutical industry.

Within the private health sector significant challenges exist regarding workforce. These include: duality of practice between the public and private sectors resulting in difficulty in accurately reporting workforce statistics; concentration of workforce in urban areas; rapid and unregulated expansion of private health professional training institutions; and lack of proper accreditation and national standards for the education of health professionals. In Jordan, Bahrain and other countries public sector employees are not permitted to engage in private practice. Most countries of the Region have little reliable data about health workforce distribution, salary structure or multiple job holding. The issue of dual employment or "moonlighting" often results in competition for services and staffing between the private and public health sectors.

Surveys of pharmaceutical prices in countries of the Region revealed substantial variations in procurement prices for the same medicines. Price ratios of brand name pharmaceuticals in retail pharmacies were found to be excessively high in ten countries of the Region. Over-the-counter dispensing and the sale of antibiotics without a medical prescription are a major concern. There is little or no drug regulatory enforcement and little or no consumer awareness of the potential negative impact of antibiotic misuse. In low- and middle-income countries up to 95% of health technologies are imported, much of which are used irrationally or suboptimally due to insufficient experience and training. This has led to an escalation in out-of-pocket expenditures and associated medical errors.

Governance of the private sector focuses on: government policy on the private sector; the existence of a regulatory system and its implementation; the institutional capacity of the ministry of health; and experience with public–private partnerships and contractual arrangements. Regulation and enforcement of standards in the private sector are among the biggest challenges faced by governments and ministries of health. The policies for engaging with the private health sector are evolving across the Region and are most developed in Group 1 and some Group 2 countries. In general, policies focus on the establishment of private sector regulatory mechanisms. In some countries, policies also encourage cooperation and partnership with the private sector to expand access and coverage. Among Group 3 countries policies and regulation of the private health sector are either weak or nonexistent. In many countries of the Region there are various associations, institutions and syndicates that represent physicians, nurses and ancillary health professionals as well as hospitals and clinics. However little information exists which explains the functions and potential influence of these bodies in improving health care.

Based on the challenges outlined above, the following conclusions and next steps are proposed.

- This is the first systematic effort at exploring the role of the private health sector within the Eastern Mediterranean Region. It is essential to assess the potential of the private health sector in meeting the regional goal of universal health coverage within countries of the Region.
- The ultimate goal is to increase the role, influence and contribution of the private health sector within the Regional health sector agenda.
- Despite the unique nature of this study, arguably the first of its kind, this review of the private health sector in all countries of the Region has limitations and information gaps.

- This study identifies many challenges faced in regard to the private health sector and its role in meeting Regional and country health system goals. The challenges are related to private health sector; weak governance and regulation, inequitable financing, duality of workforce, inappropriate and irrational use of technologies, lack of data on quality of health care, use rates and cost of care.
- The private health sector provides a unique opportunity for increased partnership, greater engagement and contribution towards Regional public health goals. Such opportunities have not been adequately explored by public sector policy-makers in most countries of the Region.
- There is a need for systematic ongoing country-level private health sector studies which will close information gaps and shed light on the private health sector.
- The WHO Regional Office for the Eastern Mediterranean has recently focused on acquiring in-depth data on private health sector regulation. Within this focus, two country studies have recently been completed in Yemen and Egypt.
- The next step must focus on developing a regional strategy for information gathering, evaluation, assessment, strengthening, cooperating with and governing the private health sector in all countries of the Region. Eventually, the role and contribution of the private health sector must become an integral part of all national health planning and universal health sector goals.

Introduction

The importance of the private health sector in most countries of the Eastern Mediterranean Region[1] is increasingly being acknowledged by ministries of health. Despite this recognition, it has not been possible 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. The most important reason for this is the lack of accurate data on the private health sector from most countries of the Region.

The first step in building a constructive partnership between the public and the private health sectors must be to acquire an understanding of the latter. There have been several reasons for not exploring the private health sector in a systematic manner. The most obvious is related to the traditional mandate of ministries of health to provide direct and free health services to all citizens. In many countries this mandate is stipulated in the constitution. Other reasons are the seemingly small size of the private health sector, the absence of tools and instruments for assessing the private health sector, reluctance on the part of ministries of health to acknowledge and collaborate with the private health sector, and the limited awareness and capacity among ministries of health to regulate and contract effectively with the private sector [1].

Most countries of the Region are entrenched in the historical model of public provision and financing. Ministries of health have been responsible for recruiting health professionals, building hospitals and health facilities, providing supplies and paying for healthcare. The progressive inability of the public sector to provide accessible, efficient and quality health care has adversely affected the image of the public health sector. This has led to a loss of trust and has encouraged the private sector to expand in an unregulated fashion. This situation has persisted in the Region for several decades and has not received the attention it demands. The result has been that, in many countries of the Region, the private health sector has assumed a larger role than the public sector in terms of both the overall financing and provision of health services. Furthermore, governance of the private health sector is sorely lacking in most countries of the Region.

Mapping the private health sector in the countries of the Region is therefore a priority which has been identified by the WHO Regional Office for the Eastern Mediterranean. A commitment to do so was included in a paper presented to the Fifty-ninth Regional Committee for the Eastern Mediterranean in 2012 [2]. Despite limitations of availability of information and the challenges associated with data mining, a systematic effort has been made to pull together the best available data and information on the private health sector in the Region.

The purpose of this report is to provide an analysis of the current status of the private health sector that will facilitate a formal dialogue and eventually lead to the development of a regional strategy for effectively engaging with the private health sector in countries of the Region. Equally, the paper recognizes the large potential role and contribution of the private health sector in making visible progress towards universal health coverage. Without the contribution of private health sector in working with the public sector the goal of universal health coverage will be an even larger challenge in most countries of the Region.

Approach and analytical framework

This study has been developed over several years, beginning in 2007. The first organized effort to collect data on the private health sector was undertaken from 2007 to 2010 and involved 12 countries of the

[1] Group 1: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates; Group 2: Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestinian territory, Syrian Arab Republic and Tunisia; Group 3: Afghanistan, Djibouti, Pakistan, Somalia, South Sudan, Sudan and Yemen.

Region: Bahrain, Egypt, Islamic Republic of Iran, Jordan, Saudi Arabia, Lebanon, Pakistan, Palestine, Sudan, Syrian Arab Republic, Tunisia and Yemen. The unpublished reports of these 12 country surveys form the basis of this study. Following the commitments made in the Regional Committee paper a renewed attempt has been made to collect updated information from the original 12 countries surveyed and to acquire additional information from all other countries of the Region.

Definition of public and private health sectors

The World Bank [3] defines the private sector to include all actors outside of government including for-profit, non-profit, formal and non-formal entities. This broad definition includes service providers, pharmacies and pharmaceutical companies, producers and suppliers, shopkeepers and even traditional healers.

For the purposes of this study, the private sector was defined to include all formal service providers working for profit and/or not-for-profit (e.g. nongovernmental organization). The focus of this study has largely been on the for-profit private sector in countries of the Region.

Analytical framework

Overall this analysis of the private health sector in countries of the Region has followed the health system building block conceptual framework [4] (see Box 1 for more detail). A brief analysis of the macroeconomic and demographic situation and its effect on the private health sector is presented. An analysis of the private health sector includes: financing, service delivery, workforce, medical products and technologies, governance and information. Box 1 lays out the framework for the analysis of the private health sector.

Data collection during 2007–2010

Country selection

During the first phase (2007–2010) 12 countries of the Region were selected based on the size of the private health sector (using health financial indicators); an equitable representation of low, middle and high income countries of the Region; and local capacity to independently undertake health system research and analysis.

Survey instruments

The survey instruments were: classification of possible private sector legislation; data collection forms for contractual public–private partnerships; classification of private health sector facilities by type and location; classification of private health sector health care providers by type and location; framework for the analysis of national health accounts and household expenditure surveys; and interview instruments for analysis of key informants perceptions of the private health sector.

Data collection and monitoring

Country investigators were given four months to collect the required data. Survey instruments, checklists and guidelines were developed by the Regional Office in order to ensure comparability of data. Other than in-depth interviews with key informants, the study did not involve any primary data collection at either the facility or household level. Close monitoring of the country studies was essential. The following safeguards were followed. Clear terms of reference and expected outputs were established. Interim reports were submitted by principal investigators mid-way through the study and field monitoring was done by advisers from the Regional Office.

Box 1. Framework for the analysis of the private sector

Macroeconomic and demographic situation and trends in privatization

Analysis of private health sector

- Financing
  - tracing flows of finances to the private sector providers
  - Source to agent to provider
- Service provision
  - type of service by provider (public health, curative)
  - coverage/use of services
  - infrastructure (hospitals, clinics, pharmacies, laboratories)
  - quality of health care
- Health workforce
  - skill mix and cadres
  - employment by sector (public/private)
- Technology and essential medicines
  - local production and technology transfer
  - high-tech medical equipment
- Governance and information
  - regulation (contracting, accreditation)
  - public–private partnerships
  - intelligence (information generation, consolidation, compilation, use)

Data collection during 2012–2013

Additional data have been collected from recent reports, published literature and sources available online. No primary data collection has been undertaken during this period. Effort has been made to update data collected between 2007 and 2010 and have all data verified by WHO country offices and ministries of health.

