Understanding the private health sector
in Libya

World Health Organization
Eastern Mediterranean Region

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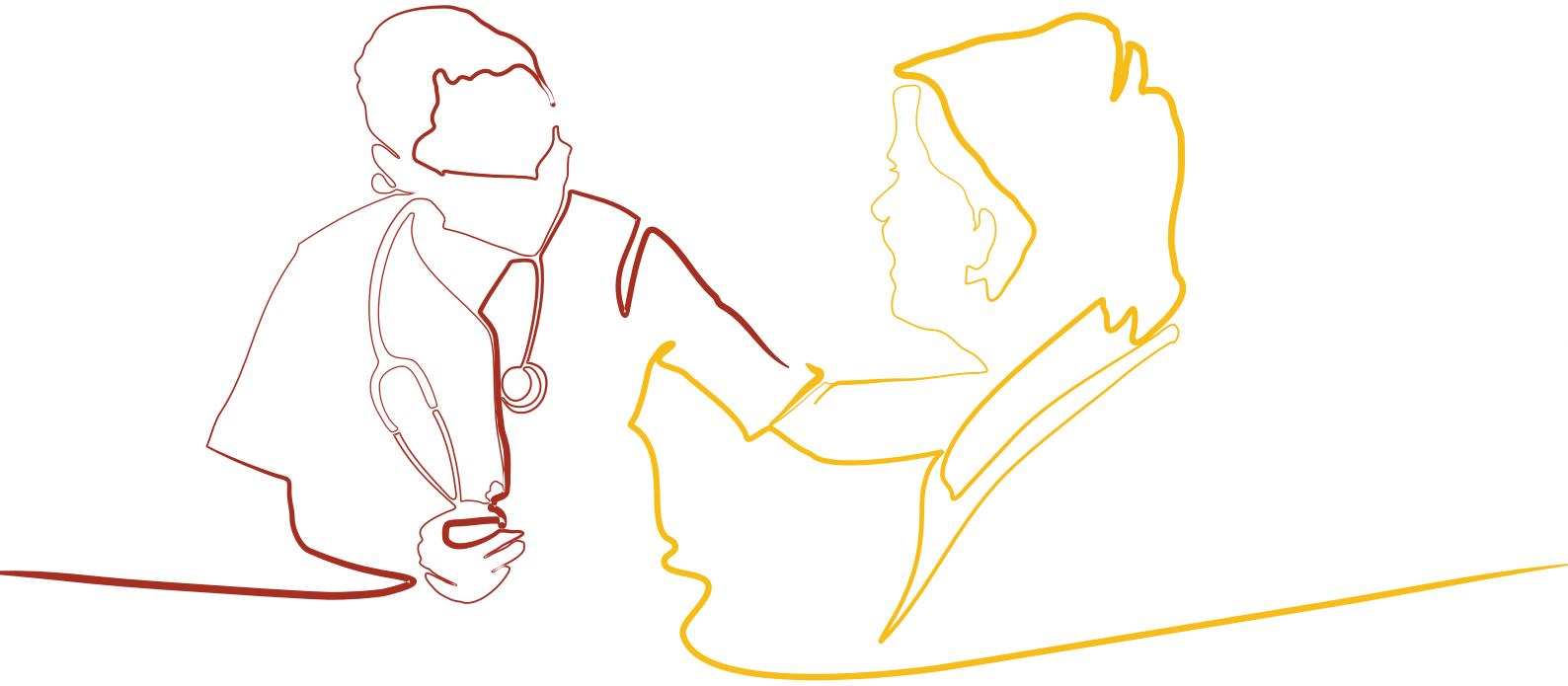


1
Country context

The population of Libya was estimated to be

6 777 452

by the end of 2019

Libya is located in North Africa on the southern coast of the Mediterranean Sea. It has a land area of 1 759 540 square kilometres, making it the fourth largest country in Africa *(1)*. The population of Libya was estimated to be 6 777 452 by the end of 2019 *(2)*. Almost 80% of the population lives in urban areas and 50% are under the age of 24 *(1)*. Oil is the backbone of the Libyan economy, as the country holds the largest oil reserves in Africa. The administrative system of Libya is relatively decentralized. The transitional Government of National Unity is based in Tripoli and controls the west of Libya, and the east of the country is ruled by a rival government in Benghazi. In 22 governorates are 101 municipalities, each with a functional council and with different directorates responsible for the planning, implementation, monitoring and evaluation of health, education and other sectors *(1)*.

2

Health status and selected health indicators

Over the three decades to 2011, the Libyan authorities invested significantly in the health sector, which led to major improvement in health service delivery and the general health of the population. This was clearly demonstrated by Libya's attainment of the Millennium Development Goals health targets. Under-5 mortality is estimated to have decreased by almost 70%, from 42 deaths per 1000 live births in 1990 to 14.5 per 1000 in 2017 *(3)*. During the same period, the maternal mortality ratio is estimated to have fallen by over 75%, from 39 per 100 000 live births to 9 per 100 000 live births in 2015 *(4)*. Skilled birth attendance coverage was reported to be at 100% in 2012 *(5)*. Table 1 outlines the main health indicators in Libya.

As of 2012, the burden of disease attributable to communicable diseases is 9.8%, to noncommunicable diseases 77.8% and to injuries 12.3%. Currently, the key public health issues are:

- **communicable diseases**
- **noncommunicable diseases**
- **promoting health across the life course**
- **health systems strengthening and preparedness**
- **surveillance and response.**

