

Review

Delivery of health services in Arab countries: a review

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تقديم الخدمات الصحية في البلاد العربية: مراجعة

نبيل قرنفل

الخلاصة: تستعرض هذه الورقة المكونات الأساسية لُنُظْمِ إيتاء الرعاية الصحية في البلدان العربية وتطورها طيلة العقود الثلاثة المنصرمة. فلقد كان للتغيرات وللتحديات التي طرأت خلال النصف الثاني من القرن العشرين أثر كبير على النُظْمِ الصحية وعلى الحصائل الصحية. وقد أنشئت شبكات كافية من المستشفيات ومرافق الرعاية الصحية الأولية في معظم بلدان المنطقة العربية، كما كان للإسهام المتزايد للمجتمع المدني دور إيجابي على النُظْمِ الصحية، إلا أن التحدي الرئيسي يتمثل بالتحرك نحو اقتصاديات السوق؛ ففي العديد من الاقتصاديات النامية، جعلت الإصلاحات في الاقتصاد الكلي من الضروري في أغلب الأحيان تقليص الإنفاق في القطاع العام على القطاعات الاجتماعية. وتم تنفيذ سياسات التشارك بالتكاليف من أجل تعويض تضاؤل الموازنات الحكومية المخصصة للصحة. إلا أن ذلك لم يكن ليقفل من الإنجازات الاقتصادية التي تحققت في جميع البلدان، ولا من التحديات الهامة التي تم التعااطي معها.

ABSTRACT This paper reviews the essential components of health care delivery systems in Arab countries and their development over the past 3 decades. The changes and challenges which evolved during the last half of the 20th century have had a significant impact on health systems and on health outcomes. An adequate network of hospitals and primary health care facilities has been established in most Arab countries of the Region. The increased participation of civil society has impacted positively on health systems. However, the main challenge is represented by the move towards market economies. In many developing economies, macroeconomic reforms have often necessitated cuts in public spending on social sectors. Cost-sharing policies have been implemented in order to compensate for diminishing government budgets allocated to health. However, this is not to minimize the enormous strides that have been made in all countries nor the important challenges that need to be addressed.

Prestation de services de santé dans les pays arabes : revue

RÉSUMÉ Le présent article examine les composantes essentielles des systèmes de prestation de soins de santé dans les pays arabes et leur évolution au cours des trente dernières années. Les changements et les difficultés qui ont été observés pendant la dernière moitié du XX^e siècle ont eu un impact important sur les systèmes de santé et les résultats sanitaires. Un réseau adéquat d'hôpitaux et d'établissements de soins de santé primaires a été mis en place dans la plupart des pays de la région. La participation accrue de la société civile a eu une influence positive sur les systèmes de santé. Toutefois, l'évolution vers des économies de marché représente la principale difficulté. Dans de nombreuses économies en développement, les réformes macroéconomiques ont souvent nécessité des coupes dans les dépenses publiques pour les secteurs sociaux. Des politiques de partage des coûts ont été mises en place afin de compenser la baisse des budgets publics attribués à la santé. Toutefois, il ne s'agit pas de minimiser les très grandes avancées qui ont été réalisées dans tous les pays, ni les difficultés importantes qui doivent être surmontées.

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Introduction

This paper, the third in a series of five reviews [1–4], highlights developments that have occurred in the various components of the delivery of health services in the Arab region. Particular attention is paid to the increasing role of the private sector in the delivery of care, in treatment abroad (“medical tourism”), as well as to the various attempts at decentralization of health care management in order to increase the autonomy of health facilities.

Ambulatory care

Member states conduct programmes for health promotion and prevention via governmental health care centres, private clinics or hospitals. National screening programmes, often in cooperation with the private sector, aim to raise awareness and promote early detection of health problems. In the 1970s, the focus of mass public education campaigns was on issues related to child and maternal health, such as immunization, antenatal care, breastfeeding and, in many countries of the region, family planning [5]. With the general improvement of health indicators related to maternal and child health [6], the focus of health campaigns in the region has been shifting towards smoking cessation, obesity, healthier lifestyles, noncommunicable diseases, screening for breast, cervical, colon and prostate cancers, and, in some countries, to HIV/AIDS awareness and prevention [7].