Limitations of the study

The study relies primarily on existing data sources on the private health sector. These sources include published literature, grey literature and reports. Some primary data were collected through in-depth interviews with key stakeholders.

Given that comprehensive and reliable data on the private health sector within countries of the Region is limited and that private health sector data collection is not routine work, there are many gaps in the data. These gaps have been identified throughout the paper.

Furthermore the data from the 12 countries of the Region collected between 2007 and 2010 are limited in their comparative analytical value. Data retrieved from national household health service and use surveys have inconsistencies; countries do not always use the same measurement tools.

A subsequent desk review undertaken in 2012–2013, mainly from online sources, was also conducted. While they were the best available data there are concerns about their validity, which are currently being verified with ministries of health with support from WHO country offices.

The important issues of quality of health care and cost of health services, which undoubtedly contribute to and affect service provision and health outcomes, were not included in the study. This study is not

conclusive, rather it points to further areas for in-depth research on the private health sector in countries of the Region.

Geopolitical, socioeconomic and demographic characteristics of countries of the Region

The Eastern Mediterranean Region comprises 22 countries in addition to the occupied Palestinian territory and is estimated to have a population of 620 million [5]. Despite its geographic continuity, cultural compatibility and common historical background, the Eastern Mediterranean Region exhibits a high degree of diversity in the macroeconomic and developmental profiles of its countries, which invariably affects the status of population health and health systems performance.

For several decades the Region has been politically volatile. For many, change was inevitable. The "Arab Spring" started in Tunisia in late 2010 and spread to Egypt, Libya, Yemen and smaller political movements in other countries of the Region. The main drivers and principal stress points were socioeconomic inequalities, high unemployment, corruption and social injustice. The population growth rate in the Region is among the highest in the world. Additionally the unemployment rate had skyrocketed, particularly among young people.

During the past ten years, at least ten countries of the Region were or continue to be in a state of crisis, internal conflict or complex emergency. Responding to such challenging situations puts additional demands on already constrained health systems due to weak governance, exodus of the health workforce, disruption of supply systems, destruction and neglect of health infrastructure, and the inevitable disruption of health services. Inflow of external assistance and poor donor coordination impose additional challenges.

Economic activity slowed sharply, and unemployment rose in a number of oil-importing countries of the Region in 2011. Growth among these countries (Afghanistan, Djibouti, Egypt, Jordan, Lebanon, Morocco, Pakistan and Tunisia) fell from 4.3% in 2010 to 2.2% in 2011, as social unrest in some of them led to large declines in tourism and investment, compounded with higher energy prices and slower economic global growth [6]. Many governments have had to put a cap on development expenditure for social services, including health. In order to maintain the integrity of the public health system, policy-makers in collaboration with multilateral and bilateral donors have introduced cost containment and cost recovery strategies, thereby jeopardizing the goal of fair financing and financial risk protection in health.

Despite this, the right to health is enshrined as one of the fundamental human rights in many international treaties and conventions. All WHO Member States as signatories to the WHO Constitution are committed to the principles and elements of the right to health [7], and most countries have signed at least one international treaty or convention that recognizes health as a human right [8]. Yet these are not always reflected in national constitutions and policies and when they are, their enforcement is often questionable.

Finally, the sociopolitical movements under way in several countries of the Region are likely to influence population health. The challenge for countries of the Region is to put in place a process of health reform that will: build a sustainable health system that uses the resources of the private sector in collaboration with the public sector; include a reliable financial plan; ensure equitable access of health services; and expand geographic coverage [9].

Table 1 below gives a brief summary of key demographic and epidemiological indicators across all countries of the Region, while Table 2 below lays out the principal macroeconomic indicators for all countries of the Region.

Table 1. Demographic and epidemiological indicators for countries of the Region, 2011

Country	Population (in thousands) total	Annual population growth rate (%)	Total fertility rate (per woman)	Crude birth rate (%)	Crude death rate (%)	Life expectancy at birth (years)
Group 1						
Bahrain	1 235	5.8	1.9	15	2	76.4
Kuwait	3 632	1.5	0.9	16	1.8	77.7
Oman	3 174	2.7	2.5	29.5	3	72.7
Qatar	1 733	NA	2.1	11.9	1.1	78.2
Saudi Arabia	28 376	3.2	3.9	22.9	3.9	73.8
United Arab Emirates	8 264	6.1	2	9.6	0.9	77.4
Group 2						
Egypt	80 410	2.4	3	30.4	6.1	73.2
Islamic Republic of Iran	75 801	1.5	1.8	18.5	4.6	72.1
Iraq	33 227	3.5	4.3	38	4.2	72.7
Jordan	6 113	2.2	3.8	28.9	7	73.0
Lebanon	4 263	1.9	1.9	24.2	5.8	81.5
Libya	5 812	2.8	2.7	24.9	4.1	72.3
Morocco	32 245	1.1	2.6	18.7	5.7	74.8
Syrian Arab Republic	21 124	2.5	3.5	34.2	3.8	73.1
Tunisia	10 549	1.3	2.1	18.6	5.7	74.7
Group 3						
Afghanistan	26 500	2.6	5.1	35.6	29.6	NA
Djibouti	865	3.9	NA	42.0	15.0	52.9
Pakistan	177 100	2.1	3.5	27.5	7.3	66.0
Palestine	4 169	2.9	4.2	29.1	2.7	72.5
Somalia	8 698	2.6	6.4	44.0	16.0	50.0
Sudan	32 671	2.8	3.9	29.6	15.9	59.8
South Sudan	8 260	2.2	6.7	NA	NA	42.0
Yemen	22 879	3.0	5.2	39.7	9.0	62.0

Table 2. Socioeconomic development indicators, 2011

Country	Unemployed (%)	Literacy rate among adults aged 15+ years (%)	GDP per capita, average US$ exchange rate	GDP economic growth annual %
Group 1				
Bahrain	4.3	93.5	17 379	7.4[a]
Kuwait	1	95.0	46 537	8.2
Oman	NA	86.0	20 764	5.5
Qatar	0.6	96.4	82 248	18.8
Saudi Arabia	5.4	88.0	15 836	6.8
United Arab Emirates	4	92.4	39 619	4.9
Group 2				
Egypt	9.4	70.4	2 646	1.8
Islamic Republic of Iran	12.3	83.2	5 655	7.5[a]
Iraq	11.1	NA	2 932	8.6
Jordan	12.9	93.3	4 445	2.58
Lebanon	6.4	91.0	9 262	3.01
Libya	11.3	88.5	12 461	2.8[a]
Morocco	8.9	56.1	2 848	5.0
Palestine	23.3	95.7	1 697	6.5[a]
Syrian Arab Republic	14.9	85.8	2 835	2.0[a]
Tunisia	18.3	77.7	3 831	–2.01
Group 3				
Afghanistan	36.0	27.0	497	7.0
Djibouti	NA	NA	1 266	4.5
Pakistan	9.5	55.0	992	3.0
Somalia	47.0	25.0	284	2.6[a]
South Sudan	12.0	37.0	1 285	1.9
Sudan	16.8	55.7	1 328	4.71
Yemen	16.0	33.6	1 219	–10.5

Source: indicators 1–3, WHO Regional Office for the Eastern Mediterranean; indicator 4, World Bank database.
[a] Country health system profile, draft report, 2010
NA data not available

Trends in privatization and implications for the private health sector

Privatization policies have followed three main trends and in turn have directly or indirectly influenced the health sector in the countries of the Region. These include: a neo-conservative free market ideology driven towards privatization generally; growth of the private health sector driven by market demands leading to a mixed public and private health sector; and maintaining the traditional mandate and role of the state in providing health care, wherein the public sector remains in control with very little or no connection with or regulation of the private health sector.

The first trend follows the private free market economic paradigm, as seen in Lebanon and the Gulf Cooperation Council (GCC) countries. GCC states are predominantly wealthy oil states and have been closely linked to US economic trends. They follow the US economic model and as a result the private sector has grown considerably. However, most GCC countries have maintained close governmental oversight of the health sector. In recent years there has been a move towards autonomy, independent health authorities have been established, and the private health infrastructure has expanded rapidly.