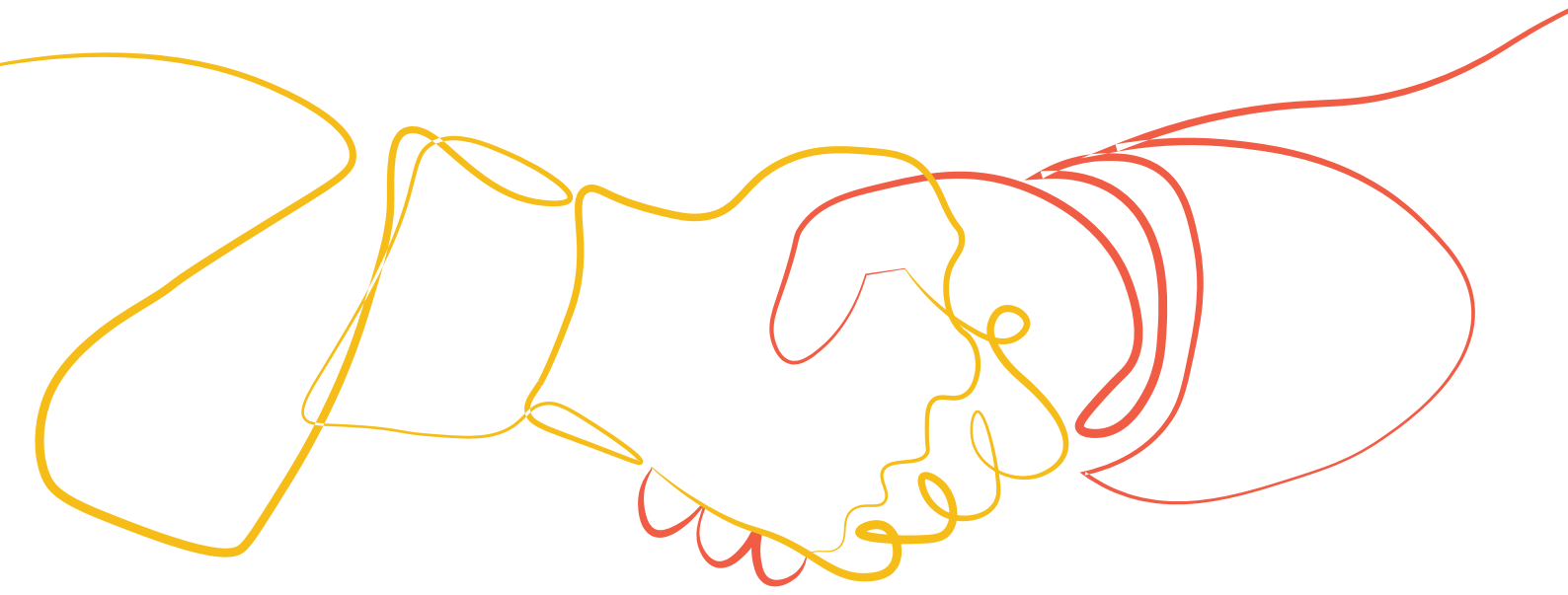
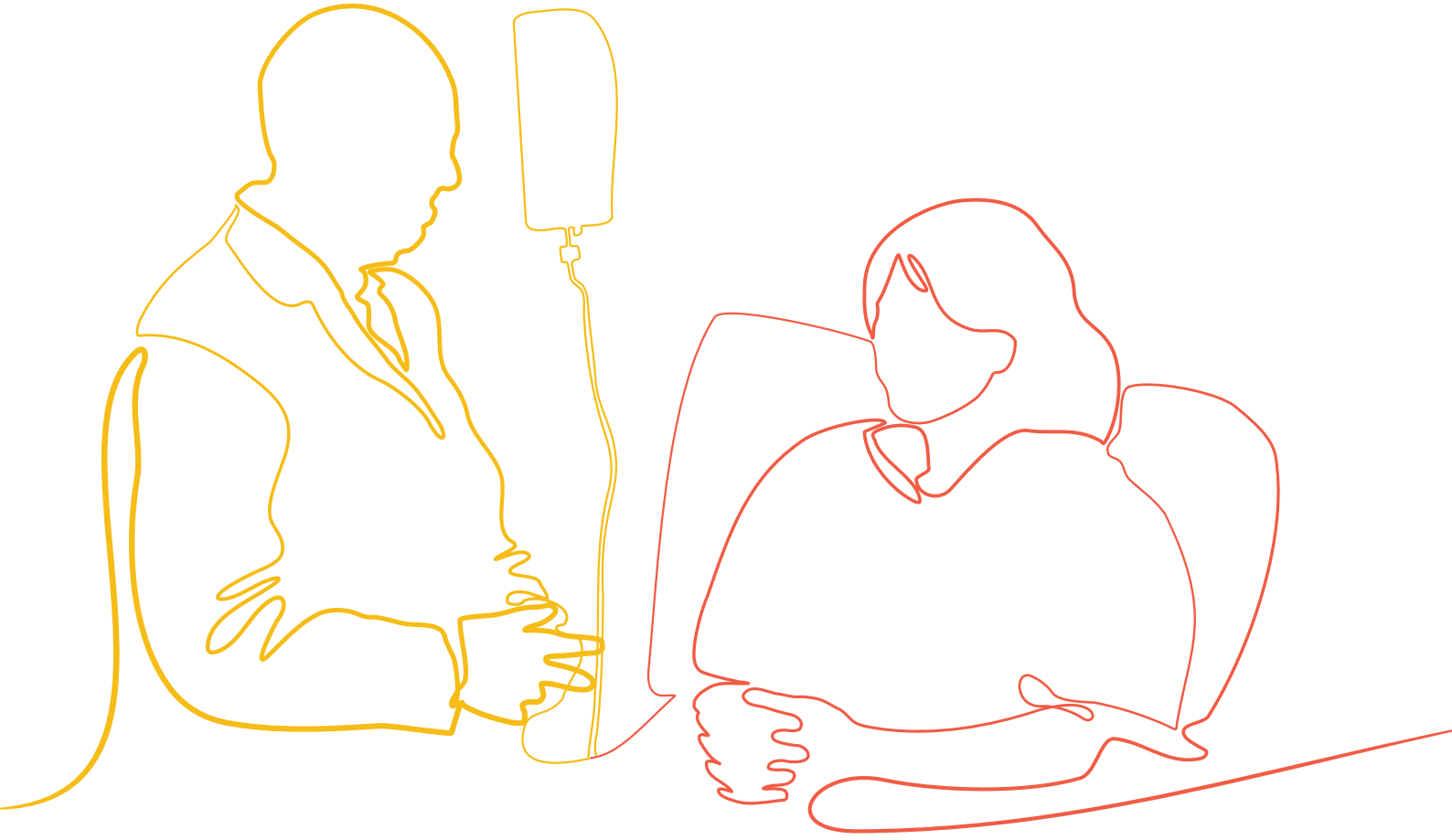


Table 1. Key health indicators in Libya

Health status (mortality)		
Mortality rate per 1000 live births, United Nations Inter-agency Group for Child Mortality Estimation	Neonatal	7
	Infant	11
	Under 5	13
Maternal mortality ratio	Per 100 000 live births	9
Mortality rate from road traffic injuries per 100 000 population	Reported 2015	60.1
Health determinants and risks		
Low birth weight among newborns, 2014		7.1%
Exclusive breastfeeding 0–5 months, 2014		67.0%
Tobacco use (13–15 years), 2010	Female	5.0%
	Male	11.0%
Adult weight-for-height (18+ years), 2014	Stunted	21.0%
	Wasted	6.5%
	Overweight	22.0%
	Obese	10.5%
Coverage of selected interventions		
Antenatal care coverage (1+ visits), 2014		99.0%
Skilled birth attendance		99.0%
Treatment success of new bacteriologically confirmed tuberculosis		61.0%
Measles immunization coverage		96.8%
DTP3 coverage among children under 5		98.6%
Health workforce		
Personnel per 10 000 population, 2015	Physicians	19.5
	Nursing and midwifery	71
	Dentists	7
	Pharmacists	6

Source: Service Availability and Readiness Assessment (SARA) of the public health facilities in Libya. WHO; 2017.



3

Organization and delivery of health services

3.1 Organization of health services

3.1.1 The public health sector

Libya's health care system has significantly improved since 1951, when it first started functioning with 14 hospitals (1600 bed capacity) and a small number of health centres. Community health facilities were introduced between 1970 and 1979. "Health for all" has been the mandate since 1980, when the Government pledged to provide free universal coverage of health services.

Decentralization of the health system started in 2000, when the central body (Secretariat of Health) was dismantled in favour of district-level management. However, in 2006, the demand for a better health system led to a shift towards centralization. The Secretariat of Health was re-established and authorized to supervise the central institutions and the secretariats of health at the district level. Eventually, in 2011 the Secretariat of Health was renamed the Ministry of Health, and a Minister of Health was appointed.

Health service provision has deteriorated considerably since the outbreak of civil war and toppling of the regime in 2011, with severe constraints in both technical capacity and financing. The onset of the second round of conflict in 2014 further resulted in fragmented health care governance due to changes in the political system of the country. Health services are now provided by both public and private providers, with some traditional medicine also available.

