World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean
Regional Committee for the Eastern Mediterranean
Sixty-fifth session
Provisional agenda item 4(e)

EM/RC65/8
October 2018

Private sector engagement for advancing universal health coverage

Executive summary

1. Universal health coverage (UHC) means that everyone can use the health services they need, of sufficient quality to be effective, without facing financial hardship. Multiple global and regional commitments identify UHC as a top priority, notably including the 2030 Agenda for Sustainable Development and the World Health Organization's (WHO) thirteenth general programme of work 2019−2023 (GPW 13) *(1)*. This paper examines the potential contribution of the private sector – defined as formal, for-profit health service providers – in advancing UHC in WHO's Eastern Mediterranean Region.

2. The private health sector is very active in the Region and provides both ambulatory and hospital services. It is also heavily involved in infrastructure development and the production and supply of medicines and health technologies. Private health sector use in the Region is particularly important in countries where government spending on health is low and in countries experiencing emergencies. However, the private health sector has mainly grown with little public policy direction and is not part of government health sector planning in many countries of the Region. It is thus an untapped resource in the context of UHC.

3. The 2017 joint WHO/World Bank Group global monitoring report on UHC reveals that almost half of the Region's population does not have access to 16 essential health services *(2)*. Contracting with private health sector providers to deliver essential health service packages using strategic purchasing options and financial protection arrangements will help Member States to achieve UHC.

4. This paper proposes a framework for action for effective engagement with the private health sector to move towards UHC. There is no system to collect information from private providers in most countries of the Region and country-level studies are therefore needed to close information gaps and gain insight into specific areas of the private health sector. However, despite these gaps and other challenges, the framework can help identify strategies and actions for Member States and facilitate their efforts to enhance the equity, financial accessibility and quality of services provided by the private health sector and harness its capacity for advancing UHC.

Introduction

5. In May 2018, the Seventy-first World Health Assembly approved the thirteenth general programme of work 2019−2023 (GPW 13) of the World Health Organization (WHO) *(1)*. GPW 13 was developed through extensive consultation, and will guide the Organization's work for at least the next five years. It identifies three interconnected strategic priorities and ambitious goals related to the 2030 Agenda for Sustainable Development. The strategic priorities and goals encapsulate the step-change in public health that needs to be achieved globally by 2023 to keep on track with achievement of the health-related Sustainable Development Goals (SDGs).

6. This paper is one of a series intended to foster discussion on the implementation of GPW 13 in the Region at the 65th session of the WHO Regional Committee for the Eastern Mediterranean. It focuses on the strategic priority of achieving universal health coverage (UHC) and its related goal: to ensure that 1 billion more people benefit from UHC. More specifically, it focuses on the role of the private sector in advancing UHC.

7. UHC means that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, without facing financial hardship. UHC is the key to attaining SDG 3 on health, as well as the health-related targets of other SDGs. The essence of UHC is

strong and resilient people-centred health systems. Progressively advancing towards UHC is a political choice with important social and economic benefits.

8. According to the 2017 WHO and World Bank global monitoring report on UHC, the estimated population of the WHO East Mediterranean Region in mid-2017 was about 650 million *(2)*. It can be concluded from the report's findings that only about 347 million people have access to basic UHC services in the Region, which represents a weighted population average of 53%. That is below the global weighted population average of 64%.

9. The World Bank considers that the private health sector consists of all actors outside of government, including for-profit, not-for-profit, formal and informal entities *(3)*. This includes service providers, pharmacies and pharmaceutical companies, producers and suppliers, and traditional healers. For the purposes of this paper, however, the private sector is defined as only formal, for-profit health service providers.

10. Since the 1990s, researchers have called attention to the previously unrecognized scale of private medical services in the developing world *(4)*. As cross-country datasets have become available, it has become increasingly clear that the private sector plays a major role in the financing and provision of care in middle- and low-income countries. Country reports show that the main factors underlying the expansion of the private health sector include: the poor image and low quality of health care in the public sector compared with the private health sector, which is perceived to be better and has a higher level of customer satisfaction; the absence of public health facilities in underserved areas; large urban migration and the inability of the public health sector to cope with the increasing population in the urban fringes; and low government spending on health and increased use of the private health sector, contributing to higher out-of-pocket spending. In addition, in countries where dual practice is legally allowed and/or prevalent, the private sector is the main source of income for most physicians. High profits and weak enforcement of the tax system have also led to private health sector growth. These factors apply to most countries of the Region.