For example, due to the increasing levels of public debt in Saudi Arabia, declining public capital expenditures and lower economic growth, the government has refocused its health policies towards increasing the private health sector role. The Ministry of Health stepped up greater private participation in the overall health sector with interest-free long-term loans for the construction and operation of hospitals and clinics and new public–private partnerships. The case of Lebanon has been different. Lebanon's public sector collapsed during the years of civil war in the 1980s, and the free market took over, filling the demand for health care, which led to massive expansion of the health infrastructure in the private sector. The government is now recalcitrantly facing the challenge of regulating the private health sector.

The second trend is seen in countries that have a mixed private and public economy. Egypt is an example where the private sector grew quickly while the public sector also remained strong. Islamic Republic of Iran and Pakistan began to follow this trend in the 1980s, and Tunisia in the past two years has begun to follow as well. In the case of Egypt there were other external factors that contributed to the rise in the private sector. In the early 1990s the Ministry of Health and Population collaborated with several development partners including the United States Agency for International Development, the World Bank and European Union to implement health sector reform. Despite the reforms, the private sector grew tremendously during this period and neither the donors nor the Ministry of Health and Population was able to implement sound mechanisms for regulation, licensing or partnership. The private sector has significantly grown over the past decade in Jordan. Almost one-third of all the health expenditure and more than half of the health sector workforce are found in the private health sector. Jordan has led the way in promoting medical tourism in the Region, much of which is in the private sector. In the occupied Palestinian territories the private sector has seen much growth, mainly because of governmental financial incapacity to provide high-quality health care, particularly tertiary health services. Other factors include lack of investment, high operating costs, high health risks, scarcity of specialized physicians, weak purchasing power of the Palestinian people and few government incentives for private health care development.

The third trend is the traditional health paradigm wherein the public sector remains the main source of health care. This example can be seen in the case of the Syrian Arab Republic and Iraq and to a lesser extent Tunisia. These countries have relied on strong central planning and public sector financing and delivery of services. Due to geopolitical, demographic and socioeconomic imperatives this trend has been changing substantially over the past decade.

There are numerous arguments for and against privatization of public goods and services. Those who support it argue that private markets are more efficient and over time will lead to lower prices, improved quality, more choices, less bureaucracy and faster delivery. However, not all supporters of the free market model believe that everything should be privatized because natural monopolies and market failures can arise and, more important, such things as health should not be commoditized. Health is seen as the right of all citizens and as such health care must be treated differently from other goods. The goal of universal health coverage for all makes it abundantly clear that health care must not be left to the market. Health care is a public good that should remain primarily in the hands of government in order to ensure equitable access.

Trade in health services in the Region

Assessing trade in health services within developing countries is challenging because information sources are diverse and inaccessible, while health professionals lack the skills to make the assessment. A multi-country study was conducted covering Egypt, Jordan, Lebanon, Morocco, Oman, Pakistan, Sudan, Syrian Arab Republic, Tunisia and Yemen [10]. There were several objectives: to estimate the direction, volume and value of trade in health services; to analyse country commitments; and to assess the challenges and opportunities for health services. Trade liberalization favoured an open trade regime and encouraged foreign direct investment. Consumption abroad and movement of natural persons were the two prevalent modes. Yemen and Sudan are net importers of health services, while Jordan promotes health tourism. In 2002, Yemenis spent US$ 80 million out-of-pocket for medical treatment abroad, while Jordan generated US$ 620 million in incoming trade.

More recent estimates suggest that Yemenis spend well over US$ 100 million in out-of-pocket medical expenses abroad while Jordan generated almost US$ 1 billion in 2011 by those coming to Jordan for medical care. Egypt, Pakistan, Sudan and Tunisia export health workers, while Oman relies on imports; 40% of the health services workforce is non-Omani. Overall, there is a general lack of coherence between ministries of trade and ministries of health in formulating policies with regard to trade in health services. The present study is the first attempt to look at trade in health services within countries of the Region. This systematic approach has helped create greater awareness and a move towards better policy coherence for trade in health services within the Region.

Rationale for the expansion of the private sector

Unregulated health systems over time often become inequitable, and quality and safety are compromised. Health care costs and fees increase and become profit-driven rather than service-oriented. Hence strong stewardship, good governance and rational regulation are essential elements of an equitable quality-driven health system. The past two decades have seen steady growth in the private health sector of low and middle-income countries. Since the 1990s researchers have called attention to the previously unrecognized scale of private medical services in the developing world [11]. As cross-country datasets have become available, the evidence has become increasingly clear that the private sector plays a major role in financing and provision of care in low- and middle-income countries. What is the rationale for this?

The country reports show that the major factors that underlie the (ir)rational expansion of the private health sector include poor image and reduced quality of health care in the public sector as opposed to better perception and a higher level of satisfaction in the private health sector; the absence of public facilities in underserved areas as opposed to government incentives which encourage the expansion of the private health sector; large urban migration and inability of the public sector to cope with the increasing population in the urban fringes; low government spending on health and increased use of the private health sector thereby by contributing to higher share of out-of-pocket spending. Finally, in

countries where dual practice is legally accepted and prevalent, the private sector is the main source of income for most physicians. High profits and weak enforcement of the tax system have also led to private health sector growth. These rationales apply equally to the majority of countries of the Region.

Current status of the private health sector in countries of the Region

The current section presents a systematic analysis of the private health sector in all countries of the Region, even though the original focus was on the above-mentioned 12 countries. The best and most-up-to-date data available on the private health sector from the Region are highlighted. We have noted where gaps in the data exist. There is a crucial need to fill these informational gaps through future research. The current status of the private health sector is presented under the following subsections: financing, service provision, workforce, technologies, governance and information.

Private health sector financing

There is a wide range in total health spending across the three Eastern Mediterranean Region country groups. On average, Group 1 countries spend US$ 900 per capita on health, Group 2 US$ 200 per capita and Group 3 US$ 50 per capita. Total health expenditure per capita as compared to private health expenditure per capita is completely inverted, and some would argue regressive. The expenditure pattern in the private sector reveals that the poorest countries, as represented by Group 3, pay the largest share to the private health sector (32%–79%), followed by Group 2 countries (19%–74%). The wealthiest Group 1 countries expend the lowest percentage in the private health sector (18%–31%). The percentage of finances that are spent in the private sector is a powerful measure of the role of the private sector, especially in Group 2 and 3 countries. It also shows the inverse relationship between total health expenditure (including public expenditure) and total private sector expenditure. One can draw the conclusion that the more governments invest in health over all, the greater the equity and the less poor populations have to pay in out-of-pocket expenses to the private health sector.

However, the overall private health sector expenditure may not be totally regressive, if private health sector expenditures are made in the form of prepayments, mostly through private health insurance schemes or public–private partnerships, such as those instituted by the government of Lebanon. The reality is that more than 20% of total health expenditure is out-of-pocket—payments made by individuals and households at the point of receiving health services and which are not reimbursed by a third-party—suggesting increased inequity in the financing of health care over all. Such out-of-pocket expenditures are predominantly made in the private health sector and are often the cause of catastrophic health expenditure as well as impoverishment of individuals and households.

As a whole approximately US$ 125 billion was spent on health in 2011 in the Region, which constitutes 1.8% of the total world health expenditure for approximately 8.7% of the world population. This discrepancy is explained by the fact that almost 40% of regional expenditure is out-of-pocket [12]. The share of out-of-pocket expenses is an undesirable and inequitable aspect of the private health sector in the Region; Group 3 countries spend 32%–79% out-of-pocket, Group 2 countries 19%–58% and Group 1 countries 11%–18%. It is easy to see that the poorest countries pay the largest out-of-pocket expenses while the richest countries pay the least amount of out-of-pocket expenses. The trend in out-of-pocket spending over the last decades has seen a decrease for rich Group 1 countries from 21% to 17%. Group 2 countries have fluctuated around 50%, and Group 3 countries have increased from 59% to 69%, further highlighting the issue of inequity. Although precise information is not available on the nature of the expenditure, there is evidence to suggest that a significant proportion is expended on medicines and diagnostic tests, followed by private consultations in the private health sector.

A few equity studies [13] conducted in selected Group 2 countries have shown that almost 5% of households face financial ruin following ill health (4.5% in Tunisia in 2005) and that a significant number of households are pushed into poverty (1.1% in Islamic Republic of Iran in 2002 and 1.4% in Morocco in 2001) due to high out-of-pocket expenditures. Vulnerable groups, particularly the poor, face even higher risk of financial ruin (Figure 1) [14]. Table 3 provides detailed data on total private health expenditure, out-of-pocket expenditure and rates of private health insurance in all countries of the Region during 2011.

