Regional review: Role of the private health sector in the provision of essential health services in the Eastern Mediterranean Region

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Scope and purpose

This report aims to assess the contribution of the private health sector to the provision of essential health services in the WHO Eastern Mediterranean Region. The report summarizes and consolidates the findings of six assessments of the contribution of the private health sector to: reproductive, maternal, newborn, child and adolescent health (RMNCAH); noncommunicable diseases (NCDs); mental health; communicable diseases and immunization; nutrition-specific interventions; and emergency care services. The objective is to provide a concise version of key assessment results for easier reference by decision-makers in the Eastern Mediterranean Region.

This assessment was done in recognition of the growing role of the private health sector in the Region and its potential contribution to universal health coverage. It is directed at policy-makers with the objective of providing information on the role of the private health sector in service provision and the challenges that hinder effective engagement with the sector towards achieving public health goals.

The private health sector is defined in the assessment studies as formal, for-profit health care providers. However, the study on the role of the private sector in nutrition-specific interventions is an exception. Here, our definition was expanded to include health and non-health sector actors, and for-profit and not-for-profit providers.

Acronyms and abbreviations

ANT	advanced nutrition transition
BCG	Bacillus Calmette-Guérin
ENT	early nutrition transition
EPI	Expanded Programme on Immunization
GCC	Gulf Cooperation Council
GINA	WHO Global database on the Implementation of Nutrition Action
IUD	intrauterine device
IYCF	infant and young children feeding practices
NCD	noncommunicable disease
NGO	nongovernmental organization
PHC	primary health care
PPM	public-private mix
PPP	public–private partnership
RMNCAH	reproductive, maternal, newborn, child and adolescent health
RTUF	ready-to-use therapeutic foods
SDGs	Sustainable Development Goals
SUN/CE	countries with significant undernutrition/countries in complex emergencies
TB	tuberculosis
UHC	universal health coverage
WHO	World Health Organization

Executive summary

The private health sector is estimated to be responsible for 53% of inpatient and 66% of outpatient care in the Eastern Mediterranean Region *(1)*. The role of the private health sector is, however, more predominant in low- and middle-income countries where the public sector is stretched.

WHO assessed the role of the private sector in provision of selected essential health services in the Region

Following resolution EM/RC65/R.3 requesting the WHO Regional Director for the Eastern Mediterranean to support assessments to identify challenges and opportunities related to the engagement of private care providers in service delivery the Regional Office conducted a series of assessment studies including one on the role of the private sector in the provision of selected essential health services – reproductive, maternal, newborn, child and adolescent health (RMNCAH), noncommunicable diseases (NCDs), mental health, communicable diseases and immunization, nutrition-specific interventions and emergency care services. The assessments were conducted by separate research teams under the guidance of the relevant technical departments at the Regional Office.

Apart from the data on mental health, which were extracted from WHO's Mental Health Atlas 2017 (MHA 2017), the individual studies were carried out in two phases. The first phase consisted of a desk review while the second phase included unstructured or semi-structured stakeholder interviews, depending on the identified information gaps from the first phase. Hence, some of the presented data are not linked with published resources. Nevertheless, the data presented in this report have been endorsed and validated by the ministries of health of the countries and territories within the scope of our assessment.

This report aims to summarize and consolidate the work of the research teams. The objective is to provide a concise version of key assessment results for easier reference by decision-makers in the Eastern Mediterranean Region.

A Governance

Across all the studied areas, the representation of the private health sector was minimal to non-existent in the development of clinical guidelines, standards and policies in most Member States. Moreover, where the sector was involved in policy-making, field reports indicate that the involvement was non-systematic, unstructured, and that little weight is usually given to the input of private sector representatives.

In countries and territories of the Region, the health ministry typically has the mandate and the responsibility to register, license and regulate private health care professionals and facilities. In Afghanistan, Djibouti, Egypt, Jordan, Morocco, occupied Palestine territory including east Jerusalem, Syrian Arab Republic and Sudan, the ministry requests private providers to have a license. The license is based on basic requirements for the facility, infrastructure, equipment and staff. There are no specifications for the quality of the services provided and no formal quality certification process exists. Reports pointed to variation in the comprehensiveness of the relevant laws and regulations in the Region as well as level of enforcement. The regulation of the sector remains a sensitive issue in almost all the low-income and lower middle-income countries. In Afghanistan and Somalia, some aspects of the regulatory function are entirely missing. Regulation of the private health sector was comparatively stronger in the upper middle-income and high-income countries such as Jordan and Oman. In these countries, a government department is mandated to implement and monitor the standards of care in the sector. Regulation of the private sector remains a major challenge due to limited resources, corruption, and lack of government accountability and transparency.

B Financing

The financing of private health services featured high out-of-pocket spending for all the studied areas with a few minor exceptions. Payment models for emergency care varied across the Region. In most countries and territories, the government-funded national health insurance scheme only covers public pre-hospital and facility-based emergency care. The sole exception to this is in cases where immediate life-saving treatment is required. There is, however, no clear delineation between patients in immediate need of saving versus those merely requiring urgent care. Examples of collaboration with the private sector in increasing the financial accessibility to some essential services were observed in Pakistan and Yemen through different financing mechanisms. Financing vouchers complemented by social franchising have been rolled out in Pakistan for about a decade to improve family planning practices. Those initiatives have reportedly resulted in a noticeable increase in the awareness and uptake of family planning methods.

C

Health information systems

Data-sharing between sectors was rarely reported, and evidence of routine communication and engagement was scant. A Regional Office background paper on private health sector engagement in advancing universal health coverage (UHC) reported poor sharing of data with ministries across the Region *(2)*.

Exchange of information is also specifically weak in some areas due to cultural, legal or religious reasons. A study conducted in Pakistan found that the private sector is particularly weak in maintaining records on abortion-related care. There is also a reported reluctance to share post-abortion complications data. The study further concluded that few hospitals and clinics have kept records about post-abortion complications, and that the information collected was patchy and incomplete *(3)*. Nonetheless, our interviews revealed that 20 for-profit hospitals in Sindh province share data regarding RMNCAH with the public sector and that the Pakistani private sector is bound to report child and maternal deaths, which may suggest variations in the robustness of health information systems across provinces.

Record retention varied from being totally absent in lower-tier facilities to being paper-based or electronic at secondary or tertiary hospitals. In facilities where data was captured, there was no standardized way of gathering, processing or analysing data to be shared with the relevant authorities for decision-making.

Systematic engagement in the surveillance of communicable diseases is also widely missing in the Region. NCD data-sharing ranges from very limited to full reporting. Nine countries of the Region have hospital-based diabetes registries (public and private), whereas five countries or territories, namely Iran (Islamic Republic of), Iraq, occupied Palestinian territory, Pakistan and Saudi Arabia, have other methods of data collection including clinic-based, primary health care (PHC) centre, private sector, or at-risk population-based information. However, it was noted that in some countries such as Pakistan, knowledge regarding data-sharing are scarce among private health care providers and accordingly, negligible data are shared by the private providers for NCD registries *(4)*. Private facilities in Morocco only share data and information with national population-based registries for cancer *(5)*. However, it is generally hospitals that maintain such registries rather than the primary health facilities. Finally, according to MHA 2017, only Egypt and Jordan have published specific reports focusing on mental health activities in both the public and private sector in the last two years.

D

Service provision

Despite the out-of-pocket cost, the private health sector is preferred by the majority of the Region's population. The high utilization rates are traced back to the unresponsiveness of the public sector, its long waiting times, difficulties in booking appointments and lack of provider choice. Frequently mentioned reasons for private health preference also included better hospitality, shorter waiting time, better laboratory and diagnostic facilities, improved nursing care and advanced infrastructure.

Being profit-driven, the private health sector is more inclined to engage in high-profit health care services. This manifests in the widespread involvement in curative rather than promotive or preventive services, in secondary rather than primary care, with an urban bias. The private sector also tends to avoid high-risk services such as emergency care.

In Egypt, Jordan and Pakistan the private sector predominates in the delivery of RMNCAH services. Rates of caesarean section are reportedly higher in the private sector. Private sector abortion services and post-abortion care are typically more developed. The sector is the major provider of contraceptive pills, condoms and contraceptive injections, whereas the public sector generally provides intrauterine devices (IUDs). The comprehensiveness of the provided services, utilization and their quality varied across the Region. Conversely, the involvement of the private sector in emergency care services is limited due to the associated high risk. Six of seven countries noted that ambulance dispatch systems were disjointed, with public and private organizations having separate dispatching. As for NCDs, private health care providers do serve as the first level of contact, especially among the rural population, with a limited role in health promotion and healthy lifestyle counselling. Screening for NCDs is not done by private PHC providers with few exceptions. It is also typically done at request rather than being a part of a standard protocol. More than 70% of countries and territories in the Region reported the availability of 13 basic technologies for the early detection, diagnosis, and monitoring of NCDs at private PHC centres *(6)*. In terms of immunization services, the private sector provides vaccinations in almost all countries, though the public sector is the main provider given that public trust in public immunization services is high.

Quality of services

The quality of care provided privately is generally considered to be superior to the public sector, especially in low-income countries. However, there is a dearth of robust data to support this perception and assess the quality of services compared to the public sector.

Lack of monitoring and evaluation, limited follow-up and lack of ongoing quality assessment remain challenges in both public and private health facilities

Health care accreditation is used as means for regulating the quality of care in many countries of the Region. However, accreditation is not a total quality improvement solution: it must be designed to meet specific objectives and be consistent with a comprehensive national strategy. Different accreditation models exist – some accreditation programmes are integrated within the health ministry (Egypt, Islamic Republic of Iran, Morocco, Saudi Arabia), others are national accrediting bodies that function independently of the ministry (Jordan, Lebanon), and in many smaller Gulf Cooperation Council (GCC) countries (Bahrain, Oman), international accrediting bodies have been contracted by the respective ministry to accredit health facilities. The accreditation programmes cover private and public hospitals along with primary care facilities. There is, however, varied capacity to implement those standards. Health facilities seek accreditation on a voluntarily basis and not as part of a formal process. Accreditation of private health care facilities is generally weak, especially at the primary health level except for most GCC countries where private health facilities are widely accredited. The larger tertiary care hospitals of the Region generally have national or international accreditation.

In 2015 a survey was conducted by WHO to review to what extent health care quality is institutionalized in the Region. The analysis indicated that, overall, national policy on quality in health care was explicit, accessible and consistent (80% of respondents) but that incentives for implementation and performance improvement were weak (40%) *(7)*. Our assessment reinforced these findings, with interviewed stakeholders (whose selection is explained in the methods section) indicating that despite the accreditation of many facilities, there is a lack of monitoring and evaluation. The limited follow-up and lack of ongoing quality assessment allow for error and corruption to occur. Examples of good practice, such as auditing and inspections, were noted. However, it seems that for the most part ongoing monitoring of quality is weak and requires improvement.

E

Challenges to PPP include lack of effective contracts, lack of guiding frameworks and widespread absence of dedicated teams within ministries of health

Intersectoral collaboration

Several examples of intersectoral collaboration and public-private partnership (PPP) have been reported in the Region. Intersectoral collaboration has been noted in mental health and nutrition-related interventions in particular. Meanwhile, PPPs spanned vertical programmes such as communicable diseases, NCDs and RMNCAH, as well as horizontal programmes concerned with health care delivery at the primary level. However, the lack of information regarding the successes and failures of different types of collaboration was particularly challenging and has restricted our ability to draw solid conclusions and deduce lessons learnt.

Among the oft-mentioned challenges with respect to PPP are the limited capacity of the governments to design effective contracts and develop guiding frameworks in addition to setting an evidence-based vision for PPPs based on the country context. There is a widespread absence of dedicated teams for PPPs within the ministries of health – with the exception of a handful of high-income countries such as Oman.

F

Conclusion

The threats to private sector engagement are mainly related to the lack of comprehensive regulatory policies and their poor enforcement, as well as the unequal power dynamic of the stakeholders involved. There are no clear legislative frameworks to govern and guide private sector engagement and to guard against PPPs overriding public sector policies. Accordingly, private sector engagement where it exists is generally non-systematic and in many cases does not consider marginalized communities. The involvement of the private sector in service provision is also sometimes perceived as a failure of the government in meeting its obligation to provide health care services to its citizens. This is further compounded by outdated legislation that is incompatible with PPPs. Furthermore, the lack of financial resources which are needed to put regulatory structures in place and to enforce regulatory measures is coupled with corruption in the public sector, affecting the regulation and accountability of the private health sector. The continuous exclusion of the sector from developing public health plans, standards, training and guidelines compromises the quality of care and opportunities for future collaboration. Prevailing dual practice by providers, such as public hospital doctors providing care privately out of hours, also presents a major conflict of interest. Finally, the misalignment in goals between the public and private sector presents a threat that needs to be considered in the various engagement mechanisms.

Despite the challenges, there are multiple opportunities for private sector engagement in the Region. Those opportunities are mainly driven by the political will to embrace UHC and the significance of the private sector in this regard. Both for-profit and not-for-profit private providers bring a unique set of skills and resources that can complement the public sector to improve access and outcomes, particularly for vulnerable, poor and rural communities. This has manifested in the health insurance laws legislated in many countries that call for the engagement of the private health sector. The political will to engage the sector is further reinforced by strong advocacy at the international, national and subnational levels to engage it in different areas. Moreover, the informal and/or indirect referral linkages between the public and private sector can be further strengthened to improve quality of services. There is also an opportunity to increase the quality of services at private health facilities by employing external health care commissions and accreditation bodies to enforce mechanisms that can improve adherence to existing mandates. Finally, COVID-19 has renewed the emphasis on multistakeholder engagement to meet population needs for emergency care and improve health status in the Region. The pandemic has also inspired many new initiatives by the private sector which can be leveraged and built upon. These include mental health support for individuals, families and health professionals.

