

Strengthening health financing systems in the Eastern Mediterranean Region towards universal health coverage

Health financing atlas 2018



World Health
Organization

REGIONAL OFFICE FOR THE Eastern Mediterranean

Strengthening health financing systems in the Eastern Mediterranean Region towards universal health coverage

Health financing atlas 2018



**World Health
Organization**

REGIONAL OFFICE FOR THE **Eastern Mediterranean**

WHO Library Cataloguing in Publication Data

World Health Organization. Regional Office for the Eastern Mediterranean

Strengthening health financing systems in the Eastern Mediterranean Region towards universal health coverage: health financing atlas 2018 / World Health Organization. Regional Office for the Eastern Mediterranean

p.

ISBN: 978-92-9022-256-9

ISBN: 978-92-9022-257-6 (online)

1. Universal Health Insurance - economics 2. Healthcare Financing 3. Health Policy 4. Eastern Mediterranean Region

I. Title II. Regional Office for the Eastern Mediterranean

(NLM Classification: W 125)

© World Health Organization 2019

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation. Strengthening health financing systems in the Eastern Mediterranean Region towards universal health coverage: Health financing atlas 2018. Cairo: WHO Regional Office for the Eastern Mediterranean; 2019. Licence: CC BY-NC-SA 3.0 IGO.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Contents

Foreword	5
Acknowledgements	6
Key messages	7
Eastern Mediterranean Region health expenditure dashboard	8
Introduction	9
Chapter 1: Overview of health financing in the Eastern Mediterranean Region	10
Chapter 2: Analytical framework	15
Chapter 3: Health financing systems: country profiles	17
1. Afghanistan	18
2. Bahrain	22
3. Djibouti	26
4. Egypt	30
5. Islamic Republic of Iran	34
6. Iraq	38
7. Jordan	42
8. Kuwait	46
9. Lebanon	50
10. Libya	56
11. Morocco	60
12. Occupied Palestinian territory	64
13. Oman	68
14. Pakistan	72
15. Qatar	78
16. Saudi Arabia	82
17. Somalia	86
18. Sudan	88
19. Syrian Arab Republic	94
20. Tunisia	98
21. United Arab Emirates	102
22. Yemen	106
Chapter 4: Conclusion	110



Foreword

I feel particularly privileged to have started my term as WHO Regional Director for the Eastern Mediterranean in 2018. It is a very special year for the Organization, marking both the 70th anniversary of WHO and the 40th anniversary of the Alma-Ata Declaration. Seventy years ago, the world realized that there was a need for an international custodian of people's health, and 30 years later global policy-makers joined forces once again to define the most cost-effective approach for achieving health for all – resilient health systems based on the principles of primary health care.

In 2015, world leaders made another audacious commitment by adopting the Sustainable Development Goals, including universal health coverage as one of the targets as a means to promote health and well-being and ensure that no one is left behind.

In its Thirteenth General Programme of Work, WHO identified universal health coverage as a main focus of its work with Member States and set a target of 1 billion more people benefiting from universal health coverage by 2023. Accordingly, universal health coverage was identified as the top priority for all health system endeavours in the Roadmap of WHO's work for the Eastern Mediterranean Region 2017–2021, and a technical paper presented at the 65th session of the WHO Regional Committee for the Eastern Mediterranean provided an estimate of the regional contribution to this global target.

The Regional Office for the Eastern Mediterranean has developed the Framework for action on advancing universal health coverage in the Eastern Mediterranean Region. The Framework provides a set of key actions for countries and their development partners to achieve progress across all three dimensions of universal health coverage: service coverage, population coverage and financial protection. I was very pleased to witness the signing of the UHC2030 International Health Partnership Global Compact and the endorsement of the Salalah Declaration on Universal Health Coverage 2018 by countries of the Region at a ministerial meeting on “The road to universal health coverage in the Eastern Mediterranean Region” in Oman in September 2018. The Declaration calls on heads of state, governments and policy-makers to progress towards universal health coverage by enhancing access to promotive, preventive, curative, rehabilitative and palliative health services, and providing adequate financial protection for all of these services.

Health financing plays an essential role in ensuring progress towards universal health coverage. The Eastern Mediterranean Region health financing atlas 2018 presents an analysis of health financing systems in the Region in order that countries can learn from the experiences of others in reforming and transforming their health financing systems to enhance performance. I hope that this initiative contributes to the efforts exerted by all Member States and their development partners in the Region to reform their health financing systems to achieve the goal of universal health coverage.

Dr Ahmed Al-Mandhari

WHO Regional Director for the Eastern Mediterranean

Acknowledgements

This report was produced by the Health Economics and Financing Programme in the Department of Health System Development at the WHO Regional Office for the Eastern Mediterranean. The authors of the report are Awad Mataria (WHO Regional Office for the Eastern Mediterranean), Callum Brindley (WHO headquarters), and Nevine Elnahass (WHO Regional Office for the Eastern Mediterranean).

We are grateful for the contributions of numerous individuals for their support in making this report possible and improving the quality of information used in the analysis. We wish in particular to thank officials at the ministries of health of all 22 countries of the Eastern Mediterranean Region for their strong support.

Special thanks are due to Mahmoud Farag and Ilker Dastan (WHO Regional Office for the Eastern Mediterranean) for their substantial technical contribution to the report.

We would also like to acknowledge the technical input of the following individuals from WHO headquarters: Hélène Barroy, Elina Dale, Justine Hsu, Matthew Jowett, Inke Mathauer, and Ke Xu.

We also gratefully acknowledge the contribution of Ala Alwan (University of Washington), Eduardo Banzon (Asian Development Bank), Sameen Siddiqi (Aga Khan University), Ahmed Al-Mandhari (WHO Regional Director for the Eastern Mediterranean), Zafar Mirza (WHO Regional Office for the Eastern Mediterranean), and Agnes Soucat (WHO headquarters) in the preparation of this report.

We would like to thank the Department for International Development of the United Kingdom, the European Commission, the Government of Japan, the Government of France, and the Grand Duchy of Luxembourg for their funding support for WHO's health financing work, which has played a critical role in enabling us to undertake several of the country assessments that were used in the analysis.

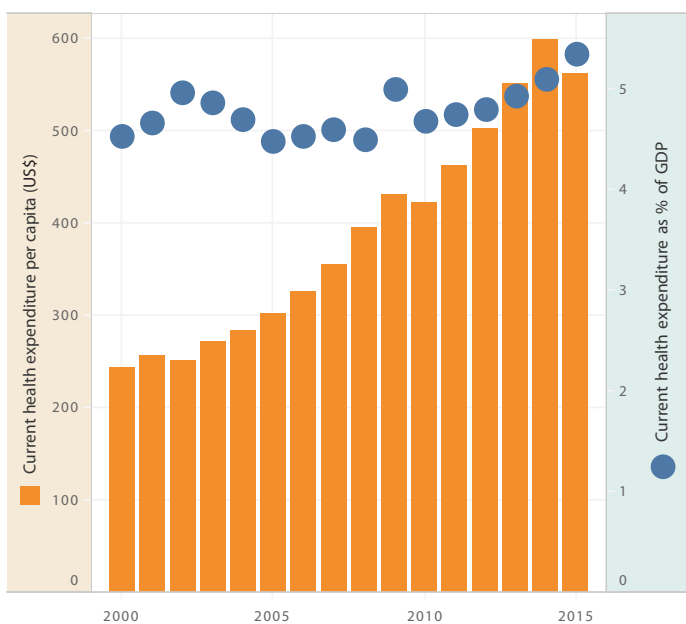
Key messages

- 1 Investment in health is insufficient compared with global trends.
- 2 Public spending on health is low despite sufficient fiscal space because it is not a high enough priority.
- 3 The population is not fully covered by equitable and efficient prepayment arrangements.
- 4 Low public spending on health and a lack of financial protection are leading to high out-of-pocket health payments.
- 5 High out-of-pocket health payments are causing a high degree of financial hardship and significant impoverishment.

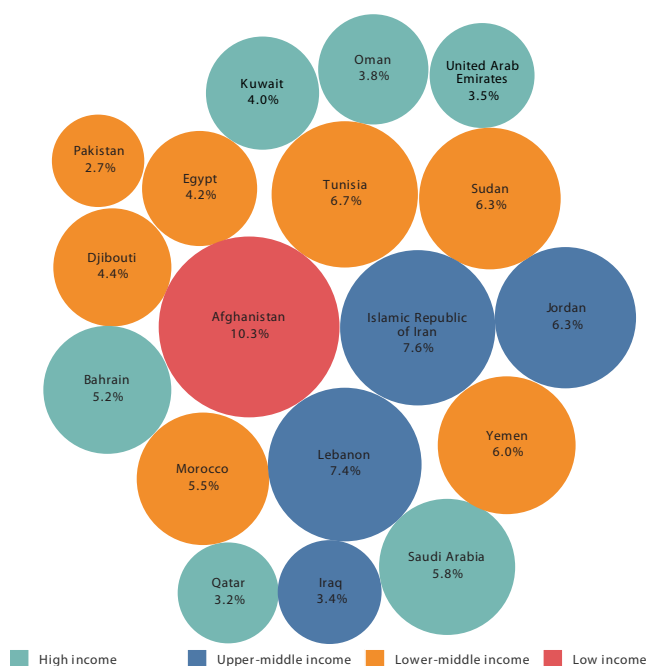
Eastern Mediterranean Region health expenditure dashboard

Population (000s)	653 116
Average current health expenditure as % of GDP	5.35
Average current health expenditure per capita (US\$)	562
Average GDP per capita (US\$)	12 120

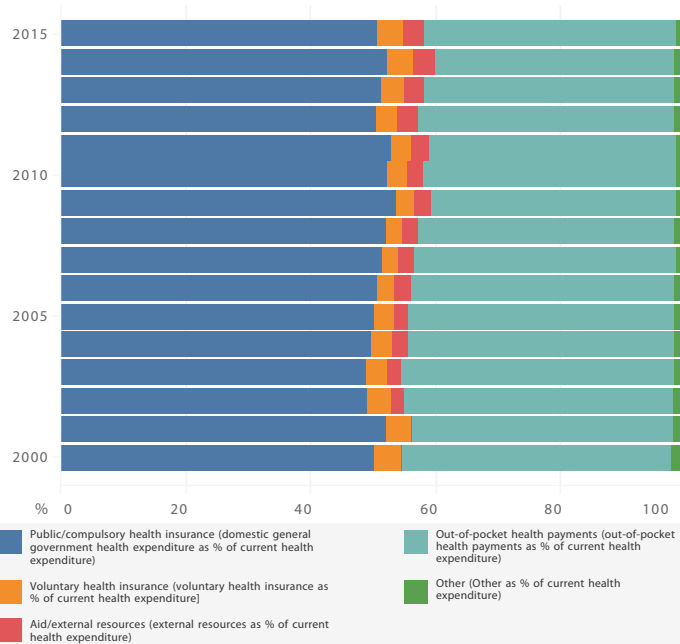
Selected macroeconomic, demographic and health expenditure indicators, 2015



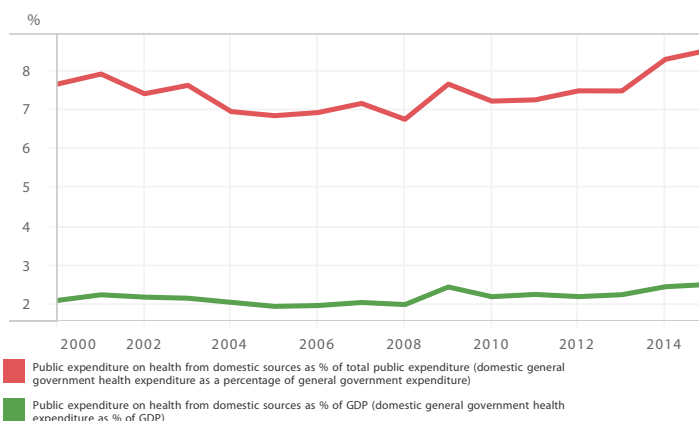
Current health expenditure per capita and as a percentage of GDP, 2000–2015



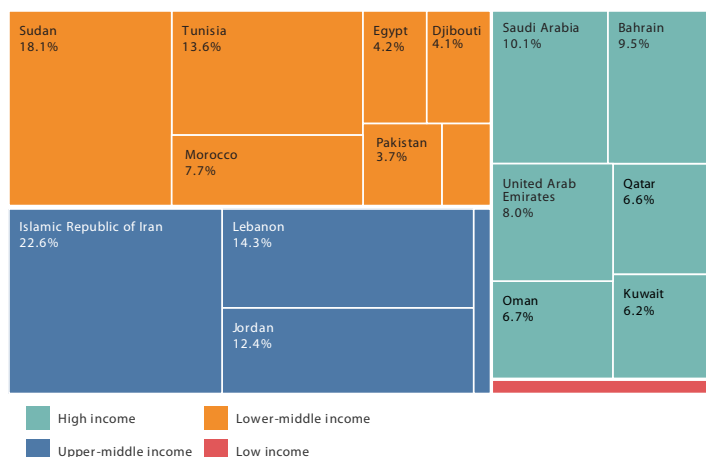
Current health expenditure as a percentage of GDP, by country, 2015



Structure of current health expenditure by financing source, 2000–2015



Public expenditure on health from domestic sources as a percentage of total public expenditure and as a percentage of GDP



Public expenditure on health from domestic sources as a percentage of total public expenditure (domestic general government health expenditure as a percentage of general government expenditure), by country, 2015

Note: regional averages are unweighted.

Source: Eastern Mediterranean regional health expenditure dashboard. Annex to: Xu K, Soucat A, Kutzin J, et al. New perspectives on global health spending for universal health coverage. Geneva: World Health Organization; 2018 (WHO/HIS/HGF/HFWorkingPaper/18.2). Licence: CC BY-NC-SA 3.0 IGO (http://www.who.int/health_financing/topics/resource-tracking/new-perspectives/en/, accessed 9 September 2018).

Introduction

More than 150 world leaders adopted the United Nations 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) in September 2015.¹ For health, this means action on 13 interrelated targets to achieve SDG 3: “Ensure healthy lives and promote well-being for all at all ages”, and in particular, the achievement of SDG Target 3.8: “Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”.² Although formulated as one target among 12 others, universal health coverage has been identified as WHO’s top priority, with all roads leading towards its achievement.³

As defined in the World Health Report 2010,⁴ universal health coverage has three dimensions: population coverage, service coverage and financial protection. Countries have been working to strengthen their health systems to progress towards universal health coverage by implementing reforms that contribute to three ultimate universal health coverage goals: reducing the gap between utilization and need; improving quality; and enhancing financial protection.⁵ All health system components, that is, governance, service delivery, financing, health workforce, medicines and technologies, and information, are closely interrelated in contributing to the fulfillment of the above universal health coverage goals.

In particular, health financing systems have proved to be essential in ensuring effective progress towards universal health coverage, as they impact three intermediate universal health coverage objectives, namely, efficiency, equity and transparency, and thereby ultimately contribute to the achievement of the three elements of universal health coverage cited in SDG Target 3.8.

Health financing systems need to be designed to:

- (a) raise sufficient and sustainable financial resources for health, which are equitably, effectively and sustainably mobilized;
- (b) pool and manage collected financial resources to guarantee equity in financing and utilization with adequate financial protection for all; and
- (c) use financial resources to provide the right incentives for providers and users alike to facilitate efficiency and enhance financial sustainability.

These objectives are facilitated by three health financing functions: revenue raising; pooling; and purchasing. In addition, special attention is given to benefit design – defining what to deliver under universal health coverage and subsequently identifying the resources needed, their management arrangements and utilization modalities, have been proposed as an effective approach to expand universal health coverage as part of the “progressive universalism” approach.⁶

The health financing atlas 2018 presents an analysis of the health financing systems in the 22 countries of WHO’s Eastern Mediterranean Region. Chapter 1 provides an overall summary of the health financing situation in the Region; Chapter 2 describes the analytical approach used to conduct the country-specific analysis based on nine elements; Chapter 3 describes the Region’s health financing systems country by country; and Chapter 4 concludes with general observations on the current situation and ways forward to improve the performance of health financing systems in the Region in the pursuit of universal health coverage.

¹ Resolution A/RES/70/21. Transforming our world: the 2030 Agenda for Sustainable Development. Agenda items 15 and 116.

² Mirza Z. Sustainable Development Agenda 2030 thrives on health. Eastern Mediterranean Health Journal. 2017;22(10):711–712.

³ Ghebreyesus TA. All roads lead to universal health coverage. The Lancet. 2017;5(9): e839–e840.

⁴ The world health report. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010 (<http://www.who.int/whr/2010/en/>, accessed 12 July 2018).

⁵ Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. Bulletin of the World Health Organization. 2013;91:602–611.

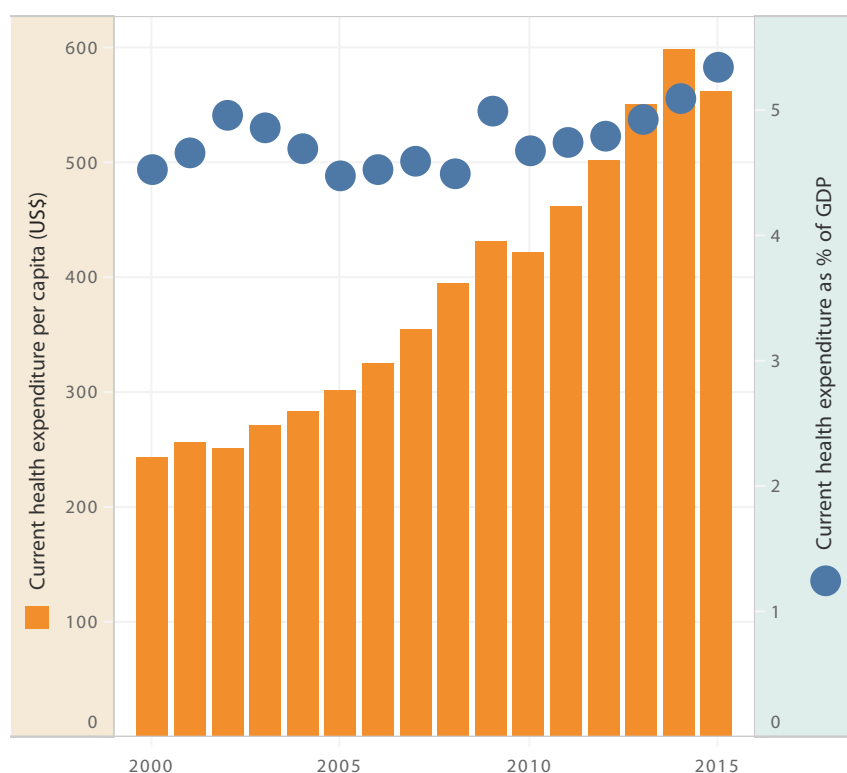
⁶ Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A et al. (2013). Global health 2035: a world converging within a generation. The Lancet. 2013;382(9908):1898–1955.

Chapter 1

Overview of health financing in the Eastern Mediterranean Region

The WHO Eastern Mediterranean Region consists of 21 Member States plus occupied Palestinian territory. It has a population of more than 653 million living in countries at various socioeconomic levels. Health system performance and population health outcomes vary considerably between countries of the Region. Inequities in health, acute and chronic emergencies, rising exposure to health risks, increasing health care costs and low levels of access to quality health care represent the main challenges facing health systems and people's health in the Region.

The Region is a low investor in health. In 2015, current health expenditure in the Region exceeded US\$ 145 billion – barely 2% of global current health spending for almost 9% of the world's population. Average per capita current health expenditure in 2015 reached US\$ 562,⁷ with huge disparities between and within countries. Current health expenditure as a share of gross domestic product (GDP) was 5.35% in 2015, almost half that observed globally (close to 10%). Fig. 1 describes the evolution of per capita current health expenditure in the Region from 2000 to 2015 – in absolute amounts and as a percentage of GDP.



Source: Eastern Mediterranean regional health expenditure dashboard. Annex to: Xu K, Soucat A, Kutzin J, et al. New perspectives on global health spending for universal health coverage. Geneva: World Health Organization; 2018 (WHO/HIS/HGF/HFWorkingPaper/18.2). Licence: CC BY-NC-SA 3.0 IGO (http://www.who.int/health_financing/topics/resource-tracking/new-perspectives/en/, accessed 9 September 2018).

Fig. 1. Current health expenditure per capita and as a percentage of GDP, 2000–2015

The level of current health expenditure varies considerably between countries; for example, Pakistan, home to almost 30% of the population of the Region, spent only US\$ 38 per person on health in 2015, while Qatar, a country of 2.4 million people, spent more than US\$ 2000 per person on health in the same year. As a percentage of GDP, Afghanistan spent 10.3% of its GDP as current health expenditure in 2015, while Pakistan spent only 2.7%; both are low-income countries. Fig. 2 shows current health expenditure as a percentage of GDP in 18 countries of the Region for which this information is available.

⁷ Note: all regional averages are unweighted.

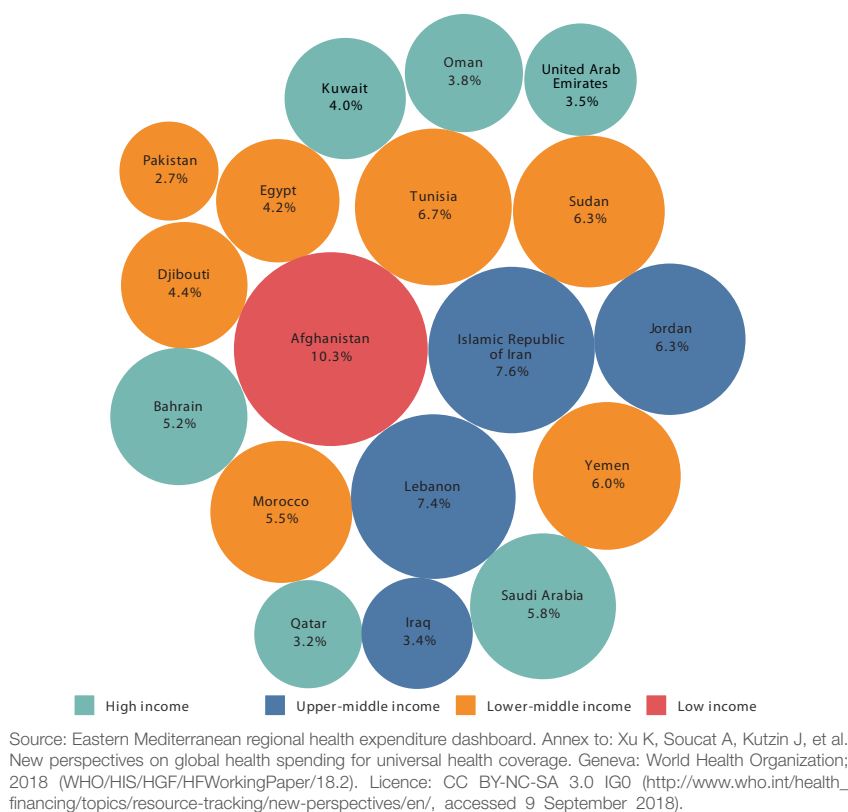


Fig. 2. Current health expenditure as a percentage of GDP, by country, 2015

The Region exhibits low public spending on health. Evidence from global best practices demonstrates that public spending is a prerequisite for progress to be made towards universal health coverage. Fig. 3 summarizes the structure of current health expenditure in the Region by financing source. It demonstrates consistently low public spending on health as a share of current health expenditure, which oscillated at around 50% between 2000 and 2015. In some low- and middle-income countries, the share of public spending in current health expenditure is as low as 20%. Public spending on health in the Region constituted only 2.5% of GDP in 2015, compared to a global average of 3.5%, as shown in Fig. 4.

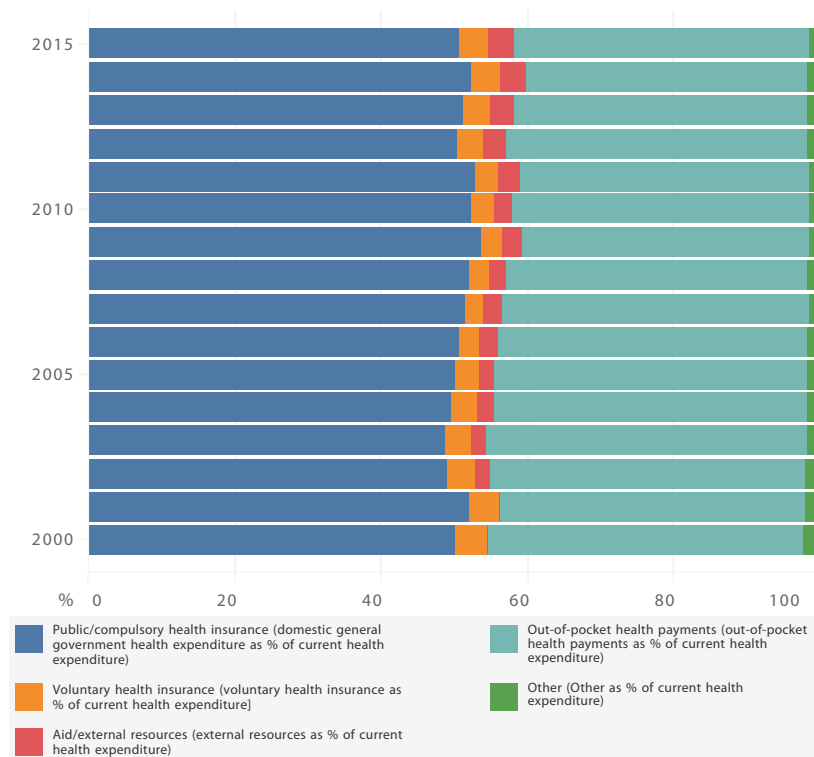
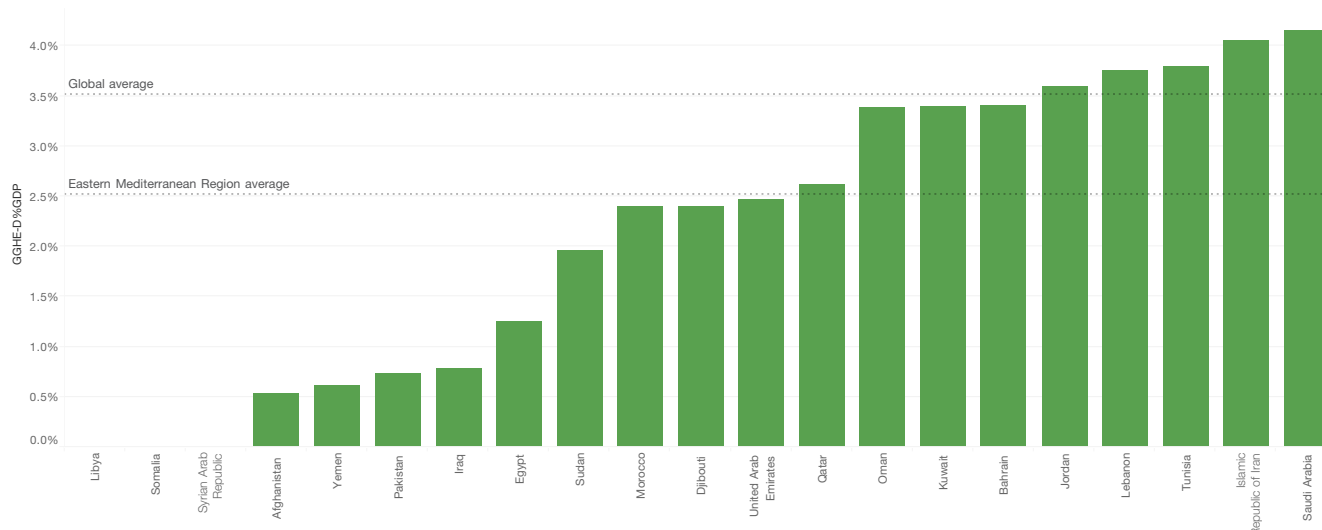


Fig. 3. Structure of current health expenditure by financing source, 2000–2015



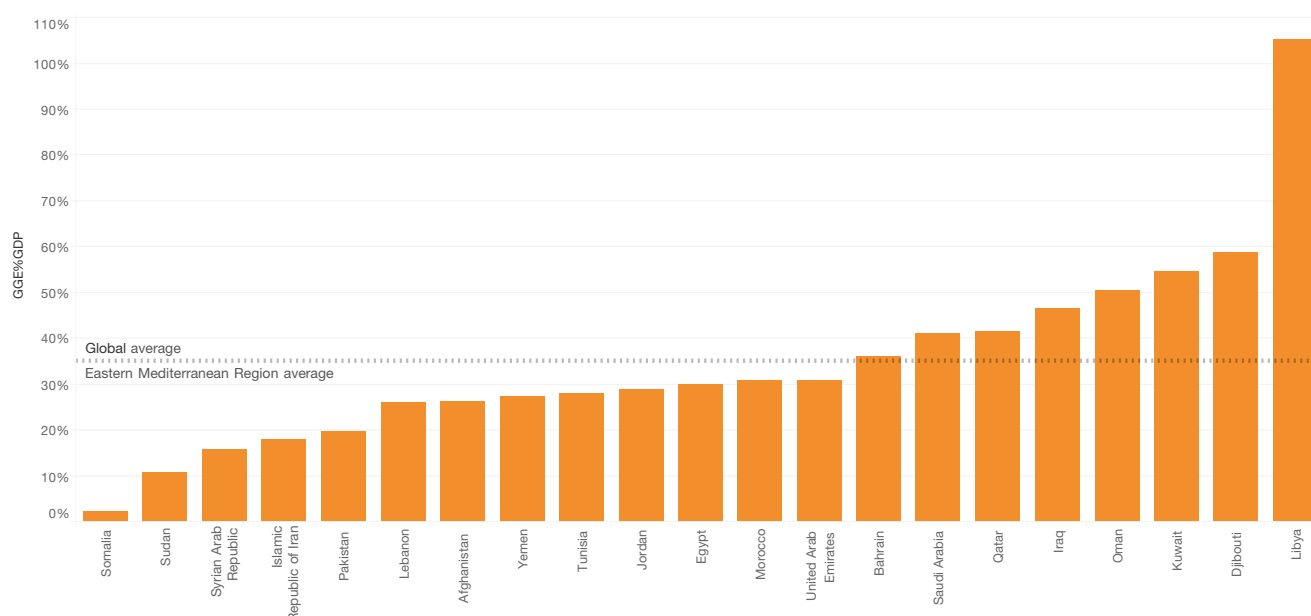
Abbreviations: GGHE-D = domestic general government health expenditure. GDP = gross domestic product.

Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.

Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

Fig. 4. Share of public spending on health as a percentage of GDP, 2015

Low public spending on health, despite high fiscal space. Public spending on health in the Region is low despite the general availability of public resources, as demonstrated by the level of fiscal space in the Region. Fig. 5 shows how the regional average fiscal space was equivalent to the global average of 35% in 2015, with a large number of countries even having a much higher fiscal space than the global average. Nevertheless, in some countries, especially those affected by acute and chronic conflict, the level of fiscal space was extraordinarily low – 2% in Somalia and 16% in the Syrian Arab Republic.



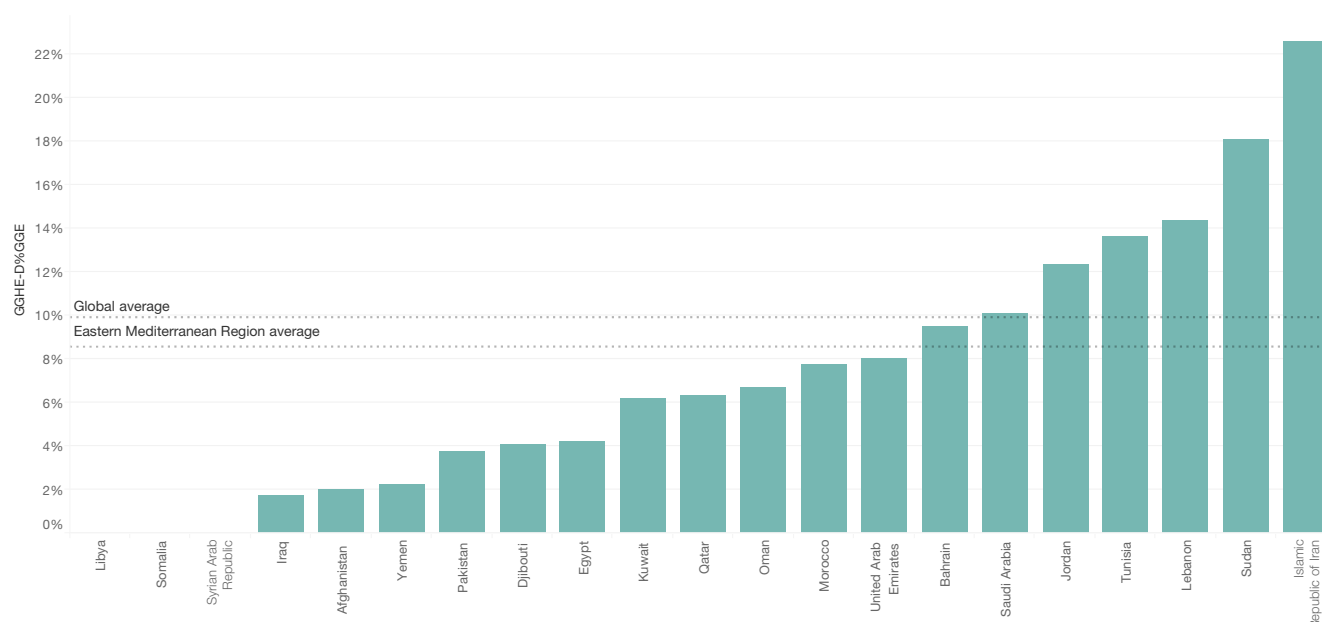
Abbreviations: GGE = general government expenditure. GDP = gross domestic product.

Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.

Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

Fig. 5. Share of general government expenditure as a percentage of GDP (“fiscal space”), 2015

Low public spending on health is primarily due to the low priority given to the health sector. Available information shows that public spending on health in the Region as a share of total public spending is on average one percentage point lower (9%) than the global average (10%) (Fig. 6), with wide discrepancies between countries of different income levels. Fig. 7 shows the low level of public investment in health in all low-income countries as well as several lower-middle income countries. The picture related to this indicator in high-income countries is mixed due to the significantly high GDP and general government expenditure levels in some of these countries.

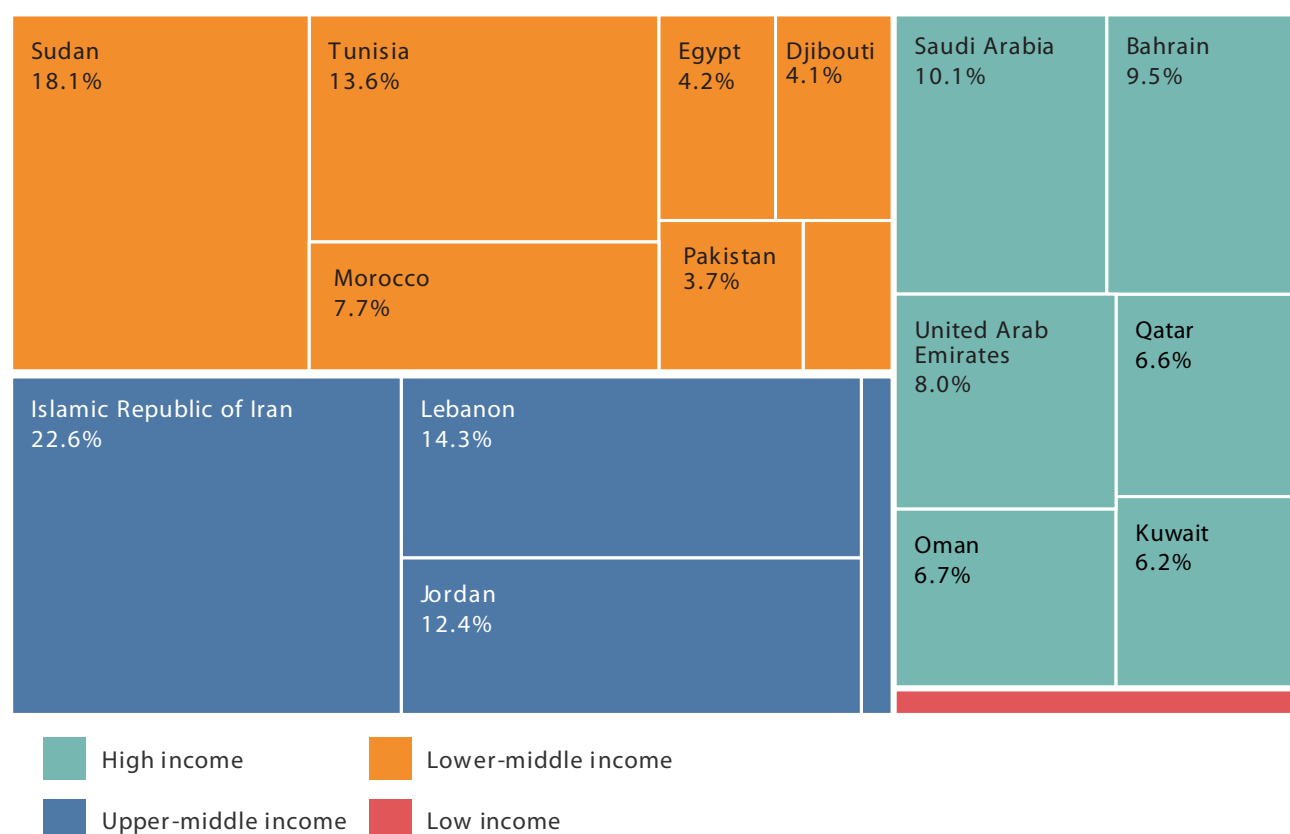


Abbreviations: GGHE-D = domestic general government health expenditure, GGE = general government expenditure.

Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.

Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

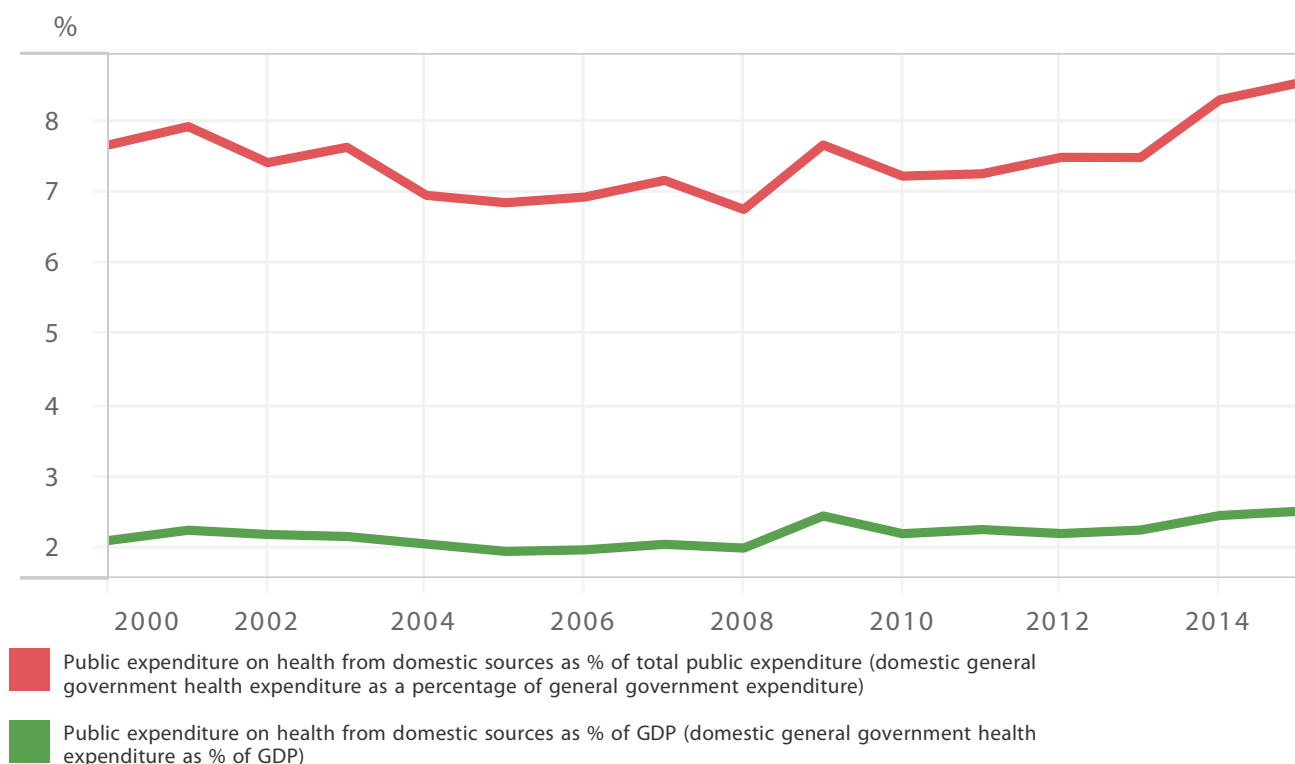
Fig. 6. Share of public spending on health as a percentage of total public spending (health prioritization), 2015



Source: Eastern Mediterranean regional health expenditure dashboard. Annex to: Xu K, Soucat A, Kutzin J, et al. New perspectives on global health spending for universal health coverage. Geneva: World Health Organization; 2018 (WHO/HIS/HGF/HFWorkingPaper/18.2). Licence: CC BY-NC-SA 3.0 IGO (http://www.who.int/health_financing/topics/resource-tracking/new-perspectives/en/, accessed 9 September 2018).

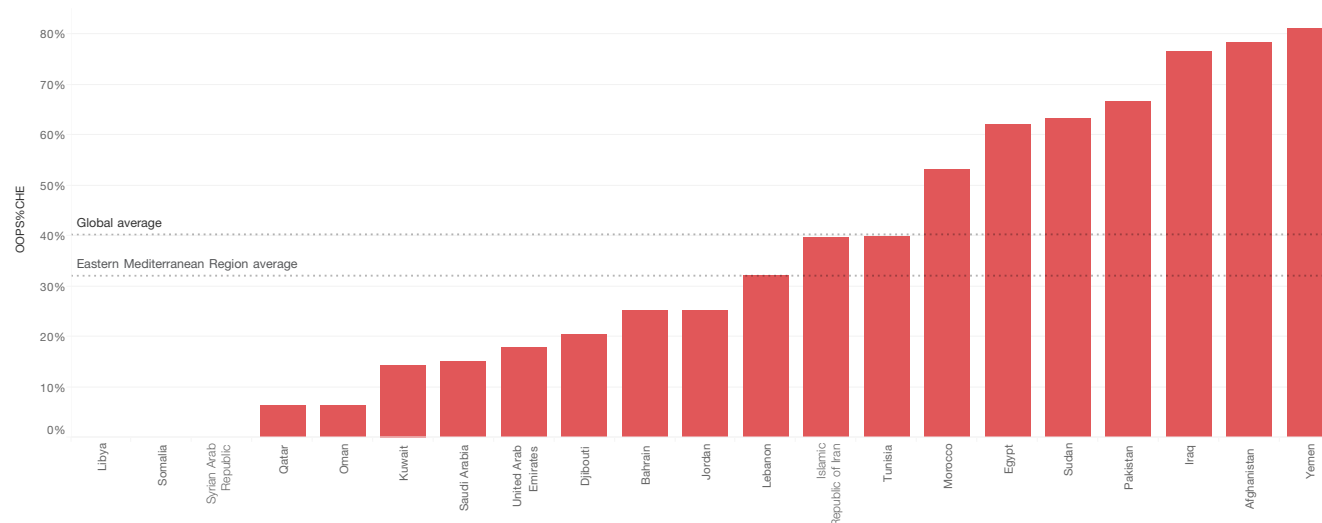
Fig. 7. Public expenditure on health from domestic sources as a percentage of total public expenditure (domestic general government health expenditure as a percentage of general government expenditure), by country, 2015

Low public spending on health has resulted in a high share of out-of-pocket payment in total current health expenditure in the Region. This low public spending on health has been observed between 2000 and 2015, with the regional average varying between 2% and 3% of GDP and between 6.5 and 8.5% of total public spending (Fig. 8). The share of out-of-pocket payment in the Region oscillated at around 40% of total current health expenditure between 2000 and 2015, compared to a global average of 32% in 2015 (Fig. 9).



Source: Eastern Mediterranean regional health expenditure dashboard. Annex to: Xu K, Soucat A, Kutzin J, et al. New perspectives on global health spending for universal health coverage. Geneva: World Health Organization; 2018 (WHO/HIS/HGF/HFWorkingPaper/18.2). Licence: CC BY-NC-SA 3.0 IGO (http://www.who.int/health_financing/topics/resource-tracking/new-perspectives/en/, accessed 9 September 2018).

Fig. 8. Public expenditure on health from domestic sources as a percentage of total public expenditure and as a percentage of GDP



Abbreviations: OOPS = out-of-pocket spending. CHE = current health expenditure.

Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.

Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

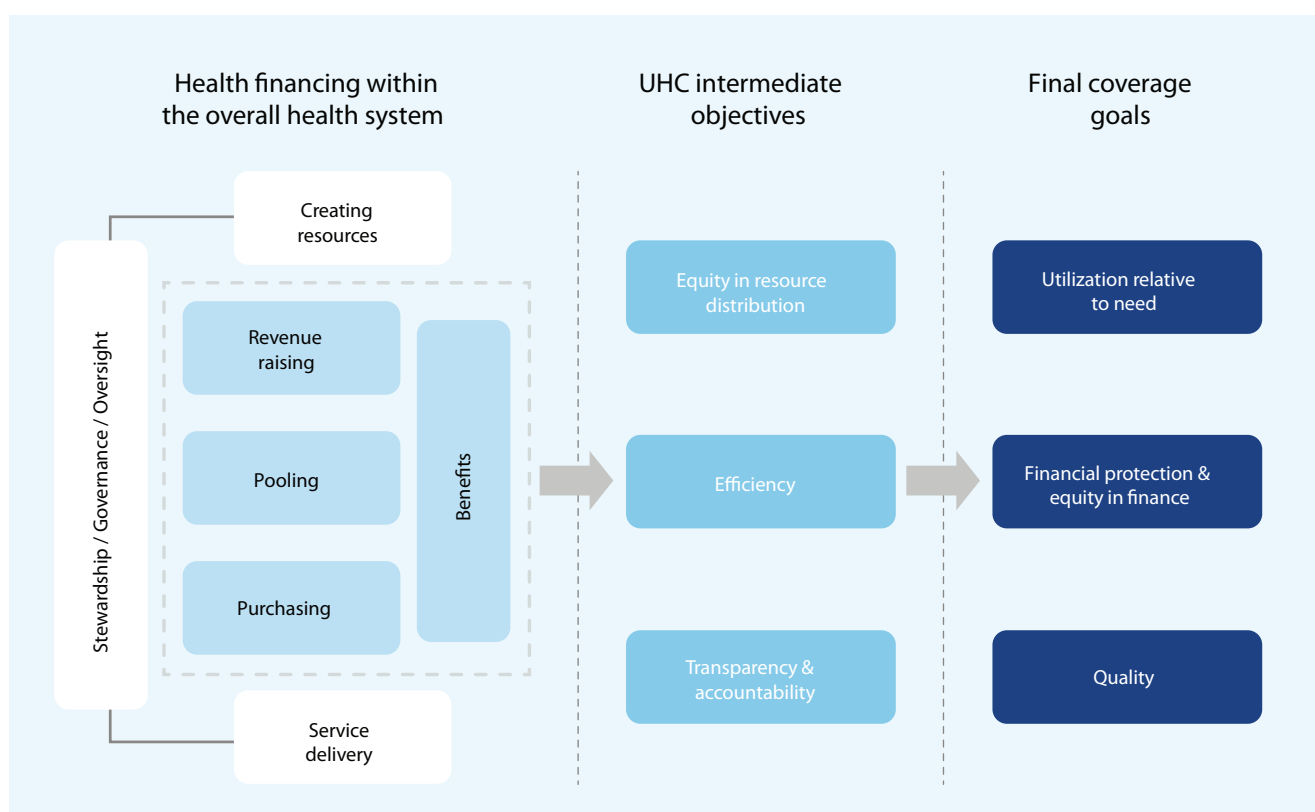
Fig. 9. Share of out-of-pocket payment as a percentage of total current health expenditure, 2015

High out-of-pocket payment can result in high levels of financial hardship. Region-wide, in 2015 an estimated 55.5 million people faced financial hardship, while an estimated 7.7 million people were pushed into poverty due to high out-of-pocket payments.

Chapter 2

Analytical framework

The framework shown in Fig. 10 has been developed to link health financing systems and their three functions – revenue raising, pooling and purchasing – with the intermediate objectives and ultimate goals of universal health coverage. It also places health financing systems within the other components/functions of health systems.⁸



Source: Kutzin J, Witter S, Jowett M, Bayarsaikhan D. Developing a national health financing strategy: a reference guide. Geneva: World Health Organization; 2017. (Health Financing Guidance No 3) Licence: CC BY-NC-SA 3.0 IGO (<http://apps.who.int/iris/bitstream/10665/254757/1/9789241512107-eng.pdf>, accessed 10 September 2018).

Fig. 10. Health financing within the context of universal health coverage (UHC)

Accordingly, the health financing atlas 2018 is built on an analytical framework consisting of nine elements that was used to describe the health financing systems in the 22 countries of the Region. The nine elements comprise: the overall macroeconomic picture and the health financing system architecture; health financing governance; the three health financing functions (revenue raising, pooling and purchasing) as well as benefit design; and finally, the three dimensions of universal health coverage (population coverage, service coverage and financial protection).

The universal health coverage index of coverage of essential health services is used to describe the status of service coverage in various countries. It is a single indicator that is computed based on tracer indicators (some of which are proxies of service coverage) to monitor coverage of essential health services. Tracer interventions include: reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access. Service coverage is typically measured on a scale of 0 to 100%, with 100% as the target, and

⁸ Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. Bulletin of the World Health Organization. 2013; 91:602–611.

therefore the universal health coverage service coverage index is presented on a scale of 0 to 100. For more details, including a list of current values of the universal health coverage index of coverage of essential health services by country, see *Tracking universal health coverage: 2017 global monitoring report*. Geneva: World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017. Licence: CC BY-NC-SA 3.0 IGO (http://www.who.int/healthinfo/universal_health_coverage/report/2017/en/).

To map each country's health financing system, an exhaustive set of questions and issues related to each of the above nine elements was considered. This was supplemented by a presentation of the time trends of selected indicators and scatter plots of others describing the evolution of health spending in each country over the 15-year period between 2000 and 2015, and comparing the current status in each country vis-à-vis others falling within the same income group.

Descriptive information was collected from a number of sources including published and grey literature, and discussed with key informants and specialized units within regional ministries of health for endorsement. For comparison purposes, all health expenditure data were extracted from the WHO Global Health Expenditure Database unless they were unavailable for the specific country or the specific indicator, in which case national sources were sought.

Chapter 3

Health financing systems: country profiles



1. Afghanistan

1. Macroeconomics

Persistent insecurity has resulted in slow economic recovery in Afghanistan. Economic growth is mainly driven by the agriculture sector. In 2016, Afghanistan's GDP was US\$ 19.5 billion, with a GDP per capita of US\$ 562, which is slightly below the average for low-income countries (US\$ 612). In 2015, general government expenditure reached US\$ 5.205 billion, constituting 26.7% of GDP. The poverty rate at the national poverty line increased from 36% in 2011/2012 to 39% in 2013/2014.

2. Health financing architecture

The Ministry of Public Health is the main steward of the health system. It sets health care financing policies and standards, including defining the Basic Package of Health Services and Essential Package of Hospital Services. Under the System Enhancement for Health Action in Transition Project, resources allocated for the Basic Package of Health Services and the Essential Package of Hospital Services (on- and off-budget) come under one umbrella through the Afghanistan Reconstruction Trust Fund platform, covering the entire country and allowing harmonization in intervention design and implementation arrangements across the provinces. A Grant Contracting and Management Unit under the Ministry of Public Health contracts out health services to nongovernmental organizations in 31 provinces while retaining responsibility for service delivery in the remaining three provinces through a contracting-in modality.

3. Revenue raising

Health services are primarily financed by three donors: the World Bank, the European Union (EU) and the United States Agency for International Development (USAID). Current health expenditure as a share of GDP has changed little between 2006 and 2015. In 2015, per capita current health expenditure stood at US\$ 60, representing 10.3% of GDP – of which public spending from domestic sources constituted 47% and external assistance around 16%. The proportion of public spending on health from domestic sources in total public spending, which reflects prioritization of the sector, remained stable between 2013 and 2015 at an average of 2% – around US\$ 3.1 per capita. As Afghanistan transitions from humanitarian to development aid, it faces significant challenges in developing a health financing system which does not heavily rely on external support.

4. Pooling

Prepayment is limited, leading to weak capacity to redistribute resources across different population groups. Nevertheless, the health financing system in Afghanistan performs well with regard to pooling. There is a national-level pool – the Grant Contracting and Management Unit – where domestic government resources and on-budget external assistance are combined and managed by the Ministry of Public Health. A certain level of fragmentation exists due to the way health services are organized, with a number of health facilities – mainly hospitals – being directly supported through bilateral donors or managed by other government ministries, for example, the Ministry of Defense, the Ministry of Interior, and the Ministry of Higher Education.

5. Purchasing

The Grant Contracting and Management Unit under the Ministry of Public Health contracts out health services to nongovernmental organizations in 31 provinces (contracting-out) and retains the responsibility for service delivery in the remaining three provinces (contracting-in). Providers under the contracting-in modality submit quarterly requests for funds to the Ministry of Public Health based on their work plans. Providers under the contracting-out approach receive their funding on a performance-based lump-sum basis. Further developments are taking place under the Sehatmandi Project (2018–2021) of the World Bank, whereby the Basic Package of Health Services and the Essential Package of Hospital Services contracts are being modified to increase the focus on achieving results. The contracts will have two parts: (a) a fee-for-service component with service providers paid a fixed tariff for certain services and (b) a lump-sum component to cover overheads and services that are hard to quantify or define precisely, for example for emergency preparedness or for participating in national immunization days. The Sehatmandi Project has also considered the harmonization of staffing and salary payment rules across various nongovernmental organizations in order to simplify financial flows.

