
Health Trends in the Middle East and North Africa

A Regional Overview of Health Financing
and the Private Health Sector



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Executive Summary



Executive Summary

In the past several decades, countries in the Middle East and North Africa have made significant improvements in developing their health systems and improving the health status of their populations. However, the region continues to face substantial and diverse political, macroeconomic, social, and health challenges. In 2010–2011, the mass uprisings over high unemployment, poverty, and political repression known as the Arab Spring began in several countries. These events led to a wave of social and political upheaval that had enduring repercussions throughout the region. Iraq, Libya, Syria, and Yemen remain embroiled in prolonged violent conflicts. Other countries are more stable but undergoing significant changes and reforms.

Though health data from the region are scarce and outdated, available information on key health indicators shows significant improvements in recent decades. Life expectancy is rising, maternal and infant mortality are declining, and health coverage is increasing to varying degrees in all countries. The Middle East and North Africa region is experiencing an epidemiological transition from a high burden of communicable disease to an increasing burden of noncommunicable disease, although the timing and pace of this transition varies by country. Noncommunicable diseases, mainly cardiovascular diseases, hypertension, and cancers, account for 60 percent of the disease

The Middle East and North Africa region is experiencing an epidemiological transition from a high burden of communicable disease to an increasing burden of noncommunicable disease, although the timing and pace of this transition varies by country.

burden and over half of premature deaths across the region (WHO 2016a). Moreover, ongoing wars in Iraq, Libya, Syria, and Yemen have created new health challenges that threaten to reverse the health advances of recent decades. In these countries, the burden of noncommunicable diseases is compounded by limited access to health services, destruction of health infrastructure, conflict-related injuries, and outbreaks of infectious diseases. The aforementioned conflicts—particularly the civil war in Syria—have created regional refugee crises that are straining the health systems of host countries, mainly Jordan and Lebanon.

The response to increasingly complex health and security challenges in the region requires an emphasis on well-functioning national health systems that provide equitable, affordable, and quality health services to all citizens, refugees, and displaced people. Developing effective health financing mechanisms for citizens and displaced people of all income levels and harnessing the private health sector's strengths and potential contributions to complement overstretched public resources are key strategies to strengthen health systems and deliver an impactful response. Effective health systems are essential not only to improving health outcomes but also to fostering regional stability and security.

To understand current health financing policies and mechanisms, as well as the current role of the private sector in the health systems of the Middle East, the USAID Middle East Regional Bureau commissioned the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus and Health Finance and Governance (HFG) projects to conduct a review of health financing and the private health sector in the 11 low- and middle-income countries in the region, focusing on the years 2008 to 2017. The countries included in this analysis are Algeria, Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, Syria, Tunisia, the West Bank and Gaza, and Yemen. This review highlights regional trends and identifies gaps in information; it is an abridged version of a full report.*

Trends in health financing and the private health sector

The following trends and observations describe the general health financing and private sector landscape across the 11 countries.

1. **All 11 countries face the challenge of poor health data for decision making.** Complete, accurate, and timely data are needed as health system dynamics become increasingly more complex. Currently, data on access to and use of public and private health services are limited. Conflict exacerbates this problem, as reliable data collection is not feasible in some areas due to security concerns.
 - a. **For health financing in general, there is a need for good data** about household health expenditures and the cost of public and private health services and programs.
 - b. **Limited data are available about the size, scope, use, and quality of the private health sector.** While some countries have registries and databases of private providers, they are often incomplete and out of date. There are few current population-based surveys that ask about sources of health care.
2. **Total and per capita health expenditures are increasing.** Health expenditure has increased in all non-fragile countries in per capita terms and as a proportion of public expenditure or of a country's economy and income.
3. **Prepayment schemes have expanded slowly.** Prepayment of health expenditure has increased in some countries as tax-based and health insurance schemes have expanded, but large segments of the population in the region are still uncovered.

*Download the full report at SHOPSPlusProject.org: Phoebe Sloane, Miloud Kaddar, Emma Golub, Daniela Gutierrez, and Intissar Sarker. 2018. *Trends in Health Financing and the Private Health Sector in the Middle East and North Africa*. Rockville, MD: Abt Associates Inc.

4. **Uncovered household expenditure on health care remains high in many countries.** Middle Eastern countries have some of the lowest levels of public expenditure on health, which translates into high levels of out-of-pocket household spending. In recent years, this situation has worsened in some countries due to drastic declines in public and export revenues, and to governance issues, instability, and conflict.
5. **Passive purchasing of health products and services is dominant.** Very limited use is made of active purchasing provider payment methods to promote productivity, quality, and equity. The result is substantial inefficiency, waste, corruption, and popular dissatisfaction with health services.
6. **Many countries have adopted new health laws and strategies that address health financing.** Countries such as Algeria, Egypt, Jordan, Morocco, and Tunisia are grappling with health system challenges—the need to increase health financing, large uninsured populations, weak planning and monitoring mechanisms, an unregulated private health sector, and an inconsistent quality of health care services.
7. **External support has never been significant.** Assistance from donors and international agencies has been limited to countries such as Egypt, Jordan, Morocco, and Yemen, mainly in the form of budget support and earmarked funding for specific projects. While external funding has increased and diversified since 2011 for countries affected by conflict, it does not cover a humanitarian response to pressing basic social and health needs.
8. **Funding health services for refugees is a major challenge.** This is especially true in countries with large refugee populations, such as Jordan and Lebanon. In countries with smaller refugee populations, such as Algeria, Egypt, and Iraq, refugees living outside of camps are often covered under public schemes similar to those for citizens.
9. **Governance of the private sector is limited and uneven.** While many countries include the private sector at least nominally in national health strategies and policies, regulation and monitoring of the private sector is weak. Some countries, such as Egypt, Jordan, and Tunisia, have public or independent entities for accreditation of public and private health facilities, but others, such as Algeria, have no formally recognized accreditation body. Reporting of the private sector into national health information systems is limited in most countries, and may include only notifiable diseases. In most countries, the private sector is fragmented or not organized to represent and advocate for itself. Professional associations and unions that include both the public and private sector are common, but there are few private sector-specific associations.
10. **Available data show that the private sector is an important and growing source of care for both the wealthy and the poor throughout the Middle East and North Africa, even in countries with strong public health sectors.** While detailed data on health service use and satisfaction are scarce, many reports and key informants suggest that use of private services is growing. The most recently available

Demographic and Health Survey, Multiple Indicator Cluster Survey, and Pan Arab Program for Family Health survey data show that the sector is a major source of care for maternal and child health and family planning for both the wealthy and poor. For example, for acute respiratory infection (ARI) symptoms, over half of children in 8 of the 11 countries were taken to a private sector source. Significant portions of women seek their modern family planning methods in the private sector, ranging from 43 percent in Egypt to 90 percent in Iraq.* Anecdotal evidence suggests that growth in use of the private sector is fueled by dissatisfaction with availability of public services and patient perceptions that private sector services are higher quality.

11. **The growing role of the private sector in service delivery increases health expenditure.**

Rapid growth in use of the private health sector results in high out-of-pocket expenditures because the cost of private sector services is generally high and few patients have health insurance. Even if they do, public and private insurance schemes usually reimburse only part of the fees and, for some services and products, none at all. Drugs purchased at private pharmacies also drive up out-of-pocket spending.

12. **In conflict and post-conflict settings, the private sector develops on an ad hoc basis in response to changing health needs, locations of violence or destruction, and the weakening of health systems, among other conflict-related factors.** The private sector is a key source of care where government services

are unavailable or have broken down, which occurred in large parts of Iraq, Libya, Syria, and Yemen. It often develops in a fragmented and unregulated way, including United Nations organizations, international and local NGOs, and for-profit providers. The private for-profit sector is often weakened, as running a business is challenging and can be dangerous under such circumstances.