1
Introduction

A

The probability of premature death due to NCDs is higher in the Eastern Mediterranean Region than in other WHO regions at

24%

South-East Asia

23%

Africa

22%

Europe

17%

Western Pacific

16%

Americas

15%

Burden of disease

The WHO Eastern Mediterranean Region suffers from a double burden of disease: the communicable diseases which are still rampant, and the noncommunicable diseases with annual death toll of 1.7 million. The four NCDs responsible for the most deaths are cardiovascular diseases, diabetes mellitus, cancers and chronic respiratory diseases. Over half of NCD deaths are premature, occurring before the age of 70, thus affecting economically productive individuals, impoverishing families, and placing a considerable burden on health systems and national economies. The probability of premature death due to NCDs is higher in the Eastern Mediterranean at 24% than in other WHO regions: the figure stands at 23% in South-East Asia, 22% in Africa, 17% in Europe, 16% in the Western Pacific and 15% in the Americas *(8)*. Future projections suggest that the four main NCDs will cause 2.4 million deaths in this Region in 2025 unless urgent action is taken. Moreover, the burden of mental illness in the Region is higher than global levels. The Global Burden of Disease Study 2015 estimated the burden of mental disorders in the Eastern Mediterranean at 4.7% of total disability-adjusted life-years, making it the ninth leading cause of disease burden. The study further revealed that the rates of mental disorders in half of the countries of the Region exceeded the predicted values *(9)*.

A grim picture is also painted of reproductive, maternal, newborn, child and adolescent health (RMNCAH) in the Region, with an average maternal mortality ratio of 164 per 100 000 live births and an under-5 mortality rate of 46 per 1000 live births, second only to the African Region *(10)*. The 2017 joint global monitoring report by WHO/World Bank Group on universal health coverage revealed that almost half of the Region's population does not have access to essential health services including services such as family planning, pregnancy and delivery care, child immunization and treatment *(11)*. Member States of the Region are signatories to the Sustainable Development Goals (SDGs) and aim to reduce maternal mortality ratio to less than 70 per 100 000 live births and under-5 child mortality rates to less than 25 per 1000 by 2030 *(12)*.

Low birth weight continues to be a very serious health issue

Sudan
Pakistan
Yemen

have prevalence of 30–40%

Djibouti
Egypt
Morocco
United Arab Emirates

are the only countries of the Region that have succeeded in meeting the global nutrition targets

Countries and territories of the Eastern Mediterranean Region have taken major actions to address nutritional challenges and to demonstrate their commitment to achieving the SDG nutrition targets by 2030. However, many are still well short of meeting the global nutrition targets of SDG 2 *(13)*. The double burden of malnutrition continues to be prominent in the Region. The regional prevalence of low birth weight is 19.31%, which is higher than the global average of 16% (excluding China) and more than double the reported prevalence in the United States of America and Europe. Low birth weight continues to be a very serious health issue in Pakistan, Sudan and Yemen with prevalence of 30–40%. Low birth weight is also an increasing issue in Lebanon, Oman, Somalia and the Syrian Arab Republic. The only four countries of the Region that have succeeded in meeting the global nutrition targets are Djibouti, Egypt, Morocco and the United Arab Emirates. The reported prevalence of exclusive breastfeeding in the Region stands at 29.3%, which indicates that countries are not observing WHO's infant feeding recommendations. In fact, many countries in the Region are experiencing a major drop in the prevalence of exclusive breastfeeding, namely Jordan, Lebanon, Morocco, Oman, Somalia, Sudan and Yemen. On the other hand, some countries appear to be moving in the right direction such as Egypt, Iran (Islamic Republic of), Iraq, occupied Palestinian territory and Pakistan *(14,15)*.

The Region also continues to experience a high burden of undernutrition among young children. The regional average of stunting, wasting and underweight exceeds the reported global average, indicating slow progress. The prevalence of anaemia has shown some improvement in countries that have implemented effective food fortification interventions, namely Jordan and Morocco. However, anaemia among children and women of reproductive age continues to be a major challenge in Djibouti, Oman and Sudan. Many countries are also facing a rapidly growing epidemic of childhood obesity. The estimated regional average for overweight and obesity among children aged less than five years exceeded the worldwide average by 2%. Childhood obesity has increased in many countries including Afghanistan, Islamic Republic of Iran, Kuwait, Libya, Oman, Pakistan, Qatar, Saudi Arabia and Tunisia, with the highest annual rates of increase being observed in Libya, Saudi Arabia and Tunisia. The same applies to adult obesity: the regional average was almost three times more than the worldwide average and is increasing over time. The highest levels of obesity were reported in Egypt, Kuwait, Libya, Qatar and United Arab Emirates *(15)*. These findings highlight the enormous differences in the nutritional status of children, women and men across the Region. Countries that are witnessing a fast rate of economic development and urbanization such as Kuwait, Saudi Arabia and United Arab Emirates have performed better than lower- and middle-income countries and countries in conflict.

B

The private health sector is rapidly expanding in the Region; however, the expansion has been guided by very limited national policy direction

Capacities are poorly understood

Services are not monitored

Largely unregulated and excluded from public health sector planning

The role of the private health sector

The private health sector consists of all health actors outside of government including for-profit, not-for-profit, formal and informal entities. This includes service providers, pharmacies and pharmaceutical companies, producers and suppliers, and traditional healers *(16)*.

The private health sector is very active and is rapidly expanding in the Region. However, the expansion has been guided by very limited national policy direction. Its capacities are poorly understood, services are not monitored and it is largely unregulated and excluded from public health sector planning *(17)*. The scale of the sector and its utilization are highly variable across the Region. It is estimated that the utilization of private outpatient services varies from 33% to 86%. The utilization of private health services by the poorest quantile ranges between 11% and 81% *(18)*. The sector is also heavily involved in infrastructure development and the production and supply of medicines and health technologies.

Given the dominance of private health sector in many aspects of health care services provision, WHO is increasingly recognizing the sector as a partner in achieving universal health coverage. This is to be achieved through the active and systematic involvement of the sector in health sector planning and health services administration. In October 2018, the 65th session of the Regional Committee for the Eastern Mediterranean endorsed the “Framework for action on effective engagement with the private health sector to expand service coverage for UHC”. The Regional Committee also adopted resolution EM/ RC65/R.3 urging Member States to “Contract with private health sector providers through strategic purchasing options and different financial protection arrangements to deliver a UHC priority benefits package”, and the Regional Director to “support assessments to identify challenges and opportunities related to the engagement of private care”. Based on this resolution, the Regional Office conducted a series of assessment studies including a survey of the role of the private sector in the provision of essential health services.

2

Methods

A

RMNCAH study

The RMNCAH study was carried out in sequential phases, starting with the formulation of a conceptual and analytical framework, followed by a desk review and stakeholder interviews from selected countries of the Region. The desk review employed two strategies to gather literature regarding the role and contribution of the for-profit private health sector in RMNCAH, as follows: a search of published articles using a systematic search strategy and methods (search engine: PubMed), then solicitation of documents from the WHO Regional Office and manual search for relevant reports.

B

NCD study

For the NCD study, we carried out a desk review to investigate the available literature regarding the role of the private health sector in combating NCDs at the PHC level in countries and territories of the Eastern Mediterranean Region. The review process employed three strategies: (1) published article search using systematic search strategy and methods on PubMed; (2) solicitation of documents from the WHO Regional Office, and (3) manual online literature search for relevant policy documents and reports. The desk review was followed by a virtual meeting between the research team and all WHO NCD focal points to gather data regarding the distribution and volume of services provided by the private health sector. Indicators to assess the quality of NCD care by private providers were also acquired. This phase was followed by stakeholder interviews to fill in the information gaps and gain further insights into the contribution of the private sector in combating NCDs.

C

Nutrition study

The study on the role of the private health sector in nutrition-specific interventions included two phases. In phase one of the project, secondary data collection was carried out through an extensive desk review of academic publications and specific reports on nutrition actions published by United Nations agencies. The WHO e-library of Evidence for Nutrition Actions (eLENA) and the WHO Global database on the Implementation of Nutrition Actions (GINA) were used to build the initial list of nutrition policies, strategies and actions developed within each of the countries. Phase two of data collection included a more in-depth analysis of the PPP qualities, characteristics, and lessons learnt, based on the experience of two countries in food fortification programmes: the Pakistan wheat flour fortification initiative and the Jordan salt iodization programme. Primary data collection in Jordan and Pakistan were based on a semi-structured interviews with key stakeholders.

1 **ANT countries**: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates
2 **ENT countries**: Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, occupied Palestinian territory and Tunisia and the West Bank
3 **SUN/CE countries**: Afghanistan, Djibouti, Gaza Strip, Iraq, Libya, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen

To enable comparison, countries and territories were divided into three categories using the WHO classification for stages of nutrition transition in the Region: advanced nutrition transition (ANT) countries;[1] early nutrition transition (ENT) countries;[2] and countries with significant undernutrition/countries in complex emergencies (SUN/CE)[3]. ANT countries are characterized by high prevalence of overweight and obesity and moderate prevalence of undernutrition and micronutrient deficiencies. ENT countries are characterized by moderate levels of overweight and obesity, moderate levels of undernutrition in specific population and age groups, and widespread micronutrient deficiencies. SUN/CE countries are either undergoing conflict or transitioning out of violence. The conflicts in these countries have left millions of people in dire need of humanitarian assistance. They have also depleted government resources, leading to dysfunctional economies and crumbling state infrastructure.

D

Emergency care study

Similarly, the study on the role of the private sector in the provision of emergency care services included two stages. First, a comprehensive literature review – including strategic and directed searches – was conducted. Data from two sources – a cross-sectional survey of key stakeholders and the existing seven countries' WHO Emergency Care System Assessment reports – were analysed to describe existing private sector engagement in emergency care in the Region. Qualitative methods were then employed to obtain the views and opinions of experts and local stakeholders as they relate to private sector participation and engagement in emergency care service provision.

E

Communicable diseases and immunization study

The study on the role of the private sector in communicable diseases and immunization was based on Pakistan as a case study for the Region. The study entailed extensive review of literature, and a total of ten policy experts were interviewed through structured questionnaires. The experts included key officials in the public health sector, owners and heads of private hospitals, and individual private health sector providers. In addition, interviews of private health care providers were conducted at the national and subnational level. Those included a sample of 30 randomly selected private health care providers. The respondents were split to cover preventive and curative health care services, through separate standardized questionnaires. Care was taken to ensure that they were private providers working specifically in the private health sector, and that those working involved in dual practice were excluded. Information was sought on their awareness of national policies, plans, norms, guidelines, standards, compliance and involvement of the private health sector in the development stage. Questions also covered key interventions for HIV, tuberculosis (TB), malaria, neglected tropical diseases and immunization delivered by the private health care providers, how they are financed, awareness of available guidelines and compliance, as well as reporting requirements and practices.

1 ANT countries: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates
2 ENT countries: Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, occupied Palestinian territory and Tunisia and the West Bank
3 SUN/CE countries: Afghanistan, Djibouti, Gaza Strip, Iraq, Libya, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen

F

Mental health study

Unlike the other studies, the data on mental health was derived solely from WHO's 2017 Mental Health Atlas (MHA 2017)[1]. Although it does not provide separate statistics on private sector involvement, it is regarded as an authoritative source on mental health policies, plans, financing, care delivery, human resources, medicines and information systems.

1 Mental health atlas 2017 – resources for mental health in the Eastern Mediterranean Region. Cairo: WHO Regional Office for the Eastern Mediterranean Region; 2019 (https://applications.emro.who.int/docs/EMROPUB_2019_2644_en.pdf?ua=1&ua=1).

3
Main findings

3.1 Private health sector governance

Private health sector-related laws and regulation

There is substantial variation in the comprehensiveness of laws and regulation related to the private health sector and level of enforcement across the Region. The regulation of private health providers remains a crucial issue in almost all the developing countries. In Afghanistan and Somalia, some aspects of regulatory function are entirely missing *(19)*.

Ministries of health in the Region typically have the mandate to register, license and regulate the private health care professionals and facilities of their national territory. In Afghanistan, Egypt, Djibouti, Jordan, Morocco, occupied Palestine territory and Sudan, private providers are obliged to have a license from the ministry. The license is based on basic requirements for the facility, physical infrastructure, equipment and the working staff. There are no specifications on the quality of the services provided and no formal quality certification process exists. Only four out of seven countries of the Region that were included in the WHO Emergency Care System Assessment reported having policies to regulate the provision of private ambulance services. Five had policies in place to govern participation in the national ambulance/pre-hospital network.

In Iraq, the Ministry of Health and the Iraqi Medical Association are responsible for regulating private hospitals and clinics, respectively. Health care providers are also required to renew their license on an annual basis. However, regulation is weakly enforced; there are no mechanisms in place to monitor performance, improve competencies or institutionalize continuous professional development. Furthermore, regulation of the health service delivery mechanisms is weak both in the public and private sector *(20)*. A similar landscape is observed in Pakistan, where the provincial health care commissions have the mandate and responsibility to regulate, register, license, accredit and maintain quality standards in the private health sector. Yet, it was reported by the Ministry of National Health Services, Regulations and Coordination in Pakistan that both the regulation and the capacity to regulate the quality of care in the private sector is weak, including the regulation of medical practice, pharmaceuticals and diagnostics markets. The Ministry further mentioned that there was no uniform approach for governing health institutions and that the capacity for contracting-in and contracting-out services was suboptimal *(21)*.

Regulation of the private health sector was better in higher-income countries such as Jordan and Oman. In these countries, a government department is responsible for implementing and monitoring the standards of care in the private health sector. In Oman, all private health care facilities need to be licensed based on strict guidelines related to aspects such as staffing and equipment before operating. This is followed by regular monitoring by inspection teams (four times annually). There is also an active "violations committee" which has reportedly closed down a number of private clinics due to their inability to conform to quality standards.

The available evidence thus suggests that the capacity to regulate private actors delivering health care services in the Region is relatively weak.

Private health sector involvement in policy-making and clinical care guidelines

Our study revealed that the private health sector is generally not adequately represented at the policy level and therefore not engaged in the development of clinical guidelines, standards and strategies related to essential services including RMNCAH and NCDs.

WHO country reports from Morocco, Saudi Arabia and Sudan shed light on the exclusion of the for-profit sector from the formation of national framework legislation on NCDs *(22–24)*. In Sudan, the private health sector has not been effectively engaged or included in national health planning processes. Likewise, in Morocco, the private sector was not actively involved in health policy design. Furthermore, the evidence from Saudi Arabia indicates not only the lack of engagement of the private health sector in policy-making but also a lack of interest in national health goals.

However, stakeholder interviews revealed that the private health sector is involved in policy-making regarding NCDs at the national and subnational levels in some countries but the engagement is unstructured, and efforts uneven. The Private Hospital Association of Jordan's involvement in policy-making is one example. However, policy engagement by of nongovernmental organizations (NGOs) is generally more common than engagement by for-profit providers. In Pakistan, the NGO Heartfile was included in the development of the NCDs National Action Plan. Similarly, Aga Khan University (originally a private medical college, now a non-profit institution) was prominent in the development of tobacco laws in the country. Nevertheless, we observed that very little weight is given to the voice of the private sector in such forums and decision-making power lies with the public sector. The drive to engage the private health sector at the policy level seems to be lacking from both sides. The public sector suffers from path dependency, tending to resist change, and the private sector believes that it has little to gain from such participation.