Ministries of health are responsible for ensuring the provision of safe vaccines to a country, with absolute adherence to the cold chain. Immunization in this region is usually carried in government facilities such as dispensaries and health centres as well as in the physicians’ private offices. In some countries, such as Lebanon, the provision of personal services in health centres is

often undertaken through contractual agreements with the voluntary private sector, represented in nongovernmental organizations, municipalities and civil society organizations [8].

Government facilities also serve to provide medical care to all population age groups, especially children, mothers and the older population. The utilization of government health centres by populations is variable; in some countries, such as in Bahrain, registration of families with the primary health care system is the norm; in others, and in spite of excellent services, a far smaller proportion of the population utilizes the public sector facilities, with a clear preference for the clinics of private providers, despite the cost implications [9]. This preference exists even among low-income groups of the population, as it is often perceived that the quality of care is better in the private sector [9]. In addition, organizational barriers such as long waiting times in public clinics, the choice of the practitioner and the short length of client–provider interactions have been cited as reasons for the low attendance at public ambulatory facilities [10].

Utilization of ambulatory facilities varies not only between Arab countries but also within countries [10]. For example, in Egypt utilization rates were shown to vary significantly by income level and between urban and rural areas [10]. Individuals in urban areas had 4.48 outpatient visits per year compared with 2.75 visits in rural areas, while those in the highest income quintile had the highest number of visits (5.11 visits) compared with those in the lowest income quintile (2.32 visits). In Lebanon, the overall average number of ambulatory visits varied across age groups [9]. Whereas children under 5 years and those over 60 years of age made an average of 6.3 visits/person/year, children over 5 years and adolescent as well as adults less than 60 years made 2.9 and 3.4 visits respectively. In Saudi Arabia, manpower factors (choice of physician,

an Arabic-speaking health team and free services) have been shown to be the most important factors in the utilization of ambulatory facilities, while overcrowding and geographical location of the primary health care centres, particularly location near public services, were the least important factors [11]. Patients’ sex, education and occupation were the most important, and age was the least important, of the patients’ characteristics associated with utilization [12]. In Gaza, Palestine, enabling factors for utilization of primary health care included older adults, higher level of income, low health status and current smoking habit [13].

Acute hospital care

Hospitals account for 40%–70% of the national health budget in most Arab countries [14]. Hospitals dominate health systems and provide concrete and visible health achievements for the public and for policy-makers in most countries. Moreover, hospitals are labour-intensive and employ half the physicians and two-thirds of the nurses in the region [14]. In most Arab countries, government-owned hospitals are the reference places for service excellence, tertiary care, training of human resources and research [14].

The period 1970–95 witnessed an impressive construction programme of public hospitals and health centres in all countries of the Arab region, in the process improving the availability of health care to a far larger proportion of the population, nearing 100% in all countries, except for countries in conflict [15] (Table 1). In an effort to improve managerial practices and promote the efficiency of hospital operations, several countries have adopted policies to promote the autonomy of public hospitals. Although the legislative arrangements differ, the intent was to promote community involvement and decrease the centrality of decision-making. Models

Table 1 Density of health care facilities in Arab countries of the Eastern Mediterranean Region, 2005

Country	No. of facilities per 10 000 population		
	Hospital beds	PHC units	% population with access to health care
Bahrain	27.4	0.3	100
Djibouti	16.1	0.6	80
Egypt	22.0	2.2	100
Iraq	13.0	0.4	97
Jordan	19.0	2.4	99
Kuwait	19.0	0.4	100
Lebanon	36.0	-	98
Libya	37.0	2.3	100
Morocco	8.7	0.9	85
Oman	21.0	3.7	97
Palestine	13.4	1.7	100
Qatar	25.2	2.7	100
Saudi Arabia	23.0	0.8	-
Somalia	-	-	72
Sudan	7.3	1.4	66
Syrian Arab Republic	14.7	0.9	95
Tunisia	19.8	2.1	95
UAE	18.8	4.0	100
Yemen	7.0	1.7	50

Source: Data retrieved from the Annual Reports of the Regional Director of the World Health Organization Regional Office for the Eastern Mediterranean. UAE = United Arab Emirates; PHC = primary health care; - = data not available.

for hospital autonomy have been in practice in Lebanon, Tunisia, Oman and lately in the Syrian Arab Republic [14].

