Understanding the private health sector
in Jordan

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WHO Library Cataloguing in Publication Data

Names: World Health Organization. Regional Office for the Eastern Mediterranean

Title: Understanding the private health sector: in Jordan/ World Health Organization. Regional Office for the Eastern Mediterranean

Description: Cairo: World Health Organization. Regional Office for the Eastern Mediterranean, 2023 I Includes bibliographical references

Identifier: ISBN 978-92-9274-081-8 (pbk.) I ISBN 978-92-9274-082-5 (online)

Subjects: Private Sector I Social Determinants of Health I Delivery of Health Care I Health Expenditures I Universal Health Insurance I Public-Private Sector Partnerships I Jordan

Classification: NLM WA 540

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Acknowledgements

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1

Country context: social determinants of health

Jordan is a small lower middle-income country with limited natural resources and scarce fresh water supplies (it is one of the world's 10 most water-stressed countries). Jordan has a total land area of 89 300 km2, of which only 7.8% is arable land *(1)*.

Around 86.6% of Jordan's population lives in urban areas, with about 50% of the population living in the Greater Amman area. The average life expectancy in 2017 was 73.5 years (73.2 years for men; 74.4 years for women). The literacy rate for 2017 (persons 15 years and older who are able to read and write) was 97.1% *(2,3)*. Jordan's performance is among the best of the countries of the WHO Eastern Mediterranean Region in terms of life expectancy, adult literacy, school enrolment, female literacy and other basic indicators.

Administratively, Jordan is divided into 12 governorates, each headed by a governor appointed by the king. The governorates are the sole authorities for all government departments and development projects in their respective areas *(1)*.

The population in Jordan has increased from 586 000 people in 1952 to 10.053 million in 2017 (Table 1). According to the 2015 population census, 13.2% of the population are Syrian refugees – accounting for 43% of all non-Jordanians in the country. The average annual population growth rate in 2017 was 2.4%. If the annual population growth rate continues at that rate, Jordan's population will double in approximately 31.5 years. Eighty-two per cent of the Jordanian population is below the age of 40. The total fertility rate is relatively high, though it has declined in recent years, from 3.7 in 2006 to 2.7 in 2017.

Table 1: Selected demographic indicators, 2006–2017

Indicators	2006	2008	2010	2011	2017
Total population	5 600 000	5 850 000	6 113 000	6 249 000	10 053 000
Crude birth rate (per 1000 population)	29.1	29.1	30.1	28.9	23.0
Crude death rate (per 1000 population)	7.0	7.0	7.0	7.0	6.1
Population growth rate (annual %)	2.3	2.2	2.2	2.2	2.4
Population < 15 years old (%)	37.3	36.9	37.3	37.3	35.4
Total fertility rate (births per woman)	3.7	3.6	3.8	3.8	2.7

Sources: *(2,3)*.

2
Health status and selected health indicators

Jordan achieved universal child immunization in 1988 and has made substantial progress in reducing the major health risks to infants and children. The country has been polio-free since 1995. Since the early 1980s, all national socioeconomic plans have emphasized the right to health and health care. Major progress has been achieved in lowering infant and child mortality rates, as well as maternal mortality rates. Presently, Jordan has one of the lowest infant and maternal mortality rates among countries in the WHO Eastern Mediterranean Region *(1)*.

Available data on morbidity confirm the public health importance of cardiovascular disease, diabetes and respiratory diseases (pneumonia and asthma). Cardiovascular-related (circulatory) conditions are the principal causes of death in Jordan, followed by cancer and external causes. Iron deficiency and anaemia have been identified as a public health problem. Smoking is a major health and economic problem in Jordan. Jordan is considered a low-prevalence country for HIV/AIDS. Thalassemia is the most common hereditary disease in Jordan *(4,5)*.

Table 2: Indicators of health status, 2017

Indicator	Value
Life expectancy at birth (years)	73.5
Infant mortality rate (per 1000 live births)	19.0
Under-five mortality rate (per 1000 live births)	21.0
Maternal mortality rate (per 100 000 live births)	19.0
Births in a health facility (%)	98.0
Anaemia among women (%)	43
Anaemia among children (%)	32
Proportion of babies at normal birth weight (%)	91.4
Prevalence of stunting (%)	8
Prevalence of wasting (%)	2

Sources: (2,5).

3

Organization and delivery of health services

Jordan has one of the most modern health care infrastructures in the Middle East. It has an extensive network of primary health care facilities, with about 2.3 centres per 10 000 population and an average patient travel time to the nearest centre of 30 minutes; this represents a high-density system by international standards. The private sector is already active in curative primary care, accounting for nearly 40% of all initial patient contacts *(1)*. Jordan has 15 inpatient beds per 10 000 population. Ten per cent of the population is admitted annually to hospitals. The average length of a hospital stay is three days, and the hospital occupancy rate is 60% *(2)*.

Jordan's health system is a complex combination of three major sectors: public, private and donors.

3.1 Public health sector

The public sector consists of two major public programmes that finance as well as deliver care: the Ministry of Health (MOH) and Royal Medical Services. Other smaller public programmes include university-based programmes, such as Jordan University Hospital in Amman and King Abdullah University Hospital in Irbid.

3.2 Private health sector

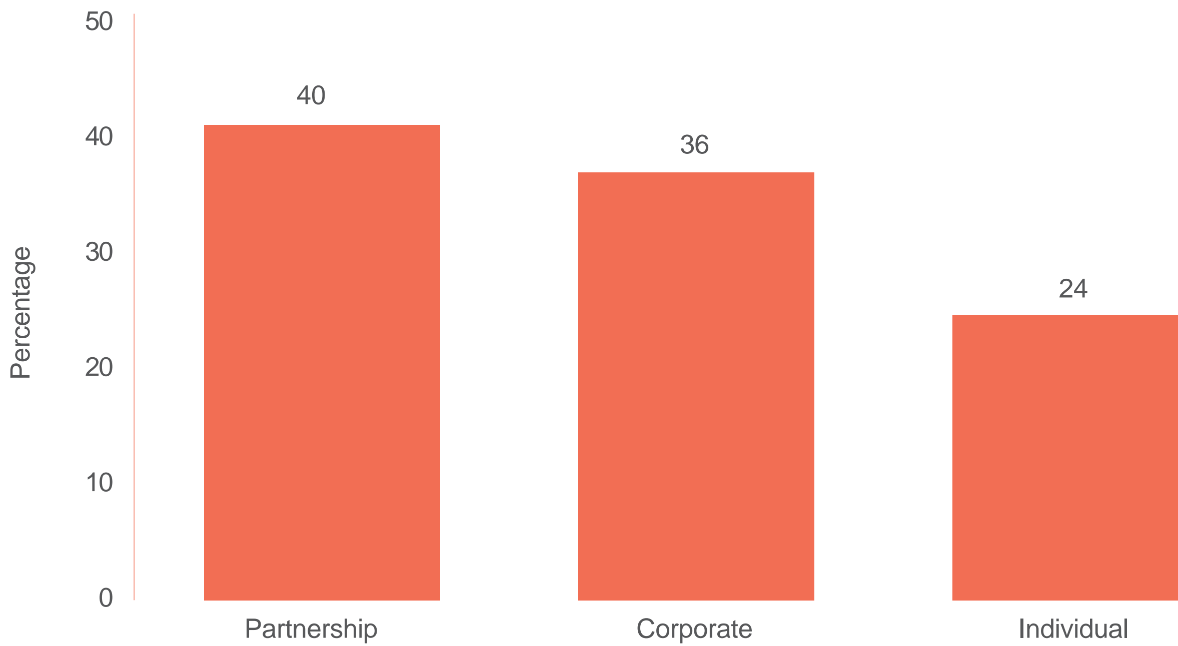
The private sector includes 66 hospitals (about a third of the total bed capacity) and many private clinics. Over 1.6 million Palestinian refugees in Jordan get access to primary care through the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) *(6)*.

3.2.1 Private for-profit health sector

The private for-profit health sector operates 51 hospitals with 3795 beds *(2)*. Data collected from private hospitals shows that 24% of hospitals are owned by individual physicians, while 36% and 40% of hospitals are owned by corporate companies and partnerships, respectively (Fig. 1). Because they need large investment, most new modern hospitals are owned by corporate companies. Almost all corporate-owned hospitals in Jordan are managed by the owners, not by professional health care managers.

As reported in literature, for-profit providers are less likely to pursue social goals. Not-for-profit providers often have better links to their community and are better able to mobilize voluntary effort and philanthropy and work for social goals *(7,8)*.