6. Benefits design

There are two main health service packages in the country: the Basic Package of Health Services and the Essential Package of Hospital Services, both forming the bedrock of the Afghan health care system. Under the Basic Package of Health Services, all Afghan citizens have a right to receive services at five standard types of health facilities: health posts, sub-health centres, basic health centres offering outpatient care, comprehensive health centres and district hospitals. The Basic Package of Health Services has seven key elements: maternal and newborn care, child health and immunization, public nutrition, communicable disease treatment and control, mental health, disability and rehabilitation services, and the regular supply of essential medicines. The Essential Package of Hospital Services establishes a standard services package for each hospital level; provides staffing guidelines for hospitals; and promotes a referral system to integrate Basic Package of Health Services facilities with hospitals and the essential medicines list. It is mandated that all hospitals providing the Essential Package of Hospital Services should have four clinical functions: medicine, surgery, paediatrics, and obstetrics and gynaecology.

7. Population coverage

Public health services are free of charge for all, according to the Afghan constitution and health law. However, gaps in coverage remain due to a number of barriers, including availability of services, affordability, and in some cases, acceptability. The volatile security situation in the country, particularly in rural areas, is also a barrier. According to the 2010 Afghanistan Living Conditions Survey, 57% of the population have access to health services within an hour's walk. A similar survey conducted in 2016–2017 found that 86.7% of the population can access health services within two hours, using any means of transportation.

8. Service coverage

Coverage by needed health services has been increasing over the past decade. However, this coverage varies according to wealth, education level and geographic area. According to the 2015 Afghanistan Living Conditions Survey, PENTA3 vaccine coverage among children aged between 12 and 23 months reached 86%, while antenatal care coverage stood at 61%, and skilled birth attendance reached 58%. The current universal health coverage service coverage index value for the country is 34, which is among the lowest in the world.⁹ Although 90% of the population live in rural areas, health workforce density in urban areas is higher than that in rural areas. Moreover, health care staff in urban areas are better qualified than those in rural areas, which adversely affects equity in service utilization. With the increasing role of the private health sector in service provision, issues of whether and how services can be purchased from private for-profit providers using public funds are yet to be resolved.

9. Financial protection

The level of out-of-pocket expenditure on health in Afghanistan is high, reaching 78% of current health expenditure in 2015 – making it significantly higher than the average for low- and lower middle-income countries (40%). In 2015, 4.8% of the population faced catastrophic out-of-pocket expenditures on health at the 10% of household total consumption or income threshold.

⁹ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile Afghanistan

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)		373	527	584
CHE per capita (US\$)		37	45	60
GGHE-D%CHE		5	5	5
OOPS%CHE		79	79	78
GGHE-D%GDP		0.5	0.5	0.5
GGE%GDP		16	21	26
GGHE-D%GGE		3	2	2
Population	20 093 756	25 070 798	28 803 168	33 736 496

Fig. 1.1. Key health financing and expenditure indicators, 2000–2015

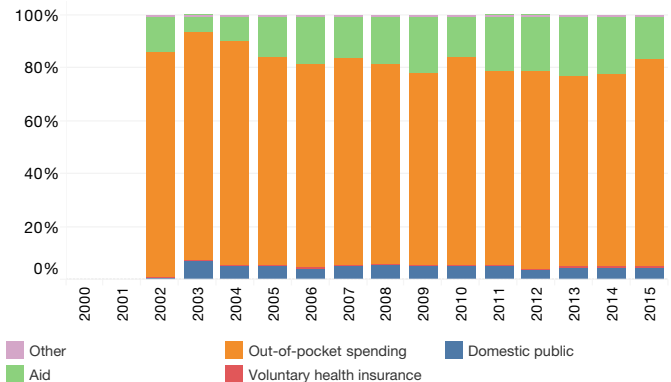


Fig. 1.2. Revenue sources

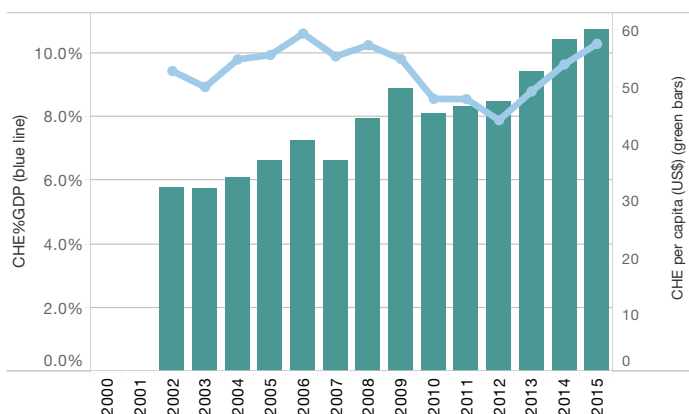


Fig. 1.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

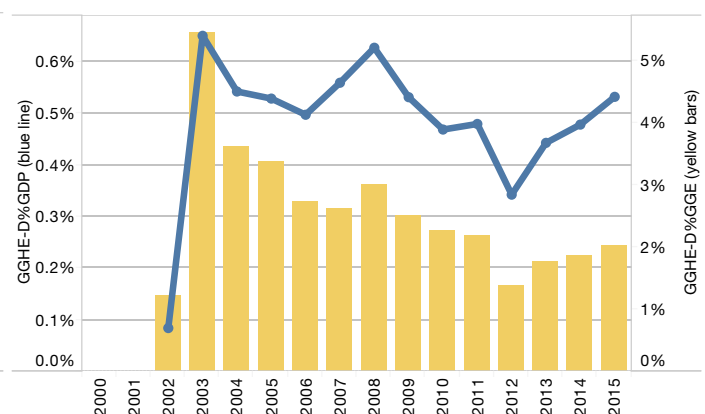


Fig. 1.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

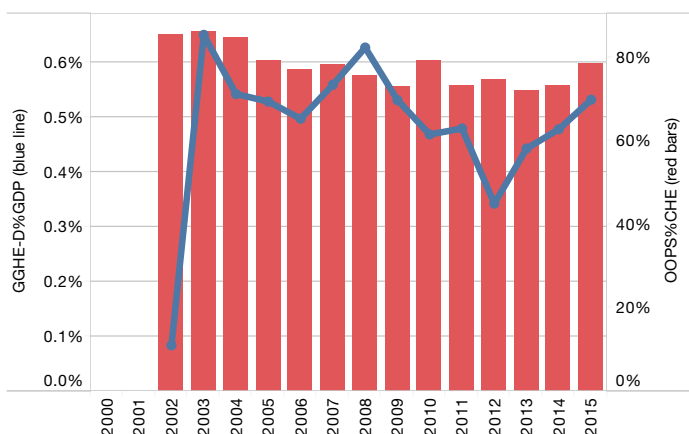


Fig. 1.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

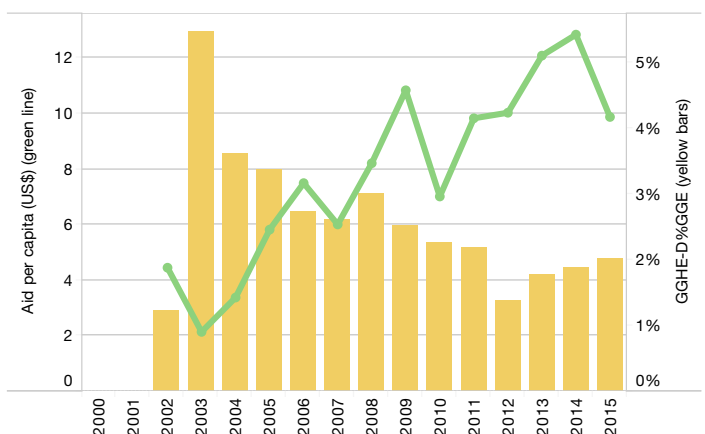


Fig. 1.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

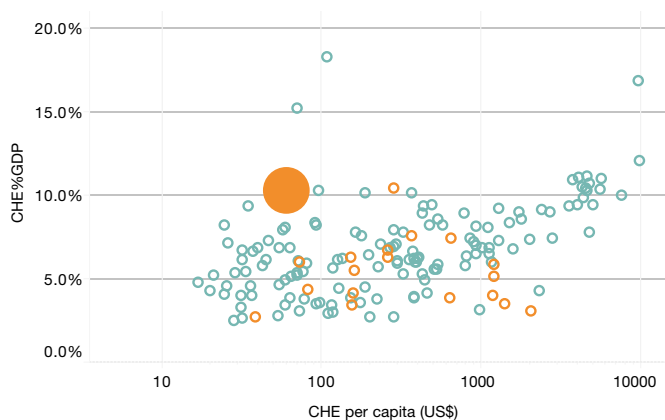


Fig. 1.7. Current health expenditure as a percentage of GDP and per capita (US\$)

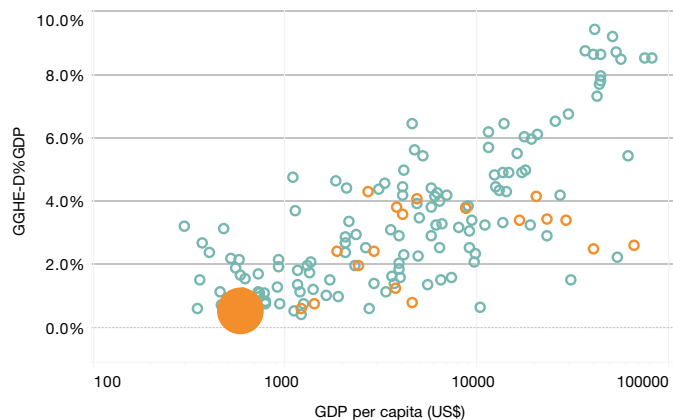


Fig. 1.8. Government health expenditure as a percentage of GDP and per capita (US\$)

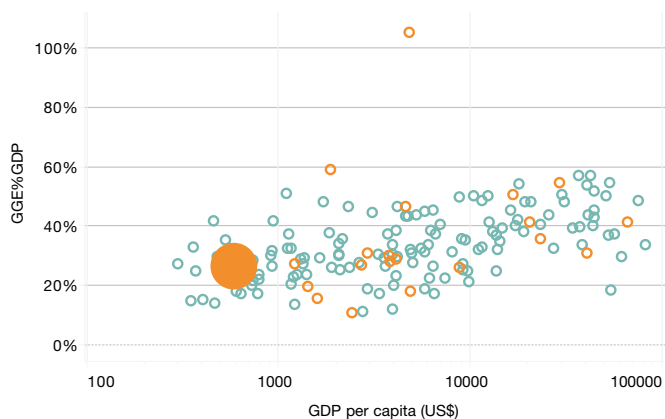


Fig. 1.9. Fiscal space and GDP per capita (US\$)

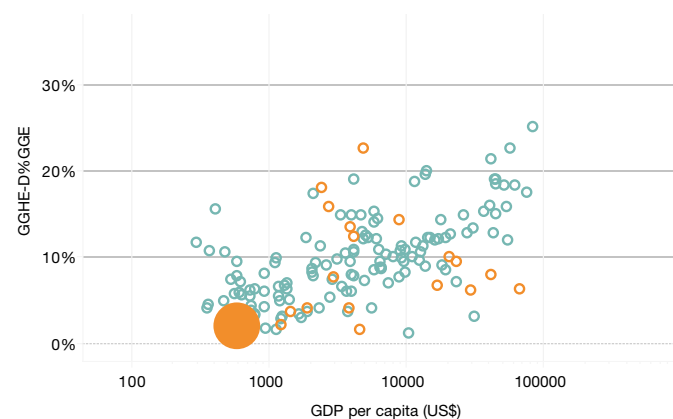


Fig. 1.10. Health prioritization and GDP per capita (US\$)

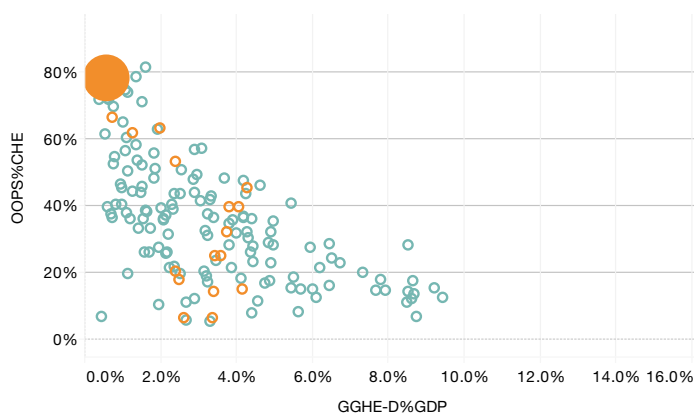


Fig. 1.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

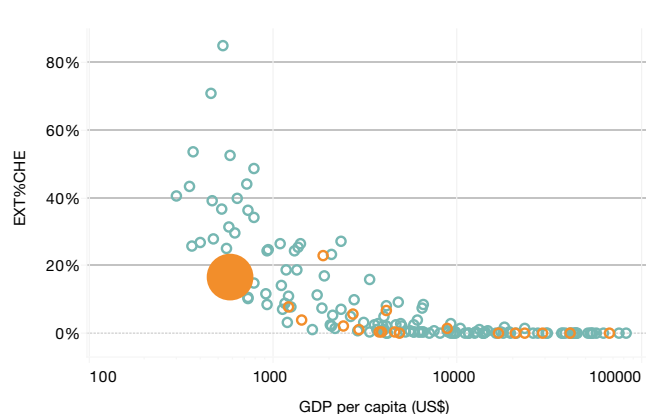


Fig. 1.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

2. Bahrain

1. Macroeconomics

Bahrain is a high-income country. In 2015, GDP was US\$ 31.7 billion, constituting a GDP per capita of US\$ 23 080. Recent economic growth has been moderate, with GDP growth decreasing from 3.5% in 2013 to 3.4% in 2014, mainly due to the sharp reduction in global oil prices. Oil revenue constitutes around 85% of government revenues. International reserves continue to fall, putting pressure on the country's exchange rate. General government expenditure reached US\$ 11.4 billion in 2015, constituting 35.9% of GDP. The poverty rate in Bahrain is not known, and the country does not suffer from extreme poverty as defined by the United Nations (UN). However, it is estimated that around 12.2% of Bahrainis live on less than US\$ 5 per day, with considerable differences in wealth noticeable among the poorest neighbourhoods.

2. Health financing architecture

The Bahraini health financing system consists of a mix of public and private financing agents, but is predominantly governed by the public sector, which includes the Ministry of Health, the Bahrain Defense Force and the Ministry of Education. Private insurance companies and households represent the main private financing agents. A Supreme Council of Health was established in 2012. It consists of 12 members including the Minister of Health, who serves as the vice chairperson. The Supreme Council of Health is responsible for developing the National Health Strategy and ensuring its implementation, and is at present overseeing a major health sector reform programme in Bahrain. The Ministry of Health is responsible for planning and provision of health services. In 2014, the Supreme Council of Health developed a social health insurance law. The law establishes: (a) the National Health Insurance Fund, Daman, to be jointly responsible for pooling health funds and purchasing health services alongside private insurance companies; (b) an independent Health Information and Knowledge Management Agency to monitor quality and prices; and (c) a National Health Regulatory Authority, which is responsible for the licensing of health professionals and facilities as well as monitoring insurance companies. Under the new reform programme, the Ministry of Health will be mainly responsible for the provision of health services in public facilities, with other private providers also contributing to the provision of these services.

3. Revenue raising

General government revenues constitute the main source of revenue for the health system, primarily through budget allocation from the Ministry of Finance. In 2015, current health expenditure reached US\$ 1190 per capita, represented 5.16% of GDP. Private health expenditure is relatively low at US\$ 402 per capita in 2015. Although Bahrain has the lowest general government expenditure of all member countries of the Gulf Cooperation Council, its general government health expenditure is one of highest in the Region, amounting to US\$ 788 per capita and constituting 9.5% of general government expenditure. Some indirect contributions come from neighbouring countries within overall support to Bahrain's government. The Labour Market Regulatory Agency is responsible for collecting fees for basic health care for all expatriate employees in all establishments, on behalf of the Ministry of Health. Under the new social health insurance law, health financing sources will be expanded by collecting contributions from the government on behalf of citizens and from employers on behalf of employees (citizens and expatriates), and heads of households are expected to pay contributions on behalf of their domestic workers.

4. Pooling

Bahrain has a pluralistic segmented health system with multiple pooling arrangements. Within the public sector, there are currently several detached pooling funds: public, parastatal and private. The Ministry of Health acts as the main pooling agent. Domestic general government health expenditure as a share of current health expenditure reached 66.2% in 2015. Other pooling arrangements include 81 charity funds, 12 private health insurers, the Bahrain Defense Force, the Ministry of the Interior and private employers. In addition, the General Organization for Social Security and the General Organization for Pension Funds each pool funds separately to cover work-related injuries. Voluntary health insurance accounted for 8.7% of current health expenditure in 2015. Under the recently enacted health insurance law, there are two main mandatory coverage arrangements: the National Health Insurance Fund, Daman, pooling citizens' contributions and those of expatriates working in small companies (with fewer than 50

employees); and private insurance companies covering expatriates working in larger companies or for those who opt out of Daman. Premiums paid for expatriates are risk-rated, with annual ceilings revised each year.

5. Purchasing

Under the current health system arrangement, the Ministry of Health is the main purchaser and provider of health services. Purchasing primarily happens from state-owned facilities, using direct budget transfer based on line-item payments, which curbs efficiency and performance improvement. The health workforce employed by the Ministry of Health are paid through salaries. In addition, a fee-for-service system is used for limited private practices and private hospitals and clinics. The new social health insurance law currently underway plans to separate purchasing from provision, and would mean that the Ministry of Health would no longer be responsible for service provision. The main purchasers of services are expected to be Daman and private health insurance companies. The government plans to pay for hospitals using diagnosis-related groups, and for primary health care using capitation, in order to allow for financial and management autonomy.

6. Benefits design

A comprehensive package of health services is provided free of charge for all nationals, and is subsidized for expatriates. The package does not explicitly exclude any promotive, preventive, curative or rehabilitative services. At present, expatriates are covered for primary health care services only, while those with private health insurance are entitled to primary health care, secondary care for acute and chronic conditions, diagnostics and physiotherapy. The new social health insurance law provides a mandatory benefit package for citizens and expatriates, focusing mainly on primary, preventive and emergency care, essential medications available on the primary health care list, and diagnostics. The benefit package provided for nationals is, however, more comprehensive than the one available to expatriates. Insured individuals are allowed to supplement their basic package with specialized or optional packages.

7. Population coverage

Around half of the population of Bahrain are expatriates. All Bahraini citizens enjoy a constitutional right to comprehensive health services. Health services are also heavily subsidized for expatriates living in Bahrain. Coverage for expatriates has developed since 1976. In 2014, all companies were mandated to provide health care for all their employees through private health insurance or social health insurance without discrimination. Currently, 41.8% of expatriates are covered by social health insurance, 3.8% by private health insurance, and 54.4% are in the process of enrolment. Domestic workers are charged for services, but under the new law, these workers are to be covered by a mandatory basic health care package.

8. Service coverage

Health care is provided by the Ministry of Health, the Bahrain Defense Force, university hospitals and private providers. Since 1960, the Government of Bahrain has provided comprehensive health care for all citizens and residents via a network of primary health care centres, clinics, and secondary and tertiary care facilities. The government dominates health care provision. Primary health care services are based on a family and community health care approach through 27 health care centres. Curative care is provided through 2046 public hospitals and 452 private hospitals. Private sector health provision is growing fast, and it is hoped that it will play a major role in health care provision in the future. In 2012, the numbers of physicians and nurses per 10 000 population were 27.2 and 51.4 respectively. In 2015, the universal health coverage service coverage index value for the country was 72, which is among the highest in the world.¹⁰

9. Financial protection

At present, health care is provided free of charge for all Bahrainis. However, it is estimated that out-of-pocket payments constituted 25.1% of current health expenditure in 2015. Under the new social health insurance law, citizens will be required to pay some user fees for some services provided by the complementary package, and to co-pay for services under the optional package, while expatriates will be expected to cost-share for services provided by the complementary and optional benefit packages. At present, no estimates are available for the two financial protection indicators.

¹⁰ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Bahrain

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	23 214	22 315	20 956	23 081
CHE per capita (US\$)	795	662	689	1 190
GGHE-D%CHE	69	72	74	66
OOPS%CHE	23	23	20	25
GGHE-D%GDP	2.4	2.1	2.4	3.4
GGE%GDP	23	25	29	36
GGHE-D%GGE	10	9	8	9
Population	664 614	889 168	1 240 862	1 371 855

Fig. 2.1. Key health financing and expenditure indicators, 2000–2015

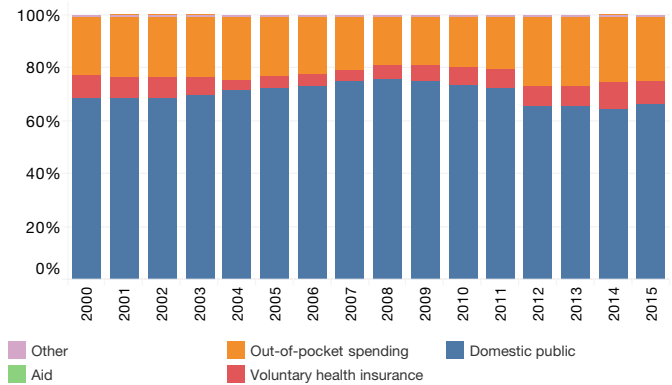


Fig. 2.2. Revenue sources

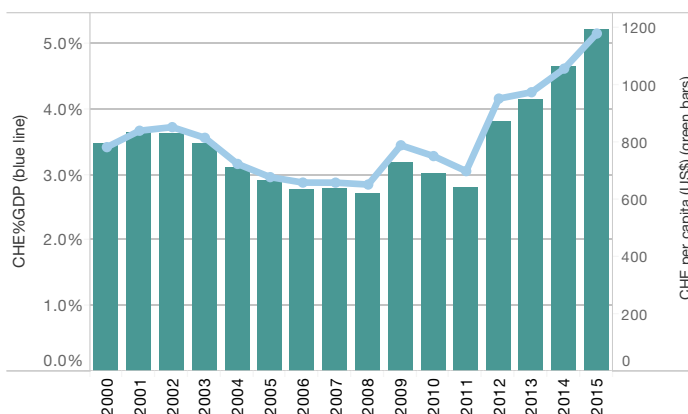


Fig. 2.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

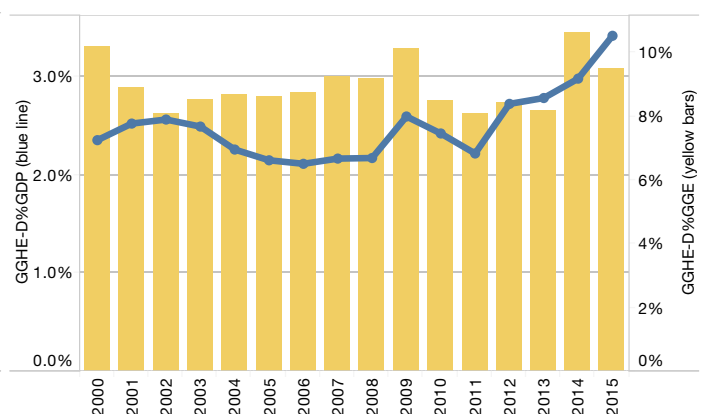


Fig. 2.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

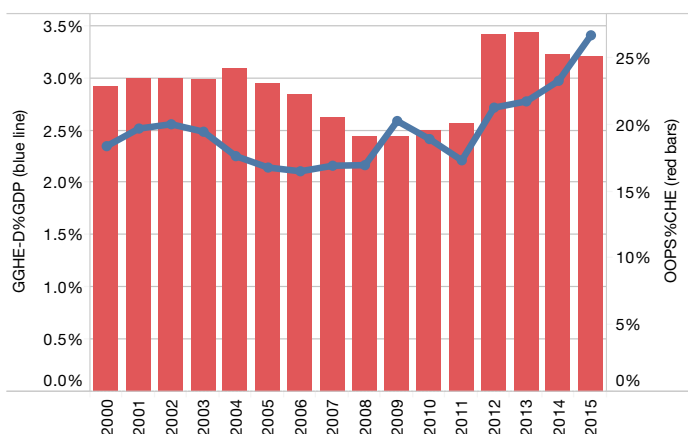


Fig. 2.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

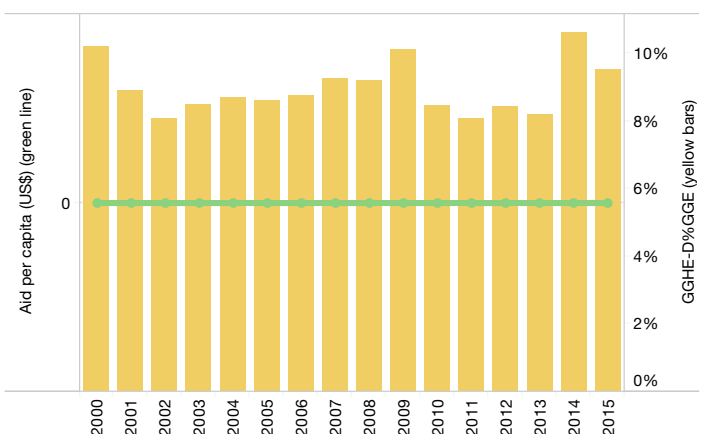


Fig. 2.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

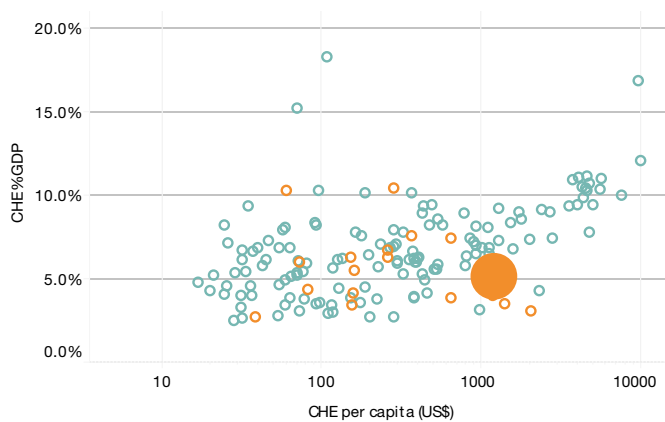


Fig. 2.7. Current health expenditure as a percentage of GDP and per capita (US\$)

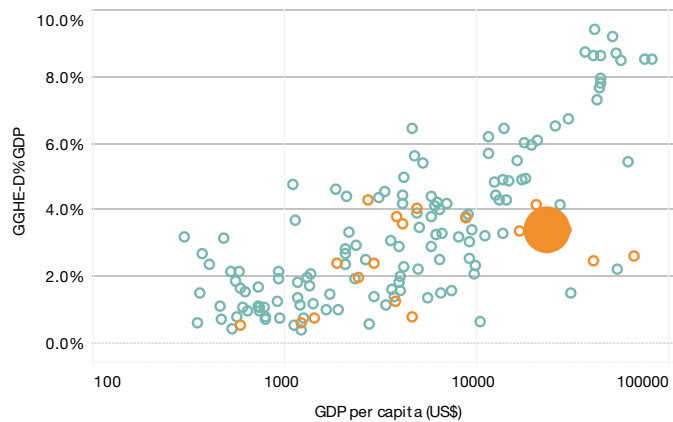


Fig. 2.8. Government health expenditure as a percentage of GDP and per capita (US\$)

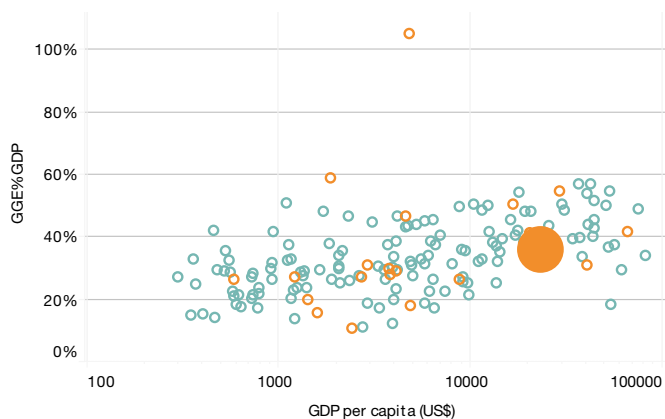


Fig. 2.9. Fiscal space and GDP per capita (US\$)

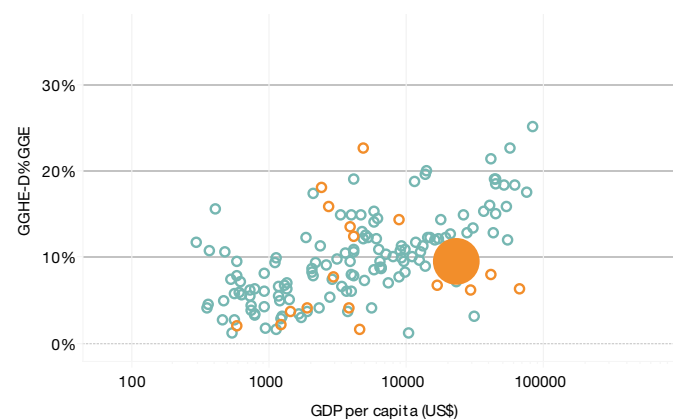


Fig. 2.10. Health prioritization and GDP per capita (US\$)

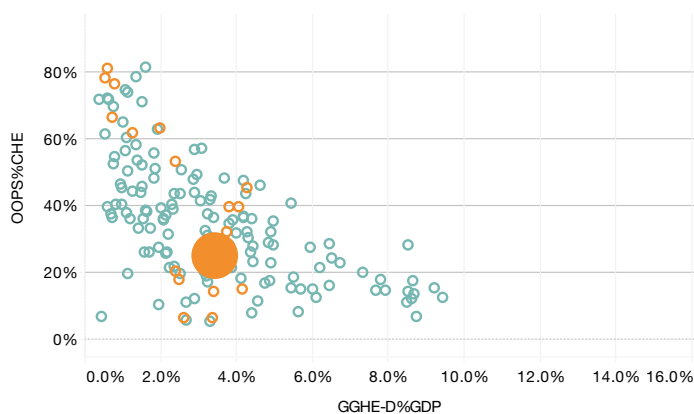


Fig. 2.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

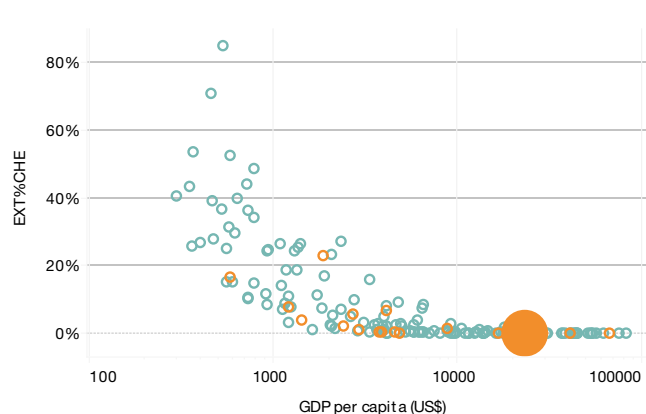


Fig. 2.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

3. Djibouti

1. Macroeconomics

Djibouti is a small lower middle-income country of 992 635 inhabitants in 2016, with more than 40% of the population living below the poverty line and 23% living in extreme poverty. Djibouti's economy depends on foreign financing, foreign direct investment, and rents from foreign countries' military bases and port services. GDP increased from US\$ 1.10 billion in 2010 to US\$ 1.72 billion in 2015, resulting in a GDP per capita of US\$ 1862 in 2015. GDP growth of 7.1% is projected for 2017. Economic growth is mainly driven by port activities, transportation services and construction. Foreign direct investment contributed 9.1% of GDP in 2016, up from 7.2% in 2015, as a result of industrial development in the new free zone and activities related to the new railway between Djibouti and Ethiopia. General government expenditure increased from US\$ 411 million in 2010 to US\$ 1.017 billion in 2015, representing an increase in its share of GDP from 37.4% to 59.1%. Although fiscal and external positions are improving gradually, risks of debt and fiscal sustainability remain.¹¹ Job creation is another challenge, with unemployment reaching 39% in 2016.

2. Health financing architecture

Despite significant progress in implementing the National Health Development Plan (2013–2017), the health system in Djibouti continues to face many challenges, especially in ensuring sustainable health financing, but equally in human resources, medical products and technologies, and health information systems. Various health sector reforms aimed at pro-poor policies have been pursued. In 2008, the National Social Security Fund was established under the Ministry of Labour and Administrative Reform as a public administrative institution with legal status and financial autonomy, by merging two public institutions: the Social Protection Organization and the National Pensions Fund. In 2014, the Universal Health Insurance Law¹² was enacted to ensure basic medical coverage for all people living in Djibouti, via two arrangements: the Compulsory Health Insurance scheme and the Social Assistance Programme for Health. The Compulsory Health Insurance scheme covers all those who have the capacity to contribute, while the Social Assistance Programme for Health covers the poorest sections of the population who do not have the financial capacity to make health insurance contributions. The main public financing agents in Djibouti are the Ministry of Health, the Ministry of Social Affairs and the National Social Security Fund, in addition to some mutual funds. Private financing agents include private insurance companies, nongovernmental organizations and households.

3. Revenue raising

Revenues for the health sector primarily depend on public funds, mainly from the State budget through the Ministry of Finance, with resources originating from taxes and grants. In 2015, per capita current health expenditure was US\$ 82, constituting 4.4% of GDP. Per capita domestic private health expenditure was US\$ 18.3, while external assistance constituted around 23% of current health expenditure. Revenues for the National Social Security Fund mainly originate from employers' (public and private) and employees' contributions under the Compulsory Health Insurance scheme, and from budget transfers on behalf of the poorest sections of the population under the Social Assistance Programme for Health, in addition to donations and returns from financial investments. Domestic general government health expenditure represented 4.1% of general government expenditure in 2015, equivalent to US\$ 44.6 per capita. There is no targeted tax for health.

4. Pooling

The National Social Security Fund has several fragmented pools covering different population groups, including the Compulsory Health Insurance scheme, the Social Assistance Programme for Health and the Universal Student Health Insurance scheme. The Compulsory Health Insurance scheme is obligatory for formal employees (public and private), independent workers and retirees and their dependents. The Social Assistance Programme for Health is a scheme that covers the most vulnerable sections of the population and their dependents. The Universal Student Health Insurance scheme is a separate pool for students under 35 years at the University of Djibouti. In

¹¹ Djibouti's Economic Outlook – October 2017. Washington, DC: The World Bank; 11 October 2017 (<http://www.worldbank.org/en/country/djibouti/publication/djibouti-economic-outlook-october-2017>, accessed 22 July 2018).

¹² Law No. 24/AN/14/7 of 5 February 2014, available at <http://www.droit-afrique.com/upload/doc/djibouti/Djibouti-Loi-2014-24-assurance-maladie-universelle.pdf>, accessed 22 July 2018.

2015, domestic general government health expenditure as a share of current health expenditure was 54.6%, while voluntary health insurance constituted only 0.66% of current health expenditure.

5. Purchasing

Purchasing primarily takes place using direct budget allocation to the Ministries of Health, Social Affairs, the Interior and Defense in a passive way, paying for salaries, equipment, medicines and supplies, and infrastructure. For health services covered by the National Social Security Fund under the Compulsory Health Insurance scheme, payments are either made to health care providers directly based on agreed fee schedules or by reimbursing the costs to beneficiaries in case of direct payment by them. The National Social Security Fund also runs its own facilities where payment is made using a line-item payment system. The Ministry of Social Affairs pays for providers against the health services used by beneficiaries of the Social Assistance Programme for Health through the National Social Security Fund. The Universal Health Insurance Law lists several provider payment methods, including capitation, diagnosis-related groups, global budget and fee-for-service. In 2013, a performance-based programme for improving maternal and child health services was introduced. The Central Purchasing Agency of Essential Medicines and Supplies was established in 2004 to ensure the adequate supply and distribution of essential medicines in the public health sector.

6. Benefits design

The Universal Health Insurance Law guarantees a universal package of health services for the entire population. Two additional packages are provided under the Compulsory Health Insurance scheme and the Social Assistance Programme for Health. The first package is composed of basic care services such as consultations, radiology, essential medicines and delivery (including caesarean section), while the second package comprises curative care and all prescribed medical exams by specialist doctors.

7. Population coverage

According to the Universal Health Insurance Law, all citizens are entitled to receive free basic medical coverage at the first level of care, with the working population entitled to receive additional benefits. Currently, only those working in the government and formal private sectors are covered. Formal employees, independent workers, students and retirees – and their dependents – are covered under the Compulsory Health Insurance scheme. Students under 35 at the University of Djibouti are covered by the Universal Student Health Insurance scheme. Individuals with no income are covered by the Social Assistance Programme for Health. It is estimated that around 300 000 individuals are currently being covered by the National Social Security Fund. The government provides services to the poor based on a certificate from the Ministry of Social Affairs after a biometric identification process. Citizens who are not covered by the aforementioned schemes, in particular the privileged classes and foreign nationals, usually receive care in the private health sector.

8. Service coverage

The health system is characterized by poor infrastructure. Access to preventive and curative health services remains a challenge. According to the National Development Health Plan (2013–2017), health care is provided by three sub-sectors: the public, para-public and private sectors. The public sector consists of: (a) health posts in rural areas and community health centres in urban areas, which act as primary referral facilities; (b) medical centres, which act as secondary referral facilities; and (c) the national reference centre, and maternity and specialized hospitals, which act as tertiary referral facilities. The para-public sector belongs to the armed forces and the social protection organization. The private sector consists of polyclinics, private pharmacies and medical practices. For areas with limited access to health facilities, regular mobile clinics are being used. The universal health coverage service coverage index value for the country is 47, an average score compared to other countries of the Region.¹³

9. Financial protection

In 2015, out-of-pocket payments as a share of current health expenditure stood at 20.4%. High household out-of-pocket payments create the risk of financial catastrophe and impoverishment. In 1996, with a national poverty line of US\$ 1.90 and US\$ 3.11 per day, 0.05% and 0.13% of the population, respectively, were pushed into poverty due to out-of-pocket payments. Moreover, 1.42% and 0.04% of the population faced catastrophic health expenditures at the 10% and 25% thresholds, respectively.

¹³ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Djibouti

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	1 275	1 341	1 522	1 862
CHE per capita (US\$)	53	61	65	82
GGHE-D%CHE	48	43	61	55
OOPS%CHE	51	42	29	20
GGHE-D%GDP	2.0	2.0	2.6	2.4
GGE%GDP	33	37	37	59
GGHE-D%GGE	6	5	7	4
Population	717 584	783 254	851 146	927 414

Fig. 3.1. Key health financing and expenditure indicators, 2000–2015

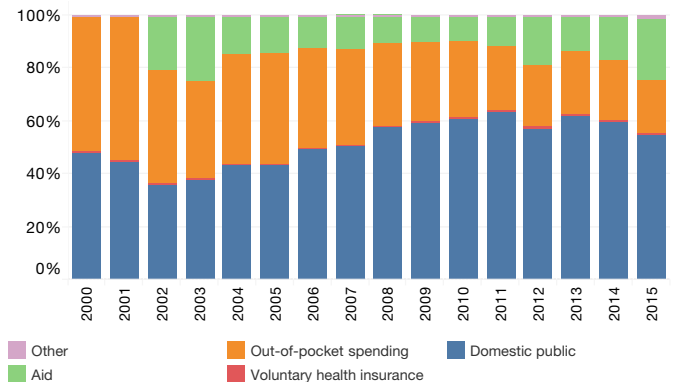


Fig. 3.2. Revenue sources

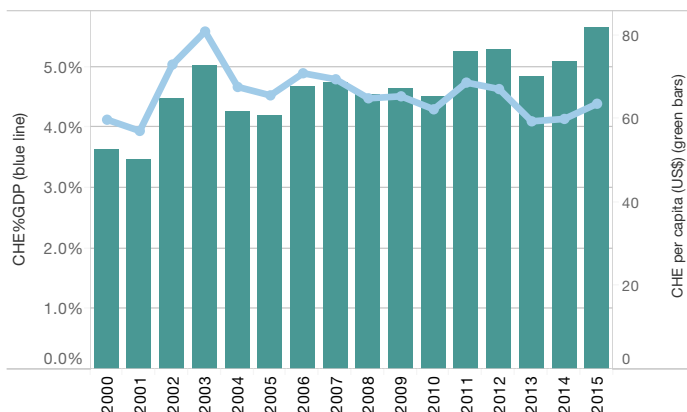


Fig. 3.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

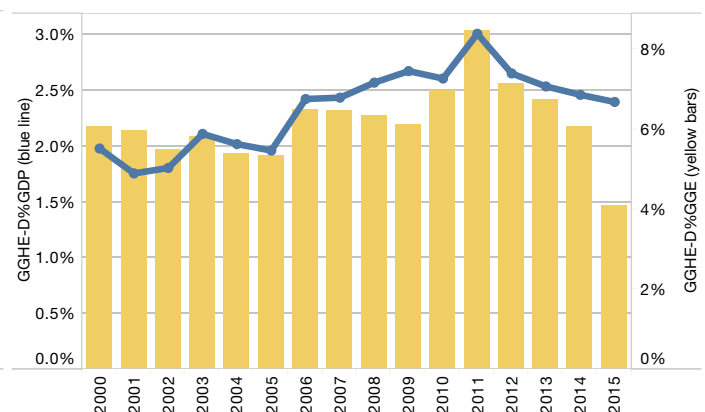


Fig. 3.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

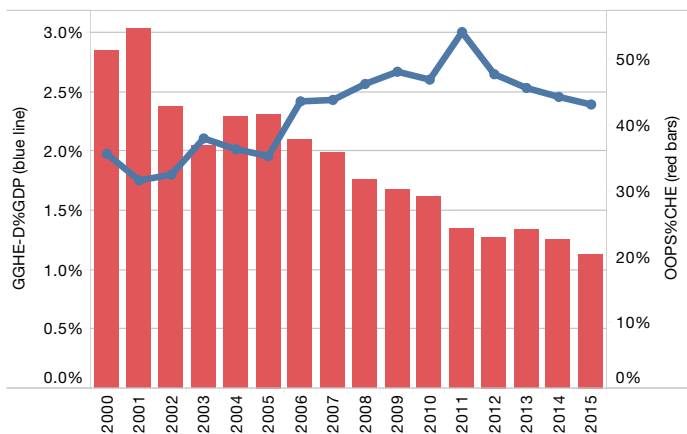


Fig. 3.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

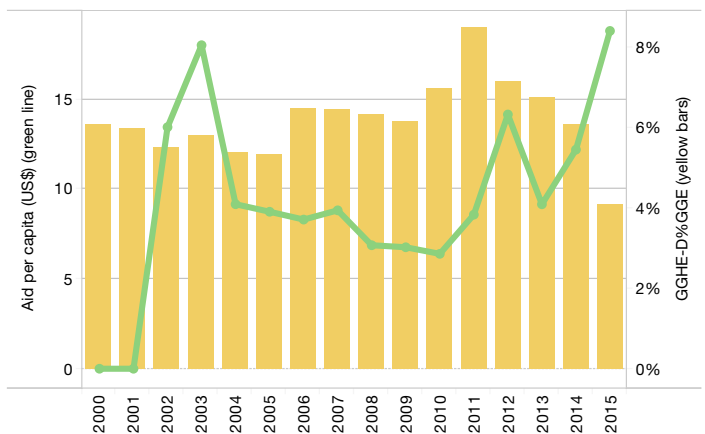


Fig. 3.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

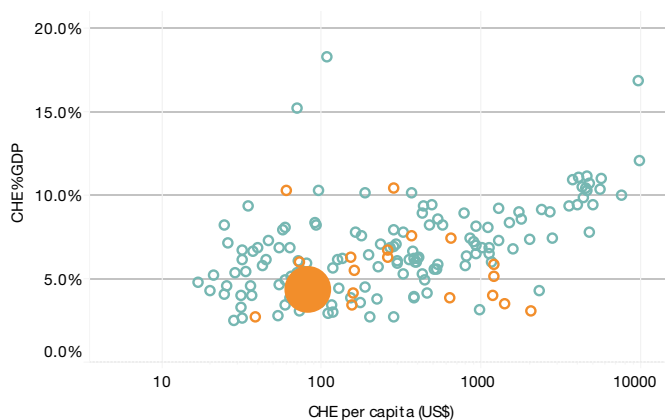


Fig. 3.7. Current health expenditure as a percentage of GDP and per capita (US\$)

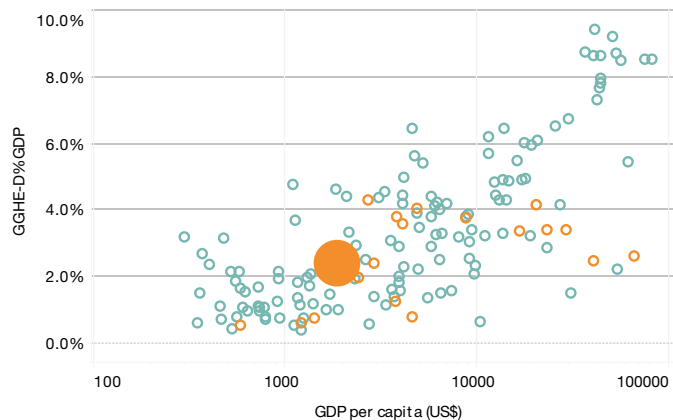


Fig. 3.8. Government health expenditure as a percentage of GDP and per capita (US\$)

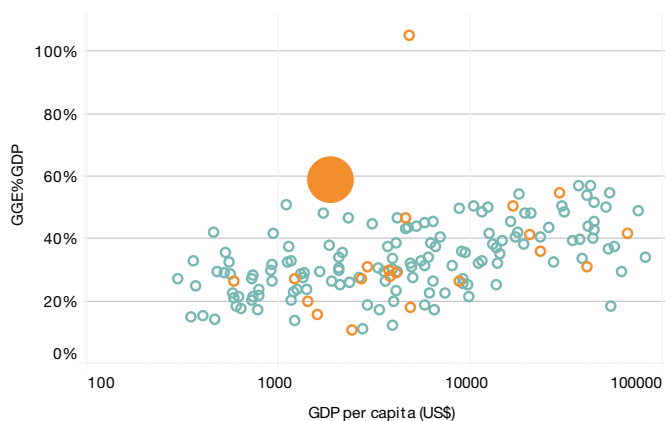


Fig. 3.9. Fiscal space and GDP per capita (US\$)

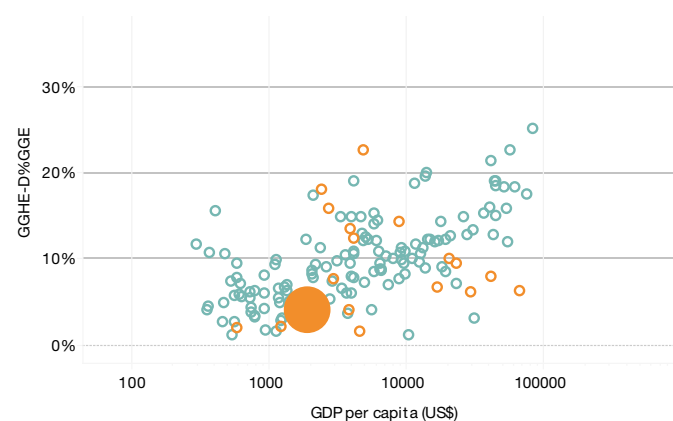


Fig. 3.10. Health prioritization and GDP per capita (US\$)

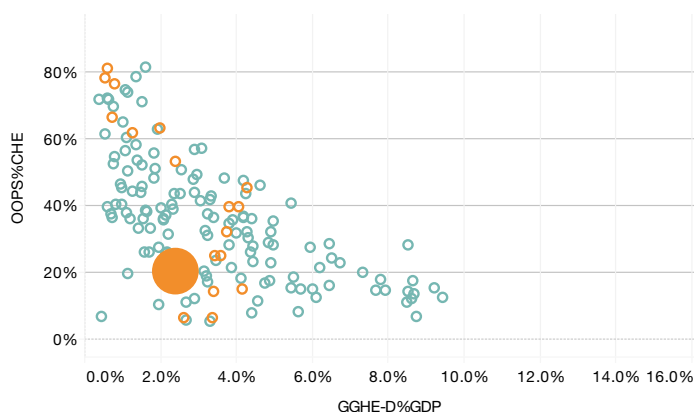


Fig. 3.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

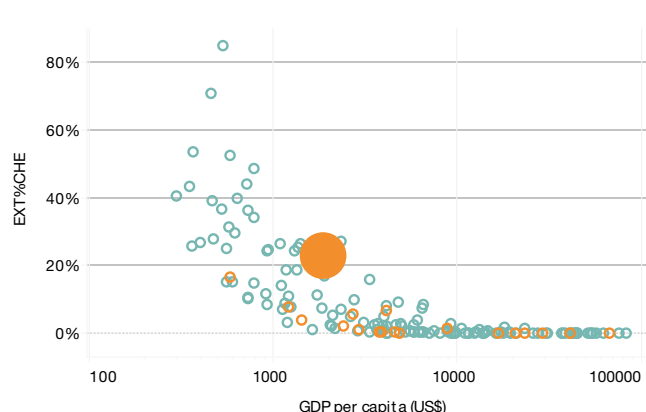


Fig. 3.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

4. Egypt

1. Macroeconomics

Significant public financial reforms continue to be implemented in Egypt, contributing to fiscal consolidation. The macroeconomic outlook is showing signs of stability following the recent liberalization of the exchange rate. However, inflation has been high in recent years. Accordingly, the Central Bank has tightened monetary policy and the government has increased its social protection expenditure to mitigate the impact of inflation on living conditions. In 2016, GDP was US\$ 336.3 billion, and per capita GDP was US\$ 3514.¹⁴ General government expenditure reached US\$ 105.672 billion, constituting 31.4% of GDP. The poverty rate at the national poverty line increased from 19.6% in 2004 to 27.8% in 2015, growing at an average annual rate of 9.2%.

2. Health financing architecture

Egypt has a complex health financing system, with multiple public and private financing arrangements. The system is fragmented, with numerous public entities involved in the management, financing and provision of care. At present, there are several financing agents in each of the public and private sectors. In the public sector, the Ministry of Health and Population receives funds from the Ministry of Finance to run its hospitals and primary health care facilities across the country's 27 governorates. Several financially autonomous organizations owned by the government exist, the largest being the Health Insurance Organization, which has the status of a parastatal entity. Moreover, a number of ministries also act as public financing agents by pooling public funds and covering different groups of the population; these include the Ministries of Defense, the Interior, and Higher Education. Private sector financing agents comprise numerous private insurance companies, funds managed by unions and professional organizations, and funds managed by non-profit organizations. Finally, households themselves act as the main financing agent, with out-of-pocket payments constituting a large share of current health expenditure. A newly enacted social health insurance law is at present providing a strategic framework for reforming the entire health financing system, calling for the establishment of a new health insurance organization to act as a single purchaser, in addition to a health providers' organization and an accreditation and management organization.

3. Revenue raising

Egypt's ability to raise public revenues primarily depends on the economic situation in the country, which affects the potential to levy taxes. Although current health expenditures as a share of GDP was 4.17 in 2015, households remain the single largest source of financing, with domestic private health expenditures constituting around 70% of current health expenditure. The new social health insurance law is expected to earmark taxes from tobacco, driving and car license renewals, and licenses to establish new health entities, in addition to revenues raised through contributions from those insured, employers, loans and grants, and general government payments on behalf of those unable to pay for health services.

4. Pooling

The level of risk pooling in Egypt is low; domestic general government health expenditure as a percentage of current health expenditure was 30.1% in 2015. Pooling is also fragmented across a number of entities: the Health Insurance Organization, a separate pool of funds for the Programme of Treatment at the Expense of the State, and the Family Health Fund, in addition to the pools of other private and public insurance entities, for example the above-mentioned ministries. The risk pooling of the Health Insurance Organization is low, as only the governmental and public labour force are mandated to participate, while workers in private entities prefer to be insured using private insurance arrangements. Citizens who work or have been working at the Ministry of Defense are entitled to a separate scheme with a separate pool. The new social health insurance law requires all citizens residing in Egypt to enroll in the new health insurance scheme under a single pool with family-based entitlement, enabling better cross-subsidization. However, the law keeps coverage for Egyptians residing outside the country voluntary.

5. Purchasing

Several ministries, the armed forces and the police, nongovernmental organizations, religious charities and private health care facilities are all involved in purchasing health care. Purchasing principally happens using direct provision

¹⁴ The World Bank data statistics estimated GDP in 2016 = US\$ 332.791 billion. See: GDP (current US\$). In: The World Bank/Data [website]. Washington, DC: The World Bank; 2018 (<https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=EG>, accessed 23 July 2018).

with no separation of the purchasing and provision functions except where the relevant institution is unable to provide the desired services itself. In 2008–2009, spending at private health facilities accounted for around 65% of total health expenditure; of this, pharmaceuticals and private clinics accounted for half. Payment for staff working in public health facilities is regulated by the Civil Service Code based on salaries and medical and administrative overheads for providers. However, capitation and reduced fees-for-service, and performance-based bonuses are used by other providers. Paying for providers and entities belonging to the Health Insurance Organization and the Ministry of Health and Population is usually based on line-item budgeting and self-generated revenues.¹⁵ Capitation payments and performance-based financing were piloted in Family Health Fund facilities, yet due to insufficient roll out, these methods are no longer being implemented. The new social health insurance law calls for selective contracting of providers according to specific quality of service measures.

6. Benefits design

In 1952, a law was enacted to make medical care free for all Egyptians in all Ministry of Health and Population institutions, specifically primary and preventive care.¹⁶ The Health Insurance Organization usually covers primary and specialized care; the Programme of Treatment at the Expense of the State covers catastrophic and tertiary care expenditures, while the Family Health Fund cover primary care and referrals for the poorer sections of the population and the uninsured. Benefit packages vary across the various private insurance schemes. The new social health insurance law guarantees the provision of diagnostic, rehabilitative and treatment services (for example, general practice services, prescribing services, inpatient and outpatient care, surgical procedures, home services and the transplant of specific organs), transferring the provision of preventive, emergency, epidemic and family services to the government.