13. **Available data show that the private sector is a key source of health care for refugees living both in and outside of camps in countries such as Jordan and Lebanon.** United Nations (UN) agencies and NGOs often provide primary and secondary services to refugees living inside and outside of camps. Refugees living outside of camps may also access the private for-profit sector, depending on their ability to pay and the availability and quality of public sector services.

This report begins with discussion of the region's health financing landscape, followed by an overview of the private health sector landscape. It concludes with recommendations for USAID investment.

*The assessment team only has data on the source of modern family planning methods for 5 of the 11 countries.

Introduction



Introduction

In the past several decades, countries in the Middle East and North Africa have made significant improvements in developing their health systems and improving the health status of their populations. However, the region continues to face substantial and diverse political, macroeconomic, social, and health challenges.

To understand health financing policies and mechanisms and the role of the private sector in the health systems of Middle Eastern countries, the USAID Middle East Regional Bureau commissioned the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus and Health Finance and Governance (HFG) projects to conduct a review of health financing and the private sector in the 11 low- and middle-income countries in the region, focusing on the years 2008 to 2017. The countries included in the analysis are Algeria, Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, Syria, Tunisia, the West Bank and Gaza, and Yemen. This publication is an abridged version of a full report.¹

A wave of social and political upheaval has had enduring repercussions throughout the region. Iraq, Libya, Syria, and Yemen remain embroiled in prolonged violent conflicts. Egypt, Lebanon, and the West Bank and Gaza continue to experience political instability. Other countries such as Algeria, Jordan, Morocco, and Tunisia are more stable but undergoing significant changes and reforms. The

economic situation varies greatly across the region, as it includes low-, middle-, and high-income countries, with a variety of economic drivers, including oil, tourism, and manufacturing. Across all 11 countries in this review, the population is largely young and urban, with over half under the age of 25 and living in cities.

The Middle East and North Africa region faces challenges in training and retaining health personnel, particularly in conflict zones and rural areas.

Though health data from the region are scarce and outdated, the information available on key health indicators shows significant improvement in recent decades. Life expectancy is rising, maternal and infant mortality are declining, and health coverage is increasing in varying degrees in all countries. The region is experiencing an epidemiological transition with the decline of communicable diseases and the rise of noncommunicable diseases (NCDs) and injuries, though the timing and pace of this transition also varies by country. NCDs, mainly cardiovascular diseases, hypertension, and cancers, account for 60 percent of the disease burden and over half of premature deaths across the region (WHO 2016a).

¹ Download the full report at SHOPSPPlusProject.org: Phoebe Sloane, Miloud Kaddar, Emma Golub, Daniela Gutierrez, and Intissar Sarker. 2018. *Trends in Health Financing and the Private Health Sector in the Middle East and North Africa*. Rockville, MD: Abt Associates Inc.

In recent decades, health infrastructure, technology, and human resources have improved in both the public and private health sectors in most countries. Countries including Egypt, Jordan, Lebanon, and Tunisia have become regional centers for medical tourism due to the perceived high quality of some services offered in their private sectors. However, the Middle East and North Africa region faces a variety of health challenges. Curative approaches, particularly for the management of NCDs, are more common than preventive approaches, which contributes to higher costs. Access to health services varies greatly across and within countries. Health services and infrastructure are concentrated in urban areas in most countries, mirroring the overall population distribution. Health coverage ranges

Patients with NCDs require access to chronic care, which is often inaccessible or absent in fragile states.

from less than 10 percent in Yemen to over 80 percent in Algeria, Jordan, and Lebanon. Coverage of care for NCDs varies. In Algeria and Egypt, for instance, chronic NCD care is covered under public insurance schemes, but those without coverage have few financing options aside from out-of-pocket (OOP) payments. The region also faces challenges in training and retaining health personnel, particularly in conflict zones and in rural areas.

Ongoing conflict in Iraq, Libya, Syria, and Yemen has created new health challenges that threaten to reverse the health advances of recent decades. In these countries, the burden of NCDs is compounded by limited access to health services, destruction of health infrastructure, conflict-related

injuries, and outbreaks of infectious diseases. Health infrastructure and medical personnel have been systematically targeted for attack in all four countries, exacerbating the region's overall challenges in retaining health care workers. In 2016, Yemen experienced perhaps the largest cholera outbreak in modern history, with over 800,000 suspected cases reported in 2017 (Lyons 2017). By 2013, 70 percent of the health workforce had left Syria (Baker and Brown 2015). Conflict and displacement are increasing demand for mental health services, which remain underdeveloped across the region (Okasha et al. 2012; Médecins Sans Frontières 2012). Yemen experienced perhaps the largest cholera outbreak in modern history, with over 800,000 suspected cases reported in 2017 (Lyons 2017). Syria has had outbreaks of polio and measles since the start of the war in 2011 (Gladstone 2017).

The aforementioned conflicts—particularly the civil war in Syria—have created regional refugee crises that are straining the health systems of host countries, mainly Jordan and Lebanon. Recent estimates place the number of Syrian refugees at 5.6 million, primarily living in Turkey (3.5 million), Jordan (1.6 million, or 9 percent of the population), and Lebanon (1 million) (UNHCR 2016, UNHCR 2018). The majority live in urban host communities, not camps. In 2017, the UN-led Regional Refugee and Resilience Plan for the Syrian crisis requested \$4.69 billion to support refugees and host communities (UNHCR 2016). According to the most recent Jordan Response Plan for the Syria Crisis, Jordan alone requires \$224 million to address the health needs of Syrian refugees between 2017 and 2019 (Ministry of Planning and International Cooperation 2016). Refugees and other displaced populations face tremendous challenges accessing and paying for health services.



A refugee camp in Aleppo, Syria in 2013. Recent estimates place the number of registered Syrian refugees at 5.6 million, primarily living in Jordan, Lebanon, and Turkey.

Photo: IHH

There are limited data on NCDs in humanitarian crises (Ruby et al. 2015). Existing evidence shows that they are a major issue for refugees and residents of both fragile and stable states in the region. Patients with NCDs require access to chronic care, which is often inaccessible or absent in such states. Relief agencies generally provide immediate basic primary care but key stakeholders have severely limited guidance on how to address NCDs in fragile environments (Ruby et al. 2015). NCD prevalence is high among Syrian refugees. A recent survey of Syrian refugees in Lebanon found that over half of refugee households had at least one member with hypertension, cardiovascular disease, diabetes, chronic respiratory disease, or arthritis (Doocy et al. 2016a).

Improving the delivery of health services contributes to fostering stability throughout the region, not only in the four fragile states, but in all 11 countries included in this report. Strengthening economic development and social services including health is key to long-term stability. This is a pillar of counterinsurgency strategies that focus on winning “hearts and minds” (Berman et al. 2011; Marrogi et al. 2015; Long 2006). All sides in conflict may use these strategies. Violent insurgent groups and US-designated terrorist groups, such as the self-proclaimed Islamic State in Iraq and Syria (ISIS) and Hezbollah, and Hamas, court civilian support by providing health and other social services (Ho and Baskaran 2015; Cammett 2014; Malka 2012). At the same time, studies have shown that US-funded provision of social services has contributed to shifting civilian support away from such groups and decreasing violence (Berman et al. 2011).

The response to increasingly complex health and security challenges in the region requires an emphasis on well-functioning national health systems that provide equitable, affordable, and quality health services to all citizens, refugees, and displaced people. Developing effective health financing mechanisms for citizens and displaced people of all income levels and harnessing the private health sector’s strengths and potential contributions to complement overstretched public resources are key to strengthening health systems and improving health outcomes.