The issue of quality assurance has gained importance and is high on most reform agendas in the region. Ministries as well as private hospitals are striving to set norms and standards for quality health care, including systems of accreditation of health facilities and guidelines for quality assurance and improvement [16]. Lebanon has initiated its hospital accreditation programme in 2000. Three rounds of accreditation surveys had been completed by 2007 [17]. International accreditation organizations such as the United States Joint Commission International, the United Kingdom Quality Healthcare Advice, the Australian Council on Healthcare Standards International, the French Haute Autorité de Santé and Accreditation Canada (formerly the Canadian Council for Health Services Accreditation) have been active in

supporting countries' efforts to secure certification. The World Health Organization (WHO) Regional Office the Eastern Mediterranean (EMRO) has called for national systems to support the accreditation of hospitals as well as medical colleges [16]. Jordan's Health Care Accreditation Council and the Saudi Arabia National Accreditation scheme are examples of national systems of accreditation.

Efforts are also underway to establish accreditation standards for primary health care centres and diagnostic facilities. In the past few years, efforts to measure hospital performance have been introduced in Lebanon, Jordan and Oman, modelled to a large extent on the WHO Regional Office for Europe's Performance Assessment Tool for Quality Improvement in Hospitals (PATH) model [18]. Hospital management practices are among the top priorities of policy-makers in the region at the present time.

Long-term care and palliative care

Long-term care hospitals have existed for a century in most countries of the region. Although these facilities have not been given the same attention as acute hospitals, nevertheless they have progressed to serve the needs of the population. Many of these long-term facilities were originally sanatoria for the treatment of tuberculosis or institutions for patients with mental illnesses and special needs. The new outlook on mental illnesses has minimized this role. Many of these long-term institutions now serve as hospices for palliative care. Others have been transformed to support the very dependent older population that family caregivers find difficult to support in their activities of daily living. Some of these institutions continue to treat communicable diseases such as leprosy. The long-term institutions in the region are usually operated by voluntary, not-for-profit, charitable

religious associations with financial support from the ministry of health as well as donations from the community [19]. The government support is based on a flat daily rate per patient.

Emergency medical services

Emergency medical services are provided in most countries of the region through the major public hospitals. The pre-hospital phase has been delegated mainly to the police and civil defence organizations. In Lebanon, emergency services are provided by the Lebanese Red Cross through annual budget subsidies provided through the Ministry of Health budget. Lately, some private for-profit organizations have started to provide emergency care and respond to house calls in Lebanon [20].

Emergency services are essential to a properly functioning health care system. Road traffic accidents are increasing in frequency in the region [21]. Compared with other Organisation for Economic Co-operation and Development (OECD), countries such as the Netherlands, France and Germany, pre-hospital emergency services in the Arab region are not as effective nor as well developed [21]. It is believed that the non-availability of reimbursement for such services has served to inhibit the development of pre-hospital emergency phases. There have been efforts lately to support the further development of these services [20].

It should be noted, however, that a large proportion of visits to emergency departments in many countries are considered non-urgent and are treated by the public as walk-in clinics [22]. It is believed that social and cultural factors have encouraged the use of emergency departments due to limited opening hours of primary care facilities in many countries, and/or the problems of arranging for transportation and care of dependants [23].

Home care

House calls by general practitioners were very frequent in the earlier half of the 20th century in the Arab region. However, the rapid expansion of the populations in many cities, leading to traffic congestion, longer distances to travel to city suburbs and safety concerns, has contributed to a diminution in the provision of house calls [24]. Recently, however, there has been a revival of the practice of house calls by family physicians and by organizations providing emergency care. These organizations, such as the Ambulance Transport Services in Lebanon, are well equipped and staffed and can provide optimal care either at home or transport the patient to the emergency departments of hospitals [K. Ashkar. Presentation at the annual conference of the Lebanese Society for Family Physicians, Beirut, 2005].

However, demographic, epidemiological, social and cultural trends are changing traditional patterns of care in the region [25]. The next decades are likely to witness increasing rates of care-dependent older people who will need prolonged home care for disability. These changes in needs and social structure will require a different approach to the care of the older population. Home care could provide a sustainable approach to avoid the need for unnecessary acute or long-term institutionalization and maintain individuals in their home and community as long as possible.