7. Population coverage

Around 59% of the total population was covered by the Health Insurance Organization in 2014, including four broad classes of beneficiaries: employees working in the government sector, some public and private sector employees, pensioners and widows, and schoolchildren and infants, who represent almost 80% of the population covered by the Health Insurance Organization. Moreover, in 2014, Law No. 127 was issued to expand health insurance to uninsured agricultural workers.¹⁷ Uninsured individuals can still seek care at Ministry of Health and Population facilities, or request financial coverage by the Programme of Treatment at the Expense of State for catastrophic and tertiary care only. In addition, private health insurance covers around 10% of the population.¹⁸ The new social health insurance law mandates that all Egyptians residing in the country are covered by health insurance, and allows those residing outside the country to choose whether or not to make health insurance contributions.

8. Service coverage

The Ministry of Health and Population and other government agencies operate a nationwide network of government-owned health care facilities where free or substantially subsidized health services are provided to citizens not covered under the Health Insurance Organization. The private sector plays an important role in providing health care through a network of outpatient and inpatient facilities and pharmacies which also includes services provided by military and police hospitals. In 2015, the universal health coverage index of coverage of essential health services value for overall quality essential health service coverage for the country was 68.¹⁹ The provision of services in urban areas is better than in rural areas, especially for reproductive, maternal, newborn and child health.²⁰

9. Financial protection

The limited financial capacity of the Ministry of Health and Population means that services are unavailable to many people. In 2015, out-of-pocket payments as a share of current health expenditure stood at 61.9%, indicating that many in the country are at high risk of financial catastrophe and impoverishment. Based on the 2017 Universal Health Coverage Global Monitoring Report, 26.20% and 3.90% of the population face catastrophic health expenditures at the 10% and 25% of household total consumption or income thresholds respectively, while with the 2011 national poverty line of US\$ 3.10 per day, 1.07% are being pushed into poverty due to direct out-of-pocket payments. Communities in Upper Egypt are further exposed to higher health risks due to the lack of basic services and infrastructure.

¹⁵ Pande A, Abdel-Hamid AMH, Elshalakani A. A roadmap to achieve social justice in health care in Egypt (English). Washington, DC: World Bank Group; 2015 (<http://documents.worldbank.org/curated/en/508181468000283284/A-roadmap-to-achieve-social-justice-in-health-care-in-Egypt>, accessed 23 July 2018).

¹⁶ Health system profile: Egypt. Cairo: Regional Health Systems Observatory, WHO Regional Office for the Eastern Mediterranean; 2006 (<http://apps.who.int/medicinedocs/en/d/Js17293e/>, accessed 23 July 2018).

¹⁷ Moataz Y, Ismail A, El-Kouny N. The new health insurance law for Egyptian farmers and agricultural workers: a critical review. In: Thimar: Research collective on agriculture, environment and labour in the Arab world/Core issues/Labour [website] (<http://www.athimar.org/List-33>, accessed 23 July 2018).

¹⁸ Abbas YM, Abul-Magd E, Elmekawy A, Abaza S. The evolution of private health insurance in Egypt within the implementation of universal health coverage. *Value in Health*. May 2016;19(3):A291 ([https://www.valueinhealthjournal.com/article/S1098-3015\(16\)00901-3/abstract](https://www.valueinhealthjournal.com/article/S1098-3015(16)00901-3/abstract), accessed 23 July 2018).

¹⁹ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

²⁰ World health statistics 2015. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/handle/10665/170250/9789240694439_eng.pdf;jsessionid=EBC2C5B34C989B802CE27AC3E6B4565C?sequence=1, accessed 23 July 2018).

Health expenditure profile

Egypt

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	2 488	2 694	3 319	3 755
CHE per capita (US\$)	129	139	145	157
GGHE-D%CHE	35	32	33	30
OOPS%CHE	62	65	63	62
GGHE-D%GDP	1.8	1.7	1.4	1.3
GGE%GDP	30	33	33	30
GGHE-D%GGE	6	5	4	4
Population	69 905 984	76 778 152	84 107 608	93 778 168

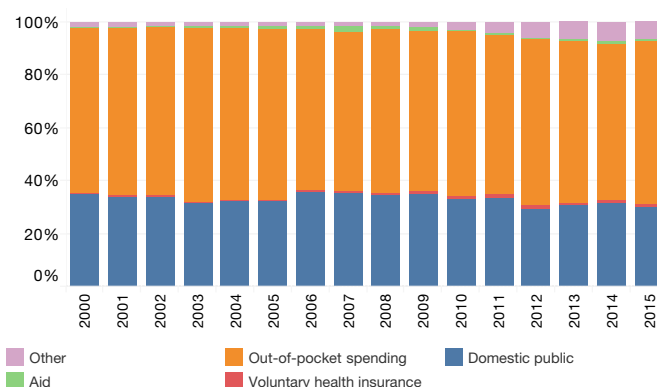


Fig. 4.1. Key health financing and expenditure indicators, 2000–2015

Fig. 4.2. Revenue sources

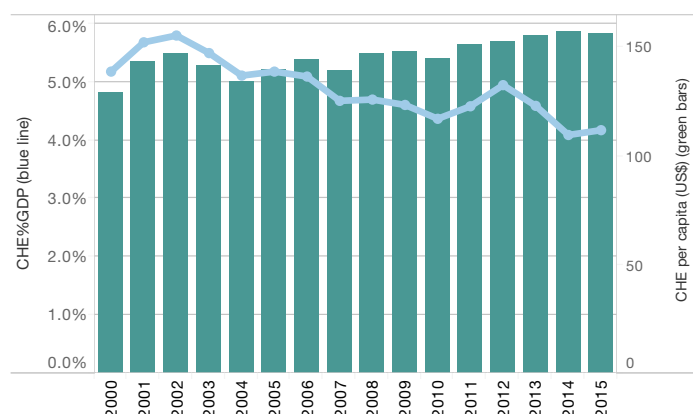


Fig. 4.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

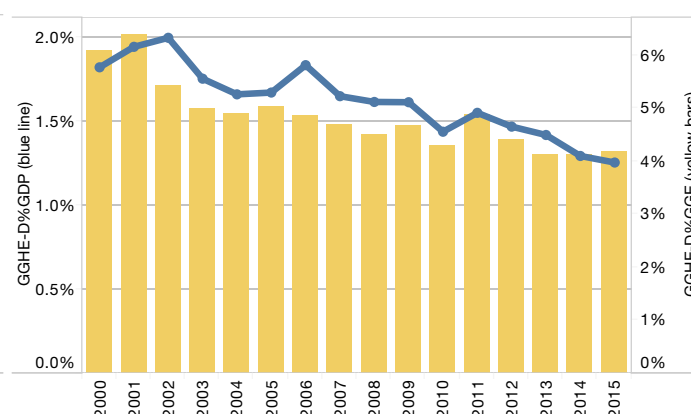


Fig. 4.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

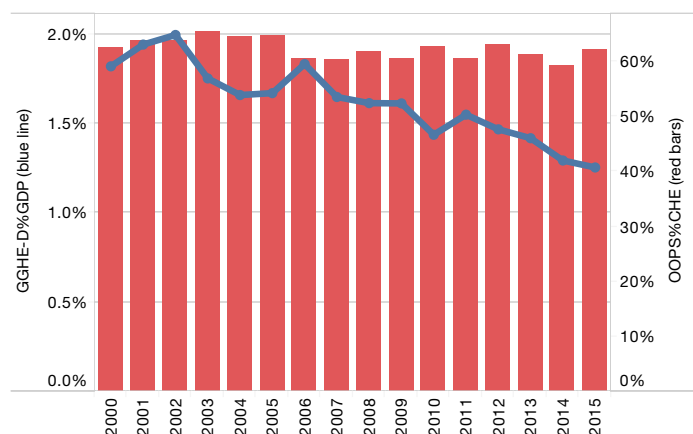


Fig. 4.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

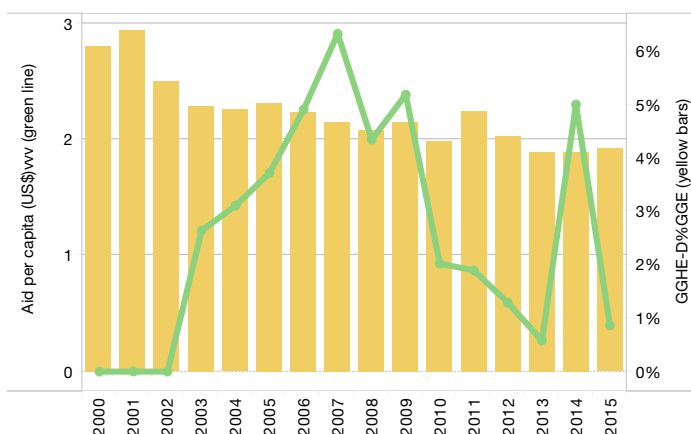


Fig. 4.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

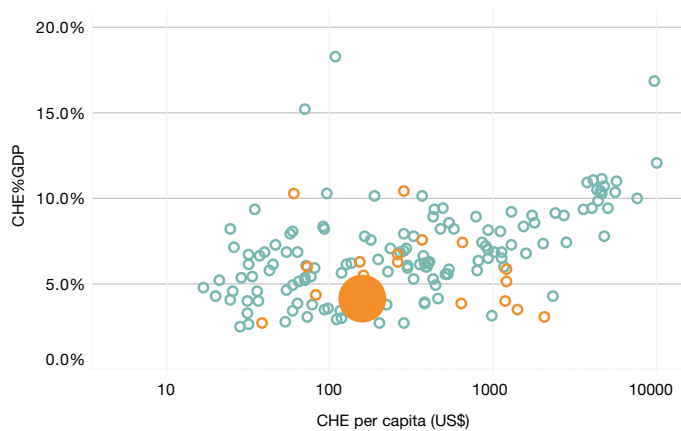


Fig. 4.7. Current health expenditure as a percentage of GDP and per capita (US\$)

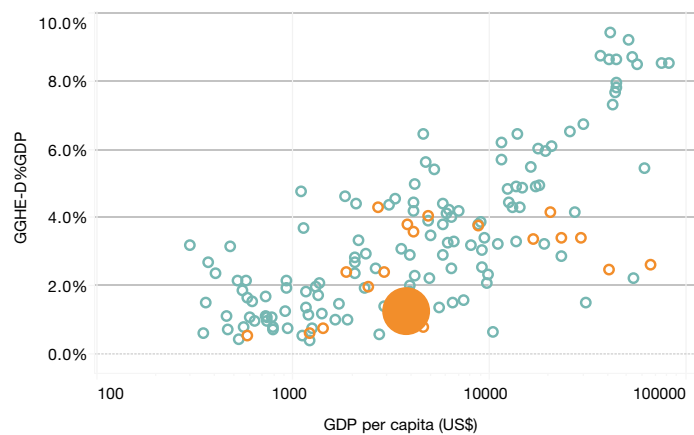


Fig. 4.8. Government health expenditure as a percentage of GDP and per capita (US\$)

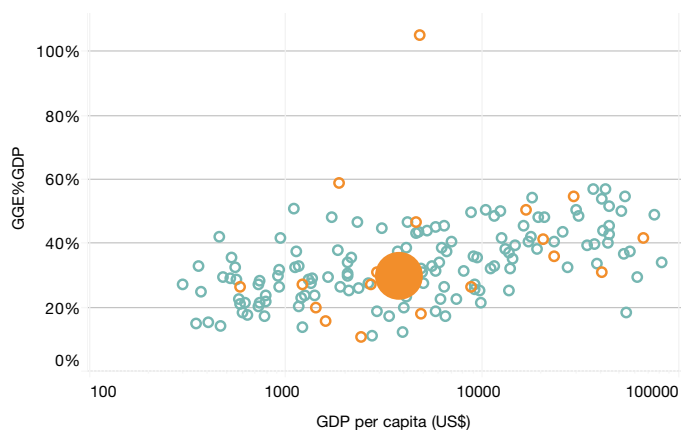


Fig. 4.9. Fiscal space and GDP per capita (US\$)

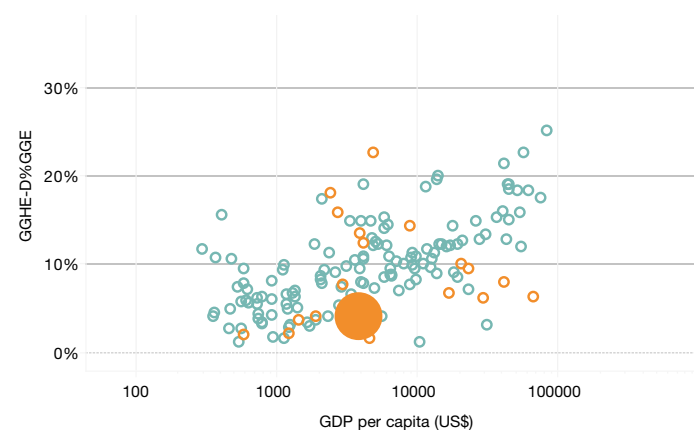


Fig. 4.10. Health prioritization and GDP per capita (US\$)

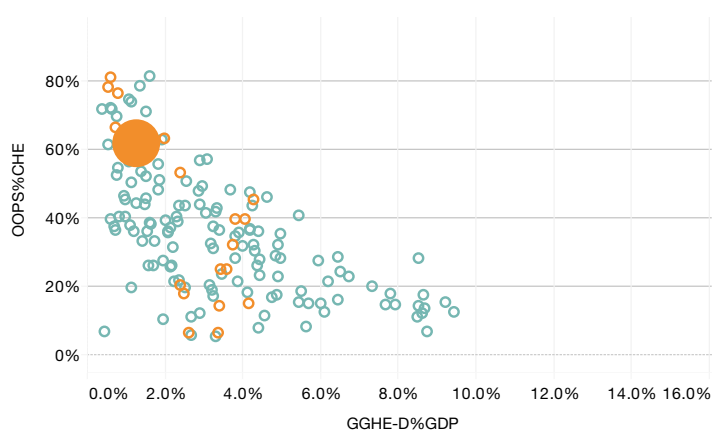


Fig. 4.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

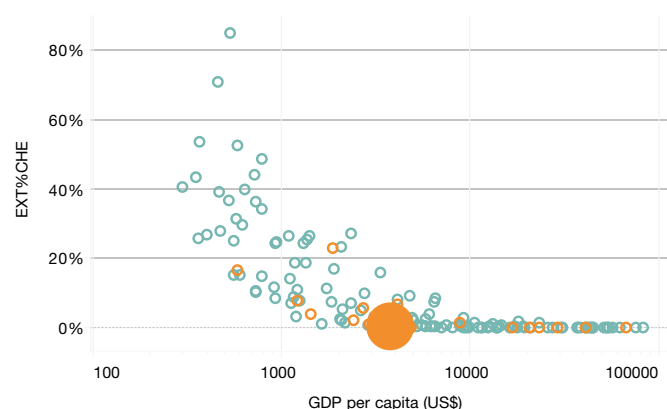


Fig. 4.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending.
 Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.
 Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

5. Islamic Republic of Iran

1. Macroeconomics

The Iranian economy has been steadily recovering in recent years, following an increase in oil production and expansion of exports after the lifting of international sanctions. Growth from 2016 to 2021 is projected to be between 4.0 and 4.5%. Inflation has also fallen significantly and is projected to remain low. However, unemployment is still high – 12.4% in 2014; the contribution of non-oil sectors to the economy is limited; the banking sector remains unintegrated into global banking systems; and foreign investment flows are fewer than expected. In 2015, GDP was US\$ 382 billion and per capita GDP was US\$ 4819. General government expenditure reached US\$ 68.607 billion in 2015, constituting 17.9% of GDP. Poverty is estimated to have fallen from 13.1 to 8.1% between 2009 and 2013 (US\$ 5.5 a day line in 2011 purchasing power parity). The poverty gap at US\$ 1.90 a day fell gradually from 2.6% in 1998 to 0.3% in 2014.

2. Health financing architecture

The health financing system in the Islamic Republic of Iran is a mixed system, structured around the Ministry of Health and Medical Education and two main public health insurance organizations – the Iranian Health Insurance Organization and the Social Security Organization. Until recently, both the Iranian Health Insurance Organization and the Social Security Organization belonged to the Ministry of Welfare and Social Security before responsibility for the Iranian Health Insurance Organization was transferred to the Ministry of Health and Medical Education. A High Council of Health Insurance is responsible for coordinating the health insurance market, and makes all major insurance policies, including population coverage, benefit package definition, tariff setting and provider payment methods. Almost all decisions and policies on resource allocation are made at central level by the Ministry of Health and Medical Education.

3. Revenue raising

There are three main sources of health financing in the Islamic Republic of Iran: the general government budget, health insurance contributions and out-of-pocket payments. A Health Transformation Plan was launched in 2014, financed by earmarking a 1% increase in value-added tax (VAT) and by the allocation of 10% of the public revenues released from a recent subsidy reform. In 2015, current health expenditure as a share of GDP was 7.6%, with domestic private health expenditure accounting for 46.6 % of current health expenditure.

4. Pooling

The Islamic Republic of Iran has a large social protection system with some 28 social insurance and assistance schemes, benefiting a large segment of the population. Besides the two main public insurance organizations (the Iranian Health Insurance Organization and the Social Security Organization), two other smaller insurance schemes, the Imam Khomeini Relief Foundation and the Armed Forces Medical Service Insurance Organization, are responsible for covering special social cases and the army, respectively. The Iranian Health Insurance Organization has several schemes, the most important ones being the Rural Health Insurance scheme and the civil servants' scheme. Pooling is fragmented, however, limiting the capacity for cross-subsidization and resulting in inefficiencies in the use of scarce health resources and inequity in coverage. The Ministry of Health and Medical Education and the public health insurance organizations receive and spend funds from the public sector budget. Domestic general government health expenditure as a percentage of current health expenditure was 53.4% in 2015.

5. Purchasing

The government plays the most important role in purchasing. In 2014, a strategic purchasing centre was established at the Iranian Health Insurance Organization, but due to many barriers, implementation is facing many challenges. Currently, health services are purchased in an almost entirely passive way. The Social Security Organization relies entirely on a fee-for-service system, while the Iranian Health Insurance Organization uses case payments for 90 high-prevalence surgical interventions (accounting for approximately 40% of total payments); neither are subject to any volume or overall cost control. The method of payment for governmental health workers is salaries. Public

facilities are paid on a fee-for-service or budget basis, while private facilities are paid on a fee-for-service basis. Under the Health Transformation Plan, the High Council of Health Insurance has increased tariffs by 47% over two years, with a 120% increase in the professional part of the tariff, mainly driven by increased payments to hospital providers. Discussion on expanding case-based payment to hospitals using diagnosis-related groups is ongoing.

6. Benefits design

Basic health care is available to the entire population and guaranteed by the Iranian constitution. Furthermore, an extensive benefit package with few exclusions is defined by the High Council of Health Insurance, and guides entitlements under the Iranian Health Insurance Organization and the Social Security Organization. Attempts are being made to use economic evaluation techniques to inform the development of benefit packages which would be covered by prepayment; nevertheless, a significant part of health expenditure goes on diagnostic services, consumables and medicines, and to a lesser degree on outpatient services.

7. Population coverage

Almost 100% of the population is covered by four major insurance arrangements. The Iranian Health Insurance Organization and the Social Security Organization together cover more than 75% of the population and account for around 50% of public spending on health. Article 29 of the constitution states that all Iranians not covered by health insurance must be insured by the Iranian Health Insurance Organization.

8. Service coverage

Social health insurance is focused on non-primary health care treatment services, which includes most ambulatory, diagnostic and hospital services. The Islamic Republic of Iran does have an extensive network of public clinics and hospitals which offer low-cost basic health care. Nevertheless, the depth of coverage varies depending on the service and setting, and to some extent on who is the insurer. Iranians are entitled to basic health care, and most receive subsidized prescription drugs and vaccinations. In 2015, the universal health coverage index of coverage of essential health services value for coverage by quality essential health services in the country was 65.²¹

9. Financial protection

Out-of-pocket payments constituted 39.7% of current health expenditure in 2015. This level of out-of-pocket payment is reflected in the figures related to financial hardship for 2013, when 15.8% and 3.8% of the population faced catastrophic health expenditures at the 10% and 25% of household total consumption or income thresholds respectively, and 0.01% of the population were pushed into poverty.

²¹ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Islamic Republic of Iran

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	3 392	4 188	4 879	4 819
CHE per capita (US\$)	178	250	380	366
GGHE-D%CHE	38	37	32	53
OOPS%CHE	60	56	59	40
GGHE-D%GDP	2.0	2.2	2.5	4.1
GGE%GDP	18	24	21	18
GGHE-D%GGE	11	9	12	23
Population	66 131 856	70 421 808	74 567 512	79 360 488

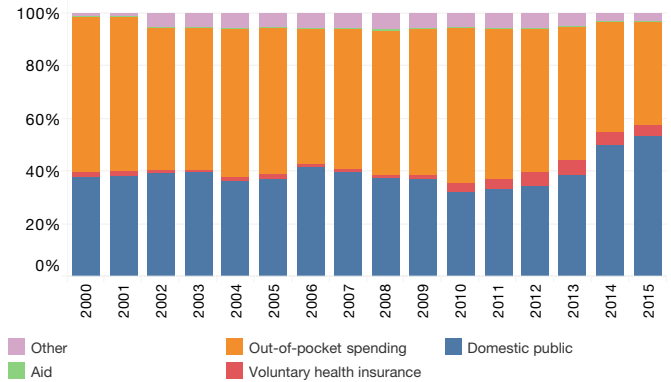


Fig. 5.1. Key health financing and expenditure indicators, 2000–2015

Fig. 5.2. Revenue sources

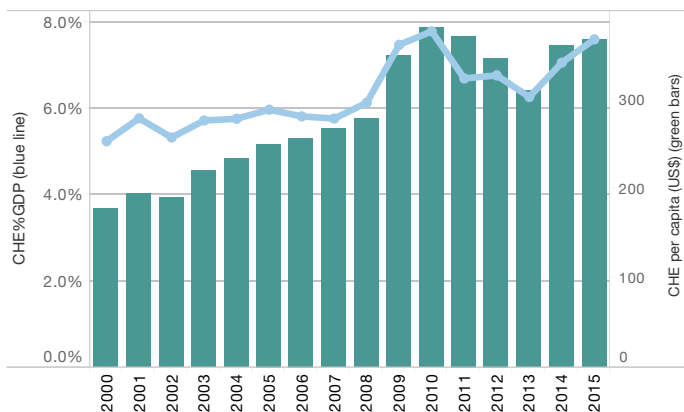


Fig. 5.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

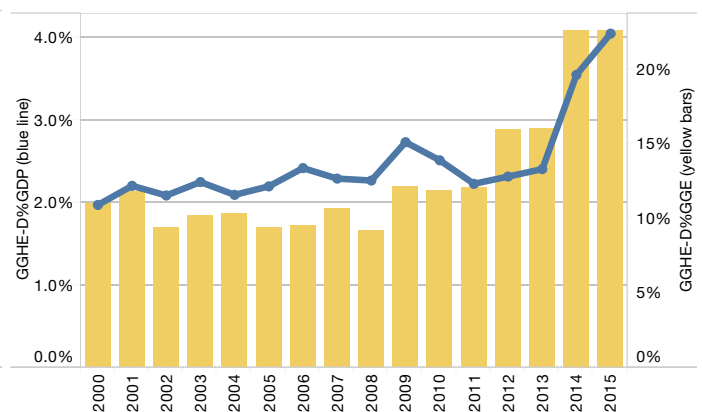


Fig. 5.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

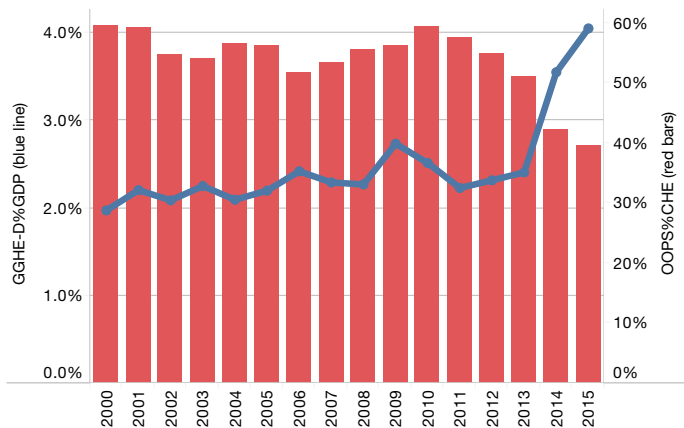


Fig. 5.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

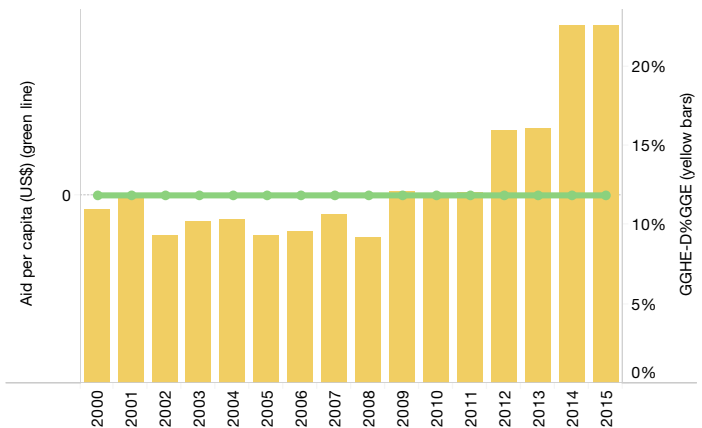


Fig. 5.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

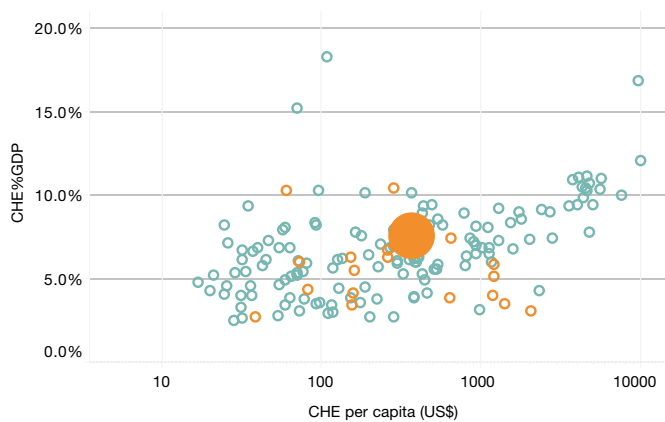


Fig. 5.7. Current health expenditure as a percentage of GDP and per capita (US\$)

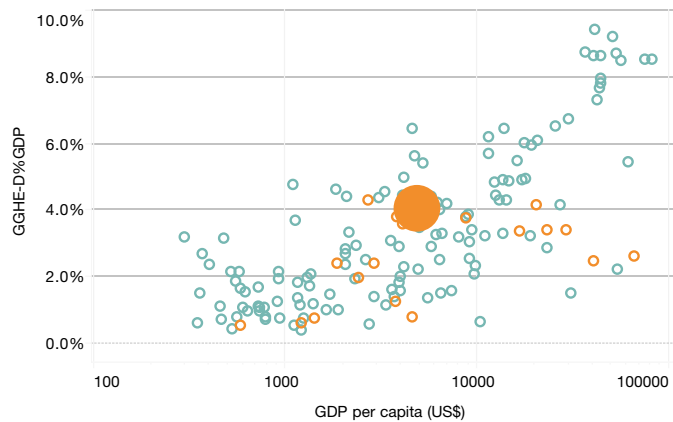


Fig. 5.8. Government health expenditure as a percentage of GDP and per capita (US\$)

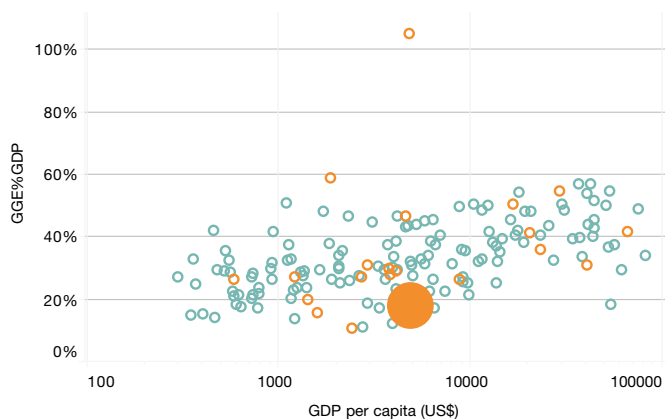


Fig. 5.9. Fiscal space and GDP per capita (US\$)

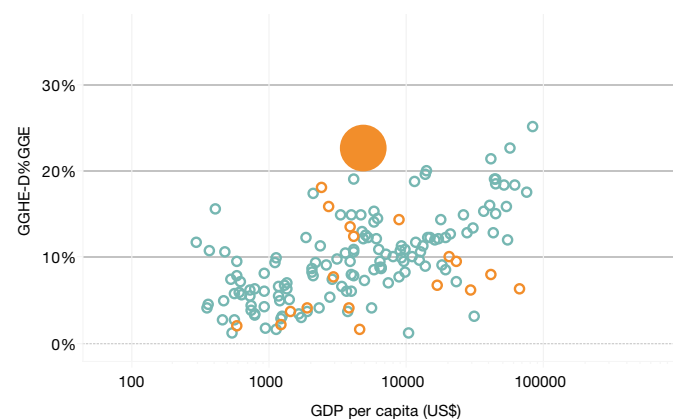


Fig. 5.10. Health prioritization and GDP per capita (US\$)

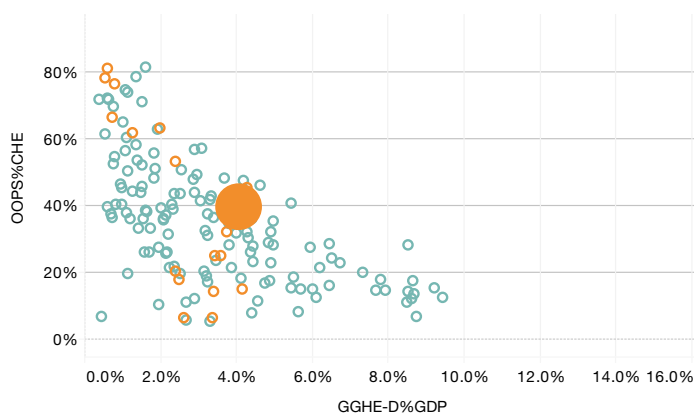


Fig. 5.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

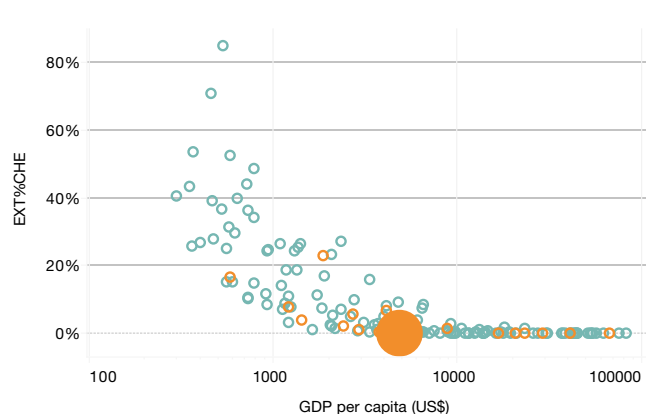


Fig. 5.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

6. Iraq

1. Macroeconomics

The ongoing acute and chronic conflict in Iraq and the reduction in global oil prices have seriously affected the macroeconomic picture in the country since 2014. Public revenues mainly originate from oil and hence are affected by alterations in global demand for oil and its price in the global market. At present, Iraq suffers from three forms of crisis, humanitarian, financial and security, all arguably affecting the macroeconomic outlook and the health financing system in the country. Nevertheless, enhanced growth in non-oil sectors and ongoing government reforms are expected to positively impact economic growth in the years to come. In 2016, GDP was US\$ 171.5 billion, representing GDP per capita of US\$ 4610. General government expenditure reached US\$ 76.5 billion in 2015, accounting for 44.6% of GDP. The poverty rate has been increasing in recent years, reaching 23% in 2014.²²

2. Health financing architecture

The health financing system in Iraq has witnessed continual change during the last 50 years – shifting from a welfare state model, where the government is the principal provider and financier of all health services, to the establishment of auto-financing facilities and the introduction of user charges, and, recently, to discussions on introducing contributory mechanisms in the form of health insurance. The health system in general and the health financing system in particular changed significantly following the 2003 war. Article 31 of the Iraqi constitution mandates the State to protect health and ensure social security. At present, the Ministry of Health is the primary public financing agent, while households are the main private financing agents.

3. Revenue raising

Sources of health revenue in Iraq are manifold. In 1986, the Popular Clinics Law was enacted, before being suspended in 2003. The law allowed the establishment of auto-financing clinics, which were run by charging nominal fees – much lower than those charged by the private sector, and which were kept by the clinics to cover part of their costs. In 2010, Iraq considered introduction of private wards at public hospitals. The latter implied that up to 25% of a hospital's beds could be run as private beds, in order to increase hospital revenues. Collected revenues were used as incentives for employees; to upgrade hospital infrastructure; and to improve the quality of care. In the post-war period until 2013, funding from government sources to the health sector increased in a routine manner. In 2014, however, due to a severe financial crisis – mainly induced by the sharp decrease in oil revenues – government allocations for health decreased substantially (by around 60%), falling to 35% of previous years' recurrent budget in 2016 and to only 5% in 2017. The capacity to raise more public resources for health is limited by the lack of diversification in and vulnerability of public revenue. In 2015, current health expenditure as a share of GDP was 3.4%, while domestic general government health expenditure as a percentage of current health expenditure stood at 23.2%, the remainder being mostly private health expenditure (76.5%).

4. Pooling

Pooling primarily happens at Ministry of Finance level. Most funds received by Ministry of Health facilities are transferred directly to the Ministry of Finance. There are isolated small health insurance programmes for employees of specific companies. In 2014, following the harsh financial crisis that resulted from the sharp reduction in oil revenues, a health insurance law was drafted and submitted to the parliament, and it has been discussed and continually reviewed since then. The law included provisions to allow the collection of nominal fees against provided services with exemption rules for poorer sections of society who would be identified by the Ministry of Social Welfare. Efforts to enact a health insurance law are also being made by the Kurdistan Regional Government.

5. Purchasing

The purchasing function is still not fully developed in the context of the current health financing system. There is no provider–purchaser split in the Iraqi health system. The Ministry of Health is the main provider and purchaser of health services. The private sector provides curative services to a limited part of the population only. Salary is the method of payment for health workers in government facilities, while a fee-for-service system is used in private

²² Strategy for the Reduction of Poverty in Iraq 2018-2022. Available at: <https://mop.gov.iq/en/static/uploads/1/pdf/15192838546d2344468c97dc099300d987509ebf27--Summary.pdf>

facilities. There is no reimbursement system for pharmaceuticals; however, medicines and other pharmaceutical products distributed in public facilities are provided with minimal user fees. At present, 60% of the Ministry of Health's recurrent budget is consumed by salaries, while 30–40% goes towards goods and services.

6. Benefits design

All services are in principle provided by the Ministry of Health, and are accessible for all Iraqis. Primary health care services are provided free-of-charge at primary health care centres. The proposed health insurance law does not have clear provisions for a benefit package but identifies a set of services which would remain free at the point of delivery, including emergency care and injury, cancer and psychiatric services.

7. Population coverage

In the public sector, health coverage for all Iraqis is provided by the Ministry of Health. The intensified national and regional humanitarian crisis has resulted in an increased number of internally displaced people and a huge influx of Syrian refugees in the country, putting further pressure on the already difficult health financing situation. The financial crisis has also resulted in a large number of government employees being made redundant, resulting in increased unemployment, vulnerability and poverty.

8. Service coverage

The service delivery model in Iraq is hospital-oriented, leading to limited efficiency and inequitable access. Following the 2003 war, health facilities belonging to Ministry of Defense and the Ministry of Military Industry were transferred to the Ministry of Health. Presidential Directorate facilities were also absorbed by the Ministry of Health. The State Company for Importation and Distribution of Drugs and Medical Appliances (Kimadia), which used to be auto-financed, stopped collecting revenues and was transformed into a storage and distribution directorate financed by the Ministry of Health. At present, the Ministry of Health is the main health care provider, both for curative and preventive services. It operates a network of close to 2700 primary health care facilities and 260 hospitals. The private sector provides curative services to only a limited part of the population. Access to health care is easier in urban areas than in rural areas due to inequity in the distribution of facilities and workforce. Access to health care has been affected by years of conflict, sanctions and ongoing military operations. There is significant reliance on the large-scale importation of medicines, medical equipment and health workforce. In 2015, the universal health coverage index of coverage of essential health services value for coverage by quality essential health services in the country was 63.²³

9. Financial protection

Increasing poverty and the rising level of informality compromise people's capacity to pay for services, including those for health. In 2015, out-of-pocket expenditures as a share of current health expenditure stood at 76.5%, compared to 61.7% in 2012 (41% of total health expenditure). In 2016, due to a severe shortage in government revenues, user fees were introduced at the primary and secondary health care levels. The sharp increase in out-of-pocket payments is primarily due to an increase in the number of people seeking care in the private sector due to the lack of services and long waiting lists for services in public health facilities, and low patient satisfaction with public health care. The high level of out-of-pocket payments is expected to be associated with a high risk of financial catastrophe and impoverishment in the country.

²³ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Iraq

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	4 572	3 725	4 253	4 547
CHE per capita (US\$)		108	140	154
GGHE-D%CHE		70	74	23
OOPS%CHE		30	26	76
GGHE-D%GDP		2.0	2.4	0.8
GGE%GDP	3	63	51	47
GGHE-D%GGE		3	5	2
Population	23 565 412	27 008 426	30 762 700	36 115 648

Fig. 6.1. Key health financing and expenditure indicators, 2000–2015

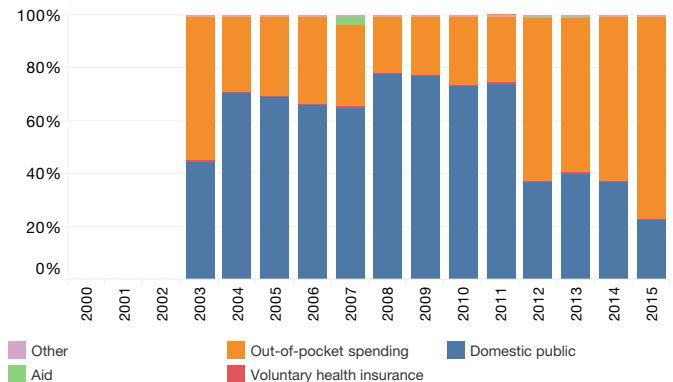


Fig. 6.2. Revenue sources

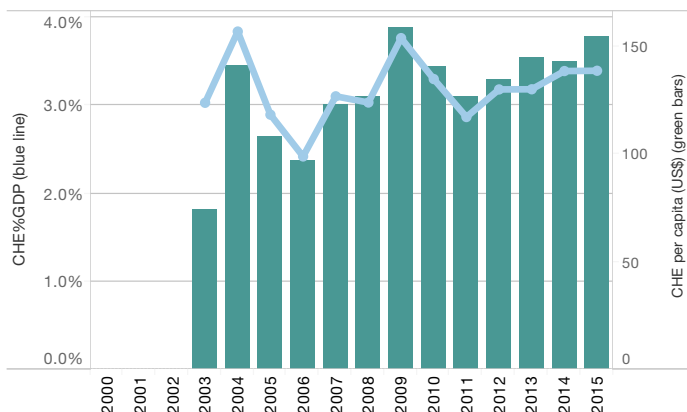


Fig. 6.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

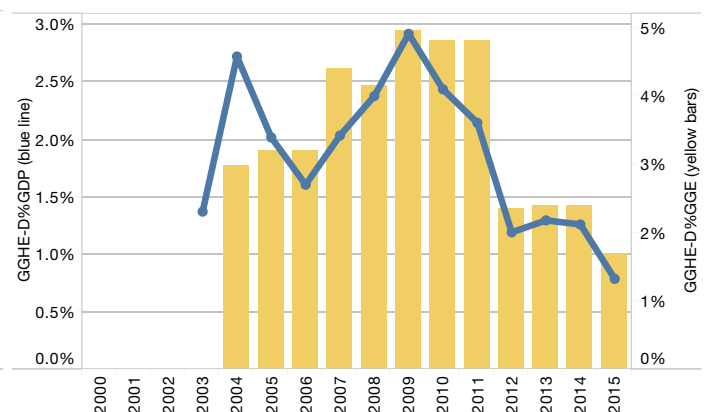


Fig. 6.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

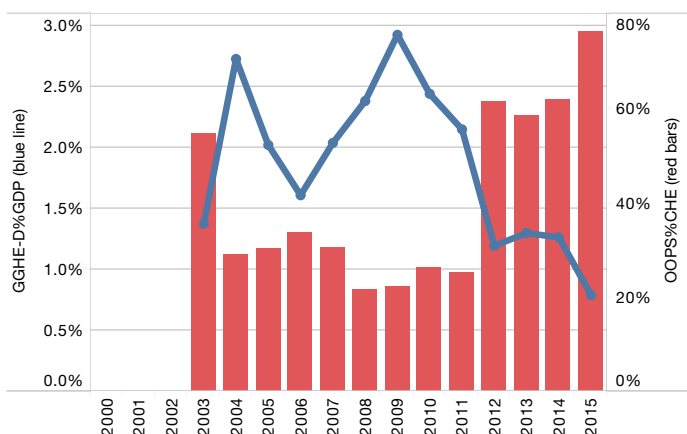


Fig. 6.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

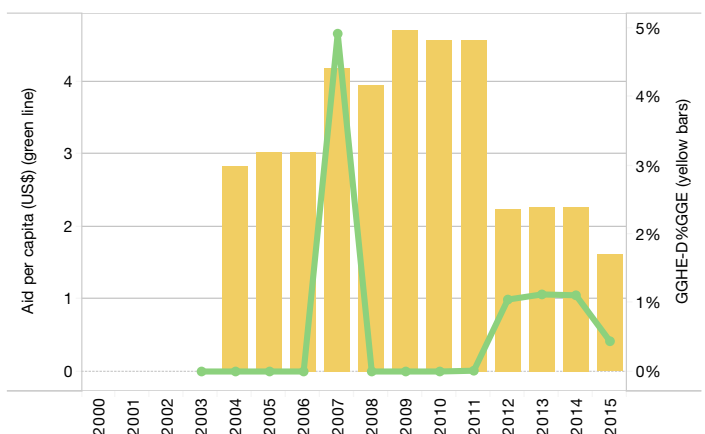


Fig. 6.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

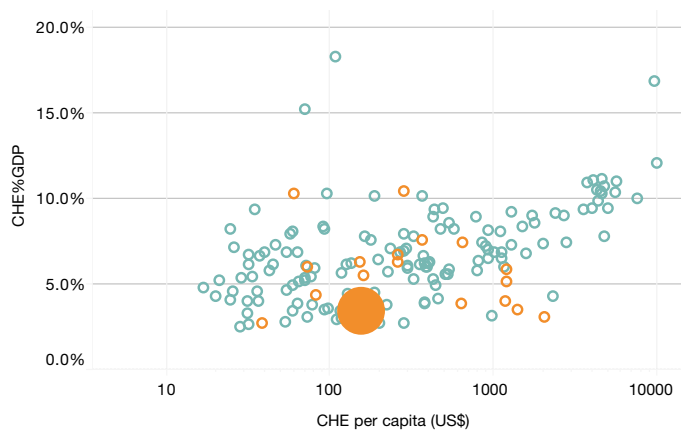


Fig. 6.7. Current health expenditure as a percentage of GDP and per capita (US\$)

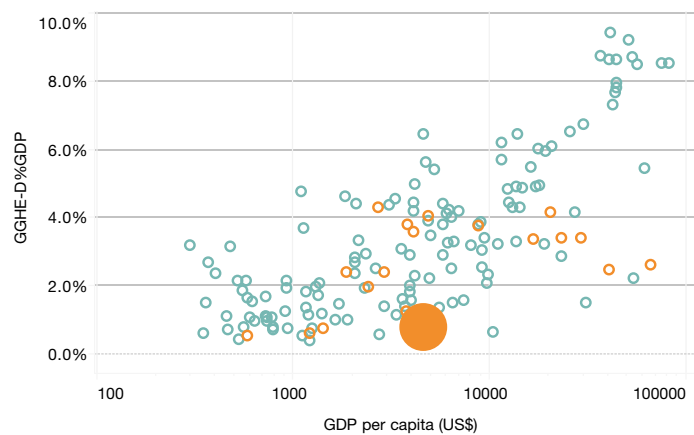


Fig. 6.8. Government health expenditure as a percentage of GDP and per capita (US\$)

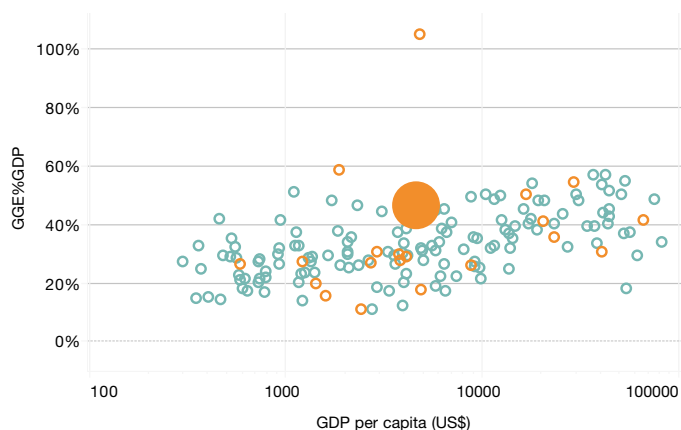


Fig. 6.9. Fiscal space and GDP per capita (US\$)

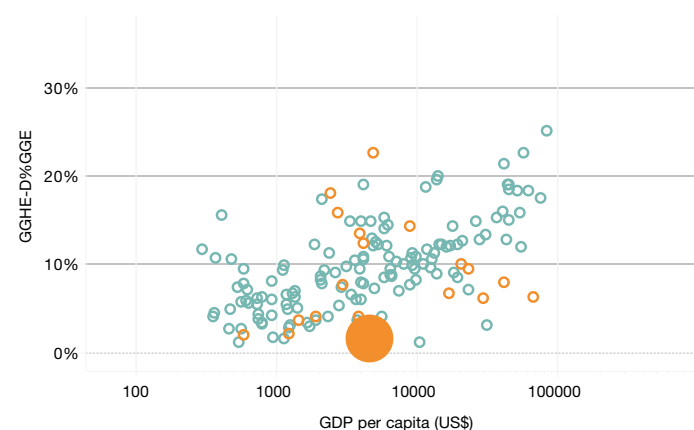


Fig. 6.10. Health prioritization and GDP per capita (US\$)

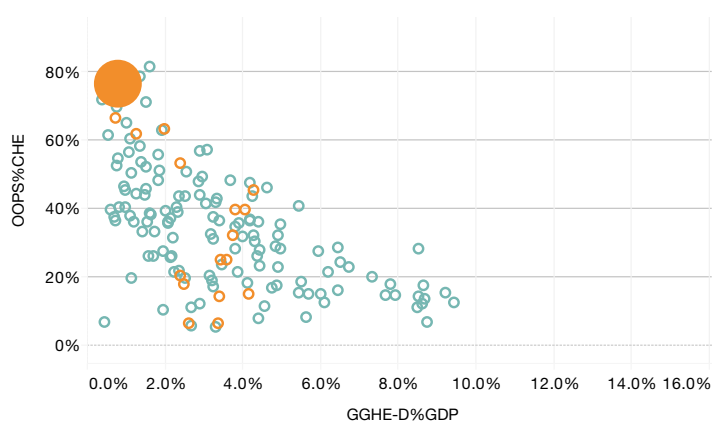


Fig. 6.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

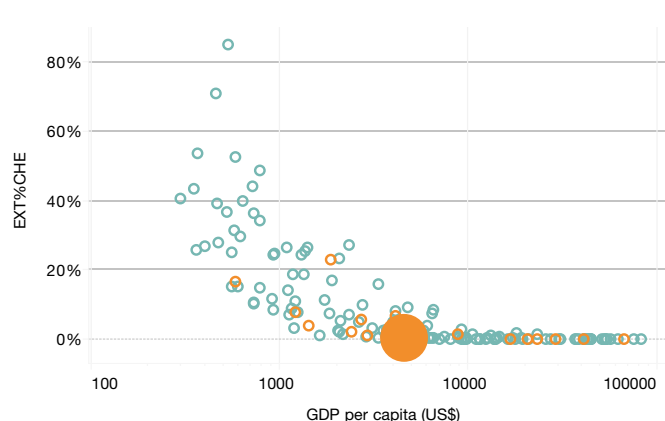


Fig. 6.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending.

Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.

Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

7. Jordan

1. Macroeconomics

The Jordanian economy is stagnant against a challenging regional backdrop. The crises in the Syrian Arab Republic and Iraq, the economic slowdown in the member countries of the Gulf Cooperation Council and the slow pace of structural reforms have all increased the risks of uncertainty in the macroeconomic outlook. Unemployment reached a historic level of 13.0% in 2015. Nevertheless, modest recovery has been taking place lately due to a revival in tourism, mining and quarrying. In 2015, GDP reached US\$ 37.517 billion, representing a per capita GDP of US\$ 4096, while general government expenditure was US\$ 10.917 billion, constituting 29.1% of GDP. The poverty ratio at the national poverty line was 14.4% in 2010.

2. Health financing architecture

The health financing system in Jordan consists of a mixture of public and private financing agents. The main public financing agents are: the Ministry of Health, which is responsible for the Civil Insurance Programme; the Royal Medical Services; the Jordan University Hospitals, including the University of Jordan Hospital and King Abdullah University Hospital; the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA); and the Social Security Corporation, which caters for occupational health and injuries. Private financing agents include nongovernmental organizations, households, private insurance companies, private self-insured firms and funds managed by professional associations. The High Health Council is responsible for general health policy in the country, and the Ministry of Trade is responsible for regulating private insurance.

3. Revenue raising

The main sources of health revenue are taxes, contributions, and copayments, which are all pooled by the Ministry of Finance. In 2015, current health expenditure as a percentage of GDP was 6.3%, amounting to a per capita current health expenditure of US\$ 257.4, with a per capita domestic private health expenditure of US\$ 93.0. External assistance represented 6.7% of current health expenditure. Health is one of the government's highest priorities, and accordingly in 2015, domestic general government health expenditure as a share of general government expenditure was 12.4%, equivalent to a per capita domestic general government health expenditure of US\$ 147.2. The Ministry of Finance is responsible for around 92% of the Ministry of Health's budget, through budgetary transfer according to historical patterns, in addition to financing the Royal Medical Services, the Jordan University Hospital and other public entities. The Civil Insurance Programme receives funds from the Ministry of Health, the Royal Court – on behalf of the impoverished and vulnerable sections of the population – and the Ministry of Finance in case of deficit. The Ministry of Planning and International Cooperation finances some health projects from its own budget, grants or loans. Recently, the government earmarked 6% of taxes on cigarettes and tobacco for the treatment of cancer patients at the Al-Hussein Cancer Foundation. UNRWA is mainly financed by the United Nations.

4. Pooling

Public funding by the Ministry of Finance is divided among multiple financing schemes. Domestic general government health expenditure constituted 57.2% of current health expenditure in 2015, while voluntary health insurance as a share of current health expenditure was 8.3%. Jordan operates two separate major public insurance schemes: the Civil Insurance Programme and the Royal Medical Services. The Civil Insurance Programme is a compulsory scheme for civil employees and their families; it also covers children under six years of age and older people, and pregnant women can opt to enroll. In addition, the Civil Insurance Programme provides voluntary coverage through individual contributions. The Royal Medical Services provide coverage for members and retirees of the armed forces and their dependents. Other pools include: the Jordan University Hospitals and private and semi-private firms, covering their employees, and in some cases family members; the Social Security Corporation, which covers work-related injuries; nongovernmental organizations, which cover specific groups of patients; and UNRWA, which is responsible for covering Palestinian refugees. Some professional associations, for example, those of lawyers, pharmacists, and medical doctors, provide coverage for their affiliates.

5. Purchasing

The Ministry of Health is the major provider and purchaser of health services in Jordan, mainly on behalf of the Civil Insurance Programme, which gives it purchasing power and the ability to pool resources. The Ministry of Health and the Royal Medical Services have centralized management systems for allocating resources to their individual health facilities. Facilities do not have their own budgets, and facility managers have little autonomy. Rather, they receive allocations of

equipment, supplies and pharmaceuticals as per their needs from central Ministry of Health and Royal Medical Services departments. Ministry of Health and Royal Medical Services facilities also receive payments based on schedules of charges from uninsured individuals. Health personnel in the public sector are paid on a salary basis. The Civil Insurance Programme can contract with public and private hospitals on a fee-for-service basis. Private sector facilities and practitioners are reimbursed based on schedules of charges. In 2004, Jordan established the Joint Procurement Department to act as the main manager of the procurement of medicines and medical supplies in the private sector through tenders.

6. Benefits design

Public programmes generally cover a comprehensive array of services, including pharmaceuticals, with limited cost-sharing. The Royal Medical Services offer a wide range of health care services, including the ability to treat complex medical cases and those of high cost referred to it by the Ministry of Health, the Jordan University Hospitals and the private sector. The Civil Insurance Programme contracts with private hospitals only to first-level/grade insurance status;²⁴ those with this level of insurance are mainly civil workers within higher and upper-middle employment levels. Uninsured individuals, even those receiving subsidized care at Ministry of Health facilities, must generally pay the full price of pharmaceuticals. Private insurance benefits are variable, with the usual forms of medical underwriting. Benefits offered by private firms are quite variable and frequently have copayments, deductibles and exclusions.