This review aims to highlight regional trends and identify gaps in information. For health financing, specific objectives included identifying trends in sources, pooling, and purchasing mechanisms with a focus on whether health financing mechanisms protect poor and disadvantaged populations from foregoing care and from impoverishment. For the private health sector, specific objectives included identifying trends in the private sector policy environment, service provision, and collaboration between the public and private sectors, with a focus on family planning, maternal and child health (MCH), NCDs, and health issues experienced by refugees.

The desk review covered the most recent Demographic and Health Surveys, Multiple Indicator Cluster Surveys (MICS), Pan Arab Project for Family Health (PAPFAM) surveys, and National Health Accounts analyses, as well as reports from WHO, the World Bank, the International Monetary Fund, USAID, UN High Commissioner for Refugees (UNHCR), the International Rescue Committee, and other international development and humanitarian aid organizations. In addition, the assessment team conducted over 50 interviews with key informants working in both the public and private health sectors. Due to the overall dearth of information available, the scope and depth of information for each country varies.

Health Financing



Health Financing

Health financing can be understood in both a broad sense and a narrow one. In the broad sense, it concerns the resources mobilized and used to improve the health status of a population and to protect them from risk factors that may damage their mental, social, and physical development. In the narrow sense, it focuses on the financing of the components and functions of the health system that is working to meet the health needs of the population. According to WHO, health financing is the “function of a health system concerned with the mobilization, accumulation, and allocation of money to cover the health needs of the people, individually and collectively, in the health system. The purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care” (WHO 2010).

Both aspects of health financing are important in the Middle East. In low-income countries or countries in conflict, the funding allocated to health services, with the exception of some preventive interventions such as immunization, has no significant impact on the population’s health unless minimum conditions for good health (basic housing, education, transport, nutrition, water and sanitation) also exist. In middle-income countries, although the aforementioned conditions exist, health financing can be negatively affected by an economic downturn

caused by an event like a sharp decline in oil prices or tourism revenues, or institutional instability resulting from conflicts in the region.

This review adopts the WHO definition of health financing and uses a common analytical framework for the 11 countries. The framework is built around the three health financing functions of revenue collection, pooling, and purchasing, and the three universal health coverage dimensions of population coverage, benefits package, and financial protection. To document those functions and dimensions, the assessment team used the WHO Global Health Expenditure Database in combination with National Health Accounts data, when available.

The following trends help describe the general health financing landscape in the 11 countries.

1. **Total and per capita health expenditures are increasing.** Although in varying proportions, health expenditure has increased in all non-fragile countries in per capita terms and as a portion of public expenditure or of a country’s economy and income.
2. **There has been slow expansion of prepayment schemes in some countries.** Prominent among them are Algeria, Jordan, Morocco, Tunisia, and the West Bank and Gaza. Prepayment of health expenditure has increased

in some countries as tax-based and health insurance schemes expand, but large segments of the population in the region are still not covered.

3. **Compared to other regions in the world, Middle Eastern countries have some of the lowest levels of public expenditures on health, which translates into high levels of OOP spending.** OOP household expenditure on health care remains high in many countries. A drastic decline in public and export revenues as well as conflicts, instability, and governance issues have exacerbated this situation (Figure 1).
4. **Expanding private sector service delivery increases health expenditures.** The cost of private sector services is generally high. Because few households have financial protection through health insurance, rapid growth in the use of the private providers results in high OOP spending. Even if households have financial protection, public and private insurance schemes usually reimburse only part of patients' fees; for some services and products, there is no reimbursement. In addition, drugs purchased at private pharmacies drive up OOP expenditure.
5. **Passive purchasing mechanisms are dominant.** Very limited use is made of active purchasing provider payment methods to promote productivity, quality, and equity. The result is substantial inefficiency, waste, corruption, and popular dissatisfaction.
6. **External support from donors and international agencies has never been significant in the region.** Exceptions are countries such as Egypt, Jordan, Morocco, and Yemen, mainly in form of budget support and earmarked funding for specific projects.
7. **Conflict and post-conflict context and opportunities.** The ongoing conflicts in Libya, Syria, and Yemen are health and financial disasters for their populations and economies. The Syria conflict has spillover effects because of refugee populations that are stressing the health systems of Jordan and Lebanon in particular. When the conflicts end, the health systems of the affected countries will need a nearly complete rebuild—offering the opportunity to help them create not the partially successful pre-conflict systems, but rather up-to-date systems less reliant on OOP expenditure, passive purchasing, and unregulated private provision.
8. **Funding health services for refugees is a major challenge.** This is especially true in countries with large refugee populations, such as Jordan and Lebanon. In countries with smaller refugee populations, such as Algeria, Egypt, and Iraq, refugees living outside of camps are often covered under public schemes similar to those provided to citizens.
9. **Many countries have adopted new health laws, strategies, and reforms that include health financing dimensions.** Countries such as Algeria, Egypt, Jordan, Morocco, and Tunisia, are grappling with universal challenges related to improving the performance of health systems—increasing health spending, covering

large uninsured populations, strengthening weak planning and monitoring mechanisms, regulating the private sector, and consistently providing quality health care services.

10. **All 11 countries face the challenge of poor data for decision making.** Complete, accurate, and timely data are needed in this region, as health system dynamics are becoming more complex and multifaceted. For example, there are limited data on household health expenditures, actual use of and access to public and private facilities, and the cost of health services and programs, particularly since 2011.

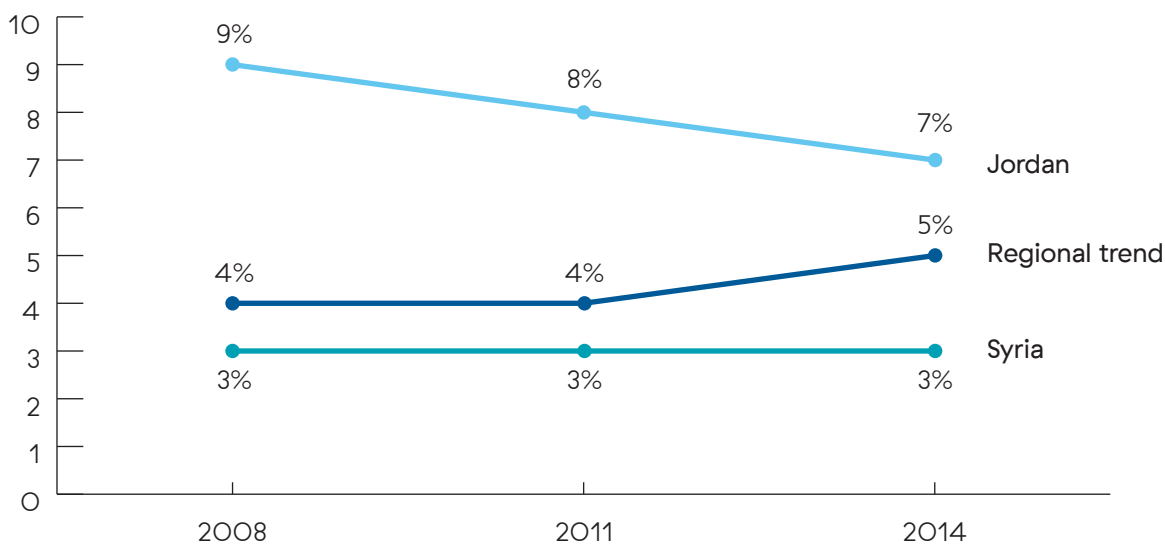
Revenue collection

The amount of revenue collected and the ways it is collected have important implications for financial protection and equity. Three key health financing indicators are used to approach the revenue collection dimension: total health

expenditures (THE) as a percentage of gross domestic product (GDP), general government health expenditure (GGHE) as a percentage of GDP, THE per capita, and GGHE as a percentage of general government expenditure (GGE).