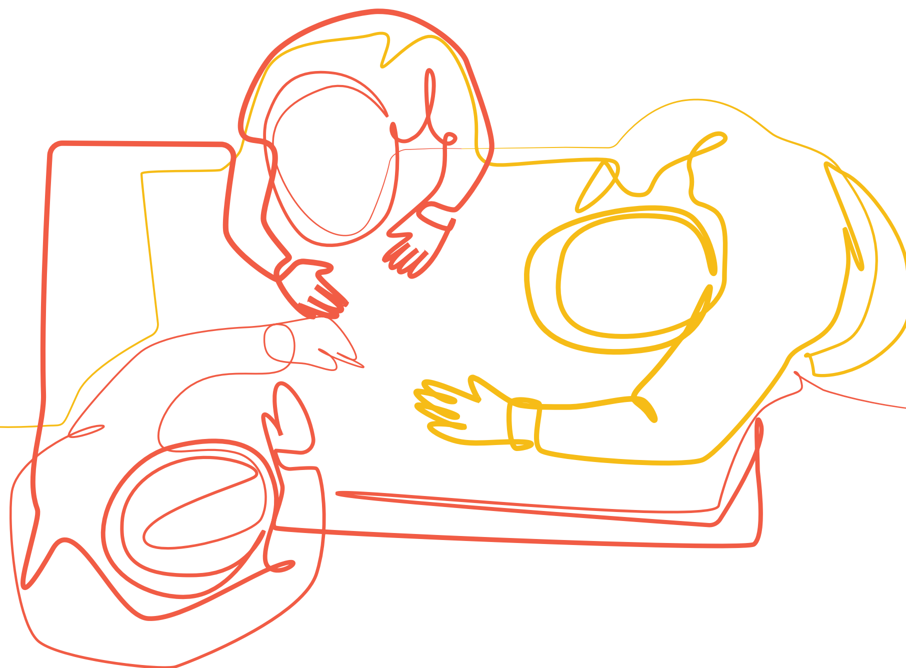
Figure 1: Ownership of private for-profit hospitals



Sources: *(4,9)*.

3.2.2 Private not-for-profit health sector

The private not-for-profit health sector runs 15 hospitals with a total bed capacity of 1197 *(2)*. Not-for-profit hospitals are operated under the umbrella of either the General Union of Voluntary Societies or missionary societies. Only one hospital, Palestine Hospital, is an independent not-for-profit hospital. Existing laws should be amended so that independent not-for-profit hospitals can benefit from all financial incentives given to philanthropic and religious organizations.



4

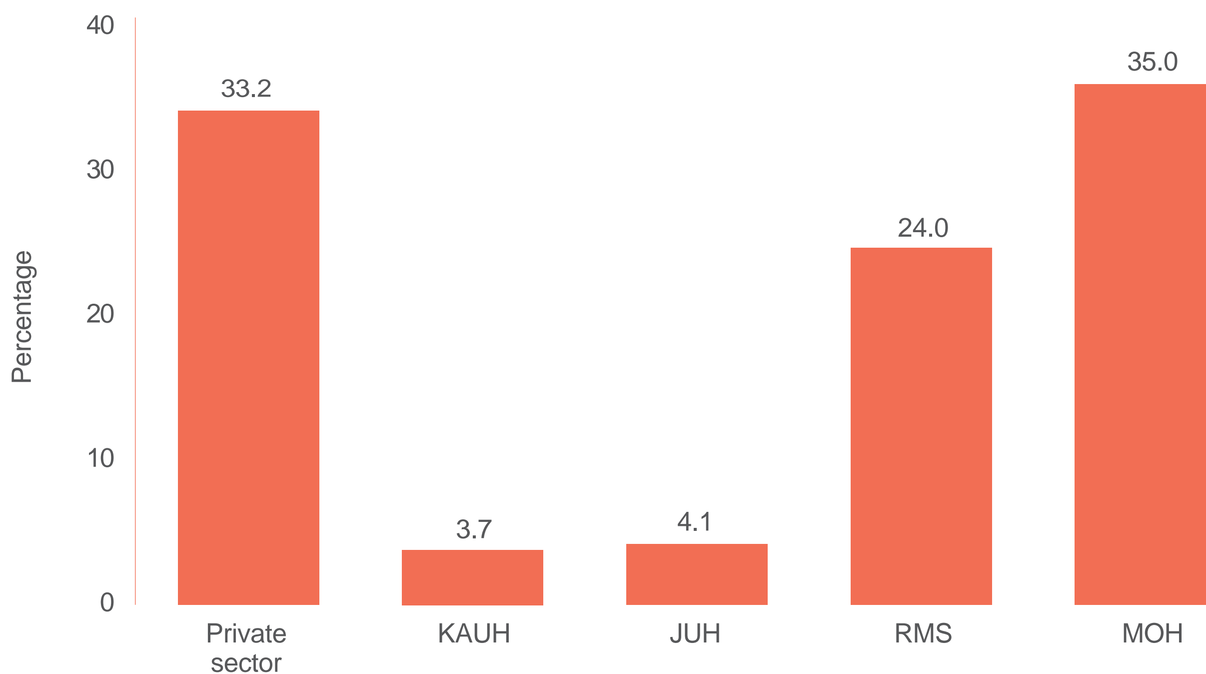
Health sector resources

The private sector operates 51 general hospitals and 15 specialized hospitals (nine gynaecology and obstetrics hospitals, three eye hospitals, one cancer centre, one psychiatric hospital and one hospital for chest diseases) *(9)*. Some private hospitals, such as the Arab Medical Center and Ibn Al Haitham Hospital, had initially started as specialized centres and were converted to general hospitals. The Arab Medical Center started as a cardiac and special surgery centre, and Ibn Al Haitham Hospital specializes in eye and special surgery. General hospitals are usually more competitive and cost-effective.

Large and modern private hospitals in Amman, such as Jordan Hospital, Specialty Hospital, Islamic Hospital, Arab Medical Center and Istishari Hospital, provide a full range of inpatient and outpatient diagnostic, therapeutic, medical and surgical procedures using the latest medical technology. Some private hospitals (Specialty Hospital and Jordan Hospital) have achieved very high success rates in off-pump cardiac surgeries, paediatric cardiac surgeries and organ transplant, especially kidney transplant (with a success rate of 97%), in addition to cochlear transplant, arthroplasty, knee replacement, dental surgeries and other sophisticated procedures.

The private health sector now operates 66 hospitals with 4992 beds, which make up about 33.2% of the total beds in Jordan (Fig. 2) *(2)*.

Figure 2: Percentage distribution of hospital beds by health subsector, 2017



JUH: Jordan University Hospital; KAUH: King Abdullah University Hospital; MOH: Ministry of Health; RMS: Royal Medical Services.
Source: *(2)*.

Jordan universities and colleges have been the main suppliers of health professionals in both public and private health sectors over the last 10 years. There are 44 university health schools and programmes in the country; the private for-profit sector runs 19 schools that teach pharmacy, nursing, paramedic studies and health management. During the 2016/2017 academic year, 41 152 students were enrolled in health education programmes in Jordan universities. Of those, 24% were enrolled in private universities and the majority (65%) were female. The annual output during 2017 was 7252 graduates, most of whom were employed by the private sector *(10).* Six thousand students (half the number of enrollees in Jordan medical schools) are studying medicine outside Jordan *(10)*.

Jordan had 22.6 physicians, 29.2 nurses (all categories), 15.6 pharmacists and 7.1 dentists per 10 000 population in 2017. Between 2013 and 2017, the percentage of all health professionals relative to the population decreased due to the increase in population resulting from the forced Syrian migration. Before the crisis in the Syrian Arab Republic, in the year 2011, the physician-to-population ratio was higher than that in most countries in the Middle East and North Africa and in other lower middle-income countries *(2)*.

NGOs represented by the General Union of Voluntary Societies run 98 not-for-profit clinics (38 general practice clinics, 20 gynaecology clinics, 10 paediatric clinics and 22 dentistry clinics) and eight medical laboratories. About 60% of these clinics are located in Amman and serve mainly the poor and lower middle-income population. They charge less than the minimum fees set by the Jordan Medical Association and provide free services for the poor. These clinics, together with the MOH health centres and UNRWA clinics, serve as the backbone of the primary health care safety net for underprivileged and low-income people in Jordan *(4)*.

5
Health financing and expenditure

5.1 Health finance

In 2015, approximately 43.0% of total health finance funds originated from private sources, 52.3% originated from the public sector and 4.7% originated from donors. Table 3 shows the total amounts allocated by original financing sources.

Private sources of financing include:

- **health care expenditure incurred by self-insured firms on behalf of their employees, and private company expenditure on commercial health insurance (11.9%); and**
- **households' out-of-pocket (OOP) expenditure on health care services, pharmaceuticals and premiums for public health insurance and private health insurance (PHI) (31.1%).**

Household OOP expenditure was the second largest source of financing.

5.2 Health expenditure

Total health expenditure, both public and private, in Jordan in 2015 was estimated at JD 2.249 billion (US$ 3.118 billion), and the per capita expenditure was JD 236 (US$ 333.3). Total expenditure on health accounted for 9% of the gross domestic product, which is considered high for a lower middle-income country. Fig. 3 shows the trend of total expenditure on health over nine years (2007–2015). This level of expenditure is more in line with that of countries of the Organisation for Economic Co-operation and Development. The proportion of government budget allocated to the health sector was 11.35% in 2015 *(11)*.