Historically, home care provision has relied on informal care (primarily from the family) and this remains the predominant pattern of care in our region for the older population. Strong family bonds and the influence of religion still facilitate the tradition of respect towards parents, grandparents and the elderly in general during their later years. However, this is fast changing and family caregivers cannot be relied upon in the not-too-distant future, because of

the migration of younger members of the family, the increasing participation of women in the labour force and the higher level of education of women in general [25]. A study in Lebanon highlighted the problems that family caregivers face in the care of the dependent older population [26]. Home care is a labour-intensive activity that relies on a variety of providers to deliver clinical and social services in the home setting. These providers include nurses, therapists, social workers, dieticians and, to a lesser extent, physicians [27]. Improving the provision of professional care in the home setting would require nurses to increasingly work independently, to exercise independent judgement, to coordinate and manage care teams and to provide more sophisticated and advanced procedures [28]. In Lebanon, the past decade witnessed the formation of several agencies to deliver home care, staffed by well trained nurses and physiotherapists [28].

Dental care and oral health

The public sector in most countries of the Arab region offers dental care at primary care facilities. A growing awareness about the importance of dental care and oral health has been supported by advances in the dental sciences as well as by a marked increase in the number of dentists and dental assistants throughout the region [29]. In many countries, there is an appreciable delay in accessing dental care because of long waiting times [26]. Public sector services are usually limited to diagnosis and extraction.

The private sector has also witnessed impressive developments in dental care, especially in the dental subspecialties and reconstructive dentistry. Nevertheless, this development has been curtailed somewhat by the poor availability of insurance coverage for dental care. Dental care in the Arab region is mainly

financed through out-of-pocket payments that raise issues of inequity for the lower socioeconomic strata of the population [20].

Utilization of diagnostic technology

The introduction of advanced diagnostic technology has had a major impact on quality of care as well as on the cost of medical care across the world. The impact of technology in the past 2 decades has been phenomenal, leading to far more accurate diagnosis, screening and treatment. This has led, however, to a major increase in the cost of medical care, and to an explosion in the purchase of medical technology principally by hospitals and to a lesser extent by health centres [30].

When the public sector is the principal provider of medical services in the region, the introduction of expensive technology can be contained to a certain extent [31]. Many countries have opted for regional centres of excellence where patients are referred for complex diagnosis and treatment. However, in the private sector, the acquisition of modern technology has been adopted as the sign of quality care and advances in medical care. In Lebanon, for example, the

number of technologies per inhabitant exceeds that of many OECD countries belonging to the [31]. Private hospitals claim that patients need to have all the services under the same roof, lest patients are lost to rival institutions [20]. Needless to say, the acquisition of such technologies promotes over-utilization since health care is an imperfect market.

Utilization of pharmaceuticals

According to WHO, up to 100 million citizens of the Arab region lack regular access to essential medicines [32, 33]. Spending on pharmaceuticals makes up a major portion of total health expenditures [32] (Table 2). Apart from the cost of medicines, patterns of consumption raise many issues related to the inappropriate usage of antibiotics and psychotropic medications [34,35] and the preference for injectable drugs over oral preparations. This pattern appears to be on the decrease at present [36,37], but for many years in the last quarter of the 20th century patients would not accept treatment unless the administration was by injection [38,39].

Several countries in the region, most notably Tunisia, Morocco, Egypt, Syrian Arab Republic, Jordan and Saudi Arabia

have developed world-class factories for the manufacture of generic medications for use by their own populations as well as for export. Unfortunately, pharmaceutical production has been met by stiff competition from in-country and regional plants, instead of defining common strategies of production and marketing that would have benefited all producers [40,41].

Traditional medicine

Alternative medicine encompasses all forms of therapies that fall outside the mainstream of medical practice. There has been a paucity of studies on the utilization of traditional medicine or other forms of alternative care in the Arab region, although its existence is well recognized and its practice acknowledged. In a study in Saudi Arabia the Holy *Qu'ran* as a was the most frequently used form of alternative medicine (50.3%), followed by honey (40.1%), black seed (39.2%) and myrrh (35.4%) [42].