7. Population coverage

A key goal of the government is to provide health insurance for all Jordanians. Population coverage by insurance programmes reached 68% in 2015. Coverage by various schemes is as follows: Civil Insurance Programme (41.7%); Royal Medical Services (38%); Jordan University Hospitals (2.5%); private insurance companies (12.4%); and UNRWA (2.5%).²⁵ Uninsured Jordanians can still benefit from exemptions through the Royal Court. Ministry of Health facilities provide services at highly subsidized prices for the entire population. The government policy aims at promoting equity, including through its Socioeconomic Transformation Programme. Accordingly, those who fall under the poverty line are entitled by law to health insurance coverage by the Civil Insurance Programme, after approval by the Ministry of Social Development; in addition, they can submit a petition to the Prime Minister or the Royal Court to receive care from other providers. Nongovernmental organizations also provide services to the impoverished sections of the population. Nevertheless, the lack of mandatory health insurance coverage meant that only 68% of Jordanians were found to be insured in the latest census conducted at the end of 2015. The Ministry of Health has also been promoting insurance coverage by providing incentives to organ donors whereby they would receive coverage for a period of five years, while blood donors would receive coverage for six months. From 2012 to 2014, Syrian refugees were covered in the same manner as insured Jordanians, before being asked to pay 20% of the costs as of November 2014, as is the case for uninsured Jordanians. Recently, a decision was made to charge Syrian refugees 80% of prices for foreigners.

8. Service coverage

Public sector facilities are owned by the Ministry of Health, the Royal Medical Services and the Jordan University Hospitals. The Ministry of Health, the Royal Medical Services, and private sector facilities provide a wide spectrum of primary, secondary, tertiary and rehabilitative services. The Jordan University Hospitals provide secondary, tertiary and rehabilitative services. UNRWA provides primary health care services only. The private sector includes hospitals, diagnostic and therapeutic centres and clinics. The universal health coverage index of coverage of essential health services value for the country is 70, which is among the highest in the world.²⁶ However, in the few past years, due to the refugees crisis and especially the huge influx of Syrian refugees in the country, demand for health services at Ministry of Health facilities and through referrals outside the Ministry of Health have increased, resulting in longer waiting times for services.

9. Financial protection

Out-of-pocket health spending reached 25.1% of current health expenditure in 2015. The extent of financial hardship due to out-of-pocket payments is low and has remained stable over time. However, the rate of catastrophic health spending is high among some segments of the population, notably the wealthiest quintile and refugees. Syrian refugees are significantly more susceptible to experiencing catastrophic health expenditures. In 2006, using the 10% and 25% of household total consumption or income thresholds, catastrophic health expenditures stood at 5.3% and 0.91% respectively. In 2006, 0.73% of households were pushed into poverty due to out-of-pocket payments. A United Nations survey in 2016 targeting Syrian refugees found that 21% of the surveyed population are facing catastrophic health expenditures.²⁷ The Royal Court refers uninsured patients facing catastrophic health expenditure to public hospitals where their full treatment costs are reimbursed.

²⁴ Coverage by the Civil Insurance Programme is divided into three levels. Each level of insurance coverage provides different set of entitlements, mainly with regard to the type of provider and the hotel service quality.

²⁵ Jordan Population and Housing Census 2015.

²⁶ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

²⁷ The Hashemite Kingdom of Jordan High Health Council, United Nations Children's Fund. Policy Brief. Health spending in Jordan. Amman: The Hashemite Kingdom of Jordan High Health Council; May 2016 (https://www.unicef.org/jordan/Policy_Brief_Health_spending_in_Jordan_May2016.pdf, accessed 4 September 2018).

Health expenditure profile

Jordan

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	3 491	4 245	4 758	4 096
CHE per capita (US\$)	336	376	383	257
GGHE-D%CHE	45	52	67	57
OOPS%CHE	39	40	22	25
GGHE-D%GDP	4.3	4.6	5.4	3.6
GGE%GDP	34	40	29	29
GGHE-D%GGE	13	12	18	12
Population	5 103 130	5 714 111	7 182 390	9 159 302

Fig. 7.1. Key health financing and expenditure indicators, 2000–2015

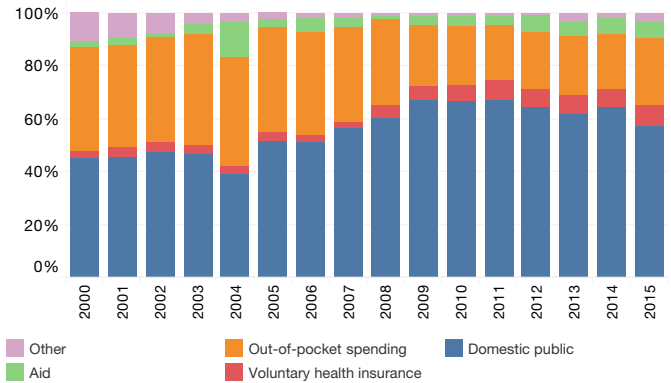


Fig. 7.2. Revenue sources

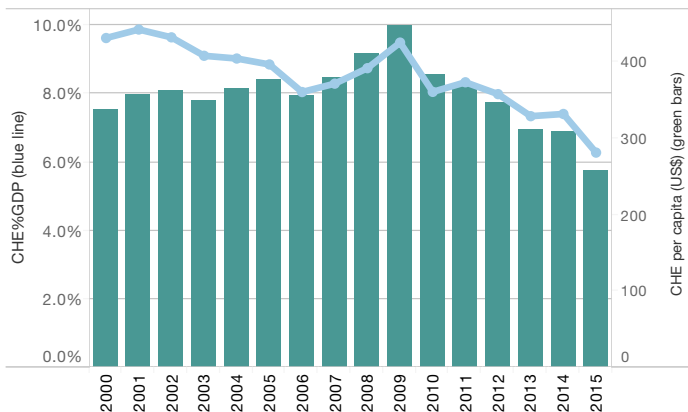


Fig. 7.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

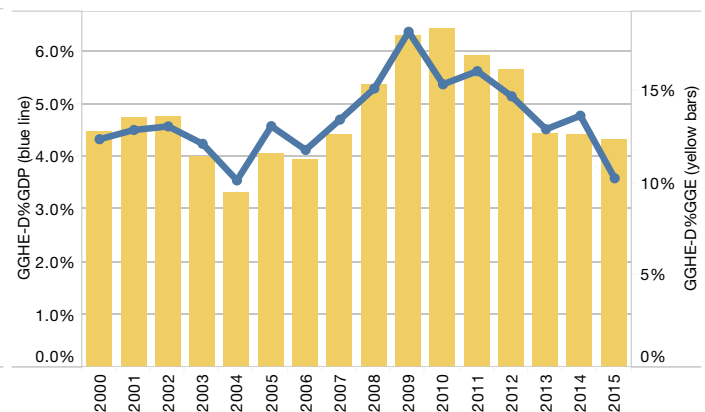


Fig. 7.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

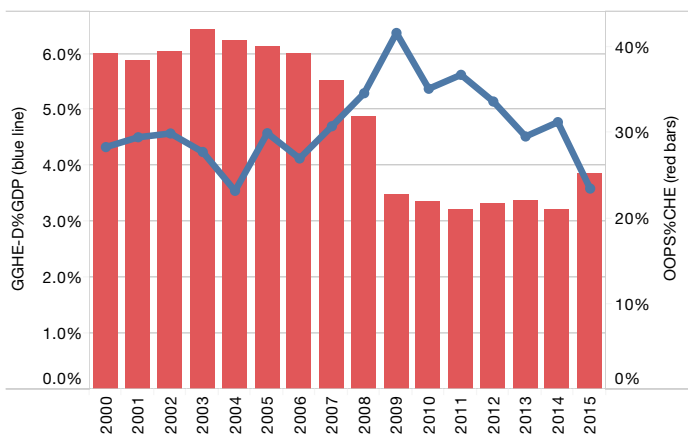


Fig. 7.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

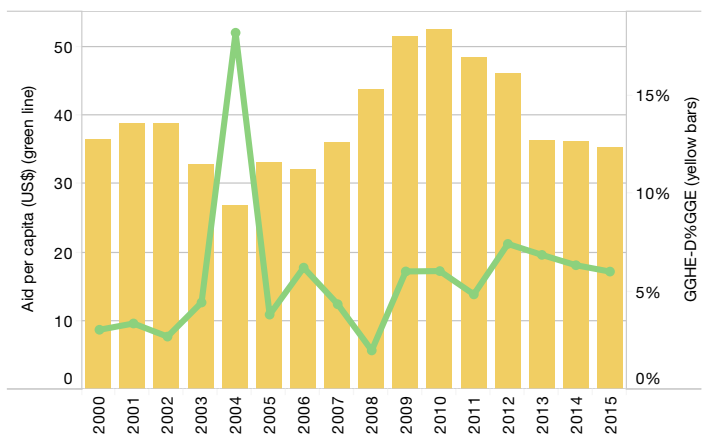


Fig. 7.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

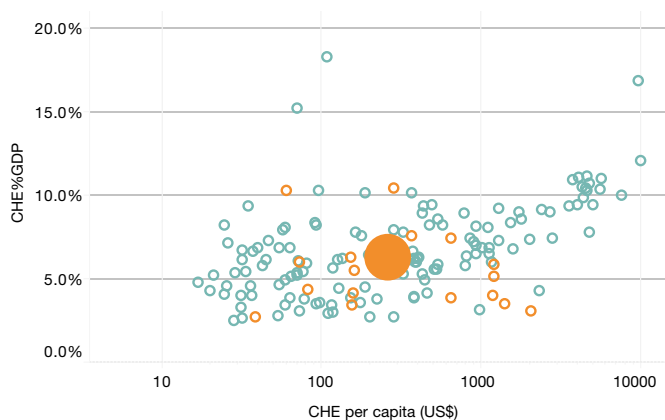


Fig. 7.7. Current health expenditure as a percentage of GDP and per capita (US\$)

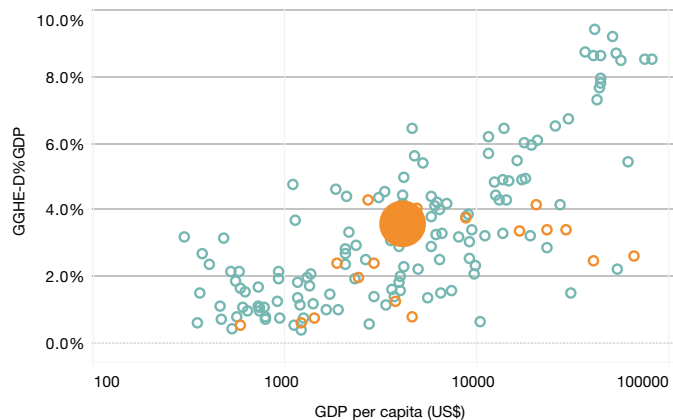


Fig. 7.8. Government health expenditure as a percentage of GDP and per capita (US\$)

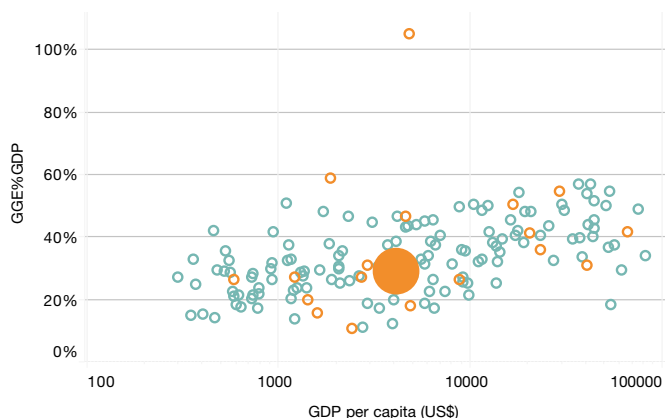


Fig. 7.9. Fiscal space and GDP per capita (US\$)

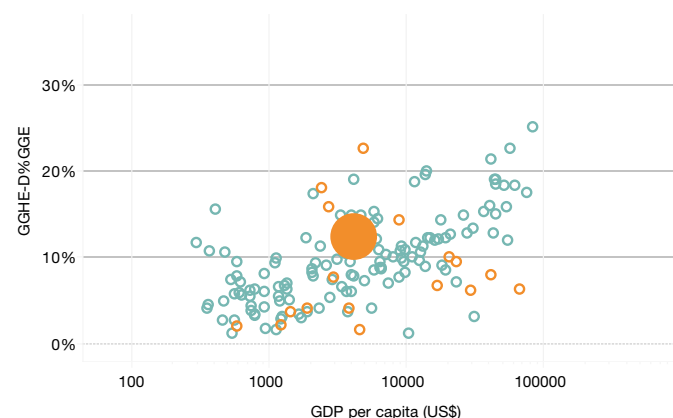


Fig. 7.10. Health prioritization and GDP per capita (US\$)

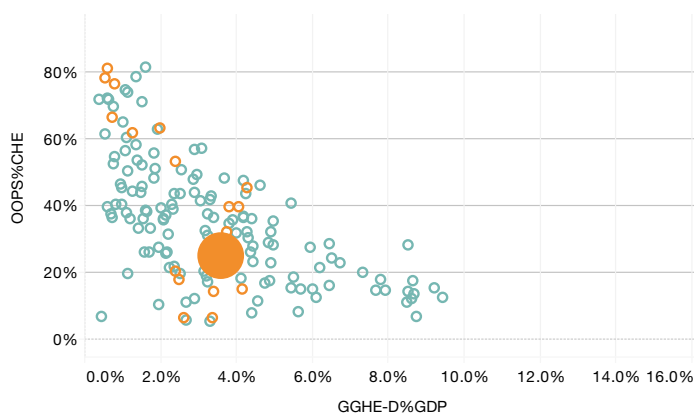


Fig. 7.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

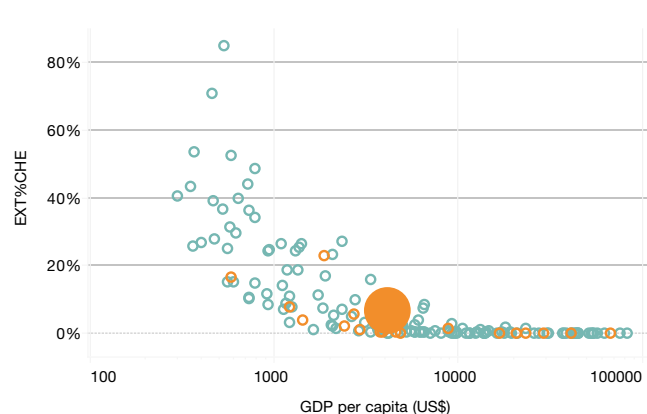


Fig. 7.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

8. Kuwait

1. Macroeconomics

Kuwait is a high-income country with an open economy which mainly depends on oil production – in 2013–2014, only around 17% of revenues were from non-oil production. The reduction in oil production in 2015–2016 led to a reduction in economic growth, which resulted in a budget deficit. In 2015, GDP was US\$ 114 billion (down from US\$ 174 billion in 2013), with GDP per capita standing at US\$ 28 980. General government expenditure has consequently decreased, standing at US\$ 62 billion in 2015 and constituting 54.4% of GDP. Nevertheless, the economy is expected to recover in the coming years, as oil output and infrastructure spending accelerate and oil prices increase. The poverty rate in the country is unknown.

2. Health financing architecture

The governance of the health system follows a decentralized approach, and is divided between central and regional administrations that are governed by the Ministry of Health and local authorities, respectively. The Ministry of Health remains the main steward and financier of the health sector, and is involved in planning, regulation, monitoring, delivery and resource allocation. In addition, governmental insurance agencies and the Ministries of Defense and the Interior play an organizational and financing role in the health sector, while private health insurance entities, households and charities also contribute to the health sector as additional private financing agents.

3. Revenue raising

The main source of revenue for health is provided by the Ministry of Finance; this revenue is mainly based on oil production revenues which constitute around 90% of total government revenue. The recent reduction in oil prices has underscored the importance of diversifying government revenues. Health is one of the government's highest priorities, and accordingly in 2015, general government health expenditure as a share of general government expenditure was 6.2%, equivalent to a per capita general government health expenditure of US\$ 983. Current health expenditure as a share of GDP was 4% in 2015, amounting to per capita current health expenditure of US\$ 1168, while private health expenditure per capita stood at US\$ 168. Other sources of health revenue are charities and the contributions of expatriates. Kuwait does not receive any external assistance for health.

4. Pooling

Currently, most health care revenues are pooled at Ministry of Finance level, with domestic general government health expenditure constituting 84.1% of current health expenditure in 2015 – one of the highest in the Region. The government has recently introduced new arrangements to ensure improved coverage for the entire population, which despite their importance are at present fragmented and often result in duplications. The new pools include the Afya and Daman schemes, and private insurance companies. Afya is an additional coverage scheme for public and private sector Kuwaiti retirees, which is run by private insurance companies. It allows those covered to access private providers alongside their public sector coverage, with funding provided by the Ministry of Health. The Daman scheme is a separate pool constituting a mandatory coverage scheme for expatriate workers and their families, financed by fixed contributions collected by the Ministry of Finance. Expatriates can also be covered by the Patient Support Fund (a nongovernmental organization) that works in cooperation with the Ministry of Health. In addition, private health insurance companies provide voluntary health insurance coverage, which is prone to adverse selection and cream skimming; they constitute only around 1.5% of current health expenditure.

5. Purchasing

Most health services are provided by the government with no separation between purchasing and provision of services. Payment to public health workers is mainly through salaries, which constitute around 58% of the Ministry of Health budget. The rest of the Ministry of Health budget is spent on the procurement of supplies (absorbing around 18% of the budget) and on treatment abroad (around 12%). Currently, the country is moving towards changing this budget format to better meet health sector needs with regard to both demand and supply.

6. Benefits design

An open-ended package of health services is provided for all Kuwaitis. Expatriates can access primary and secondary health care services depending on the type of health insurance coverage they have, and against nominal user fees. The package includes preventive and promotive services, for example health education and nutrition, vaccination, growth and development follow-up, and curative services. Kuwaitis are fully reimbursed for all medicines listed under Circular 365, while expatriates are highly subsidized in this regard. The package of services provided through the Afya scheme in the private sector is more strictly defined, and capped at KD 17 000 per person per year.

7. Population coverage

According to the Ministry of Health, coverage by prepayment is mandatory for the entire population. All Kuwaitis are covered by the national health system through budget allocations. Expatriates, who represent almost 50% of the population, are required to have public health insurance coverage through the Daman scheme or the Patient Support Fund, even if they are also covered by another type of insurance. Retired Kuwaitis – those above 55 years – are guaranteed coverage for private facilities under the Afya scheme alongside their original public sector coverage; at present, around 117 000 individuals are covered under Afya. Some sections of the population are also covered by private health insurance schemes as a form of supplementary and complementary coverage.

8. Service coverage

The Ministry of Health is the main provider of health services, in addition to other governmental entities, including the Armed Forces Hospital under the Ministry of Defense, and the Ministry of Social Affairs. Primary health care is provided via around 95 primary health care centres. Secondary health care is provided through six general hospitals. Tertiary health care is provided through 11 national specialized hospitals and clinics. Private sector health care services are provided through clinics, medical centres and around 12 private hospitals. Between 2005 and 2012, the number of physicians and nurses increased from 18 to 27 per 1000 population, and from 37 to 56 per 1000 population, respectively. However, the health workforce continues to rely heavily on expatriate workers. In 2015, the universal health coverage index of coverage of essential health services value for the country was 77, which is among the highest in the world.²⁸

9. Financial protection

Kuwait has a comprehensive system of social welfare financed by government oil revenues. It provides free medical services to all Kuwaiti citizens and offers welfare services for the impoverished sections of the population. However, in 2015, out-of-pocket payments constituted around 14.3% of current health expenditure. According to some estimates, unaffordable medicines are a major barrier to receiving adequate health care for approximately one third of the population (mainly expatriates).

²⁸ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Kuwait

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	29 228	39 071	31 436	28 980
CHE per capita (US\$)	735	929	867	1 169
GGHE-D%CHE	76	80	85	84
OOPS%CHE	22	18	14	14
GGHE-D%GDP	1.9	1.9	2.3	3.4
GGE%GDP	37	28	45	55
GGHE-D%GGE	5	7	5	6
Population	2 050 741	2 276 623	2 998 083	3 935 794

Fig. 8.1. Key health financing and expenditure indicators, 2000–2015

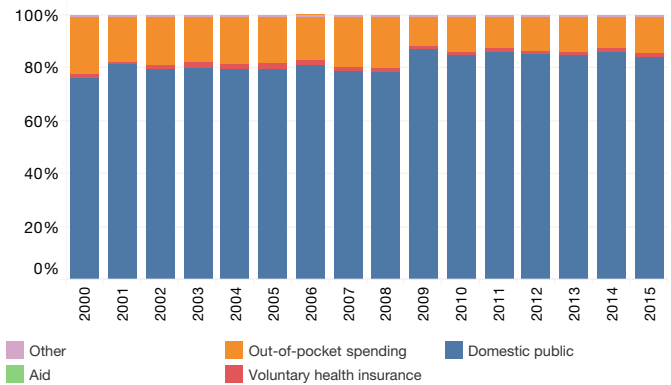


Fig. 8.2. Revenue sources

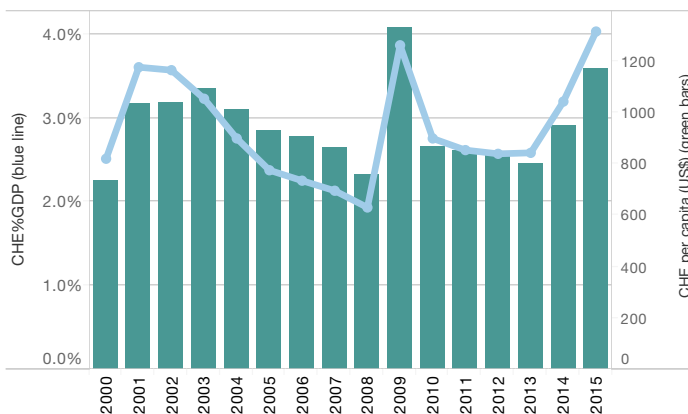


Fig. 8.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

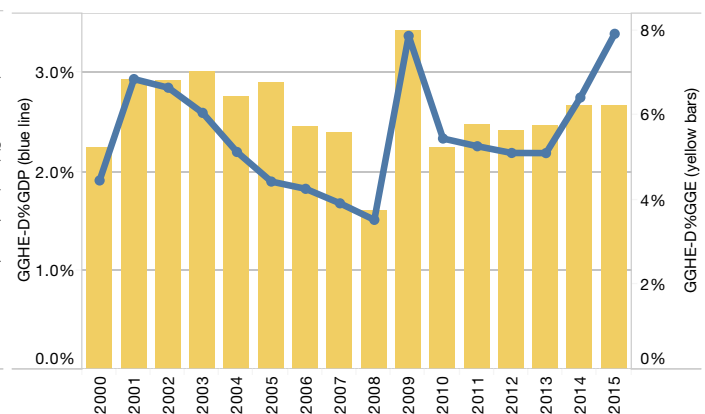


Fig. 8.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

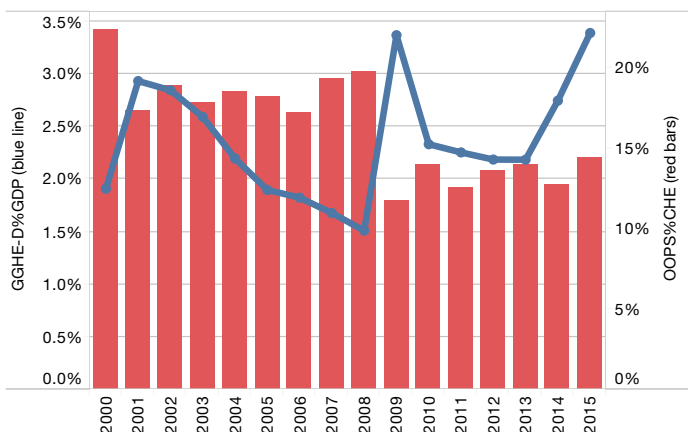


Fig. 8.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

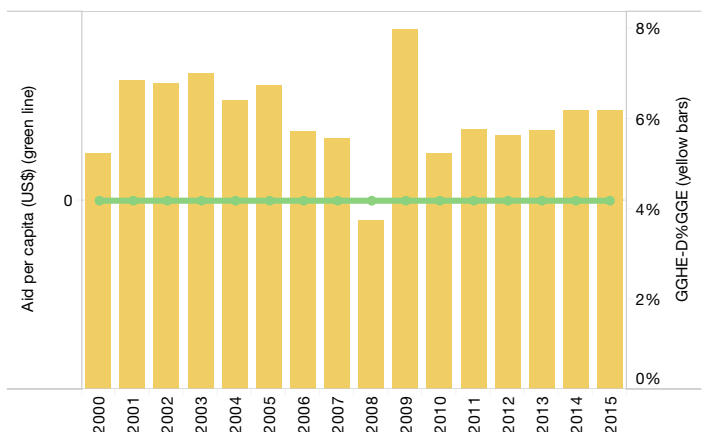


Fig. 8.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

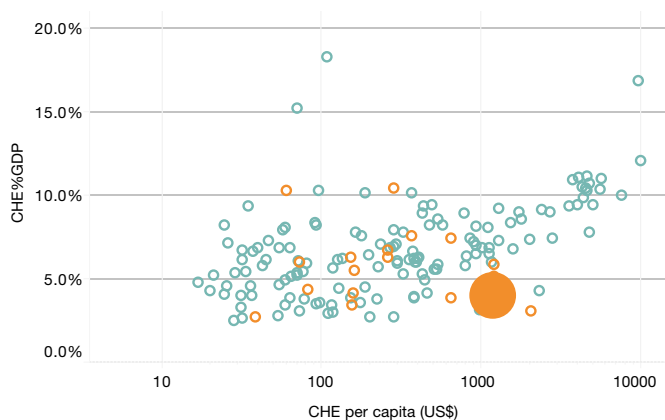


Fig. 8.7. Current health expenditure as a percentage of GDP and per capita (US\$)

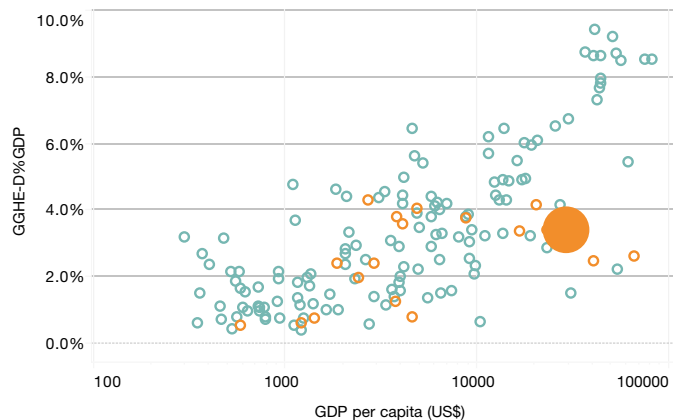


Fig. 8.8. Government health expenditure as a percentage of GDP and per capita (US\$)

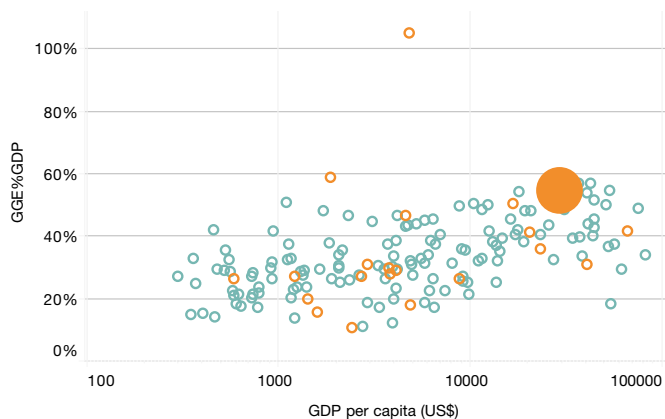


Fig. 8.9. Fiscal space and GDP per capita (US\$)

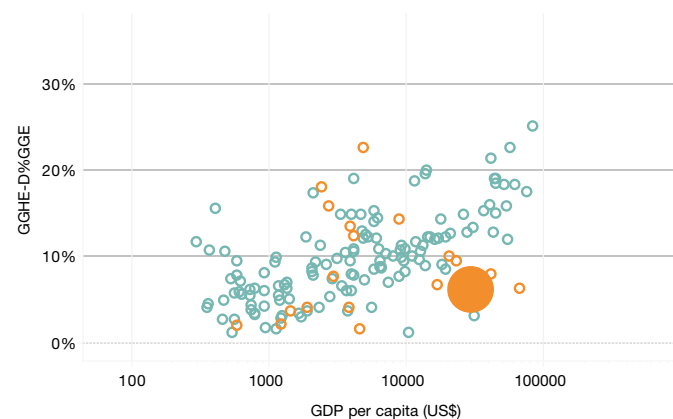


Fig. 8.10. Health prioritization and GDP per capita (US\$)

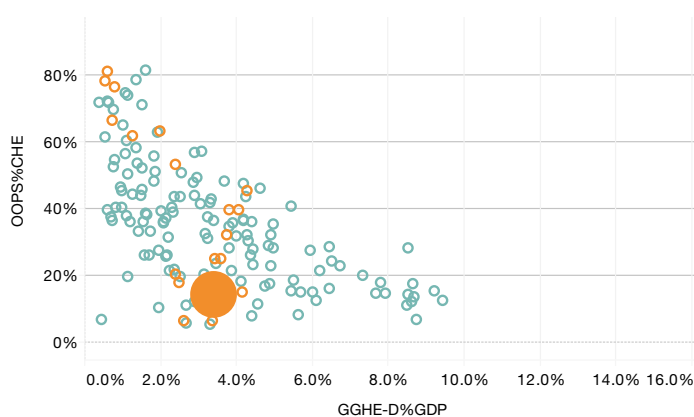


Fig. 8.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

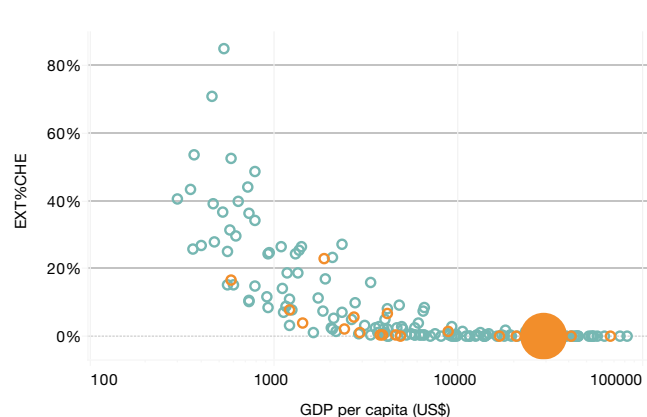


Fig. 8.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

9. Lebanon

1. Macroeconomics

Lebanon is a middle-income country with a free-market and service-driven economy. Since 1975, Lebanon has been destabilized by several political and armed conflicts. Lebanon rebuilt much of its war-torn infrastructure by borrowing heavily. The Syrian refugee crisis which began in 2011 put extraordinary fiscal pressure on the economy. Its GDP amounted to US\$ 50.800 billion in 2015, representing GDP per capita of US\$ 8682, down from US\$ 9022 in 2013. Lebanon has broadly managed to preserve its macroeconomic stability and market confidence. In 2015, general government expenditure was US\$ 13.311 billion with per capita general government expenditure of US\$ 2275, constituting 26.2% of GDP. In 2012, 27.4% of the population were impoverished.²⁹ In 2017, the Lebanese government approved initiatives to encourage foreign investment to improve the country's infrastructure and exploit offshore energy resources.

2. Health financing architecture

The health care system in Lebanon is a pluralistic system. The Ministry of Public Health is responsible for the overall governance and regulation of the health sector, including in the purchasing and provision of some health services. In addition, several other ministries are involved in the management, financing and provision of health care, including the Ministries of Labour, National Defense, the Interior, Economy and Commerce, and Housing and Cooperatives. Private financing agents include private insurance companies under the authority of the Ministry of Economy and Trade, nongovernmental organizations and households. In addition, international organizations including the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) and the United Nations High Commissioner for Refugees (UNHCR) cater for the needs of Palestinian and Syrian refugees, primarily using their own systems. Furthermore, in the context of the Syrian crisis, bilateral donors such as the EU directly support national and international nongovernmental organizations to fill the gaps in financing for health service provision for refugees.

3. Revenue raising

In 2015, per capita current health expenditure was US\$ 645, constituting 7.4% of GDP. Households are the major source of health sector revenue, with per capita domestic private health expenditure standing at US\$ 310 in 2015. Revenues are also received from nongovernmental organizations and donor funding. Additional revenue-raising mechanisms are being put in place, including taxes on tobacco and alcohol, vehicle registration fees, and road tolls. In 2015, domestic general government health expenditure per capita was US\$ 326, constituting 14.3% of general government expenditure. External funding constituted only 1.4 % of current health expenditure.

4. Pooling

The health financing system is fragmented across several pools. The Civil Servant Cooperative and the National Social Security Fund constitute two employment-based social insurance schemes. The National Social Security Fund is under the authority of the Ministry of Labour. The Civil Servant Cooperative covers government employees and their dependents, while the National Social Security Fund covers formal private sector employees and their dependents in addition to contracted employees and wage earners in the public sector. The National Social Security Fund is further fragmented into three different funds: the Sickness and Maternity Allowance Fund, the Family and Education Allowance Fund, and the End-of-Service Indemnity Fund. There are four schemes covering members of the Military and Security Forces and their dependents: the Army Medical Brigade, the Internal Security Forces, the General Security Forces and the State Security Forces. The Ministry of Housing and Cooperatives manages separate pools – mutual funds – for syndicates, associations and other professional groups. Private health insurance is based on risk-adjusted premiums. The Ministry of Public Health also acts as a financing agent for the private sector by allocating funds to cover hospital beds in the private sector. Furthermore, UNRWA and UNHCR manage separate pools of funds for health care for refugees. In 2015, domestic general government health expenditure accounted for 50.5% of current health expenditure, while voluntary health insurance represented 17.2%.

²⁹ According to the most recent estimates obtained by the Central Administration for Statistics and the World Bank, the average annual level of consumption per person in 2011–12 was about LBP 7 788 000, or US\$ 14.2 per person per day, in Lebanon.

5. Purchasing

The health care system is hospital oriented, capital intensive and requires large-scale imports of medicines and medical equipment. All public agencies contract out for hospital care, which makes them the main payer. Public hospitals have organizational and financial autonomy. Payment from public and private payers to contracted hospitals is billing based, depending on the type and volume of services provided. The Ministry of Public Health budget mainly goes to hospital care and pharmaceuticals and to a lesser extent to salaries. It contracts around 30 public and 123 private hospitals. Payment by the Ministry of Public Health used to be on a flat-rate basis, and succeeded in introducing programme budgeting by allocating a total budget per programme for a few items within its budget. In 2014, the Ministry of Public Health implemented a new contracting system with public and private hospitals, which directly linked hospital performance with the reimbursement rate they were paid. United Nations agency funds are channelled through a number of international and local nongovernmental organizations for provision of care. Reimbursement of providers by the Ministry of Public Health involves a fee-for-service system for non-interventional hospitalization; capitation for pregnant women; case-based payment for surgical procedures; budgetary transfers for public hospitals; and in-kind payment for comprehensive primary health care services delivered by nongovernmental organization health centres. The government piloted a universal health care-primary health care project where performance-based reimbursement was used as the main provider payment method.

6. Benefits design

The benefit package depends on the nature of coverage and type of insurer. The Basic Health Service Package covers both preventive and curative care as follows: services related to general medical care, pediatrics, dental and oral health, reproductive health and cardiovascular medical care; this coverage includes essential medicines as per a defined list. In addition, the National Social Security Fund covers reimbursement to the user for curative and ambulatory care: up to 95% for cancer medicines and 85% for all other medicines and services. The Civil Servant Cooperative offers the same coverage with the addition of dental care. Military and security force funds fully cover hospitalization and ambulatory services. Private insurance and mutual funds offer a number of coverage arrangements. Generally, the Ministry of Public Health funds hospitalization costs and the cost of some specialized treatments such as chemotherapy. In many instances, the benefits offered by the Ministry of Public Health are superior to the coverage offered by social insurance schemes and private insurance companies, which means many individuals prefer to use Ministry of Public Health coverage rather than these forms of insurance. Although the Ministry of Public Health does not cover ambulatory care services, it provides in-kind support to a national primary health care network. The level of coverage a dependent of an insured person receives depends on the nature of the dependent's relationship to the insured person – that is, whether the dependent is a relative, or a patient, for example. As part of the national poverty-targeting programme, both the Ministry of Public Health and the Ministry of Social Affairs offer minimum complimentary services for the most vulnerable sections of the population. UNRWA also provides almost free primary health care services to the entire refugee population, but partially covers the costs of secondary and tertiary care with a number of contracted hospitals. In addition, a number of national and international nongovernmental organizations offer mother and child health care, care for older people and mental health packages within the context of the Syrian crisis response.

7. Population coverage

Different population groups are covered by different arrangements. The National Social Security Fund is the main insurer, covering around 28% of the population. Military schemes cover around 9% of the population, followed by the Civil Servant Cooperative which insures around 5%. At present, there are mutual fund arrangements for parliamentary employees, judges and university and school teaching staff. Mutual funds and private insurance cover 12% of the population each. Nevertheless, around 53% of the population remain uninsured. The Ministry of Public Health provides hospital coverage for those who are uninsured through contracting with private and public hospitals with minimal copayment. Vulnerable sections of the population covered by the Ministry of Public Health and the Ministry of Social Affairs are as follows: children under 5 years old, women of reproductive age, older people, people with disabilities and people with mental health disorders. Around half a million Palestinian refugees already reside in Lebanon, and in 2015, the population of the country increased by 25% due to the influx of more than one million registered and more than 750 000 unregistered Syrian and Palestinian refugees. UNRWA is the main entity responsible for Palestinian health coverage. The Ministry of Public Health, UNHCR and other nongovernmental organizations cooperate to provide health coverage for Syrian refugees. Syrian refugees access primary health care through nongovernmental organizations, the Ministry of Public Health, and UNHCR-supported health centres. In addition, UNHCR contracts with public and private hospitals to provide selected secondary health care services for registered Syrian refugees, covering 75% of the fees.

8. Service coverage

The health system is hospital oriented. The private sector is the main provider, providing more than 85% of services, with nongovernmental organizations and the public sector providing the remaining services. The Ministry of Public Health directly provides primary health care through a large network of primary health care centres, established in collaboration with nongovernmental organizations and municipalities. In 2017, the total number of public primary health care centres within the National Primary Health Care Network was 213. The Ministry of Public Health also contracts for curative care with around 153 hospitals (public and private). Primary health care is provided by four main providers: the Ministry of Public Health; other public entities such as the Ministry of Social Affairs and local municipalities; nongovernmental organizations; and the private sector. At present, there is no gate-keeping system, and any citizen can choose to use health services at any level of care without referral, except for some high-technology services and operations. Lebanon has a surplus of physicians compared to nurses and paramedical staff. In 2016, the number of physicians and nurses per 10 000 population was 31.0 and 34.2 respectively. Hospital bed distribution favours the capital and suburbs. Around 10–15% of registered physicians do not practice in the country. UNRWA also owns 29 health care centres around the country. After the surge in refugees, the Ministry of Social Affairs and the Ministry of Public Health reported an average 40% increase in the utilization of their services. In 2017, 89% of refugees report that they had access to the ambulatory care they needed, and 80% had access to hospital care. The current universal health coverage index of coverage of essential health services value for the country is 68.³⁰

9. Financial protection

Out-of-pocket payment constituted 32.1% of current health expenditure in 2015. The country has been implementing a series of reforms to lower out-of-pocket spending by giving more autonomy to the more efficient public hospitals, strengthening primary health care, improving quality of services, containing the cost of pharmaceuticals – responsible for around 50% of out-of-pocket payments – and empowering patients. In 1999, 0.03% of the Lebanese population fell into poverty due to out-of-pocket expenditures, at the poverty line of US\$ 1.90 per day. In the same year, 44.85% or 10.03% of the population faced catastrophic health expenditures at the 10% and 25% of household total consumption or income thresholds, respectively. According to the 2004–2005 household survey, 7.5% and 15.2% of households faced catastrophic health expenditures at the 25% and 15% of household total consumption or income thresholds,³¹ respectively.

³⁰ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

³¹ Salti N, Chaaban J, Raad F. Health equity in Lebanon: a microeconomic analysis. *International Journal for Equity in Health*. 2010;9:11 (<http://doi.org/10.1186/1475-2875-9-11>, accessed 3 September 2018).

Health expenditure profile

Lebanon

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	7 702	7 545	10 010	8 682
CHE per capita (US\$)	822	575	753	645
GGHE-D%CHE	30	38	40	51
OOPS%CHE	58	47	44	32
GGHE-D%GDP	3.2	2.9	3.0	3.8
GGE%GDP	42	32	29	26
GGHE-D%GGE	8	9	10	14
Population	3 235 366	3 986 852	4 337 141	5 851 479

Fig. 9.1. Key health financing and expenditure indicators, 2000–2015

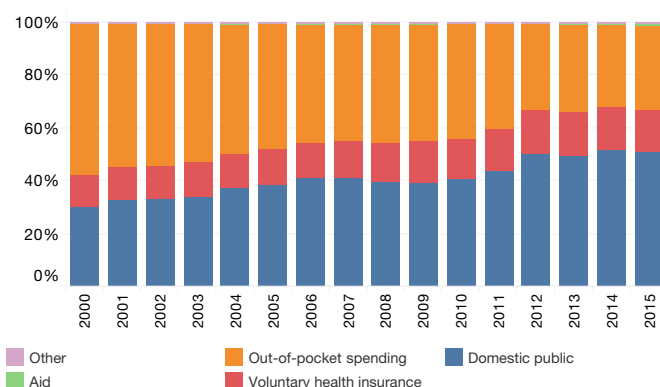


Fig. 9.2. Revenue sources

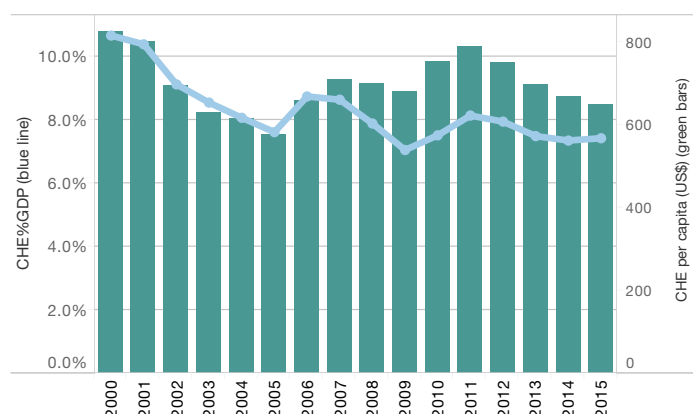


Fig. 9.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

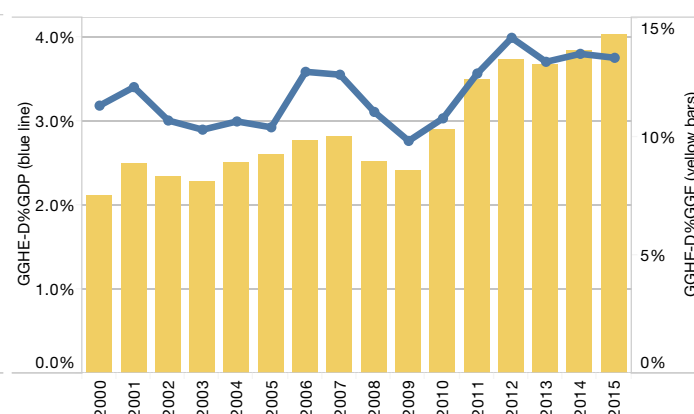


Fig. 9.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

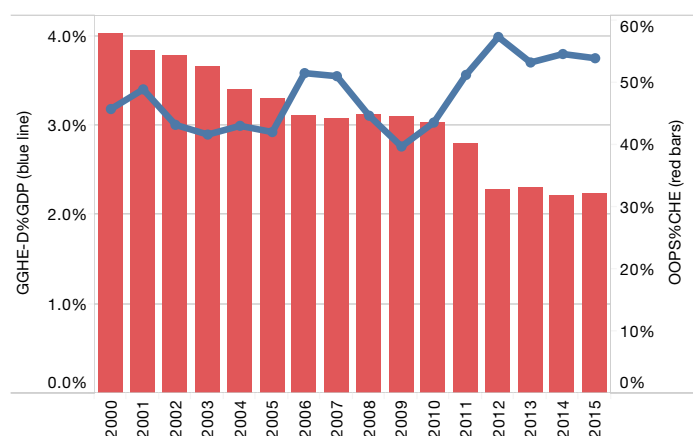


Fig. 9.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

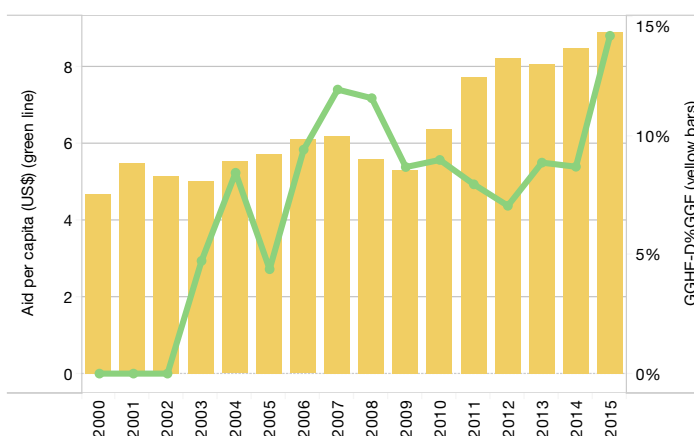


Fig. 9.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

Health expenditure profile Lebanon

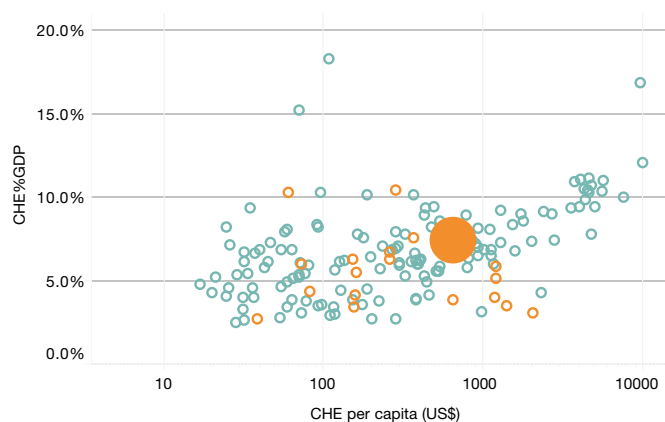


Fig. 9.7. Current health expenditure as a percentage of GDP and per capita (US\$)

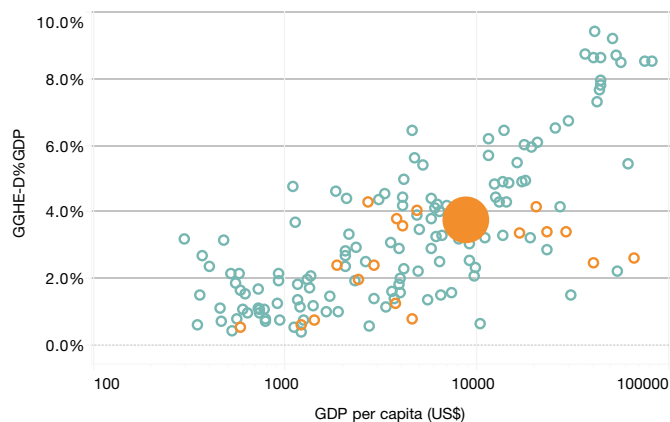


Fig. 9.8. Government health expenditure as a percentage of GDP and per capita (US\$)

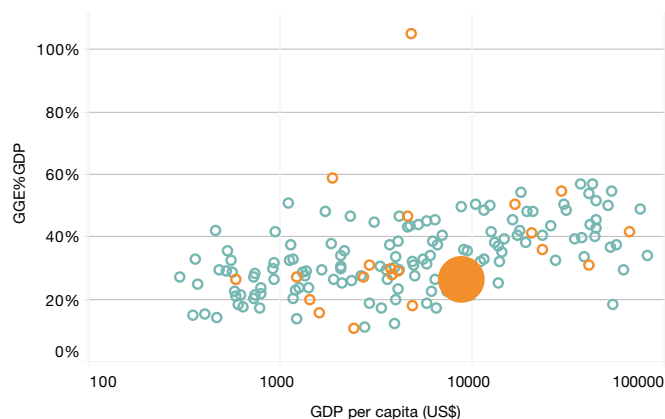


Fig. 9.9. Fiscal space and GDP per capita (US\$)

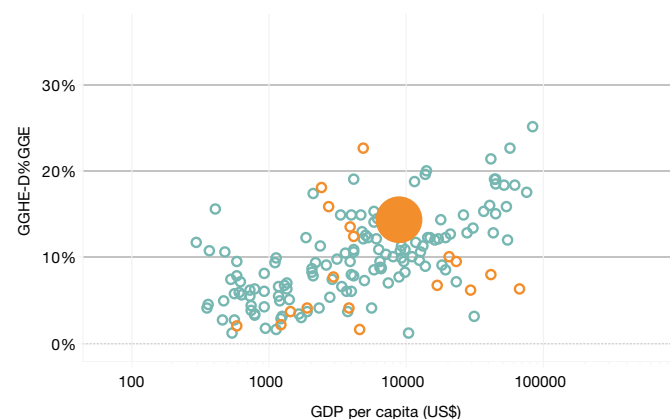


Fig. 9.10. Health prioritization and GDP per capita (US\$)

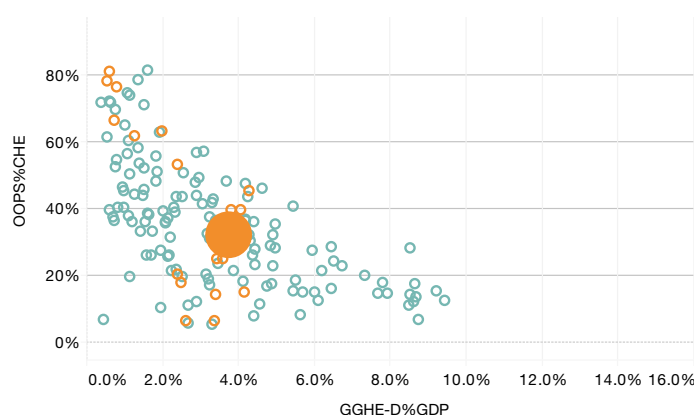


Fig. 9.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

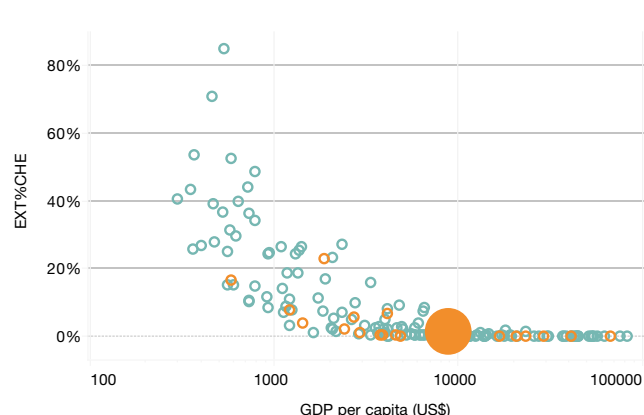


Fig. 9.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending.

Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.

Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

10. Libya

1. Macroeconomics

Libya is an upper-middle income country, with a per capita GDP of US\$ 5 541 in 2015. Libya's economy primarily depends on the oil sector, which contributes up to 65% of GDP and almost 96% of government revenues. GDP decreased to US\$ 20.5 billion in 2016, one fourth of its level in 2010, due to the ongoing violent political conflict in the country. Despite recent slight improvement, the inflation rate continues to be high, affecting individuals' purchasing power. General government expenditure stood at US\$ 31.3 billion in 2015. Although exact statistics regarding poverty in Libya remain unavailable, it is estimated that about one third of Libyans live at or below the national poverty line.

2. Health financing architecture

Law 106 of 1973 states that health is the responsibility of the government. The health system is governed by the Ministry of Health with intensive involvement from development partners. A United Nations strategic framework for 2019–2020 coordinates international support for the ongoing humanitarian efforts in the country. The Libyan health system is decentralized at district (*sha'biya*) level, under the overall supervision of the General People's Committee for Health and Environment.³² This committee is responsible for planning, policy making, monitoring, and regulating providers. In 2009, the General People's Congress issued a decree calling for the development of the health system based on principles of solidarity and universal coverage, through social health insurance schemes, welfare funds, and private insurance. In 2010, a new health insurance law was enacted mandating health insurance coverage for all citizens through their employers. The law was however not implemented due to the deteriorating political situation in the country. In 2017, the Health Insurance Fund was established to insure employees in the education sector. The main public financing agents are the Ministry of Health and autonomous hospitals. Donors, households and nongovernmental organizations act as private financing agents.

3. Revenue raising

The health financing system has deteriorated in recent years due to fragmented governance and limited public financial resources. In 2011, current health expenditure constituted 5.0% of GDP, amounting to a per capita current health expenditure of US\$ 313. Health care is financed through a mixture of financing arrangements including government spending, households, and corporations. Government spending on health is based on allocations from the Ministry of Finance mostly based on national oil industry revenues and taxes. In 2011, domestic general government health expenditure represented 6.4% of general government expenditure, equivalent to a per capita domestic general government health expenditure of US\$ 198, while per capita domestic private health expenditure was US\$ 115.

4. Pooling

Health funds are primarily pooled by the government at Ministry of Finance level, alongside an additional smaller pool related to social health insurance. In 2011, domestic general government health expenditure represented 63.3% of current health expenditure. Funds from donors are pooled separately. Private health insurance plays a minor role in the country.

5. Purchasing

Health services are financed, owned and directly managed by the government through the Ministry of Health. The Ministry plans its budget based on expenditures from previous years. Resources are mainly concentrated at secondary and tertiary health levels, and budget allocation is generally delinked from performance. Around 4% of the health budget is allocated for primary health care, while 53% is allocated for salaries. All publicly provided health services are paid for using incremental salaries and line item budgets. From 2004 on, all hospitals were considered autonomous institutions with their own budgets and separate bank accounts. The government created a Medical Supply Organization, which is responsible for purchasing a large proportion of the medicines required on behalf of the state.