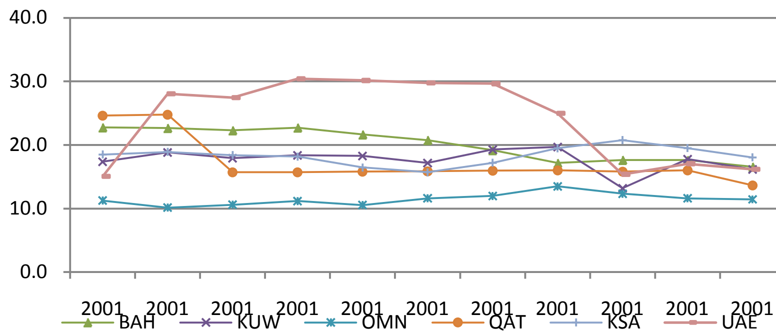

Figure 1a. Trends in share of out-of-pocket spending for Group 1 countries

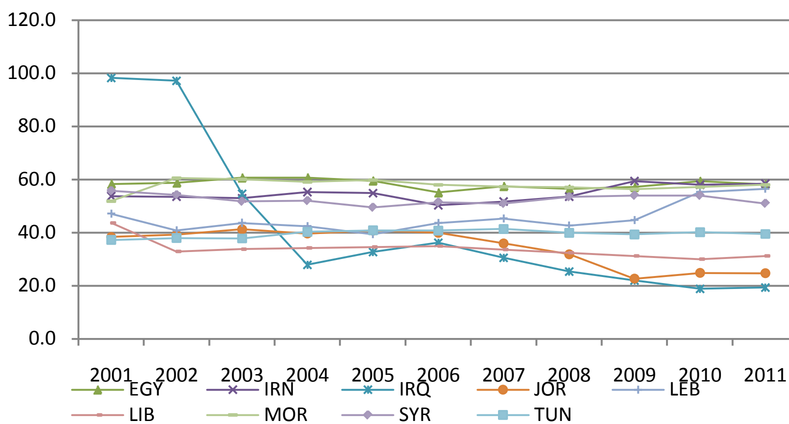

Figure 1b. Trends in share of out-of-pocket spending for Group 2 countries

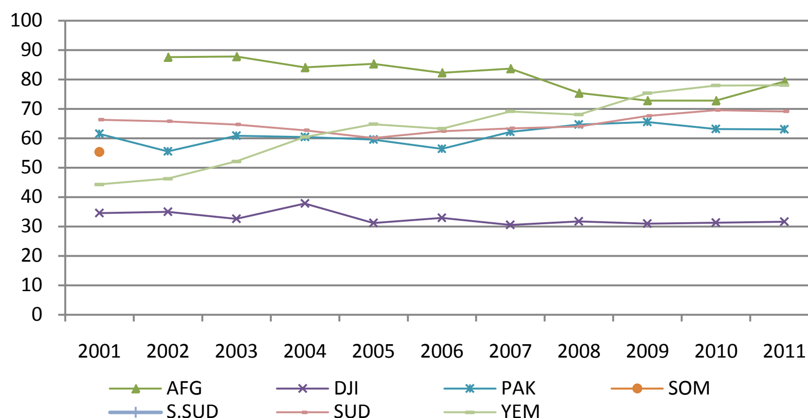

Figure 1c. Trends in share of out-of-pocket spending for Group 3 countries

Service provision in the private health sector

The proportion of private sector outpatient services ranges from 33% to 86%. The percentage of private sector services used by the poorest quintile ranges between 11% and 81% based on up-to-date data from ministries of health in Group 2 and 3 countries [15]. Generally, the role of the private health sector is not well defined, its capacities are poorly understood, information is lacking and practices are generally not monitored. The range of services provided is variable, and in many countries and standards are questionable, regulation is poor and there is insufficient information about the financial burden imposed on users of these services.

Private sector hospitals

The government is a major provider of hospital services in all Group 1 countries; however the private sector is growing. The density of hospital beds ranges between 12 and 21 per 10 000 in Group 1 countries. Of these the proportion of private hospital beds ranges from 6% to 22%, the highest being in Saudi Arabia. In countries such as Bahrain and United Arab Emirates, the number of private hospitals is higher but their size in terms of hospital beds is much smaller. A wide range of secondary and tertiary health services are delivered by the private sector that are similar to those found in the public sector.

The density of hospital beds in Group 2 countries ranges between 9.3 and 37 per 10 000 population. Of these there is a wide range among countries; between 7% and 83% of hospital beds are found in the private health sector. The highest is Lebanon, where the number of private hospitals is six times greater than that in the public sector. More than 80% of the total hospital beds in Lebanon are in the private health sector. The health system in Lebanon is characterized by an oversupply of private hospital beds [16]. In Group 3 countries, the density of hospital beds ranges between 3.9 and 7.3 per 10 000 population and the proportion of private hospital beds ranges between 8.5% and 22%. For instance in Sudan 8% of the hospital beds are in the private sector. In poorer countries the public sector remains dominate in regard to hospital beds and long term care.

Private hospitals are concentrated in urban settings in all countries of the Region. Barring a few tertiary hospitals in the metropolitan cities, there is limited information available on the range of services offered, quality of care and the fees charged for such services.

Table 3. Private health sector expenditure in countries of the Region, 2011

Country	Total expenditure on health per capita at US$ exchange rate	Private expenditure on health as % of total health care expenditure	Out-of-pocket expenditure as % of private expenditure on health	Out-of-pocket expenditure as % of total health care expenditure	Private insurance as % of private expenditure on health	Private expenditure on health (US$ million)	Private insurance (US$ million)	Out of pocket expenditure (US$ million)	Non-profit institutions serving households (US$ million)
Group 1									
Bahrain	740	29	57	17	23	284	66	162	13
Kuwait	1 500	18	91	16	9	754	71	683	NA
Oman	598	19	60	11	23	327	74	195	NA
Qatar	1 776	21	64	14	24	710	173	453	4
Saudi Arabia	758	31	58	18	19	6 611	1 281	3 838	50
United Arab Emirates	1 640	26	63	16	27	3 314	906	2 094	314
Group 2									
Egypt	137	60	98	58	2	6 710	113	6 558	10
Islamic Republic of Iran	346	60	97	58	3	15 611	439	15 144	28
Iraq	332	19	100	19	NA	1 851	NA	1 851	NA
Jordan	392	32	77	25	18	801	145	613	12
Lebanon	622	74	76	56	20	1 974	397	1 496	9
Libya	398	31	100	31	NA	797	NA	797	NA
Morocco	186	66	88	58	12	3 939	459	3 479	NA
Syrian Arab Republic	101	51	100	51	NA	1 070	NA	1 070	NA

Table 3. Private health sector expenditure in countries of the Region, 2011 (*continued*)

Country	Total expenditure on health per capita at US$ exchange rate	Private expenditure on health as % of total health care expenditure	Out-of-pocket expenditure as % of private expenditure on health	Out-of-pocket expenditure as % of total health care expenditure	Private insurance as % of private expenditure on health	Private expenditure on health (US$ million)	Private insurance (US$ million)	Out of pocket expenditure (US$ million)	Non-profit institutions serving households (US$ million)
Group 3									
Afghanistan	56	84	94	79	NA	1 528	NA	1 436	89
Djibouti	105	32	99	32	1	30	<	30	NA
Pakistan	30	73	86	63	NA	3 832	12	3 308	NA
Somalia	NA	NA	NA	NA	NA	NA	NA	NA	NA
South Sudan	NA	NA	NA	NA	NA	196	7	186	3
Sudan	104	72	97	69	1	3 309	33	3 194	11
Yemen	88	79	99	78	1	1 733	22	1 710	NA

NA data not available

Table 4 provides an overview of the distribution of hospitals and hospital beds in the private and public sectors. In several Group 2 countries the number of private hospitals is greater than public hospitals. However, it is only in Lebanon that the number of hospital beds in the private sector is much higher.

Table 4. Distribution of private/public hospitals/beds in countries of the Region by group

Country	Hospitals		Hospital beds		Total	Percentage of private hospital beds	Hospital beds per 10 000 population
	Private	Public	Private	Public			
Group 1							
Bahrain	13	10	384	1 702	2 086	18	17
Kuwait	15	15	1 247	6 703	7 950	15	22
Oman[a]	10	55	360	5 499	5 859	6	16.7
Qatar	4	6		1694			12
Saudi Arabia	137	298	14 165	46 871	61 036	23	21.4
United Arab Emirates	33	54	2557	7 024	9 802	26	20
Group 2							
Egypt[a]	1 351	646	31 653	96 820	128 473	25	16
Islamic Republic of Iran[a]	170	682	17 323	114 232	131 555	13	17.5
Iraq[a]	231	96	2 886	40 182	43 068	7	13
Jordan[a]	61	45	4 041	8 065	12 106	33	18
Lebanon[a]	189	30	12 000	2 500	14 500	83	34.5
Libya	103	97	2 088	20 689	22 777	9	37
Morocco[a]	NA	141	7 973	21 734	29 707	27	9.3
Palestine[a]	33	40	1 174	5 183	6 357	18	15.2
Syrian Arab Republic	376	124	8 962	22 858	31 820	28	15.5
Tunisia[a]	116	174	3 400	19 632	23 032	15	23.0
Group 3							
Afghanistan[a]	NA	126	NA	10 132			3.9
Djibouti[a]	2	11	105	364	469	22	5.8
Pakistan[a]	692	972	20 000	108 137	128 137	16	6
Somalia[a]	NA	NA	NA	NA			NA
Sudan[a]	170	416	2 607	27 855	30 462	9	7.3
South Sudan				1200			
Yemen[a]	175	239	NA	16 095			7.1

[a] Data confirmed by WHO country office or Ministry of Health

Private clinics and primary care

Despite gaps in information, ambulatory services in the private health sector mainly provide outpatient treatment care, diagnostic services, rehabilitation and in some polyclinics inpatient treatment.