However, the public health sector remains the main health service provider. Preventive, curative and rehabilitation services are provided to all citizens free of charge. At present, almost all levels of health services are decentralized except hospitals and specialized centres.

The Ministry of Health operates through an administrative and a technical workforce and has an extensive central organizational structure. The Ministry of Health, headed by the Minister, directly supervises the following central institutions:

- **the Health Information Centre**
- **the National Centre for Disease Control**
- **the National Council for Medical Responsibilities**
- **the National Programme for Organ Transplantation**
- **the Medical Supply Organization**
- **the Centre for Human Resource Development**
- **the Authority of Ambulance Services**
- **hospitals and medical centres**
- **directorates of health services at the municipality level.**

The Minister of Health is assisted by the Undersecretary of Health, who effectively works as the head of the staff of the Ministry. The Ministry is administratively responsible for 16 directorates, with departments and offices under each directorate. At the district level, the District Health Officer is responsible for providing comprehensive health care services to all citizens free of charge (Public Health Law No. 106 of 1973). Initially the District Health Officer's responsibility was to oversee hospital quality of care. However, since the hospitals have become more autonomous, the District Health Officer now oversees only the primary health care (PHC) facilities working at the municipal level. Health care is delivered through a series of PHC units, centres, polyclinics, rehabilitation centres and general hospitals in urban and rural areas, in addition to several specialized tertiary care hospitals.

3.1.2 The parastatal health sector

The Ministry of Defence has one hospital in Tripoli, and the National Oil Corporation has a small hospital in Tripoli as well.

3.1.3 The private health sector

For-profit

The private health sector was formally organized in March 2014 through a business council for clinics known as the General Federation of Inpatient Clinics

The private health sector was formally organized in March 2014 through a business council for clinics known as the General Federation of Inpatient Clinics, which is recognized by the Government. The 44 members of this Federation are the owners of the health centres, and each of one of them has an official capacity to represent the rights of the Federation. The priorities of the Federation are to collaborate with the Government in revising and updating the regulation, licensing mechanisms, accreditation mechanisms, and to achieve universal health coverage through public–private partnership (PPP). Unfortunately, the Federation is neither receptive to public health programmes nor to exchange of information with the Government. Furthermore, it has no programme for continuous medical education.

Not-for-profit

The establishment of nongovernmental organizations (NGOs) was first allowed in 1971. The Association Act allowed for an expanded role of NGOs in the health sector and organized their registration mechanisms, role and scope of work.

The Libyan Red Crescent Society was established in 1957. It is the only NGO that provides health services in Libya. The Society has two hospitals with a total bed capacity of 60 beds in Tripoli and 15 beds in Benghazi. It also has many outpatient clinics and pharmacies. The major source of funding is user fees (86%).

Traditional medicines are found in several outlets selling herbal and alternative medicines and in a few traditional medicine clinics. This sector is unregulated and there are no available data about its scale or activities.

3.2 Delivery of health services

As anywhere, the health care delivery system operates on three levels:

1. The first level consists of the PHC which provide curative and preventive services. PHC centres serve between 10 000 and 26 000 citizens, and polyclinics serve approximately 50 000 to 60 000 citizens. Both PHC centres and polyclinics are staffed with specialized physicians. They include laboratories, pharmacies and radiology services.
2. The second level is general hospitals in rural and urban areas, where care is provided to those referred from primary facilities.
3. The third level is composed of tertiary care, which includes specialized hospitals and medical centres.

3.2.1 Primary health care facilities

Primary health service delivery in Libya is provided through 1559 public health care facilities (Table 2). Nearly half of them (47%) are health care units, 37% are health care centres, 4% are polyclinics, and 13% are other types of facilities such as dental clinics and tuberculosis centres.

Table 2. Primary health care facilities

Category	Number	Proportion of total
Health care centres	571	36.6%
Health care units	728	46.7%
Polyclinics	56	3.6%
Other	204	13.1%
Total	1559	100%

Source: Service Availability and Readiness Assessment (SARA) of the public health facilities in Libya. WHO; 2017.

3.2.2 Secondary and tertiary health care facilities

In 2017, there were 97 public hospitals in Libya. Recently, 204 additional health facilities have been upgraded and given “hospital” status. Of all hospital facilities, 27 (16.8%) are rural, 48 (29.8%) are general, and 22 (13.7%) are specialized hospitals. Table 3 shows the distribution of secondary and tertiary health care facilities across the country.

Table 3. Distribution of secondary and tertiary health care facilities across Libya

Region	Rural hospitals	General hospitals	Specialized hospitals	Total
East	6	7	0	14
Benghazi	4	8	8	19
Central	3	5	2	10
South	4	5	0	9
Tripoli	3	9	11	23
West	7	14	1	22
Total	27	48	22	97

Source: Service Availability and Readiness Assessment (SARA) of the public health facilities in Libya. WHO; 2017.

4

Health resources by sector

The private sector has the highest share of health resources by number of facilities (Table 4), whereas the public sector has the greater share of human resources. Since there are no tertiary private hospitals in Libya, bed capacity is much higher in the public sector.

The official figure for the health workforce in the private sector is 15 442 personnel, based on the information from the Health Information Centre of the Ministry of Health. The number of full-time medical and paramedical personnel is 9157, and the number of part-time personnel is 6285. It is worth noting that part-time personnel are considered to have illegal status given that dual work practice is not allowed in Libya *(6)*. Table 5 shows the number of health workers in the private health sector, 2018 *(6)*.

Table 4. Health resources private sector, 2018

Facility type	Private (for-profit)
Individual clinics/outpatient posts	235
Clinics/dispensaries	537
Maternity homes	-
Small hospitals (<50 beds)	235
General hospitals	0
Specialty hospitals	1
Diagnostic centres	19
Laboratories	411
Blood banks	0
Ambulances	0
Medical colleges	1
Training institutions	0
Pharmacies	3089
Beds	4623

Source: Daganee M, Rashid, R. Private health facilities report, Libya 2019. Information and Documentation Center, Ministry of Health, Libya *(6)*
Note: *Full-time in private sector (2018).