Data related to the role of for-profit private health care providers in establishing clinical care guidelines related to NCDs were scarce. One reason could be that the countries seldom make their own guidelines and instead rely on WHO guidelines. Regulatory efforts by some non-profit organizations have been reported in Pakistan, such as the Young Doctors' Association, a small NGO working towards regulation and accountability in the private health sector, which initiated a campaign to regulate the prices of secondary and tertiary care at private hospitals. The campaign was then taken to the highest judicial level of the country, the Supreme Court, which then directed the matter to the provincial health care commissions.

Summary of private health sector governance in the Region

Policy-making	National health policy directions are slowly incorporating the private sector into the strategic vision, particularly in high-income countries; however, frameworks for engagement are lacking.
Regulation of sector	National policies vary and several developing countries completely lack some aspects of regulation. Corruption in the public sector hampers regulation in some developing countries. Jordan and Oman have some regulatory and accountability mechanisms in place.
Licensing of private providers	The health ministry generally provides licensing. Re-licensing is either not commonly required or is not enforced in most countries.
Engagement in the formation of national policies	The private sector is minimally represented at the policy level and little weight is given to its opinion. There is no drive to include the private health sector, from either the public or private side.
Clinical guidelines	The private sector is generally not involved in the formation of clinical practice guidelines, with a few exceptions.

3.2

Private health sector financing

There is limited inclusion of the private sector in national health insurance programmes in the Region – most private health providers rely on OOP payments

Private health sector financing can be regarded as a reflection of the limited financial protection in the Eastern Mediterranean and the generally high OOP expenditures which are mostly absorbed by the private sector. In Sudan, OOP reached 66.22% of health expenditure in 2018 *(25)*. In Pakistan, private funds represent 63.6% of the total health expenditure, 89% of which are from private households *(26)*. Almost 63% of the private health expenditures are absorbed by private outpatient clinics, with some 31% absorbed by private hospitals.

In most countries and territories of the Region, private health providers rely on OOP payments in a fee-for-service model to sustain their business. This is mainly due to the limited inclusion of the private sector in national health insurance programmes and the timid private health insurance presence. Out of the seven countries of the Region that were included in the WHO Emergency Care System Assessment, only one country reported coverage for private facility-based emergency care through national health insurance, and none reported coverage for private pre-hospital emergency care. In four countries, all facilities – regardless of public or private status – had mandates requiring the provision of emergency care to all who present with acute illness or injury, regardless of ability to pay. In the remaining three countries, this mandate only applied to public facilities. In all but one country, emergency care provided at private facilities is paid for by patients at point of care. Five countries reported that private facilities also accepted private insurance, and only one reported that a cost-sharing scheme existed. Policies were in place in three countries to reimburse private health care organizations when uninsured public patients access private emergency care. To summarize, in most countries, government-funded national health insurance schemes only cover public pre-hospital and facility-based emergency care. Should publicly-insured patients seek care at a private hospital, insurance cannot be used, and patients must pay OOP. The only exception to this is in cases where immediate life-saving treatment is required. There is, however, no clear delineation between patients in need of life-saving treatment versus urgent (but not immediately life-saving) emergency care. A lack of such distinguishing features can create further delays in care as staff determine if payment is required. The private health sector often prefers not to be involved in emergency care, given that this field is considered to be a high-risk service for low reward *(27)*. Well-defined financial plans are thus critical in engaging the private health sector.

The cost of care in the private sector is highly variable in the Region. It was estimated that 24% of Syrian refugees in Jordan use the for-profit sector and pay an average of US$ 59 per visit (9% of monthly family income). Although the expenditure is not catastrophic, it is significant for one visit for a chronic condition. On the other hand, interviewees from Pakistan mentioned that the private providers charged minimally at the primary care level as they usually prescribe generic medicines. However, it was reported that when it comes to RMNCAH, doctors working in private clinics are reported to charge about three times more than trained birth attendants and about twice as much as lady health visitors, nurses and midwives. Charges are also higher in urban than rural areas, and poor women are usually charged less than wealthier women *(3)*. The situation is broadly similar in the rest of the Region. Catastrophic payments are common for private health services including caesarean sections *(28)*.

Examples of collaboration with the private health sector in increasing the financial accessibility to some essential services were observed in Pakistan and Yemen. Financing vouchers complemented by social franchising have been rolled out in Pakistan for about a decade to improve family planning practices. Two NGOs, Greenstar and Marie Stopes Society, have also worked with mid-level private providers on increasing the uptake of long-acting contraceptives. The Pakistan Reproductive Health Franchise programme is also using vouchers, and works entirely with private providers in a social franchise network, the Suraj Network *(29)*. In Yemen, the Yamaan Foundation for Health and Social Development has similarly offered voucher programmes to increase contraceptive uptake, typically long-acting reversible contraceptives *(30)*. Nonetheless, these efforts are insufficient. Social security, private health insurance systems, and even the *zakat* funds and *Bait-ul-Mal*, state-managed Muslim charity systems, are missing large segments of the poor population *(31)*.

Literature recommends the optimization of payment methods to facilitate buy-in from private sector actors *(32, 33)*. The development of reimbursement and funding models is essential *(34)*. Predefined frameworks for costing and tariff estimates for services provided by the private health sector are required. Such frameworks should also be documented in established policies. One persistent challenge is that there is no existing information on the cost of care for specific conditions. This means that it is not possible to truly develop funding models to ensure that fee structures are honoured. Notwithstanding the lack of data, the lack of standards and guidelines has also been cited as a barrier to the development of appropriate fee structures and reimbursement models.

Private health sector financing

- **Social and private health insurance schemes are not well developed but efforts are being made at the policy level in most countries of the Region.**
- **Various models of supply- and demand-side financing have been tried and tested with varied results. Voucher schemes for antenatal care and family planning are common in many countries but are generally not considered to be a sustainable option.**
- **OOP payments are resulting in catastrophic expenditure for prenatal care. Postnatal complications are common in the Region.**
- **In most countries, the government-funded national health insurance scheme only covers public pre-hospital and facility-based emergency care. Should publicly insured patients seek care at a private hospital, insurance cannot be used, and patients pay their own way.**

3.3 Health information systems in the private sector

Our findings suggest that health information systems in the Region present a wide spectrum from the highly developed (e.g. Al-Shifa, Oman) to weak systems (Afghanistan, Pakistan). The systems generally cater for the flow of information from public sector facilities of all tiers and do not feature private health sector representation.

Inadequate data communication and information-sharing between the public and private sectors is a persistent issue

There are no policies or regulations in most countries of the Region mandating the reporting of health information by the private sector and when present, they are usually unenforced. In Djibouti and Jordan, the private health sector is mandated by law to keep records and share information, including public health statistics and cancer registry reports, with the government *(35, 36)*. However, the issue of data communication and information-sharing persistently exists between the public and the private sectors. In Jordan, most private health practitioners do not keep medical records for their patients, nor do they prepare regular statistics about their activities. Moreover, exchange of information between the private and public sectors is minimal *(35)*. Similarly, our interviews in Oman with the private health sector found that private hospitals generally have their own health information systems, but the data are rarely shared with the government. They also highlighted that the data collected in the health sector as a whole lacks comprehensiveness and that many vital RMNCAH indicators are missing. In Iraq, higher-tier facilities (secondary and tertiary hospitals) come directly under the regulatory control of the Ministry of Health. Those facilities are mandated by law to share monthly childbirth data. The information (mostly paper-based) is recorded and utilized in the development of protocols and guidelines related to RMNCAH. On the other hand, private clinics (primary care level) are under the domain of the Iraqi Medical Association and are not mandated by law to share information. In Sudan, some private health facilities claimed that they submit regular reports to the health ministry and receive no feedback.

A Regional Office background paper on private health sector engagement for advancing UHC reported poor sharing of data with ministries of health across all countries and territories *(2,17)*. A study in selected countries of the Region reached a similar conclusion: the study found that private health care providers in Jordan, Morocco and Pakistan were not sharing data with the health ministries, compared to 38% of providers in Lebanon and 100% of providers in Saudi Arabia. Furthermore, it was estimated that 100% of private providers keep records of diabetic patients in Jordan, Lebanon, Morocco and Saudi Arabia, but only 31% do so in Pakistan *(17)*. In Yemen, the quality and quantity of data are poor, while Morocco completely lacks an information system for the follow-up of private health sector activities *(36)*. In the occupied Palestinian territory there is also a lack of record-keeping, data consolidation and sharing by private practitioners, who are not involved in monitoring and evaluation of NCDs with the public sector *(37)*.

All Member States discussed a lack of standardized data collection, management and linkage processes across emergency units and ambulance services. Most countries noted that the private sector had access to newer technology and electronic health records in comparison to its public counterpart. Although electronic emergency care data were regularly captured in the private sector, the data were rarely linked to any public sector data or shared with government authorities. In one country where most public and private facilities and ambulance services kept electronic health records, different institutions used different electronic health record systems, rather than one common system across the country. Improving the ability to synchronize data-sharing between different systems to facilitate the real-time sharing of patient information, especially between government and nongovernment institutions, could significantly improve the quality of emergency care.

Nine countries and territories of the Region have hospital-based diabetes registries (public and private), whereas five – Iran (Islamic Republic of), Iraq, occupied Palestinian territory, Pakistan and Saudi Arabia – have other methods of data collection including clinic-based, primary health centre, private sector and at-risk population-based information. However, it was noted that in some countries such as Pakistan, knowledge of data-sharing is scarce among private health care providers and that they share negligible data for NCD registries *(38)*. Private facilities in Morocco only share data and information with national population-based registries for cancer *(5)*. However, it is generally the hospitals that maintain such registries rather than primary-level facilities. The flow of information for the registries varies between national level in Iran (Islamic Republic of), Iraq and Saudi Arabia, and subnational coverage in Pakistan and the occupied Palestinian territory *(6)*. According to MHA 2017, 10 Member States in the Region have a mental health-specific data report compiled in the last two years for the public sector, or for both public and private sectors. Afghanistan, Morocco, the occupied Palestinian territory and Oman are among those that have compiled mental health data, either in the public system, the private system, or both. Pakistan, Sudan and Yemen have not compiled mental health data in a report for the purposes of policy-making, long- and short-term planning or management. A mental health-specific report on activities in the public sector has been published in the last two years in Bahrain, Iran (Islamic Republic of), Iraq, Lebanon, Qatar, Saudi Arabia, Syrian Arab Republic and the United Arab Emirates. Conversely, in Egypt and Jordan, a specific report focusing on mental health services in both the public and private sector has been published in the last two years. Systematic engagement in the surveillance of communicable diseases is also mostly missing in the Region.

Exchange of information is specifically weak in some areas due to cultural, legal or religious reasons. A study conducted in Pakistan found that the private sector is particularly poor at maintaining records on abortion-related care. There is also a reported reluctance in sharing post-abortion complications data. The study further concluded that although few hospitals and clinics have kept records about post-abortion complications, the available data were patchy and incomplete *(3)*. Nonetheless, our interviews revealed that 20 for-profit hospitals of Sindh province share data on RMNCAH with the public sector and that the private health sector is bound to report child and maternal deaths, which may suggest regional variations in the robustness of health information systems across provinces.

Summary of health information systems

RMNCAH

- The private health sector rarely collects, maintains or shares health-related data with the government. Data regarding abortion and post-abortion complications specifically is not recorded in developing countries.
- There is some information flow to the government; typically, from higher tiers of private health sector. However, the information is fragmented and does not comprehensively cover indicators.
- A mixed information system, with private and public components, is operating in Oman.

Surveillance, monitoring and evaluation of NCDs and communicable diseases

- Hardly any information is collected on NCDs by the private health sector in the low- and middle-income countries such as Pakistan and Sudan.
- Private health facilities in high-income countries such as Saudi Arabia share NCD information with the public sector.
- The private health sector is not involved in evaluating NCD-related progress at the national level.
- Systematic engagement in the surveillance of communicable diseases is widely missing in the Region.

Data-sharing for NCD registries

- Diabetes and cancer registries are generally maintained at the national level, with information flowing from the private and public tertiary care hospitals.
- The private health sector is neither involved in evaluating NCD-related progress at the national level nor in monitoring NCDs and risk factors through a WHO STEPwise approach to surveillance (STEPS survey).

Emergency care

- Although electronic emergency care data were regularly captured in the private sector, these data were rarely linked to any public sector data or shared with government authorities.

3.4 The role of the private health sector in service delivery

A Service utilization

Private providers are concentrated in urban areas and are generally more focused on curative care rather than preventive, rehabilitative or health promotion services, for commercial reasons

As a major provider of health care services in the Eastern Mediterranean Region, the private health sector is diverse, delivering services at all tiers. Private providers are concentrated in urban areas and are generally more focused on curative care rather than preventive, rehabilitative or health promotion services, for commercial reasons. Anecdotal evidence suggests that around 50% of health care services in Iraq are provided by the private sector. In the Islamic Republic of Iran, the private sector is the major provider of outpatient health services, with 37% of the population receiving free primary care services at private facilities based on a partnership with the Ministry of Health and Medical Education *(39)*. A study in Somalia estimated that 90% of all curative care in the country is provided by the private health sector and that 75% of the population uses private health facilities *(40)*. In Pakistan, despite the fact that larger public hospitals are the major providers of critical hospital admissions and the main lifeline for the poor, 70% of the population (66% rural and 76% urban), including many of lower socioeconomic status, attend private medical providers for routine consultations. Private providers include doctors, nurses, paramedics, laboratory technicians, pharmacists, retail drug sellers, traditional healers and unqualified practitioners. Private health facilities in Pakistan comprise 73 650 total private institutions, eight tertiary care hospitals, 692 small- and medium-sized hospitals and 20 000 beds *(41)*. In Egypt, Pakistan and Tunisia, the private facilities are generally concentrated in urban districts where the patient base has higher incomes and services are more profitable *(42, 43)*. Frequently mentioned reasons for private preference included better hospitality, shorter waiting lists, better laboratory and diagnostic facilities, nursing care and advanced infrastructure. Despite the associated OOP payments, the population still preferred the private sector due to the commutes and long waiting times for public health facilities, rendering high opportunity costs for daily wage workers in particular.