Figure 1 indicates the level of THE within a country relative to that country's national income (GDP). The regional WHO-Eastern Mediterranean Regional Office average was around 4 percent in 2008 and then stabilized between 4.5 and 5 percent between 2011 and 2014.² Most of the countries included in this analysis have a percentage that is higher than the regional average, except Syria (around 3 percent). Jordan has one of the highest levels of THE as a percentage of GDP (approximately 7.5 percent in 2014). Higher-income countries tend to spend a greater share of their GDP on health. Political instability and a decline in the price of oil have impeded national income growth for several of the countries in recent years.

Figure 1. Health expenditure relative to national income: Total health expenditure as a percentage of GDP, 2008–2014

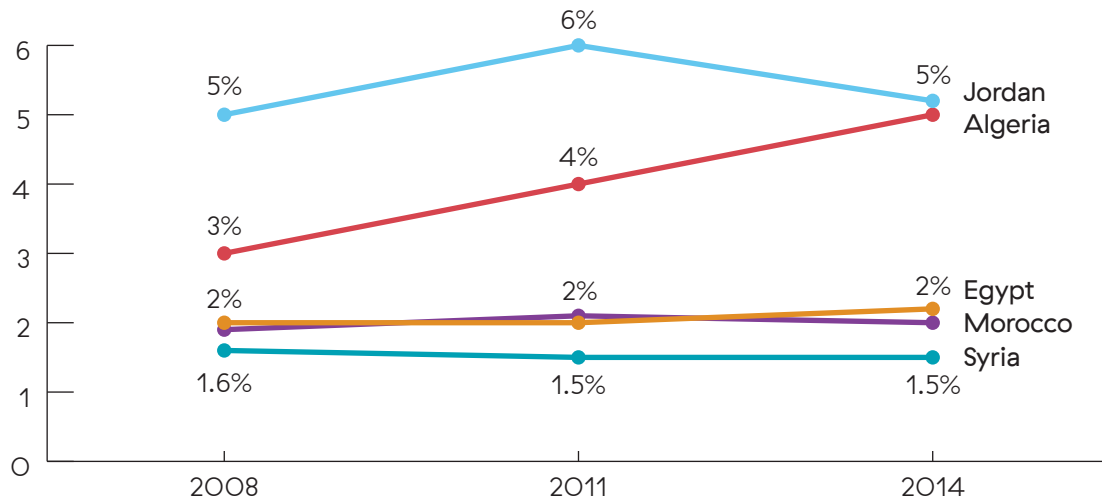


Source: WHO Global Health Expenditure Database, 2008–2014

² The regional trend in all graphs is from the WHO–Eastern Mediterranean Regional Office, which includes more countries than the 11 in this report. The Eastern Mediterranean region includes 21 states in the Middle East, North Africa, Horn of Africa, and Central Asia.

GGHE as a percentage of GDP (Figure 2) shows both the fiscal capacity of the government and its commitment to health relative to other uses of public spending. In Egypt, Syria, and Morocco, the share of GGHE as a percentage of GDP is rather low and consistent (1.5 to 2 percent), while Jordan has the highest percentage (just over 5 percent) among the countries analyzed. Algeria is the country with the highest growth in this indicator, which rose from approximately 3 percent in 2008 to just over 5 percent in 2014.

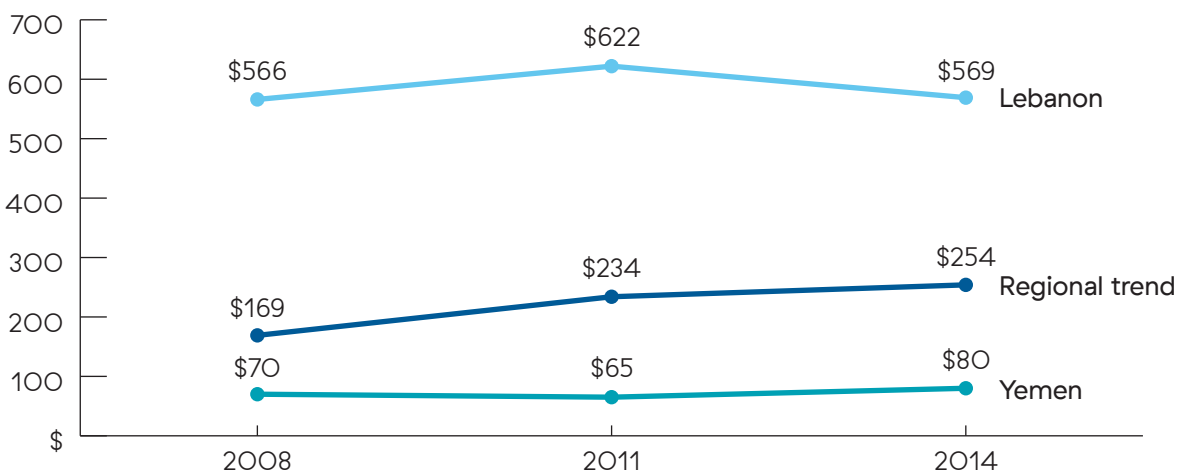
Figure 2. Government health expenditure relative to national income: GGHE as a percentage of GDP, 2008–2014



Source: WHO Global Health Expenditure Database; 2008–2014

Figure 3 represents THE per capita for each country compared to the regional average, which increased from \$169 in 2008 to \$254 in 2014. Most of the high-income countries had higher per capita health expenditures than the regional average. Lebanon had the highest per capita health expenditure at more than \$622 in 2011, but it fell to \$569 in 2014. Yemen, a state experiencing severe conflict, has very low, steady per capita health spending.

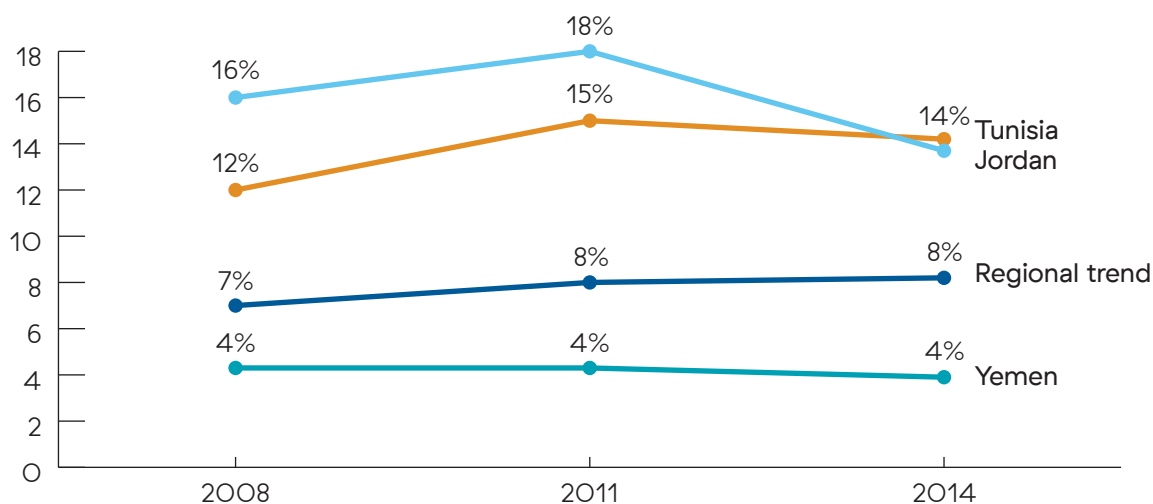
Figure 3. Total health expenditure per capita (USD), 2008–2014



Source: WHO Global Health Expenditure Database; 2008–2014

GGHE as a percentage of GGE is an indicator of the priority that a government gives to funding health relative to other public expenditure. Both GGHE and GGE include the revenues raised and expenditure made from compulsory social health insurance contributions. African heads of state recommended a target of 15 percent of total government expenditure that should be devoted to the health sector (called the Abuja Target). None of the 11 Middle Eastern and North African countries has recently reached this 15 percent target. Jordan and Tunisia are closest with rates of 13.7 percent and 14 percent, respectively, in 2014. The regional average stood at 8 percent in 2014 (Figure 4).