11. Globally, the private health sector plays an important role in health service provision in both developed and developing countries, and the Eastern Mediterranean Region is no different. Although there is wide recognition of this role, in most countries of the Region it has not been possible to formulate an evidence-based policy and strategy to make use of the private health sector to expand service coverage. With a renewed global impetus to achieve UHC by 2030 in the context of the Agenda for Sustainable Development, there is now an urgent need to build effective partnerships with the private health sector, because without them, the goal of UHC will not be achieved by government alone.

12. Contracting with the private health sector is emerging as a powerful tool for harnessing its resources to help achieve health sector goals *(5)*. The interest of the private health sector in ensuring ongoing revenue flows through contractual arrangements gives the public sector (as contractor) the ability to influence the behaviour of private providers, including compliance with quality standards and to agree on provider payment terms suitable for both sectors. However, contracting for health services is a complex process that requires substantial government capacity in order to plan, negotiate, implement and monitor on an ongoing basis the contracted services.

13. In October 2017, a presentation was made in a pre-session meeting of the 64th session of the Regional Committee for the Eastern Mediterranean on the role of the private health sector in advancing UHC. Member States requested the Regional Director, in resolution EM/RC64/R.1, to develop a regional framework for action on advancing the role of the private health sector in the move towards UHC, and to present it at the 65th session of the Regional Committee in 2018. Earlier, in 2016, the 63rd session of the Regional Committee had adopted resolution EM/RC63/R.2 on scaling up family practice towards UHC. That resolution urged Member States to strengthen public–private partnerships in service delivery through family practice. The importance of non-state providers had already been recognized in 2014 in the framework for action on advancing UHC in the Eastern Mediterranean Region, which requested countries to strengthen their

engagement with, and regulation of, the for-profit and not-for-profit private sector for service provision in support of UHC.

14. An important reference in WHO's possible relations with the private sector is the Framework of Engagement with non-State Actors (FENSA). FENSA was adopted by the Sixty-ninth World Health Assembly in 2016. It is the first overarching framework for WHO governing all kinds of engagement with all kinds of non-State actors (nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions). Its purpose is to provide a set of rules in order to strengthen and enhance WHO's engagement with non-State actors while reinforcing WHO's management of the potential risks related to these engagements.

15. This paper:

- presents the current state of the private health sector in the Eastern Mediterranean Region;
- explains why engagement with the private health sector in service delivery is necessary; and
- proposes a framework for action on effective engagement with the private health sector which encourages Member States to advance UHC by expanding health services.

Analysis of the private health sector in Eastern Mediterranean Region

16. Despite limitations, a systematic effort has been made to gather the best available information on the private health sector in the Region. Data for this paper were collected from four sources:

- the 2017 update of the WHO report *Analysis of the private health sector in countries of the Eastern Mediterranean: exploring unfamiliar territory (6)*;
- private health sector factsheets prepared for 17 Member States of the Region (World Health Organization, unpublished research, 2015);
- a WHO review of private health sector regulations for four selected countries of the Region – Egypt, Lebanon, Morocco and Yemen *(7)*; and
- a recent literature review of the private health sector in developing countries, including review of initiatives and reports from academia and international development agencies over the past five years.

17. The framework for the analysis of the private health sector followed the conceptual framework of the six health system building blocks *(8)*:

1) service provision: type of service by provider (curative, public health), coverage/use of services, infrastructure (hospitals, clinics, pharmacies, laboratories) and quality of health care;

2) health workforce: skill mix and cadres, and employment by sector (public/private);

3) financing: tracing the flow of finances to private sector providers from source to agent to provider;

4) technology and essential medicines: local production and technology transfer, and high-tech medical equipment;

5) governance: regulation (contracting, accreditation) and public–private partnerships; and

6) intelligence: information generation, consolidation, compilation and use.