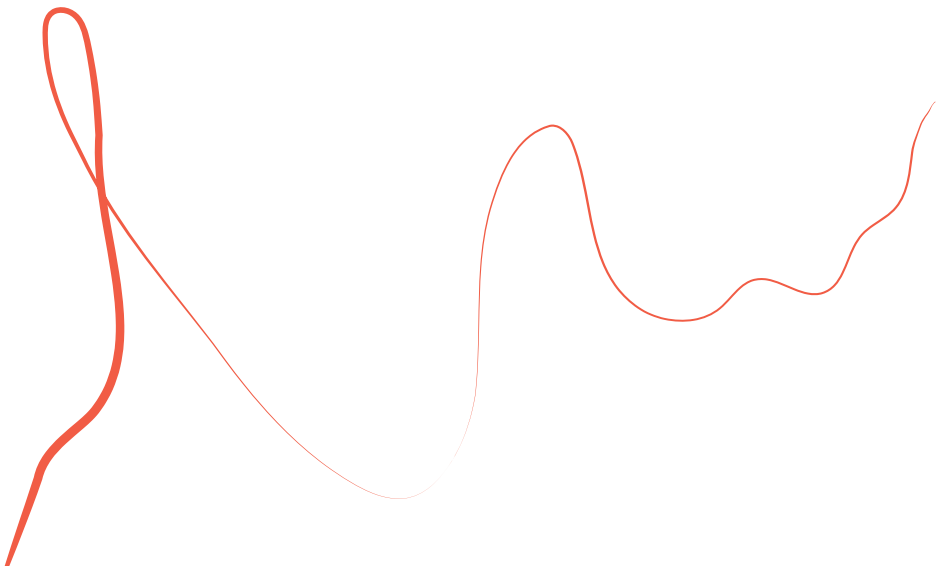
It is worth noting that access to private facilities in some countries such as Afghanistan is restricted by social accessibility of private primary health services. Given the religious beliefs and social customs which prohibit female patients from seeking health care from male physicians and the fact that only a quarter of the physicians at private facilities are female, the services are fairly inaccessible for women *(44)*.

RMNCAH services

The private health sector is integral in the provision of services related to family planning, pregnancy and delivery care, child immunization and treatment. As such, the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), the regional framework for newborn, child and adolescent health 2019–2023 and the regional reproductive and maternal health guiding documents put great emphasis on the role of the private sector in reaching SDG targets related to the health and well-being of women and children *(45,46)*.

The countries and territories of the Eastern Mediterranean Region differ in their landscapes of public and private RMNCAH services provision. Of the 36 studies included in our review, 27 reported on the contribution of the private sector in delivering reproductive and maternal health services in countries/territories of the Region. The proportion of outpatient RMNCAH services provided by the private sector in selected countries/territories is shown in **Annex 1**.

Egypt, Jordan and Pakistan were found to have a predominant private sector in the delivery of RMNCAH services. There was a preference among both rural and urban women for the private sector when seeking antenatal and postnatal care. In Jordan, it is estimated that 58% of women prefer the private health sector for family planning services *(47)*. The Pakistan Demographic and Health Survey outlines a 5% increase in dependence on the private health sector for obtaining modern contraceptives, from 30% in 2006–2007 to 35% in 2012–2013 *(48)*. The body of evidence suggests that the private health sector is the major provider of oral contraceptives, condoms and contraceptive injections whereas the public sector is the predominant provider of intrauterine devices (53%) *(49)*. A study in the Faisalabad district of Pakistan (n=600) estimated that 48% of the population received family planning services from private hospitals or clinics *(50)*. Meanwhile, IUD insertion was observed to be 1.9 times more prevalent in public hospitals than in clinics *(51)*.



A very similar health system landscape exists in Egypt. Antenatal, postnatal and children's health care are predominantly provided by the private sector, despite the fact that a private antenatal visit is estimated to cost 10 times more than a public visit that is provided free of charge in the morning (and for a low fee in the afternoon). Yet, the private sector provided around 90% of antenatal care in the country in 2014. The private health care utilization rates remain high in Egypt due to the unresponsiveness of the public sector, long waiting times, difficulties booking appointments and lack of provider choice *(52)*. Nonetheless, there has been a steady decline in the private sector contribution to family planning service delivery since 1995. According to recent estimates, 43% of users obtain their contraceptives from the private sector, down from 64.3% in 1995. Some quoted reasons for the decline include inadequate knowledge about family planning methods among private providers, leading to poor patient counseling and low demand for contraceptives *(53)*.

In Iraq, private obstetric care and fertility clinics are well utilized. Private neonatal care services are thought to be of higher quality. However, immunization is only offered by the public sector. The caesarean section rates are high in most governorates of Iraq. In 2002, the caesarean section rate for public hospitals in Baghdad was 30% of all births (compared to an acceptable standard of 5–10% in most countries), but the recorded rate was much higher in private hospitals at 48% *(54)*. Access to contraceptives remains very low: around 5% of the poulation has access to family planning in public facilities *(20)*.

Six studies reported on the contribution of the private sector in delivering child health services in the Region. In rural areas of the Punjab, Pakistan, it was reported that 28% of mothers took their children to private facilities seeking care for communicable diseases *(55)*. Another study conducted in rural parts of Pakistan (n=7025) estimated that 75% of mothers took their children to private providers for the management of diarrhoea and pneumonia at the PHC level and 44% sought care from the public sector (the categories were not mutually exclusive) *(56)*. It was also understood that caregivers seek care from private doctors only if they have the financial means. If they do not have the money, caregivers tend to seek care from government doctors initially and shift to private care if their child's case fails to improve *(57)*.

Immunization services

The private health sector provides vaccination in almost all countries and territories of the Region, but the public sector is the main provider as trust in public immunization services is high.

According to official estimates in Pakistan, the Government provides approximately 97% of immunization services to children through the Expanded Programme on Immunization (EPI). However, a recent population survey in urban Karachi estimated that of the 75% of children who were immunized, 25% received vaccinations from the private sector. This discrepancy may be explained by the concentration of private providers in urban areas or by the fact that private hospitals are delivered vaccines through the health ministry and thus considered public in the official estimate, yet regarded as private in the survey. The main provider of private sector immunizations was private for-profit physicians (80%), with a smaller proportion provided by the non-profit sector (amount not quantified).

The non-profit sector generally plays an important role in extending access to traditional EPI vaccines, particularly in low-income countries. This is due to the fact that non-profit facilities are situated in rural as well as urban areas and are more likely to coordinate with public services than the for-profit sector. A study in Pakistan compared Bacillus Calmette-Guérin (BCG) immunization among newborns and use of tetanus toxoid during pregnancy in contracted NGO facilities with that of government facilities in two remote rural districts. This study estimated BCG immunization coverage to be 10.6% higher in contracted NGO clinics than in government clinics *(57)*.

NCD services

Given the increase in utilization of private sector services in the past few decades, the public sector alone is unable to offer all services required to control NCDs. Therefore, engagement of the private health sector in the fight against NCDs is no longer an option but a necessity.

Technologies for early NCD detection at the primary level are generally more available in the private sector, yet screening is seldom done at private health facilities. According to a 2017 WHO assessment of national capacities for the prevention and control of NCDs, 59% of countries/territories in the Region reported availability of 13 basic technologies for early detection, diagnosis and monitoring of NCDs in public PHC facilities compared to 71% in private PHC facilities *(6)*. It is important to note that the availability of 13 essential technologies for the early detection, diagnosis, and management of NCDs in the private sector increased from 6.8/13 in 2015 to 9.2/13 in 2017 *(58)*.

Moreover, an assessment of the availability of NCD medicines in countries/territories revealed they were available in 36% of public facilities and 54.7% of private facilities (anti-diabetics: 49.5% of public versus 65% of private facilities; anti-hypertensive: 34.7% public, 57.1% private; anti-asthmatics: 30% public, 43% private) *(59)*. Another article reported that cardiovascular medicines were available in 26% of public facilities versus 57% of private facilities in developing countries *(60)*.

59%

of countries/territories report availability of 13 basic technologies for early detection, diagnosis and monitoring of NCDs in public PHC facilities compared to

71%

in private PHC facilities

In the Islamic Republic of Iran, the free primary care services provided through private facilities include screening of breast, gastrointestinal and cervical cancers *(40)*. On the other hand, in Iraq, even though 33% of people recommend going to a private doctor or clinic for management of adult hypertension and 38% for a cough, respectively, the available evidence is that screening of NCDs is not undertaken by the private sector at primary care level *(61)*. Similarly, in Sudan, NCD screening is typically carried out above PHC level. Nonetheless, a study estimates that 22% of NCD screening and treatment and 22.6% of outpatient and primary care is provided by the for-profit private sector *(62)*. Interviews in Oman revealed that the private health sector is involved in providing screening stations for NCDs (hypertension, diabetes) in community-based campaigns. In Jordan, the NGO sector was active in NCD screening but no involvement of the for-profit health sector was reported. Almost half of the Jordanian households have access to NCD medicines within 15 minutes of travel time; however, inequity remains a problem *(60)*. The Syrian Arab Republic reported that screening for breast cancer (mammography) and diabetes (fasting blood sugar) is done at primary care level by the private sector.

Emergency care

Emergency care has the potential to address nearly half of deaths and more than a third of disability annually in low- and middle-income countries

Emergency care systems address a wide range of medical, surgical and obstetric conditions, including injuries and complications of pregnancy and NCD. The hospital emergency department is often the first point of contact with the health system, providing life-saving health services, particularly in areas where there are barriers to access. With sound planning and organization, emergency care has the potential to address nearly half of deaths and more than a third of disability annually in low- and middle-income countries.

In much of the Eastern Mediterranean Region, emergency care services are offered by both public and private entities. The private sector plays a significant role in delivering these services alongside the public sector; these contributions extend beyond delivery of care into other key elements such as equipment and cleaning services, supply chain and health care provider training. However, data on the utilization of such services are lacking.

Ambulance dispatch systems were disjointed between the private and public sectors in six of seven countries included in the WHO Emergency Care System Assessment. It is believed that unified central dispatch would reduce the delays commonly experienced when an interfacility transfer is requested. Nonetheless, despite the obvious benefits, such integration of public and private dispatching systems would face both logistical and political barriers.

B Quality of services

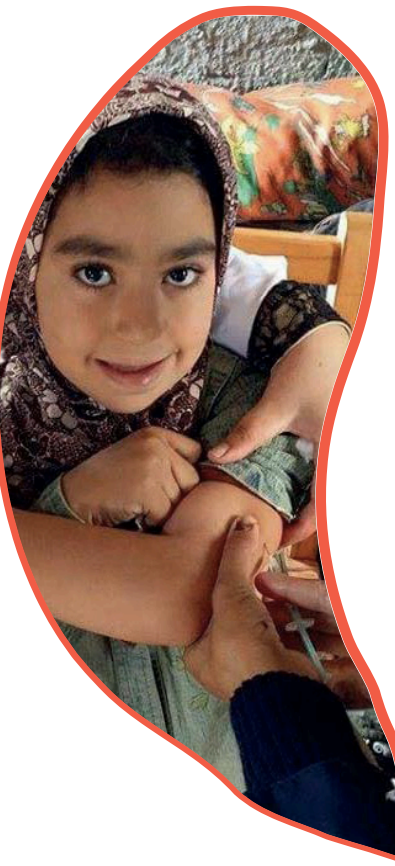
The Region is characterized by countries with crises of great magnitude bordering highly prosperous, stable nations. Health systems vary enormously from one jurisdiction to the next and are influenced by a broad range of health determinants, including exposure to conflicts and wars. As a result, the quality of health care services has deteriorated. The quality of care provided by the private health sector is generally considered to be superior to the public sector, especially in low-income countries. However, there is a dearth of robust data to support this perception and assess the quality of services compared to the public sector.

Quality health care can be defined in many ways but there is growing acknowledgment that quality health services should be: safe – avoiding injuries to people for whom the care is intended; effective – providing evidence-based health care services to those who need them; people-centred – providing care that responds to individual preferences, needs and values; and timely – reducing waiting times and sometimes harmful delays.

To realize the benefits of quality health care, health services have to be: equitable (providing care that does not vary in quality on account of gender, ethnicity, geographic location or socioeconomic status); integrated (providing care that makes available the full range of health services throughout the life-course); and efficient (maximizing the benefit of available resources and avoiding waste *(63)*.

Summary of health information systems

- **Patients are informed of their rights, and encouraged to participate in their own health care;**
- **Health care staff accept personal responsibility for contributing to performance, safety and organizational improvement;**
- **Managers of institutions have the skills, confidence and authority to manage their own resources and develop internal systems;**
- **Clinicians are trained in evidence-based medicine, performance assessment and teamwork – and supported by continuing medical education;**
- **Professions are organized to accept ethical responsibility for self-regulation and public accountability**
- **Quality is assessed based on achievements and performance (process and outcome) rather than failures and capacity (resource inputs);**
- **Data and information are shared between institutions and agencies to support transparency, communication, improvement and learning.**



Many of these features are missing in low-income countries, which are characterized by top-down command and control, dysfunctional health ministries, patient exclusion, professional indifference and denial of personal responsibility. Even in higher-income countries, these ideals have yet to be fully achieved, despite the efforts of several generations.

Quality of RMNCAH services

The private health sector is the main provider of contraceptive pills, condoms and contraceptive injections, whereas IUDs are generally provided by the public sector. An assessment of family planning services in rural parts of Pakistan estimated that 70% and 75% of public and private sector clients are not being offered the recommended "cafeteria approach" to choose between the available contraceptive methods, respectively, *(50)*. Another nationwide study in Pakistan concluded that a similar pattern of treatment was followed in both the public and private sectors for post-abortion care, with misoprostol being the drug of choice *(3)*. The models of social franchising to increase family planning practices (Greenstar and Marie Stopes Society) were found to be performing well on quality indicators. Both models attained a mean score of 6.7 out of 8 on waste disposal mechanisms, 12.5 out of 15 on supplies, 2.7 out of 4 for user-centred facilities and 6.5 out of 11 on clinical governance *(29)*.

Quality of NCD management

NCD care and management at the primary care level does not require very sophisticated equipment and the essential apparatus is generally available at private clinics. The six basic technologies for NCD care – blood pressure measurement device, scales, height measuring equipment, blood sugar and blood cholesterol measurement devices with strips, and urine strips for albumin assay – are "generally available" in 97% of the world *(8)*.