Figure 4. Government prioritization of health: government health expenditure as a percentage of general government expenditure, 2008–2014



Source: WHO Global Health Expenditure Database; 2008–2014

The barely growing regional average for GGHE/GGE over 2008–2014 indicates little increase in the priority that Middle Eastern governments give to health. All other regions of the world invest more in health (18.1 percent in the Americas, 15.5 percent in Europe, and 14.3 percent in the Western Pacific in 2014). Most of the countries studied invested less than 10 percent over this time period although four countries—Jordan, Tunisia, Lebanon, and Algeria—exceed the regional average. Countries that are below the regional average, such as Yemen, have a consistently low GGHE/GGE. This is due to their political contexts, such as Yemen’s ongoing conflict, and economic factors, including the decline in oil prices and thus the drop in oil income.

Pooling

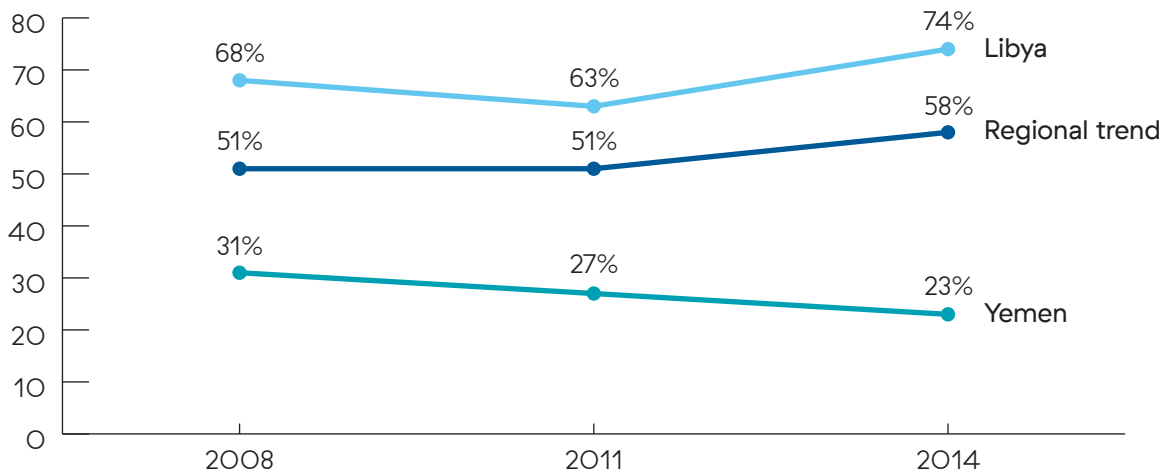
Pooling refers to accumulating revenue via prepayment financing mechanisms to ensure that unpredictable individual financial risks are accounted for and are distributed among all members of the pool. Three main mechanisms are generally used to pool revenue and health risks: (1) state-funded health systems funded through taxation, (2) social health insurance funded by mandatory employee and employer contributions, and (3) voluntary private health insurance. In most Middle Eastern countries, these pooling arrangements co-exist, but their respective roles and institutional setups vary considerably. Pooling levels across countries are measured using two indicators: GGHE as a percentage of THE, and social security funding (social health insurance pooling of mandatory contributions) as a percentage of GGHE. This analysis found that prepayment of health expenditure has increased in some countries as tax-based and health insurance schemes expand, but pooling and cross-subsidization of health financial risk between the rich and poor remain limited. Large segments of the population in the region are still uncovered.

GGHE as a percentage of THE indicates a country's pooling or risk sharing level and the commitment of its government to cover its population's healthcare. GGHE includes both central and local government tax-funded health spending, payroll tax-funded mandatory social health insurance, and external revenues (loans and grants) that flow through government accounts. Expenditures from these sources comprise mandatory prepayment for health care. This indicator is important to universal health coverage because mandatory prepayment is the main recommended source of funding in a universal health care system.

The regional average rate of GGHE/THE grew from 51 percent in 2008 to 58 percent in 2014 (Figure 5). Of the countries studied, Libya had the highest rate of GGHE/THE with 74 percent in 2014. This highlights how countries with a relatively high income tend to have more mandatory prepayment sources. On the other hand, Yemen had the lowest rate of GGHE/THE, with 23 percent in 2014. According to health experts (e.g., McIntyre and Kutzin 2014), a rate below 30 percent indicates a serious problem of collective coverage of health expenditures. Among the countries surveyed, only Yemen falls below the 30 percent mark, where it has stayed since 2009.

Large segments of the population in the Middle East and North Africa do not have health coverage.

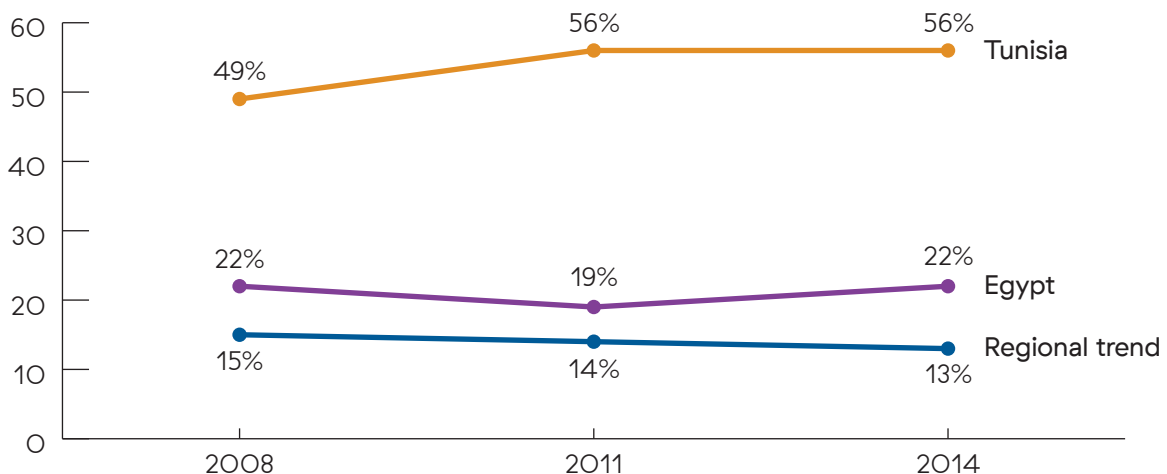
Figure 5. General government health expenditure as a percentage of total health expenditure, 2008–2014



Source: WHO Global Health Expenditure Database; 2008–2014

Social security funding as a percentage of GGHE measures the share of social health insurance contributions to GGHE. Social health contributions in all countries come primarily from mandatory withholding from formal sector wages (and related charges to employers). Hence, the share of the economy in formal employment affects the potential for social security funding as a percentage of GGHE. The regional average share of social security in GGHE ranges from approximately 15 percent in 2008 to 13 percent in 2014 (Figure 6), which is lower than in other regions (55 percent in Europe, 75 percent in the Americas, and 67 percent in the Western Pacific in 2014). This is mainly due to the modest role of social health insurance in oil-dependent economies (except Algeria), and low-income countries.