18. The private health sector is growing in the Region. Being a for-profit sector, it is inherently market driven and is not sensitive to equity considerations. It is therefore concentrated in urban centres and caters for those who can pay. Although it is a leading outpatient health service provider in most countries of the Region, its role, capacities and workings are poorly understood. Private health sector use in the Region is particularly high in countries where government spending on health is low. The private health sector is poorly regulated, and the existing sporadic partnerships between the public and private sectors are not adequately organized,

mapped or understood. In addition, the private health sector has grown with little public policy direction and is not part of government health sector planning in many countries of the Region. It is thus an untapped resource in the context of UHC.

19. As the experience of Iraq, Libya, Somalia, Syrian Arab Republic and Yemen has shown, the private sector can play an important role in countries experiencing emergencies. It adopts a dynamic approach to deal with the evolving health needs of the population, while governments typically weaken or cease to exist. Reports indicate that the private sector is a key source of health care for refugees: 64% of Syrian refugees registered with the United Nations High Commissioner for Refugees (UNHCR) in Egypt seek care in the private sector *(9)*. In Jordan, a 2015 UNHCR survey found that 58% of Syrians who sought medical care went to a private facility first (defined as a private clinic/hospital, nongovernmental organization, or pharmacy) *(10)*.

20. Governance of the private health sector depends on government policy, the existence of a regulatory system and its implementation, the institutional capacity of the ministry of health and its experience with public–private partnerships, and contractual arrangements. In general, public policies in developing countries tend to focus on regulatory systems, although increasingly policies are also being developed for partnership with the private health sector to expand access and coverage. Health regulatory systems cover the workforce, facilities and services, and regulation is supposed to apply to both public and private sectors. More specifically, regulation of the health workforce includes licensing and registration, (re)certification, credentialing and professional privileges, and delineating where and when health workers can work legally. Regulation of facilities includes licensing and (re)accreditation. Service regulation addresses quality, safety and cost.

21. Policies for engagement between the public and private health sectors are growing in most countries of the Region. Regulatory responsibility usually rests with ministries of health, more specifically the departments of health legislation and regulation (Gulf Cooperation Council countries and Morocco), directorate for the private health sector (Afghanistan), directorate of quality assurance (Egypt), directorates of inspection (Tunisia and Morocco) or contracting units (Lebanon). Pakistan has established a Ministry of Health Services, Regulation and Coordination that focuses on improving regulatory capacity.

22. Laws, regulations and levels of enforcement vary considerably across the Region. In low-income countries, policies and commitment to regulate the private health sector are weak or non-existent. In Afghanistan, Somalia and Yemen some aspects of the regulatory function are missing entirely. Countries that have had longer experience of engaging with the private health sector, such as Lebanon, have better developed policies and procedures. On the other hand, some countries, such as Afghanistan and Pakistan, have recently developed policies and are already partnering with the private sector by contracting out delivery of health services. Full information on regulation is not available for most countries of the Region. In the Islamic Republic of Iran, the Medical Council regulates the quantity and licensing of medical professionals and private medical practices, and the Ministry of Health and Medical Education and universities of medical sciences oversee accreditation of all hospitals and medical facilities as well as the registration, licensing, pricing and quality control of facilities, medicines, laboratory materials, food products and nutritional supplements. The Lebanese Ministry of Public Health approves licenses for health facilities and health professionals and establishes quality standards, but does not control the production, quality or geographical distribution of the health workforce, which is severely imbalanced in favour of cities. In Tunisia, the Ministry of Public Health has adopted well-defined legal and regulatory standards that have been updated and revised carefully, and closely regulates the licensing of health professionals.

Table 1. Percentage of outpatient/ambulatory health services provided by the private health sector in selected countries

Interventions/services	Egypt[a]	Iraq[b]	Jordan[c]	Morocco[d]	Palestine[e]	Syrian Arab Republic[f]	Tunisia[g]	Yemen[h]
Source of modern methods of contraception (percentage of women of reproductive age currently using modern contraception)	44	90	56	NA	74	NA	NA	46
Place of delivery (percentage of women who gave birth in health facility in the 5 years prior to the survey)	71	11	34	11	36	56	15	37
Diarrhoea treatment for children under 5 (percentage of children aged 0–59 months who sought treatment outside home for diarrhoea)	78	NA	41	NA	NA	NA	NA	63
Acute respiratory infection (ARI) treatment for children under 5 (percentage of children aged 0–59 months who sought treatment outside home for ARI symptoms)	78	43	40	NA	62	69	45	68

NA = not available

Sources:

[a] Ministry of Health and Population (Egypt), El-Zanaty and Associates/Egypt, ICF International. Egypt Health Issues Survey 2015. Cairo: Ministry of Health and Population/Egypt and ICF International; 2015.