Despite incomplete information regarding the availability of diagnostic equipment in the private sector at primary care level, a 2016 study in the Region found functional glucometers present in all private primary health care facilities in Jordan, Lebanon, Morocco and Saudi Arabia, and in 74% of facilities in Pakistan. Fasting blood glucose levels could be measured in 100% of presenting patients in Jordan, Morocco and Saudi Arabia, 92% of patients in Lebanon and 69% of patients in Pakistan. Equipment for determining haemoglobin A1c was available in all private primary care facilities of Jordan and Saudi Arabia, 78% of such facilities in Lebanon and 20% of such facilities in Morocco *(17)*. Evidence from interviews in Oman suggests that the private health sector has all the required laboratory and diagnostic support. It was also noted that some private clinics in Djibouti had diagnostic equipment such as electrocardiogram (ECG) and ultrasound *(64)*. Services that were generally missing in private facilities across the Region included mammography, echocardiogram, x-ray, ECG and exercise tolerance test.

Services that were generally missing in private facilities across the Region included mammography, echocardiogram, x-ray, ECG and exercise tolerance test

A 2016 study found that service guidelines for the management of diabetes in private outpatient clinics are available in all private health facilities of Jordan, Lebanon, Morocco and Saudi Arabia *(17)*. Yet, our assessment of multiple countries/territories of the Region suggests the private sector is not meeting its potential in terms of standardization of NCD service packages and establishing treatment guidelines *(57)*.

Limited information is available regarding the availability of trained NCD physicians or specialists in the private sector at the primary care level.

Quality of emergency care

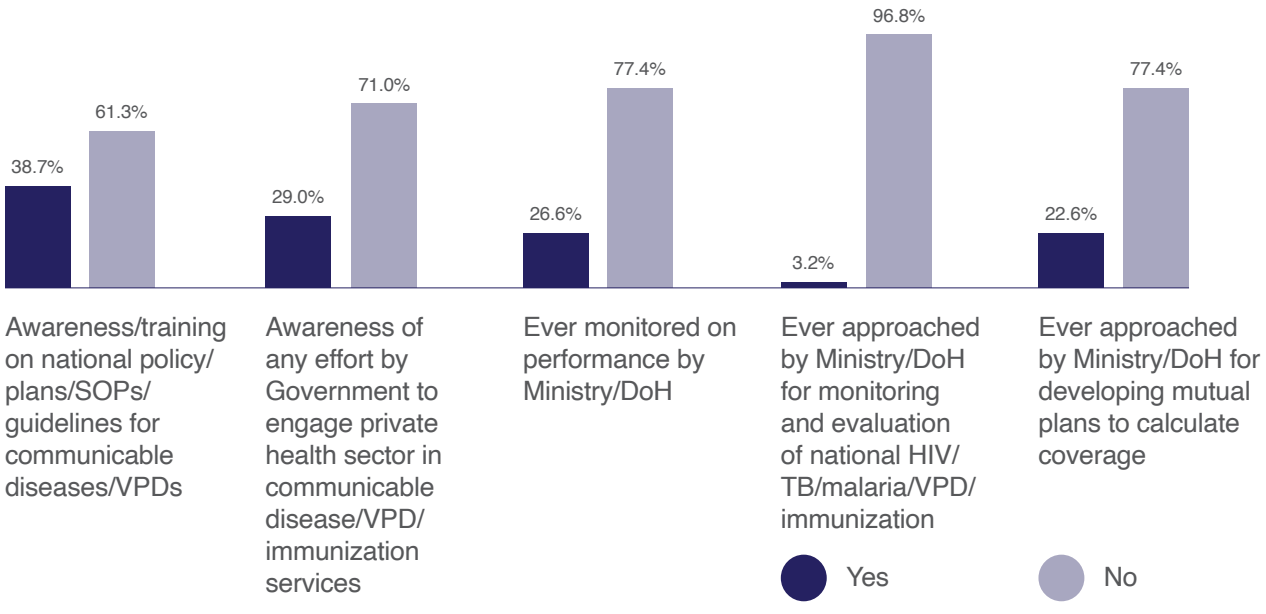
A descriptive study from Afghanistan highlights that private emergency care services, despite being used by a large portion of the population, are not delivered to the standards of public health care. The integration of the private sector (NGOs and corporations) with the Ministry of Public Health and the civilian government has, however, resulted in significant improvements in the access to care and its quality in a post-conflict nation *(65)*. In Iraq, the quality of care in both the public and private sectors is far from desired levels with virtually no accreditation system or effective standards in the country *(20)*. The comparison between the quality of services at the private and public facilities yields mixed results, though the private health sector appears to have the edge overall *(66,67)*.

A study in the Islamic Republic of Iran also highlighted concerns over the quality of care in an existing partnership. Of particular concern is that private sector suppliers with little to no emergency care knowledge have begun to market and sell emergency care equipment and services, without regulation *(68)*. In Pakistan, ambulances of Rescue-15 – a collaboration between the private sector, an NGO and the police department to provide a better response to road traffic collisions for day-to-day emergency care service provision – were reportedly lacking life-saving equipment and did not meet international standards. Ambulance personnel were found to be undertrained. There was a lack of protocols and guidelines to inform patient care, transportation and vehicle maintenance. However, despite all of these challenges, patients were mostly satisfied with the emergency care service received *(69)*.

Quality of care for communicable diseases and immunization

In Pakistan, awareness in the private health sector of the available national guidelines, standards and diagnostic techniques was found to be lacking (**Fig.1**). A study conducted by the WHO Regional Office found that only 38.7% of private providers in Pakistan received training on national policy/plans, standard operating procedures and guidelines on communicable diseases, vaccine-preventable diseases (VPDs); 29% were aware of any effort by government to engage the private sector in communicable disease/VPD/immunization services; 22.60% were ever monitored on performance by the Ministry or provincial department of health; 3.20% were ever approached by the Ministry or provincial department for monitoring and evaluation pertaining to national HIV, TB, malaria, VPDs and immunization; and 22.60% were approached by the Ministry or department of health to develop mutual plans to calculate coverage. Further details on the study findings on guideline adherence for specific conditions are outlined in **Table 1**.

Fig. 1: Subnational-level private providers' responses on awareness, training, mutual plans and monitoring



Note: SOPs: standard operating procedures; DoH: department of health

Table 1: Subnational-level private providers' responses on guidelines and implementation trends

Intervention	Reference to national guidelines			Level of Implementation		
	Some awareness	No awareness	Local presence of a copy of guidance	Never	Sometimes	On a daily basis
Testing persons with signs and symptoms of chronic liver disease for hepatitis C infection	71%	29%	29%	6.50%	35.50%	58.10%
Testing persons with signs and symptoms of COVID-19	74.20%	6.50%	19.40%	12.90%	87.10%	0%
Testing persons with signs and symptoms of HIV infection	80.60%	6.50%	12.90%	67.70%	32.30%	0%
Testing persons with signs and symptoms of hepatitis B infection	48.40%	0%	51.60%	3.20%	71%	25.80%
Testing persons with signs and symptoms of malaria, tuberculosis and dengue fever	77.40%	0%	22.60%	16.10%	67.70%	16.10%
Testing persons with signs and symptoms of typhoid fever	59.10%	0%	41.90%	12.90%	67.70%	19.40%
Testing persons with signs and symptoms of other communicable diseases (e.g. cholera, gastroenteritis, acute respiratory infections, Ebola)	51.60%	19.40%	29%	48.40%	35.50%	16.10%

Health care accreditation

Health care accreditation is a vehicle for developing and verifying effective internal quality management systems but is not a substitute for them

Health care accreditation is used as means for regulating the quality of care in many countries of the Region. However, health care accreditation is not a total quality improvement solution; it must be designed to meet specific objectives and be consistent with a comprehensive national strategy. It is a vehicle for developing and verifying effective internal quality management systems but is not a substitute for them. A programme can support a systematic approach to quality improvement when it is supported by other quality tools, strong leadership, transparency and stakeholder involvement.

Different accreditation models exist in the Region; some accreditation programmes are integrated within the ministry of health (Egypt, Islamic Republic of Iran, Morocco, Saudi Arabia), while others have national accrediting bodies that function independently of the health ministry (Jordan, Lebanon). In some smaller GCC countries (Bahrain, Oman), international accrediting bodies have been contracted to accredit health facilities. The programmes cover public and private hospitals in addition to primary care facilities. Most have developed or adapted existing standards. There is, however, a substantial variation in their capacity to implement those standards *(5)*. Accreditation of private facilities is hardly seen at PHC level except for GCC countries where private facilities are generally accredited. The larger tertiary care hospitals of the Region do have national or international accreditation.

Available information shows that 13 out of 22 countries or territories have a policy on regulatory licensing of health care institutions. Eleven have an accreditation policy. Only three accreditation programmes were directly linked to health insurance or third-party payments. Seven countries have a national accrediting body that includes standards for primary care, ambulatory care and laboratory services *(70)*.

13
Countries or territories have a policy on regulatory licensing of health care institutions

11
Countries or territories have an accreditation policy

3
Only three accreditation programmes were directly linked to health insurance or third-party payments

7
Seven countries have a national accrediting body that includes standards for primary care, ambulatory care and laboratory services

In 2015, a survey was conducted by WHO to review the extent to which health care quality was institutionalized in the Region. The survey focused mainly on existing quality policies, structures, methods and resources for quality and safety. Responses were received from Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Morocco, Oman, occupied Palestinian territory, Pakistan, Saudi Arabia, Sudan and Tunisia. Analysis indicated that, overall, national policy on quality in health care was explicit, accessible and consistent (80% of respondents), but that incentives for implementation and performance improvement were weak (40%) *(7)*.

This was further reinforced by interviewed participants who indicated that despite the fact that many facilities receive accreditation, there is a lack of monitoring and evaluation. Limited follow-up and ongoing quality assessment allow for error and corruption to occur. Examples of good practice, such as auditing and inspections, were noted. However, it seems that for the most part, ongoing monitoring of quality is weak and requires improvement. The decision to utilize a private over a public health care service seems to be influenced by community perception about the quality of care provided. This was seen in a 2008 study in Pakistan that found that the population seemed to favour private emergency care for conditions involving women and children, without evidence of superior quality *(71)*.

Health care accreditation appeals to providers as it can offer the assessment of their compliance with predefined standards in an environment where overall care delivery is known to be highly variable. Nevertheless, the effectiveness of the approaches to improving health care – including accreditation, clinical guidelines, performance indicators and risk management – depends more on the capacity of individuals and organizations to change attitudes and behaviour than any new technologies. Surprisingly few governmental programmes begin with a clear view of what accreditation is intended to achieve, or how it will relate to similar mechanisms, especially statutory regulation.

C Capacity-building in service delivery

Training opportunities are better in the public sector

Assessment of various health systems in the Region highlights that the private sector is not involved in the public sector capacity-building plans and that training opportunities are better in the public sector. There were no data regarding the capacity of the private health sector itself in dealing with NCDs at the primary care level. Moreover, the role of the private sector in NCD capacity-building and training of health professionals at the primary care level seems to be absent *(58)*. Nonetheless, our analysis suggests that the proportion of private physicians practicing at PHC level who attend refresher courses on management of diabetes was determined to be 100% in Morocco and Saudi Arabia, 80% in Lebanon and 50% in Pakistan *(17)*.

Emergency care training was available in all seven countries of the Region that were included in WHO's Emergency Care System Assessment. The most common provider of such training was ministries of health (n=6), followed by NGOs (n=5), private for-profit health care organizations (n=4), and public universities (n=4). Although no action priorities focused on private sector engagement in emergency care training, there was some discussion of the private sector contributing to emergency care training. One country, Pakistan, reported detailed emergency medicine fellowships and postgraduate degrees offered by some private institutions in Karachi, stating that these programmes were limited in that they do not confer any government specialist certification.

D Community engagement

Community mobilization is at a nascent stage at best in most of countries surveyed. This is evident in the sporadic efforts and lack of concerted strategies for harnessing community action. Most of the efforts of the private health sector are also limited in scope, confined to raising awareness. The community plays little role in other areas such as early referral, self-management and rehabilitation of NCDs *(58)*. Examples of community engagement have been noted in the areas of breast cancer awareness and breastfeeding promotion at the PHC level in the Islamic Republic of Iran.

Service delivery

Types of services

1 Preventive services including health promotion and screening are generally not offered at PHC level by the private sector; services are directed towards curative care.

2 Early detection of NCDs at the primary level in public and private sectors is very limited.

3 Abortion and post-abortion care are typically more developed in the private sector, but the rate of caesarean section is also higher.

4 Immunizations are sometimes provided by the private sector.

5 NGOs generally are involved in risk assessment, but not the for-profit sector.

Quality of care

1 Service delivery in the majority of countries is assumed to be better in the private sector compared to the public sector, in terms of laboratory and diagnostic services, availability of medicines and opportunity cost.

2 Desk review suggests that the quality of care is better in the private sector in Jordan and Sudan. Both sectors were found to be equally inadequate in Pakistan. Oman's public sector was considered to be superior to the private sector in terms of team-based approaches and continuity of care.

3 Private providers at the primary level rarely follow guidelines. However, those working at higher tiers are conversant with clinical standards.

4 Private providers have been observed to lack continuity of care and multidisciplinary approaches to treatment.

Training and capacity-building

1 Training opportunities are better for public health care providers.

2 Continuous capacity-building for private providers is limited.

3 Private providers are generally not involved in capacity-building activities on NCDs or sexually-transmitted infections. An exception was noted in Oman where short courses on NCDs are being offered to private providers.