Figure 6. Social security fund as a percentage of general government health expenditure, 2005–2014



Source: WHO Global Health Expenditure Database; 2008–2014

The 11 countries included in this analysis are mostly above the WHO-Eastern Mediterranean Regional Office regional average. Tunisia stands out from the others with the highest rate of 56 percent. Of the 11 Middle East and North Africa countries in this report, Egypt has one of the lowest rates at 22 percent, below the recommended 30 percent.

Purchasing and payment methods

Purchasing refers to the transfer of pooled funds to health care providers. Several specific issues require consideration, including provider payment (how health care providers are paid and what incentives payment mechanisms create), strategic or active purchasing versus passive purchasing, and organizational structure and governance of the purchaser. This analysis showed that passive purchasing of health products and services is dominant in most countries. Very limited use is made of active purchasing provider payment methods to promote productivity, quality, and equity. The result is substantial inefficiency, waste, corruption, and popular dissatisfaction.

Regarding provider payment mechanisms, SHOPS Plus and HFG observed various arrangements across

countries, ranging from a single entity overseeing pooling and purchasing to separate organizations dealing with those issues. Most countries are trying to establish a mix of purchasing arrangements. The ministry of health remains the main institutional purchaser of health services, but the purchaser could be a semi-autonomous or autonomous public entity such as the Central Medical Stores in Tunisia and Algeria for pharmaceutical products or a mandatory insurance fund such as the Health Insurance Organization in Egypt or the Mandatory Health Insurance in Morocco. Purchasing could be undertaken centrally by one of these institutions such as the Social Health Insurance entity in Algeria or at a more decentralized level, where each decentralized organization is responsible for purchasing services for its resident population. There are very few examples of this decentralized organization in the Middle East and most of them are pilot projects.

Regarding payment methods, passive purchasing is dominant in tax-based financing, but health insurance organizations are playing an increasingly important role as purchasers, mainly through contracting. Since most sources of funding are either a government budget allocation or OOP payments, fee-for-service and flat budgets are the

Passive purchasing of health products and services is dominant in the 11 countries in the Middle East and North Africa studied.

Photo: Jordan Association for Family Planning and Protection



dominant payment methods for services. In the public sector, the flow of funds is generally not linked to performance and is based on a rigid system of line item budgeting built on historical trends with inputs such as drugs and supplies, provided in kind, and salaries unrelated to productivity or quality. Generally, ministries of health and public institutions provide budgets, inputs, and salaries based solely on qualifications and experience, not performance. The few exceptions are external contracting with public and private sector providers for select and specialized services such as dialysis and cancer treatments. Ministries of health tend to automatically transfer budgets to hospitals and health facilities, and social health insurance pays providers based on bills submitted. Initiatives have been launched to implement different provider payment mechanisms such as capitation and performance-based payments with both public and private providers, such as in Egypt, Jordan, and Lebanon. Most of these projects are limited in scale except when both the purchaser and the provider are in the private sector, as in Jordan and Lebanon.

In most of the countries studied, separating purchasing and provision functions is on the health system reform agenda to encourage active purchasing and to link provider payments to provider performance, efficiency, and the delivery of quality services. However, implementation is very slow because the reform requires a new allocation of resources, considerable information, and management capacity. For example, most countries are trying to establish gatekeeping mechanisms

at the primary health care level and appropriate referral routes to access hospital and specialized services. Success has been limited thus far, because the preconditions for success are not thought through and put in place, and deeply rooted existing behaviors and practices impede change.

Population coverage

Population coverage refers to the share of the total population that is eligible (beneficiaries) for a set of interventions such as promotive, preventive, curative, rehabilitative, and palliative health services. For this, it is important to assess the share of the eligible population that actually has access

to quality health services and is financially protected, meaning that the use of and any payment required for these services does not expose the user to financial hardship.

In most of the countries analyzed, population coverage is high as health care services in the public sector are officially free of charge for almost all

citizens or residents, whether they are covered through a tax-based free medical assistance mechanism (such as in Jordan, Morocco, West Bank/Gaza, and Tunisia) or through social or voluntary health insurance schemes. Available data show that population coverage is relatively high in Algeria, Jordan, West Bank/Gaza and Tunisia, reaching more than 60 percent of the total population. Population coverage is increasing in other countries such as Lebanon and Morocco. Covering 60 percent of the population is moderate by global standards—low relative to the US and Europe, but high compared to sub-Saharan Africa and South East Asia. However, population coverage is low by global standards

Population coverage is generally high as health care services in the public sector are officially free of charge for almost all citizens or residents. The exceptions are countries in conflict.

in countries in conflict such as Libya, Syria, and Yemen, and especially among refugees and other marginalized groups.

Various issues affect coverage levels across the region. Key among them are:

- The level of coverage is closely linked to social and professional status, location of residence, type of health insurance, and other factors that tend to favor those of higher socioeconomic status.
- Shortages of health products and services are frequent in the public sector, which is intended to cover the informal sector and disadvantaged population.
- The population to be covered is not always well identified, especially in rural areas, in the informal sector, and among the unemployed or undocumented immigrants.
- In countries such as Jordan, Palestine, and Tunisia, some population groups have double or even triple coverage by overlapping programs, while others have none.
- Health insurance membership is compulsory for some groups and voluntary for others. This voluntary character of health insurance seems to work in countries with higher levels of coverage, likely because insurance premiums are entirely paid for or are heavily subsidized. In countries with lower levels of coverage, premiums may not be fiscally feasible and the value for many informal households of prepayment not broadly understood and accepted given the size of the population not yet covered.

True population coverage can only be effectively captured through regular national and local household surveys. Surveys such as censuses, the Demographic and Health Surveys, and the Multiple Indicator Cluster Surveys show disparities

in coverage and access to different categories of health care services by area of residence, gender, or socio-professional category. However, these surveys are conducted infrequently and focus on maternal, reproductive, and child health, and the information they contain is useful but not sufficient to inform health financing policies and programs. Disparities in coverage and access are aggravated by war, conflict situations, and large flows of refugees, or in cases of severe constraints on public finances. In these contexts, reliance on the private sector is growing and household spending is increasing even faster than in non-conflict countries.

Benefits package

Very few countries included in this analysis have been able to adopt an explicit definition of the range of services that different population groups are entitled to and under what conditions. Many countries, such as Algeria, Egypt, Iraq, Libya, and Syria, have official health policies, plans, or strategy documents that claim the population is entitled to benefit from all types of preventive and curative services in the public sector without any restriction. Countries in the region are slowly changing these benefits for three reasons: (1) the burden of disease has changed to be dominated by NCDs and injuries and therefore, costs are rapidly growing, (2) health systems are increasingly diversifying in terms of legal status, service delivery, funding, and types of services for various population groups with different levels of payment, and (3) new funding and delivery arrangements are being introduced in the public and private sectors, leading to changes in the services included in the benefits package such as in Egypt, Jordan, Lebanon, and Tunisia.

Consequently, several health institutions in the countries studied are introducing restrictive measures such as copayment for certain services and products, mechanisms to limit patients' direct access to hospitals and specialists without referral,



Health providers in Algeria. Algeria is one of five countries studied that, on paper, entitles its citizens to benefit from all types of preventive and curative services in the public sector without any restriction.