Table 5. Number of health workers in the private health sector, 2018

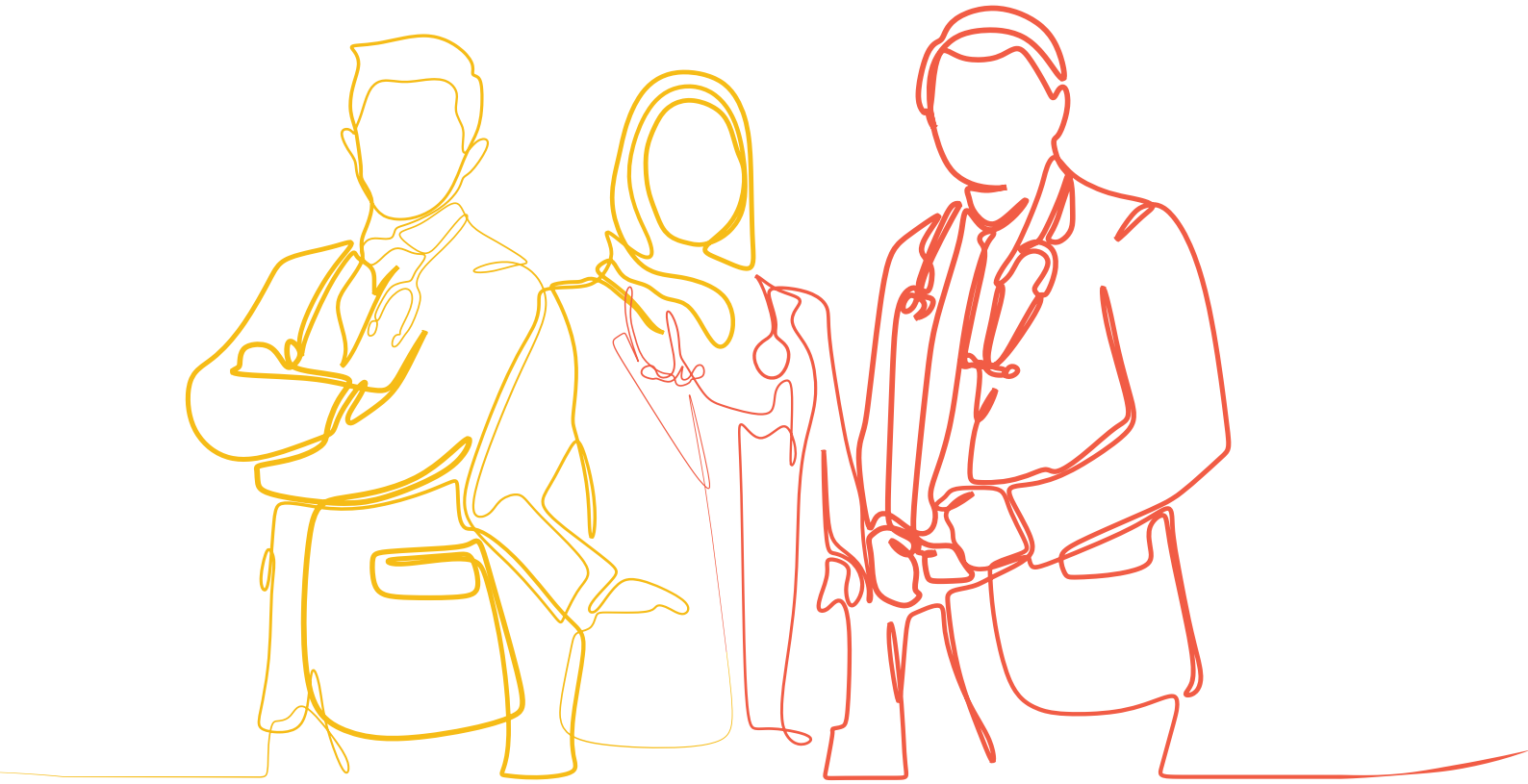
Health workers	Number
Doctors (general)	719*
Specialists	2690*
Dentists	444*
Nurses	2330*
Midwives	162*
Pharmacists	8621*
Paramedical (other jobs)	1659*
Technicians (laboratory and radiology)	600*

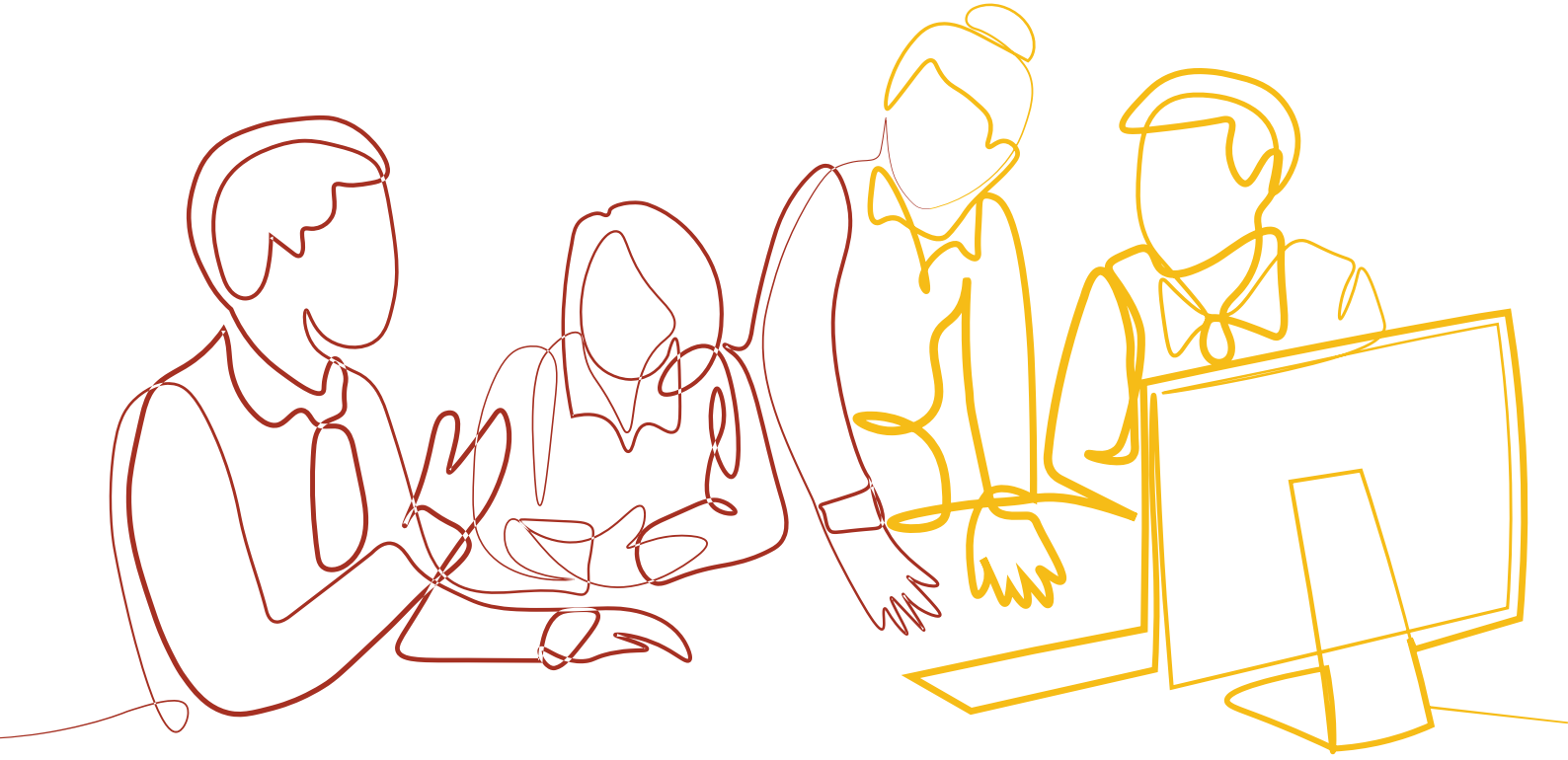
Source: Daganee M, Rashid, R. Private health facilities report, Libya 2019. Information and Documentation Center, Ministry of Health, Libya *(6)*
Note: *Full-time in private sector (2018).

72 colleges and education institutes in the public and private sectors provide medical and allied health education under the supervision of the Ministry of Education

The country's private health sector depends on public health sector staff, which results in an alarming brain drain from the public sector. Several factors such as better workplace conditions, professionalism, management style and incentives are among the factors that attract health personnel to seek private health sector employment. The Government has now established a committee to review salaries and incentives in the public health sector to address this critical issue. The distribution of the health workforce by specialty can be found in Annex 1.