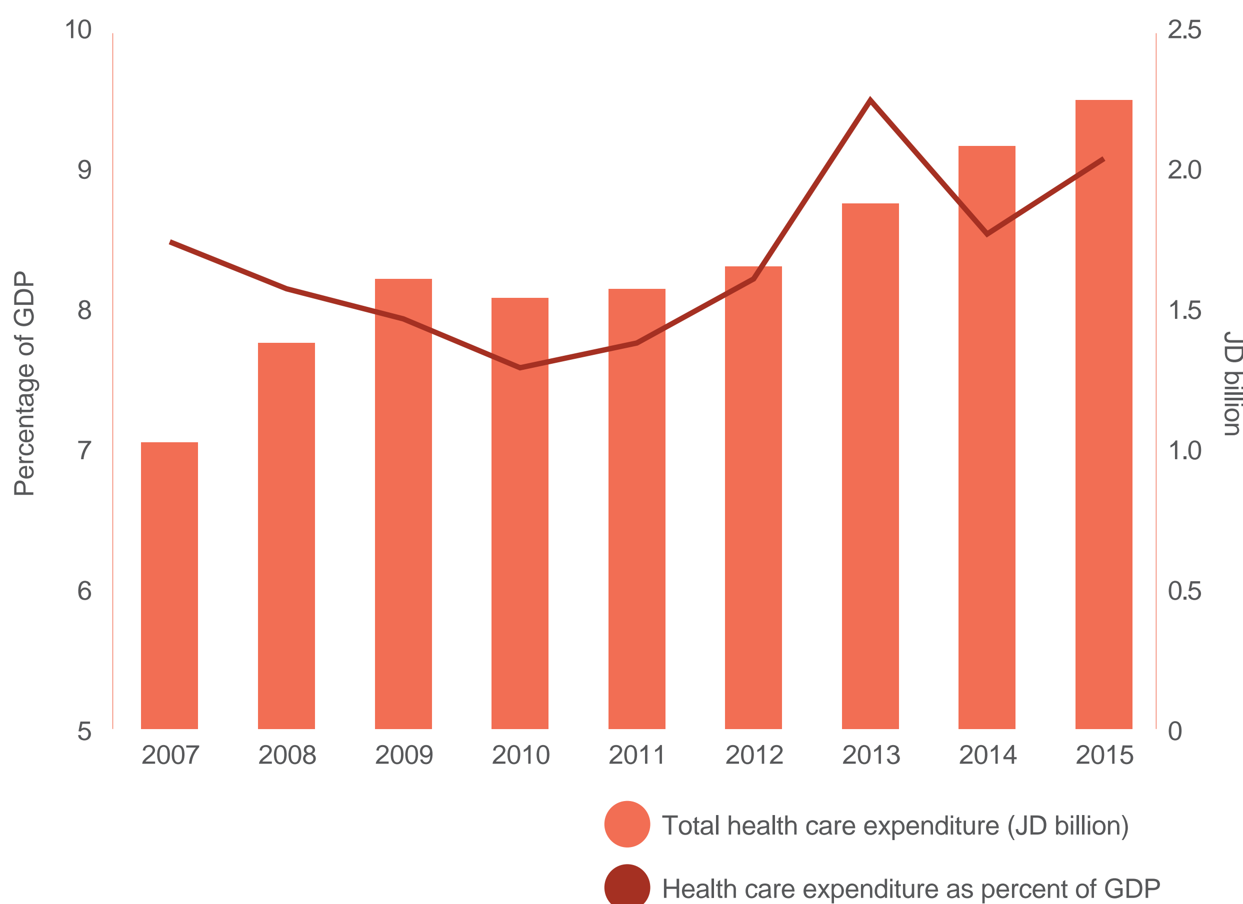
The public sector accounted for 64.96% of health expenditure, the private sector for 31.44%, NGOs for 2.89% and UNRWA clinics for 0.72%.

Expenditure on pharmaceuticals was very high and reached JD 581.9 million in 2015, which accounted for 2.18% of gross domestic product and 25.87% of the total health expenditure; more than 50% of pharmaceutical expenditure (54.64%) was incurred in the private sector. Public expenditure on curative care accounted for 74% of all public expenditure on health in 2015, and expenditure on primary care accounted for 18%, while almost all private expenditure was on curative care *(11)*.

5.3 Household health care expenditure

Household expenditures are either paid to providers as OOP expenditures in public and private health facilities or are paid as premiums for public health insurance and PHI. OOP expenditure as a percentage of total health expenditure decreased slowly from 2012 to 2015 but was still more than 25%. The private sector got the lion's share, about JD 549 million (75% of total household expenditure) *(11)*.

Figure 3: Trend of Jordanian health care expenditure, 2007–2015



GDP: gross domestic product.
Source: *(11)*.

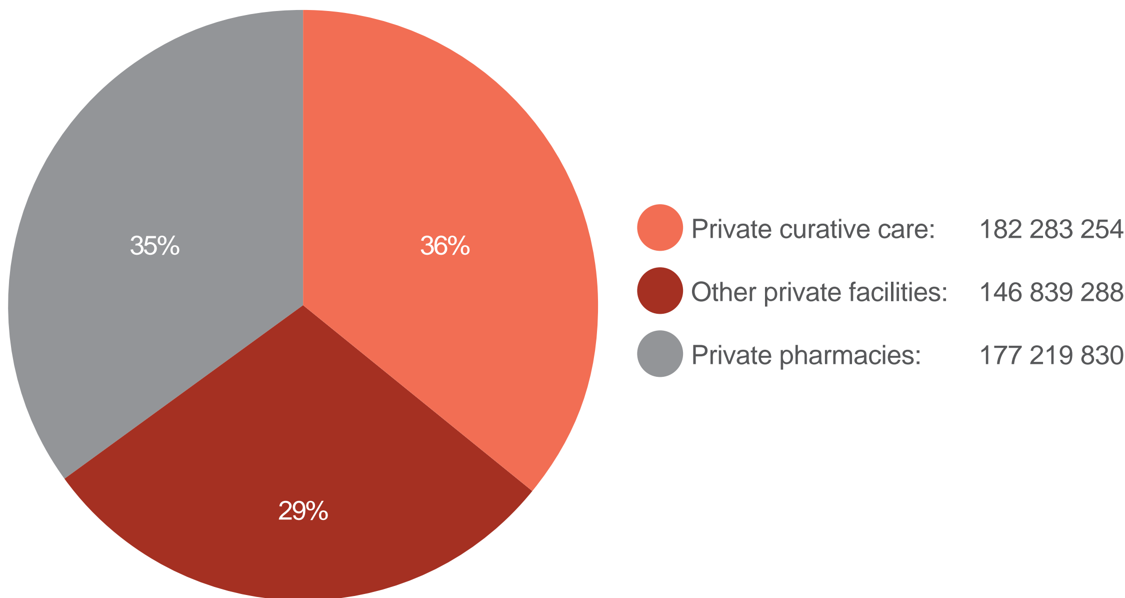
OOP expenditure represented 82% of total household expenditure in 2015. Total OOP expenditure on health services by Jordanian households in the private sector amounted to around JD 506.3 million in 2015. Fig. 4 shows the distribution of this OOP expenditure: household expenditure on pharmaceuticals amounted to 35%, on private hospitals to 36%, and on other private facilities to 29% *(11)*.

Table 3: Total health finance amounts allocated by original financing sources, 2015

	Ministry of Finance	Ministry of Planning	Other government entities	Private firms	Households	UNRWA	Donors	Total
Allocation (JD)	892 906 132	14 293 630	316 574 999	279 901 176	730 709 235	17 248 125	94 532 685	2 346 165 982
Percentage of total[a]	38.1	0.6	13.5	11.9	31.1	0.7	4.0	100

UNRWA: United Nations Relief and Works Agency for Palestine Refugees in the Near East.
[a] Percentages do not add up to 100% due to rounding.
Source: *(11)*.

Figure 4. Breakdown of out-of-pocket health expenditure in private sector, 2015



Source: *(11)*.

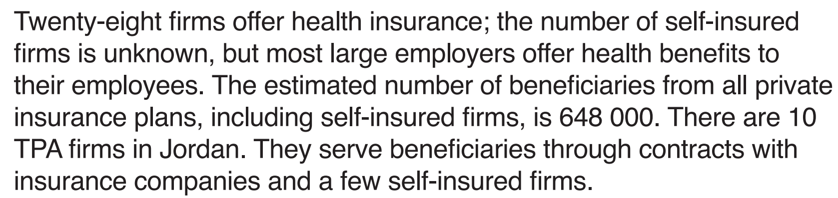
5.4 Health insurance coverage

According to the population census of 2015, various types of health insurance cover only 68% of Jordanians and 55% of the State's overall population *(12)*. The Government is committed to moving towards universal health coverage (UHC) in Jordan. In terms of distribution of health insurance coverage among Jordanian citizens, the MOH–Civil Health Insurance Program covers 41.7%. This is followed by the Royal Medical Services–Military Health Insurance Program, which covers 38.0%, and by private insurance, which covers 12.4%. University hospitals cover 2.5%, UNRWA covers 2.5% and overseas insurance covers 0.4%. The remaining 2.5% are covered by other insurers. It is estimated that 8% of citizens hold more than one type of health insurance *(11)*.

There is a need to unite all public coverage schemes into a single public health insurer and for all people in Jordan to be required to have health coverage.

5.5 Private health insurance

As mentioned above, 12.4% of insured Jordanians are covered by the health insurance plans of private (commercial) companies or by self-insured firms. Health insurance premiums represent only 12% of all insurance premiums. Insurance executives have not considered health insurance a highly profitable product. Commercial insurers may function in two ways: as insurers or as third-party administrators (TPAs). Self-insured firms pay directly for health care services on behalf of their employees and their dependents. They also assume full financial risk for their health insurance plans. These firms may contract with TPAs to administer their health plans, thereby reducing the administrative costs associated with managing the health insurance programmes *(11,13)*.



Twenty-eight firms offer health insurance; the number of self-insured firms is unknown, but most large employers offer health benefits to their employees. The estimated number of beneficiaries from all private insurance plans, including self-insured firms, is 648 000. There are 10 TPA firms in Jordan. They serve beneficiaries through contracts with insurance companies and a few self-insured firms.