³² The country is divided into 23 districts or *sha'biyat*, each of which consists of a number of people's congresses. The total number of people's congresses is 468.

6. Benefits design

Health care services are provided free of charge by the government. However, the poor quality of services and limited trust in the public sector deters utilization. There is an extensive shortage of medicines and medical supplies in the country and a very low stock of vaccines.

7. Population coverage

In principle, the government provides universal health coverage for all health services free of charge. Following the recent crisis situation in the country, many Libyans working in the governmental sector received health insurance coverage, which entitled them to use the expensive private clinics. Furthermore, some local companies and institutes contract with private insurance companies to cover their workers at local private clinics. In 2018, the Ministry of Education and the Public Health Insurance Fund agreed on the provision of health insurance for employees in the education sector.

8. Service coverage

The Libyan health system is a mixture of public and private health care providers, with the public sector being the main health service provider. Health care is delivered through a network of primary health care units and centres, polyclinics, rehabilitation centres, general hospitals and tertiary care specialized hospitals. In 2009, Libya had 96 hospitals with 20 289 beds, 25 specialized units with 5970 beds, 1355 primary health care centres, 37 polyclinics and 17 quarantine units. Following the recent crisis and ongoing conflict, the capacity of the health system was compromised and many health facilities were either damaged or became non-functional. Furthermore, Libya has been facing a severe shortage of health workforce, medicines and medical supplies. This has resulted in many health services becoming progressively unavailable and in more people seeking health services at hospitals. In 2017, around 1.3 million people were in need of humanitarian health assistance. In 2018, the Services Availability and Readiness Assessment found that the overall general service readiness of public hospitals is at 68%, while that of public primary health care facilities is at 37% – with 17 hospitals (18%), 273 primary health care facilities (20%), and 18 other health facilities (8%) currently closed. The lack of medicines means that 71% of people with chronic diseases face challenges in accessing the essential medicines they need. Due to irregular payment and shortage of supplies, efficiency is undermined. The current universal health coverage service coverage index value for the country is 63.³³

9. Financial protection

In 2011, out-of-pocket payments constituted around 36.6% of current health expenditure. An estimated 1.6 million Libyans are affected by the current conflict, and around 1.3 million are in need of humanitarian health assistance. The World Bank has estimated that in 2014, 32% of the population were at risk of catastrophic expenditures for surgical care.

³³ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Libya

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	7 725	9 178	10 249	4 773
CHE per capita (US\$)	265	238	345	
GGHE-D%CHE	49	65	70	
OOPS%CHE	51	35	30	
GGHE-D%GDP	1.7	1.7	2.4	
GGE%GDP	28	29	54	105
GGHE-D%GGE	6	6	4	
Population	5 355 751	5 792 688	6 169 140	6 234 955

Fig. 10.1. Key health financing and expenditure indicators, 2000–2015

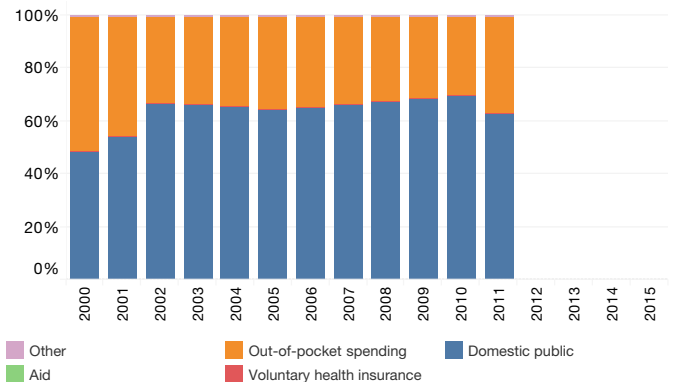


Fig. 10.2. Revenue sources

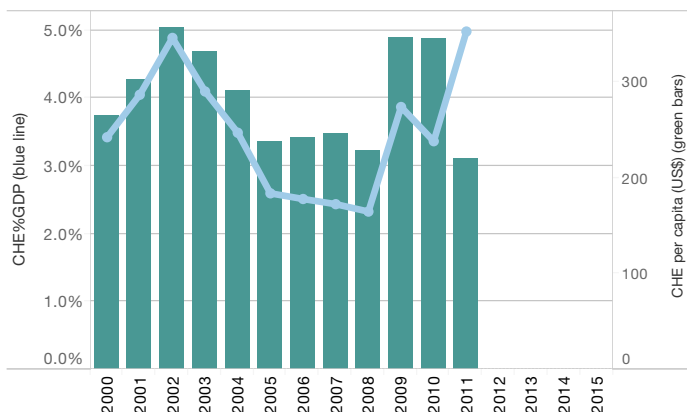


Fig. 10.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

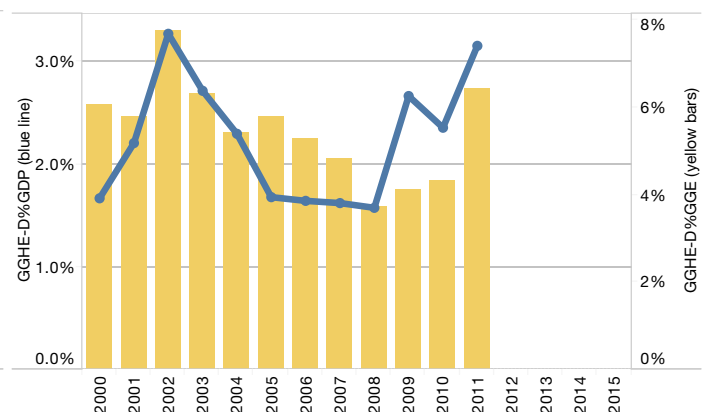


Fig. 10.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

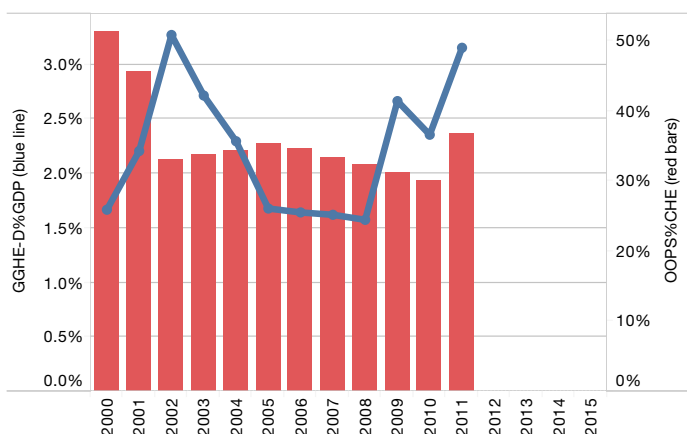


Fig. 10.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

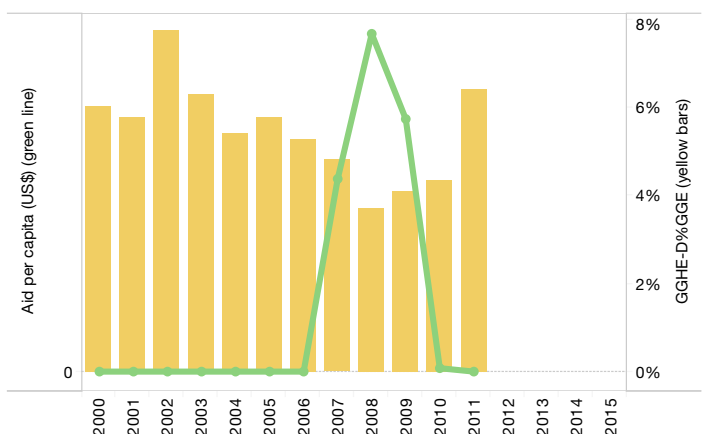


Fig. 10.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

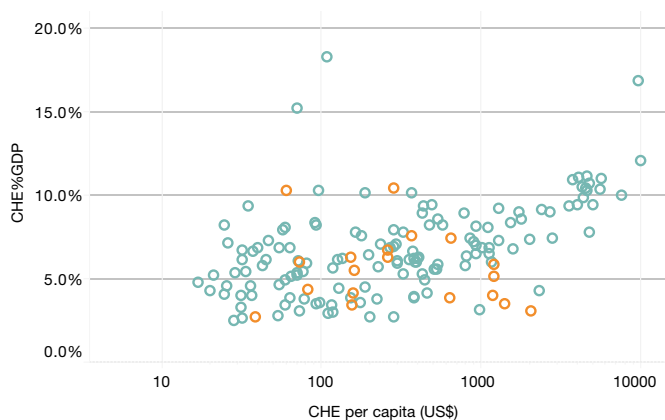


Fig. 10.7. Current health expenditure as a percentage of GDP and per capita (US\$)

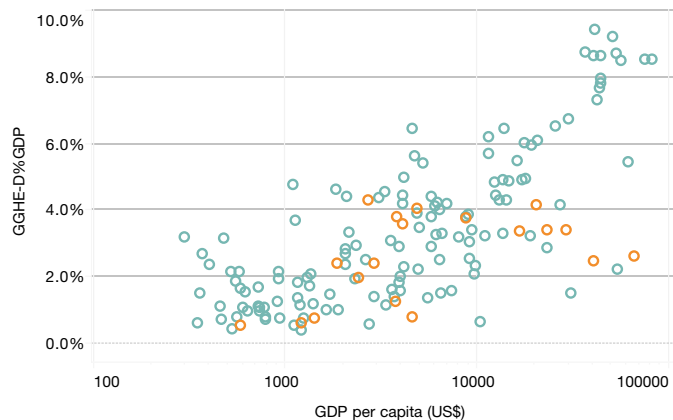


Fig. 10.8. Government health expenditure as a percentage of GDP and per capita (US\$)

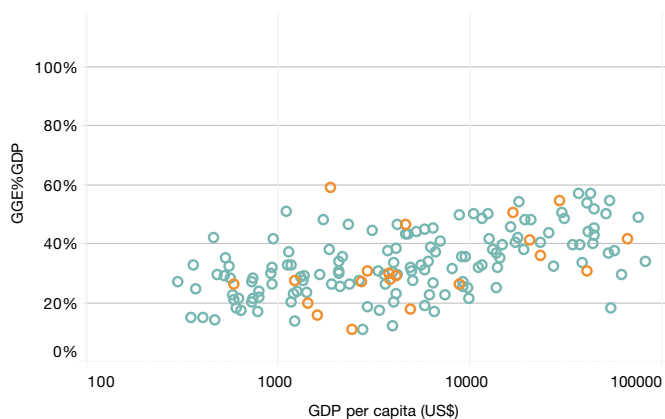


Fig. 10.9. Fiscal space and GDP per capita (US\$)

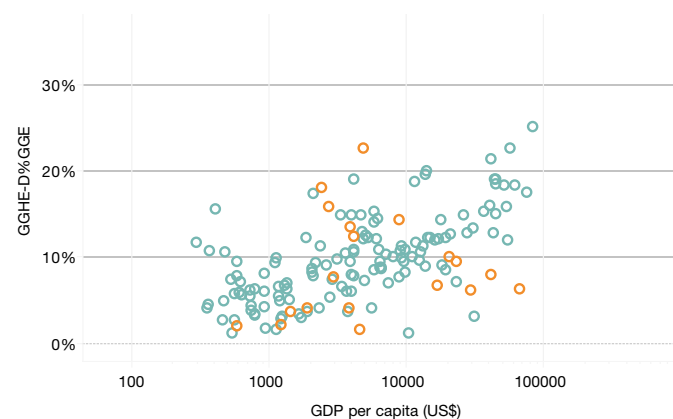


Fig. 10.10. Health prioritization and GDP per capita (US\$)

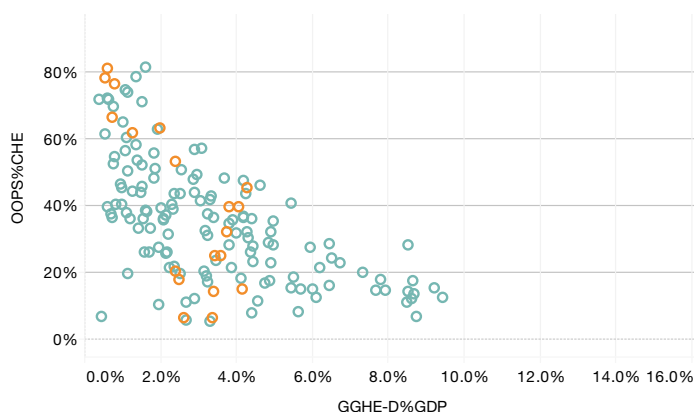


Fig. 10.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

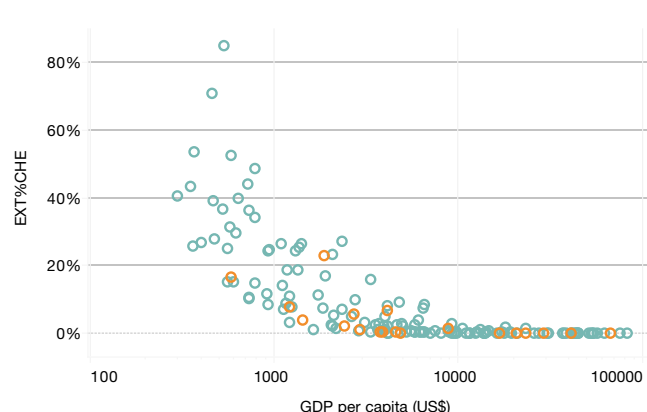


Fig. 10.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

11. Morocco

1. Macroeconomics

Following low economic performance in 2016, strong recovery in agricultural production is expected to boost economic growth. Meanwhile, Morocco continues to face challenges related to the education sector, employment, and inflation. Efforts are being made to maintain fiscal alignment within the overall government budget and to ensure specific key programme targets are met in terms of their expenditures and revenues. In 2016, GDP was US\$ 101.4 billion, resulting in a GDP per capita of US\$ 2832. General government expenditures stood at US\$ 31.065 billion in 2015, constituting 30.6% of GDP. The poverty rate at the national poverty line fell gradually from 16.3% in 1998 to 4.2% in 2014.

2. Health financing architecture

Overall responsibility in the health system for both public and private sectors lies within the Ministry of Health. In recent years, the Moroccan health financing system has undergone many changes. In 2002, Law 65-00 guaranteed basic medical coverage for all. Accordingly, in 2005, Morocco initiated a health financing system transformation process to ensure access to health care without financial difficulties. Subsequently, Article 31 of the 2011 Constitution emphasized the right to health care, social protection and medical coverage for all citizens. The two main public financing schemes are the Mandatory Health Insurance scheme and the Medical Assistance Scheme. The Mandatory Health Insurance scheme is operated by two agencies: the National Fund of Social Welfare Organizations and the National Social Security Fund. In addition, there are around 30 independent funds – *Mutuelles* – covering selected population groups. To ensure proper supervision and adequate regulation of the various prepayment schemes, the National Agency of Health was established in 2005. At present, this agency also collects the annual contributions from beneficiaries of the Medical Assistance Scheme who are eligible for payments. Budget transferred from the Ministry of Finance on behalf of the Medical Assistance Scheme is directly channeled to the Ministry of Health. Private financing agents are primarily households and some voluntary schemes established for certain professions.

3. Revenue raising

The main sources of funding for health in Morocco are taxes, health insurance contributions, out-of-pocket payments, and to a lesser extent external funding. In 2011, a cohesion fund was established to support the health and education sectors. In 2015, per capita current health expenditure was US\$ 159.8, constituting 5.5% of GDP, with per capita private and general government health expenditures standing at US\$ 89 and US\$ 69, respectively. External funding did not exceed 1% of current health spending in 2015. The proportion of public spending on health from domestic sources in total public spending, which reflects the prioritization of the sector, was 7.7% in 2015.

4. Pooling

There is no unified single pool that ensures effective overall cross-subsidization between the various income groups in the country. Pooling is relatively fragmented among multiple funds, some of them operating separate pools. The National Fund of Social Welfare Organizations operates nine public-sector schemes, each covering a different category of civil servants, but all nine schemes are managed by one board, which acts like one pool. The National Social Security Fund manages a pool covering formal private sector workers. In addition, there are separate pools for around 30 independent funds – *Mutuelles* – which cover selected population groups, with legal provisions for integrating them into the National Social Security Fund within five years. The Medical Assistance Scheme does not have a separate fund, and its resources are pooled at Ministry of Finance level as part of general government revenue before being allocated to providers. The interdepartmental committee for health coverage is currently discussing the creation of an independent fund for The Medical Assistance Scheme. Private health insurance also covers a small part of the population. Domestic general government health expenditure constitutes 43.3% of current health expenditure, while voluntary health insurance as a share of current health expenditure was around 1.2% in 2015.

5. Purchasing

Law 65-00 obliges health insurance organizations to split purchasing from provision. Accordingly, the National Social Security Fund abandoned almost all of the clinics it owned, and from 2005 on began contracting with private and

public providers. Payment for hospitals is input-based and makes use of programme budgeting; however, there is a move towards output-based payments is planned. Article 11 of Law 65-00 envisioned payment for hospitals through capitation, global budget and a fee-for-service system. Payments in the private sector are on a fee-for-service basis, which constitute a heavy burden on public insurance schemes; private sector payments made up around 90% of these schemes' spending in 2013. Salaries are the main payment method for health workers in the public sector. Payments for services provided at public health facilities are directly made by the various health insurance schemes, while patients have to pay for private sector services themselves and ask for reimbursement – unless special approval is secured.

6. Benefits design

An essential package of health services is well-defined for the primary health care level, and includes vaccinations; treatment of diarrheal diseases and respiratory infections; pregnancy and postpartum care; prevention and treatment of sexually transmitted diseases; and tuberculosis care. All primary health care services are available in urban and rural areas free of charge. The National Social Security Fund and the National Fund of Social Welfare Organizations provide different benefit packages in practice, according to the insured group. The National Fund of Social Welfare Organizations provides its beneficiaries with a larger benefit package than that provided by the National Social Security Fund, and this also has different levels of reimbursement; for example, the National Fund of Social Welfare Organizations reimburses 100% of the cost of chronic diseases care, while the National Social Security Fund reimburses only 70% of these costs, while for inpatient care, the National Fund of Social Welfare Organizations reimburses 100% of the costs, in contrast to National Social Security Fund, which covers 90% of the costs. Private insurers generally offer larger benefit packages than the National Social Security Fund; however, benefits are often capped by the type of illness and per person, thus limiting overall benefits. The Medical Assistance Scheme offers a broad range of free services in principle, but limited availability in public hospitals leads to implicit rationing.

7. Population coverage

All Moroccans are eligible to receiving care at Ministry of Health facilities at subsidized rates. The impoverished are entitled to free care at public health facilities. This was initially done upon presentation of a Poverty Card – *certificat d'indigence* – which was then replaced by coverage by the Medical Assistance Scheme. In addition, around 62% of the population is covered under the Mandatory Health Insurance scheme, while 34% of the population are covered by both the National Social Security Fund and the National Fund of Social Welfare Organizations. In 2016, the Medical Assistance Scheme covered 9.7 million individuals (28% of the population) who were either impoverished or vulnerable. Private health insurance schemes and *Mutuelles* only cover a small part of the population.

8. Service coverage

All residents are eligible for free public primary health care services. Around 25% of the population currently live more than 10 km from a formal health centre. The number of hospitals increased from 52 in 1960 to 150 in 2017; however around 40% of the population face challenges accessing hospital care – moreover, four provinces do not have any hospitals. The Medical Assistance Scheme had contributed to increasing access for the impoverished and most vulnerable sections of the population. In 2015, the universal health coverage index of coverage of essential health services value for the country was 65.³⁴

9. Financial protection

Public insurance schemes have contributed to enhancing financial protection for all by focus on the impoverished and vulnerable sections of the population. However, most of the insured have to pay in advance to receive the services they need before being reimbursed, which imposes a burden on some individuals. In 2015, out-of-pocket payments as a share of current health expenditure stood at 53.1%. A 2017 health accounts study found that out-of-pocket payments as a share of current health expenditure had fallen to 50.7%, which is still high. These high out-of-pocket payments have been exposing a significant number of individuals to financial hardship and impoverishment. Accordingly, in 2006, 22.0% and 2.70% of individuals encountered catastrophic health expenditures at the 10% and 25% of household total consumption or income thresholds, respectively. In the same year, 3.18% and 0.63% of the population were pushed into poverty at the national poverty lines of US\$ 3.11 and 1.90 per day, respectively.

³⁴ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Morocco

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	1 771	2 125	2 555	2 890
CHE per capita (US\$)	70	101	150	160
GGHE-D%CHE	25	26	40	43
OOPS%CHE	54	59	56	53
GGHE-D%GDP	1.0	1.2	2.3	2.4
GGE%GDP	25	31	31	31
GGHE-D%GGE	4	4	8	8
Population	28 849 622	30 521 070	32 409 640	34 803 320

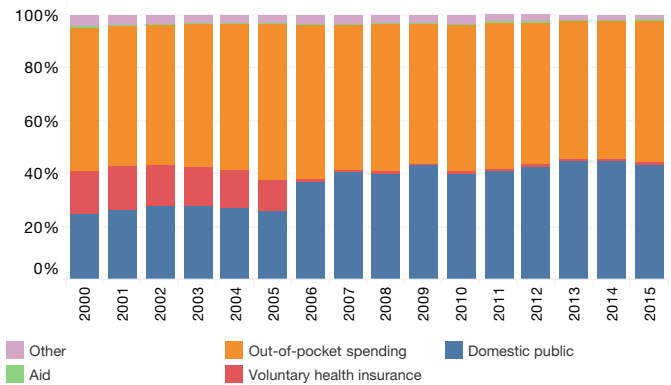


Fig. 11.1. Key health financing and expenditure indicators, 2000–2015

Fig. 11.2. Revenue sources

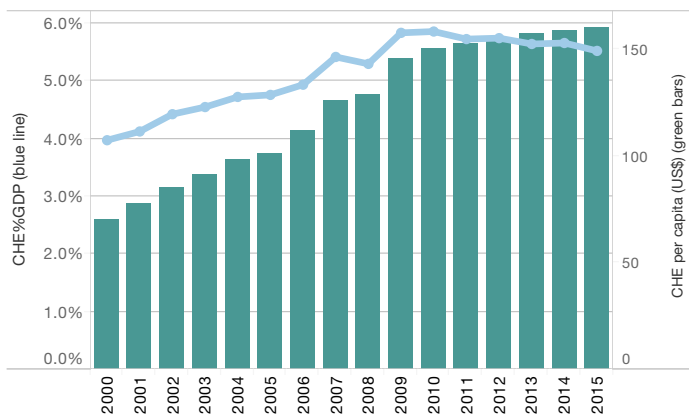


Fig. 11.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

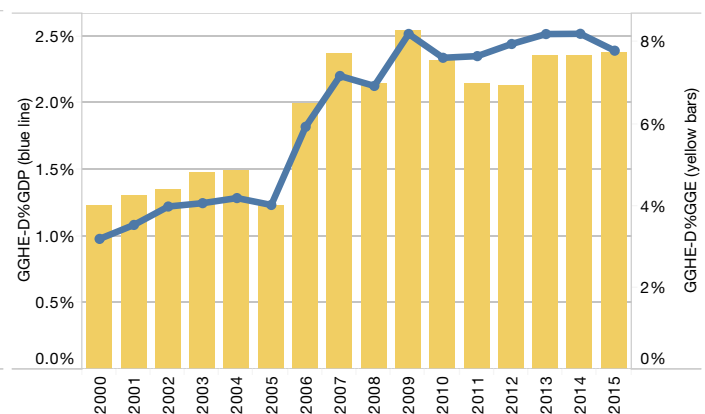


Fig. 11.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

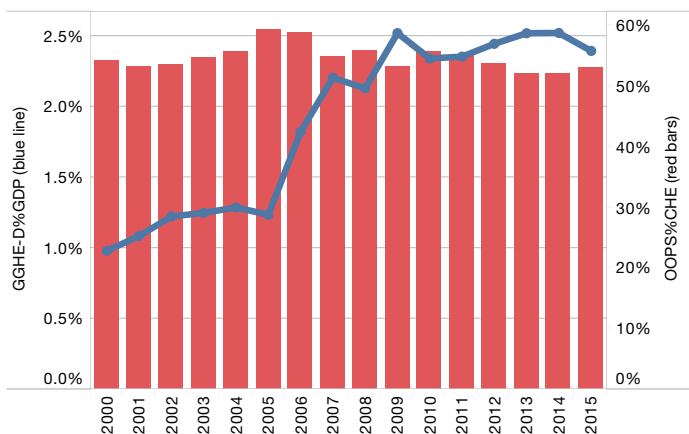


Fig. 11.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

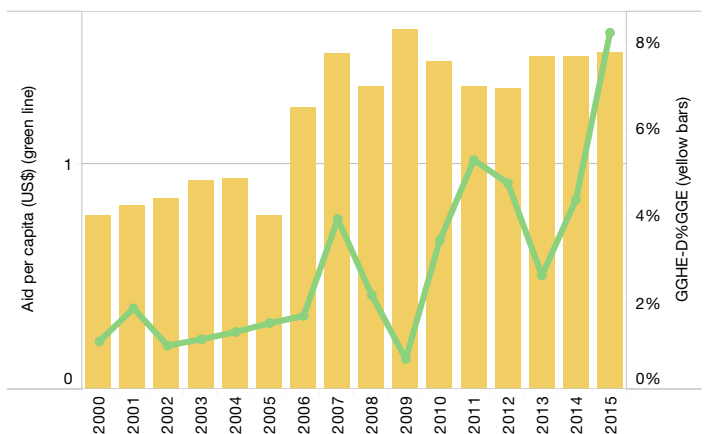


Fig. 11.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

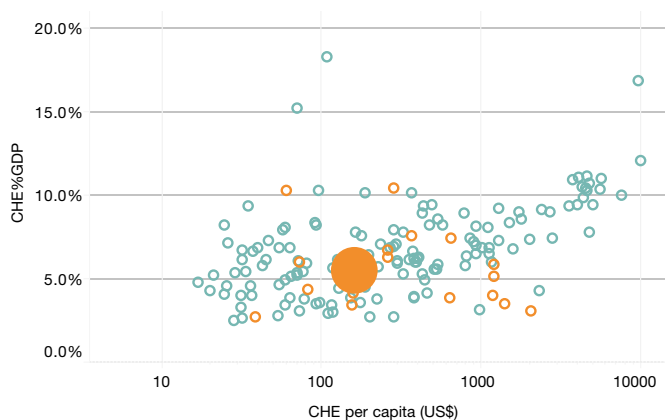


Fig. 11.7. Current health expenditure as a percentage of GDP and per capita (US\$)

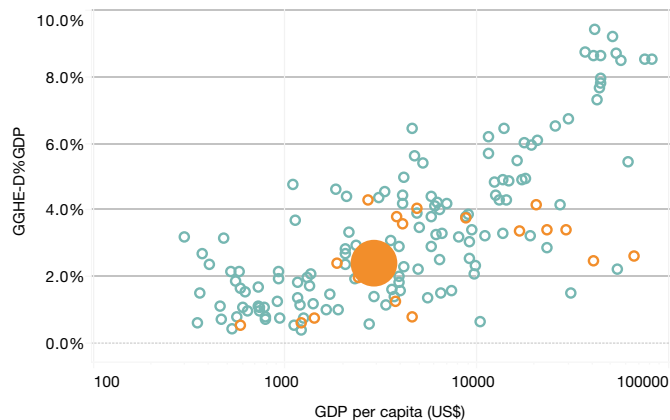


Fig. 11.8. Government health expenditure as a percentage of GDP and per capita (US\$)

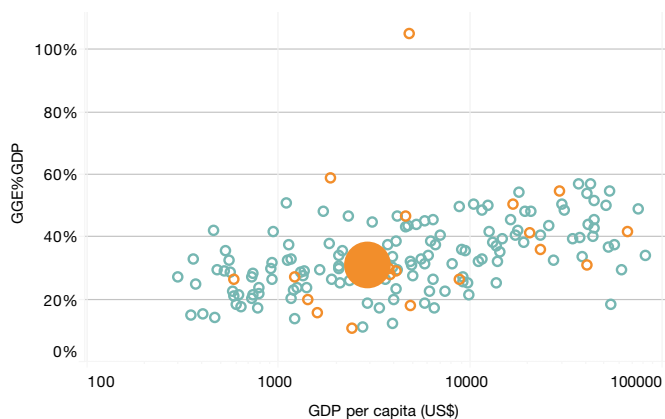


Fig. 11.9. Fiscal space and GDP per capita (US\$)

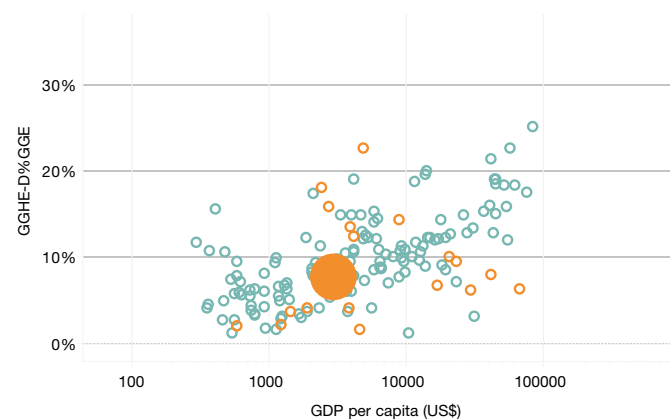


Fig. 11.10. Health prioritization and GDP per capita (US\$)

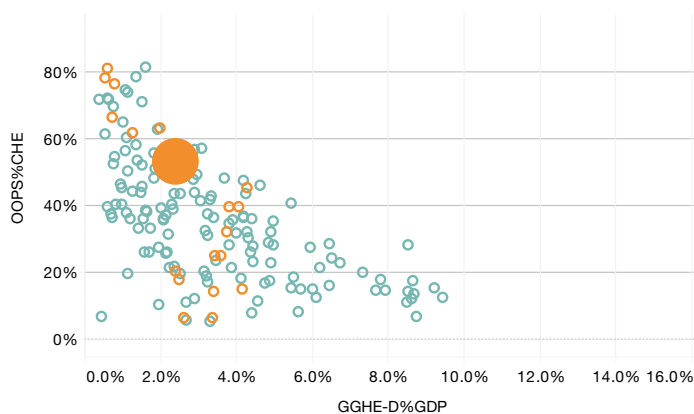


Fig. 11.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

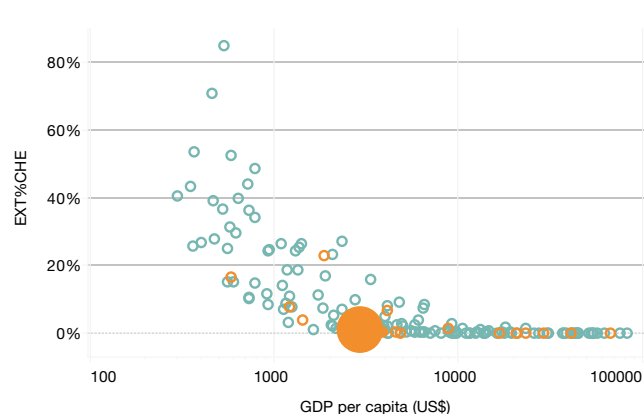


Fig. 11.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

12. Occupied Palestinian territory

1. Macroeconomics

The Palestinian economy is affected by chronic conflict and political instability. In 2013, the occupied Palestinian territory slipped into recession. This was mitigated by reconstruction efforts which contributed to increasing GDP to US\$ 13.426 billion in 2016, representing a 6% growth in that year.³⁵ Nevertheless, 29.2% of the population were living below the national poverty line in 2017. In 2016, general government expenditure as a share of GDP was 26.4%.

2. Health financing architecture

Several entities are involved in financing and managing the health sector, including: several ministries, for example, the Ministry of Health, the Ministry of Finance, the Ministry of the Interior, the Ministry of Social Development and the Ministry of Prisoners' Affairs; nongovernmental organizations and civil society organizations; the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA); insurance companies; and households. The Ministry of Health is responsible for governing and regulating the entire health sector to ensure effective collaboration and appropriate use of health resources. The Ministry of Health manages the Government Health Insurance scheme, and centrally directs and finances public health services.

3. Revenue raising

In 2016, current health expenditure stood at US\$ 1.420 billion,³⁶ with total health expenditure as a share of GDP reaching 10.7%. All public revenues originating from taxes and Government Health Insurance contributions and copayments are transferred to the Ministry of Finance, which defines the Ministry of Health budget based on historical allocations without taking collected revenues into consideration. External donors play an important role in funding the health sector – their contribution is estimated at 14%, which remains unpredictable. This has resulted in a high share of private health expenditure (45.5%). In 2016, general government expenditure as a share of GDP was 26.4%,³⁷ while general government health expenditure as a share of general government expenditure was 10.8%. Inadequate financial resources for health constitute a clear obstacle for the development of the health sector.

4. Pooling

The Government Health Insurance scheme is the main public health insurance scheme in Palestine. It is compulsory for all public sector employees and retirees and their families. It also covers impoverished families and unemployed individuals and their dependents, as well as families of prisoners in Israel through special budget transfers. It also acts as voluntary insurance provider for the rest of the population. Voluntary enrollment guarantees instant access to the scheme's benefit package, infringing risk pooling by increasing the risk of adverse selection. Revenues collected from the scheme's premiums and copayments are collected by the Ministry of Health and transferred and pooled at Ministry of Finance level. Several additional pools exist under grouped participation within trade unions. Funds from external donors are distributed among the Ministry of Health/the Government Health Insurance scheme, UNRWA and nongovernmental organization and civil society organization health service providers. General government health expenditure as a share of current health expenditure stood at 38.2% in 2016. The government has been taking corrective measures to overcome Government Health Insurance financial imbalances and administrative weaknesses.

5. Purchasing

The Ministry of Health directly provides primary, secondary and tertiary health care services and purchases unavailable tertiary care from other domestic or international providers through special contracts. UNRWA also directly provides primary health care services for refugees and purchases selected secondary and tertiary care from nongovernmental organizations and private providers. Private insurance schemes purchase services from private

³⁵ Palestinian Central Bureau of Statistics. State of Palestine: 2018; Palestinian Health Accounts. Ramallah: 2016.

³⁶ Palestinian Health Accounts. Ramallah: 2016, 2018.

³⁷ Palestine: GDP, current US dollars. In: TheGlobalEconomy.com [website]. 2018 (https://www.theglobaleconomy.com/Palestine/Government_size/, accessed 26 July 2018).

providers and nongovernmental organizations. Purchasing is in general passive. Public hospitals and primary health care centres are paid using a line-item budget method, with providers being paid in salaries. Salaries account for a large share of the Ministry of Health budget and do not take individual performance into account. A fee-for-service method is used to pay other domestic and international providers, but a shift towards using some form of diagnosis-related groups is currently being considered. Medicines are purchased using tenders from local and international manufacturers and importers. Salaries have not been regularly paid due to dependency on irregular external funding.

6. Benefits design

The entire population is entitled, irrespective of insurance or refugee status, to immunizations, prenatal and postnatal care, preventive and curative care for children until the age of five, preventive services, and mental health services, with no patient cost sharing. The Government Health Insurance scheme provides the insured population with a comprehensive benefit package through Ministry of Health primary, secondary and tertiary care facilities, with minimal co-payments and limited exemption for some categories. UNRWA provides free comprehensive primary care services, and secondary care with copayment. In recent years, the economic recession has curbed the packages provided by private insurance schemes.

7. Population coverage

According to the 2017 census conducted by the Palestinian Central Bureau of Statistics, 78.3% of the Palestinian population are currently covered by some form of prepayment – with over 81.4% being covered by the Government Health Insurance scheme or UNRWA. Government Health Insurance coverage increased significantly between 1995 and 2000. From 2000 on, with the start of the Second Intifada, thousands of families were provided with free insurance coverage to protect them in the deteriorating situation. UNRWA covers 3.5 million individuals – including almost 70% of the population of the Gaza Strip. Several special groups are covered under the Government Health Insurance scheme, including: the unemployed sponsored by the Ministry of Labour; the impoverished sponsored by the Ministry of Social Affairs; and Israeli detainees and their families sponsored by the Commission of Detainees' and Ex-Detainees' Affairs. At present the entire population of the Gaza Strip is covered by the Government Health Insurance scheme free of charge. Private insurance schemes cover around 2% of the population – mainly those working at private firms in the West Bank. The voluntary Jamiyaat insurance covers around 1% of the population. Palestinians living in East Jerusalem are mandated to be enrolled in Israeli health insurance programmes. Duplication of coverage is common, resulting in wastage of scarce resources. In 2017, 28.6% of the population were simultaneously covered by the Government Health Insurance scheme and UNRWA.

8. Service coverage

There are five major health service providers in the occupied Palestinian territory – the Ministry of Health, the Military Medical Services, UNRWA, nongovernmental organizations, and private for-profit providers. The Ministry of Health manages 27 hospitals with a total of 3325 beds, and 466 primary health care centres, constituting 54% of the total national number of beds and 63% of the total national number of primary health care centres. The Military Medical Services operates 20 primary health care centres and 3 hospitals with a total number of 161 beds. Nongovernmental organizations operate around 34 hospitals with a total of 2061 beds, and 189 primary health care centres, while the private sector runs 16 hospitals with a total of 536 beds. UNRWA focuses primarily on primary health care services and operates 64 primary health care centres and only one hospital with a total of 63 beds in the West Bank. In 2014, about 74% of eligible refugees utilized UNRWA's health services. According to health service delivery data, between 2010 and 2016, the number of primary health care centres increased from 706 to 739, and the number of hospital beds per 10 000 population increased from 12.6 to 12.8 in 2016. The Ministry of Health is currently working on implementing a people-centred approach that focuses on the family practice model as a means to improve the integration of primary and secondary health care services to ensure progress towards universal health coverage.

9. Financial protection

In 2016, out-of-pocket payments constituted around 45.5% of total health expenditure. In the last two decades, the percentage of households facing financial hardship and impoverishment due to high out-of-pocket spending on health has increased considerably. A study conducted in 2009 estimated that 1% of the population faced catastrophic expenditures on health due to out-of-pocket payments, while around 0.8% were pushed into poverty. During this period, unpredictable donor funding has been negatively affecting public financing and has increased reliance on out-of-pocket payments, particularly among the rural population and refugees.

Health expenditure profile

Occupied Palestinian territory

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	1 421	1 377	2 202	2 707
CHE per capita (US\$)	127	159	265	282
GGHE-D%CHE	33	38	36	41
OOPS%CHE	40	34	41	46
GGHE-D%GDP	2.9	4.4	4.4	4.3
GGE%GDP	25	28	28	27
GGHE-D%GGE	11	16	16	16
Population	3 035 000	3 508 000	4 048 000	4 682 000

Fig. 12.1. Key health financing and expenditure indicators, 2000–2015

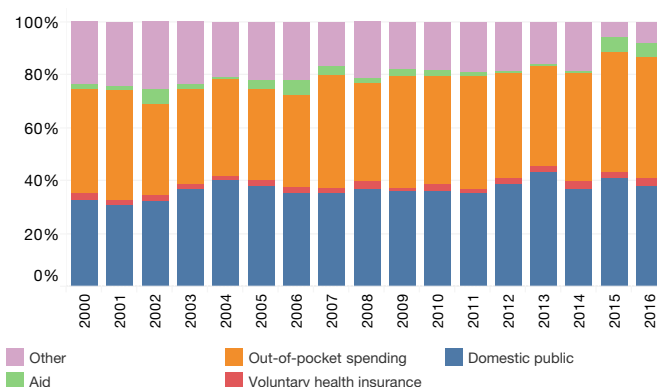


Fig. 12.2. Revenue sources

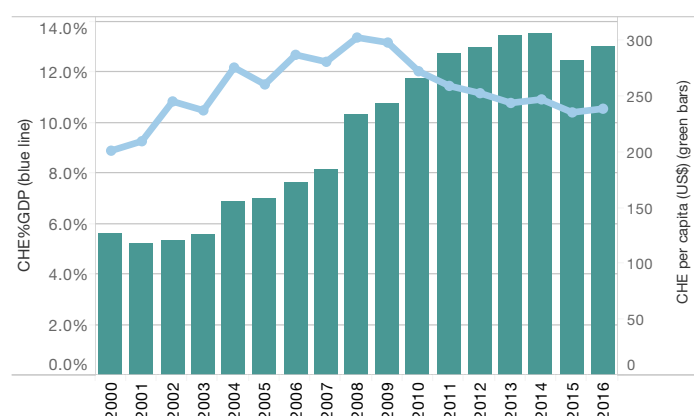


Fig. 12.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

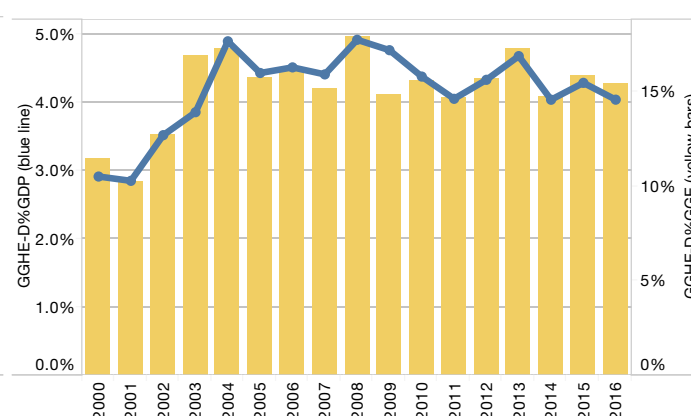


Fig. 12.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

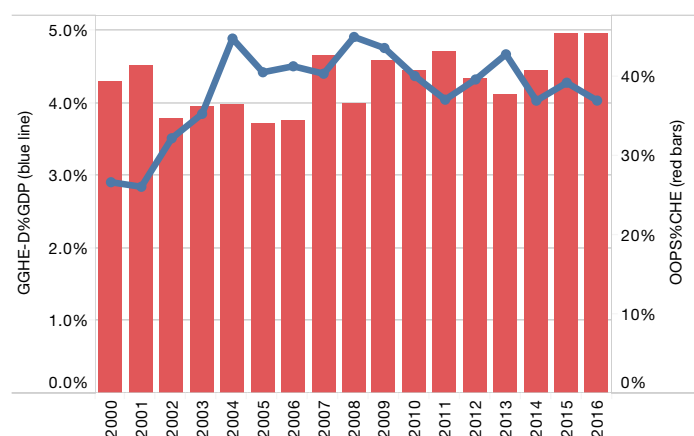


Fig. 12.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

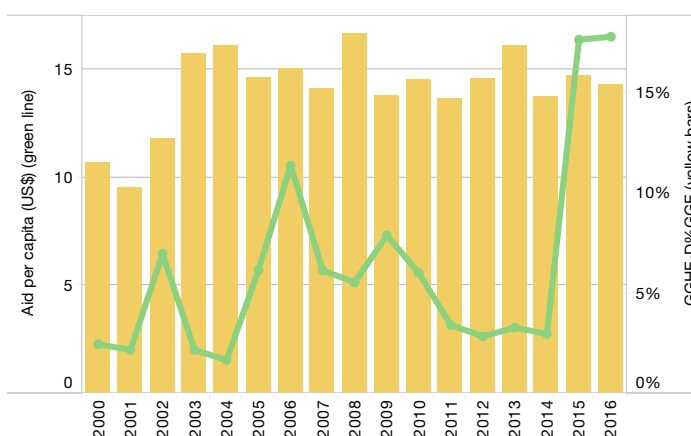


Fig. 12.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

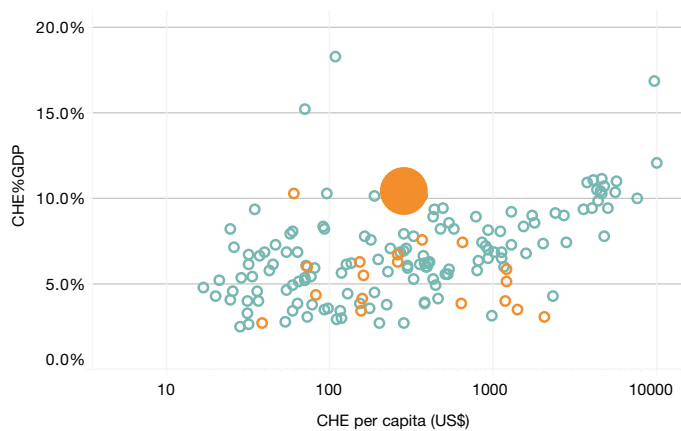


Fig. 12.7. Current health expenditure as a percentage of GDP and per capita (US\$)

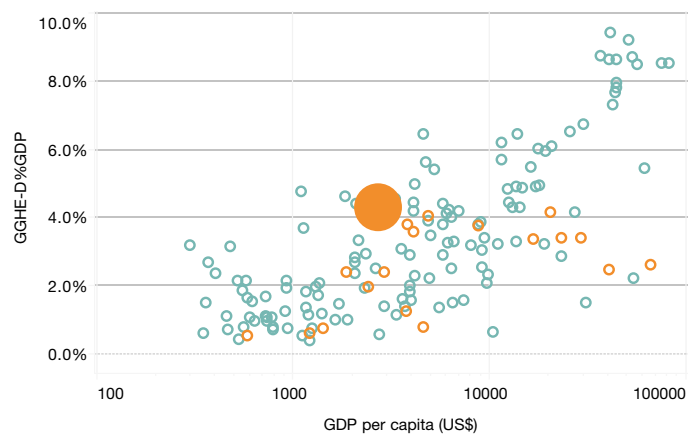


Fig. 12.8. Government health expenditure as a percentage of GDP and per capita (US\$)

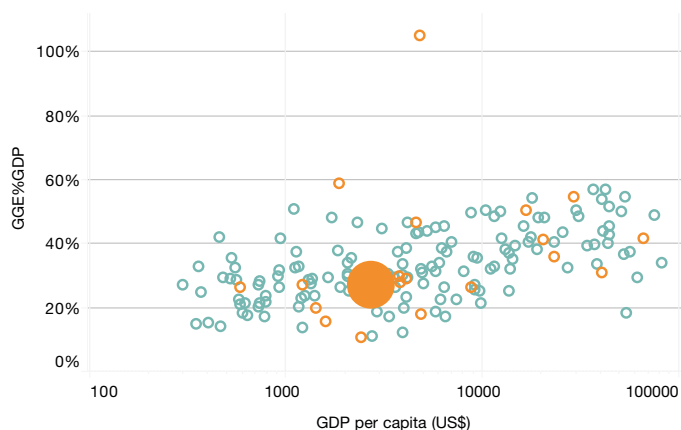


Fig. 12.9. Fiscal space and GDP per capita (US\$)

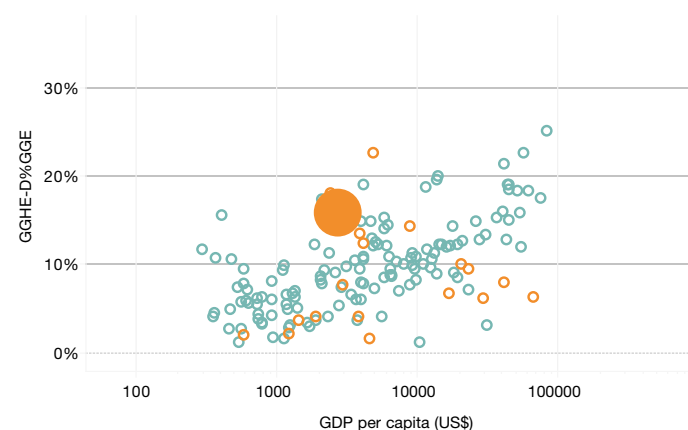


Fig. 12.10. Health prioritization and GDP per capita (US\$)

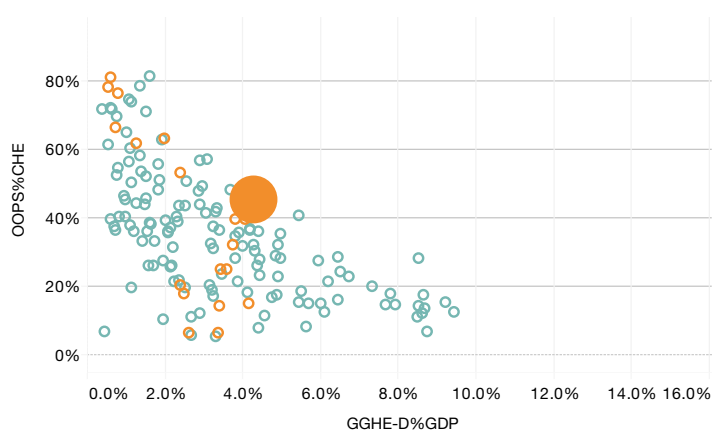


Fig. 12.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

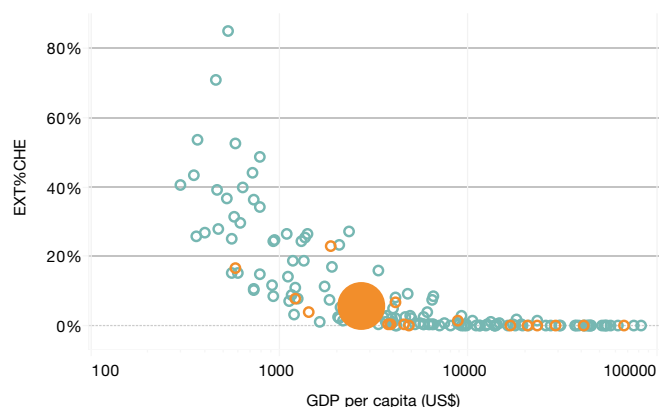


Fig. 12.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

13. Oman

1. Macroeconomics

Reduction in oil production together with low oil prices and financial deficits have placed the economy in fairly weak position in recent years. Real GDP growth in Oman has been falling over the past few years, and a reduction of 14% was observed in 2015, resulting in a GDP per capita of US\$ 16 627 in 2015. It is expected that growth will pick up following a rise in oil prices, and improvements in other sectors stemming from the government's economic diversification programmes. In 2015, general government expenditure constituted 51% of GDP, amounting to US\$ 35.3 billion – with around 70% of government revenues coming from oil and gas. The level of poverty in Oman is not well defined, but 20% of Omani households have been found to spend less than the national average.

2. Health financing architecture

The Ministry of Health is the steward of the health sector and the entity responsible for formulating national health policies and plans, as well as monitoring their implementation. In 2014, the Health Vision 2050 report was launched by the Ministry of Health to describe the features of the health system, including the health financing system, in the year 2050. The government continues to be the main financing agent in the health sector, with the Ministry of Health budget being allocated by the Ministry of Finance to primarily cover the cost of various health system inputs such as salaries, infrastructure, medicines and supplies. Private health insurance companies and households constitute additional private financing agents; however, they play a lesser role in financing health care.

3. Revenue raising

Although current health expenditure as a share of GDP was stagnant from 2010 to 2014, at around 2.7%, it increased to 3.8% in 2015 – resulting in a per capita current health expenditure of US\$ 636, which is lower than in other member countries of the Gulf Cooperation Council and countries with a similar level of economic development. The main source of public funds in the health sector is general government revenue, in addition to small contributions from insurance against car accidents and social security taxes on private sector employees. Domestic general government health expenditure as a share of general government expenditure – a measure of the level of health sector prioritization – was 6.7% in 2015, corresponding to US\$ 562 per capita. Per capita domestic private health expenditure was US\$ 75 in 2015, mainly originating from premiums paid to private health insurance companies and minimal cost-sharing paid for annual file registration and charges on outpatient visits, in addition to out-of-pocket payments. Oman receives almost no external support from donors.

4. Pooling

At present, pooling primarily takes place at the level of the Ministry of Finance, which is responsible for collecting all government revenues. The Health Vision 2050 report indicated that a national health insurance programme would be established to pool all health funds from various sources and guarantee access to quality health care for all individuals. Domestic general government health expenditure as percentage of current health expenditure was 88.2% in 2015. Voluntary health insurance exists; however, it is not adequately regulated and at present accounts for only 3.3% of current health expenditure. Major private companies provide health insurance for their employees and their dependents through various private insurance companies, creating parallel pools.

5. Purchasing

There is no purchaser-provider split in Oman, as the Ministry of Health is the main purchaser and provider of all services. The mission of the Ministry of Health Purchasing and Supply Directorate is to supply public hospitals with consumables, medical equipment and services. It has been found that 80% of the Ministry of Health budget is absorbed by salaries, while less than 10% is being spent on medicines.

6. Benefits design

The Ministry of Health is committed to the Health for All goal, and aims to provide a comprehensive package of health services for the whole population of the country based on primary health care, including promotive, preventive,

curative and rehabilitative care. In an attempt to rationalize costs, some benefits that are not proven to be cost-effective, such as dentures and cosmetic plastic surgery, are not part of the public package and can be purchased from the private sector upon personal request.

7. Population coverage

The Government is committed to providing nearly free health care to all citizens and non-nationals (expatriates) employed by the government, with small copayments for each health facility visit. Expatriates working in the private sector are covered by the private health sector in exchange for fees; where services required are not available in the private sector, government health services can be used. Private companies mostly cover their employees and their dependents through private health insurance as a part of their compensation package.

8. Service coverage

Health services are mainly provided by the Ministry of Health, which manages its own hospitals and health facilities at the national, regional, and local levels. The government is responsible for around 74% of hospitals and 90% of hospital beds. Ministry of Health services are almost universally accessible and nearly free of charge. Tertiary care is provided through four specialized Ministry of Health referral hospitals. Other entities such as the Armed Forces Medical Services, the Medical Services for the Royal Oman Police, the Petroleum Development Oman Medical Services and Sultan Qaboos University Hospital, are also involved in providing curative services. Mobile medical teams are also available and provide health care for 2% of the population living in remote areas. In cases where a particular service is unavailable, the government can offer coverage for treatment abroad. There is a rapidly growing private sector, which aims to cater for the needs of expatriates; however, an increasing number of Omanis are also using private sector services. In 2015, the universal health coverage index of coverage of essential health services value for the country was 72, which is among the highest in the world.³⁸ The recent decrease in the Ministry of Health budget is threatening the capacity of the public health sector, with some Ministry of Health facilities already suffering from a shortage of some medicines and doctors and nurses, as these medical professionals leave the public sector or move to nearby countries.