The proportion of private clinics in Group 1 countries ranges from 15%–88%. Based on information available, United Arab Emirates has over 2000 private clinics and care centres. Concerns have been raised of the high price of the services offered at these clinics in the general press and the ministry of health has formulated policies to curb this trend.

In Group 2 countries, the proportion of private clinics varies from 5% to 78%. In the case of Egypt there are over 50 000 private clinics, and this poses a huge challenge for any government to bring them under a regulatory regime. Some facilities provide high-tech diagnostic and therapeutic services and cater to the high end of the expatriate population.

The percentage of private primary care clinics varies between 20% and 90% within Group 3 countries. There are almost 75 000 private clinics in Pakistan alone which are unregulated. In Sudan the private health sector has greatly expanded, particularly in urban cities and high-income rural areas. Problematically, the type and magnitude of private services is unknown. There is anecdotal evidence that the focus is on curative services with some preventive services and interventions. A 1997 study estimated that 90% of all curative care in Somalia was provided by the private health sector and that 75% of the population used private primary health centres [17]. The situation in all Group 3 countries is similar: there is scant information on quality of health care and fees for services. In general, private care providers are reluctant to invest in preventive care or in remote and/or impoverished areas.

The absence of regulatory systems and formal mechanisms to monitor the quality of health care are among the greatest challenges governments face. Although the quality of health care provided by the private health sector is considered by the population to be better than the public sector, there is limited evidence to support this perception. There are tremendous gaps in information regarding the range, quality and cost of services within the private health sector.

Table 5 below provides disaggregated data on public and private clinics and centres, pharmacies and diagnostic facilities within the three Regional country groups.

Table 5. Public and private: primary health care clinics centres, pharmacies and diagnostic facilities

Country	Primary health care clinics and centres		Pharmacies		Diagnostic facilities	
	Private	Public	Private	Public	Private	Public
Group 1						
Bahrain	179 (88%)	24	101 (78%)	29	22(43%)	29
Kuwait	272 (75%)	92	374	100	99	147
Oman[a]	922 (79%)	232	422 (59%)	287	NA	NA
Qatar[a]		21				21
Saudi Arabia	364 (15%)	2 037	2 281 (27%)	6022	73 (89%)	9 (only laboratories)
United Arab Emirates	2 057 (89%)	243	1 329 (93%)	111		

Country	Primary health care clinics and centres		Pharmacies		Diagnostic facilities	
	Private	Public	Private	Public	Private	Public
Group 2						
Egypt[a]	51 484 (78%)	4 937	61 522 (97%)	1 852	NA	NA
Islamic Republic of Iran[a]	1 576 (5%)	27 007	8 141 (91%)	836	4 243 (52%)	3 840
Iraq[a]	NA	2441	NA	NA	NA	NA
Jordan[a]	4 000 (78%)	1119	2 090 (65%)	1 111	365	NA
Lebanon[a]	768 (82%)	170	2679 (99%)	28	1 114 [18]	90
Libya	415 (23%)	1372	1 934 (58%)	1 372	311	
Morocco[a]	319 (10%)	2689	7 257	NA	NA	NA
Palestine[a]	251 (29%)	629	650 (79%)	171		282
Syrian Arab Republic	107 (5%)	1791				
Tunisia[a]	6 273 (75%)	2083	1 942	NA	214	NA
Group 3						
Afghanistan	12 200	NA	12 000 (98%)	200	NA	NA
Djibouti[a]	13 (19%)	56	13 (22%)	46	5 (22%)	18
Pakistan[a]	73 650 (92%)	5941	40 000 (73%)	15 000	2 400 (60%)	1 600
Somalia[a]	NA	NA	NA	NA	NA	NA
Sudan[a]	691 (27%)	1 900	2 407 (96%)	107	1 317 (61%)	843
South Sudan		1 440				
Yemen[a]	695 (45%)	852	3 315	NA	1 265	NA

[a] Data confirmed by WHO country office or Ministry of Health
NA data not available

Pharmacies and diagnostic facilities services

Approximately 60% of all pharmacies in countries of the Region are in the private sector. Group 1 countries range from 27% to 90% of pharmacies in the private health sector while Group 2 countries range from 60% to nearly 100%. In Egypt there are more than 60 000 pharmacies in the private sector, which poses a major regulatory challenge. The situation is similar in Group 3 countries where 22% to 98% of pharmacies are in the private health sector. In Pakistan alone there are more than 40 000 pharmacies in the private sector, essentially unregulated.

There is anecdotal evidence that a high level of irrational prescriptions leads to the development of bacterial resistance antibiotics, ineffective treatment, adverse effects of drugs, drug dependence, risk of transmission of infection and economic burden to the patient and the society. In many countries pharmacies are not managed by qualified personnel and where they are, the boundaries between dispensing physicians and prescribing pharmacists seem is often vague [**Error! Bookmark not efined.**10]

There are major data gaps on private diagnostic and laboratory services in countries of the Region. In the Islamic Republic of Iran, Pakistan, Saudi Arabia and Sudan more than 50% of the diagnostic facilities are in the private health sector. Such facilities provide routine and tertiary diagnostics including: computed tomography, magnetic resonance imaging and more. With the exception of certain high-tech diagnostic facilities in large cities, quality of health care is a major concern. The high cost of these services can also pose a major financial burden to the consumer.

Health workforce in the private sector

Major challenges related to the private health sector health workforce include: duality of practice between public and private sectors and the complexity of accurate reporting as a result; concentration of workforce in urban areas; rapid and unregulated expansion of health professional training institutions in private sector institutions; and lack of proper accreditation and national standards for health professionals' education.

The exceptions are Jordan and the GCC countries where public sector employees are not permitted by law to work in private practice. The Islamic Republic of Iran has some regulation in this regard. Iranian physicians are not allowed to practise in the private sector for the first five years following medical school training. The real problem lies with most of the Group 2 and 3 countries where physicians frequently work in both the private and public sectors.

Despite gaps in information Table 5 below provides information on the distribution of physicians and nurses in the public and private sectors.

In Bahrain and Oman the proportion of physicians and nurses is higher in the public sector, while the reverse is true in Saudi Arabia and United Arab Emirates. Both of the latter countries have demonstrated an increasing trend towards privatization. From 2007 to 2011 Saudi Arabia increased the number of physicians in both the public and private sectors. For other health professionals the trend has been higher. The United Arab Emirates is the only country that has managed to collect detailed data which disaggregates not only public and private practitioners but also by medical specialty and by geographic location.

Workforce data on Group 2 countries is very limited. Lebanon has an inordinately high proportion of its workforce in the private health sector, yet the exact statistics are unknown. Despite a strong public sector in Jordan, 60% of physicians, 98% of dentists, 93% of pharmacists and 40 % of nurses work in the private health sector. They cover approximately 3000 clinics, 48 general hospitals, 8 specialized hospitals with 3600 hospital beds and 1666 pharmacies. In Egypt there is anecdotal evidence that most physicians engage in private practice after fulfilling their morning duties in the public sector [19]. As well, the Egyptian National Health Care Provider Survey (Ministry of Health and Population/Data for Decision Making) found that 89% of physicians in the sample followed multiple jobs [19]. Despite low remuneration in the public sector, incentives do exist for physicians including job security, access to postgraduate training, use of hospital facilities, retirement benefits and prestige. Physicians can refer patients from the public sector to their private practice, using the government sector as a quasi-recruiting resource.

Many Group 3 countries have a severe workforce shortage in both the public and private sectors. In Pakistan, twice as many physicians work in the private sector alone. The majority of public sector physicians also work in the private health sector in the afternoons. Physicians can be contracted with several private hospitals without any limitation. Table 6 below shows disaggregated data on the public and private workforce in countries of the Region.