Private third-party payers typically evolve in response to gaps in coverage or perceived deficiencies of the public health sector. Thus, private insurance provides coverage for mostly middle- and upper-class professionals who are ineligible for the public insurance programme, withdraw from a public insurance programme, or seek supplemental or additional coverage. However, private programmes do not offer a real comprehensive coverage alternative to publicly financed health coverage schemes. Of the 28 companies licensed to provide health insurance, only one offers full-package coverage. The comprehensive package costs about 56% of an average Jordanian annual income; thus, only a small percentage of the population can buy full coverage through PHI *(14)*.

The Insurance Directorate in the Ministry of Industry, Trade and Supply regulates and supervises the local insurance sector, including the PHI sector. The Jordan Association for Medical Insurance (JAMI) is a non-profit, nongovernmental association. Among its members are public health insurance organizations, private insurance companies and self-insured companies. Its main objective is to protect and serve the interests of its members by providing them with logistic, informational, legislative, technological and legal support inside and outside Jordan.

However, the principle of guaranteed access is not mandated in the private sector. As under-regulated insurance schemes, insurance companies in Jordan attract the young and healthy and shift unwanted risk onto the public sector. They apply several mechanisms to protect themselves from poor risks. Legislation is too broad to effectively shape this growing market and regulate its contribution towards national health policy goals. Insurers are not so far competing based on quality, efficiency and innovation *(14)*.

Private health coverage arrangements in Jordan may well contribute to improving UHC if their role is clearly defined and they are given fair incentives. Proper public regulation is also important to correct for market failures of PHI, such as cream skimming, medical exclusions and premium escalation. Health policy-makers should probe the possibility of designing a common, minimum benefit package that all public and private health insurers must cover. Benefits offered by insurers could be better than the minimum, but not worse. A standard benefit package should contain cost-effective clinical services, include health prevention and promotion and some outpatient drugs, and provide financial protection against costly diseases *(14)*.

6
Private health sector analysis and stakeholder perspectives

6.1 Private sector growth and its determinants

The Jordanian authorities have developed a competitive legal and fiscal framework for investors and have opened the economy to outside markets and signed a number of bilateral free trade agreements. For entrepreneurs who would like to invest in Jordan, laws No. 16 of 1995 and No. 13 of 2000, and the Investment Law of 2014, offer an advantageous framework *(15)*. These laws list industry, agriculture, health, tourism, hospitals, electricity generation and distribution, railway transportation, and aviation as priority sectors in which investments can benefit from incentives in terms of income and sales taxes and customs duties.

However, as reported by *The global competitiveness report 2017–2018*, the top four problematic factors for doing business in Jordan are tax rates, insufficient access to financing, policy instability and inefficient government bureaucracy *(16)*. Therefore, further sound economic policies and growth-enhancing reforms are essential to improve the investment environment.

6.1.1 Service quality

A patient satisfaction survey for inpatients in 15 private hospitals in Amman revealed that 40% were very satisfied and 54% were satisfied. Despite generally high levels of satisfaction, some pockets of dissatisfaction were reported by patients (communication with patients, bills, post-discharge instructions, side-effects of prescribed medicines, keeping of case records for future reference) *(17)*.

From the staff perspective, it was reported that nurses who worked in private hospitals were more satisfied and intended to retain their jobs more than nurses who worked in public hospitals *(18)*.

6.1.2 Technical quality

No studies about technical quality in the private or public sector in Jordan were found. A study of quality assessments and pricing estimates of diabetes and caesarean section services in the private health sector in five Eastern Mediterranean Region countries, including Jordan, performed by the WHO Regional Office for the Eastern Mediterranean in 2013, showed that most private outpatient facilities had basic equipment for patient examination and maintained patient records. In Jordan, indicators such as availability of infrastructure, availability of essential drugs, keeping of patient records, staff strength, process of care, patient follow-up and patient satisfaction were almost 100% met *(19)*.

6.1.3 Medical malpractice

Statistics on medical malpractice are not available in Jordan. Only a few cases have been brought before the courts. This does not necessarily indicate low rates of malpractice; rather, it reflects the permissive culture of society in Jordan.

It is expected that the Medical Liability Law, if properly executed and followed, will safeguard the legal interests of patients and health care professionals in both the public and private health sectors, with the ultimate goals of enhancing the quality of health care services, expanding UHC and promoting medical tourism to Jordan.

6.2 Private clinics (curative primary care)

The MOH is the major provider of health services in the field of primary health care, with small contributions from other health providers. The private sector is active in curative primary care, with a marginal role in preventive and promotional health service.

Private clinics account for nearly 40% of all initial patient contacts (26% for-profit, 5% not-for-profit and 9% private pharmacies), just behind the MOH, which accounts for 49% of outpatient visits (the initial patient contact within the health care system). Private clinics provide a comprehensive array of curative services, including pharmaceuticals and dental services. Private practice is mainly confined to urban areas and caters to better-off Jordanians who can afford private sector fees. Thirty-six per cent of private clinics are located in Amman *(4,20)*.

The Jordan Health Utilization and Expenditures Survey 2000 indicated that private for-profit facilities are more likely to be chosen by the affluent, those with more education, full-time workers, and residents of urban areas *(21)*.

Private physicians run about 4500 clinics; about a third of these clinics were established between 2013 and 2018. Sixty per cent of the private clinics are specialty clinics. General practice is not as common as specialty practice in Jordan. The average Jordanian prefers to consult a specialist doctor directly for any illness *(22)*. This may be one of the causes of the high percentage of health expenditure in Jordan. However, the Jordan Health Utilization and Expenditures Survey 2000 revealed that 9% of initial patient contacts take place in private pharmacies. This figure raises many legal and quality issues related to the role and practices of private pharmacies in Jordan.

Group practice is increasing in Jordan. Interviews with referents revealed that cost savings and the desire to work in a collegial professional environment were the main reasons that physicians decide to practice in groups. Dozens of group practice buildings and hundreds of private clinics and diagnostic centres dominate Al Khalidi Street in Jabal Amman (the name of the street comes from the Al Khalidi private hospital). This street attracts patients from all locations in Jordan and from many Arab countries. Many claim that the rate of physicians per square metre in this street is the highest in the world *(4)*.

The private sector plays an important role in the family planning market. According to the 2012 Jordan Population and Family Health Survey and the Higher Population Council, the private sector – including NGOs; the Jordan Association for Family Planning and Protection; UNRWA; and private sector clinics, hospitals and pharmacies – serves about 55.4% of modern method users *(21)*.

6.3 Private hospitals (secondary and tertiary care)

In Jordan, private not-for-profit hospitals preceded public hospitals. The 1990s witnessed a surge in the number of new private hospitals, as 23 hospitals were established. The lack of barriers to entry, along with the potential for profits and the growing market in medical tourism, invited many investors to tap into this sector. From 1997 to 2017, the number of private hospitals increased from 43 to 56, with hospital beds increasing by 25% over the same period.

6.4 Human resources in the private health sector

It is estimated that the health industry in Jordan employs about 150 000 workers; 60% are employed by the private sector. Most of the health labour force is Jordanian. It is also reported that about 4000 Jordanian physicians and a significant number of qualified nurses are working outside Jordan *(23)*.

Table 4. Selected health personnel working in the private sector, 2017

	All sectors (No.)	Private sector	
		No.	%
Physicians	22 739	14 586	64
Dentists	7107	5904	83
Pharmacists	15 668	14 464	92
Nurses (all categories)	29 272	11 868	41
Midwives	3608	1729	48

Source: *(2)*.

6.5 Legal and regulatory framework and governance in the private health sector

6.5.1 Registration and licensing of private health facilities

Private health care organizations in Jordan, except those providing radiology services, are generally licensed by the MOH based on fulfilment of minimum requirements for criteria such as location, physical infrastructure, equipment and human resources. Other government agencies and health professional organizations participate in licensing. The criteria and process for ensuring the quality of care are not usually identified.

6.5.2 Registration and licensing of health care personnel

Chapter 2 (articles 5–9) of Public Health Law No. 47 of 2008 defines the regulatory structure for licensing health care professionals *(24)*. Each health profession has a law or by-law that regulates all aspects of the profession (e.g. licensing, minimum education and certificates, areas of practice, code of ethics). The licensing of health care professionals

in Jordan is a joint effort between the professional associations and the MOH. The MOH employs various criteria for licensing established by the professional associations as input into its decision to grant licenses to health care personnel throughout Jordan.

In addition, the minister of health exercises considerable powers in determining an individual's adherence to licensing rules and regulations; however, strict coordination between the minister's office and the professional organizations is needed to carry out these responsibilities effectively *(24)*.

6.5.3 Renewal of licensing of health care personnel

Prior to 2018, health professionals could hold their licenses for life, without mandatory requirements to update their skills and knowledge or actively participate in continuous training programmes. On 1 April 2018, the Government of Jordan officially endorsed the new Bylaw for Health Professional License Renewal No. 46. The by-law requires all health professionals to renew their licenses every five years by participating in formal continuing professional education *(25)*.

With this by-law, Jordan joins other Arab countries, including Oman, Qatar, Saudi Arabia and the United Arab Emirates, in enforcing mandatory license renewal legislation tied to continuing professional development *(26)*.

This license renewal initiative is the first of its kind to systematically develop the broader health workforce in Jordan and is aligned with the country's Vision 2025 goal of achieving UHC. The results of this by-law could contribute to safer care, shorter hospital stays and lower infection rates, leading to better quality of health services and more satisfied patients.