9. Financial protection

In 2015, out-of-pocket payments as a share of current health expenditure was 6.4%, which is one of the lowest rates among the member countries of the Gulf Cooperation Council and in many cases better than European rates, and which is expected to be associated with a very low risk of financial hardship. In 1999, 0.63 % and 0.10% of the population faced catastrophic expenditures at the 10% and 25% of household total consumption or income thresholds, respectively.³⁹ More recently, in 2008, when out-of-pocket payments reached 12.4% of current health expenditure, it was found that 2.6% and 1% of the population face catastrophic expenditures at the 10% and 25% of household total consumption or income thresholds,⁴⁰ respectively.

³⁸ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

³⁹ Ibid

⁴⁰ Omani Ministry of Health sources.

Health expenditure profile

Oman

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	18 158	17 076	18 779	16 627
CHE per capita (US\$)	558	444	515	636
GGHE-D%CHE	82	82	83	88
OOPS%CHE	12	11	10	6
GGHE-D%GDP	2.5	2.1	2.3	3.4
GGE%GDP	36	35	34	51
GGHE-D%GGE	7	6	7	7
Population	2 267 991	2 511 269	3 041 460	4 199 810

Fig. 13.1. Key health financing and expenditure indicators, 2000–2015

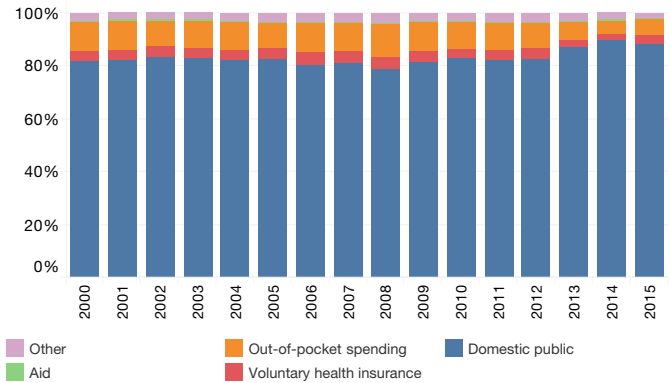


Fig. 13.2. Revenue sources

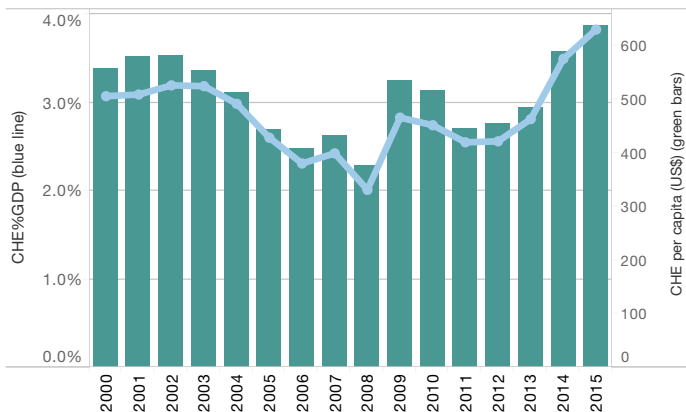


Fig. 13.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

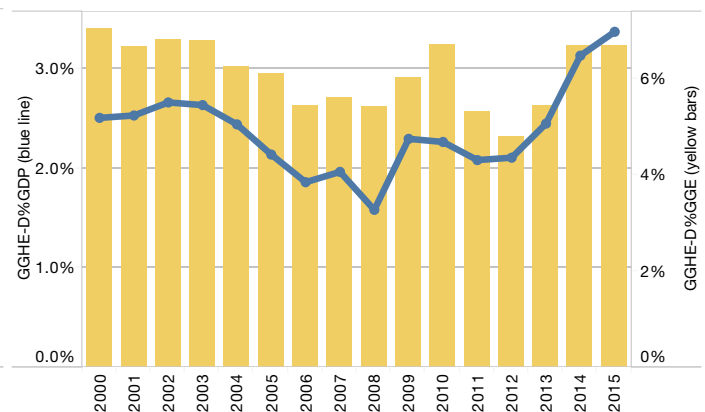


Fig. 13.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

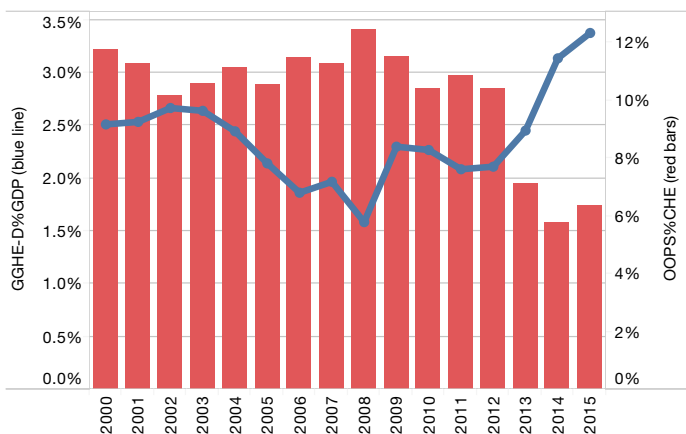


Fig. 13.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

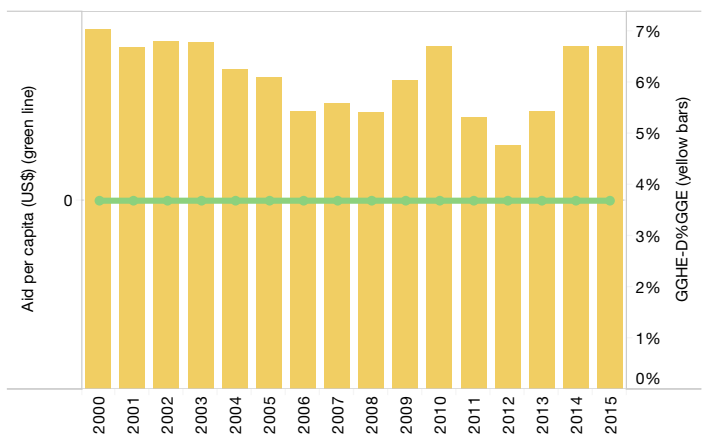


Fig. 13.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

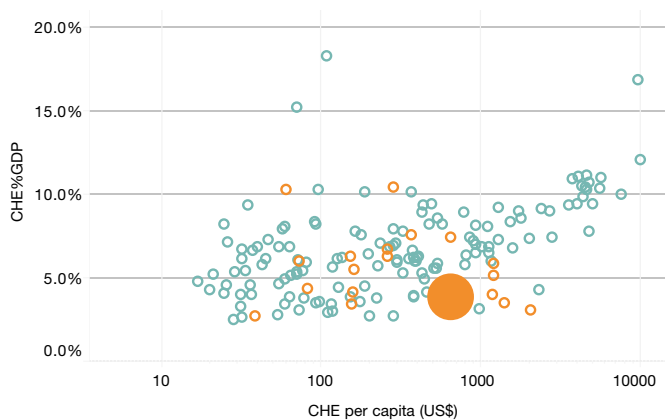


Fig. 13.7. Current health expenditure as a percentage of GDP and per capita (US\$)

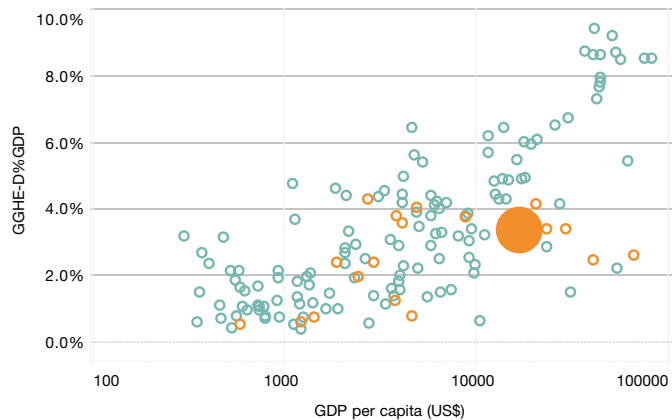


Fig. 13.8. Government health expenditure as a percentage of GDP and per capita (US\$)

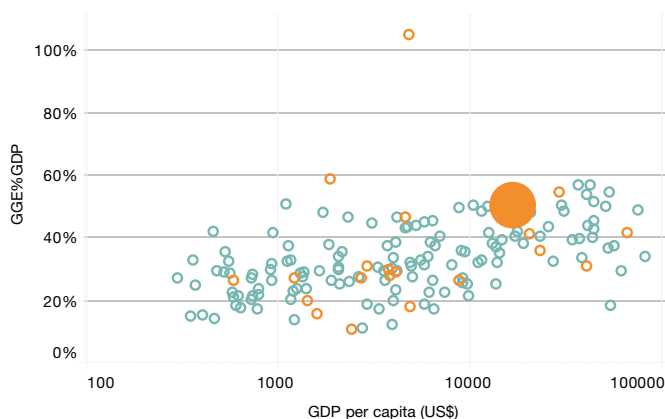


Fig. 13.9. Fiscal space and GDP per capita (US\$)

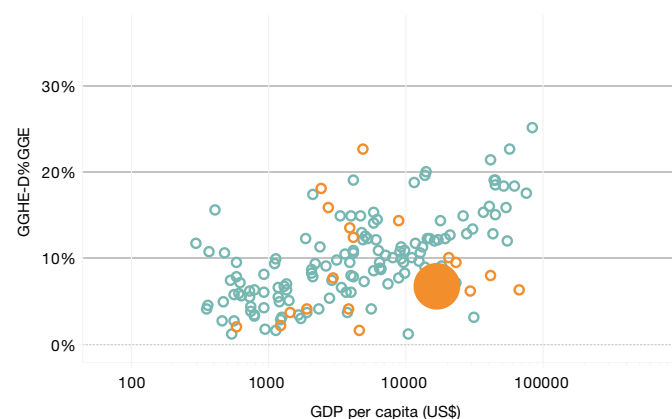


Fig. 13.10. Health prioritization and GDP per capita (US\$)

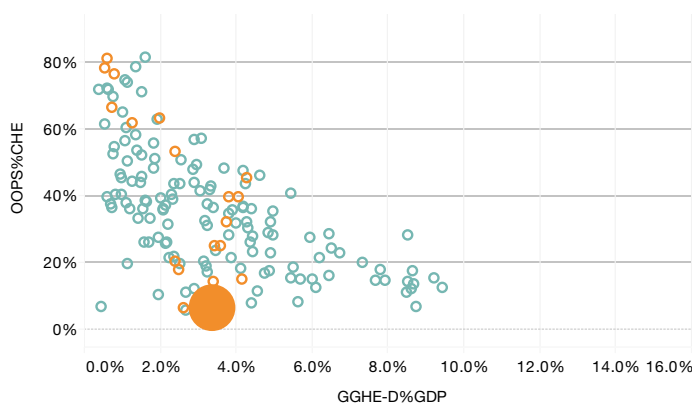


Fig. 13.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

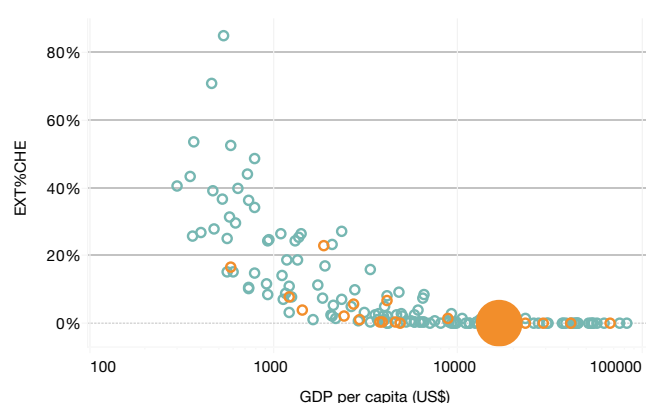


Fig. 13.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

14. Pakistan

1. Macroeconomics

Pakistan is the fifth most populous country in the world. Pakistan's macroeconomic outlook is promising due to structural reforms, improved energy availability and investments on the China–Pakistan Economic Corridor. The poverty rate at the national poverty line fell progressively from 50.4% in 2005–2006 to 24.3% in 2015–2016.⁴¹ GDP amounted to US\$ 267.5 billion in 2015, constituting a GDP per capita of US\$ 1413, shifting Pakistan from low-income to lower-middle income status. Pakistan has one of the lowest taxation rates of around 15% of GDP. In 2015, its general government expenditure reached US\$ 52.8 billion, constituting 19.7% of GDP.

2. Health financing architecture

Pakistan has a federal system where different levels of authority manage and fund different public programmes, with a certain degree of overlap. In 2011, a constitutional amendment resulted in the devolution of the health sector from the federal to the provincial level, shaping the current architecture of the health financing system. Public health financing agents include: (a) federal government and its related ministries: the Ministry of National Health Services, Regulation and Coordination, and the Ministry of Defense; (b) provincial governments; (c) district governments; and (d) social assistance and protection schemes, targeting the impoverished and implemented either separately or jointly by federal and provincial authorities. The social assistance and protection schemes include: the Prime Minister National Health Programme, operated by the State Life Insurance public insurance company; the Pakistan Bait ul Mal scheme; the Employees Social Security Institutions scheme; the Zakat fund; the Sehat Sahulat Programme of Khyber Pakhtunkhwa Province, also operated by the State Life Insurance company; the Prime Minister National Health Programme-specific arrangement of Punjab Province, operated by the Punjab Health Initiative Management Company; and the Social Health Protection Initiative in Gilgit Baltistan Province. In addition, there are autonomous financing agents, such as Pakistan's Railways and the Water and Power Development Authority. Private financing agents are mainly households, private insurance companies, and some nongovernmental organizations.

3. Revenue raising

Taxation and household private payments are the main sources of revenue for health. Current health expenditure as a share of GDP was 2.7% in 2015, representing a per capita current health expenditure of US\$ 38.9 – out of which US\$ 26.1 came from domestic private expenditures. Per capita domestic general government health expenditure was US\$ 10.4 in 2015, constituting 4% of general government expenditure. External health expenditure accounted for only 3.8% of current health expenditure in 2015. Social security funds are sources of revenues for some social assistance programmes, and contributions of private employers are the main source of funds for the Employees Social Security Institutions scheme.

4. Pooling

The largest pool is part of overall general government revenue, whereby the Ministry of Finance allocates the health budget across the different levels of the government, that is, the federal, provincial and district levels, as well as between different government organizations. Domestic general government health expenditure constituted 27.5% of current health expenditure in 2015. Private insurance is another form of risk pooling, which however plays a minimal role – the share of voluntary health insurance in current health expenditure in 2015 amounted to only 0.6%. Different private schemes with separate pools are financed from specific sources to cover specific subpopulation groups, for example, the federally and provincially run and funded health programmes, recently launched to cover families living below the poverty line of US\$ 2 per person per day for selected health conditions (see above). In addition, the Employees Social Security Institutions scheme is a compulsory health insurance scheme with a pool funded by private employers, and is intended to cover all employees and their dependents working in companies employing more than 10 employees. Around 50 insurance companies also offer private health insurance coverage, and act as separate pools.

⁴¹ In 2016, the government adopted a new poverty line, setting a higher standard of living compared to the previous poverty line of 2001. Based on the Cost of Basic Needs method, the new poverty line is Pakistan Rupee 3032 per adult per month.

5. Purchasing

Purchasing of health services is fragmented – both horizontally and vertically. Purchasing and provision vary across the different schemes. The State Life Insurance company purchases services for its beneficiaries under the federal Prime Minister National Health Programme and the Sehat Sahulat Programme of Khyber Pakhtunkhwa Province. The Employees Social Security Institutions scheme and provincial and federal health systems directly provide their services using 12 000 facilities owned by the Federal and Provincial Health Ministries. Salaries are the main payment method for workers in the government and semi-government sectors as well as in autonomous bodies and nongovernmental organizations. In the private sector, profit-sharing mechanisms are combined with salaries, which create incentives for private-sector employment. The Prime Minister National Health Programme enrolls and contracts public and private providers with a recent initiative to introduce strategic purchasing, moving towards a purchaser–provider split. In addition, a few recent initiatives have used global budget transfer to private not-for-profit rural support organizations to manage primary health care centres and give more autonomy to large-scale hospitals. Federal government finances national vertical programmes at the provincial level. In the absence of needs-based resource allocation and strategic purchasing, the supply of health care is oriented towards secondary and tertiary care located in urban areas.

6. Benefits design

There is indiscriminate expansion of health care benefits, based on expert opinion and the influence of clinical practitioners. The government offers a benefit package through its facilities at primary, secondary and tertiary health care levels, free of charge, for all civil workers who have the choice of using services at public hospitals and clinics or those provided by social security health institutions and charity hospitals. The government also provides free preventive and primary health care services for all. The federal and provincial programmes under the Prime Minister National Health Programme cover all required hospitalization using a positive package of tertiary care – with an annual cap of Pakistan Rupee 250 000 (around US\$ 2150) per family – and a negative package of secondary care. The Employees Social Security Institutions scheme's package covers sickness, maternity and work injury care.

7. Population coverage

Every citizen is entitled to publicly provided health care, which is not well-defined. Federal and provincial health insurance programmes target families living below US\$ 2 per day, covering at present around 3.5 million impoverished families (around 20 million individuals) out of a target of around 14 million families (around 100 million individuals). The Employees Social Security Institutions scheme covers all employees working in entities with more than 10 employees. In addition, a small section of the population benefits from private insurance coverage. The Organizational and Institutional Set-Up of Health Financing Arrangements assessment, conducted in 2015, found that about 33% of the population is covered by the public system; less than 3.5% of employees are covered under the Employees Social Security Institutions scheme; and that individuals belonging to the informal sector are not covered.

8. Service coverage

Health service provision is managed by many actors, including the government, private social security schemes, nongovernmental organizations, and autonomous bodies. The government provides preventive and some curative services, while curative services are mainly provided by the private sector and nongovernmental organizations. It is estimated that around 80% of the population access curative health care from the private sector and 20% from the public sector. In addition, military health care services cover both soldiers and retired soldiers, and their families. There is at least one primary health care facility in every union council and one secondary care hospital in every district (*tehsil*). According to the Pakistan Bureau of Statistics, the public sector comprises 1167 hospitals, 5695 dispensaries, 5464 basic health units, 675 rural health centres, and 733 mother and child health centres. Individuals rely on large hospitals for their common health care needs, with those living in urban areas having easier access to hospitals than those living in rural areas. The universal health coverage index of coverage of essential health services value for the country is 40.⁴² There is no gatekeeping or referral note at the primary health care level to restrict patient flow to the secondary and tertiary levels of health care delivery. Pakistan recently initiated a pilot scheme to implement the family practice approach in 12 districts, before scaling it up nationally. This will help improve the quality of care at primary health care level and act as a gatekeeper for the higher levels of health care delivery.

⁴² Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

9. Financial protection

According to a World Bank survey on social protection in Pakistan conducted in 2007, 54% of all economic shocks faced by people were due to health-related expenses, and people coped with this by reducing food intake (33%), putting a child to work (10%) or pulling a child from school (8%). Evidence shows that the underfunded health system created unofficial payments to access public hospital services. Catastrophic health insurance is being provided in Pakistan via the Rural Support Networks. In 2015, out-of-pocket payments reached 66.5% of current health expenditure, pushing 2.44 % and 1% of the Pakistani population into poverty at the poverty lines of US\$ 3.11 and US\$ 1.90 per day, respectively. Moreover, 1.03% and 0.02% of the population face catastrophic health expenditures at the 10% and 25% of household total consumption or income thresholds,⁴³ respectively.

⁴³ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile Pakistan

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	1 052	1 208	1 289	1 413
CHE per capita (US\$)	32	35	33	38
GGHE-D%CHE	35	22	22	27
OOPS%CHE	62	71	70	66
GGHE-D%GDP	1.1	0.6	0.6	0.7
GGE%GDP	19	17	20	20
GGHE-D%GGE	6	4	3	4
Population	138 523 280	153 909 664	170 560 176	189 380 512

Fig. 14.1. Key health financing and expenditure indicators, 2000–2015

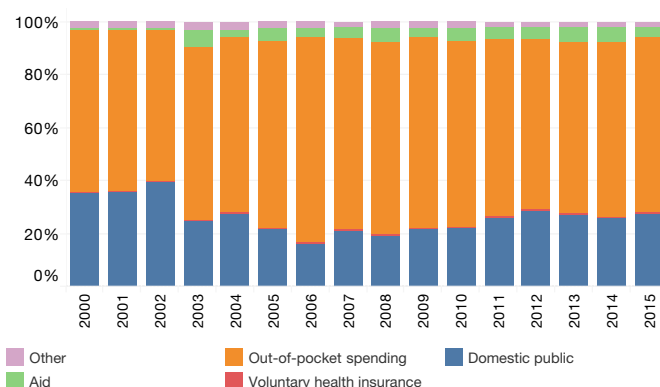


Fig. 14.2. Revenue sources

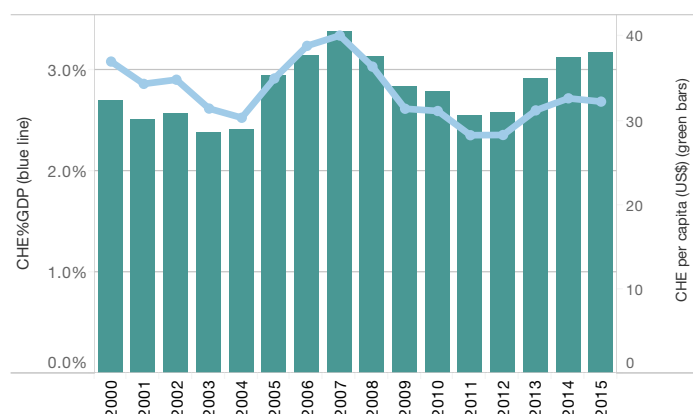


Fig. 14.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

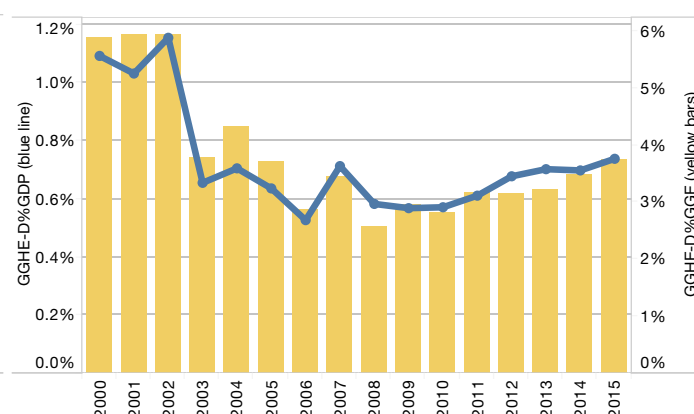


Fig. 14.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

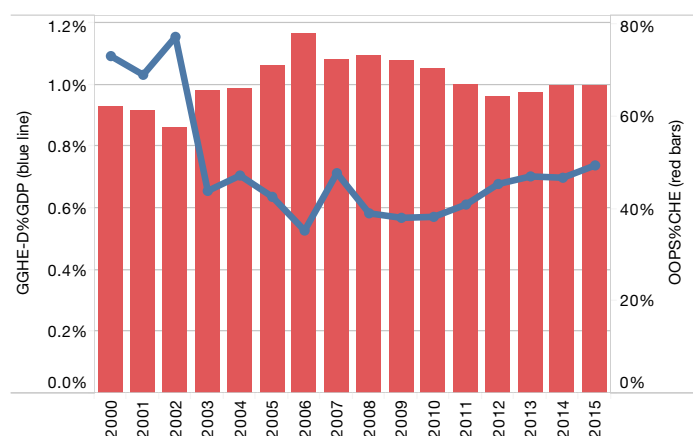


Fig. 14.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

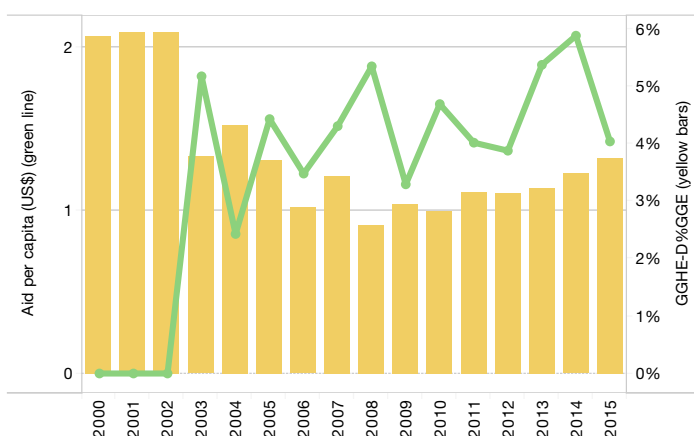


Fig. 14.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

Health expenditure profile Pakistan

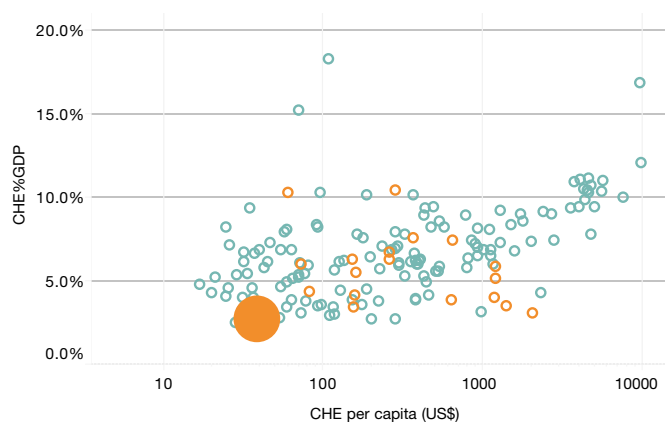


Fig. 14.7. Current health expenditure as a percentage of GDP and per capita (US\$)

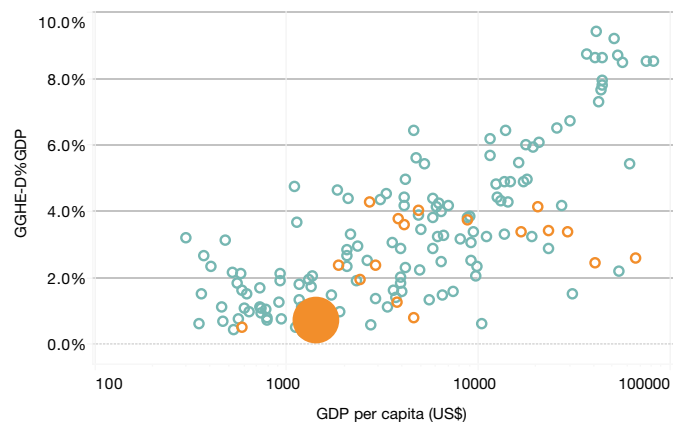


Fig. 14.8. Government health expenditure as a percentage of GDP and per capita (US\$)

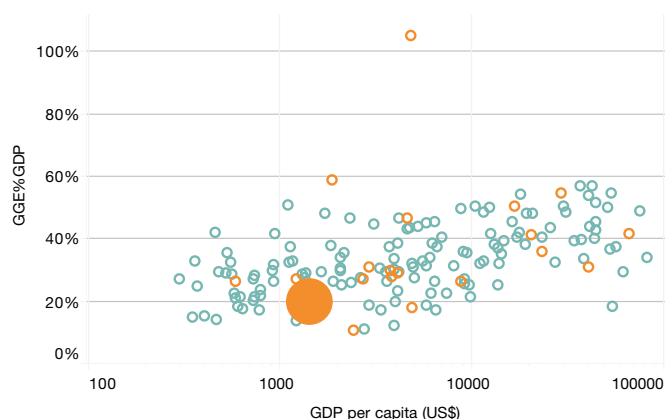


Fig. 14.9. Fiscal space and GDP per capita (US\$)

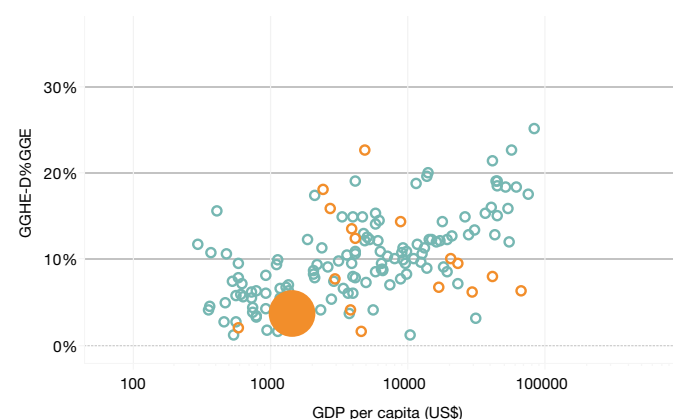


Fig. 14.10. Health prioritization and GDP per capita (US\$)



Fig. 14.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

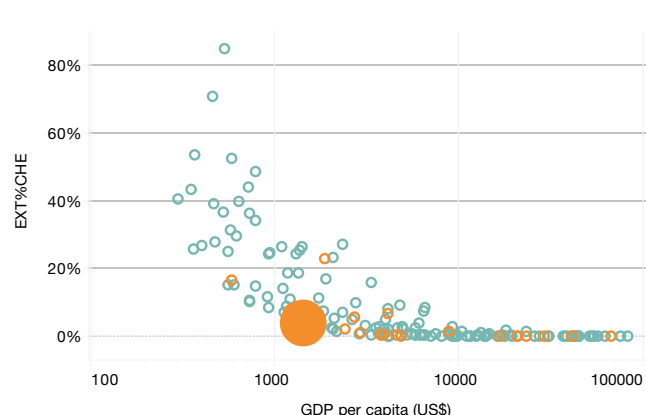


Fig. 14.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending.

Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.

Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

15. Qatar

1. Macroeconomics

Qatar is one of the smallest and wealthiest countries in the world. Its economic growth has slightly slowed in recent years due to weakness in the non-hydrocarbon sector. Its GDP fell from US\$ 206.225 billion in 2014 to US\$ 164.641 billion in 2015, resulting in a per capita GDP of US\$ 66 347. While revenues from hydrocarbon products are the backbone of Qatar's economy, accounting for around 90% of government revenues, Qatar's National Vision 2030 roadmap of 2008 emphasized the importance of non-hydrocarbon activities and investment opportunities for economic growth. In 2015, general government expenditure was 68.357 billion, accounting for 41.5% of GDP. It is estimated that 9.8% of Qatari households are living in poverty according to the national poverty line in 2012–2013.

2. Health financing architecture

Qatar has undergone several health governance reforms in recent years. In 2005, the National Health Authority was replaced by Ministry of Public Health, and in 2009, the Supreme Council of Health was established to supervise the entire health sector. At present, the Ministry of Public Health is the steward of the health system, and is responsible for setting the country's national health system policies, strategies and plans in light of Qatar's National Vision 2030. The Department of Financing and Health Insurance was established in 2007. In 2013, the National Health Insurance Corporation was established to operate the National Health Insurance System in Qatar. However, in 2015, the government stopped the scheme with the aim of replacing it with private health insurance. The Ministry of Public Health endorsed a national health strategy for five years (2018–2022) with a focus on health system development and the improvement of the population's health. The main financing agents in the public sector are the Ministry of Public Health, the Hamad Medical Corporation, the Primary Health Care Corporation, and other ministries, including the Ministries of the Interior, the Armed Forces and the Amiri Guard. Private financing agents in the country are households, private insurance companies, private corporations, and nongovernmental organizations, including the Zakat fund.

3. Revenue raising

In 2015, current health expenditure in Qatar represented 3.1% of GDP, equivalent to a per capita current health expenditure of US\$ 2030. Health care is mainly financed through general government revenues. In 2015, Qatar spent 6.3% of its general government expenditure on health, amounting to a per capita domestic general government health expenditure of US\$ 1734. Other sources of revenue for the health sector include the contributions of corporations and households. In 2015, domestic private health expenditure per capita reached US\$ 296. Qatar receives no external assistance for health.

4. Pooling

Pooling primarily takes place at Ministry of Finance level. In 2013, the National Health Insurance System, Seha, was established as part of the Qatari health sector reform programme. Funds used to be pooled in a single pool administered by the National Health Insurance Corporation, with premiums being paid by the government and employers on behalf of Qataris and non-Qataris, respectively. Since the suspension of Seha in 2015, more private insurance companies – 21 companies in total – became involved in pooling health resources in a fragmented manner. In 2015, voluntary health insurance constituted 7.4% of current health expenditure, while domestic general government health expenditure constituted of 85.4% of current health expenditure.

5. Purchasing

The Ministry of Public Health does not directly provide health care. The government finances the Primary Health Care Corporation and the Hamad Medical Corporation through a fixed annual lump-sum budget based on data on previous years and through negotiations with the Ministry of Finance. Health care providers are paid through salaries. Purchasing reform was one of the main aims of Seha. Accordingly, the National Health Insurance Corporation – before being suspended – began to enter into annual providers' network agreements with public and private health care providers and introduced activity-based budgeting for the public health sector. Qatar has

introduced its own outpatient classification system as part of the strategy towards establishing and implementing prospective reimbursement mechanisms. It envisions that activity-based funding will become the main provider payment mechanism.

6. Benefits design

Public health services are accessible for the whole population. In 2014, with the launch of Seha, a benefit package for the insured population was defined to fully cover all essential health services, and was complemented by a dental package. Many private companies provide their employees and their families with additional health care benefits. Benefit packages offered by private insurance companies range from a basic package to premium packages, which could include regional and international coverage.

7. Population coverage

The government provides free and subsidized access to public health care facilities for citizens and expatriates upon issuance of a health card. Based on a survey conducted in 2010, 98% of Qatari and 82% of non-Qatari households hold health cards.⁴⁴ In 2014, Seha was extended to all Qatar citizens. It was envisioned that the scheme would be further extended to cover all non-nationals before it was suspended in 2015.

8. Service coverage

Health care is provided by a mixture of public, private and parastatal organization providers, with the public sector being the main provider. The Hamad Medical Corporation is the main inpatient provider in the country with 12 hospitals (nine specialized and three community hospitals). In 2012, the Primary Health Care Corporation was established as an independent entity. This corporation is comprised of 23 primary health care centres. Other public health care providers include Qatar Petroleum, the Qatar Armed Forces, and the Ministry of the Interior. Parastatal providers include Qatar Petroleum, the Qatar Red Crescent Society, the Qatar Orthopedic and Sports Medicine Hospital, and the Sidra Research and Medical Center. Companies with more than 500 workers are required to operate a clinic with at least one physician and one nurse for their employees and their dependents. In 2014, there were four private hospitals, 300 medical and dental clinics and polyclinics, 32 diagnostic centres, and over 300 pharmacies and medicine stores in the country. Currently, the universal health coverage index of coverage of essential health services value for the country is 77.⁴⁵

9. Financial protection

Comprehensive care is provided free of charge to all Qatari nationals. The government contribution to the health sector has been increasing over the past few years, resulting in decreasing household expenditures on health care. Out-of-pocket payments for health as a share of current health expenditure decreased from 18.7% in 2010 to 6.2% in 2015. This reflects the government's aim to reduce the financial burden of health expenditure on households.

⁴⁴ Hussin AH, Ali FMH, Reka H, Gjebreab O. Tracking access, utilization and health system responsiveness to inform evidence-based health care policy: the case of Qatar. *Journal of Local and Global Health Perspectives*. 2015 (www.qscience.com/doi/pdf/10.5339/jlghp.2015.2?download=true, accessed 4 September 2018).

⁴⁵ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Qatar

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	60 016	60 835	69 334	66 347
CHE per capita (US\$)	1 206	1 563	1 241	2 030
GGHE-D%CHE	60	75	71	85
OOPS%CHE	30	19	19	6
GGHE-D%GDP	1.2	1.9	1.3	2.6
GGE%GDP	30	29	31	42
GGHE-D%GGE	4	7	4	6
Population	592 267	864 863	1 779 676	2 481 539

Fig. 15.1. Key health financing and expenditure indicators, 2000–2015

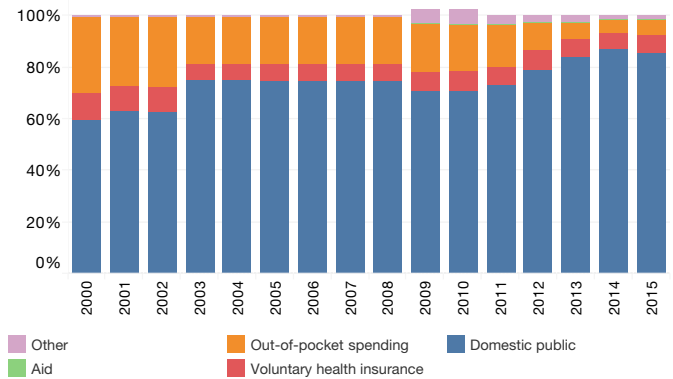


Fig. 15.2. Revenue sources

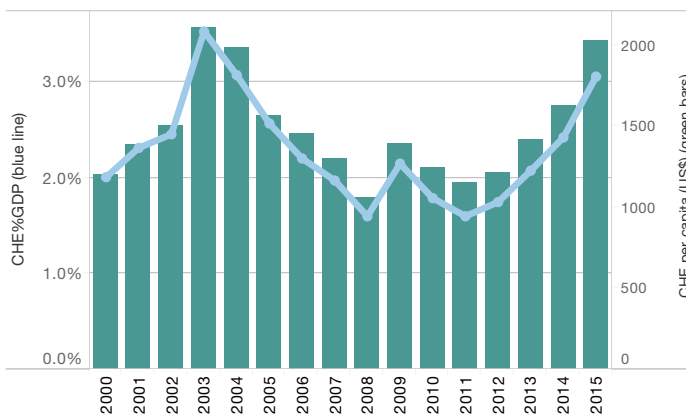


Fig. 15.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

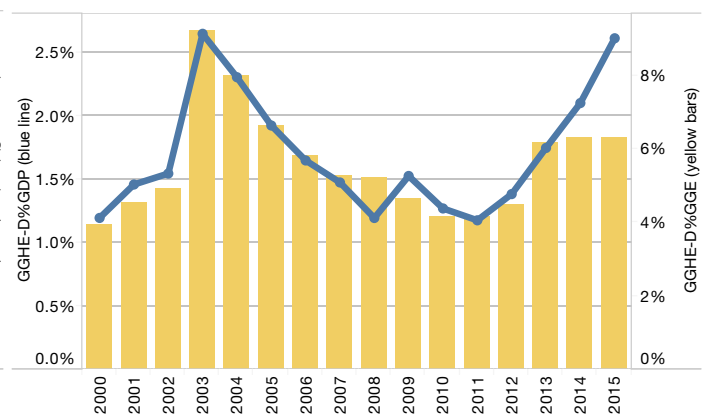


Fig. 15.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

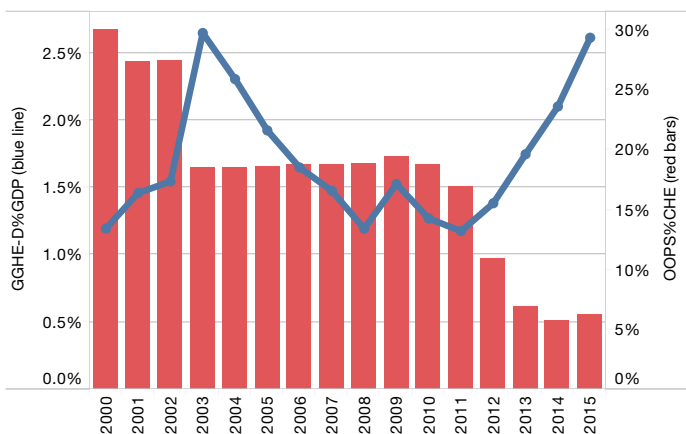


Fig. 15.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

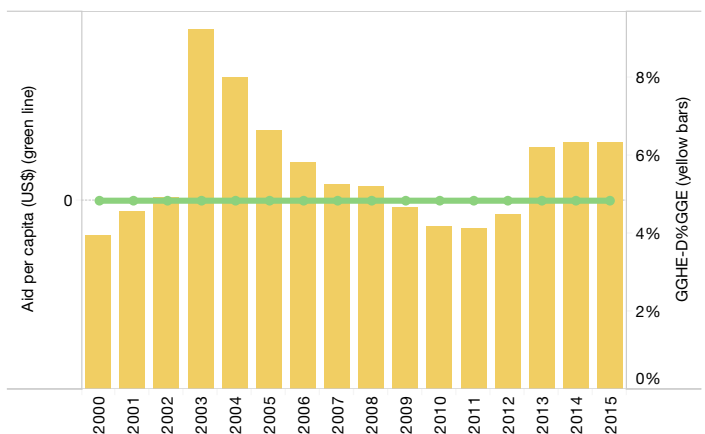


Fig. 15.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

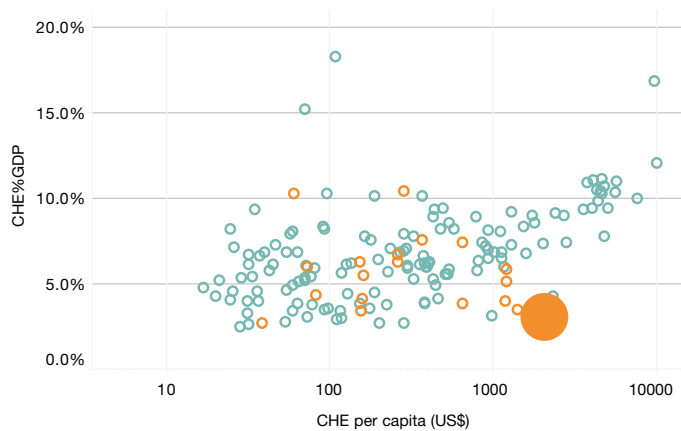


Fig. 15.7. Current health expenditure as a percentage of GDP and per capita (US\$)

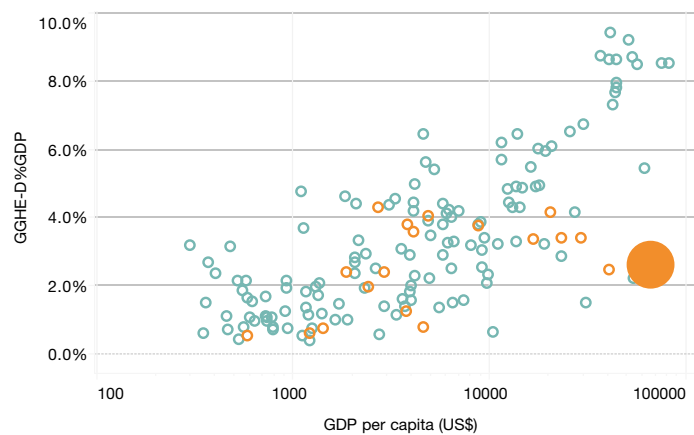


Fig. 15.8. Government health expenditure as a percentage of GDP and per capita (US\$)

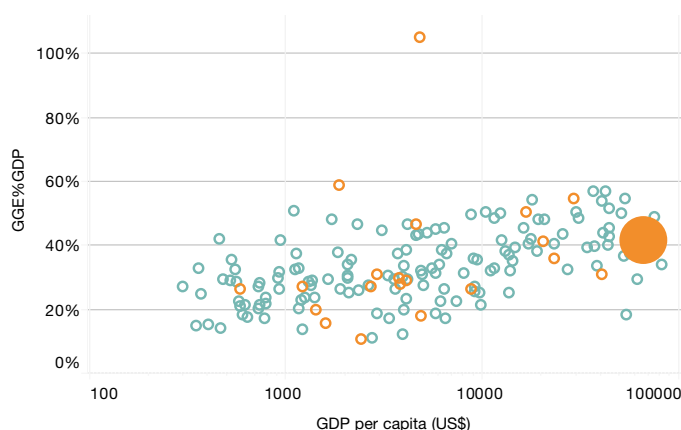


Fig. 15.9. Fiscal space and GDP per capita (US\$)

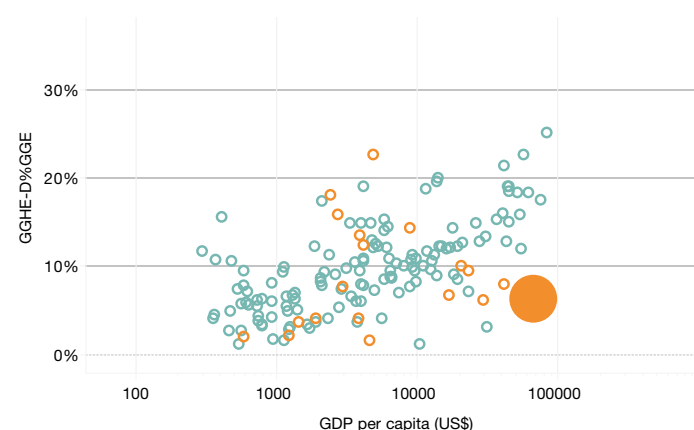


Fig. 15.10. Health prioritization and GDP per capita (US\$)

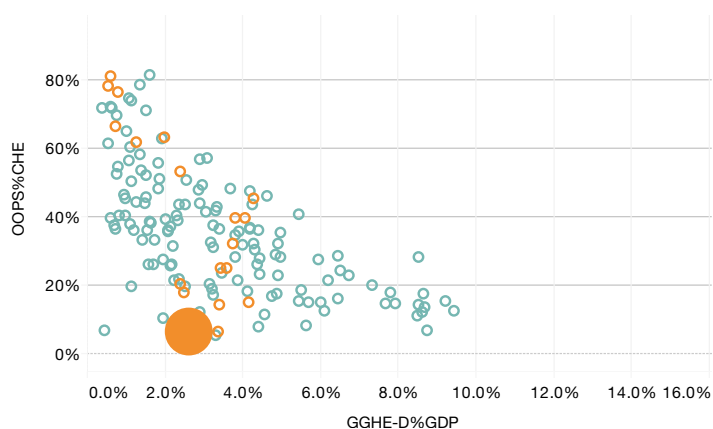


Fig. 15.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

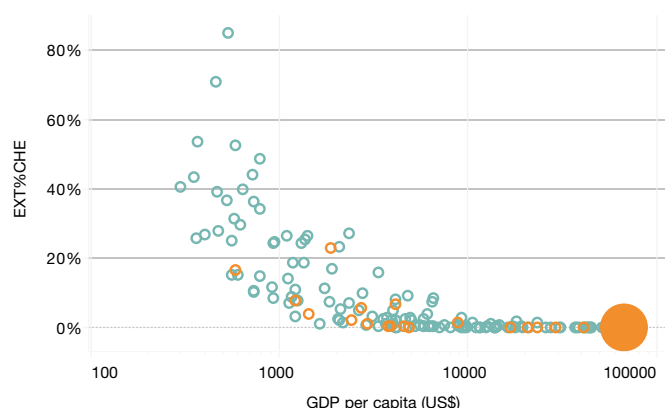


Fig. 15.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending.
 Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.
 Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

16. Saudi Arabia

1. Macroeconomics

Saudi Arabia is a high-income country with per capita GDP of US\$ 20 471 in 2015. The country has witnessed rapid urbanization in recent years, and in 2015 almost 83% of its population lived in urban areas. Around 80% of the government's annual budget is derived from oil revenues. Changes in national spending patterns and reductions in international oil prices have negatively affected the levels of general government expenditure levels, which fell from US\$ 304 billion in 2014 to US\$ 266 billion in 2015, constituting 41.2% of GDP in 2015. A national transformation plan – Vision 2030 – has recently been drawn up with the aim of diversifying the economy over the next 15 years, making it less dependent on the oil sector.

2. Health financing architecture

Saudi Arabia has a complex health financing system with numerous public and private financing entities. In the public sector, the Ministry of Health is the major financing agent, in addition to the Ministry of the Interior, the Ministry of Defense, the National Guard Health Affairs and the Ministry of Higher Education. Private financing agents include private insurance companies, households and charitable health societies. In 1999, the Council of Cooperative Health Insurance was established to regulate the health insurance market. The Ministry of Health is responsible for planning for the health sector, as well as for regulating and monitoring all health service provision in the country. At present, the health financing system is undergoing major reforms as part of the national transformation plan Vision 2030, which will be implemented in two stages. The overall aim of the plan is to move from a government-dominated health financing model towards one with significantly more private sector participation, and to have a single independent regulator for public and private providers by 2022.

3. Revenue raising

The main source of funding for the health sector comes from the government's annual budget, transferred mainly to the Ministry of Health budget and other governmental sectors. In 2015, per capita current health expenditure reached US\$ 1194, representing 5.83% of GDP, while private health expenditure per capita stood at US\$ 343. In 2015, general government health expenditure constituted 10.1% of general government expenditure – equivalent to per capita general government health expenditure of US\$ 852. Other sources of health revenue are charities and contributions from expatriates and their employers. Saudi Arabia does not receive any external assistance for health. The recent drops in global oil prices have placed the health budget under strain, pushing the government to consider introducing payroll-based funding as well as new potential sources of funds, including sin taxes, health fees from visitors, billing private health insurance companies for treating their beneficiaries at public facilities, health fees to cover domestic servants, payments from car insurance companies for treating car accident-related conditions and revenues from better enforcement of insurance for blue-collar expatriate workers.

4. Pooling

Pooling of health funds is fragmented. It takes place at Ministry of Finance level, which allocates the public health budget across the following entities: various ministries; a mandatory scheme entitled Complementary Employment-Based Health Insurance, which is managed by the Council of Cooperative Health Insurance; private health insurance companies; and around 45 charitable organizations providing coverage to low-income sections of the population. Complementary Employment-Based Health Insurance is not unified under one single pool, and is operated by independent private health insurance companies, of which there were 26 in 2012. Health insurance companies create risk-based pools, whereby insurers charge different premiums for different risk categories and based on company size. Premiums paid by small-scale employers are critical for the success of the Complementary Employment-Based Health Insurance programme, since about 50% of total expatriates are employed by small-scale companies. In 2015, domestic general government health expenditure as a share of current health expenditure was 71.3%, while voluntary health insurance accounted for 9.3% of current health expenditure. The ongoing reform entails the establishment of a single risk pool – the Purchasing Programme – which would combine all state contributions and government subsidies for health. In the long term, the Purchasing Programme would be expected to compete with private health insurers.

5. Purchasing

There is no separation between purchasing and provision in the public sector, with some services occasionally procured from private sector providers. However, in the private health sector, the Complementary Employment-Based Health Insurance programme purchases services using a competitive market approach. With regard to the provider payment methods used, the 20 regional health directorates rely on receiving a global budget from the Ministry of Health, which is then allocated to their hospitals in advance. Salaries are the main method of payment for health workers. Output-based payments would be the main method of payment in the long-term plan of the ongoing reform.

6. Benefits design

In accordance with the unified health policy, nationals receive free care in the public health sector. The Complementary Employment-Based Health Insurance programme has a predetermined minimum health benefit package with predetermined copayment. Private health insurance companies offer different health insurance packages that range from a basic plan to a high-level plan, each with a relevant cap on expenditure. Those insured can in some cases request to be referred to receive care from other providers than the ones included in the coverage agreement.

7. Population coverage

The government is mandated to provide free health care to all citizens and expatriates working in the public sector. Employers have to cover all non-nationals working in the private sector; this coverage is also a condition for renewal of residence permits. All other government health care providers⁴⁶ also guarantee coverage for their employees and their dependents at their own facilities. Coverage for dependents of expatriates depends on the type of contract the employee holds. In 1999, health insurance coverage became mandatory for all expatriates and all citizens working in the private sector under the Complementary Employment-Based Health Insurance programme, with services provided in the private sector, and in cases of unavailability, insured individuals were allowed to use public facilities. In 2015, the Complementary Employment-Based Health Insurance programme reported that around 10 million people were insured nationwide, out of whom 30% were Saudis. Population groups in the country who may not be insured include blue-collar expatriates, domestic workers, illegal migrants and refugees.

8. Service coverage

In the public sector, health care is mainly provided by the Ministry of Health, which provides around 60% of all health services and has 41 835 hospital beds, in addition to facilities owned by other governmental sectors. In 2016, the private sector had a total of 152 hospitals, with 17 428 beds. Private health care provision is most widespread in large cities, such as Riyadh, Dammam and Mecca. In 2016, the total number of hospitals in Saudi Arabia was 470, with a total of 70 844 beds. Tertiary care is mainly provided by public providers, even for those with private insurance. In 2016, the Kingdom had 28.3 and 57.0 physicians and nurses per 10 000 population, respectively. In 2002, the Council of Health Services was established with the aim of developing policies for the coordination and integration of all health care providers. In 2015, the universal health coverage index of coverage of essential health services value for the country was 68.⁴⁷

9. Financial protection

Health care is provided for free to all Saudi nationals. The government continues to allocate a large pool of funds towards the development of the health care sector and provides initiatives for private sector operators to enter the health care market in the Kingdom. However, the financing of the system is currently under strain due to pressure on the general budget from recent macroeconomic trends. In 2015, out-of-pocket payments as a share of current health expenditure stood at 15%.

⁴⁶ Other government health care providers include: referral hospitals (for example, King Faisal Specialist Hospital and Research Centre); the Security Forces Medical Services; the Army Forces Medical Services; the National Guard Health Affairs; Ministry of Higher Education hospitals (teaching hospitals); the Saudi Arabian Oil Company (Saudi Aramco) hospitals; the Royal Commission for Jubail and Yanbu health services; school health units of the Ministry of Education; and the Red Crescent Society.