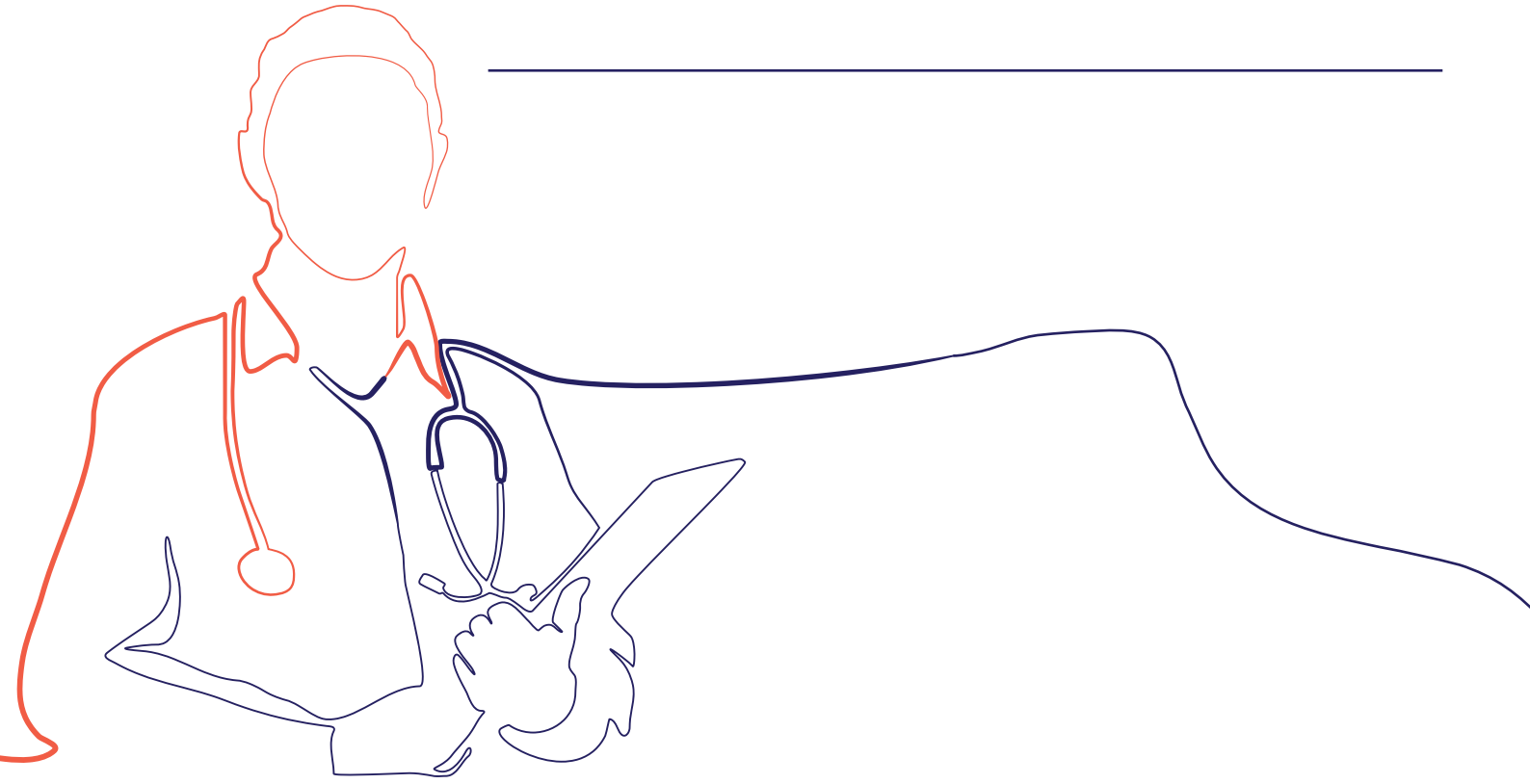
Accessibility of services

1 The fees for private primary care are high compared to the public sector, where services are generally offered for free at PHC level.

2 Private health sector fees are not prohibitive at PHC level and thus considered to be affordable by most people.

3 Low-income patients generally utilize the public sector. However, in the case of long travel and waiting times, the opportunity costs can outweigh private sector fees.

4 The for-profit private health sector is generally concentrated in urban areas.



3.5 Examples of intersectoral collaboration

A Intersectoral collaboration in mental health

In the Region, governments manage

46%

of prevention and promotion programmes for mental health, compared with

69%

in the rest of the world

And

33%

of programmes are jointly managed with NGOs while

22%

are managed by NGOs – both more than in the rest of the world

In MHA 2017, countries are asked to identify ongoing collaboration between government mental health services and other departments, services and sectors. They are also asked to identify the number and type of stakeholder groups that were collaborating with government mental health services at the time in the planning or delivery of mental health promotion, prevention, treatment and rehabilitation services. Nineteen countries of the Region responded to this section, with 18 (95%) of these countries reporting ongoing collaboration between government mental health services and other departments, services and sectors, and 16 (84%) having formal collaboration (as defined above). These overall regional rates mirror the rest of the world, where 81% of countries report having at least one formal collaboration with stakeholder groups.

More than half of the countries of the Region have formal collaboration with local (63%) and international (58%) NGOs. The next most frequent formal collaboration is with other government sectors, such as social affairs (47%), education (47%), justice (26%) and interior/home affairs (32%), along with the academic sector/institutions (37%), the private sector (26%), professional associations (32%), and service users and family or caregiver groups (26%). Nine (47%) countries of the Region reported ongoing collaboration with service users and family or caregiver advocacy groups, and all of these have regular meetings at least once per year. Five (26%) countries meet the criteria for formal collaboration.

According to the MHA 2017, of the ongoing mental health programmes, governments manage 46% of prevention and promotion programmes in countries of the Region, compared with 69% in the rest of the world, while 33% of programmes are jointly managed with NGOs and 22% are managed by NGOs – both more than in the rest of the world.

B Intersectoral collaboration in nutrition-specific interventions

Role of the private sector in promoting good nutritional practices, providing micronutrients for children and mothers and the therapeutic feeding of malnourished children

Following WHO guidelines, all ANT countries have integrated the promotion of infant and young children feeding practices (IYCF) at the primary care level as part of the antenatal and postnatal packages of care. A role for the private sector in the development and implementation of IYCF actions was only reported in Bahrain and Oman. In Bahrain, the IYCF programme was co-developed by the International Baby Food Action Network, and the agencies for importing and distributing breastmilk substitutes in the country. Oman, on the other hand, has involved the private sector in its Nutrition-Friendly Schools Initiative. No further information was available on the extent, performance or scope of the private sector involvement in these activities. Lack of adequate monitoring and enforcement mechanisms of the Code of marketing of breast-milk substitutes (the Code) was reported in Bahrain and Saudi Arabia *(72,73)*. In Kuwait, overprescribing of infant formula by private physicians has also been identified as one of the main challenges in implementing the Code *(74)*. Similarly, ENT countries have taken several actions to promote good nutritional practices among infants, young children, pregnant and lactating women. At the policy level, all countries under this category have enacted laws and regulations to protect and promote exclusive breastfeeding by implementing the Code. However, none of these countries have succeeded in achieving full implementation of the Code regulations. Information about private sector compliance and its promotional activities was also lacking. Based on the literature, the private sector was not involved in the development and implementation of IYCF actions in ENT countries.

For SUN/CE countries, engagement of the private sector in the implementation of the IYCF programme was reported in some interventions. First, the National Breast-Feeding Campaign in Pakistan *(75)*, through which 50 million people were reached by IYCF messages disseminated through different platforms. The programme was funded by corporate social responsibility budgets. Second, Code advocacy in Pakistan: the United Nations Children's Fund (UNICEF) worked with senior medical professionals at public hospitals to increase their capacity in implementation of the Code. This programme ensured the commitment of the hospitals in restricting unregulated prescriptions of formula milk. Third, a breastfeeding promotion campaign in Iraq: in 2017, UNICEF initiated a new private sector partnership with the national mobile network provider Zain to implement a child-focused, behavioural change communication campaign. The partnership included breastfeeding promotion *(76)*.

Countries' actions in the provision of micronutrients for children and mothers were mainly led by the ministries of health with the support of United Nations and international development agencies as well as national NGOs. Within ANT and ENT countries, programmes to provide different micronutrient supplementation (vitamin D, iron, folic acid) to different age groups are led by the government with no involvement from the private sector. In SUN/CE countries, engagement of the private sector in the implementation of vitamin A supplementation programmes was reported only in occupied Palestine territory through the government partnership with local producers of fortified biscuits and milk *(77)*. Meanwhile, engagement of the private sector in severe acute malnutrition treatment was reported only in Sudan where in 2019, the Federal Ministry of Health in partnership with UNICEF collaborated with local ready-to-use therapeutic food (RTUF) manufacturers to strengthen the supply chain in three states in Darfur and the states of South Kordofan and Khartoum. This partnership resulted in maintaining an adequate reserve of RTUF in the supply pipeline.

Legislative initiatives include:

Banning industrially produced trans-fatty acids

National policies for salt reduction

Nutrition labelling

Restricting the marketing of unhealthy foods and beverages to school-age children

Role of the private sector in nutrition actions targeting obesity

According to best practice, the implementation of legislation to combat obesity requires the engagement of food manufacturers in the project development and implementation phases. Legislative initiatives include banning industrially produced trans-fatty acids, national policies for salt reduction, nutrition labelling, and restricting the marketing of unhealthy foods and beverages to school-age children.

Private sector involvement in obesity interventions is widely reported in ANT countries. The Ministry of Health in Bahrain has partnered with the food sector to reduce the amount of salt added to bakery products. Similarly, the United Arab Emirates has worked closely with the private sector to implement various obesity awareness initiatives such as the Healthy Children 2021 initiative and the Health Heroes smart app. Qatar has established a large-scale multisectoral network including the private sector, media, education and research centres as well as the tourism sector to support the implementation of its interventions to reduce obesity. Its experience illustrates the role of the tourism sector (hotels and restaurants) in increasing the reach of obesity awareness and the benefits of partnering with the private sector in mobilizing resources.

A similar multisectoral programme was implemented in Oman to prohibit the marketing of high-fat, energy-dense and/or micronutrient-poor foods and beverages on school premises. The “United for Healthier Kids U4HK” initiative led by Nestlé Middle East and implemented in the Kuwait and the United Arab Emirates to help parents establish healthier eating, drinking and lifestyle habits for children aged four to 12, is solely a private sector initiative and an important example of potential conflict of interest. In Saudi Arabia, the Al-Haraka Baraka physical activity promotion initiative is a collaborative effort between a public university (King Saud University), a non-profit organization (Arab Nutrition Center) and the private sector (Mars Middle East Inc.). This initiative is designed as an educational programme targeting children of 6–12 years of age *(78).*

ENT countries have also taken major steps towards developing policies and implementing strategies to prevent and combat obesity in partnership with the private sector. Multisectoral national strategies for the prevention and control of NCDs were reported in Morocco and Tunisia. These involved different partners in the policy implementation, including ministries such as the health, education and sports, alongside United Nations agencies, WHO, national NGOs and the private sector, including representatives of the food industry. Salt reduction initiatives in the Islamic Republic of Iran informed the reduction of salt content in food products. Morocco implemented an awareness campaign targeting bakers and involving 300 bakeries in the region of Grand Casablanca in 2014, which ensured the commitment of 70% of these bakers to reducing salt in bread. In Tunisia, a salt reduction programme was implemented in one city with 22 local bakers, the aim being to reduce the salt content of bread over a specific period. A three-year school-based intervention study was also conducted in Tunisia which consisted of educational sessions to promote healthy eating and physical activity among children. In Lebanon, several local NGOs were involved in promoting healthy nutrition through national media awareness campaigns delivered in schools. The Health-E-PALS intervention was also conducted among schoolchildren to promote healthy eating and physical activity based on social-cognitive theory.

However, of SUN/CE countries, only Pakistan has taken action to control the increased prevalence of obesity among adolescents and adults. In 2019, the Pakistan Ministry of National Health Services, Regulations and Coordination developed a policy paper on adolescent (boys and girls) nutrition in Pakistan *(79)*. This project was run in collaboration with the World Bank, the Global Alliance for Improved Nutrition (GAIN) and the South Asia Food and Nutrition Security Initiative (Safansi). In 2020, the health ministry in Pakistan also took serious steps toward eliminating industrially-produced trans-fatty acids. This programme is supported by the Scaling Up Nutrition (SUN) Business Network and GAIN, in partnership with the International Food and Beverage Alliance and supported by Resolve to Save Lives *(80)*. Both initiatives involve partnership between the Government of Pakistan and the private sector. However, evaluation data are not yet available at this stage.

C PPPs

While informal relationships do often exist, it is important to ensure that robust contracts are in place that clarify the roles, responsibilities, terms and costs of the services being provided

PPP is a formal, prolonged contractual arrangement in which the public sector contracts the private sector for the provision of services, which in the case of health may include clinical and non-clinical services *(81)*. Contracting of private health care is heavily reliant on the political environment and legislative framework of the country. Thus, the establishment of a legal and legislative precedent is important for these partnerships to develop. Contracting can offer many benefits, including improving access and equity, but the main driver is that it offers government a mechanism to create incentives to improve performance and accountability *(82)*. This may be done through linking funding and reimbursement to the quality of service provision *(83)*.

In the Eastern Mediterranean Region, contracting was cited as a barrier to private sector engagement. Participants cited a lack of skilled negotiators, particularly as it relates to emergency care service provision. Other barriers arise due to the limited capacity of the public sector to design, negotiate and award contracts; undertake cost, price, and volume analysis; optimize payment methods; and effectively monitor contract performance. Those are in addition to the difficulty of regulating the private sector and the fact that national health information systems do not adequately capture the data flowing from the private sector. These challenges are further compounded in countries in crisis such as Sudan, where natural disasters and prolonged conflict situations have disrupted infrastructure *(84)*. While informal relationships do often exist, it is important to ensure that robust contracts are in place that clarify the roles, responsibilities, terms and costs of the services being provided.
The importance of funding and reimbursement models was also highlighted as essential to ensure that the interests of the private provider are protected. It is worth noting that the countries that included the private health sector in their national strategic vision have produced better mechanisms of engaging the sector, such as Oman.

PPPs for reproductive, maternal, newborn, child and adolescent health

In Pakistan, PPP models involving community midwives have helped to improve family planning practices

RMNCAH-related PPPs have been rolled out in many countries including Afghanistan, Islamic Republic of Iran and Pakistan. However, their effectiveness remains questionable. Under a PPP model in Pakistan, "task sharing", a strategy used in many countries to mitigate doctor shortages, was undertaken with community midwives, while community health workers connected patients with local facilities, which has been instrumental in improving family planning practices *(85)*. From 2011 to 2013, the landscape notably improved in the areas where the community midwives model was implemented: awareness about family planning methods improved by 14%, current contraceptive use increased by 5%, and long-term modern method IUD (intrauterine device) use increased by 6% among married women of reproductive age *(86)*.