Photo: Kyle Spradley/CAFNR

reduction and adjustment in reimbursement rates, and explicit definition of the range of services that different population groups are entitled to and under what conditions. For example, in Algeria, Tunisia, and the West Bank and Gaza, services for people suffering from chronic diseases are explicitly defined. Specific health benefits may take the form of a positive list, where services covered are precisely itemized, or a negative list, where services that are excluded from coverage are specified. In other countries, there may also be guidelines for how the population can access certain services. For example, patients may need to follow a referral route and start by visiting the primary health care level to access specialist services, a practice known as gatekeeping. Explicit rationing approaches are still being developed. The most dominant rationing mechanism used in the public sector is the chronic underfunding of health services, which leaves a significant financial burden on households, for

example, to purchase drugs not available at the facility. Some health insurance organizations, aiming to balance income and expenditures, are increasingly reducing reimbursement levels without making explicit changes to the benefits package through various mechanisms. Performance and consequences of all these arrangements and measures varies within and between the countries studied and more studies are needed to assess the actual practices and their effects.

Financial protection

Financial protection refers to funding health services in a way that protects individuals and households from the catastrophic and impoverishing consequences of paying for health care. The two commonly used indicators to track financial protection are the incidence of catastrophic health expenditures and the incidence of impoverishment

due to health care spending. According to the WHO, financial catastrophe is when direct OOP payment exceeds 40 percent of household income net of subsistence needs (WHO 2010). Few countries conduct household expenditure surveys and therefore publicly available data on these indicators are limited. OOP payments as a share of THE provides important, yet less direct, insight into the potential level of financial protection since the greater the share of OOP payments, the lower the likelihood that a population is financially protected and vice versa.

Most low- and middle-income countries in the region have low levels of public expenditure on health, which translates into high levels of OOP

household spending and low financial protection. OOP spending ranged from as low as 21 percent in Jordan to 76 percent in Yemen in 2014. As seen in the following table, most countries have an OOP spending rate that exceeds 30 percent of THE. The only exceptions are Algeria from 2008 to 2014, Jordan from 2009 to 2014, and Iraq from 2008 to 2011. Yemen's OOP spending rate is high, reaching 76 percent in 2014. Egypt, Morocco, and Syria have had a relatively stable rate of around 58 percent over the years. In contrast, Algeria and Libya have low OOP spending rates (around 26 percent in 2014); the lowest rate of OOP spending is in Jordan, which reduced household contributions from 32 percent in 2008 to 21 percent in 2014.

Out-of-pocket expenditure as a percentage of total health expenditure

Year	Yemen	Morocco	Egypt	Syria	Tunisia	Lebanon	Libya	Iraq	Algeria	Jordan
2008	68	57	56	53	40	44	32	25	26	32
2009	74	56	57	54	38	42	31	26	27	23
2010	74	57	58	54	36	46	30	26	29	22
2011	72	58	57	53	36	46	37	25	28	21
2012	72	57	58	54	37	37	30	38	26	22
2013	75	59	56	54	36	38	30	37	26	22
2014	76	58	56	54	38	36	26	40	26	21



Effects of conflict on health financing

Plagued by war, political instability, and low oil prices, the economies and health financing of countries in conflict, such as Iraq, Libya, Syria, and Yemen, are heavily impacted. Civil war has left countries' economies extensively damaged and has inflicted a heavy human cost. The social and economic impacts of the conflicts are large and growing. The lack of sustained access to health care, education, housing, and food have exacerbated the impact of the conflicts and pushed millions of people into unemployment, poverty, and exile. With the ever-increasing cost of war and the collapse in trade and export revenues, the fiscal situation is dire. The severe drop in oil revenues in Libya and Iraq, for example, and disruptions in trade in Syria and Yemen have placed even more pressure on the countries' external balances, resulting in the rapid depletion of their international reserves. Their governments continue to prioritize spending on the military and emergencies.

The intensity and length of the conflicts have resulted in previous trends worsening, which has resulted in the decline of public funding and an increase in OOP payments. However, this information remains anecdotal and is not documented by any reliable sources due to the conflict and the dismantling of existing data collection and information systems. In these countries, economic growth is weak or negative, health infrastructure is devastated, the functioning of public administration has deteriorated, and OOP payment in both the public and private sector has become the dominant source of funding.

In Syria, it is estimated that more than 50 percent of public hospitals and community health centers are closed or only partly functional (Coutts et al. 2015). The health infrastructure still in place is in critical condition since it is difficult to access electricity, fuel, and drinking water. In addition, many staff who used to work in these structures have been killed during the crisis, and massive migration also has depleted the health workforce—less than 50 percent of Syrian and Iraqi medical personnel remain active due to migration. The remaining personnel and specialists are not able to respond to the growing demand for care.

External support from donors and international agencies has never been significant in the countries studied except in Yemen, mainly coming from UN agencies and representing less than 1 percent of public expenditures before the war (WHO 2006). Support also has fallen dramatically as organizations have either scaled back their projects and activities or withdrawn completely from the countries. Even obtaining assistance for the emergency humanitarian

responses in the region was a significant challenge (European Civil Protection and Humanitarian Aid Operations 2017) but external funding has increased in recent years and donors aim to respond to humanitarian crises. For example, in Syria, almost half of the European Commission's humanitarian assistance goes to immediate lifesaving and emergency humanitarian operations. This assistance includes the provision of safe drinking water, sanitation and hygiene, food, child protection activities, and emergency items (European Civil Protection and Humanitarian Aid Operations 2017).

These circumstances in combination with other factors such as inflation, reduction of imports of medicines, depreciation of the local currencies, increases in transportation, insurance and maintenance costs, reduced supply of electricity and water, high unemployment, and food insecurity have presented major challenges for public health service delivery. The result is a health disaster for the population.

Countries in conflict have experienced a dramatic decrease in national health spending, particularly of public financing, a relative substitution of donors and UN agencies (although donor funding remains largely inadequate compared to the unmet needs of the affected population). Other changes include new vital and active roles for local and international NGOs, a focus on emergency health relief, an increase of external referrals and treatment abroad, and a shift to household health expenditures becoming the dominant source of funding.

Impact of refugees on health financing

Covering health services for refugees is a major challenge in countries with large refugee populations, such as Jordan and Lebanon. In countries with smaller refugee populations, such as Algeria, Egypt, and Iraq, refugees living outside of camps are often covered under the same public schemes that citizens are. In Syria and Lebanon, Syrian refugees face considerable difficulties in paying for health care. Until 2014, the Jordanian Ministry of Health provided free services to Syrians registered with the Ministry of Interior. Since 2016, Syrians have been charged at the subsidized rate for non-Jordanians in Ministry of Health clinics, though they still receive reproductive health services for free, except for facility delivery. One survey of refugees living outside of camps in Jordan found that over half of Syrian refugee households reported OOP expenditures for their most recent medical visit (Doocy et al. 2016a). According to the 2016 UNHCR survey, 81 percent of Syrian refugee households in Jordan spent JOD 105 (\$148) on health care in the month before the survey, though their monthly income was only JOD 233 (\$328) (UNHCR 2016).

Private Health Sector



Private Health Sector

The private sector (Box 1) is increasingly being recognized as a key health partner in the Middle East and North Africa and globally. Often facing significant financial and human resource constraints, governments are unable to meet all of the population’s health care needs on their own. As such, health systems are increasingly leveraging the assets and mobilizing the resources of both the public and private sectors. The private health sector can improve the efficiency of resource use, alleviate the patient load at public facilities, and decrease wait times. The private sector can also deliver services and drugs in areas not reached by ministries of health.

Despite these potential benefits, private sector involvement in the health systems of the 11 countries studied has not been optimized due to a number of factors, including the traditional mandate across Middle Eastern and North African countries whereby the state provides free social services to the population, a lack of communication between the public and private health sectors, a lack of knowledge regarding the scope of the private sector, weak regulation of the private sector, and poor private health sector reporting.

Box 1. The private health sector defined

Private sector entities contribute to the health system in the following ways.