Table 6. Workforce: public–private disaggregated data

Country	Workforce per 10 000 population			
	Private sector		Public sector	
	Physicians	Nurses	Physicians	Nurses
Group 1				
Bahrain[a]	8.3	10.3	12.4	31.1
Kuwait	6	12	20	44
Oman[b]	4.0	5.3	14.0	35.2
Qatar[c]	NA	NA	2.2	4.6
Saudi Arabia[b]	16.4	38.1	7.7	9.7
United Arab Emirates[a]	15	17	10	30
Group 2				
Egypt[b]	NA	NA	8.0	14.2
Iran[b]	NA	NA	4.7	16.6
Iraq[b]	NA	NA	7.8	14.9
Jordan[b]	16.5	20.2	10.6	26.4
Lebanon[d]	32.9	20.1	3.6	6.1
Libya[a]	NA	NA	20	6
Morocco[b]	2.5	NA	3.7	9.0
Palestine[b]	12	8.6	7.7	8.8
Syrian Arab Republic[a]	NA	NA	16	15
Tunisia[b]	NA	NA	12.3	32.5
Afghanistan[b]	NA	NA	2.54	3.23
Group 3				
Djibouti[b]	0.3	0.5	1.7	4.9
Pakistan[b]	19	1.9	7.8	2.9
Somalia[b]	0.1	0.3	0.1	0.4
Sudan[b]	NA	NA	4.1	5.1
South Sudan	NA	NA	NA	NA
Yemen[b]	2.8	5.5	3	7.2

[a] Country health system profile. Draft document 2010
[b] Data confirmed by WHO country office
[c] Ministry of Health data
[d] Based on the total registered physicians and nurses from syndicate databases until end 2012. There were registered until end 2012, 14 971 medical doctors, of whom 1490 were in public practice, and 10 731 nurses, of whom 2500 were in public practice.

Most countries of the Region have little reliable data with regard to workforce distribution, salary structure and multiple job holding. Ambulatory and primary care is often delivered by physicians working independently or in partnership with other physicians and/or other health care professionals. Physicians work under different scenarios: self-employment or contractual and are paid either by fee-for-service, capitation or salary. The issue of dual employment or "moonlighting," can result in competition between the public and private sectors for services and staffing. In general the dual employment of medical staff in many countries of the Region has negatively affected the health sector. Public health care employees build time and collateral towards public pensions while referring patients to their private clinics, where they are unregulated and can charge higher fees for service.

Private medical and allied institutions

Accreditation and regulation of the health care workforce and private health educational institutions are often not enforced, particularly in Group 2 and 3 countries. In Saudi Arabia, the accreditation of higher education institutes began with the establishment of a National Commission for Academic Assessment and Accreditation in 2005 [20]. In other countries ministries of health and higher education oversee medical schools and all other health educational programmes. Most of Group 1 countries have modelled private medical schools and other health educational programmes after international schools and standards.

Table 7 below shows the number of private and governmental medical schools in 14 countries of the Region. Roughly 50% are private medical schools. Jordan, Morocco and Tunisia each have four public medical schools and no private medical schools. Similarly, in Iraq there are 18 public medical schools and none in the private sector. The number of medical schools has rapidly increased over the past three decades. If the future is not carefully planned there may eventually be issues related to quantity versus quality of medical training.

The challenges related to medical and nursing education are common to all countries of the Region. Despite progress made in updating medical and nursing curricula in some selected institutions, the vast majority of schools still follow programmes which, by and large, have not evolved and are not competency-based. Family medicine training programmes have been initiated in several countries, however their scope remains limited. The underlying factors include: lack of effective coordination between service providers, ministries of health and higher education institutions; limited institutional capacity to provide large-scale training for family physicians, as well as capacity to retrain general practitioners into family physicians; and the inability to establish family medicine as an attractive career path for fresh graduates [21,22].

Table 7. Medical universities in selected countries of the Eastern Mediterranean Region

Country	Medical schools		Schools of pharmacy	
	Public	Private	Public	Private
Egypt [23]	19	2	12	10
Bahrain[a]	1	2	0	0
Islamic Republic of Iran[b]	48	17	–	–
Iraq[a]	18	0	20	7
Jordan[a]	4	0	2	6
Libya	8	1	8	0
Lebanon	1	5	1	4
Morocco	4	0	1	0
Pakistan	32	39	–	–
Saudi Arabia [20]	17	3	17	7
Syrian Arab Republic	5	3	3	6
Sudan[b]	15	11	7	9
Tunisia[a]	4	0	1	0
Yemen	6	1	3	11

[a] Ministry of Health data
[b] WHO country office data

Medicines and medical devices in the private health sector

Availability of medicines

Information on access to medicines is not readily available. Between 2004 and 2006 surveys on access to essential medicines were undertaken mainly by national ministry of health teams, or by a nongovernmental organization in the case of Pakistan or academic staff in Kuwait, in nine low- and middle-income countries. The surveys showed that the availability of core medicines varied considerably among countries and was generally lower in the public sector than in the private sector. Low- and middle-income countries face challenges due to insufficient government financial resources to purchase essential medicines for the public sector; limited stocks of essential medicines in the public pharmaceutical supply system and health facilities; and inequitable access to safe, quality-assured essential medicines [2].

Pricing of medicines

Price surveys undertaken by WHO and ministries of health in some countries of the Region showed that public procurement prices for generic medicines were acceptable; although there was a substantial variation found in prices for the same generic medicines between countries.

Public sector ratios of local medicine prices to international reference prices for original brand pharmaceuticals were excessively high in the 10 countries surveyed. The majority of these countries reported price ratios that were five times higher than the international reference prices [24]. In most of the surveyed countries there are no clear criteria for selecting essential medicines or a National

Essential Medicines List is not in place or used, nor are guidelines for limiting the numbers of registered medicines and health technologies.

Irrational prescribing of medicines

Over-the-counter dispensing and sale of antibiotics without a prescription is common practice in the Region and is a major concern. This is mainly caused by weak medicine regulatory systems in place, no medicine regulatory enforcement or penalties exercised and insufficient patient information and education on the potential negative impact of antibiotic misuse. There is limited governmental control on medicine promotion and advertisement which influence the use of medicines offered by the private health sector.

Despite the introduction of computerized patient profiles in Jordan in 2000, rules and regulations concerning dispensing of medicines are often violated, and most medicines are sold over-the-counter without a prescription. In many cases the Ministry of Health's role in regulating medicines and technologies is practically absent. In Lebanon drug expenditures as a percentage of total health expenditure is very high. Uncontrolled price increases on pharmaceuticals and a high fixed profit margin (43%) triggered the government to initiate a new law that incorporates a sliding scale for drug prices. This law cut down the price of medicines by almost 25%.

Medical devices

Low- and middle-income countries import up to 95% of all health technologies. Unfortunately many are used irrationally or suboptimally because of insufficient experience and training in the health workforce. Irrational use can lead to high out-of-pocket expenditure, technical misuse and medical errors associated with health technologies. These are major concerns in high-income countries as well as low- and middle-income countries [24]. Analysis of reports from 12 countries shows that the private sector should play an important role in providing and managing these important technical resources. The results of the study are grouped as follows.

Lack of efficient regulatory bodies

Regulatory bodies are responsible for oversight of the growth of the private sector, licensing facilities and medical products (drugs, vaccines, diagnostics and devices) and monitoring performance in regard to quality and safety of medical devices. Most Group 1 countries have established bodies which are responsible for regulating, pricing and quality control covering all health technologies and medical devices in both the public and private sectors. In general, there are no legal restrictions on the purchase of medical equipment and supplies within the private sector. In most Group 2 and 3 countries private sector regulation is either weak or absent. Lebanon is an exception. The Ministry of Public Health oversees hospital accreditation which is considered the tool for regulating quality and costs. Sudan has rules and regulations for the import and licensing of medical technology. Private facilities are required to send reports on a regular basis however there is a problem with compliance. Regulatory functions in Syrian Arab Republic are performed by the Ministry of Health and professional associations; however compliance by the private sector is low. The range of medical services offered by the private sector has significantly increased in Tunisia, Pakistan and Yemen, yet regulatory oversight by the government remains weak.

Investment in high-tech technology and rising costs

Private hospitals are introducing sophisticated marketing campaigns to attract patients. The focus of the campaigns is often on expensive high-tech technologies as an indicator of high quality services. Group 1 and 2 countries, driven by commercial incentives, are competing to invest in state-of-the-art technologies, with no regulatory systems in place nor certificate-of-need programmes. In Jordan 50% of

all medical technology is found in the private sector and is driven by the country's success in medical tourism. The private sector has invested heavily in high-tech imaging technology. The opposite is true in the public sector where funding agencies limit supply and use by controlling reimbursement of unnecessary procedures. Some Group 2 countries such as Egypt do not have certificate of need policies for procurement of new technologies. Certificate-of-need policies do not exist in Group 3 countries, resulting in high country expenditure on medical devices.