In Libya, 72 colleges and education institutes in the public and private sectors provide medical and allied health education under the supervision of the Ministry of Education. The split of the health education institutes by sector and specialty can be found in Annex 2.





5
Health financing and expenditure

5.1 Health expenditure

Libya spends 4% of its GDP on health, which represents 8.3% of Government spending. Per capita expenditure is US$ 960. Table 6 outlines the health expenditure data in 2016.

Table 6. Health expenditure data in 2016

Per capita health care expenditure in US$	960
Percentage allocated to the Ministry of Health from the general budget	8.3%
Health expenditure as percentage of GDP	4.0%
State expenditure on health sector of total health expenditure	93%
Private (household) out-of-pocket expenditure	7.0%

Source: Health Information Centre, Ministry of Health.

Since independence in 1951 and as per Law No. 106 and Its by-laws (1973), the health care provided by public health facilities is free for the whole population. Consequently, 93% of total health expenditure is financed by the public sector.

As a result of this free care strategy, several improvements to public health facilities have been achieved. Nonetheless, there are areas that continue to suffer from the shortage of medical and nursing staff.

With all the challenges and inadequacies of services in the public health sector, the private health sector has grown rapidly. One noticeable observation is the high average rate of outpatient consultation fees relative to the standard of living of the majority of the population. Consultations in the private sector vary from 20 to 65 Libyan dinars (US$ 4–13), which is considered a hefty amount by most of the population. This has created an inequitable predicament, in which the poor can only access the public sector, whereas the middle class can access both public and private health centres.

Overbilling does occur and is one of the determinants of the financial barriers for health insurance beneficiaries. Unfortunately, there are no data about the extent of overbilling. There are also some problems related to the application and enforcement of the regulations. Usually when overbilling is practised, it is in the form of out-of-pocket expenditure.

5.2 Health finance

The private health sector consists mainly of private capital groups or companies. The largest financing source of the private for-profit sector is direct payment for services and facilities by patients. Other sources include health insurance reimbursement and personal investments, while the private not-for-profit sector depends entirely on donations *(7)*.

The payment mechanism for health insurance is based on negotiated tariffs within national conventions that define the billing procedures. Unfortunately, there is no information on the size of investment in the private health sector.

5.3 Out-of-pocket expenditure

Private health patients pay directly for received services in clinics and hospitals. It should be pointed out here that Decree No. 63/2008 by the Ministry of Economy and Trade provides a comprehensive price list of medical and dental procedures, as well as laboratory and pharmaceutical products. Health Act 106, article 59 also states that the Minister of Health should determine the price of all health services. However, the Ministry of Economy and Trade is still in the process of determining the cost of the services. The tariffs for private health services were determined in 2008 and have not been revised since, which is one of the reasons behind the current lack of compliance by the private health sector. There is also a huge variation in the tariffs for different services across different private sector categories in different parts of the country. The cost of services also varies by mode of payment and coverage type (i.e. out-of-pocket versus health insurance). In 2018, the Ministry of Health formed a committee by Decree No.480/2018 to update the prices of services in the private health sector.

5.4 Private health insurance

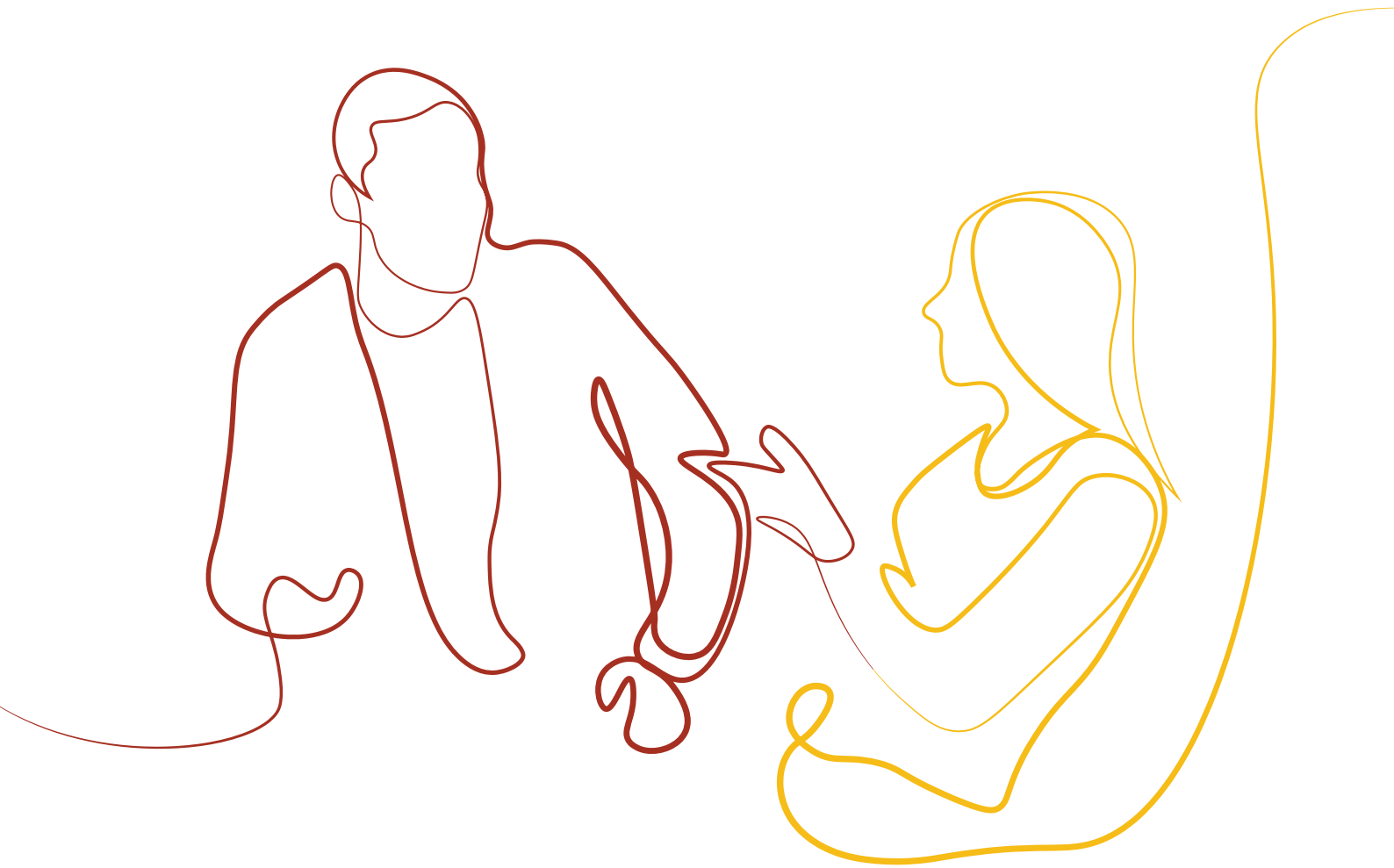
Under Libyan Insurance Law No. 20 issued on 28 January 2010 and its by-laws, health insurance is mandatory for all citizens and residents. The Health Insurance Fund was created upon the recommendation of the National Centre of Health System Reform by Decree No. 854 in 2017. In 2019 it was reported that "As a first step, health insurance was launched for the education sector state employees with a view to rolling it out to all Libyan citizens" *(8)*. Disappointingly, it has not yet started any actual health insurance activities.

The private health insurance sector in Libya is still relatively small, with about 250 000 beneficiaries from oil companies, banks, the Social Security Fund, civil aviation and telecommunications sectors. Private health insurance currently covers about 4% of the whole population.