[b] Central Organization for Statistics and Information Technology (Iraq), Kurdistan Regional Statistics Office, Ministry of Health (Iraq), United Nations Children's Fund (UNICEF). Iraq Multiple Indicator Cluster Survey 2011. New York: United Nations Children's Fund; 2013.

[c] Department of Statistics (Jordan), ICF International. Jordan Population and Family Health Survey 2012. Calverton, Maryland: Department of Statistics (Jordan) and ICF International; 2013.

[d] Morocco national survey on population and family health 2010–2011. Ministry of Health (Morocco), Pan Arab Project for Family Health (PAPFAM), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and World Health Organization (WHO).

[e] Ministry of Health (Palestine), Palestinian Central Bureau of Statistics, United Nations Children's Fund (UNICEF). Palestine Multiple Indicator Cluster Survey 2014. New York, United States: United Nations Children's Fund; 2015.

[f] United Nations Children's Fund (UNICEF), Central Bureau of Statistics (Syrian Arab Republic), Ministry of Health (Syrian Arab Republic), Pan Arab Project for Family Health (PAPFAM). Syria Multiple Indicator Cluster Survey 2006. New York: United Nations Children's Fund; 2006.

[g] Ministry of Regional Development and Planning (Tunisia), National Institute of Statistics (Tunisia), United Nations Children's Fund (UNICEF). Tunisia Multiple Indicator Cluster Survey 2011-2012. New York: United Nations Children's Fund; 2014.

[h] Yemen national health and demographic survey 2013. Rockville, Maryland, USA: Ministry of Public Health and Population (Yemen), Central Statistical Organization (Yemen), Pan Arab Project for Family Health (PAPFAM), and ICF International. 2015.

23. The private health sector is very active in the Region and provides both ambulatory and hospital services. It is also heavily involved in infrastructure development and the production and supply of medicines and health technologies. Private care providers are reluctant to invest in preventive care or in remote or deprived areas. Non-existent or weak regulatory systems and weak mechanisms for monitoring the quality of health services offered by private health providers are major challenges.

24. Based on available data from ministries of health in middle- and low-income countries of the Region, the private health sector provides between 33% and 86% of outpatient or ambulatory services. It also provides between 11% and 81% of the health services used by the poorest quintile in those countries *(11)*. The proportion of all primary health care facilities that are private clinics ranges from 15% to 88% in high-income countries, from 5% to 78% in middle-income countries, and from 20% to 90% in low-income countries. There are almost 50 000 private clinics in Egypt and 75 000 private general practitioners in Pakistan that do not fall under any proper regulatory system. Table 1 shows the use of private outpatient services in eight selected countries for four interventions: as a source of modern methods of contraception (in 44–90% of cases); as the place of delivery (11–71%); for provision of diarrhoea treatment for children under 5 (41–78%); and for provision of acute respiratory infection treatment for children under 5 (40–78%).

25. The total number of hospital beds in the Region is estimated to be 740 000, 80% of which are in public hospitals and the remaining in private (18%) and not-for-profit (2%) hospitals. Governments continue to be a main provider of hospital services in all high-income countries, but the private hospital sector is growing fast. The proportion of private hospital beds ranges from 6% to 22% in high-income countries, the highest being in Saudi Arabia. In middle-income countries, 7% to 83% of hospital beds are in the private sector, the highest proportion being in Lebanon.