6.5.4 Regulation of medical professional fees

Since 2008, doctors' fee schedules have been under continuous debate and a source of dispute among stakeholders. Most physicians, especially consultants, charge self-insured patients more than the maximum fee level. The Jordan Medical Association in October 2018 increased doctors' fees by 25%, but it was faced with hard opposition from the public, social media, consumer and patient protection associations, and JAMI. As a result, the Jordan Medical Association decided to freeze this decision and go back to the 2008 fee schedule *(27)*. An additional consideration within this debate is that any increase in the fees of doctors will be reflected in the cost of insurance policies and may negatively affect the national goal of expanding UHC.

6.5.5 Regulation of hospital fees

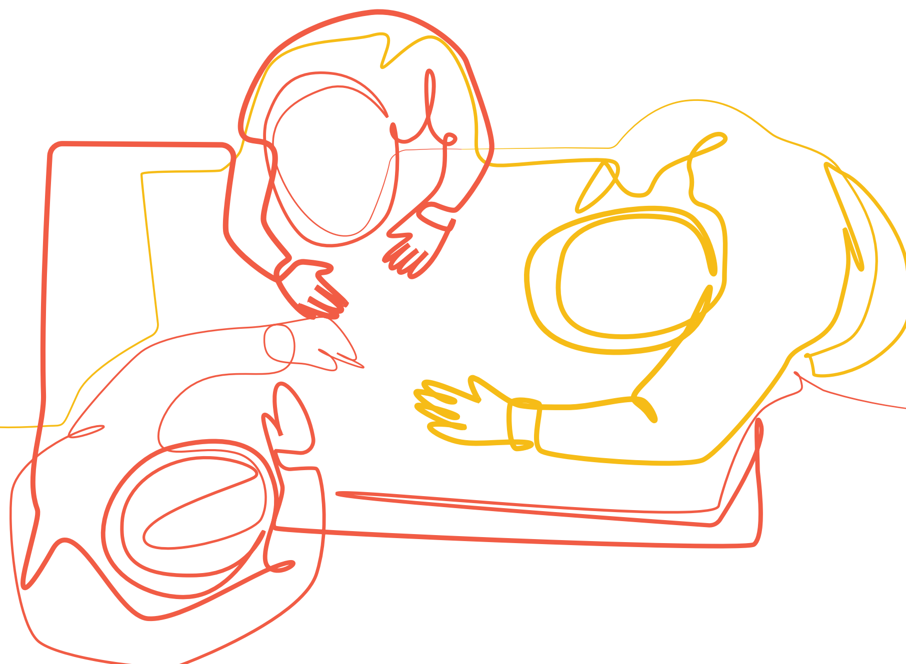
The hospital fees charged in the private sector result from the Private Hospitals Association's voluntary fee schedule. As stipulated in the Private Hospitals Bylaw No. 54 of 2014 *(28)*, all private hospitals must prepare an itemized listing of their fees (except for physician services). The fee list is submitted to the MOH for approval. The approved list, as indicated by the official MOH seal of approval, must be framed and in full view of the public *(28)*.

6.6 Quality, accreditation and oversight of services in the private health sector

In Jordan, health care quality and safety is mainly regulated through initial licensing procedures that are mandatory before opening any hospital. Licensure is done only once, by the MOH, and requires adherence to specific requirements, although none of those requirements relate to the quality of health care or health outcomes. However, the Medical Liability Law, which came into force on 31 August 2018, stipulates some basic medico-legal standards that health care providers should adhere to that are related directly to the quality of health care and health outcomes. With technical support from the US Agency for International Development (USAID), in 2006 Jordan adopted a national programme for health services accreditation. In 2007, the Health Care Accreditation Council was founded and registered as a private, non-profit, shareholding company.

Since inception, the Council has accredited and reaccredited a number of public, private and non-profit health care institutions in compliance with its standards. It is expected that the quality and safety of health services in both the public and private sectors will be enhanced as a result of this programme. However, the absence of any economic, professional or regulatory incentives for health care organizations (in both the private and public sectors) to seek accreditation may pose a challenge for the sustainability of the national accreditation programme in Jordan.

As of 2018, 11 private hospitals, 13 MOH hospitals, eight Royal Medical Services hospitals, two university hospitals and 100 MOH centres had been accredited by the Health Care Accreditation Council *(29).* Seven private hospitals (Jordan Hospital, Specialty Hospital, King Hussein Cancer Center, Istiklal Hospital, Istishari Hospital, Luzmila Hospital and Al-Essra Hospital) have also been accredited by Joint Commission International.



Public-private partnership in health service delivery

7.1 Legal framework for public-private partnerships

The Public-Private Partnership Council, headed by the prime minister, and the Public-Private Partnership Unit, linked to the finance minister, were established to facilitate and support public-private partnerships (PPPs) *(30)*.

The increasing number of contracts between the MOH and other health sectors, including the private sector, during the last five years (e.g. Royal Medical Services, Jordan University Hospital, King Abdullah University Hospital, King Hussein Cancer Center, Jordan Hospital, Specialty Hospital) reflects the high political commitment to the execution of contractual agreements *(4)*.

7.2 Contractual arrangements between the MOH and the private sector

As of 2009, six contracts with the private health sector were in existence. Four of these contracts were based on fee-for-service reimbursement (King Hussein Cancer Center, Luzmila Hospital, Red Crescent Hospital, and all private hospitals for emergency cases); for births – as an exception – normal delivery and caesarean section or complicated delivery were charged on a case basis (JD 80 and 100, respectively). The other two contracts (Al Mowasah and Al Haya hospitals) were based on a flat fixed rate per bed (bed leasing) *(22)*.

In 2006, following the opening of Prince Hamza Hospital (a 450-bed public referral hospital) in East Amman, the MOH did not renew contracts with four private hospitals in Amman (Al Mowasah Hospital, Al Haya Hospital, Luzmila Hospital and Red Crescent Hospital). Only three contracts for purchasing health services from the private sector are still valid: with the King Hussein Cancer Center for cancer cases, with all private hospitals for emergency cases (covering all Civil Health Insurance beneficiaries) and with all private hospitals for first-class Civil Health Insurance beneficiaries.

Another type of contract with some private hospitals was for providing a bundle of services according to a flat rate for each bundle. Examples of these bundles included cardiac catheterization, open-heart surgery, normal delivery and caesarean section. These contracts were terminated in 2018.

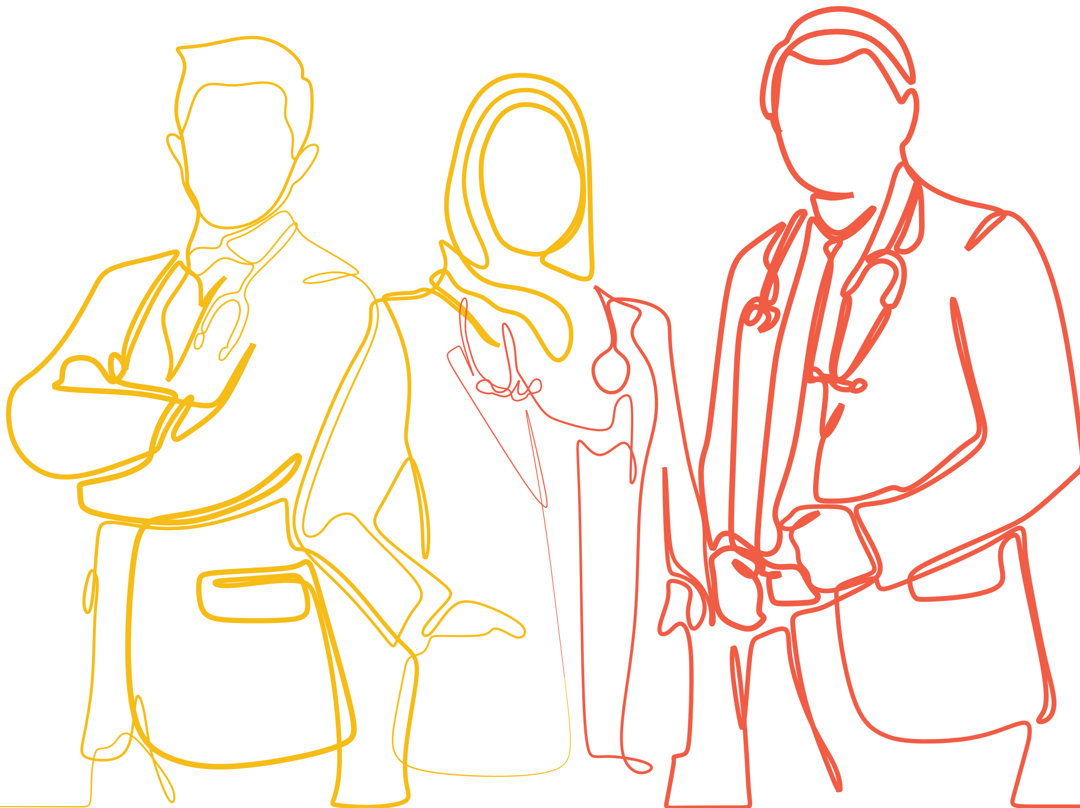
The MOH now is contracting out renal dialysis services, under which kidney dialysis machines in private hospitals are leased according to a discounted rate per patient (JD 25), while the MOH provides the consumables and medical supervision *(31)*.