Few private health providers are willing to risk the incurred health costs of their patients, which results in general distrust of the insurance policies

There are many insurance companies offering health insurance. Premiums must be paid annually in advance. Monthly payments can be structured only if an organization is willing to lend the policy-holder the entire amount and collect the loan in monthly instalments. There are 38 medical conditions that are covered by a supplementary health insurance document. Insurance does not cover the following 11 conditions: disaster (natural or man-made), epidemic and endemic diseases, AIDS, drug addiction and drug use, conflict, war injuries and injuries due to suicides and criminal acts.

Payments to hospitals/clinics and health providers in the form of fee-for-services are processed on the basis of contractual arrangements between the third-party administrator and the insurance company. Insurance claims of the clinics are processed after a long process of discussion about the tariffs, type of services covered and procedure of payment. Poor understanding of insurance concepts among private health sector providers leads to greater focus on revenue maximization at the expense of considerations of efficiency, equity and the sustainability of health care financing. Few private health providers are willing to risk the incurred health costs of their patients, which results in general distrust of the insurance policies.



6

Private health sector analysis and stakeholder perspectives

6.1 Private health sector growth and its determinants

The speedy expansion of the private health sector in Libya has been brought about by the complex problems in the public health sector and its political landscape. It is worth noting that the number of private outpatient clinics is now almost equivalent to the number of public PHC centres.

The growth of the private health sector can be analysed through the tremendous growth rates of private health facilities over time, as illustrated in Table 7.

Table 7. Comparative growth in the private health sector between 2007 and 2019

Health facilities	2007	2019	Growth rate (%)
Outpatient clinics	258	537	108
Private hospitals	67	235	250
Dental clinics	156	371	138
Pharmacies	1543	3089	100
Laboratories	166	411	147
Diagnostic imaging centres	4	19	375

Source: (6)

6.2 Private health sector resources

There is inequity in the distribution of private health sector resources. The major coastal cities have the highest concentration of private health facilities. The distribution of private health sector facilities in Libya is as follows:

- **Outpatient clinics:** Analysis by municipality shows that 22 municipalities have no outpatient clinics. Outpatient clinics are more common in Benghazi (43), Misrata (32), Al Khoms (28) and Hai Alanadulus (24). Outpatient clinics offer almost all the important consultative services. Gynaecology and paediatric consultative services are more common in the outpatient clinics, whereas ophthalmology and cardiology consultative services are less frequently observed *(6).*

- **Private hospitals:** There are 235 private hospitals in Libya, although 64 municipalities do not host one. The majority of private hospitals are in Misrata (25), Zliten (18), Benghazi (17), Tripoli (16), Abuslim (14), Hai Alandalus (13) and Ain Zara (11).

- **Dental clinics:** There are 371 private dental clinics in Libya, with 1377 dental chairs. The majority (70%) of dental clinics are registered as individual entities and are rented (69%). Thirty-six municipalities have no private dental clinics. Private dental clinics are abundant in Misrata (36), Benghazi (35), Tripoli (32), Abuslim and Hai Alandalus (27 each), Azzawia (15), Ain Zara and Zwara (14 each).

- **Pharmacies:** There are 3089 pharmacies in Libya. Of these, 85% are registered as individual entities and 75% are established in rented premises.

- **Laboratories:** There are 411 private laboratories in Libya. The municipalities with the highest number of private laboratories are Benghazi (35), Tripoli (29), Hai Alandalus (27), Ain Zara (14), Al Khoms (16) and Sabha (13). Thirty-one municipalities do not have private laboratories.

- **Imaging centres:** Currently, there are 19 private diagnostic centres in Libya, of which 13 are registered as company owned; the rest are individually owned. Analysis shows that 86 municipalities do not have diagnostic centres. The private diagnostic centres are mostly present in Benghazi, Zliten and Tripoli.

6.3 Regulatory framework and governance of the private health sector

6.3.1 Legal framework

The private health sector is governed by a number of laws dating back to 1973, as follows:

1973: The private health sector in Libya is acknowledged through Law No. 106 in five articles (55–59). Article 55 defines medical institutions, article 56 outlines licensing mechanisms, article 57 specifies the structure and other prerequisites for medical institutions, article 58 defines private clinics and article 59 authorizes the Minister of Health to determine the fees of curative treatment and related equipment, respectively. This law was significant because, for the first time, payment for health services was mentioned in the definition of medical institutions and, secondly, because licences became mandatory for private health institutes and for practising health *(9).*

1975: The Ministry of Health via Decree No. 654 issued bylaws for curative hospitals and private clinics. Although the law and bylaws were available, they did not trigger any major investment in the private sector.

1992: Law No. 9 was concerned with the conduct of economic activities. It has 18 articles. Article 2 allows private sector engagement in fields such as health, education, agriculture, industry, trade and engineering (Law 9/1992, Law 21/2001 and Law 1/2004 on conducting economic activities, Ministry of Economic Affairs and Trade).

1993: Cabinet issued two decrees, nos. 589 and 590, explaining how to obtain a licence from the Ministry of Health and defining the specialties. These decrees encouraged investment in the private health sector, and the establishment of private health facilities has been on rise ever since.

2001: Law No. 21 was introduced to reinforce Law No. 9 (1992), then partially amended by Law No. 1 (2004).

2008: Decree No. 63 by the Ministry of Economic Affairs and Trade stipulates that it is to provide a comprehensive price list of medical and dental procedures, as well as of laboratory and pharmaceutical products.

The price list is not strictly followed by the private health sector. This decree has encouraged investment in the private health sector. Health Act 106, Article 59 (1973) states that the Minister of Health should determine the price of all the services. In 2018, the Ministry of Health formed a committee by Decree No. 480/2018 to update the prices of services in the private health sector.

6.3.2 Licensing and registrations process

The two Cabinet decrees of 1993 explain how to obtain a licence from the Ministry of Health (No. 589) and define the specialties (No. 590).

Licensing of health care providers

Under Law No. 106 and its by-laws (Law 09/1992, No. 21 2001 and No. 1 2004 on conducting economic activities – Ministry of Economic Affairs and Trade), it is mandatory for all health professionals to be registered with the concerned directorate of the Ministry of Health. The issuance and renewal of licences are managed by the Doctors Syndicate and Technicians Syndicate. The prerequisites for registration involve the completion of a registration form, having an attested degree/certificate from a teaching institute, and receipt of the registration fee.

Licensing of health facilities

The Ministry of Economic Affairs and Trade is responsible for issuing licences for private health facilities. A special multisectoral committee assesses, studies and evaluates the renewal and issuance of applications for licences of any health facility. The licence is then endorsed by the Ministry of Health, which gives the green light to the Ministry of Economic Affairs and Trade. The owner of the facility must fulfil the following criteria:

- **Libyan nationality**
- **properly qualified**
- **physically fit for the performance of work**
- **good character and has no criminal record**
- **registered as a professional with the Ministry of Health**
- **registered with the relevant professional syndicate**
- **registered with the Medical Insurance Authority.**

The construction laws applying to health facilities depend on the type of health facility to be opened. These laws have specifications regarding structural design, materials, construction and land area, for example (Law 09/1992, No. 21 2001 and No. 1 2004 on conducting economic activities – Ministry of Economic Affairs and Trade).