26. In 2014, about US$ 153 billion was spent on health in the Region, which constitutes 1.8% of total world health expenditure for 8.7% of the world's population *(12)*. In the same year, the share of out-of-pocket spending in the Region varied between 6% and 76%, with the highest out-of-pocket payment in the poorest countries and the lowest in the richest countries. Out-of-pocket spending is a good proxy indicator for spending on private health care. A closer look at health expenditure in the same year shows that the poorest countries spent 36%–79% as private health expenditure, while the wealthiest countries spent between 10% and 37%, and middle-income countries between 26% and 66%. Out-of-pocket spending on health has decreased over the past two decades in high- and middle-income countries from 22% to 13% and from 48% to 41%, respectively, but has remained at more than 60% in low-income countries *(12)*. Although precise information about the nature of the expenditure is not available, evidence suggests that a substantial proportion is spent on medicines and diagnostic tests, followed by private consultations. Data from middle-income countries of the Region show that almost 5% of households face financial ruin following ill health (4.5% in Tunisia in 2005) and many households are pushed into poverty (1.4% in Morocco in 2001) because of high out-of-pocket expenditure *(13)*.

27. Information on the distribution of the health workforce between the public and private sectors in the Region is limited and unreliable. Data from Gulf Cooperation Council countries indicate a higher proportion of physicians working in the public sector: 90% in Kuwait, 80% in Oman, 65% in Saudi Arabia and 61% in the United Arab Emirates. In Lebanon, the private hospital sector is the main employer of the health workforce; of the available nurses working in Lebanon, 80.3% work in private hospitals *(14)*. In Jordan, 43% of physicians and 51% of nurses work in the private health sector and the country is a destination for medical tourists. In the Islamic Republic of Iran, the private sector focuses mainly on secondary and tertiary health care in urban areas. Regulation of health workforce practice is not fully developed in most countries. Licensing standards are not well developed, and re-licensing (linked to continuous professional development) is not required or implemented. Dual medical practice, i.e. working in both public and private sectors, is common in most countries of the Region, and few countries restrict it. Gulf Cooperation Council countries allow only nationals to engage in dual practice and they are a small proportion of the overall health workforce. The Egyptian national health care provider survey found that 89% of physicians in the sample had multiple jobs *(15)*. In Pakistan, too, most public sector physicians work in the private sector in the afternoon.

Physicians prefer to keep two jobs because of low salaries in the public sector. A review of dual practice reported that it was likely to decrease the amount of time spent in government jobs. This reduces the access of low-income people to medical care as they cannot afford to seek care in the private sector *(16)*. In most of the countries of the Region that are experiencing emergencies, public services have been interrupted and most available health professionals provide services through the private sector.

28. On average, more than 60% of pharmacies in countries of the Region are in the private sector *(6)*. Between 27% and 90% of pharmacies in high-income countries are owned and managed within the private sector, while in middle-income countries, 60% to nearly 100% of pharmacies are privately owned, and in low-income countries the proportion ranges from 22% to 98% *(6)*. In Egypt and Pakistan, more than 60 000 and 40 000 pharmacies, respectively, are in the private sector, and they are weakly regulated *(6)*. Over-the-counter dispensing and sale of antibiotics without a prescription is common practice in the Region, and in many countries, pharmacies are not managed by qualified personnel and where they are, the boundaries between prescribing physicians and dispensing pharmacists are vague.

29. Various surveys in middle- and low-income countries have shown insufficient supply of essential medicines in the public sector and patients buying medicines from private pharmacies. Over-the-counter sale of prescription-only medicines, unethical drug promotion and induced demand for medicines and health technology by medical professionals at the behest of the suppliers and producers are significant problems. Growing antimicrobial resistance in the Region is one consequence of these practices and is a major public health concern. Other issues include ineffective treatment, adverse drug reactions, drug dependence and an economic burden on both patients and society. Deliberate promotion of high cost medicines is a common practice among private physicians. Irrational use of health technology, especially in the private sector, is also a serious problem leading to high out-of-pocket expenditure, technical misuse and medical errors associated with health technologies. There is limited government control of medicine promotion and advertising, which influence the use of medicines offered by the private health sector.

30. There are major gaps in information about private diagnostic and laboratory services in the Region. In the Islamic Republic of Iran, Pakistan, Saudi Arabia and Sudan, more than 50% of diagnostic facilities are in the private health sector *(6)*. Most tertiary diagnostics, such as computed tomography and magnetic resonance imaging, are in the private sector. Diagnostic facilities in the private health sector are characterized by high prices, unneeded tests and lack of information about quality, which affect poor patients the most.