In Sindh, as part of the reforms programme, tenders were advertised for NGO management of poorly functioning rural health centres and secondary care Taluka Hospitals in nine districts, in an attempt to expand access to underserved populations *(17, 87)*. The contracts implement an essential package of health services at facility and outreach level, financed through government funds. Maternal and child health vouchers and contracting out were implemented in two districts of Sindh through the Norway-Pakistan Partnership Initiative, with the private sector engaged to rapidly expand coverage. Punjab, under its reforms programme, is planning a voucher scheme for maternal and childcare services jointly financed by government and international donors *(17)*. Currently, the Sehat Sahulat Card scheme targeting both private and public providers is being implemented in two districts of Punjab for emergency maternal care services by a national NGO, but it lacks funding support from the state. Additionally, the management of four hospitals in Punjab has been outsourced to the Tayyip Erdogan Trust *(88)*.

PPPs for communicable diseases and immunization

Through the President's Primary Health Care Initiative in Pakistan, implemented across four provinces, management of the frontline basic health units was contracted to an NGO *(89)*. The facilities contracted under this arrangement are providing communicable disease and immunization services. However, the immunization-related outreach services are provided through vertically-run prevention programmes. Additionally, from 2003 to 2008, extensive contracting-out of HIV control services was undertaken in Pakistan, with the government purchasing services from NGOs through performance-based contracts *(90)*.

Pakistan has also been a leader in engaging all care providers in tuberculosis (TB) control. Public-private mix (PPM), which now constitutes 32% of total TB case notifications, involves several of the world's leading NGOs in the field. TB diagnosis and treatment services are provided to patients through a network of 1571 TB management units, of which 1140 (73%) are in the public sector and the remaining 431 (27%) in the private sector. The National TB Control Programme has developed a successful strategy to involve the non-state health sector in the provision of TB services, especially the private health sector through major NGOs. The proportion of TB case notifications from PPM doubled from 20% in 2013 to 41% in 2019 *(91)*. However, much remains to be done. According to the TB Joint Programme Review, only 7% of private physicians are involved in TB control in Pakistan, which impacts case notification and discovery of missing cases.

PPPs for noncommunicable diseases

Partnerships with the private sector that include NCDs are underway in the Eastern Mediterranean Region, although strategic planning or frameworks appear absent. Such PPPs are popular in Afghanistan, Egypt, Iran (Islamic Republic of) and Pakistan. However, none exclusively focus on NCDs. Across the Region, PPPs are found in telemedicine, community awareness via social media and service delivery related to NCDs.

PPPs for food fortification initiatives

In several countries of the Region, health ministries have developed partnerships with the private sector to implement food fortification initiatives

Salt iodization and wheat flour fortification are the two most common food fortification initiatives in ANT countries.

The solution to the double burden of malnutrition in the Region requires a political commitment on the part of governments to pool all available resources, including those of the private sector, to be able to develop cross-sectoral and holistic interventions addressing the nutritional issues at hand. In the Eastern Mediterranean Region, wheat flour fortification initiatives are led by health ministries with the support of several United Nations and international development agencies, and in partnership with the private sector. Key partners in flour fortification programmes include UNICEF, WHO, millers' associations and the Micronutrient Initiative.

Salt iodization and wheat flour fortification are the two most common food fortification initiatives in ANT countries. Flour fortification is mandatory in Bahrain, Kuwait, Oman and Saudi Arabia. The remaining countries have introduced voluntary measures for flour fortification. Most of the ANT countries have achieved good coverage of flour fortification and have reported improvement in health outcomes as a result. Based on the findings, it is evident that the related PPPs in ANT countries are well-established and thus can easily be scaled up to other countries in the Region.

However, the situation is different for ENT countries where PPPs in food fortification are well-established only in some countries. Major challenges in implementation are attributed to the lack of financial resources, sustainability of resources and weak enforcement mechanisms. Other challenges arising from the activities of the private sector are notable in Egypt, where a large number of salt producers, repackagers and unlicensed enterprises threaten the sustainability of salt iodization in the absence of effective governmental monitoring mechanisms *(92)*.

SUN/CE countries are experienced with PPP in the implementation of the food fortification initiatives. The working experience of Pakistan and Sudan with their national fortification alliances are examples that can be used in scaling up food fortification initiatives in other countries. The opportunities and challenges they encountered reveal a great deal about the requirements of effective PPP, including the need for a regulatory framework, identified roles and responsibilities, commitment from all partners, accountability and transparency.

In general, countries of the Region have developed partnerships with the private sector in the implementation of food fortification initiatives as well as policies promoting exclusive breastfeeding and healthy diets. **Annex 2** includes a summary of the nutrition interventions deployed in the Region and the challenges encountered.

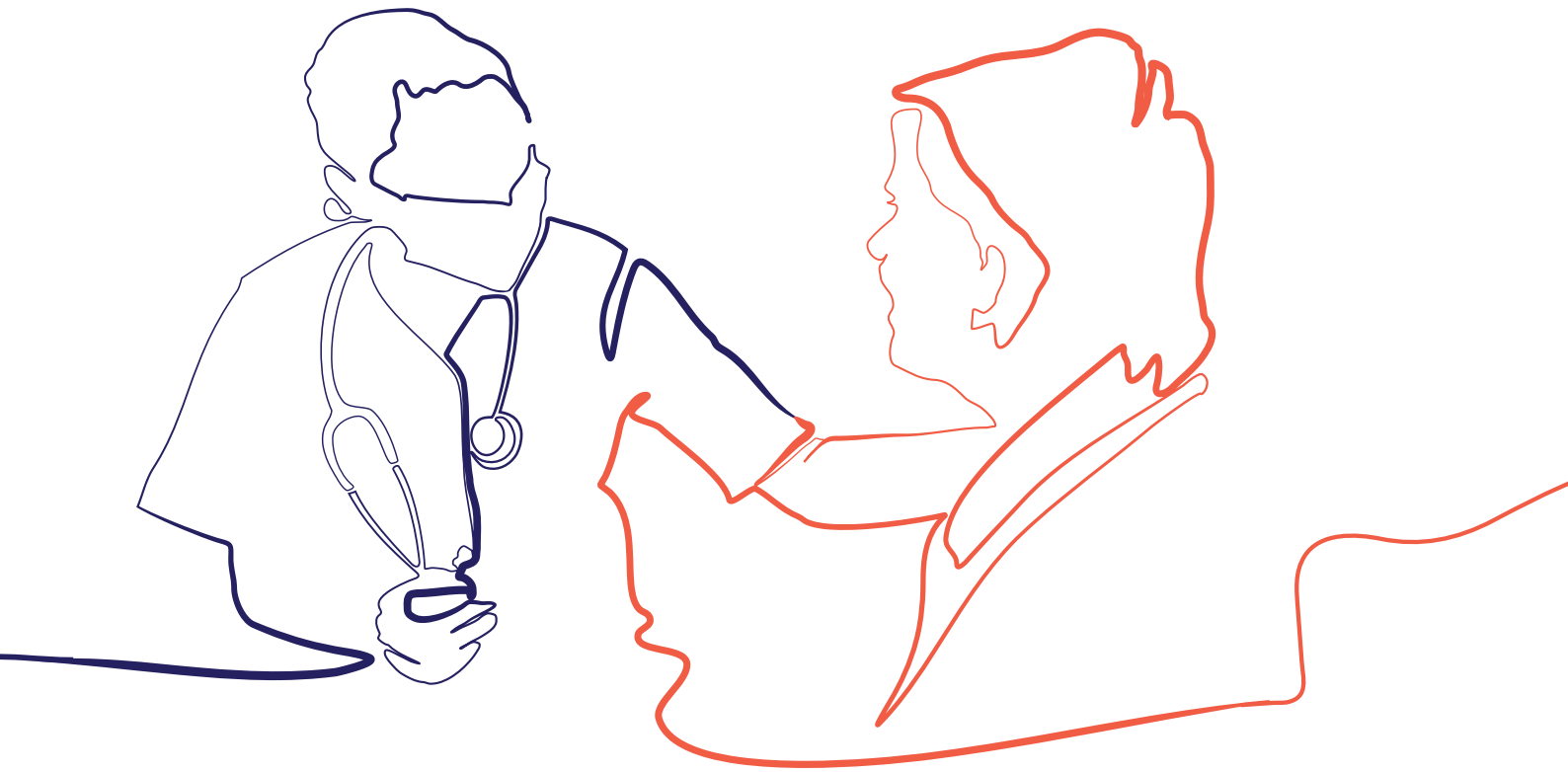
Horizontal PPPs

A rare example of nationwide, health system-level (rather than programme-specific) partnership is the Sehat Sahulat social protection programme in Pakistan. The programme is a horizontal PPP in that it includes private hospitals in the provision of services. Beneficiaries of this health insurance scheme can visit any of the government and private medical facilities listed as contracted hospitals on the programme's website. Currently, the programme covers inpatient services only, but with the intention of extending to outpatient services in future. Sehat Sahulat entitles beneficiaries and their family members to free emergency services, hospitalization, medical treatment, surgical procedures, maternity services, referral transportation, follow-up and consultations under its secondary care package. A priority package also covers chronic diseases such as TB and hepatitis, among others.

Outsourcing of district health care service delivery to national and international NGOs was initiated through the World Bank-led Multi-Donor Trust Fund in six underserved districts, with selected NGOs made responsible for entire district health systems, including district hospitals, PHC facilities and outreach programmes. While no formal evaluation was carried out at the end of the project, it was clear that the model could not achieve the desired impact *(17)*.

Sindh province in Pakistan has other notable examples, including the Indus Health Network, through which the private sector manages public hospitals and primary care clinics under PPP. The Indus Health Network has also set up regional blood centres under PPP agreement in order to facilitate blood transfusions and blood management at government facilities. In addition, Integrated Health Services is a national health care group with operations across all regions in Pakistan providing a wide range of curative and preventive health services along with research, consultancies, public health training and health infrastructure development. Under the Sindh PPP Act 2010, a performance-based partnership agreement was signed between the Department of Health Sindh and Integrated Health Services in March 2015. Under this agreement, 111 health facilities, including 105 rural health centres and six Tehsil headquarter hospitals in 20 districts of Sindh, were contracted out to Integrated Health Services.

Baluchistan has three major PPP initiatives to extend access to services. Mercy Corps, Médecins Sans Frontières and Save the Children entered into formal agreements with the government to strengthen health care facilities including 90 basic health units and four district hospitals, and to establish birthing stations *(69)*. Unlike Khyber Pakhtunkhwa and Sindh, the financing is provided by the NGOs rather than the State.



4
Conclusion

Private sector engagement strengths

The private health sector is the predominant health care provider in many developing countries. The quality of services in some health care facilities (such as IVF, neonatal care, diagnostic and laboratory services) is perceived to be better than in their public sector counterparts. The private health sector is also known for quality health care services at the tertiary level. Thus, the sector has the trust of the masses and remains the preferred choice for the majority. Many health sector strategies have supported the establishment of relevant PPPs and emphasized the need for designated units for engagement with the private sector. In addition, several examples of private health sector engagement and best practices have been identified. Those examples provide models for the different ways through which the private health sector can offer facilities, staffing and equipment to the government during surge times in the Region.

The engagement of the private sector is well established in mental health, nutrition-specific interventions and emergency care. In mental health, the private health sector, both for-profit and not-for profit, is active. Moreover, a regional framework is already in place for scaling up action on mental health with a strategic priority to integrate priority mental conditions in the basic health delivery package of government and social/private insurance reimbursement schemes. As for nutrition, 17 countries in the Region have enacted laws or regulations for implementing the International Code of Marketing of Breast-Milk Substitutes with business and NGO partners. Furthermore, eight countries have developed nutrition surveillance systems, and the majority have reported the existence of monitoring and evaluation systems *(13)*. The private health sector also plays a significant role in delivering emergency care alongside the public sector in the Region; these contributions extend beyond delivery of emergency care into other key elements, such as the supply chain and health care provider training. Multiple countries have mandates requiring the provision of emergency care to all who present with acute illness or injury, regardless of ability to pay, at all facilities.

Poor quality of service delivery by the private health sector is not unusual, especially in rural settings

Private sector engagement weaknesses

The private health sector suffers from urban bias where providers are generally concentrated in the urban areas and limited services are offered to the rural population. Those providers are mainly active in curative health care services, with little emphasis on promotive and preventive care.

The sector remains unregulated, expensive and market-driven in countries and territories of the Eastern Mediterranean Region. High-income countries have regulatory mechanisms to ensure recertification and relicensing, while regulation remains weak in low- and middle-income countries. Few countries of the Region have mandates to regulate private sector ambulance operations, but most countries have a mandate to regulate private facility-based emergency care. However, evidence suggests that the mandate is rarely enforced. Furthermore, many existing nutrition-related policies have not materialized into impactful interventions. Of the 17 countries that have enacted the International Code of Marketing of Breast-Milk Substitutes in law, only six countries have fully implemented the required measures. The Region also lags in implementing nutrition labelling standards, developing dietary guidelines, promoting reformulation of foods and beverages, and banning trans-fatty acids *(13)*.

Poor quality of service delivery by the private health sector is not unusual, especially in rural settings. Private primary care facilities are generally one-person clinics and a skills-mix, multidisciplinary approach is not practiced. The level of knowledge and expertise among the private providers is variable. Furthermore, continuous medical education and improvement among private providers at primary level is generally missing. Intersectoral referral pathways (formal and informal) are weak, which results in a lack of continuity of care in the case of low-income clients.

Private health sector information systems also have many shortcomings. The existing legislation and regulatory capacity to enhance reporting are deficient. Accordingly, the collection, maintenance and dissemination of data are considered poor at most private health facilities except for tertiary facilities, which share fragmented information with the government in some countries. This lack of records maintenance leads to absence of continuity of care and weak evidence-based decision-making. Moreover, poor health information systems result in limited information about the diversity, functions and motivations of the sector in the Region, as well as incomplete understanding of the effectiveness of ongoing PPPs.

PPPs in nutrition-specific interventions across the Eastern Mediterranean Region are still in their infancy with modest involvement of some business sectors such as media, hotels, telecommunications and entertainment. Moreover, no framework specific to engagement of the private health sector for emergency care was found.

Private sector engagement opportunities

Despite the challenges, there are multiple opportunities for private sector engagement in the Region. Those opportunities are mainly driven by the political will to embrace UHC and the significance of the private health sector in this regard. Both for-profit and not-for-profit private providers bring a unique set of skills and resources that can complement the public sector to improve access and outcomes, particularly for vulnerable, poor and rural communities.

This has manifested in the health insurance laws of many countries that call for the engagement of the private sector. The political will to engage the private sector in health is further reinforced by strong advocacy at the international, national and subnational levels to engage the sector in different areas such as RMNCAH. In addition, the existing needs gap in mental health can be addressed by systematically involving the sector in health care in relevant services.