6.3.3 Quality standard and public health responsiveness

Public and private health facilities as well as health care workforces are required to follow a control standard in accordance with Health Law No. 106 (1973) and Health Minister Decree No. 654 (1974). The administrative structure of the Ministry of Health includes a dedicated directorate for the private health sector (Decree No. 11, 2013), which in 2018 was given the status of Department, working under the Directorate of Medical Services. The Department for the Private Health Sector is executing its tasks as outlined in the 2013 decree, Article 16 of which empowers the Department. Before the authorization of the opening of any private facility, the person in charge must demonstrate that he or she has fulfilled the prerequisites for the practice. In 2018, a new centre for health facilities accreditation was established to accredit public and private health facilities, as stipulated by Decree No. 181 (2018). The Health Institutions Accreditation Centre has started to establish accreditation standards and develop an accreditation methodology. There is no nongovernmental hospital accreditation agency in Libya. Most hospitals and private clinics apply for and obtain international organization standards via ISO certification.

6.4 Public–private partnerships

The private sector has expanded significantly in the Eastern Mediterranean Region in recent decades. PPP has proven to be the path for upgrading health services. This formula is intended to improve the delivery of basic services, with better coverage and quality of and infrastructure for health care, as well as increasing community demand for health services *(10).*

In Libya, there is political commitment to engage the private sector to form partnerships, as seen in Law No. 9 (1992), consisting of 18 articles related to the conduct of economic activities. Article 2 of this law allows private sector engagements in health, education, agriculture, industry, trade, engineering and beyond (Laws No. 9 1992, No. 21 2001 and No. 1 2004 on conducting economic activities – Ministry of Economic Affairs and Trade, and a press statement of the Vice President of the Government of National Accord on 24 December 2018). The importance of PPP in health emerged as one of the recommendations of the National Centre of Health System Reform workshop held in January 2019 *(11).* However, there is no policy or institutional framework for PPP or private sector engagement, no organizational capacity and no guidelines. Neither is there a designated unit or staff within the Ministry of Health.

The private sector has expanded significantly in the Eastern Mediterranean Region in recent decades

There are different forms of partnership between the private and the public health sectors in Libya under Law No. 9 1992 and Administrative Contract Regulation Decree No. 563, dated 26 October 2007. The first step to such partnerships was the outsourcing of activities outside of the main mission of hospitals, especially nonclinical support services such as catering, cleaning and gardening, the main services now being delivered by private companies in public hospitals. These are done through contracts with the private sector. With this breakthrough, the door to partnerships has opened, with opportunities for extended collaboration such as maintenance of hospital equipment; sanitation; the

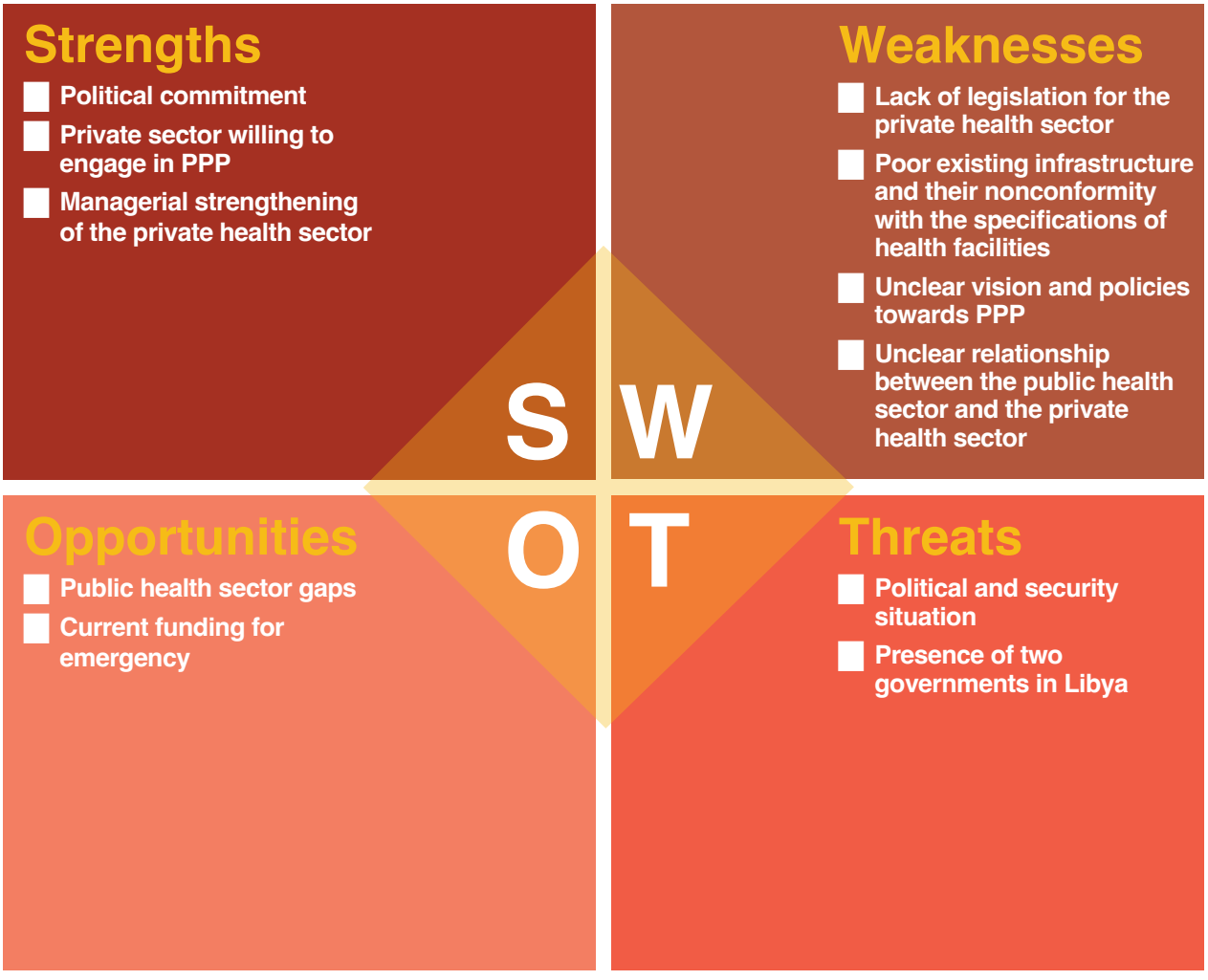
purchasing of specialized clinical services such as cardiology, cardiac surgery, orthopaedic surgery and neurosurgery; and, eventually, human resources. Recently, private hospitals have been allowed to recruit, through contracts, private companies to manage reception services in public hospitals.

In fact, the plan of the Ministry of Health to move from outsourcing to concrete partnerships is slowly taking form within the PPP framework.

6.5 SWOT analysis for PPP in the health sector

The main points of strength of health sector PPPs are the expressed political commitment and the willingness of the private sector to formalize existing public–private collaboration into partnerships (Table 8). The managerial strengthening of the private sector in Libya is favourable for PPPs. However, existing mistrust between the sectors is aggravated by the lack of transparency of the private sector and poor information exchange, especially regarding finance and administration. The current conflict and economic downturn as well as the presence of two governments in Libya are multiple interlacing factors and the major determinants undermining PPPs.