We can identify two types of usage: the first is based on traditional, folkloric remedies that have been transmitted from generation to generation; and a newer more sophisticated wave that actively markets herb-based medicines or other alternative treatments for financial

Table 2 Total pharmaceutical expenditure as a percentage of total health expenditures and as a percentage of gross domestic product (GDP) in selected Arab countries

Country, year	Total pharmaceutical expenditure	Total health expenditure	Pharmaceutical expenditure/ <i>per capita</i> health expenditure	Pharmaceutical expenditure/GDP
	US\$ million	US\$	%	%
Egypt, 2009	3559	43	34.2	1.89
Iraq, 2008	1617	50	36.8	2.46
Jordan, 2010	701	120	35.9	3.08
Sudan, 2010	1349	35	36.0	2.20
Syrian Arab Republic, 2010	621	29	36.0	1.11
Morocco, 2010	1440	45	27.8	1.58
Qatar, 2010	194	118	6.0	0.59
Saudi Arabia, 2010	3500	132	18.0	2.00
Tunisia, 2010	895	85	44.0	2.02

Source [32].

gain. The latter can be controversial because treatments may be promoted, especially via the mass media, without the need to secure authorization from the ministry of health, as is the practice with standard medications [20]. There are no scientific committees to review the composition and efficacy of these remedies.

Private health care sector

As was noted earlier, the public sector has been dominant in health care in most countries of the Arab region. However, within the context of health reforms, and with support from donor countries and international organizations (principally the World Bank), several countries such as Lebanon, Jordan, Morocco and others have envisioned a greater potential role for the private sector in health care provision in the hope of improving the cost-effectiveness, responsiveness, efficiency, quality and equity of care [43].

There is a need to define the private sector. A dichotomy exists between the voluntary not-for-profit charitable, religious organizations and the for-profit, proprietary private sector. Unfortunately, very little evidence is available on the comparative advantage of the public sector, and ideological differences often confuse the debate. Most countries rely on a mix of public and private sector stakeholders leading to a “melting of public-private boundaries” as observed by Saltman [44,45]. The private provision of care has in fact increased in social and home care recently.

The private sector has been an active partner in health development. In most countries, the proportion of office-based practitioners and dentists per population has been on the rise, as well as the number of private pharmacies [46]. Physicians’ fees and medications have been reimbursed through out-of-pocket payments that were, and

continue to be, dominant in the financing of health care in the region [47]. The voluntary not-for-profit organizations of civil society have been active in rural and low-income areas for a long time. Private providers capture a significant and growing share of the health care delivery system, even in less developed countries [48]. In a sample of 40 developing countries, an average of 55% of physicians worked in the private sector in conjunction with 28% of hospital beds [49].

The current interest in the role of the private sector has a new focus, however, namely handing over the management and operations of public facilities (mainly hospitals) to the private sector. In other words, the call is for the public sector to disengage from the direct provision of medical services and to focus instead on the governance and stewardship functions that only the state can exercise [49]. This of necessity must be accompanied by the direct disbursement of funds to the private sector to operate the public facilities as well as by consumer payments at the point of care. Insurance and third party funders would cover the cost of care through the collection of premium, capitation fees, deductibles and co-payments.

Understandably, this process has been met with some resistance from the public sector [50]. The public sector can claim that the basic problems it faces in the provision of services are related to salary scales and other civil service regulations. This will affect the capability of government to recruit high-level, experienced professionals to undertake the regulatory functions that are at the core of governance. In the same vein, the public sector cannot recruit the human resources necessary for planning, programming, cost analysis and budgeting. These deficiencies would by necessity lead to an unregulated private sector. In addition, the perception of greater privacy, speed of service and quality of care has not been demonstrated in developing countries [50]. Instead, tales abound

of regressive payments, poor quality of service and informal payments that impact on the essential role of the state to maintain equity in health care access and in payment.

This controversy has brought forward the notion of “buyability”. Governments should contract for goods and services that they can buy and focus instead on goods that are not buyable. Moreover, Lebanon and Jordan have had experience with buying services from the private sector; in this process, the private sector is supported without the need for the ministry to own a physical asset. The role of the ministry is thus to provide services not facilities [51].