Moreover, the informal and/or indirect referral linkages between the public and private sector can be further strengthened to improve quality of services. The technical capacity of higher private health sector tiers in certain fields such as abortion services and post-abortion care can be leveraged in many countries.

Both for-profit and not-for-profit private providers bring a unique set of skills and resources that can complement the public sector to improve access and outcomes, particularly for vulnerable, poor and rural communities

COVID-19 has renewed the emphasis on multi-stakeholder engagement to meet population needs for emergency care and improve health status

There is an opportunity to increase the quality of services at private facilities by employing external health care commissions and accreditation bodies to enforce mechanisms able to improve adherence to existing mandates. In addition, a health care system with bylaws that mandate accreditation is likely to increase compliance and enhance service quality.

Thus, intersectoral partnerships offer a potential opportunity to improve the standard of current care for health services in the Region. There are also multiple successful PPPs that could be scaled up. Those include the flour fortification initiatives in Iran (Islamic Republic of) and Jordan which resulted in 100% fortification coverage. Moreover, the increasing role of the private sector in the implementation of obesity-related interventions was reported in ANT countries.

Finally, COVID-19 has renewed the emphasis on multistakeholder engagement to meet population needs for emergency care and improve health status in the Region. The pandemic has also triggered many new initiatives by the private sector, some of which can be leveraged and built upon. These include mental health support for individuals, families and health professionals.

Challenges to private sector engagement

The challenges to private sector engagement are mainly related to the lack of comprehensive regulatory policies and their poor enforcement, as well as the unequal power dynamic of the different stakeholders.

There are no clear legislative frameworks to govern and guide private sector engagement and to guard against PPPs overriding public sector policies. Accordingly, private sector engagements, when present, are generally unsystematic and in many cases inconsiderate of marginalized communities. The involvement of the private sector in service provision is also sometimes perceived as a failure of the government in meeting its obligation to provide health care services to its citizens. This is further compounded by outdated legislation incompatible with PPPs. Furthermore, the lack of financial resources to cement regulatory structures in place and for the enforcement of regulatory measures, coupled with corruption in the public sector, affect regulation and the accountability of the private health sector.

The continuous exclusion of the private health sector from developing public health plans, standards, training and guidelines compromises the quality of care and the chances for future collaboration. Moreover, dual practice by providers presents a major conflict of interest.

Finally, the misalignment in goals between the public and private sector presents a threat that needs to be considered when engaging the private health sector in the Region.

5
Way forward

Cross-cutting recommendations

Policy

- Develop national policies and related strategies to engage with the private health sector across all stages of policy development moving to implementation and monitoring.
- Clearly state the private health sector engagement policy in all health domains at all levels including the primary level, subnationally and nationally.
- Increase the allocated health budget to the ministry of health, with a separate allocation for PPPs.
- Ensure representation of private health care professionals at the policy level for the formulation of clinical standards, guidelines and strategies related to provision of essential health services.
- Renew the licensing of health professionals every five years with strict requirements of continuing medical education to ensure the quality of care being provided.
- Establish a separate directorate/ commission to ensure the registration of all facilities and licensing of all providers. Similarly, the private facilities need to be accredited and only those eligible can engage with the public sector.
- Political leadership is needed whereby key personnel within the public sector take the lead in creating the partnership. Patronage of a figurehead (President, Prime Minister or health minister) is helpful, as seen in Pakistan.

Process

- Maintain systematic dialogue and shared decision-making among partners.
- Create a platform for the exchange of information regarding good practices, ongoing innovations and lessons learnt.
- Incentivize and mandate the private sector to share data with the government and set mechanisms for the public sector to utilize the information in the formulation of strategic and operational plans.
- Strengthen, integrate and digitalize private sector health information systems.
- Build the technical capacity of the government to carry out core stewardship functions, including regulation and accreditation; strategic planning; monitoring and evaluation; assessing and managing the market and operational risks; and designing PPP contracts and payment mechanisms that align the incentives towards achieving public health goals.
- Include the private sector in disease-specific clinical training and other continuing education activities; consider providing accredited certification to encourage participation.
- Map the private health sector in terms of its volume, scale, scope and finances prior to designing partnerships.
- Develop a clear description of the plan for addressing the established needs and consider the risks in addition to the benefits that are likely to emerge from the partnership.
- Establish an independent organization/ department in the public sector for managing PPPs.
- Clearly state the range of services in PPP contracts with detailed reference to the responsibilities of both parties.
- Consider the financial capacity for long-term PPP to ensure the sustainability of efforts.
- Map and strengthen the referral linkages between the public and private sector.
- Streamline the contracting process of private health services.
- Ensure flexibility in adapting to technological innovations, information technology, needs of the target population, funding environments and changes to strategic objectives over time.

Monitoring and evaluation

- Plan PPPs in a way that ensures the proper implementation of the regulatory and legal measures.
- Establish a legal claims department in the health ministry to address the concerns of the private health sector and to ensure an indirect accountability mechanism for private providers.
- Support PPPs with a well-established monitoring and evaluation framework, with mandatory reporting by the public and the private health sectors, and enforcement by government.
- Develop a systematic approach to evaluate the impact and outcomes of PPP as well as generating evidence on the drivers of successes versus failures in PPPs.

Service delivery

- Incentivize the private health sector to contribute to health promotion and preventive care.
- Involve the private health sector in service delivery (especially in areas where public sector coverage is low) and in raising community awareness.
- Implement mandatory credentialing and registration of facility-based providers.

Specific recommendations

RMNCAH

- Clearly outline the package of services to be provided at each health care level related to antenatal care, postnatal care and childhood illnesses.
- Address abortion and post-abortion services, family planning, neonatal care and community awareness-raising through PPPs.
- Offer capacity-building activities related to antenatal and postnatal care, family planning, weaning practices, Integrated Management of Newborn and Childhood Illnesses and syndromic management of sexually-transmitted infections to private health care providers at minimal cost.
- Introduce standardized comprehensive data forms capturing the number of antenatal visits, immunizations, childbirth and postnatal care, uptake of contraception and child mortality in health information systems.
- Implement demand-side financing in the form of voucher schemes for improved contraception uptake.

NCDs

- Introduce standardized comprehensive data forms capturing risk factors, morbidity, prognosis and NCD-related mortality in health information systems.

Mental health

- Use partnerships as a way to bridge the existing gaps in care for mental health in the Region such as perinatal depression, which has an estimated incidence of 95%.
- Seek support from different stakeholders and involve them in the partnership (e.g., Ministry, provinces, primary care personnel) at regional and local levels.p

Nutrition

- Support PPPs with well-established legislation and regulatory measures which mandate the implementation of a set of standards and specifications that ensure access to healthy and safe food.
- Governments to lead PPPs. This is very specific to Eastern Mediterranean countries where PPPs are being driven by international development agencies. Under such scenarios, the work of the development partners may be limited to supporting the government in strengthening its relationship with the private sector rather than dismissing the government oversight role in the implementation of nutrition policies.
- Establish a social fund with contributions from the private sector to support the implementation of nutrition programmes targeting the most vulnerable populations in the Region.

Communicable diseases

- Avoid delegating immunization services to the private for-profit sector without a regulatory mechanism in place to ensure proper coverage.

Emergency care

- Plan for private sector engagement such that it addresses instances of surge or outbreak, and not just day-to-day service provision.
- Coordinate ambulance dispatch centrally, regardless of the service provider.
- Develop out-of-hospital and facility-based emergency care as well as ambulance service accreditation and quality standards based on country-specific context.

6
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7
Annexes

Annex 1

Proportion of RMNCAH services provided by the private sector in selected countries/territories of the Eastern Mediterranean Region

RMNCAH related services	Egypt	Iraq	Jordan	Morococo	Occupied Palestinian territory	Syrian Arab Republic	Tunisia	Yemen
Percentage of women of reproductive age using modern contraception from the private sector	44	90	56	NA	74	NA	NA	46
Percentage of women giving birth in a private facility	71	11	34	11	36	56	15	37
Percentage of children (0–59 months) who sought treatment from a private provider for diarrhoea	78	NA	41	NA	NA	NA	NA	36
Percentage of children (0–59 months) with acute respiratory infection who sought treatment from private providers	78	43	40	NA	62	69	45	68

NA: data not available.

Annex 2 PPPs in nutrition-specific interventions in the Eastern Mediterranean Region

Nutrition intervention	Country/territory	Private sector actors	Challenges
IYCF	**Bahrain** **Oman** **Pakistan** **Iraq**	Breast-milk substitute manufacturers Entertainment sector Mobile networks	Data not available
Vitamin A supplementation	**Occupied Palestinian territory**	Local producers of fortified milk and biscuits	Data not available
Supply of RTUF	**Sudan**	Local manufacturers of RTUF	Data not available
The Code	**Afghanistan, Bahrain, Djibouti, Egypt, Gaza Strip, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Qatar, Saudi Arabia Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen**	Breast-milk substitute manufacturers	Lack of adequate monitoring and enforcement mechanisms of the Code including the regulation of private sector compliance

Nutrition intervention	Country/territory	Private sector actors	Challenges
Wheat flour fortification (voluntary and mandatory)	**Afghanistan, Bahrain, Djibouti, Gaza Strip, Kuwait, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Morocco, occupied Palestinian territory, Pakistan, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, United Arab Emirates, Yemen**	Millers associations	Sustainability Funding Monitoring and evaluation Compliance of the private sector Reaching the most disadvantaged populations
Salt iodization (voluntary and mandatory)	**Afghanistan, Bahrain, Egypt, Kuwait, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestinian territory, Oman, Pakistan, Qatar, Sudan, Syrian Arab Republic, United Arab Emirates, Yemen**	Salt producers	Sustainability Funding Monitoring and evaluation Compliance of the private sector Reach to disadvantaged populations
Reduction of trans-fatty acids	**Bahrain, Islamic Republic of Iran, Jordan, Kuwait, Oman, Qatar, Pakistan, Saudi Arabia, United Arab Emirates, Yemen**	Food manufacturers	Political commitment Labelling Enforcement
Salt reduction	**Bahrain, Islamic Republic of Iran, Jordan, Kuwait, Oman, Qatar, Saudi Arabia, Tunisia**	Food manufacturers Bakers	Political commitment Labelling Enforcement
Food labelling	**Bahrain** **Morocco** **Saudi Arabia** **Tunisia** **United Arab Emirates**	Food manufacturers	

Nutrition intervention	Country/territory	Private sector actors	Challenges
Marketing of unhealthy foods and beverages to school-age children	**Egypt, Islamic Republic of Iran, Morocco, Oman**	Food manufacturers	Data not available
Obesity awareness campaigns	**Morocco, United Arab Emirates**	Tourism Entertainment, Technology Food manufacturers Bakers	Data not available

8
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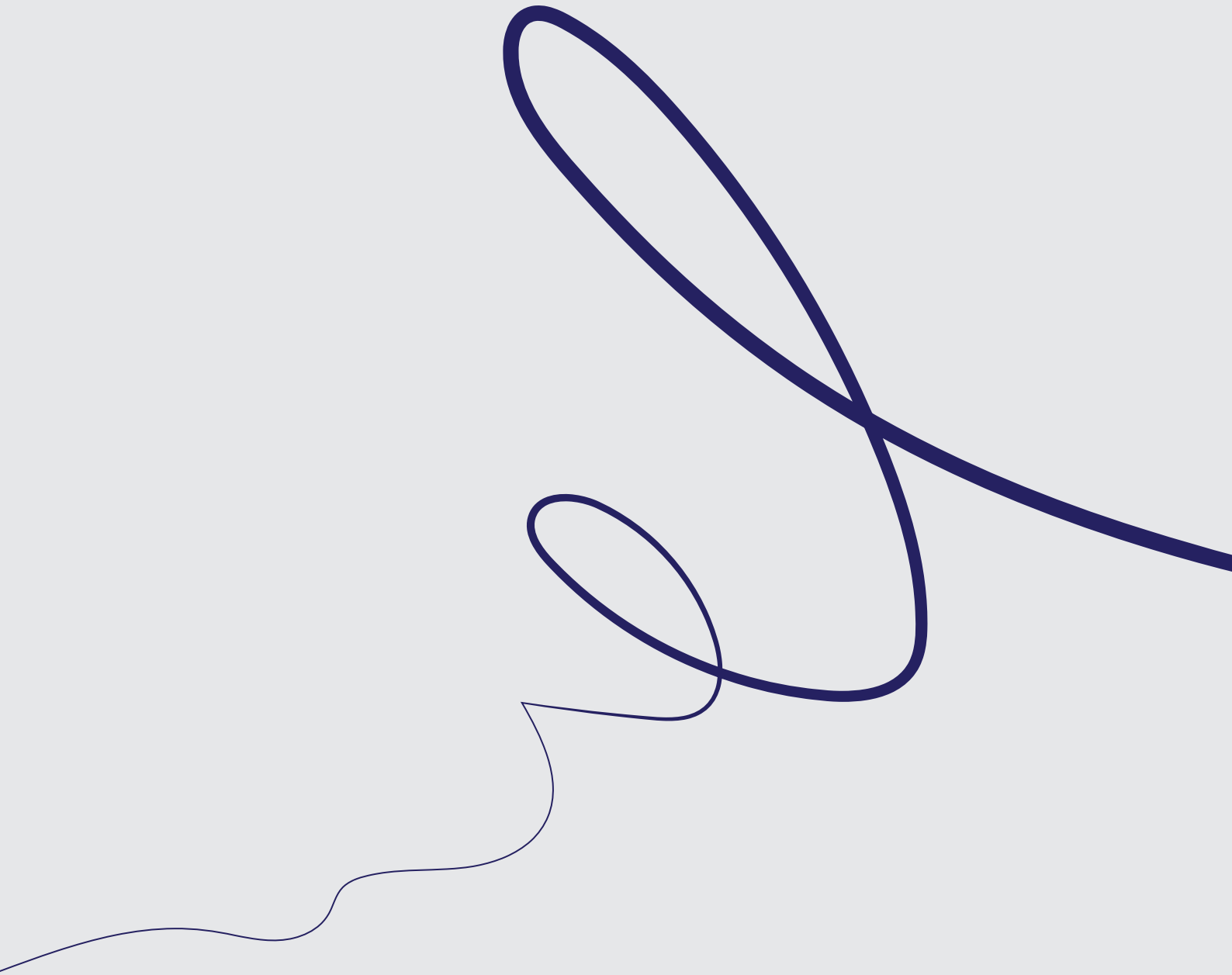

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