⁴⁷ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Saudi Arabia

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	14 831	16 362	18 460	20 471
CHE per capita (US\$)	628	559	645	1 194
GGHE-D%CHE	72	72	65	71
OOPS%CHE	18	16	20	15
GGHE-D%GDP	3.1	2.5	2.3	4.2
GGE%GDP	33	28	34	41
GGHE-D%GGE	9	9	7	10
Population	20 764 312	23 905 654	27 425 676	31 557 144

Fig. 16.1. Key health financing and expenditure indicators, 2000–2015

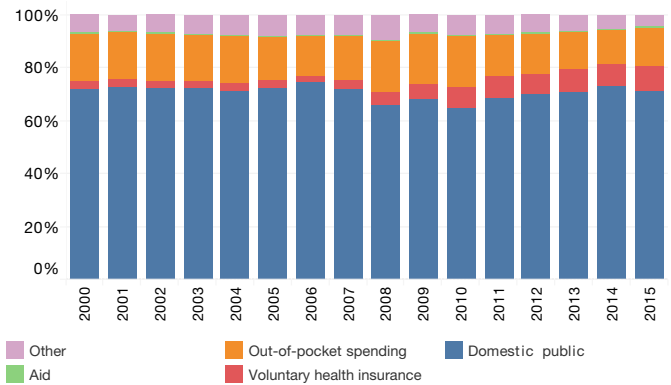


Fig. 16.2. Revenue sources

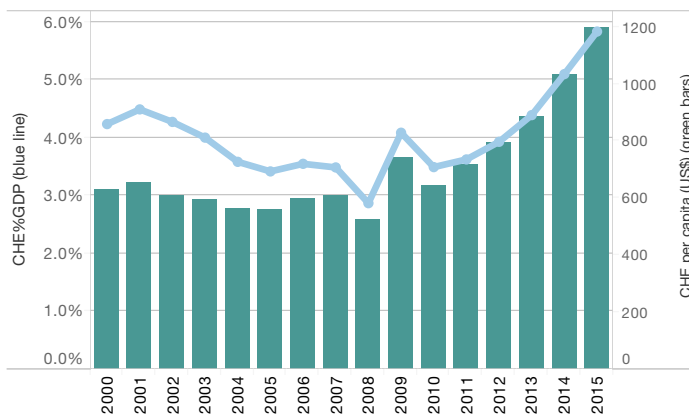


Fig. 16.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

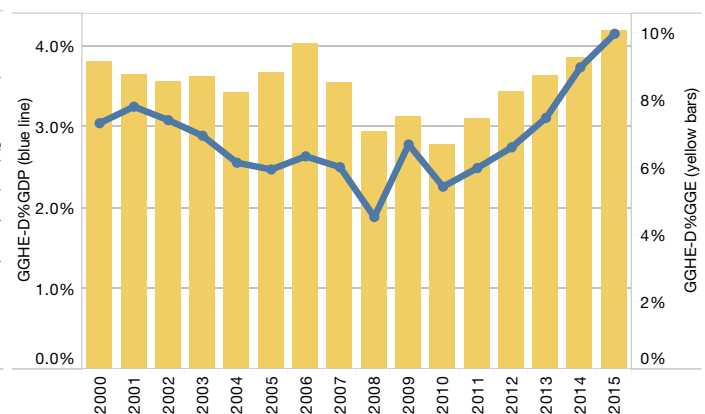


Fig. 16.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

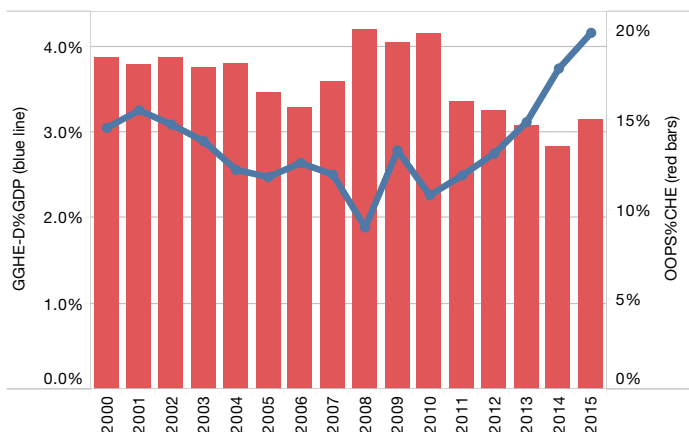


Fig. 16.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

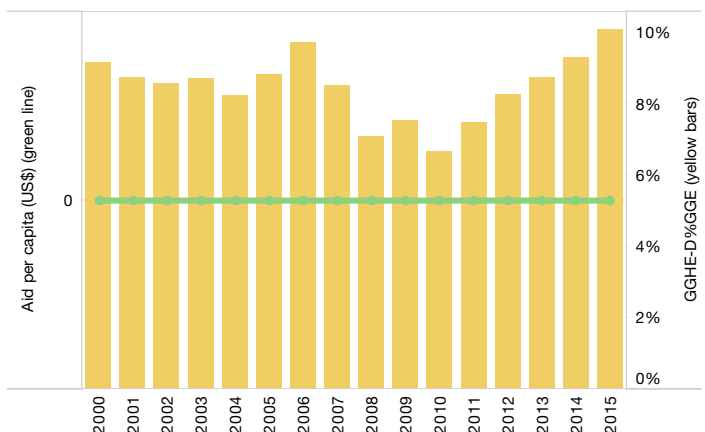


Fig. 16.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

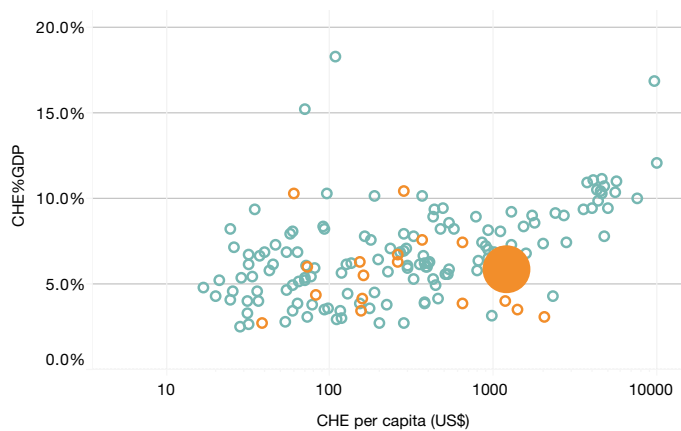


Fig. 16.7. Current health expenditure as a percentage of GDP and per capita (US\$)

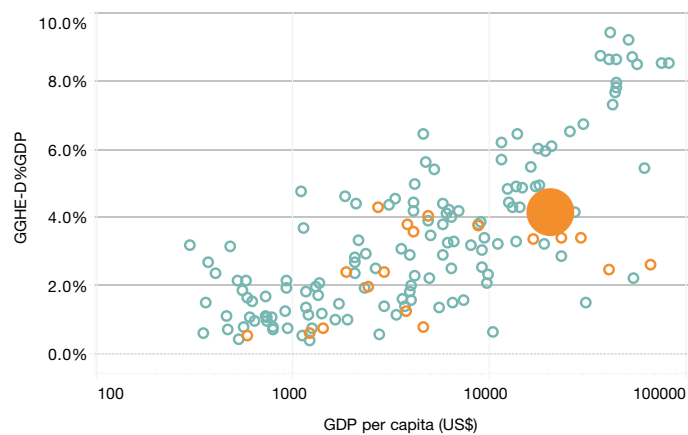


Fig. 16.8. Government health expenditure as a percentage of GDP and per capita (US\$)

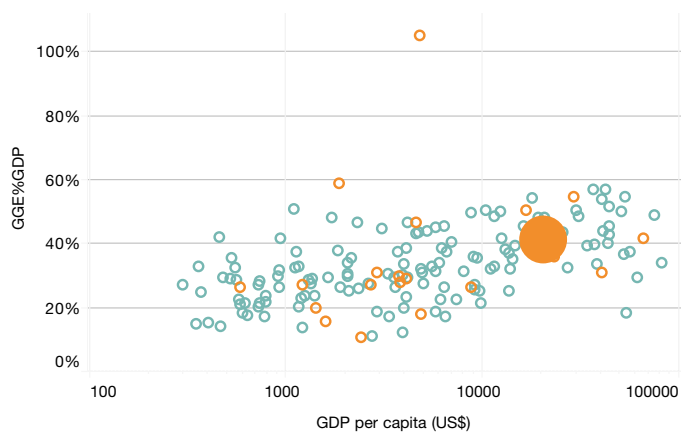


Fig. 16.9. Fiscal space and GDP per capita (US\$)

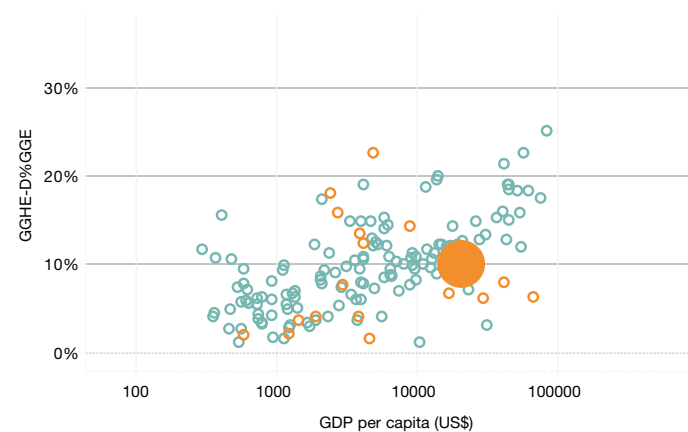


Fig. 16.10. Health prioritization and GDP per capita (US\$)



Fig. 16.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

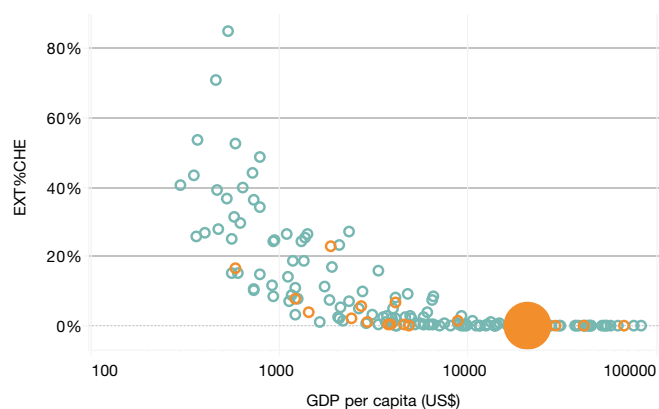


Fig. 16.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

17. Somalia

1. Macroeconomics

Although Somalia's economy has been slowly growing after the civil war, the economy is still fragile as it relies greatly on agriculture, the livestock sector, and remittances. GDP increased from US\$ 5.3 billion in 2012 to US\$ 6.3 billion in 2016, growing at an average annual rate of 4.5%. However, Somalia is estimated to be the fifth poorest country in the world, with a per capita income of US\$ 435. Poverty levels in Somalia are extremely high and about half of the population live below the poverty line. Poverty is especially exacerbated by problems related to the government's ability to function effectively, insecurities, and natural disasters.

2. Health financing architecture

The Somali government has placed health services among its top priorities. The health sector has a vision and has developed comprehensive medium-term plans (2013–2016) in which strategic objectives with high-level benchmarks and indicators are clearly articulated. There is a federal health ministry, in addition to a ministry of health in each of the country's zones. In 2013, the three health authorities decided to scale up the female community health workers programme, which has been recognized as one of the most cost-effective and sustainable interventions to address barriers in access to primary health care.

3. Revenue raising

The Somali health sector has predominantly been financed through out-of-pocket payments for health by the general population and by donors and development partners. The governments in the country's three zones also provides minimal funding to the health sector. The Somali diaspora also support the public health sector. External financing has greatly exceeded government contributions to the health sector in Somalia. Total health expenditure as a share of GDP was 8% in 2014. The country's private expenditure on health as a share of total health expenditure was 79% in 2014.

4. Pooling

There is limited institutional capacity to collect and allocate funds for health from domestic sources. Contributions from external sources are mostly earmarked for disease-specific programmes, and most of these contributions have been decreasing in recent years.

5. Purchasing

A contracting out approach has been used to purchase some health care services.

6. Benefits design

Around half of the population have access to basic health services provided through development and humanitarian investment. There is a need to close the financing gap to ensure the provision of health services to the remaining half of the Somali population.

7. Population coverage

The majority of the population is not covered by any form of prepayment.

8. Service coverage

The majority of the population suffers from limited and inequitable access to basic health care services, especially in rural areas and among the nomadic population. In the north-west and the north-east, access to basic health services in densely populated areas appears to be adequate. In the south and central areas of the country, about 60% of the population have no access to health care due to the limited number of health facilities, the poor quality of health care services, the high number of internally displaced persons, and prevailing insecurity in these areas.

9. Financial protection

Public spending per capita in Somalia currently stands at around US\$ 12. This level is far below the global standard for health sector investment, and increases the financial burden of health expenditure on households, especially for the impoverished sections of the population, as it results in high out-of-pocket payments for health for large numbers of people in the country. Private expenditure on health as a share of total health expenditure was 79% in 2014.

No comprehensive health expenditure data for Somalia are currently available.

18. Sudan

1. Macroeconomics

Economic growth in Sudan has been adversely affected by repeated conflicts and international sanctions in recent years. Furthermore, the separation of South Sudan in 2011 resulted in a significant reduction in oil revenues adversely affecting public revenues and government expenditure. Over the last 10 years, GDP has increased – from US\$ 45.5 billion in 2006 to US\$ 96.7 billion in 2015 – thanks to countries' macroeconomic policies, which resulted in improvements in the business, mining and agriculture sectors. In 2015, general government expenditure reached US\$ 10.5 billion, constituting 10.9% of GDP. In 2015, the poverty rate at the national poverty line was 36.1%.

2. Health financing architecture

The health system in Sudan follows a three-level devolved governance arrangement – federal, state and local – which is also reflected in the architecture of the country's health financing system. The health financing system has passed through several reforms in its history: following independence free health care was provided to all Sudanese nationals, until user charges were introduced in the early 1990s, which was followed by the introduction of selective solidarity schemes, such as the free treatment initiatives scheme, which covered the cost of care of the vulnerable sections of the population, and then the establishment of a national social health insurance scheme – the National Health Insurance Fund – in 1994. Since then, efforts have been made to cover larger numbers of people with a focus on bringing the impoverished and vulnerable sections of the population under the umbrella of the National Health Insurance Fund. A health financing policy and strategy were developed in 2015 and endorsed in 2016. The National Health Coordination Council is responsible for bringing together all stakeholders at federal and state levels to ensure alignment and policy coherence and consistency in line with the desired policies and strategic directions.

3. Revenue raising

In 2015, Sudan's current health expenditure was USD\$ 6.1 billion – equivalent to a per capita current health expenditure of USD\$ 152 and representing 6.3% of GDP. Domestic private health expenditure constituted 66.9% of current health expenditure in 2015, while external funding at less than US\$ 3 per capita represented only 1.9% of current health expenditure. Besides the revenues raised using mandatory contributions under the National Health Insurance Fund, budget transfer using the Zakat Fund has been employed to subsidize the coverage of the impoverished and vulnerable within the social health insurance system. Sudan's limited fiscal space, primarily due to weak capacity to collect taxes, and the low priority given to health in the public budget, affects the level of public revenue allocated for health.

4. Pooling

Several pooling arrangements exist, including: the Federal and State Ministries of Health, which receive funding from the Ministry of Finance and Economic Planning at federal and state levels to cover all Sudanese nationals with selected primary health care services; the National Health Insurance Fund, an autonomous institution formerly under the supervision of the Federal Ministry of Health and now under the supervision of the Ministry of Social Security and Development, and separate pools established at state level; the Khartoum State Health Insurance scheme; the Ministry of Finance and Economic Planning; Armed Forces, Police, and Ministry of the Interior employment-based social health insurance schemes; and a growing private insurance market. A new National Health Insurance Law was passed by the parliament in 2016 mandating enrollment in the National Health Insurance Fund for all Sudanese, refugees and expatriates under one single pool. Until recently, health insurance funding was fragmented across 18 National Health Insurance Fund state branches, with no effective cross-subsidization. As part of the new National Health Insurance Law, the boards of the various state branches were abolished in an attempt to unify all the pools in a single national pool.

5. Purchasing

The National Health Insurance Fund purchases services for the population it covers from more than 1000 providers, and owns around 300 primary health care facilities. State Ministries of Health as well as the Armed Forces and Police Insurance schemes also have their own facilities. The Khartoum State Health Insurance scheme and private health insurance schemes however purchase services from other public and private providers. The main type of payment under the National Health Insurance Fund is fee-for-service, while in the States of North Kurdoan and Elgazeira, new types of provider payments have been introduced, including capitation and global budget besides the fee-for-service method. Most of the funds transferred from the Federal Ministry of Health are allocated to salaries and development projects. The new National Health Insurance Law and Health Financing Policy and Strategy have introduced a complete split between purchasing and provision, and promote strategic purchasing. They aim to transform the National Health Insurance Fund into a health purchasing agency that acts as a single purchaser for health services, and is no longer involved in the direct provision of health services.

6. Benefits design

Prior to the new National Health Insurance Law, the National Health Insurance Fund used to provide its population with a comprehensive package of inpatient and outpatient services; while the benefit package was generous, it leaned towards secondary and tertiary health care. The Federal and State Ministries of Health provide free and subsidized public health services through their facilities. In 2003, a specific package of primary health care services was introduced in the public sector. However, a facility survey conducted in 2011 found that only 24% of the public primary health care facilities provided the intended package. The new National Health Insurance Law specifies three benefit packages: a Basic Benefit Package, to be provided to the entire population; an Additional Benefit Package, to be added on top of the Basic Benefit Package, and to be provided to civil servants and the impoverished; and a Special Benefit Package, which was introduced to attract private sector and other informal sectors under the umbrella of the National Health Insurance Fund. The Armed Forces and Police Insurance schemes cover all registered medicines in Sudan, while the National Health Insurance Fund, the Khartoum State Health Insurance scheme, and private health insurance schemes have their own lists of the medicines they cover. Discussions are ongoing to define a universal health coverage package that would include primary health care, emergency service care, caesarean section services and selected high-cost catastrophic services such as heart surgeries.

7. Population coverage

Sudan recently expanded coverage by the National Health Insurance Fund from formal sector coverage only to include the impoverished and vulnerable sections of the population, with subsidization from public funds and in particular the Zakat Fund and the Ministry of Finance and Economic Planning. At present, the National Health Insurance Fund is required to cover the entire formal sector, using the family as the unit of enrollment. It also covers the informal sector and small entities on a voluntary basis, using the individual as the unit of enrollment. Some initiatives, such as the under five free-of-charge initiative, also contribute to expanding population coverage by prepayment. Similar attempts are being made to cover expatriates and refugees. Coverage by health insurance at present reaches 46.3% of the total population of Sudan, with almost 60% of the covered population defined as impoverished or vulnerable and about 56% belonging to the informal sector. The new National Health Insurance Law mandates coverage for all Sudanese, refugees and expatriates, and efforts are already being made to earmark new public resources to move in that direction. In addition, in 2017 the National Health Insurance Fund signed an agreement with the office of the UNHCR to cover 10 000 Syrian refugees in Khartoum State as a pilot project guided by the “New Ways of Working” and “Humanitarian Development and Peace Nexus” approaches.

8. Service coverage

There are wide disparities in geographic coverage with regard to primary health care facilities and health workforce in Sudan. In 2011, a facility survey found out that 14% of the population lack geographic coverage by health facilities. Furthermore, utilization of health services was found to increase as household income increased. The survey also showed that usage of chronic health services in urban areas is more frequent than in rural areas (0.7% versus 0.4%), and that the opposite is true for primary health care, where the utilization rate was 58.2% in rural areas and 48.2% in urban areas. The introduction of user fees was found to decrease health service utilization, especially preventative care. This was found to also be the case with the disruption of health care and the destruction

of health centres due to internal conflict. Both the public and private sectors provide secondary and tertiary health care, and non-profit organizations are involved in providing and covering different types of programme in collaboration with the Federal Ministry of Health. Sudan is progressing towards implementing a National Quality Policy and Strategy, and prioritizing quality in its health system. An autonomous accreditation council under the Federal Ministry of Health will be established to accredit facilities before contracting with the National Health Insurance Fund. Currently, the universal health coverage index of coverage of essential health services value for the country is 43.⁴⁸

9. Financial protection

Out-of-pocket payments for health as a share of current health expenditure have increased dramatically in recent years, reaching 63.2% in 2015. According to the Household Health Utilization and Expenditure Survey, in 2012, out-of-pocket payments caused 7.8% of households to face catastrophic expenditures on health, while 2.2% of households were pushed into poverty. The government is working on identifying those health services that cause people to be pushed into poverty, in order to provide/cover these services to increase financial protection for the population.

⁴⁸ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Sudan

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	1 723	2 561	2 591	2 404
CHE per capita (US\$)	62	105	138	152
GGHE-D%CHE	34	39	33	31
OOPS%CHE	62	55	61	63
GGHE-D%GDP	1.2	1.6	1.7	2.0
GGE%GDP	10	20	18	11
GGHE-D%GGE	12	8	10	18
Population	28 079 664	31 990 002	36 114 884	40 234 880

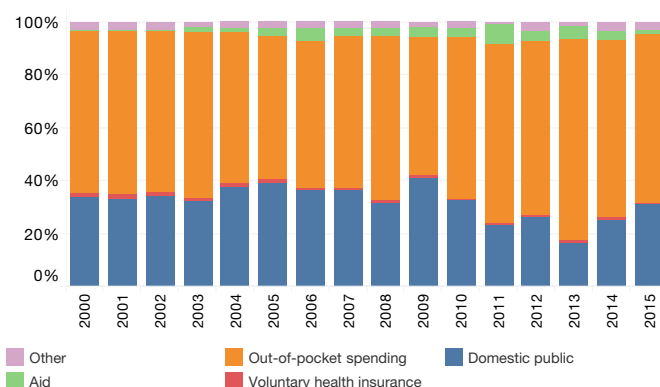


Fig. 18.1. Key health financing and expenditure indicators, 2000–2015

Fig. 18.2. Revenue sources

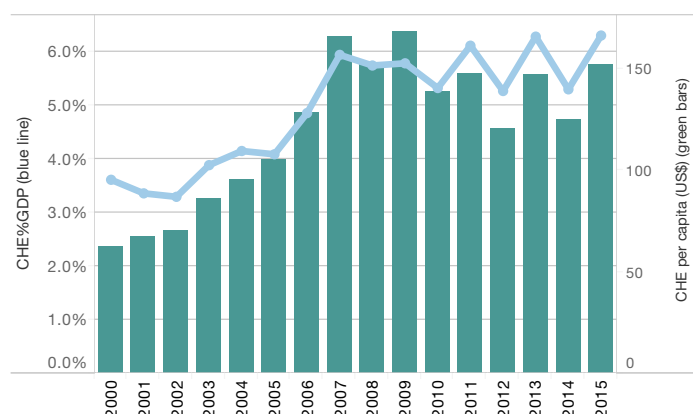


Fig. 18.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

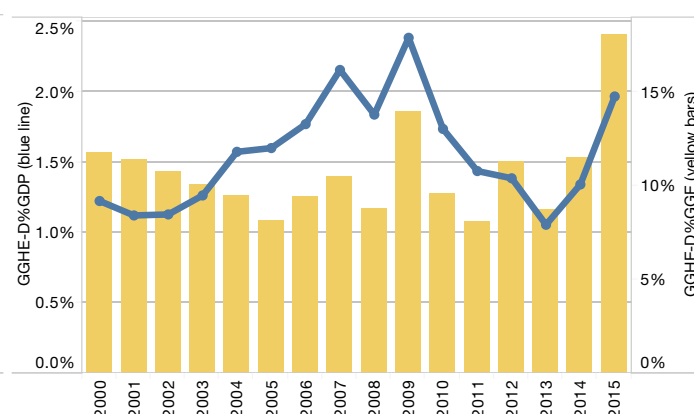


Fig. 18.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

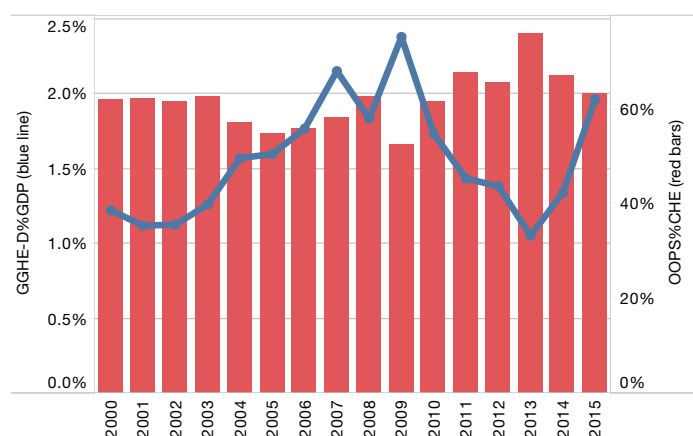


Fig. 18.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

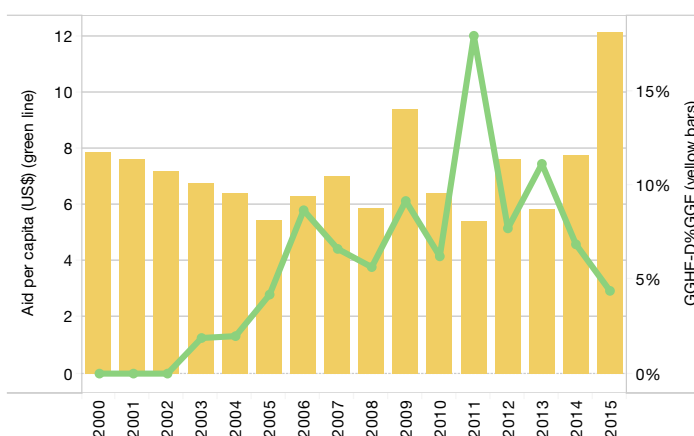


Fig. 18.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

Health expenditure profile

Sudan

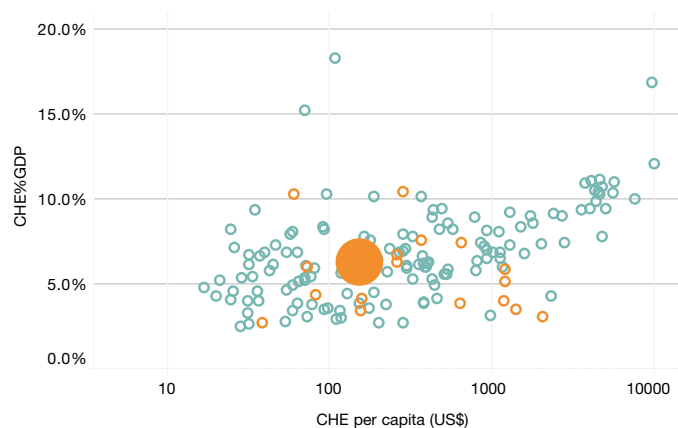


Fig. 18.7. Current health expenditure as a percentage of GDP and per capita (US\$)

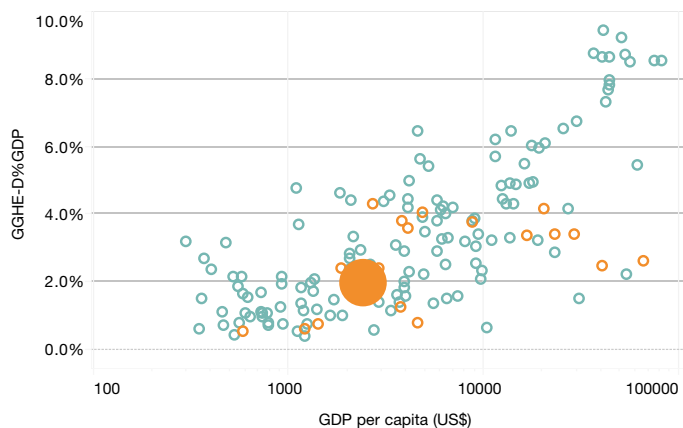


Fig. 18.8. Government health expenditure as a percentage of GDP and per capita (US\$)

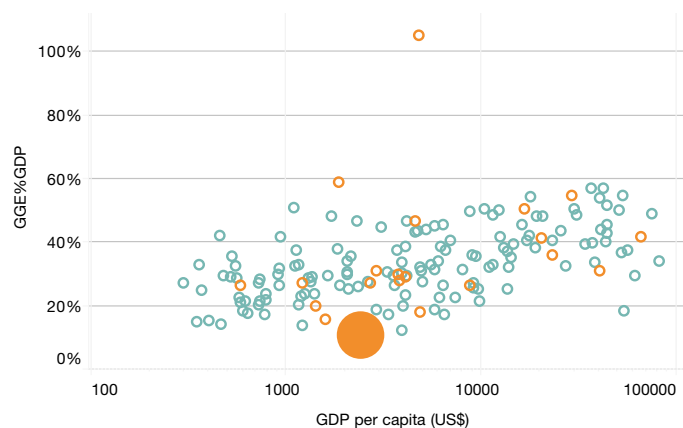


Fig. 18.9. Fiscal space and GDP per capita (US\$)

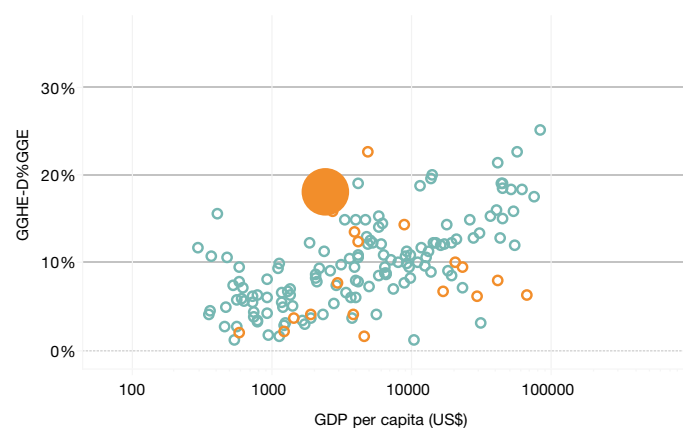


Fig. 18.10. Health prioritization and GDP per capita (US\$)

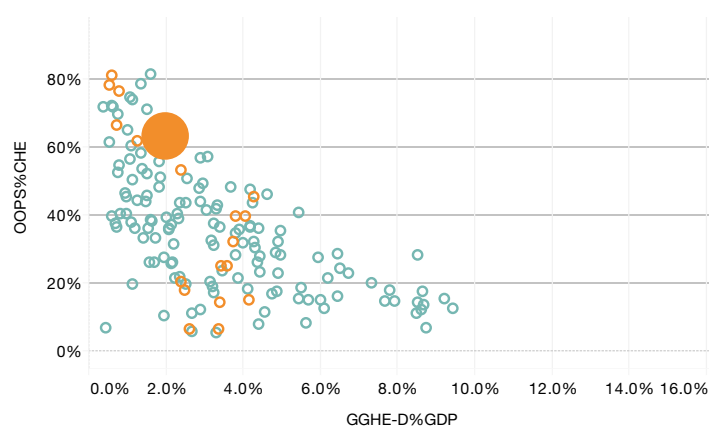


Fig. 18.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

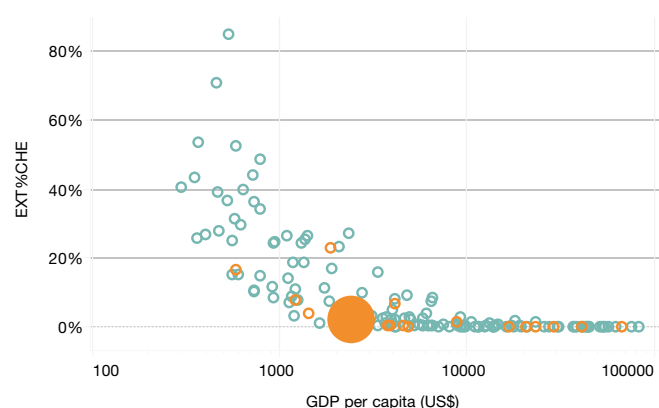


Fig. 18.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending.

Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.

Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

19. Syrian Arab Republic

1. Macroeconomics

The conflict in the Syrian Arab Republic continues to cause severe damage to the Syrian people's lives and the economy. The economic outlook depends on political solutions to the conflict and the reconstruction of the country's infrastructure and social capital. GDP was US\$ 73.67 billion in 2012. GDP was estimated to have contracted by an annual average of 19% in 2015 and was projected to continue to contract in 2016 by 8%. The conflict has significantly damaged the country's public and private assets, including health. Poverty in the Syrian Arab Republic has increased significantly in the past five years but data on the poverty rate are not available at the moment.

2. Health financing architecture

The Ministry of Health's strategy for health development views primary health care as the key component, and stresses the promotion and development of secondary and tertiary health services in line with needs. Before the conflict, the Syrian Arab Republic was a middle-income country with relatively good health indicators. Since 2011 however, 57% of the Syrian Arab Republic's public hospitals have been damaged, while 37% are no longer functioning.

3. Revenue raising

Prior to the conflict, health care was primarily funded by the government through a regular budget and out-of-pocket payments in the private sector. Total health expenditure as a share of GDP has decreased over the last 10 years, and stood at 3.3% in 2014. General government expenditure on health as a share of total health expenditure has also decreased, and stood at 46.3% in 2014. Private expenditure on health as a share of total health expenditure was 53.7% in 2014.

4. Pooling

Pooling primarily takes place at Ministry of Finance level, with provisions to establish a health insurance scheme to cover the population.

5. Purchasing

There is no purchaser-provider split, and the Ministry of Health is the main provider for all health services.

6. Benefits design

Before the conflict, services were offered free of charge for all at public health facilities. Government employees and their dependents could also be fully or partly reimbursed for their charges/claims incurred at private health care facilities and for the cost of medications.

7. Population coverage

The Syrian constitution defines the right of all members of the population to comprehensive health coverage. Before the conflict, the Ministry of Health provided comprehensive coverage to the entire population, and was extending its services to small communities scattered around major settlements.

8. Service coverage

Before the conflict, the Ministry of Health had established a complete network of health centres, hospitals and health units, thus making health services and new technologies more accessible to meet the needs of the expanding population.

9. Financial protection

No national health insurance system existed in the Syrian Arab Republic before the conflict. Private expenditure on health as a share of total health expenditure was 53.7% in 2014.

Health expenditure profile

Syrian Arab Republic

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	2 271	2 607	2 773	1 596
CHE per capita (US\$)	104	107	94	
GGHE-D%CHE	36	50	45	
OOPS%CHE	64	49	54	
GGHE-D%GDP	1.6	2.1	1.5	
GGE%GDP	29	28	30	16
GGHE-D%GGE	6	7	5	
Population	16 410 848	18 294 612	21 018 834	18 734 988

Fig. 19.1. Key health financing and expenditure indicators, 2000–2015

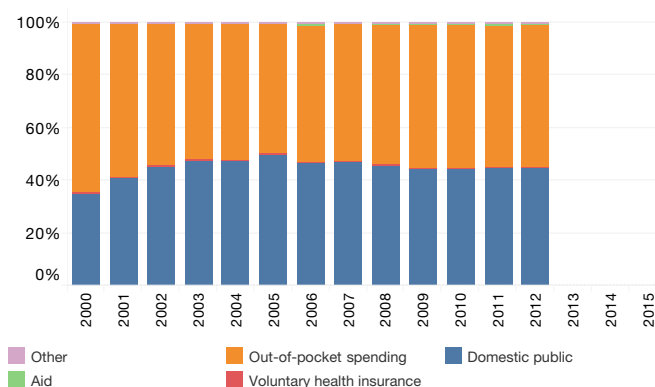


Fig. 19.2. Revenue sources

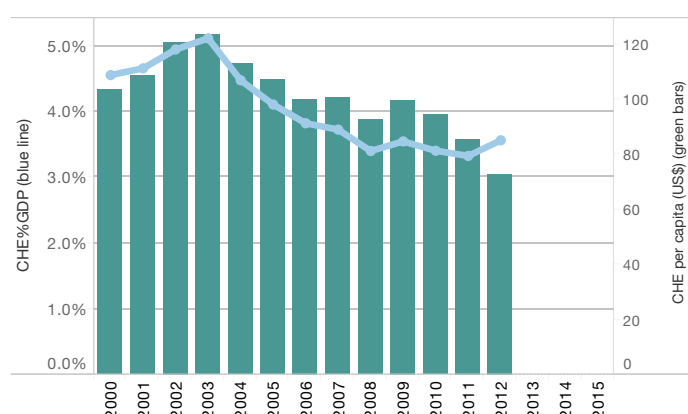


Fig. 19.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

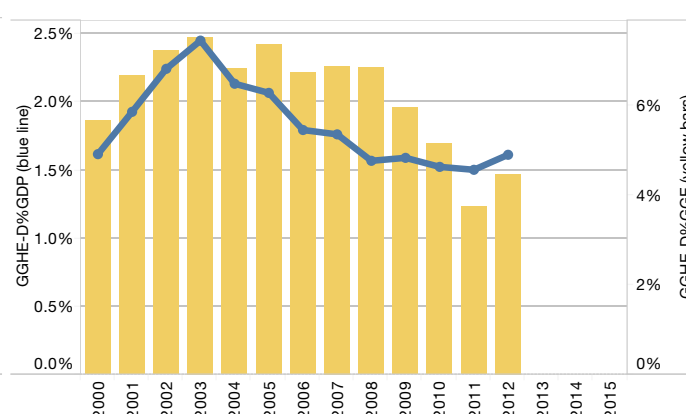


Fig. 19.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

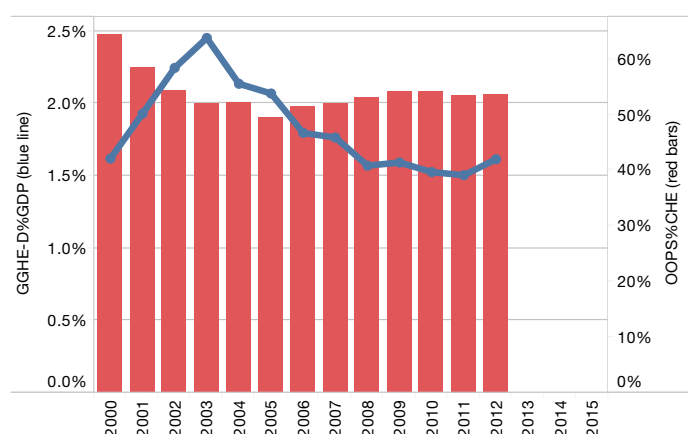


Fig. 19.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

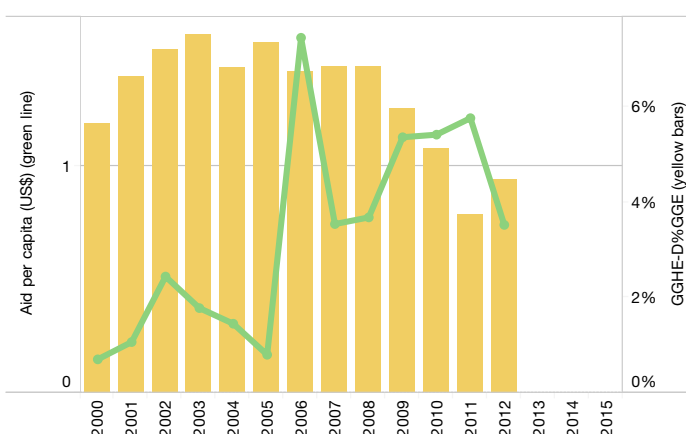


Fig. 19.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

Health expenditure profile Syrian Arab Republic

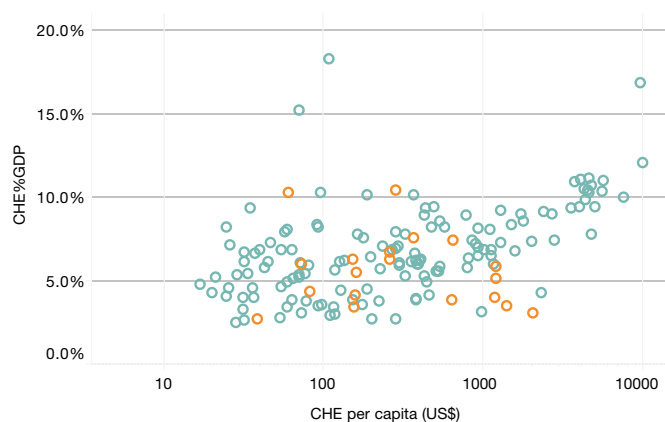


Fig. 19.7. Current health expenditure as a percentage of GDP and per capita (US\$)

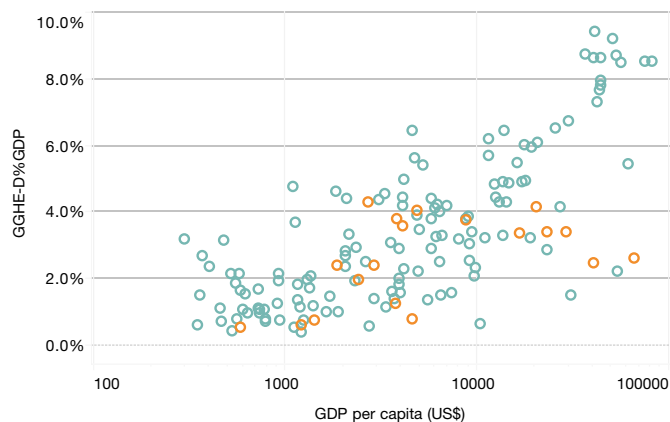


Fig. 19.8. Government health expenditure as a percentage of GDP and per capita (US\$)

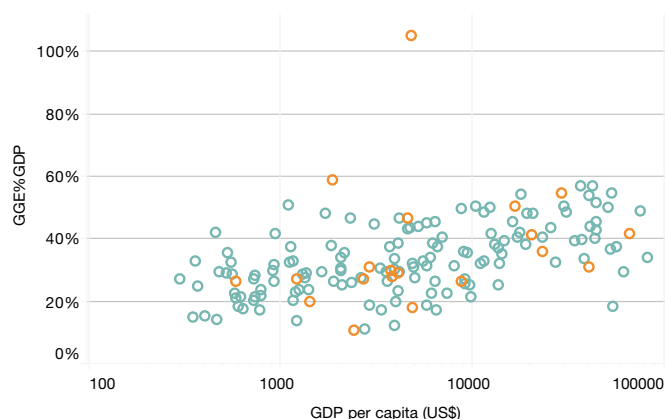


Fig. 19.9. Fiscal space and GDP per capita (US\$)

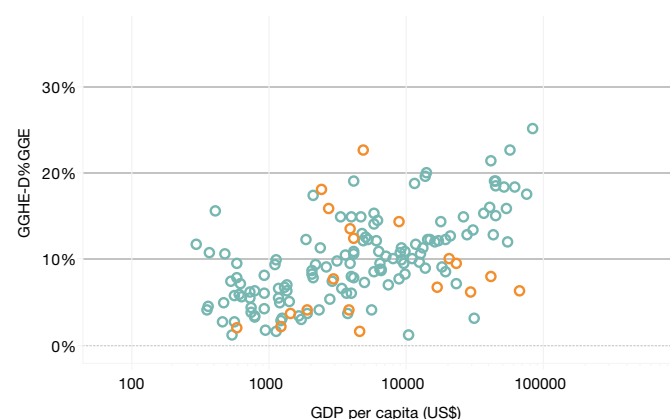


Fig. 19.10. Health prioritization and GDP per capita (US\$)

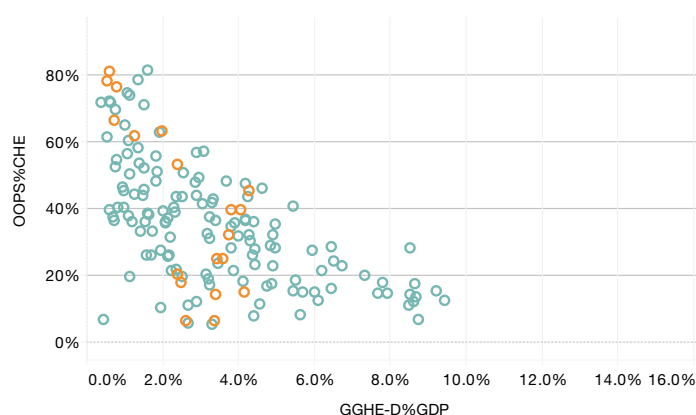


Fig. 19.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

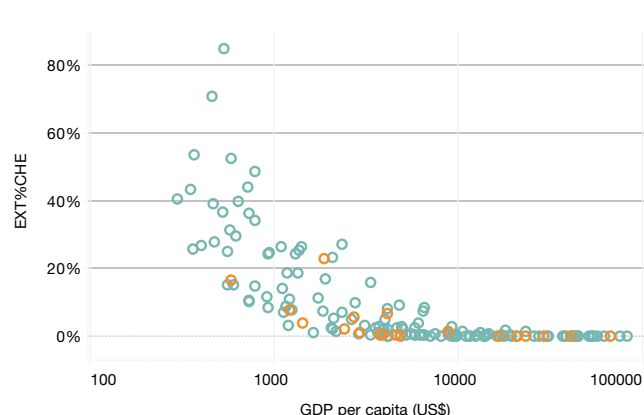


Fig. 19.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending.

Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.

Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

20. Tunisia

1. Macroeconomics

While Tunisia advances towards political stabilization, economic stability and growth are taking longer than expected. The country continues to struggle with high levels of unemployment and fiscal deficit. In 2016, the Tunisian economy grew at an annual rate of 1%, resulting in a GDP of US\$ 42.1 billion and per capita GDP of US\$ 3689. In 2015, general government expenditure reached US\$ 12.068 billion, constituting 27.9% of GDP. The poverty rate was estimated at 15.2% in 2015.⁴⁹

2. Health financing architecture

The 2014 constitution entailed commitments to health and universal health coverage as citizens' rights. The Ministry of Public Health is responsible for supervising the entire health sector. Recent decades have witnessed several reforms in the health financing system – starting from a liberalization of the public sector to an increasing role of the private health sector. Today, the main financing agents are the Ministry of Public Health, the National Health Insurance Fund, the Ministry of Defense, and the Ministry of the Interior, as well as private insurers.

3. Revenue raising

Main sources of revenues for health are general government, social health insurance contributions, and private expenditures. Current health expenditure as a share of GDP was 6.7% in 2015, amounting to a per capita current health expenditure of US\$ 258, with private expenditure per capita of US\$ 111.7. The share of general government health expenditure from domestic sources in total public spending remained stable between 2006 and 2015 at an average of 12%, before recently increasing in 2015 to around 14%, equivalent to a per capita general government health expenditure of US\$ 145.3. External expenditure on health has not exceeded 0.4% of current health expenditure.

4. Pooling

Attempts to reform the health financing system began in the late 1990s, with the aim of enhancing access and promoting financial protection. Accordingly, the National Health Insurance Fund was established in 2004 in an attempt to merge all pre-existing mandatory health insurance schemes. Today, there are two main pooling arrangements: the mandatory National Health Insurance Fund, covering employees in the formal sector; and the Medical Assistance Schemes programme, aiming at covering the vulnerable population. The Medical Assistance Schemes programme are divided into Medical Assistance Schemes-1 (completely free) and Medical Assistance Schemes-2 (with copayment) according to the level of income. As such, there is substantial fragmentation through the existence of multiple schemes. Moreover, those covered under the National Health Insurance Fund can opt for one of three coverage arrangements: public sector, family doctor, or reimbursement – as the names suggest, the key difference is in the style of coverage and type of providers. The presence of the three coverage arrangements further fragments the system, with inequities in terms of coverage. Domestic general government health expenditure was around 56.3% of current health expenditure in 2015, while voluntary health insurance as a share of current health expenditure was 3.3%.

5. Purchasing

All personal preventive care is provided free of charge to all Tunisians. The National Health Insurance Fund purchases health services from public and private providers and also directly provides services at a number of facilities for its beneficiaries. Services purchased by the National Health Insurance Fund are paid for using case-based payments and a fee-for-service system at public facilities, and case-based payments at private facilities. There is however a cap for payments made by the National Health Insurance Fund to public facilities, which is negotiated at the beginning of each year. Outside National Health Insurance Fund funding, a budget is provided by the state to public-sector facilities to pay for the salaries of health care providers and for inputs for the institutions. This is adjusted every year according to hospital activity. Payment for physicians in the private sector is based on a fee-for-service system and lump-sum payment for 54 selected hospital interventions/pathologies. In addition, private facilities could receive additional payments for specific services. Facilities also generate resources from copayments

⁴⁹ National Institute of Statistics. Tunisia: 2017.

and user fees, amounting to around 30% of public hospital revenues. In relation to medicines, the Tunisian Central Pharmacy has a monopoly for importing medicines, and also supports local production. Pharmacists receive a profit margin based on medicine prices.

6. Benefits design

There is no clearly defined benefit package. Accordingly, various implicit and explicit rationing mechanisms exist, depending on the type of provider (public or private). All individuals covered by the National Health Insurance Fund under the public sector arrangement are entitled to a wide spectrum of benefits provided by the public sector, but subject to availability. The services include diagnostics, treatment, prevention, promotion, rehabilitation, mental health, palliative care, and accident-related care. However, individuals opting for the family doctor or reimbursement arrangements have access to a more explicit list of services including surgical interventions. Benefits provided to individuals opting for these two arrangements are subject to an annual ceiling. The ceiling however does not apply in the case of certain identified chronic illnesses. Insured individuals under the Medical Assistance Schemes programme do not have a specifically defined benefit package, and are entitled to care provided in the public sector.

7. Population coverage

It is estimated that between 85% and 92% of the population are covered by the various health insurance schemes. The National Health Insurance Fund covers all public sector employees and their families as well as those belonging to the formal private sector. In 2010, the National Health Insurance Fund covered approximately 68% of the total population, distributed as follows: 62% under the public sector arrangement; 17% under the family doctor arrangement; and 21% under the reimbursement arrangement. The Medical Assistance Schemes programme covered 28% of the population in 2011. It is estimated that between 8% and 15% of the Tunisian population remain uncovered by any form of health insurance. There are ongoing discussions about increasing population coverage to uninsured groups such as the unemployed.

8. Service coverage

Currently, health care is delivered by an extensive network of public health facilities, comprised of: 2079 basic health care centres, 121 district hospitals, and 33 regional hospitals, in addition to university hospitals and specialized national institutes. There is also a growing private sector and a para-public sector, military hospitals, and hospitals belonging to the Ministry of the Interior. Around 90% of the population live less than 5 km away from a health facility; however, various regional disparities exist regarding population proximity to a health facility.⁵⁰ For those covered by the National Health Insurance Fund, patients insured under the public sector arrangement can only use public health sector facilities; those insured under the family doctor arrangement are only entitled to private health services; and those under the reimbursement arrangement use the private sector, where they need to make payments in advance and are reimbursed at a later stage. For medical emergencies, patients can access all levels of the public health system. Access to specialists is direct for ambulatory care delivered at primary health care centres, particularly in urban settings. In 2010, the universal health coverage service coverage index value for the country was 65, which is among the highest in the world.

9. Financial protection

Social protection has recently emerged as a government priority. Out-of-pocket payments for health as a share of current health expenditure was 39.9% in 2015, resulting in a high risk of financial catastrophe and impoverishment. In 2010, 0.44% or 1.17% of the Tunisian population fell into poverty due to out-of-pocket payments at the national poverty lines of US\$ 1.90 and US\$ 3.11, respectively. Moreover, 16.69% or 2.37% of the population faced catastrophic health expenditures at the 10% and 25% of household total consumption or income thresholds,⁵¹ respectively.

⁵⁰ Chahed MK, Arfa C. Monitoring and evaluating progress towards universal health coverage in Tunisia. *PLoS Med.* 2014;11(9):e1001729 (<https://doi.org/10.1371/journal.pmed.1001729>, accessed 27 July 2018).