31. While regulatory bodies are responsible for oversight of the pharmaceutical and health technology sector, licensing facilities, registering medical products and monitoring the quality and safety of medical devices, in most middle- and low-income countries private sector regulation is either weak or non-existent. The Ministry of Public Health in Lebanon oversees hospital accreditation, which is a tool for regulating quality and costs. Sudan has regulations on the importation and licensing of medical technology; private facilities are required to send regular reports, but compliance is low. Regulatory functions in the Syrian Arab Republic are performed by the Ministry of Health and professional associations, but again, compliance by the private sector is low. The range of medical services offered by the private sector has significantly increased in Pakistan, Tunisia and Yemen, but regulatory oversight by government is weak. This lack of regulation is either due to a lack of capacity and resources or to a lack of enforceable legal authority. Powerful lobbying by interest groups often undermines the regulatory framework.

Framework for action to engage the private health sector to expand service coverage for UHC

32. Engaging the private health sector to expand health service coverage in the context of UHC requires strengthened public–private engagement. Such engagement goes beyond regulation of the private health sector and requires a comprehensive approach. A framework for action is needed which takes into account the objectives to be achieved, strategies to be adopted, responsibilities of both the public and private health sectors and of development partners, and the development of policy, legal and organizational frameworks.

Such a framework does not exist at present. This paper attempts to fill that gap by proposing a framework for action for effective engagement with the private health sector to move towards UHC (Annex 1). This framework would help achieve four objectives:

- expanding and improving equitable access to health services;
- establishing a national health service for UHC with the participation of the private health sector;
- assuring improved quality of services provided by the private health sector through agreed standards, regulation and incentives; and
- enhancing the financial protection goal of UHC through strategic purchasing from the private health sector.

33. The framework includes the following five recommended strategies, each with three levels of engagement – consultation, involvement and partnership:

- develop a policy framework, organizational systems and financing strategies for engaging private health sector providers in the country's health system;
- develop strategic options for private health sector engagement, including strategic purchasing, and facilitate and institutionalize private health sector engagement, including capacity-building;
- improve the quality of services in the private health sector;
- ensure that regulatory mechanisms for health systems are enforced effectively in the private health sector; and
- develop monitoring and reporting mechanisms for private health sector providers.

Conclusion

34. The renewed impetus for UHC in the context of the 2030 Agenda for Sustainable Development and GPW 13, and concerns about patient safety and financial protection, highlight the need to build the capacity of ministries of health to effectively design, manage, monitor and evaluate their engagement with the private sector for health service delivery. Contracting with private health sector providers to deliver essential health service packages using strategic purchasing options and financial protection arrangements will help Member States in advancing UHC.

35. The importance of partnership with the private health sector is increasingly being acknowledged by ministries of health, and policies for engaging with the private health sector are developing across the Region. However, many challenges still exist in ensuring the effective contribution of the private health sector to the achievement of public health goals in the Region.

36. Involvement of the private health sector provides a unique opportunity to advance UHC. This has not been adequately explored by public sector policy-makers in most countries of the Region. Many information gaps remain and there is no system to collect information from private providers in most countries of the Region. Country-level studies are therefore needed to close information gaps and gain insight into specific areas of the private health sector.

37. Despite the many challenges, the regional framework for action on engagement with the private health sector to expand service coverage for UHC can help Member States to identify strategies and actions to facilitate their efforts. WHO will assist Member States in strengthening their capacity to engage with the private health sector for service delivery. Countries are urged to endorse this framework, which will enhance the equity, financial accessibility and quality of services provided by the private health sector and harness its capacity for advancing UHC.

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Annex 1

Framework for action on effective engagement with the private health sector to expand service coverage for universal health coverage