Governance

Governance of the private sector depends on: government policy on the private sector; the existence of a regulatory system and its implementation; institutional capacity of the ministry of health; and experience with public–private partnerships and contractual arrangements. Regulation and enforcement of standards in the private sector are among the largest challenges faced by governments and ministries of health. Across the countries of the Region the level of governance and government policies varies considerably. Table 7 below provides an overview of the governance of the private health sector in countries of the Region, all of which are works in progress and will require regular updating.

Government policies on the private sector

Policies for engagement between the public and private health sectors are evolving in most countries of the Region. They are more developed in Group 1 and some Group 2 countries. In general, policies favour the establishment of a private sector regulatory mechanism. In some countries, policies also encourage cooperation and partnership with the private sector to expand access and coverage. Countries that have had a strong history of highly centralized planning and public sector dominance such as Syrian Arab Republic, and to a certain extent Iraq and Tunisia, are still framing policies for the private health sector. Those that have a longer experience of engaging with the private sector such as Lebanon and Jordan have better developed policies and procedures. Among Group 3 countries the policy as well as commitment to regulate the private sector varies from weak to nonexistent. On the other hand some countries such as Afghanistan and Pakistan have well defined policies and already partner with the not-for-profit private sector through contracting out of health services.

Existence of regulatory system and its implementation

Health regulatory systems cover workforce, facilities and services. Regulation should be equally applicable to the public and private sectors. More specifically, regulation of the health workforce should include licensing and registration, (re)certification, credentialing and professional privileges which delineates where and when the workforce can work legally. Regulation of facilities should include licensing and (re)accreditation. Service regulation should address quality, safety and cost. The present report concluded that comprehensive information on regulation is not available for most countries of the Region. The following section focuses on the capacity of existing institutions that are responsible for regulation of the private health sector in countries of the Region.

Ministries of health have assumed regulatory responsibility in most countries. The departments of health legislation and regulation (GCC countries and Morocco), directorate for private health sector (Afghanistan), directorate of quality assurance (Egypt), directorates of inspection (Tunisia and Morocco) or contracting units (Lebanon) have been assigned this responsibility. Pakistan has recently established a ministry of health services, regulation and coordination that focuses on improving the regulatory capacity. Throughout the Region there is substantial variation in the adequacy of the laws and regulations as well as level of enforcement. In Afghanistan and Somalia, some aspects of the regulatory function are missing entirely.

National health regulatory authorities, which function independent of ministries of health, has been established in some countries of the Region (Bahrain and Jordan). These are new initiatives and authorities have yet to fully assume their functions. Food and drugs should also fall under their mandate. Several countries are making efforts to establish and/or strengthen national drug regulatory authorities. Several models exist. Some authorities function under the ministry of health while others are independent. The Jordanian and Saudi food and drug administrations are independent of the ministries of health, similar to the US model.

Throughout the Region associations, syndicates and orders are set up to represent health care workers (physicians, nurses and other health professionals) as well as institutions (hospitals, clinics, diagnostic centres). Such associations are most well developed in Lebanon where they engage in self-regulation, however limited. Many associations have developed a code of ethics as means to enhance self-regulation. However adherence is limited, and there are no proper mechanisms for monitoring. This code exists in Egypt, Morocco, Pakistan, Islamic Republic of Iran and Sudan where some of these countries see themselves as forums for self-protection rather than promoting better health care. Little is known about the functions and potential influence of these bodies in improving health care.

Countries that have demonstrated commitment to strengthening regulatory capacity have met with some success. The Islamic Republic of Iran's Medical Council regulates the quantity and licensing of medical professionals and private medical practices. The Council oversees accreditation of all hospitals and medical facilities as well as the registration, licensing, pricing and quality control of facilities, medicines, laboratory materials, food products and nutritional supplements. The Lebanese Ministry of Public Health approves licenses to health facilities and health professionals and establishes quality standards. It does not, however, control the production, quality or the geographic distribution of the health workforce, which is severely imbalanced in favour of the cities. Jordan is more advanced in regard to public regulation of and cooperation with the private sector. The legal system is robust, and physicians and other healthcare personnel are held liable for malpractice. Private sector fees for physicians, laboratory work, X-rays and hospital services are regulated by the Ministry of Health. In Tunisia the Ministry of Public Health has adopted well defined legal and regulatory norms that have been updated and revised carefully. The licensing of health professionals is highly regulated by the Ministry of Public Health. Ambulatory, secondary and tertiary care facilities must conform to specific regulations. The installation of private pharmacies is restricted and defined by the needs of the population. Medical transport, centres of hydrotherapy, private clinics, imaging centres, radiology centres and medical laboratories are regulated through well defined criteria and norms.

Accreditation, quality and safety of private health care facilities

Health care accreditation is used as means for regulating the quality of care in many countries of the Region. Different models exist; some accreditation programmes are integrated within the ministry of health (Saudi Arabia, Egypt, Morocco), others are national accrediting bodies that function independently of the ministry of health (Jordan, Lebanon), and in many smaller GCC countries international accrediting bodies have been contracted to accredit health facilities. The accreditation programmes cover private and public hospitals and primary care facilities. There are some programmes in the Region that give accreditation to laboratories and other diagnostic services. Most have developed or adapted existing standards, there is however a substantial variation in their capacity to implement. Many hospitals are eager to be accredited in order to attract medical tourism.

Most Group 1 countries rely on international programmes for accreditation of health facilities. In Saudi Arabia the Central Board of Accreditation of Health Institutions officially regulates all hospitals. In 2008, 97% of all private health facilities were fully accredited in Saudi Arabia. In Group 2 countries health care

quality and safety is mainly regulated through initial licensing procedures that are mandatory before opening any health care institution. Licensure is done only once by the ministry of health and requires availability of the license but does not pay attention to quality of health care or health outcomes. Most health care accreditation initiatives in the Region are still in their infancy.

Experience with public–private partnerships and contractual arrangements

There is increasing commitment by the public sector to partner the private sector (both for-profit and not-for-profit) in most countries of the Region. The nature of partnership should be collaborative or contractual. The public sector is increasingly moving towards public–private partnerships with non-state actors to improve access, efficiency and quality of health care. A multi-country study [25] to review contracting in ten countries of the Region showed that Afghanistan, Egypt, Islamic Republic of Iran and Pakistan already have experience outsourcing for primary care services. Jordan, Lebanon and Tunisia have extensive contracts with hospitals and ambulatory care facilities, while Bahrain, Morocco and Syrian Arab Republic mainly outsource non-clinical services. While many countries promote public–private partnerships, the legal and bureaucratic prerequisites vary tremendously from country to country and with duration of experience. There are risks associated with setting up public–private partnerships which include reliance on donor funds, limited number of providers in rural areas, party-vested interests leading to irrational control over the contracting process, and poor monitoring and evaluation mechanisms. The study concluded that contracting provides the opportunity to have greater control over private providers in countries with poor regulatory capacity, and if used judiciously public–private partnerships can improve health system performance [25].

Many Group 1 countries and facilities contracted with international management companies to either fully or partially manage their hospitals. However, the increased private management expenditure and ongoing poor performance of some of those companies convinced the Saudi Arabia government to return to direct operation in some facilities. Throughout Group 1 countries, the maintenance and cleaning of health facilities and the full management operations of some hospitals are outsourced. All Group 1 countries offer many incentives to attract the private sector including interest-free long-term loans for the construction and operation of hospitals and clinics and pertinent support services.

Most Group 2 countries face challenges in outsourcing clinical services. In Egypt, the contractual arrangement model for providing the basic benefit package through a family health fund was not successful and has been discontinued. The Islamic Republic of Iran has experienced challenges due to underfunding, loose contractual structures, unfair fees, delayed payments and inconsistent Ministry of Health and Medical Education policies. In Jordan existing legal mandates and regulations give the Ministry of Health the required authority to form public–private partnerships which are now common. In Lebanon, the private sector dominates at all levels. Private providers, mainly hospitals, depend to a large extent on public funding through public–private partnerships. The Ministry of Health purchases private hospital services for its citizens at high cost. Primary health care services have been outsourced in several Group 3 countries (Afghanistan and Pakistan). Evaluation in Afghanistan has shown positive results, while in Pakistan the results are inconclusive. Table 8 gives an overview of all countries of the Region and their status as it pertains to private health sector governance issues; established policies and regulatory systems, institutional capacity and public-private partnerships that are intact or yet to be established.