Vouchering was also used by the MOH to buy family planning services and women's health services from private sector practitioners in partnership with international donors such as the Private Sector Project for Women's Health; the Communication Partnership for Family Health; the Jordan Communication, Advocacy and Policy project; the Health Policy Project; and Sustaining Health Outcomes through the Private Sector (SHOPS) Plus, all of which are funded by USAID *(32,33)*.

7.3 Outsourcing contracts

The MOH has been outsourcing the management of hospital general services, such as catering, housekeeping, laundry and security, to private contractors for more than 20 years. The main responsibility of the contractors is usually to manage and staff these services, while the MOH provides the physical facilities, including equipment and consumables. The most significant reasons for outsourcing these services, as reported by a referent from the MOH, are to reduce costs, enable hospital management to focus on core services, and improve patient satisfaction.

However, failure to manage outsourcing contracts properly has been a major obstacle to achieving the proposed benefits of outsourcing for MOH hospitals and, in some cases, has led to reverse results in efficiency, quality and customer satisfaction.



8

Strategic analysis of the private health sector and PPP in Jordan

The preceding chapters gave a thorough analysis of the private health sector in Jordan. The following summarizes the strategic issues of this sector based on the SWOT analysis model.

8.1 Strengths

- Modern infrastructure (38% of total hospital beds)
- Advanced medical equipment with state-of-the-art technologies (about half of the country's medical technology)
- Lead provider of many high-tech medical procedures and organ transplantations
- Well-organized associations of health professionals
- The establishment of the Private Hospitals Association
- International reputation and affiliations with many leading international medical associations and organizations
- Ability to attract significant foreign funding, mainly from Gulf countries
- Good representation in all national health policy and regulatory bodies
- Major employer of experienced and highly trained health personnel (64% of physicians, 92.3% of pharmacists, 84.3% of dentists and 50% of registered nurses)
- Major driver of medical tourism (attracts a quarter-million patients each year, which contributes US$ 1 billion annually as total income; the medical tourism sector ranks first in the Region and fifth on a global level)
- High standard of service quality, as perceived by patients
- The contribution of the private sector to 43% of total health care expenditures
- Advanced health insurance companies and TPAs
- Availability in all governorates (although concentrated in Amman)
- Ability of the for-profit and not-for-profit subsectors to complement each other with little competition, if any
- Capacity levels: about a third of the country's hospital admissions, surgical operations and deliveries take place in private hospitals
- Advanced pharmaceutical industry (ranks second in national exports, with a worldwide reputation)

- An extensive and countrywide network of community private pharmacies
- Availability of the national Health Care Accreditation Council
- Accreditation of many hospitals nationally and internationally

8.2 Weaknesses

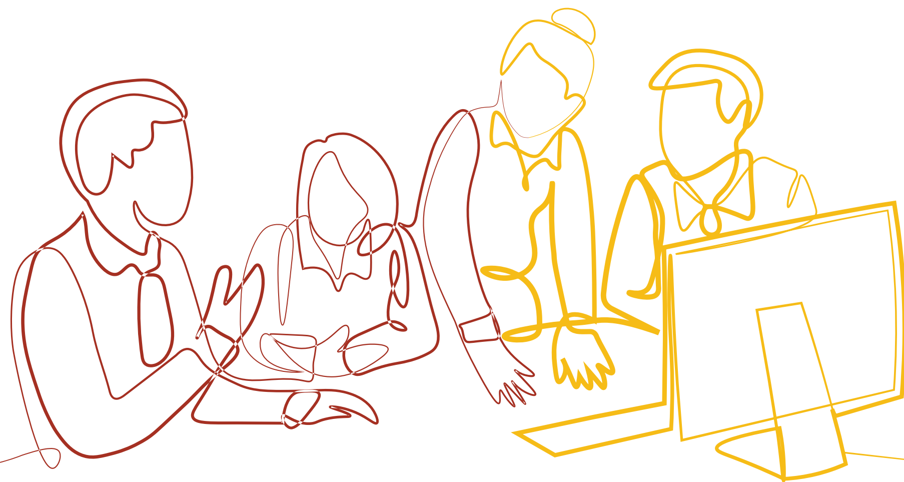
- Predominant drivers being commercial and marketing incentives, with very little social responsibility
- Poor and fragmented health information and reporting systems
- Low occupancy rates (37%)
- Shortage of evidence-based quality programmes
- Unorganized medical workforce
- Inadequate coordination between the public and the private sector and among the private sector organizations in technology acquisition and service delivery
- Lack of structural and legal strength in the Jordanian Hospital Association to play an oversight role with regard to hospital members
- Lack of PPPs
- Tendency to perform unnecessary surgical or diagnostic procedures and the presence of some unethical practices, such as taking commissions, overprescribing, tax evasion and overcharging
- Lack of legislation or charter to delineate clinical privileges for private doctors in outpatient settings
- Limited role of private physicians in primary health care and health promotion
- Existence of many small hospitals with financial and administrative problems
- Lack of professional managers (most hospitals are run by owners or family members or shareholders)
- Over-the-counter sale of most medicines, including antibiotics
- Shortage of continuing training programmes
- Weak adherence to standard treatment protocols and infection surveillance

8.3 Opportunities

- Jordan’s liberal economic policy and signing of a number of bilateral free trade agreements
- Strengthening of PPP being a major policy direction; the endorsement of the Public-Private Partnership Law
- Jordan’s competitive advantages, making it an ideal springboard to access regional and international markets
- Availability of internal and external financing
- High-calibre human resources and low labour costs
- Macroeconomic stability
- Political support from the highest level and a stable political and security climate
- Availability of investment laws and tax incentives for hospitals and medical technology
- Positive progress in Jordan’s overall investment environment, as shown by international indicators
- No legal restrictions on the purchase of equipment and supplies within the sector
- Representation of stakeholders in all health policy and regulating bodies
- Emphasis in all national strategies and plans on the role of the private sector and the importance of building robust PPPs
- Existing legal mandates for contracting out health services
- Competitive advantage due to weaknesses in the health sectors of many countries of the Region resulting from unstable conditions
- Achieving UHC for all citizens being a strategic objective of the Government
- Prospective demand (45% of residents are not covered by formal health coverage)
- Possibility of securing international financing for health services provided to refugees
- Endorsement of the Medical Liability Law

8.4 Threats

- Severe competition
- Slow economic growth (the private sector is only affordable to a small population)
- Increasing taxes and unstable tax legislation
- Multiple organizing and monitoring bodies
- Unsustainable public financing
- Unstable policies and legislation
- Weak incentives for PPPs
- Drug pricing policy and accelerating pharmaceutical costs
- Weak administrative and technical regulatory arms at the MOH
- Investment not being based on needs assessments and robust economic feasibility studies
- Bureaucracy, delays and multiplicity in licensing process, which hinder market entry
- Fall in the medical tourism market starting in 2014
- Delays in settlement of private hospitals' claims on some Arab countries and the Government of Jordan
- Migration of qualified Jordanian health staff to work out of the country



9

Policy directions for harnessing the private health sector to achieve UHC

Based on the detailed analysis of the private health sector within the socioeconomic and health system contexts, structured interviews with selected stakeholders, and the above SWOT analysis, the following policy directions and strategic interventions are proposed to harness the private health sector in Jordan in the pursuit of public health goals.

9.1 Governance and stewardship

- Since the MOH is heavily involved in service delivery and lacks the technical and administrative capacity to regulate the health care system, it is suggested that the regulatory role is separated from the MOH and placed with an independent regulatory body headed by the minister of health, similar to the Jordan Food and Drug Administration or the Jordan Medical Council.

- If the regulating function stays within the MOH, the Government's capacity to regulate the private sector should be strengthened. The MOH needs proper systems in place and skilled staff, which can be achieved through recruitment and through training and technical aid to existing staff. However, overregulation of the private sector also needs to be avoided so as not to suppress its development.

- As stewardship is a shared process between the Government and the private sector, private health associations and the Jordanian Hospital Association also need capacity-building and technical support to pursue basic stewardship functions such as regulating, monitoring, providing incentives and disseminating information.

- Stewardship requires a well thought-out, analysis-based policy that recognizes and involves the private sector and assigns it roles. It involves setting system goals, identifying priorities, analysing resource requirements, building consensus and communicating.

- There is a need to control bureaucratic measures and facilitate the process of licensing, regulating and monitoring. A "one-stop shop" model is needed to license and regulate the private health sector, in contrast to the existing multiplicity of licensing and controls that hinder market entry and restrain PPP.

- Licensing and regulating procedures should be based on measurable standards that aim to improve services, and enforcement measures should be built on incentives rather than punishments only. Penalties should be based on objective criteria, and the implementation of penalties – especially the closure of a health facility – should be subject to court decision.

- The High Health Council should be empowered to monitor and control the implementation of national health policies and strategies and should be supported financially and technically to pursue this role.

- The Jordanian Hospital Association should be empowered legally, administratively and technically to play an oversight role that complements but does not compete with the MOH.

- Giving its heterogeneous makeup and and the lack of a unified organizational umbrella, the private sector in Jordan should be encouraged to develop a private health sector representative body to give the sector a consolidated voice for engaging in public-private collaboration.

- The public and private health sectors should take the necessary measures to bring the Medical Liability Law into full operation, as this law is considered one of the main avenues to service quality and equity.