There is a need for an effective, rational dialogue between the public and the private sectors to determine mutually beneficial partnerships. Attitudes towards the private sector are changing [52]. Policy-makers can no longer ignore private health providers. They should pursue options for working with the private sector in order to achieve each sector’s objectives.

It is now believed that health services with mixed delivery systems enabled by strong government funding have better performance [53]. However, privatization can only succeed in meeting society’s goals when the state exercises strong stewardship. Reforms that increase the role of the private sector in financing health care will increase expenditures, and systems that rely heavily on private finance for health care tend to be less progressive [54]. The increase in private finance need not lead to the evolution of the public sector into a “poor service for the poor” [50].

Treatment abroad

Treatment abroad is the phenomenon of people travelling to other countries for medical treatment. This may be motivated by high medical costs in the home country, prohibitions against certain treatments or even refusal of

doctors to perform a specific medical treatment. There may also be the desire to avoid long waiting lists for certain operations. Treatment abroad is not a new phenomenon in the Arab region; most countries sent complex medical cases abroad for treatment in the 1960s and 1970s, at a time when the health systems of many Arab countries were still rudimentary. Patients from the Gulf countries were sent to Beirut, Cairo, Paris, Germany and other cities for medical treatment. Beirut had the reputation of being the “hospital of the Orient” and continues to aspire to this role and reputation [S. Haroun, unpublished]. However, as Arab countries developed their health systems, especially at the tertiary level, the need to send patients for treatment abroad diminished, and only continued for the very wealthy and certain dignitaries. Then, starting in the late 1970s, the tables began to turn as Arab countries themselves realized that offering treatment for patients from other countries was financially beneficial and that there was a demand that could be met. Thus, several countries from the region such as Yemen, Algeria, Libya and Syrian Arab Republic started to send patients to Jordan for treatment [R. Hinnawi, T. Fardous, unpublished]. This was accomplished either through contractual arrangements between governments or third party payors or by private patients seeking better care and paying out-of-pocket. This has led to the establishment of several private hospitals in Amman to cater for this need, as well as to the repatriation of physicians from abroad. It is claimed that Jordan receives a greater revenue from health care (US\$ 1 billion in 2007) than it spends on its population (US\$ 650 million).

The term “medical tourism” has come to mean not only the treatment of patients in other countries, as described above, but also to indicate non-essential and elective treatments such as cosmetic surgery, spa treatments,

treatment for substance abuse and dermatological conditions such as hair transplantation. The entry of several Arab countries into the World Trade Organization has facilitated this development. In fact, the Ministry of Health in Jordan has been very supportive of medical tourism and has advocated and supported contracts with friendly countries to promote medical care in the country [R. Hinnawi, T. Fardous, unpublished].

The Deloitte Center for Health Tourism forecasts that “as more employers and health-insurance firms add the ‘global option’ into their plans, the number of American health tourists will soar to over 2 million in 2009—rising to 10 million by 2012” [55]. In 2007, over 400 000 international patients travelled to Singapore for a wide array of medical procedures, nearly half of them from the Middle East. Half a million foreign patients will travel to India for medical care in 2008, whereas in 2002 the number was only 150 000 [56]. According to a study by the Confederation of Indian Industry and McKinsey, medical tourism will bring \$2.2 billion in revenues for Indian hospitals by 2021 [57].

Meanwhile, in the Gulf countries, the Crown Prince Courts and the Rulers’ offices continue to send their citizens for care in Europe and the United States of America (USA). Some of the medical conditions are indeed serious and require more accomplished centres of excellence; other cases are not so serious. This is to be seen as one of the favours that the Court bestows on its citizens. The events following the 11 September 2001 terrorist attacks in the USA decreased the flow of patients to that country in favour of European destinations as well as to Thailand, Singapore and Malaysia.

Parallel to these developments, the United Arab Emirates (UAE) has taken measures to itself become an international centre for medical tourism, especially for thalassotherapy (treatment by the sun for skin

diseases) as well as for other medical conditions. A report by the Abu Dhabi Chamber of Commerce and Industry optimistically maintains that the UAE will gain approximately AED 7 billion (US\$ 1.9 billion) annually in medical tourism profits by 2010 [58]. High-profile projects such as Dubai Healthcare City show that times are changing. The project Chief Executive Dr Muhadditha Al Hashimi expressed the ambition for Dubai to become a medical hub just as it had become a hot-spot for tourism: “Usually anyone with the smallest health problem gets the next flight out. We want our patients back.” [Gulf News, March 2008].