Strategies (levels of engagement)	Continuum of engagement	Actions/interventions	Support from WHO and other development partners
1. Develop a policy framework, organizational systems and financing strategies for engaging private health sector providers in the country's health system	Consultation[a]	1.1 Define the objective in engaging the private health sector in the country's health service delivery and the nature/level of that engagement. 1.2 Create a broad consensus among political, administrative and civil society stakeholders on policy approaches and priorities for engaging the private health sector, embodied in the form of a policy document.	• Facilitate policy dialogue between the ministry of health, the private health sector and other stakeholders. • Strengthen/develop the capacity of Member States to engage with the private health sector in health service delivery.
	Involvement[b]	1.3 Develop a framework for costing and tariff estimates for services provided by the private health sector as prioritized in the policy.	
	Partnership[c]	1.4 Partner with experts and research groups to identify demand and areas to engage the private health sector, methods of innovative financing, a package of services, population coverage, and other aspects of private health sector engagement as prioritized in the policy document.	
2. Develop strategic options for private health sector engagement, including strategic purchasing, and facilitate and institutionalize private health sector engagement, including capacity-building	Consultation	2.1 Identify appropriate models of private health sector engagement/partnership options and financing methods, including contracting, strategic purchasing and other options, as appropriate to the country. 2.2 Identify health financing possibilities and relevant information systems to incorporate activities undertaken through engagement with the private health sector.	• Help develop financing methods for contracting, purchasing, information systems and other options to engage the private health sector. • Build capacities to develop a universal health coverage priority benefit package.
	Involvement	2.3 Develop the institutional system to implement private health sector engagement, including financing methods, purchasing authorities, and contracting and management units at the ministry of health. 2.4 Define relevant provider payment methods to ensure effective delivery of the identified services/interventions by private health sector providers.	
	Partnership	2.5 Jointly define the scope and range of services and interventions to be provided by the private health sector, either jointly with the public sector or separately. 2.6 Identify the target populations to be covered by private health sector providers under the partnership.	
3. Improve the quality of services in the private health sector	Consultation	3.1 Develop policies for accreditation of facilities and the required standards through incentives and disincentives with private health sector syndicates/associations.	• Help develop guidance for national quality indicators and accreditation policies through extensive stakeholder consultation.

		3.2 Establish a system for reporting and information-sharing from the private health sector to appropriate authorities.	• Help develop a reporting/information system for monitoring quality and performance for all health care facilities/providers.
	Involvement	3.3 Develop unified quality indicators for both the public and private services covering all essential medical products and services.	
	Partnership	3.4 Fully engage the private health sector (syndicates/ associations) in developing accreditation standards, quality certification, reporting, monitoring and creating consumer awareness.	
4. Ensure that regulatory mechanisms for health systems are enforced effectively in the private health sector	Consultation	4.1 Update necessary legislation for the health sector. 4.2 Strengthen ministry of health enforcement capacity in licensing, legal authority, resources and staffing. 4.3 Establish/strengthen the licensing and regulation of the health workforce, regulation of dual practice, and the prevention of clinical negligence/malpractice. 4.4 Establish and empower an autonomous authority for accreditation of health facilities. 4.5 Provide feedback and information to the private health sector on regulatory decisions related to medical products.	• Provide support to conduct a review of health sector legislation and assessment of regulatory provisions and related institutions for private health sector engagement. • Share successful experiences in government enforcement of private health sector regulation.
	Involvement	4.6 Establish mechanisms to ensure compliance with accreditation processes and requirements. 4.7 Ensure that recruited staff are registered/licensed in accordance with the country's requirements and maintain their registration/license.	
	Partnership	4.8 Develop protocols at the facility level for accreditation, quality monitoring, information-sharing and reporting systems, upgrading licensing/training/skills and continuing medical education.	
5. Develop monitoring and reporting mechanisms for private health sector providers	Consultation	5.1 Develop a checklist of information categories for reporting purposes, including physical standards, staffing, resources deployed, volume of services and quality indicators.	• Develop guidance on the minimum list of indicators for private health sector monitoring. • Support the establishment of a routine and reliable data-reporting mechanism. • Help develop a system for data authenticity, verification, analysis, and monitoring and evaluation reports.
	Involvement	5.2 Develop protocols for reporting to appropriate authorities, encryption, and security and storage of relevant information. 5.3 Exchange information with public authorities on specified public health indicators.	
	Partnership	5.4 Establish a mechanism to collect and report reliable data for monitoring the performance and compliance of the private health sector. 5.5 Partner with the private sector to establish independent networks to monitor and evaluate services and ensure that standards are met.	

[a] One-time or short-term involvement, for example through focus groups, meetings, and interviews.

[b] Ongoing participation in the process, for example as a source of feedback or through involvement in planning.

[c] Involvement in decision-making.