- It is essential that Jordan's public and private health insurers adopt standard definitions for medical procedures, such as ICD-10, ensuring that procedures linked to fees are comparable.

- The establishment of a Medical Tourism Commission to regulate the sector and promote it internationally would be beneficial.

9.2 Purchasing and financing

- UHC could be improved by expanding risk-pooling and promoting health equity. All interviewed stakeholders emphasized the need to unify all public schemes (mainly the civil and army schemes) into a single public health insurer, and the need for all people in Jordan to be required to have health insurance to attain the core objective of reaching UHC.

- The Government should be freed from the obligation of covering the costs of tertiary health care for the wealthy uninsured. Government subsidies should be directed to low-income persons only. This will enable the public sector to secure resources for providing quality services and extend coverage to vulnerable groups.

- The Government should institute a policy of tax benefits to companies and firms for providing health insurance to their employees. This would take the burden off of the public sector, encourage the continued development of the private sector and increase UHC.

- The Government should establish a national fee-setting committee in charge of reviewing reference costs and prices in the public and private sectors and should develop a transparent methodology for pricing health care services:

  - This committee should be responsible for setting and maintaining updated public and private fees and have wide representation (public and private sector, medical associations, hospitals, insurers and academia).

  - This committee should develop comprehensive fees associated with clinical guidelines, aiming to compensate packages of services including physicians, facilities, medicines and diagnostic procedures.

- The Government and the Electricity Distribution Company should reconsider the tax rates and electricity tariffs imposed on private hospitals in a way that enables this sector to recover and adapt to the sharp decline of patients coming to Jordan for treatment.
- Transparent dissemination of costing findings is needed. Better data on costs are needed to support UHC. Reliable cost data are important for budgeting and timely reimbursement of public and private providers.
- Partnerships with private insurers could educate the public on the benefits of health insurance. A partnership between the Civil Health Insurance Directorate and private insurers should be established to educate the general public about health insurance and possibly market the essential health package.
- Strategic purchasing should be implemented by introducing financing models based on results and quality.
- Reimbursement mechanisms should be adopted based on prospective payment methods, such as diagnostic-related groups, case based, bundle of services, global budget and per diem. This may promote productivity, quality and competitiveness and encourage the private health sector to play a more active role in UHC.
- Small private hospitals should probe the possibility of merging or expanding to be able to achieve economies of scale and stay in business.
- Private hospitals are encouraged, through the Private Hospitals Association, to engage in corporate partnerships for the provision of supporting services such as laundry, catering, medical waste disposal and maintenance.
- Reliable and accurate reference costs should be set through a multistakeholder commission and supported by modern information technologies and by using international standard classification of diseases and procedures.
- Monitoring physicians' fees and keeping charges below the upper limits may encourage patients in the second and third income quintiles to seek outpatient care in the private sector. This may help lower the pressure on the public health sector, especially in urban settings.
- To build and maintain good collaboration and positive partnership between the public and private sectors and to achieve continuity of patient care, it is recommended that the Government secure enough financial allocations to pay private hospitals and drug stores on time.

9.3 Service delivery

- The referral process between public and private facilities, as well as between MOH facilities, is a key area to be strengthened in the interests of improved patient care. Treating patients at the primary health care level is less costly; the resulting savings should be used to extend coverage for the population.

- The MOH, with support from international donors, is encouraged to explore more PPPs in primary health care to extend coverage for underserved areas or for essential health services such as reproductive health, child health and family planning.

- The MOH should consider extending the outsourcing of tertiary services in the private health sector. In this way, the Government may achieve broader population coverage of tertiary care in a cost-effective way and can focus more on primary and secondary health care.

- General practice should be encouraged, especially to new graduates, by facilitating licensing procedures, providing tax incentives and securing more flexible bank financing.

- To provide more accessible, equitable and cost-effective UHC, an essential benefits package of health services for private and public sectors should be developed. In addition, a negative list (i.e. of medical conditions that may be excluded from coverage) should be mandated. Exclusions must be based on fair and equitable principles for the whole population to avoid discrimination against underprivileged groups.

- The Government should encourage and incentivize the establishment of private, not-for-profit community hospitals. These hospitals, if properly managed, hold the promise of remedying many of the private sector's shortcomings. They would combine the efficiency of the private sector with the universality and social spirit of the public sector, while promoting professionalism. The moral and financial support of such institutions would change the nature of private facilities from profit-making to community-based hospitals aiming to serve the interests of patients and the needs of society.

- Jordan has a large refugee population. Refugees living outside camps are mainly covered by MOH facilities in the same way as citizens; this has affected the accessibility, availability and quality of these services to Jordanians. The Government should direct international donors to provide health services to refugees at primary, secondary and tertiary levels in partnership with the non-profit and for-profit private health sector.

- Full bundles of medical tourism services and door-to-door services should be designed.

9.4 Human resources

- A national plan to manage and contain the migration (brain drain) of health professionals should be developed, with participation from all stakeholders from the public and private sectors.
- The MOH should engage in wider PPPs in human resources to attract physicians and highly skilled professionals from the private sector to serve in public hospitals in some understaffed medical specialties. This partnership may be extended to bridge geographical and gender gaps.
- The Government should encourage the private sector to establish medical schools or should partner with the private sector for this purpose. Such a policy would discourage students from studying medicine abroad and attract medical students from other countries in the Region; this would have a positive macroeconomic impact.
- Health facilities in the private sector should have regular training programmes for all health professionals. In addition, the Government should provide training support and incentives to private providers to encourage conformance to good practice norms.
- Incentives should be given for organizing health workers into private practice groups.
- A reliable and accurate national database on health human resources should be built.
- Private practitioners should have opportunities for upgrading and improving clinical knowledge and skills through participation in public sector-sponsored training.
- A system for checking the credentials and admission privileges of consultant physicians in the private sector should be developed and enforced.

9.5 Pharmaceuticals and technology

- Adherence to joint procurement strategies in the public sector should be enforced, and the possibility of pooled procurement in the private health sector should be explored.
- The Government should provide fair and sustainable incentives for the private pharmaceutical sector to develop and grow.
- The Government should consider removing value-added tax and import duties from all inputs to all medical institutions so as to reduce the operating cost to the private health sector.
- Affordable prices are needed for medications, especially those included in the national essential health package.

- Establishment of a certificate of need mechanism should be considered prior to high-cost investment in health for both public and private sectors.

- The drug pricing policy, which is based on a profit-maximizing model, should be rebuilt on an affordability-based pricing system with reduced profit margins.

- Rules and regulations that ban over-the-counter dispensing of prescription medicines should be activated and enforced. This should be performed in partnership with the Government, the pharmacists association and other stakeholders.

- All national medical and pharmaceutical bodies should participate in developing and implementing policy instruments related to the National Essential Medicines Lists, formularies, standard treatment guidelines, and measures to ensure access to affordable, quality-assured medicines.

- The private pharmaceutical sector should play an active role in ensuring the availability of quality-assured generic and innovative products, improving equity in access, encouraging appropriate use and keeping costs affordable.

- Sharing information and promoting public awareness of the potential negative impact of medicines and antibiotic misuse should be encouraged.

- The Government should have enough budgetary allocations to pay for the due bills of the pharmaceutical sector.

- The public and private sectors should work together to implement the Rational Drug Strategy, which involves (a) key policy intervention directed at the prescribing behaviours of providers, (b) the behaviour and expectations of consumers, (c) drug pricing policy, and (d) pharmaceutical promotion practices. Lowering expenditures on drugs could generate savings that would enable extension of population coverage. The role of the practicing pharmacist should move from drug dispensing towards drug therapy and patient management, with more emphasis on meeting the health needs of the population. Private pharmacies should participate in providing patient counselling to promote healthy lifestyles and avoid risk factors.

9.6 Quality of services

- The MOH, in partnership with professional bodies, should develop standard treatment protocols and performance standards to ensure that effective care is always provided to those who need it, ineffective services are not provided, and preventable complications of health services are eliminated.

- A national quality improvement framework should be developed to complement licensure requirements and accreditation standards and to facilitate full implementation of the Medical Liability Law.

- A national performance measurement framework should be developed encompassing indicators relating to safety, effectiveness, appropriateness, access and efficiency.
- A national incentive package should be designed to reward private facilities and professionals who voluntarily seek accreditation, adhere to national treatment protocols and improve performance indicators.
- Corporate and clinical governance approaches to ensuring quality are well known and are important to achieving quality of care.
- Quality should be fostered by connecting Government incentives and PPP contracting with performance and quality indicators.
- Research and educational projects should be commissioned to foster and spread the "culture of quality" in all health sectors.

9.7 Recommendations for PPPs and private sector engagement

9.7.1 Ensuring conducive environment for operationalizing PPPs in health

- The Government should modify policies to facilitate and incentivize the private sector to become more organized and quality oriented. The Government should also strengthen its own key stewardship functions, including regulation, information collection and oversight.
- Political and financial barriers to PPPs should be spelled out and addressed, with emphasis on sufficient budgetary allocations and timely payment.
- A PPP steering committee should be established and should include both public and private partners.
- Information about possible PPPs in health should be shared among all stakeholders.
- Donors should also encourage PPPs by connecting donor-funded programmes with priorities of mutual agreement between both sectors.
- The private sector should be more prepared for engagement with the public sector and implement changes to improve quality, cost and access to services and information.
- The private sector needs to get organized by creating new structures (associations, syndicates, etc.) that represent key subgroups of allied health professionals.
- Private providers should work together and share experiences and identify areas (e.g. quality assurance, utilization review, cost analysis) that may require additional training, technical assistance or operational research.