The World Bank ranked Jordan number one in the Arab region and the fifth in the world as a medical tourism hub. Jordan’s medical tourism revenues in 2007 exceeded US\$1 billion. According to a study prepared by the Private Hospitals Association, over 250 000 patients from around 84 Arab and foreign countries were treated in Jordanian private hospitals, clinics and medical centres last year. Iraqi patients treated by Jordan’s private medical sector amounted to 45 000 in 2007, while Palestinians and Sudanese both comprised around 25 000 patients. The study also showed that more than 1800 US citizens, 1200 British citizens and 400 Canadian citizens sought medical treatment in Jordan last year. Hazaimah noted that treatment expenditures in Jordan were only 25% of the cost in the US, which included airline tickets and the patient’s stay in addition to site-seeing tours [59].

Decentralization of health services

Decentralization as a tactic for improving health care delivery was highlighted in 1986 by WHO within the district health system approach for Health for

All, following the Alma-Ata International Conference on Primary Health Care in 1978 [60]. Decentralization was predicted to achieve health goals through improved efficiency in service and financial allocations, as well as through increased accessibility and community participation leading to improved health status. It was also predicted that decentralization would improve quality, promote transparency, efficiency and accountability and hence lead to greater equity and legitimacy. From a political and social perspective, it was believed that decentralization would promote democratization, political stability and market freedom in health care worldwide [61]. It was argued that decentralization could be political, fiscal and administrative, leading to de-concentration, delegation, devolution and even to privatization [62]. Donor agencies and organizations to developing countries encouraged the process of decentralization as an effort to promote primary health care [63,64].

Decentralization in the Arab countries has been determined essentially for political reasons of government, with health and other ministries following suit. Arab countries are at different stages and levels of the decentralization process. Sudan adopted decentralization in 1993, mainly for political reasons. Lebanon called for decentralization in the Taif Agreement of 1990, following the civil war [65]. The UAE is constitutionally a federal state. Another example is Egypt, which realized that excessive centralization was inhibiting national development. "By building the appropriate policy and institutional frameworks, [it was felt] that decentralization should inject dynamism into social and economic development and create, at the local level, a form of governance which will be able to better respond to the demands for more efficient and better quality services, while making decision-makers more accountable to the people." [66].

The basic prerequisites for decentralization include a strong political commitment, a well-defined legislative framework, the mobilization of adequate resources and a strong community involvement [67]. The responsibilities of the ministry of health will evolve under decentralization to become principally the formulator of policies; setting norms, standards and protocols for service delivery; ensuring equitable allocation of resources; maintaining an effective management information system; assessment of health system performance; ascertaining quality assurance; regulating health care delivery (public and private sectors); and maintaining liaison with international health organizations and aid agencies.

In principle, decentralization can be a powerful instrument to improve health service delivery, but it can also pose significant risks and challenges that have to be carefully addressed if the potential benefits are to be realized. There is clear evidence that the issue is not whether or not to decentralize but rather how to design, implement and monitor better policies to achieve national health policy objectives [62].

Health delivery in conflict situations

The geopolitical situation of the Arab region is extremely challenging because so many countries are in a state of crisis or are emerging from conflict. These countries are currently experiencing emergency health situations due to military intervention and occupation, internal civil strife, political and economic tension and/or displacement and migration of large populations. Additionally, chronic emergencies and disasters (both manmade and natural) have had a dramatic impact on the livelihood and the health status of communities,

threatening their lives and disturbing their emotional and social well-being. In 2002, an estimated 250 000 persons in the WHO Eastern Mediterranean Region were killed or displaced by disaster or conflict. An estimated 90 million persons are currently living under difficult circumstances as a result of war, disaster and/or sanctions. Specifically, an estimated 12.7 million people have been displaced or have left their country of origin. The challenge is to sustain or improve the health status of vulnerable populations already living under exceptional circumstances as well as to deliver effective quality health humanitarian assistance to national authorities in the event of an emergency [67].

Summary

Governments have an important role in health development in the Arab region. 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 protect 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 should 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 implemented under strong leadership and governance from governments [31].

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