Table 8. SWOT analysis for PPP



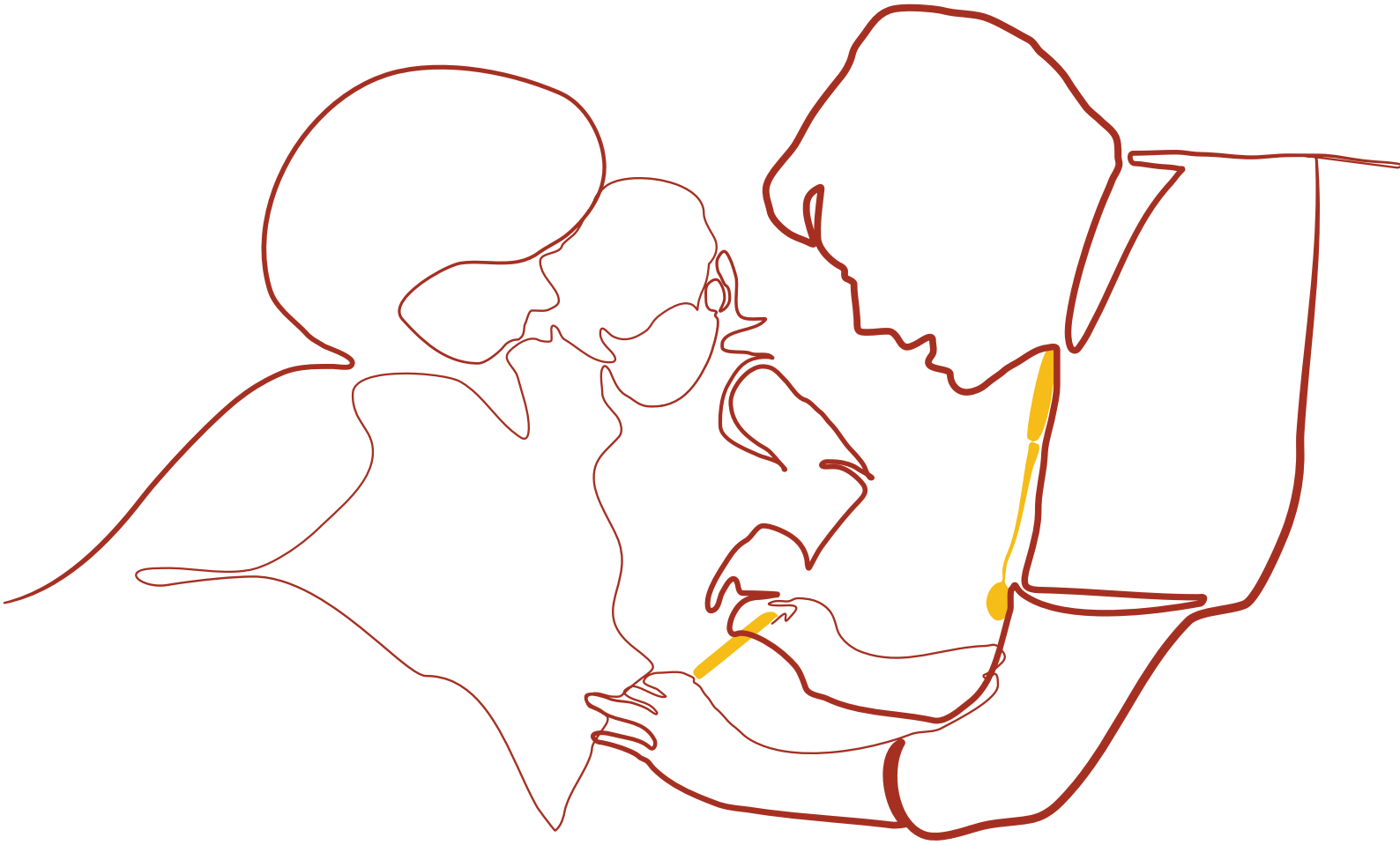
6.6 Recommendations for engaging with the private health sector

The assessment has revealed significant opportunities in both the short term and the long term for partnerships between the public and private health sectors.

The health system in Libya is still restricted by the free services approach, which has been shown to be unrealistic given the continuously increasing cost of health services. There is an urgent need to change this free care concept and to develop an appropriate communication plan to deliver a new understanding to legislative bodies, decision-makers and the public. Investment in PHC and the reform of health financing in Libya is necessary to establish a sustainable capacity and a resilient health system that can maintain essential services and mitigate new or emerging issues. A system-oriented intervention is thus required.

Effective engagement of the private health sector for improved health outcomes requires a policy and operating environment that enables strong public–private interaction, cooperation and partnership. The health sector should therefore take the following actions:

- Strengthen national capacity to effectively regulate, supervise and assure the quality of public and private health sector services:
  - to address barriers to affordable finance for the private health sector; and
  - to target and harmonize incentives for private providers delivering essential health services.
- Develop a mechanism for joint public–private human resource planning, conduct a market survey of the entire pharmaceutical sector and assist public facilities to procure drugs through the private sector during stockouts.
- Establish a national PPP steering committee as a sector-wide forum to create a space for all private health sector groups to discuss health system issues that directly impact their constituencies. This can motivate key subsectors to organize themselves and enable the private health sector to participate in the national forum.
- Foster partnerships with the private sector through an action plan. The intent of this strategy is to support the Government and private stakeholders to enhance public–private engagement at all levels of the Libyan health system. This strategy would provide a comprehensive snapshot of the private health sector landscape, revealing the multiple health services and health system functions in which private health sector actors are making a significant contribution *(7)*.



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Annexes

Annex 1. Distribution of health workforce by specialty

Table A1.1. Distribution of full-time human resources in outpatient and inpatient facilities, 2018

Specialty	Full-time outpatient facilities	Full-time inpatient	Total
Specialist	1198	1492	2690
General practitioner	295	460	755
Dentist	293	151	444
Dental technician	46	44	90
Pharmacist	126	211	337
Pharmacy technician	40	40	80
Nutrition technician	19	27	46
Midwife	10	152	162
Nurse	497	1833	2330
Laboratory technician	153	307	460
Radiology technician	10	130	140
Administrative/services staff	445	1214	1659
Total	3132	6061	9193

Source: Daganee M, Rashid, R. Private health facilities report, Libya 2019. Information and Documentation Center, Ministry of Health, Libya.

Table A1.2. Distribution of part-time human resources in outpatient and inpatient facilities, 2018

Specialty	Part-time outpatient facilities	Part-time inpatient facilities	Total
Specialist	850	140 739	2257
General practitioner	275	486	2257
Dentist	228	115	343
Dental technician	41	20	61
Pharmacist	100	128	228
Pharmacy technician	33	39	72
Nutrition technician	12	17	29
Midwife	18	123	141
Nurse	253	1169	1422
Laboratory technician	94	160	254
Radiology technician	26	95	121
Administrative/services staff	137	459	4355
Total	2067	4218	6285

Source: Daganee M, Rashid, R. Private health facilities report, Libya 2019. Information and Documentation Center, Ministry of Health, Libya

Annex 2. Split of health education institutes by sector and specialty

Table A2.1. Split of health education institutes by sector and specialty, 2018

College	Medicine	Dentistry	Nursing	Pharmacy	Health sciences	Public health	Technician	Total
Public	18	14	8	10	3	3	11	67
Private	1	3	0	1	0	0	0	5
Total	19	17	8	11	3	3	11	72

Source: Study of Medical and Allied Health Education in Libya. 2018; WHO (Ministry of Health).