- Communication and trust should be improved between sectors through joint committee dialogue and exchange of information, with a focus on shared interests, mutual benefits and clear responsibilities.
- Contracted services should be subject to accreditation and quality indicators.
- Operational research on PPP should be conducted.

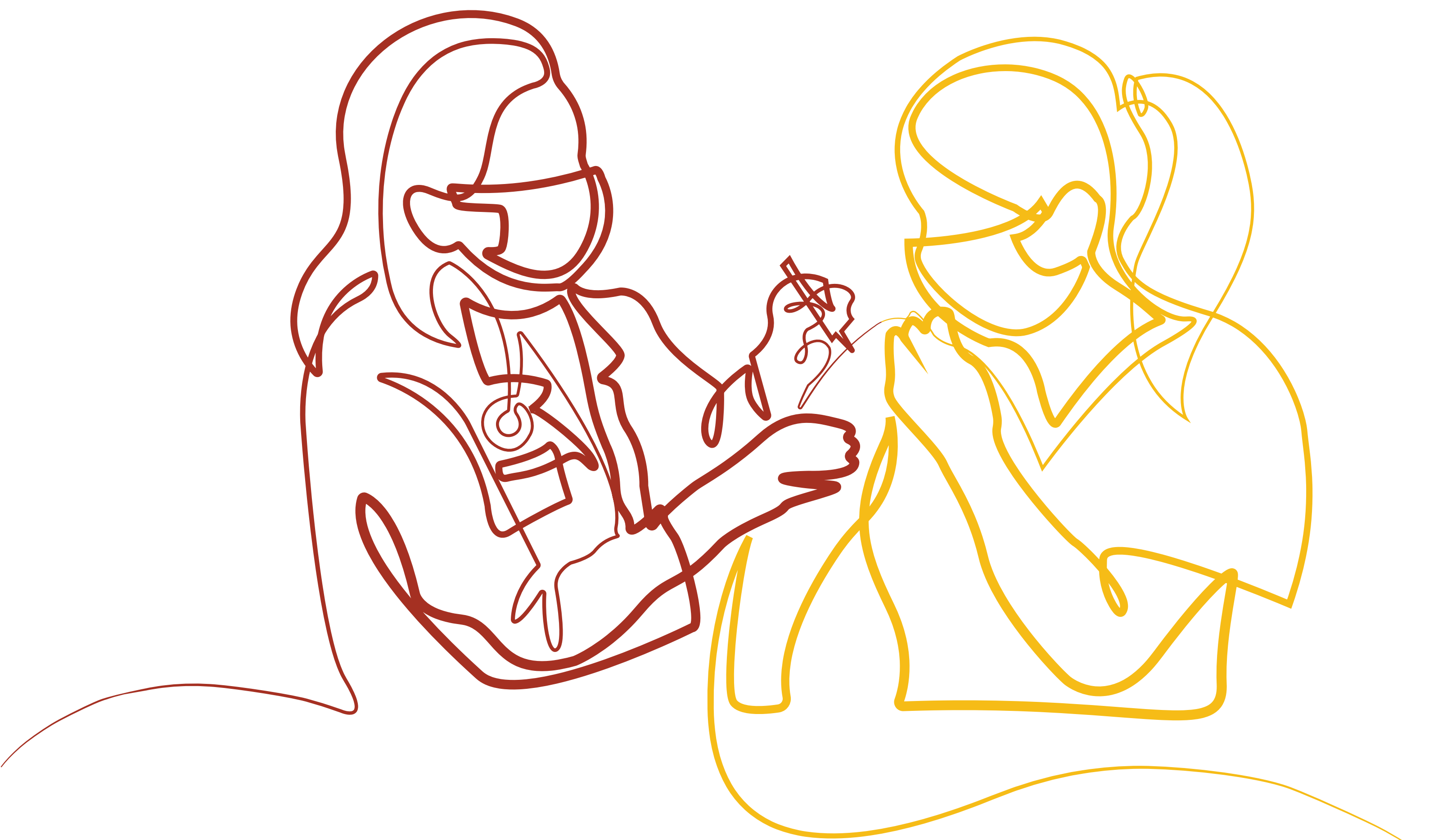
9.7.2 Building robust and sustainable PPPs based on mutual interest with the aim of achieving public health goals

- Given the amount of excess capacity in the private sector (68%), the Government could accelerate its plans for contracting out health care services. Contracting can increase use of the private sector and reduce the need for greater capital investment in the public sector.
- Health policy-makers should probe the possibility of designing an essential benefits package that public and private health insurers must cover.
- The concept of "strategic purchasing" should be introduced for contracting with the private sector and should be based on result- or performance-based funding and prospective payment mechanisms to promote quality, effectiveness and efficiency of services.
- Government incentives (e.g. continuing education, tax incentives, training opportunities, soft loans, fair prices) are important to the viability of the private sector and should be tailored to match the needs and stated health policy of the country. These incentives will also set the platform for true partnership between the two sectors – a partnership built on mutual interest and confidence.
- A continuing national programme for capacity-building in contract design, contract management and contract monitoring is greatly needed.

9.7.3 Effectively implementing health PPPs

- A PPP unit should be established in the MOH.
- MOH and Ministry of Finance capacity to implement PPPs should be strengthened.
- The capacity of key private sector organizations to implement PPPs should be strengthened, and contracting skills should be improved.
- Costing and pricing skills among public and private stakeholders should be strengthened.

- Both parties should be aware of and prepared to deal with the risks inherent in public-private engagement, such as conflict of interests, low financial impact, favouritism among providers, and bureaucracy.
- Risk-sharing mechanisms should be in place in case of failure.
- Expectations of and guidelines for public-private engagement should be developed and shared.
- Competitive and open bidding based on both technical responsiveness and price should be extended and encouraged.
- The development of a cost analysis system to provide real cost information is greatly needed for negotiating fair contract prices.
- The public and private sectors should develop and implement a computerized health information system to manage contracts effectively and efficiently.



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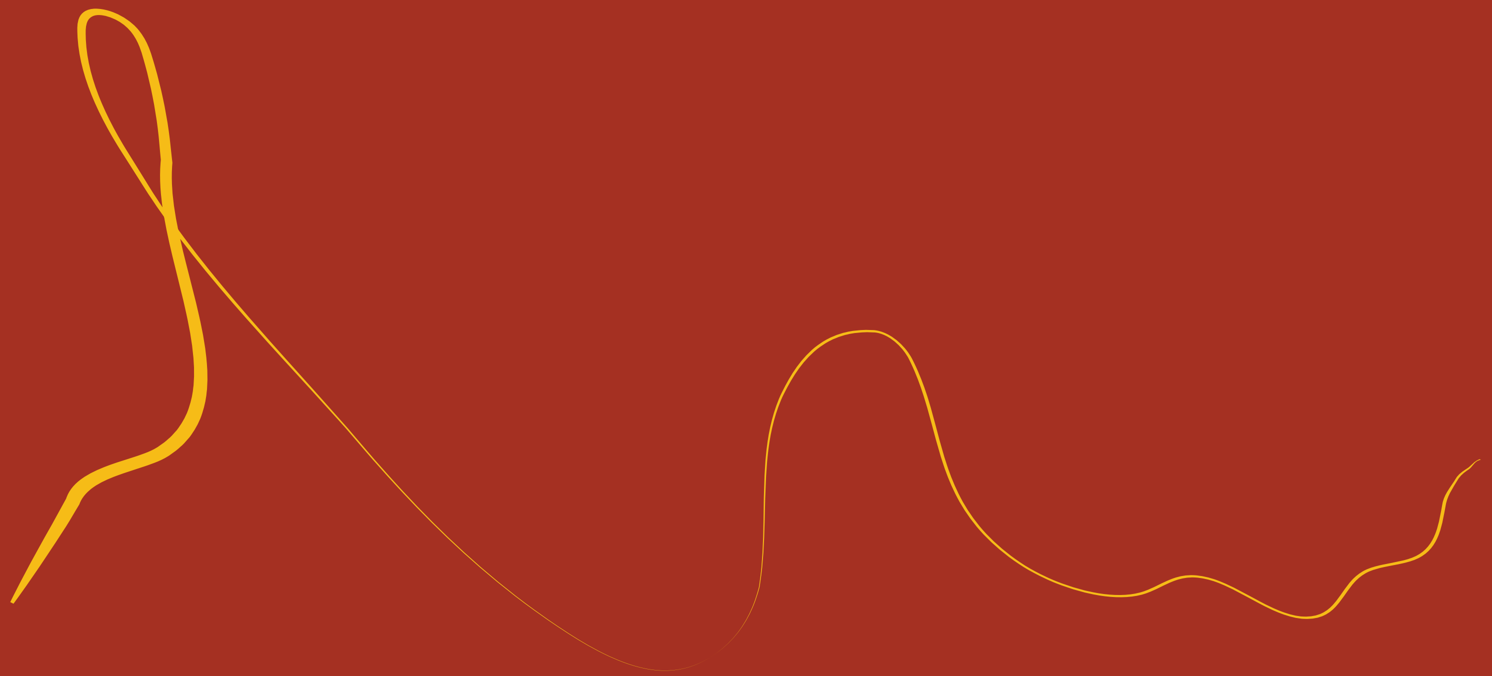

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