Table 8. Overview of private health sector governance in countries of the Region

Country	Established policy on private health sector	Established regulatory system	Implementation of regulatory system	Institutional capacity of Ministry of Health	Public–private partnerships	Contractual laws for public–private partnerships
Group 1						
Bahrain	Some policies, not comprehensive	For providers and facilities, meets international standards	Satisfactory, no certificate of need, accreditation system in place	Ministry of Health, National Regulatory Authority	Nonclinical services, outsourcing of hospital beds	Laws are under revision
Kuwait	Well-developed policies	Meets international standards	Satisfactory	Ministry of Health	Nonclinical	Laws are in place
Oman	Some policies, not comprehensive	For providers and facilities	Satisfactory	Ministry of Health	Nonclinical	Laws are in place
Saudi Arabia	Well developed policies	Meets international standards	97% facilities fully accredited and regulated	Ministry of Health	Most nonclinical and some clinical	Laws and contracts are in place
United Arab Emirates	Well developed policies	Meets international standards	Satisfactory, accreditation system in place	Ministry of Health, health authorities	Most nonclinical and some clinical	Laws and contracts are in place
Group 2						
Egypt	No overarching policy, incentives for private health sector growth exist	No, General Department of Quality oversees accreditation	General Department of Quality unable to implement	Ministry of Health and Population, General Department of Quality	Mixed success with basic benefits package through family health fund	None yet, attempts at pilot projects
Islamic Republic of Iran	Established policies but not adhered to	Established system for quality of health care, licensing, hospital accreditation	Implementation varies and is not consistent	Iran Medical Council	Some clinical and nonclinical public–private partnerships	Some laws exist and are under revision
Iraq	Ministry of Health working on policy	Ministry of Health upgrading system	Ministry of Health unable to monitor and regulate	Ministry of Health, National Regulatory Authority	No data	No data
Jordan	National policies, legal mandates and regulations	National programme for accreditation and regulation	Licensing, code of ethics, quality of health care not followed	Ministry of Health	Some clinical and nonclinical public–private	Laws are in place but not comprehensive

Country	Established policy on private health sector	Established regulatory system	Implementation of regulatory system	Institutional capacity of Ministry of Health	Public–private partnerships	Contractual laws for public–private partnerships
					partnerships	
Lebanon	Strong policies in place but not comprehensive	System for quality of health care, licensing, fees, hospital accreditation	Satisfactory, accreditation system in place	Limited capacity	Ministry of Public Health purchases services from private sector	Laws are in place, need updating
Libya	No comprehensive policy	No data	No data	Ministry of Health	No data	No data
Morocco	Comprehensive policy in place	National programme for accreditation and regulation	Directorate of regulation and inspection, needs strengthening	Ministry of Health	Some clinical and nonclinical public–private partnerships in place	Laws are in place but not comprehensive
Tunisia	Well defined and updated policy	Well defined legal and regulatory norms	Satisfactory at all levels	Ministry of Public Health and affiliated departments	Many at all levels of private health sector	Laws and contracts are in place
Group 3						
Afghanistan	No comprehensive policy	Not developed	Limited capacity	Department of private sector in Ministry of Public Health	Outsourcing of primary health care services	Well developed contracting unit in Ministry of Public Health
Djibouti	No comprehensive policy	Not developed	Limited capacity	Ministry of Health	No data	No data
Pakistan	No comprehensive policy	Weak regulatory system	No licensing mechanism to practise medicine	Ministry of regulation recently established	Outsourcing of primary health care services to nongovernmental organizations	Weak to non-existent
Somalia	No comprehensive policy	No regulatory system in place	No oversight or implementation	Weak to absent	None	Not in place
Sudan	None yet, Ministry of Health working on new policies	Not well established	Weak implementation	Some capacity at federal level	Outsourcing of diagnostic services, not planned	Not updated
Yemen	No comprehensive policy	Limited capacity for regulation	None reported	Ministry of Health	Limited experience	Not updated

Challenges and gaps in relation to the private health sector

The rapid expansion and the increasing role of the private health sector in the countries of the Region is a fact that is recognized by all. How well the private sector can be harnessed to contribute to health system goals is a challenge that has not been adequately addressed. The foregoing analysis of the private health sector in the Eastern Mediterranean Region lends itself to the identification of the following challenges.

- There has been an irrational expansion of the private sector due to the poor image and reduced quality of care offered by the public health sector; absence of public facilities in underserved areas; urban migration and inability of the public sector to cope with the increasing population.
- Ministries of health lack the capacity to effectively engage with or regulate the private health sector in most countries of the Region. Legislation and regulation in relation to the private sector needs updating, and the capacity to enforce standards needs to be strengthened.
- Many ministries of health encourage partnership with the private health sector under different contractual arrangements; however the process needs to be open, competitive, and transparent with clear outcomes and deliverables.
- Regulatory bodies, that oversee the growth of the private sector, license facilities as well as medical products (drugs, vaccines, diagnostics and devices), and monitor performance are either not present or are not able to control the quality and safety of health services. In some countries the regulatory function is lacking in almost its entirety;
- Almost 40% of health spending in the Region is out-of-pocket, which can be as high as 75% in some Group 2 and 3 countries. Such expenditures are predominantly made in the private sector and are the cause of catastrophic health expenditure as well as impoverishment of individuals and households.
- Almost 5% of households face financial catastrophe following ill health. There is evidence to suggest that a significant proportion is incurred on medicines and diagnostic tests followed by consultations mostly in the private health sector.
- The use of private sector outpatient services in some countries ranges from 33% to 86%. Generally, the role of the private health sector is not well defined, its capacities are poorly understood, information is lacking, and practices are generally not monitored.
- Absence or weak regulation and insufficient formal mechanism to monitor the quality of health care service offered by private providers are among the major challenges. There are gaps in data/information regarding the range, quality and cost of services at private facilities.
- There is a high level of irrational pharmaceutical prescribing in private as well as public settings leading to development of bacterial resistance to antibiotics, ineffective treatment, adverse effects of drugs, drug dependence, risk of transmission of infection, and economic burden to the patient and the society.
- Over-the-counter dispensing and sale of antibiotics is largely due to lack of drug regulatory enforcement and/or lack of awareness among consumers. There is limited control exercised by the ministries of health on the promotion of medicines used in the private sector.
- In many countries private pharmacies are not managed by qualified personnel and where they are, the boundaries between dispensing physicians and prescribing pharmacists seem to get blurred.
- There are major gaps in information in the availability of diagnostic and laboratory services in the private sector. There are concerns about the quality of services offered. The high cost of these services can pose a major financial burden to the consumer.

- In low- and middle-income countries up to 95% of health technologies are imported, much of which are used irrationally or suboptimally due to insufficient experience and training of practising health workers. Irrational use can lead to escalation of out-of-pocket expenditure.
- Workforce challenges in relation to the private health sector include: duality of practice between public and private sectors, concentration of workforce in urban areas, rapid and unregulated expansion of health professional training institutions in private sector institutions and lack of proper accreditation and national standards for health professionals' education.
- The majority of countries of the Region have little reliable data with regards to distribution, salary structure or multiple job holding. The issue of dual employment or "moonlighting," results in the private and public healthcare sectors somehow competing for services and staffing.
- The number of private medical schools in most countries of the Region is rapidly increasing and there are questions about quantity versus quality of medical training in these institutions.
- In many countries of the Region associations, syndicates and orders of physicians and other health professionals plus institutions such as hospitals and clinics exist in different forms. There is a major information gap as to the functions and potential influence of these bodies in improving health care.

Conclusions and next steps

- This is the first systematic effort at exploring the role of the private health sector and to assess its potential role towards universal health coverage in countries of the Region. The purpose is to raise the importance of the private health sector within the regional political agenda and build political will and commitment among policy-makers.
- Despite its unique nature and arguably being the first baseline study of the private health sector in the Eastern Mediterranean Region, this study has many limitations including gaps in data/information, reliance on secondary sources of information some of which need further verification, and the extended period of time over which this study was undertaken.
- This study has identified many challenges posed by the private health sector, if it is to play a mainstream role in achieving health system goals. These challenges are related to weak governance and regulation, inequitable financing, duality of workforce, inappropriate and irrational use of technologies, and lack of information on the quantity, quality, distribution, use and cost of care provided by private providers.
- The private health sector provides a unique opportunity for increased partnership, greater engagement and contribution towards public health goals. These opportunities have not been adequately explored by public sector policy-makers in most countries of the Region.
- There are many gaps in information, and there is no system to collect information from the private providers in most countries of the Region. There is thus a need for regular country level studies to bridge information gaps and acquire insights into specific aspects of the private sector.
- The WHO Regional Office for the Eastern Mediterranean has recently focused on acquiring in-depth information about the status of the regulation of private sector. In this regard two country studies have recently been completed in Yemen and Egypt.
- The next steps for future work should, as a priority, focus on securing better evidence and developing a regional strategy on the private health sector in countries of the Region. Eventually, the role and contribution of the private health sector should become better acknowledged at the country level, and the private sector should become integral to national planning processes.

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Little information is available on the role and contribution of the private health sector towards the achievement of public health goals in the Eastern Mediterranean Region. This report marks the first systematic effort to gather information about the private health sector in the Region and to assess the potential role of the private sector towards universal health coverage in countries. It aims to raise awareness among public health policy-makers on the potential contribution of the private health sector towards public health goals and to facilitate dialogue on the subject.

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