⁵¹ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Tunisia

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	2 688	3 124	3 704	3 828
CHE per capita (US\$)	136	169	218	258
GGHE-D%CHE	53	51	56	56
OOPS%CHE	39	42	42	40
GGHE-D%GDP	2.7	2.7	3.3	3.8
GGE%GDP	25	24	26	28
GGHE-D%GGE	11	11	13	14
Population	9 699 197	10 102 482	10 639 931	11 273 661

Fig. 20.1. Key health financing and expenditure indicators, 2000–2015

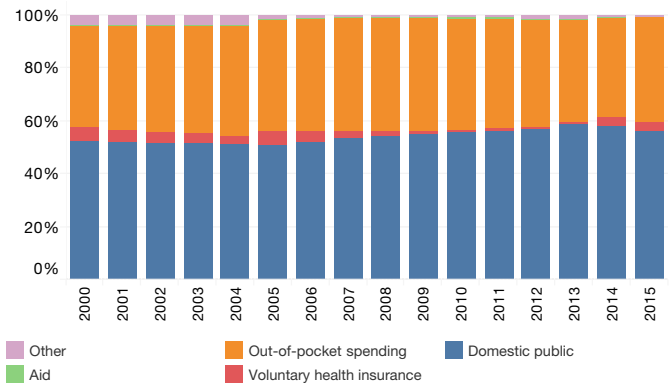


Fig. 20.2. Revenue sources

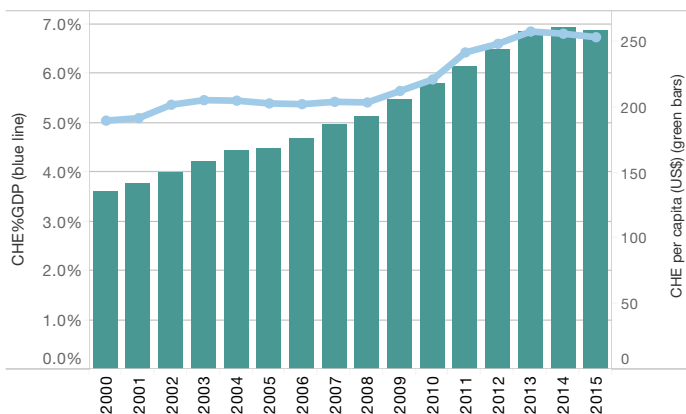


Fig. 20.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

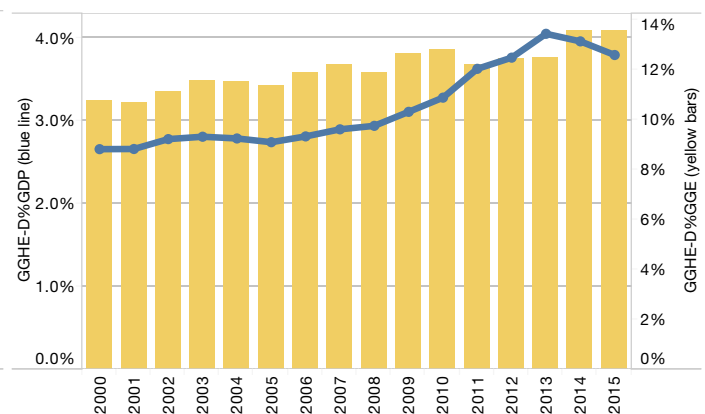


Fig. 20.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

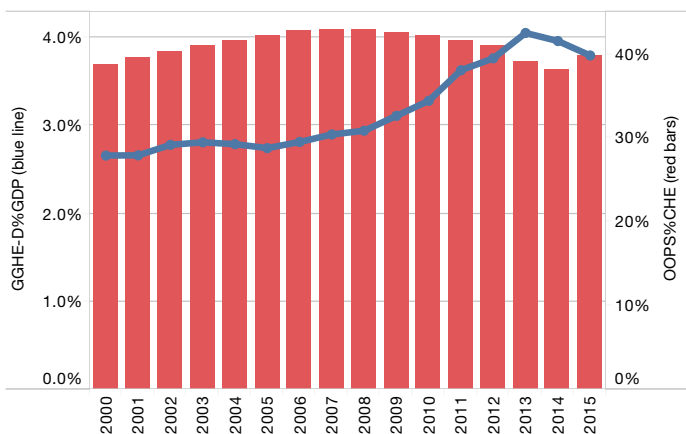


Fig. 20.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

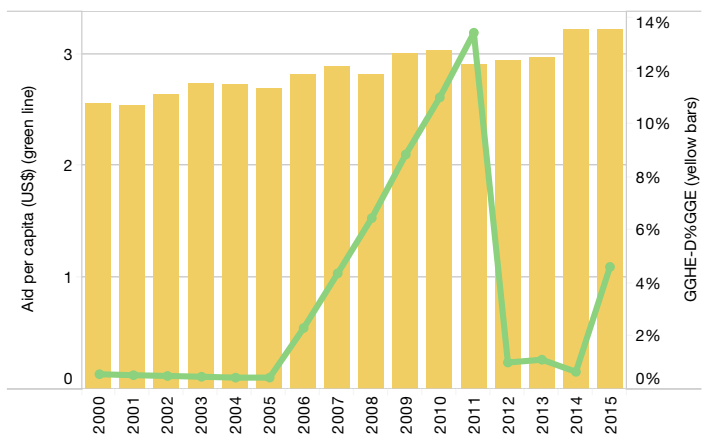


Fig. 20.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

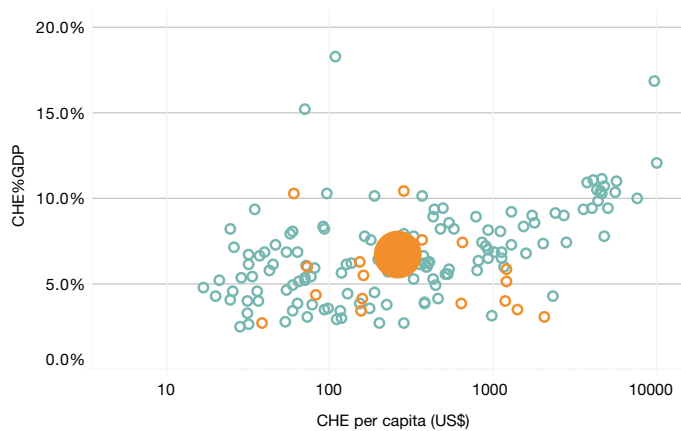


Fig. 20.7. Current health expenditure as a percentage of GDP and per capita (US\$)

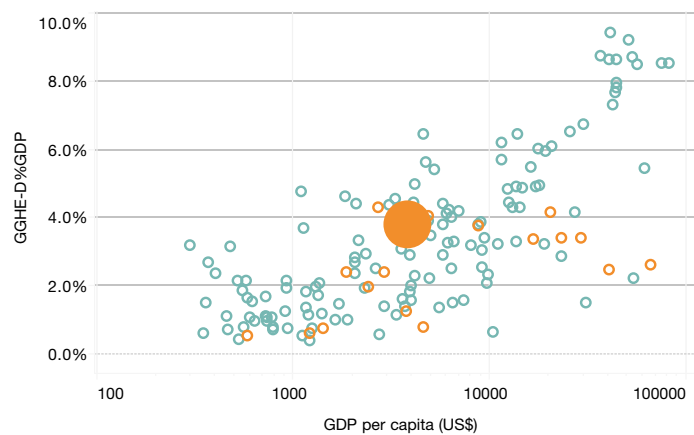


Fig. 20.8. Government health expenditure as a percentage of GDP and per capita (US\$)

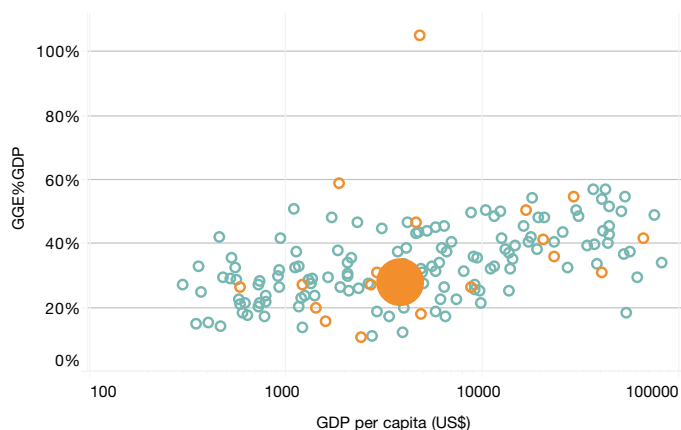


Fig. 20.9. Fiscal space and GDP per capita (US\$)

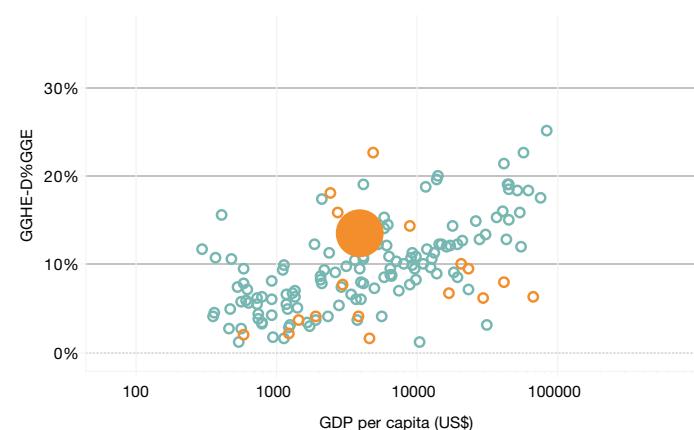


Fig. 20.10. Health prioritization and GDP per capita (US\$)

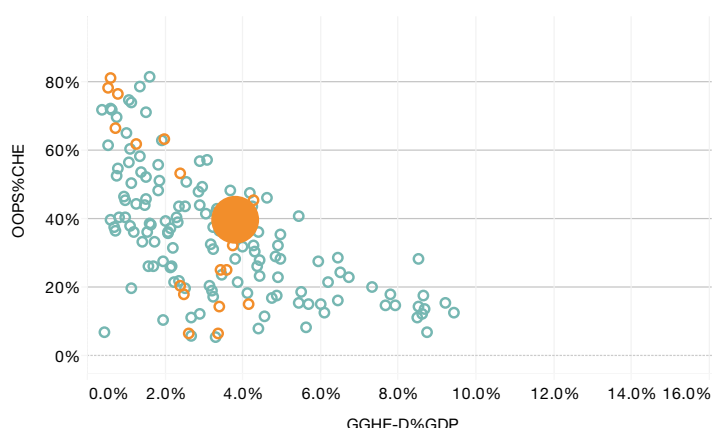


Fig. 20.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

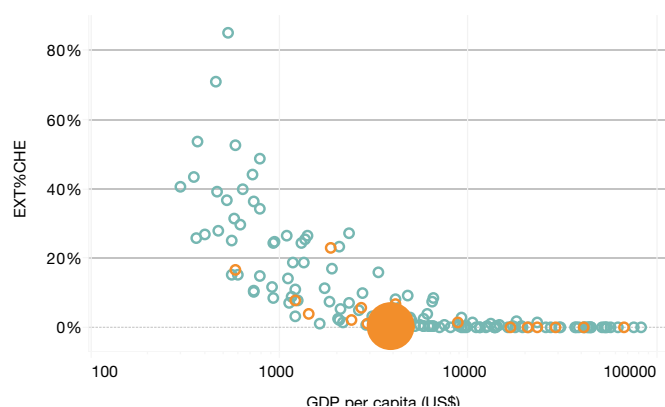


Fig. 20.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending.
 Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank.
 Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

21. United Arab Emirates

1. Macroeconomics

The United Arab Emirates is a high-income country, with a GDP of US\$ 370.3 billion in 2015, constituting a GDP per capita of US\$ 40 450. The United Arab Emirates has an open economy, and had an annual growth rate of 3.6% in 2015. Before the discovery of oil in 1950, the United Arab Emirates economy was mainly driven by agriculture and fishing. At present, it primarily depends on oil and gas revenues which in 2014 contributed 34.3% of nominal GDP and 64% of total government revenue. In recent years, the United Arab Emirates has developed several strategies based on the knowledge-based economy to promote economic diversification and ensure sustainability. In 2015, the reduction in global oil prices resulted in a drop in oil revenues to just over 50%. Growth is however expected to rise as oil production increases, oil prices rise, and investments accelerate before the Dubai Expo in 2020. There is no consistent estimate of poverty in the United Arab Emirates, and poverty is not seen to be a serious problem among the national population. Nevertheless, the Dubai Economic Council in 2011 estimated that 16.9% of residents are impoverished – out of whom 7.2% are Emiratis – according to the national poverty line,⁵² with discrepancies across the Emirates – families living in the northern Emirates spend less than the national average. In 2015, general government expenditure stood at US\$ 114.4 billion, representing 30.9% of GDP.

2. Health financing architecture

The health sector in the United Arab Emirates is governed and financially managed at two levels: the federal level and the Emirate level. Federally, the Ministry of Health and Prevention is responsible for regulating and overseeing the public health sector as well as the provision of health services with a focus on the northern Emirates of Ras-al-Khaimah, Ajman, Umm-al-Quwain, Sharjah, and Fujair. In 2007, the Emirates of Abu Dhabi and Dubai established their own health authorities: the Health Authority of Abu Dhabi and the Dubai Health Authority; and in 2010, Sharjah established its own Sharjah Health Authority. These authorities were established to regulate and operate the health sector in the respective emirates. In 2007, an insurance authority was also established under federal law to regulate and supervise health insurance in the Emirates. Accordingly, in 2007 a public joint stock company known as Daman was established under the Health Authority of Abu Dhabi to manage the insurance scheme in the Emirate of Abu Dhabi. In 2011, the Dubai Healthcare City Authority was also established to regulate Dubai's health care free zone. Private financing agents in the United Arab Emirates include various private insurance companies and individual households.

3. Revenue raising

General government revenue constitutes the main source of funds for the health sector. This revenue mainly originates from oil revenue, taxes, and contributions from households and corporations. In 2015, current health expenditure stood at US\$ 12.8 billion, representing 3.5% of GDP, and per capita current health expenditure was US\$ 1402, out of which domestic private health expenditure constituted US\$ 403. Domestic general government health expenditure constituted 8.0% of general government expenditure in 2015, amounting to a per capita domestic general government health expenditure of US\$ 998.9. The United Arab Emirates does not receive external funding for health.

4. Pooling

The Emirates of Abu Dhabi and Dubai have established their own health insurance programmes based on the principle of splitting financing and provision. In 2015, domestic general government health expenditure constituted 71.3 of current health expenditure. The Emirate of Abu Dhabi was the first to introduce a separate health pool under the Thiqa programme, which mandates coverage for all Emiratis living in Abu Dhabi, besides ensuring basic or enhanced health coverage for expatriates and their families living in Abu Dhabi. In the Emirate of Dubai, the Dubai Health Authority manages two pools: Enaya, which involves all Dubai government employees; and Saada, which targets all Emiratis living in Dubai. Expatriates living in Dubai are covered by private health insurance paid by their employers. Funds for each scheme are not collected in a single pool, as employers and sponsors purchase health insurance from a number of companies, including Daman, rather than a single insurance company. In the northern Emirates, funds are pooled at the federal level. In 2015, voluntary health insurance represented 7.2% of current health expenditure in the United Arab Emirates.

5. Purchasing

In the northern Emirates, the Ministry of Health and Prevention is the main purchaser and provider of health care. In the Emirate of Dubai, the Dubai Health Authority is the main purchaser and provider for government employees and

⁵² People living under AED 80 a day, or AED 2400 a month, are considered impoverished.

for Emiratis living in Dubai, and several private insurance companies also purchase services for the insured national and expatriate population. A similar arrangement has also been introduced in Abu Dhabi through the Daman health insurance company, which purchases services for all nationals and expatriates living in Abu Dhabi from the Abu Dhabi Health Services Company, Seha, or from private providers. In Abu Dhabi, provider payment for inpatient care is carried out using a form of diagnosis-related groups, while for out-patient care, salaries, and fee-for-service and pay-for-performance systems are used for both general practitioners and specialists. In some private hospitals, the pay-for-performance system is used in addition other payment methods.

6. Benefits design

Previously, the United Arab Emirates did not face financial difficulties in the provision of universal access to a comprehensive range of health services for the entire population. Recently however, health needs have been increasing and have become more complex. Benefit packages vary according to the insurance company; there are legislated minimum benefits that the insurance company needs to cover, but the insured individual can however opt for supplementary health insurance. In the Emirate of Abu Dhabi, basic and enhanced insurance packages are being provided to the insured population. In Dubai, nationals and government employees receive a comprehensive benefit package. From 2001 on, government clinics no longer provided free medicines to expatriate cardholders, who were required to purchase them from private pharmacies instead.

7. Population coverage

Health care used to be free for all and in general the Ministry of Health and Prevention provides comprehensive coverage for the whole population. In 2001, the government introduced charges for expatriates against the use of health care services to reduce the draw on public funds. The last decade has witnessed a special focus on universal health coverage, with the United Arab Emirates enacting Article 19 mandating health coverage for the whole population. Hereafter, the Ministry of Health and Prevention started extending its services to small communities scattered around major settlements. For expatriates, who currently comprise 80% of the population, a yearly payment is required to obtain a health card, which then entitles the holder to access health care at Ministry of Health and Prevention facilities against minimal fees. Employers and sponsors are required to provide health insurance coverage for expatriates. The health card and/or health insurance is a mandatory requirement for expatriates without which work permits are not issued. Abu Dhabi and Dubai mandated health insurance coverage to all nationals and expatriates living in the two Emirates in 2006 and 2013, respectively. However, unlike Abu Dhabi, Dubai employers also provide health insurance for dependents on a voluntary basis, and require sponsors to provide health insurance for unemployed individuals under their sponsorship. In Dubai, 10 000 and 130 000 individuals are covered by Enaya and Saada, respectively. In Abu Dhabi, to be enrolled in the Thiqa programme, nationals who are between 18 and 75 years old first need to undergo Weqaya screening. The Emirates of Sharjah and Ajman are gradually moving towards expanding health insurance coverage to their residents, and have announced health insurance coverage for their government employees. The Sharjah government has subsequently extended health insurance to all citizens aged 55 years and above. Mandatory health insurance for expatriates has yet to reach every emirate in the United Arab Emirates, although some employees have private health insurance paid for by their employer, for which there is no reliable data.

8. Service coverage

Health service provision in the United Arab Emirates is divided between public and private providers. The Ministry of Health and Prevention continues to play a pivotal role in service provision; in 2015, there were around 38 public hospitals with 7022 beds, and 124 public clinics in the United Arab Emirates. In addition, the United Arab Emirates has three health care cities: Sheikh Khalifa Medical City, Dubai Medical City and Sharjah Health Care City. Sharjah Health Care City is a health care free zone that allows 100% foreign ownership of companies – it has 160 clinical partners, including hospitals, outpatient medical centres and diagnostic laboratories covering more than 150 specializations. In Abu Dhabi, the Abu Dhabi Health Services Company, Seha, directly and indirectly owns and manages governmental health facilities. In 2013, Seha owned and operated 12 hospital facilities with 2 644 licensed beds, 46 primary health care clinics, 10 disease prevention and screening centres, three mobile clinics, one school clinic, two blood banks, four dental centres, two employee health care centres, and one vaccination centre. In 2015, the universal health coverage index of coverage of essential health services value for the country was 63, among the highest in the world.⁵³

9. Financial protection

Despite new government austerity measures, households still pay to access health care at the point of service. In 2015, out-of-pocket payments for health constituted 17.8% of current health expenditure. According to World Bank development indicators, 9.5% of the population are at risk of catastrophic expenditures for surgical care and 2% are at risk of impoverishment from expenditures for surgical care.

⁵³ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

United Arab Emirates

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	43 150	57 044	35 576	40 451
CHE per capita (US\$)	1 508	1 324	1 398	1 402
GGHE-D%CHE	69	57	71	71
OOPS%CHE	22	30	18	18
GGHE-D%GDP	2.4	1.3	2.8	2.5
GGE%GDP	32	16	33	31
GGHE-D%GGE	8	8	9	8
Population	3 154 925	4 579 562	8 270 684	9 154 302

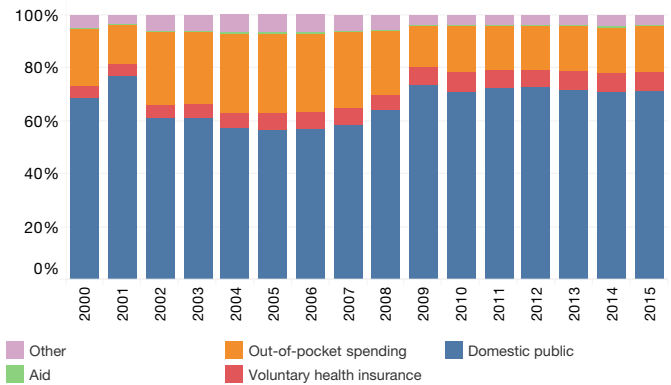


Fig. 21.1. Key health financing and expenditure indicators, 2000–2015

Fig. 21.2. Revenue sources

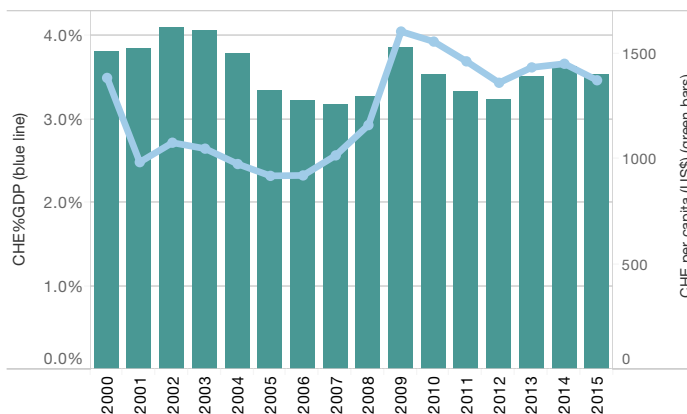


Fig. 21.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

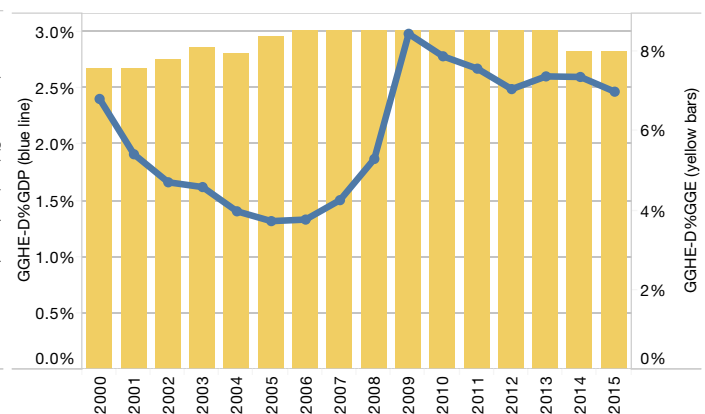


Fig. 21.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

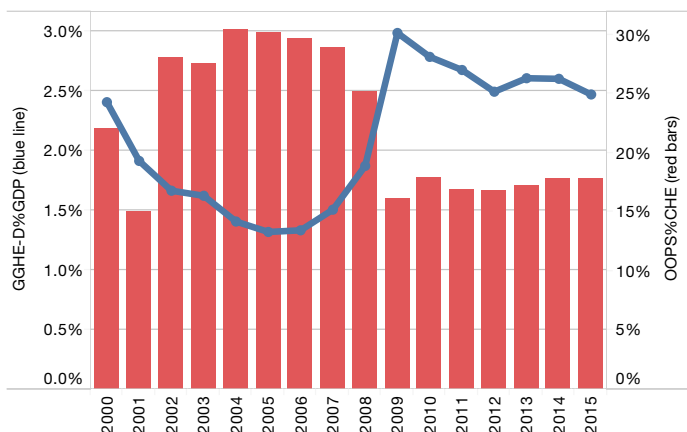


Fig. 21.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

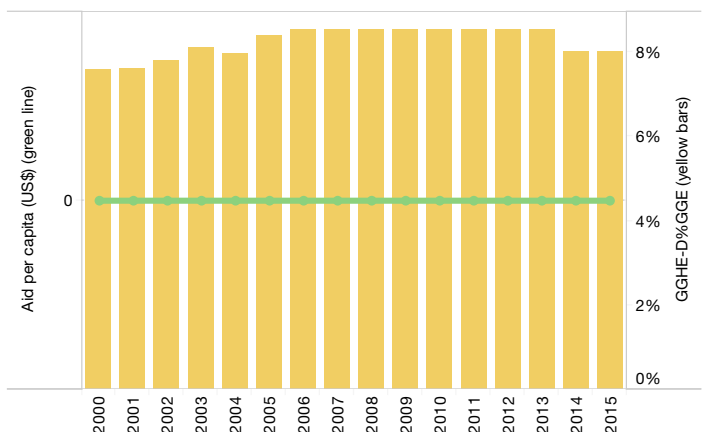


Fig. 21.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

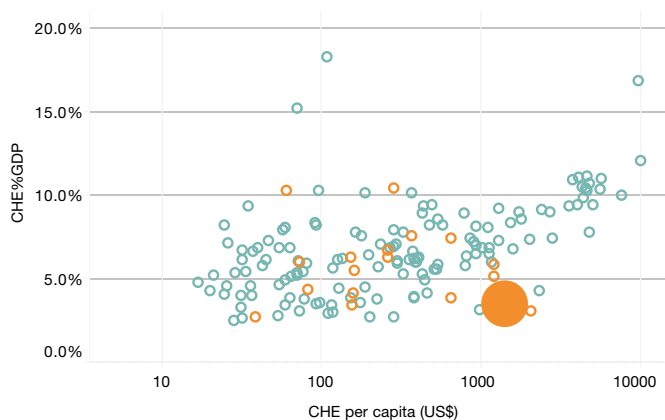


Fig. 21.7. Current health expenditure as a percentage of GDP and per capita (US\$)

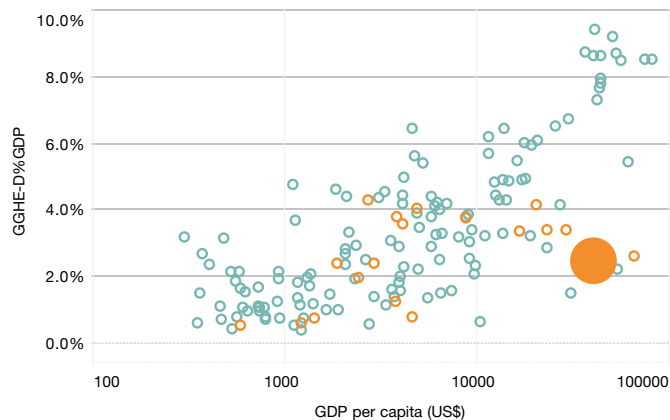


Fig. 21.8. Government health expenditure as a percentage of GDP and per capita (US\$)

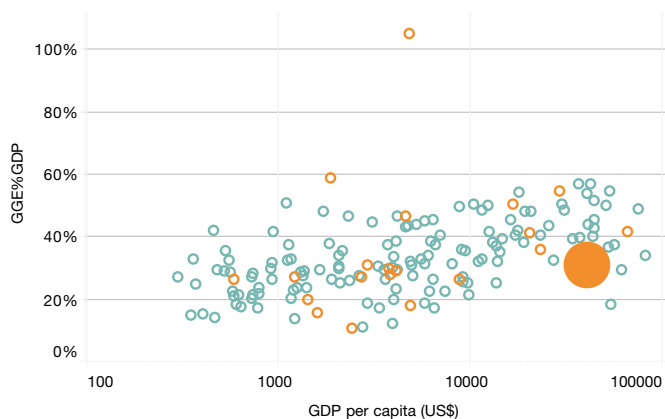


Fig. 21.9. Fiscal space and GDP per capita (US\$)

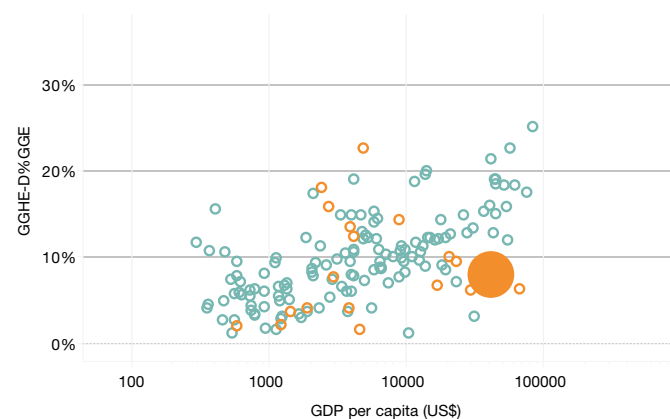


Fig. 21.10. Health prioritization and GDP per capita (US\$)

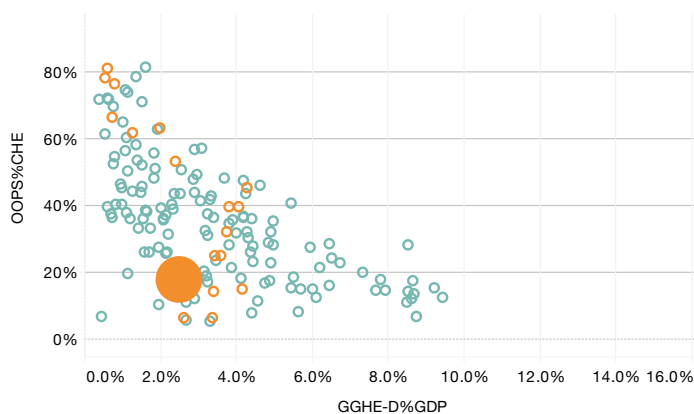


Fig. 21.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

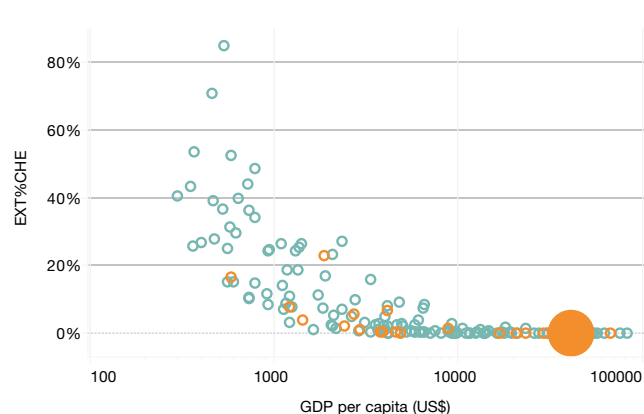


Fig. 21.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

22. Yemen

1. Macroeconomics

Yemen is a low-income country which has been affected by acute conflict since early 2015. As a result, its economy has shrunk by more than one third; employment opportunities have declined substantially; and infrastructure has been critically destroyed. Increasing inflation, pressure on the exchange rate and earmarking a high share of the budget for subsidizing fuel have all led to a sharp contraction in liquidity and a further decrease in GDP. In 2015, Yemen's GDP was approximately US\$ 32.4 billion, while GDP per capita was US\$ 1 204. The government budget greatly depends on oil and gas revenues, which as result of the war and the reduction in oil prices fell to 3% of GDP in 2015 compared to 13% in 2013. General government expenditure stood at US\$ 8.9 billion in 2015 with a per capita general government expenditure of US\$ 329.1, constituting 27.5% of GDP. Before 2015, nearly half of the Yemeni population lived below the poverty line. Since 2015, the World Bank estimated that poverty levels have reached more than 80%, with around 75% of the population in need of humanitarian assistance.

2. Health financing architecture

The Ministry of Public Health and Population is the main steward of the health sector, and is responsible for overall governance, planning, regulation and health care provision. In addition, the health system is decentralized at the district level, with district health management teams responsible for health service planning, provision and coordination within their districts – including working with private and nongovernmental health care providers. The main public financing agents include the Ministry of Public Health and Population, the Ministry of Defense, the Ministry of the Interior and the Ministry of Civil Services. Private financing agents include households, private insurance companies, nongovernmental organizations, and international organizations and donors.

3. Revenue raising

In 2015, current health expenditure constituted around 6.0% of GDP, amounting to a per capita current health expenditure of US\$ 72.0. Households funded the majority of health expenditures, with domestic private health expenditure per capita standing at US\$ 59.1. External financing contributed to 7.8% of current health expenditure in 2015. The Ministry of Public Health and Population receives the majority of its budget from direct budget transfer from the Ministry of Finance; however, the government budget greatly depends on oil and gas revenues, which results in instability due to volatility of oil prices and the current conflict. The government also levies taxes, including income tax and VAT, as well as taxes on special goods, such as cigarettes and qat. In 2015, domestic general government health expenditure represented 2.2% of general government expenditure, corresponding to a per capita domestic general government health expenditure of US\$ 7.3.

4. Pooling

In general, risk pooling is very limited, with government expenditure on health constituting the main pool. The government enacted a social health insurance law in 2012, which would have resulted in pooling contributions from employers and employees; however due to the conflict the implementation of the law is currently suspended. The law only targets the formal sector, representing around 30% of the population, which compromises the risk pooling function by limiting coverage to a relatively better-off section of the population. In 2015, domestic general government health expenditure constituted 10.2% of current health spending, while voluntary health insurance represented only 1.1% of current health spending.

5. Purchasing

The Yemeni health system reflects a relative absence of separation of payer, provider and regulatory functions. Health services are principally directly provided by the government. Few health care providers have sufficient capacity in contracting and claims management, as they contract with insurance companies or third party administrators. In general, line-item and global budgets are being used, with no clear incentives for providers. Some providers enjoy financial and managerial autonomy and receive their budget from the Ministry of Finance, which creates incentives for increasing efficiency and quality in service delivery. After the conflict began, the payment

of civil servants' salaries was interrupted and the procurement of supplies became dependent on contributions and support provided by international organizations. There is a plan to introduce hospital budget autonomy and introduce pay for performance, for example, in Al-Thawra Hospital in Sana'a. In addition, since the start of the conflict several private health insurance companies have begun to emerge.

6. Benefits design

In 2002, a district health system approach was adopted to ensure the provision of comprehensive primary health care services as part of an essential package of health services delivered at health units, health centres and district hospitals, as well as via mobile clinics. After the conflict began, WHO developed a minimum service package, covering general services, trauma care, child care at all levels, nutrition, communicable and noncommunicable diseases, reproductive, maternal and newborn health, and mental health. WHO is working to roll out the minimum service package at the primary care and referral hospital levels across the country, with a focus on highly vulnerable districts.

7. Population coverage

The government has opted for social health insurance as a means to expand coverage by prepayment. Nevertheless, the current social health insurance law only targets the formal sector, which constitutes around 2 million people, including civil servants, pensioners, formal private sector employees and employees of semi-governmental institutions. Taking into account family membership, around 50% of the population would be covered by social health insurance – once enforced – leaving the most vulnerable groups of the population uninsured. There is a special coverage arrangement for the military and police. In addition, some ministries, including the Ministry of Finance and the Ministry of the Economy, used to offer private health insurance to their employees, covering services provided inside the country by private hospitals or medical doctors, or outside the country, in countries such as Jordan.

8. Service coverage

Access to health services and the distribution of health facilities have long been a challenge. In 2017, it was estimated that 14.8 million people lacked access to basic health care, including 8.8 million people living in severely underserved areas. The Ministry of Public Health and Population oversees public health facilities, including central hospitals, district hospitals, health centres, and primary health units, as well as two independent tertiary health care hospitals. Due to the conflict, 23% of health facilities – more than 1900 out of 3507 in 16 governorates – are either not functioning or only partially functioning due to being structurally damaged during the war, because they were already in poor condition, or because they happened to be close to military targets. The Global Health Cluster was initiated to enhance service coverage. In 2017, the number of health facilities in the country operated/supported by the Global Health Cluster partners reached 1618, including 229 district hospitals, 50 governorate hospitals, 522 health centres, 619 health units, 183 mobile teams and 15 specialized centres. The Global Health Cluster succeeded in delivering health services to around 9.5 million people. WHO is currently supporting the concept of inter-district hospitals, which aim at covering several districts with no or low-performing district hospitals, and to give priority to the referral system and inter-facility coordination and reinforce the role of the district and government health office. In 2015, the universal health coverage index of coverage of essential health services value for the country was 39, placing Yemen among the countries with the lowest level of service coverage in the world.⁵⁴

9. Financial protection

In 2015, out-of-pocket payments for health stood at 81.0% of current health expenditure. This high level of out-of-pocket payment is associated with a high risk of financial catastrophe and impoverishment, especially among the low-income sections of the population. In 2005, using a household budget survey, it was estimated that 17.06% or 2.40% of the population faced catastrophic spending on health at the 10% and 25% of household total consumption or income thresholds, respectively, and that 8% of households were pushed into poverty due to out-of-pocket payments for health. In the context of the conflict, it is expected that a higher percentage of the population will be pushed into poverty due to high out-of-pocket health payments. WHO estimates that in 2018, 16.4 million Yemenis are in need of health care.

⁵⁴ Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank; 2017 (https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/, accessed 11 February 2019).

Health expenditure profile

Yemen

	Year			
	2000	2005	2010	2015
GDP per capita (US\$)	2 330	2 507	2 377	1 204
CHE per capita (US\$)	96	115	123	72
GGHE-D%CHE	51	32	22	10
OOPS%CHE	43	65	74	81
GGHE-D%GDP	2.1	1.5	1.2	0.6
GGE%GDP	28	32	30	27
GGHE-D%GGE	7	5	4	2
Population	17 874 724	20 582 928	23 606 780	26 916 208

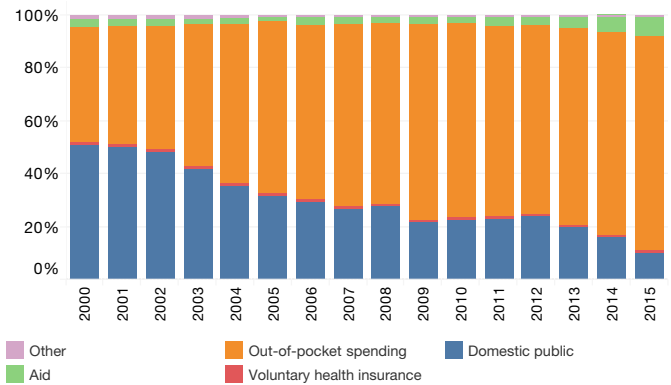


Fig. 22.1. Key health financing and expenditure indicators, 2000–2015

Fig. 22.2. Revenue sources

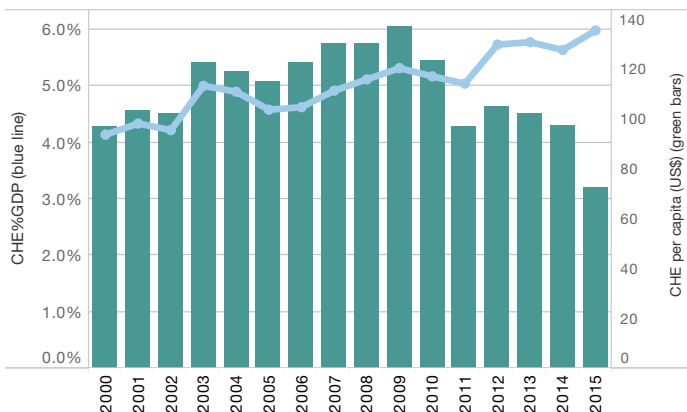


Fig. 22.3. Current health expenditure (CHE per capita [US\$] and CHE as a percentage of GDP)

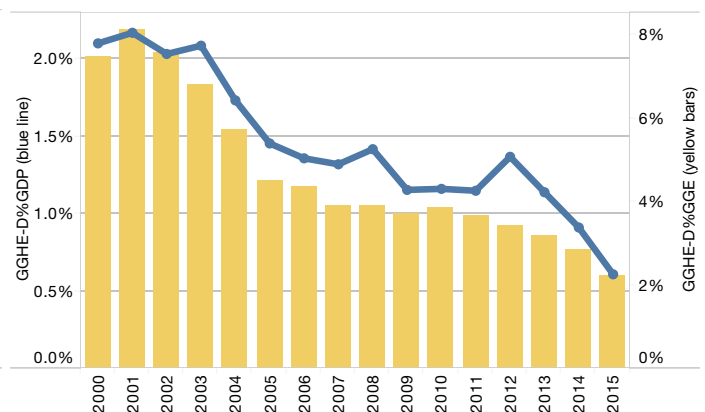


Fig. 22.4. Public expenditure and health prioritization (GGHE-D as a percentage of GDP and GGHE-D as a percentage of GGE)

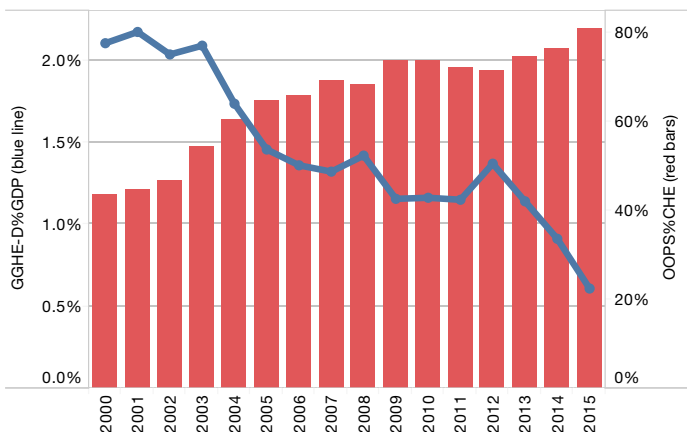


Fig. 22.5. Public expenditure and out-of-pocket spending (GGHE-D as a percentage of GDP and OOPS as a percentage of CHE)

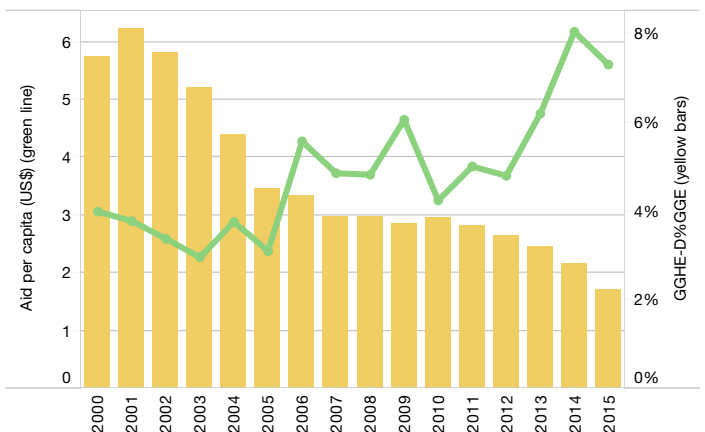


Fig. 22.6. Aid and health prioritization (EXT per capita [US\$] and GGHE-D as a percentage of GGE)

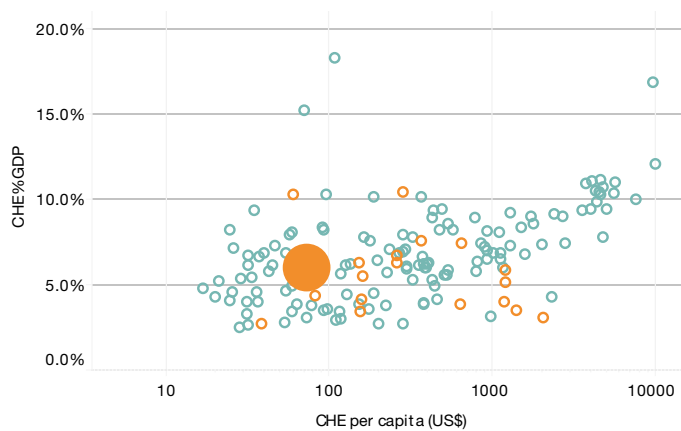


Fig. 22.7. Current health expenditure as a percentage of GDP and per capita (US\$)

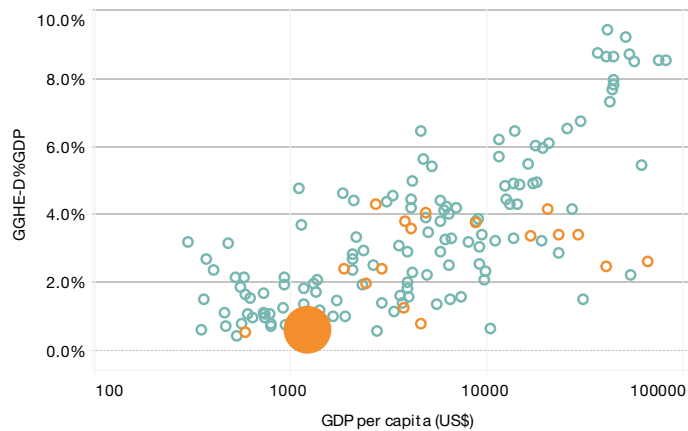


Fig. 22.8. Government health expenditure as a percentage of GDP and per capita (US\$)

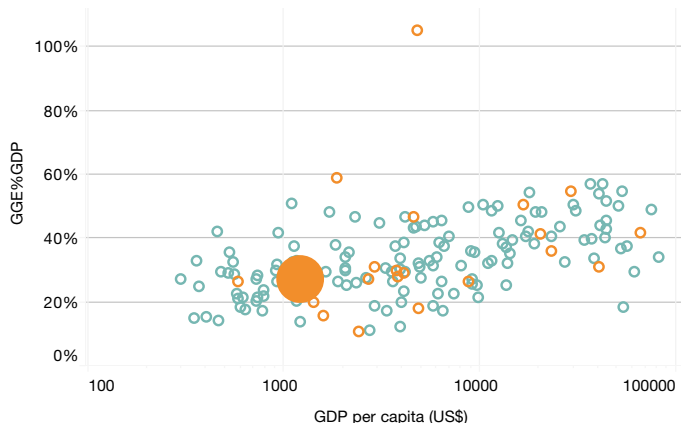


Fig. 22.9. Fiscal space and GDP per capita (US\$)

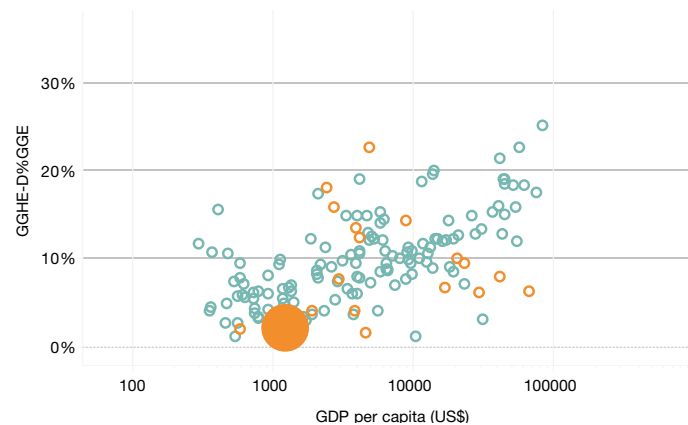


Fig. 22.10. Health prioritization and GDP per capita (US\$)

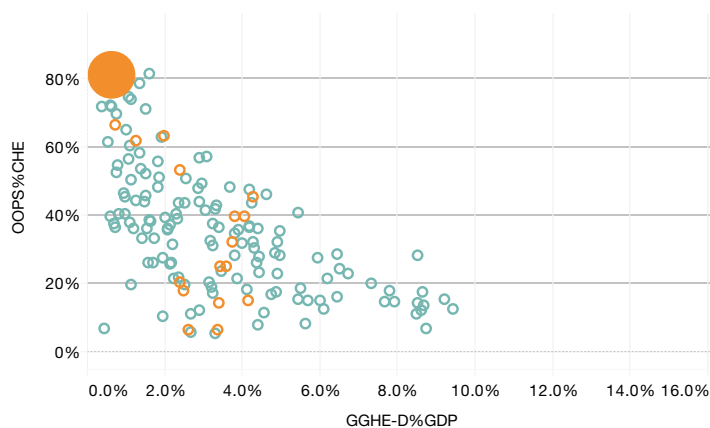


Fig. 22.11. OOPS as a percentage of CHE and GGHE-D as a percentage of GDP

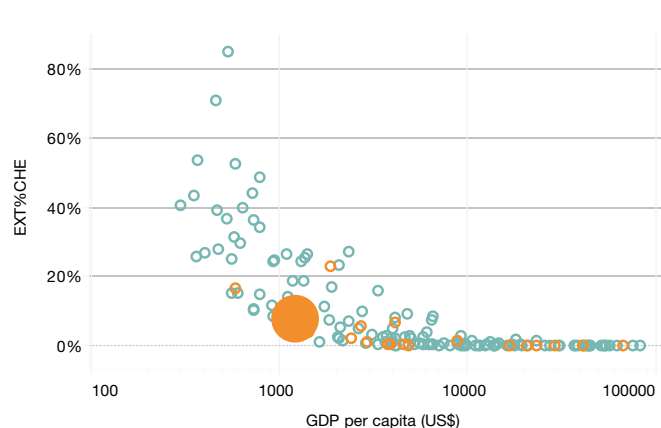


Fig. 22.12. EXT as a percentage of CHE and GDP per capita (US\$)

- country being profiled
- other country in the Eastern Mediterranean Region
- country not in the Eastern Mediterranean Region

Abbreviations: CHE = current health expenditure. GGHE-D = domestic general government health expenditure. EXT = external resources. GGE = general government expenditure. GDP = gross domestic product. OOPS = out-of-pocket spending. Note: Expenditure excludes capital investments. Macroeconomic data such as GDP and GGE are taken from international sources including the International Monetary Fund and the World Bank. Source: WHO global health expenditure database. For more information visit <https://bit.ly/2sdLJDW> or contact nha@who.int

Chapter 4

Conclusion

The Eastern Mediterranean Region has particular needs which warrant adaptive solutions to ensure effective and sustainable progress towards universal health coverage. The complex and acute emergencies in most low-income countries and many middle-income countries of the Region severely impact the capacities of their health systems to fulfil their goals. Furthermore, the exodus of refugee populations is putting pressure on the health systems of nearby countries. The significant population in the informal sector in low- and middle-income countries poses a challenge to traditional coverage arrangements. The large expatriate population in high-income countries calls for a paradigm shift in fulfilling the universal health coverage imperative to transcend the notion of citizenship. Demographic and epidemiological transitions call for a revision of the benefit packages using efficiency, equity and sustainability criteria. Finally, the proliferating private sector calls for innovative approaches to harness its benefits to serve public health goals.

Several countries of the Region have been working to develop their own vision to pursue universal health coverage. Oman has formulated a report entitled Health Vision 2050; Morocco has generalized the Medical Assistance Scheme, a state-funded insurance programme to cover the 8.5 million poor and near poor people in the country; and Pakistan is piloting the Prime Minister National Health Programme in selected districts of its four provinces and four regions. Several countries have embarked on transforming their health system – the Islamic Republic of Iran has funded a Health Transformation Plan to achieve universal health coverage by 2025; and Saudi Arabia, Bahrain and Kuwait have devised overhauling strategies to enhance the performance of their health systems, focusing on efficiency and sustainability goals.

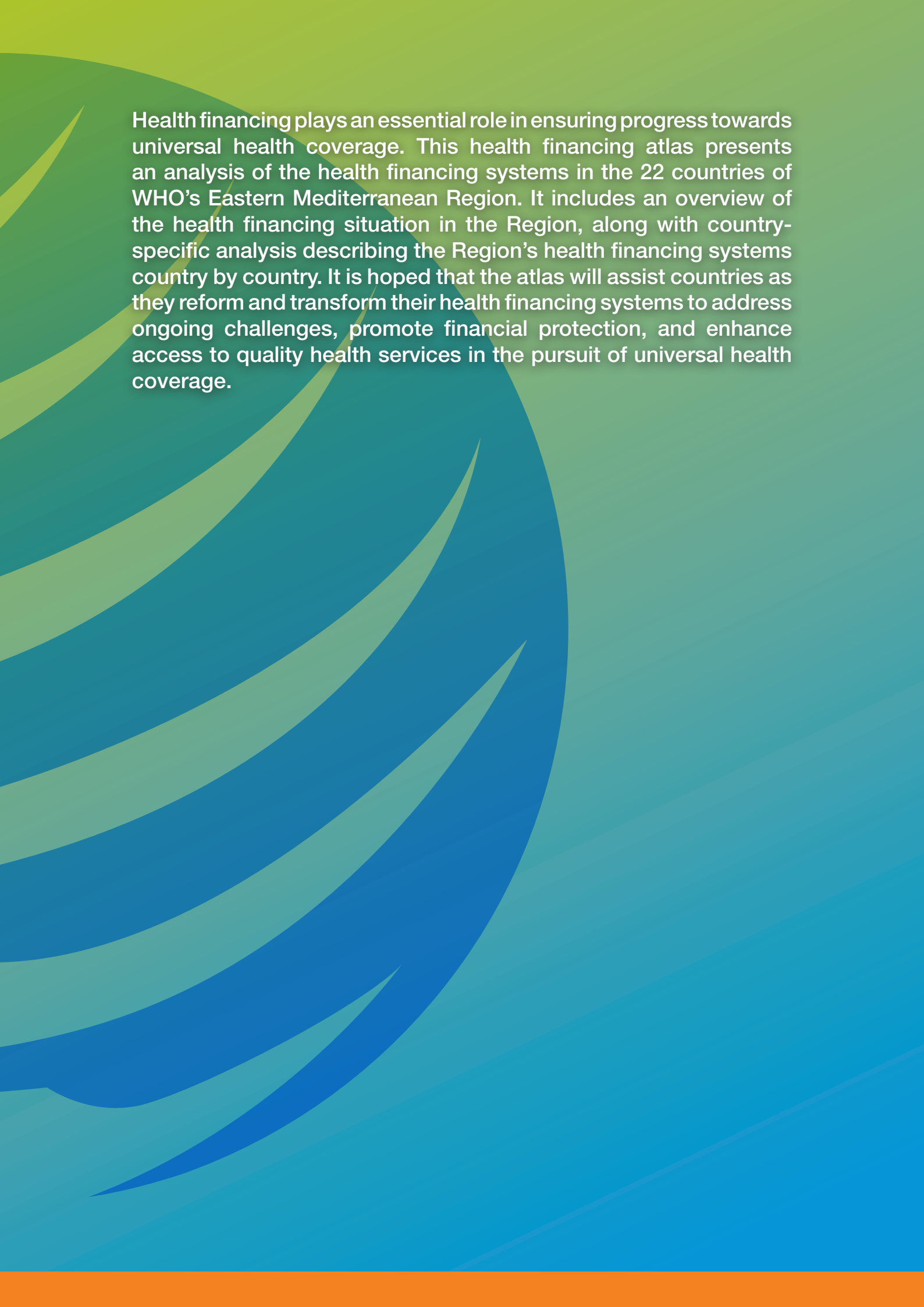
Multiple prepayment arrangements have been developed to cover formal sector employees – mainly those belonging to the public sector, but sometimes those in the formal private sector. Vulnerable groups, including the poor, the near-poor, the unemployed, children and older people, refugees and internally displaced people, and those suffering from complicated health conditions, often remain uncovered. The presence of multiple coverage schemes, which are uncoordinated and not necessarily mutually exclusive, leads to inescapable fragmentation and duplication, compromising efficiency and equity. The United Nations 2030 Agenda for Sustainable Development calls for “leaving no one behind” and for countries to prioritize the most vulnerable sections of their populations to achieve global commitments.

WHO has implemented an inclusive consultative process to identify concrete, evidence-informed actions for countries, which are now incorporated in four strategic components of the updated *Framework for action on advancing universal health coverage in the Eastern Mediterranean Region*.⁵⁵ To ensure implementation, universal health coverage needs to become everybody's business. The United Nations Sustainable Development Agenda is generating the momentum and providing the tools to monitor progress towards universal health coverage, and the world is joining forces to support countries who express the political commitment to move ahead. A recent example of such initiatives was the establishment of the International Health Partnership for Universal Health Coverage 2030 (UHC2030), which “provides a multi-stakeholder platform that promotes collaborative working at global and country levels on health systems strengthening” in order to achieve the Partnership's mission “to create a movement for accelerating equitable and sustainable progress towards universal health coverage”.⁵⁶

The *Health financing atlas 2018* provides countries with an analysis of their health financing systems and acts as a guide as they reform and transform their health financing systems to address ongoing challenges, promote financial protection, and enhance access to quality needed health services in the pursuit of universal health coverage.

⁵⁵ WHO Regional Office for the Eastern Mediterranean. Framework for action on advancing universal health coverage in the Eastern Mediterranean Region (Updated September 2016). Cairo: WHO Regional Office for the Eastern Mediterranean; 2016 (applications.emro.who.int/docs/Technical_Notes_EN_16287.pdf, accessed 28 July 2018).

⁵⁶ The WHO/World Bank partnership: International Health Partnership for Universal Health Coverage 2030. See UHC2030 [website] (<https://www.uhc2030.org/>, accessed 28 July 2018).



Health financing plays an essential role in ensuring progress towards universal health coverage. This health financing atlas presents an analysis of the health financing systems in the 22 countries of WHO's Eastern Mediterranean Region. It includes an overview of the health financing situation in the Region, along with country-specific analysis describing the Region's health financing systems country by country. It is hoped that the atlas will assist countries as they reform and transform their health financing systems to address ongoing challenges, promote financial protection, and enhance access to quality health services in the pursuit of universal health coverage.