Delivering services: doctors, nurses, midwives, and community health workers in for-profit, nonprofit, and faith-based organizations

Financing care: health insurance companies and private companies

Providing pharmaceuticals and laboratory and diagnostic services: pharmaceutical wholesalers, distributors, retail pharmacies, laboratories, and diagnostic facilities

Engaging in policy dialogue and advocacy: private provider associations

A closer look at the current and prospective role of the private health sector in the Middle East and North Africa is particularly important at this point in time given that regional instability and conflict are reshaping many countries' health systems and needs.

Four main trends describe the private health sector across the 11 countries:

1. **Governance of the private sector is limited and uneven.** While many countries include the private sector at least nominally in national health strategies and policies, regulation and monitoring of this sector is weak. In most countries, the private sector is fragmented and not well coordinated to represent and advocate for itself.
2. **Limited data are available about the size and scope of the private sector.** While some countries have registries and databases of private providers, they are often incomplete or outdated. Data on the use of private sector services is also scarce.
3. **The data that are available show that the private sector is an important and growing source of care throughout the Middle East and North Africa.** This is the case to varying degrees across all countries for which data is available, even those with strong public health sectors.
4. **In conflict and post-conflict settings, the private sector develops ad hoc in response to changing health needs, locations of violence/destruction, and the weakening of health systems, among other conflict-related factors.** The private sector is a key source of care where government services are unavailable or have broken down.
5. **Available data show that the private sector is a key source of health care for refugees living both inside and outside of camps in**

countries such as Jordan and Lebanon. UN agencies and NGOs often provide primary and secondary services to refugees living inside and outside of camps. Refugees living outside of camps may also access the private for-profit sector, depending on their ability to pay and the availability and quality of public sector services.

Governance

In the 11 countries included in this review, the capacity of governments to engage and leverage the private sector is limited. Most countries have included the private sector in national health plans at least nominally and several have public-private partnership (PPP) strategies, but these frameworks often lack regulations and mechanisms to support implementation. Even in Lebanon, where the private sector is dominant, government oversight is weak. Some countries, such as Egypt and Jordan, have public or independent entities that are responsible for the accreditation of public and private health facilities, but others, such as Algeria, have no formally recognized accreditation body. According to key informants, suspicion between the public and private providers is a key barrier to collaboration throughout the region. Private sector actors often view their public counterparts as inefficient and overly bureaucratic, while the public sector sees the private as uncooperative or too focused on making a profit.

While registries of private providers and facilities exist, they are usually out of date or incomplete, and private sector reporting into the national health management information system is limited. Some countries have a central registry of private providers, which is usually part of a larger registry of all licensed providers. For example, in Egypt and Jordan, the public sector and professional associations register public and private providers or facilities at the time they are licensed. There is currently no mechanism for updating this registry

when providers move or close. Egypt's Ministry of Health and Population also has a registry for private providers, but it is not updated regularly. Reporting of the private sector into national health information systems is minimal in most countries, usually limited to notifiable diseases. In some countries, the private sector may underreport in order to avoid taxes or government controls.

Suspicion between the public and private providers is a key barrier to collaboration throughout the region.

In most countries, the private sector's ability to organize, represent, and advocate for itself is weak. Across countries, public and private providers are generally required to register with professional associations, unions, or syndicates for their cadres when they become licensed. While these associations tend to be active and well organized, they do not advocate for the private sector's specific interests. In some countries, such as Egypt and Lebanon, associations help set quality standards and prices for services, and serve as arbiters of complaints against individual providers. Associations for private providers or facilities exist in certain countries, including the Private Hospital Association in Jordan and the recently founded *Syndicat National Medecins Liberales* (National Union of Private Physicians) in Algeria. These associations vary in their level of activity and their ability to represent and advocate for their members in policy making.

Public-private partnerships

While there are many PPPs throughout the region, most developed on an ad hoc basis and not as part of larger national PPP strategies. Many countries include the private sector in national policies, but

few have dedicated PPP legislation or government departments. Egypt and Morocco have better developed PPP policies, and Egypt has a PPP Central Unit. Contracting out services by the public sector to the private is permitted in most countries, but its prevalence varies. Contracting is very limited in Algeria, for instance, while in Lebanon almost all public health services are contracted out to NGOs or private hospitals. Lebanon is engaged in efforts to reform its contracting system so that it is based on clear performance and quality standards (WHO 2017b). PPPs also exist between the public sector and multinational pharmaceutical firms in several countries, including Algeria and Morocco. Egypt has two PPPs to develop hospitals in partnership with private universities (Ministry of Finance 2017). In Morocco, a PPP between the Ministry of Health and the Lalla Salma Foundation led to the establishment of the National Cancer Institute in 2016 (Oxford Business Group 2017).

Although rare, regional PPPs exist. For example, the King Hussein Cancer Center in Jordan is a regional destination for oncology training and care. According to key informants, Libya had a contract with the King Hussein Cancer Center to send its citizens to Jordan for cancer treatment that recently ended. Public sector physicians from the West Bank and Gaza travel to train in oncology at the cancer center as well.

In dealing with conflict and its effects, several ministries of health have established partnerships with local and international NGOs to improve service delivery in areas where public capacity is limited. In Iraq, for example, Médecins Sans Frontières (MSF) is collaborating with the Ministry of Health to provide mental health services in public facilities (MSF 2012). International Medical Corps provides mental health services in several public facilities in Jordan (International Medical Corps 2017).

Box 2. Why patients seek care in the private sector

- Convenience, including longer hours of operation
- Perceived higher-quality services and greater provider competence
- Better response times, attractive facilities, and more personal consultation with physicians
- Availability of drugs during public stockouts, and wider drug availability
- Access to specialists and specialized diagnostic equipment
- Perception that monetary cost of goods and services indicates higher quality
- Perceived confidentiality regarding stigmatized illnesses

Service delivery

The private sector is robust in some countries (Egypt, Jordan, Lebanon, Tunisia, West Bank and Gaza), and it plays a smaller but essential role in service delivery in others (Algeria, Iraq, Morocco). As in other parts of the world, health systems in the Middle East and North Africa are mostly under the purview of ministries of health, which are responsible for the financing, regulation, policy development, human resources management, and delivery of health services.

Data on the private sector, though limited, suggest that there is a wide range in the size and scope of the private sector across countries. In countries such as Egypt and Lebanon, the majority of hospitals, primary health care clinics, and pharmacies operate in the private sector. In other countries, the growth of this sector is recent. For example, Algeria's first private hospital opened in 2014.

Dual practice is legal and common in most countries, which can lead to competition between public and private sectors for personnel and other resources. The exception to this insight is Jordan, where dual practice is illegal and rare. Public sector salaries are generally lower and providers may refer patients to their private practices where they can charge higher fees (WHO 2014). In countries such as Egypt and the West Bank and Gaza, public clinics typically close in the early afternoon and providers then work at their private practices later in the day. This arrangement leads to shorter hours of operation in the public sector, limiting access.

While information on private providers' role in health service delivery is limited, available data show that the private sector is a significant source of care for family planning and MCH services throughout the region. The most recent population-based surveys provide information on the source of care for only a handful of illnesses or other health-related issues in certain countries. Although limited, these data present an important view of the private health sector's role in the region.

For example, the most recent population-based surveys show that the private sector is a major source of care for child health, including treatment of ARI symptoms (Figure 7) and diarrhea (Figure 8). For ARI symptoms, over half of children in all countries, except for Jordan, were taken to a private sector source. Diarrhea treatment shows similar trends, though data is only available for three countries. In most countries, the most common private providers consulted for both ARI and diarrhea treatment were pharmacies or private physicians.

Figure 7. Source of acute respiratory infection treatment for children under five (%)

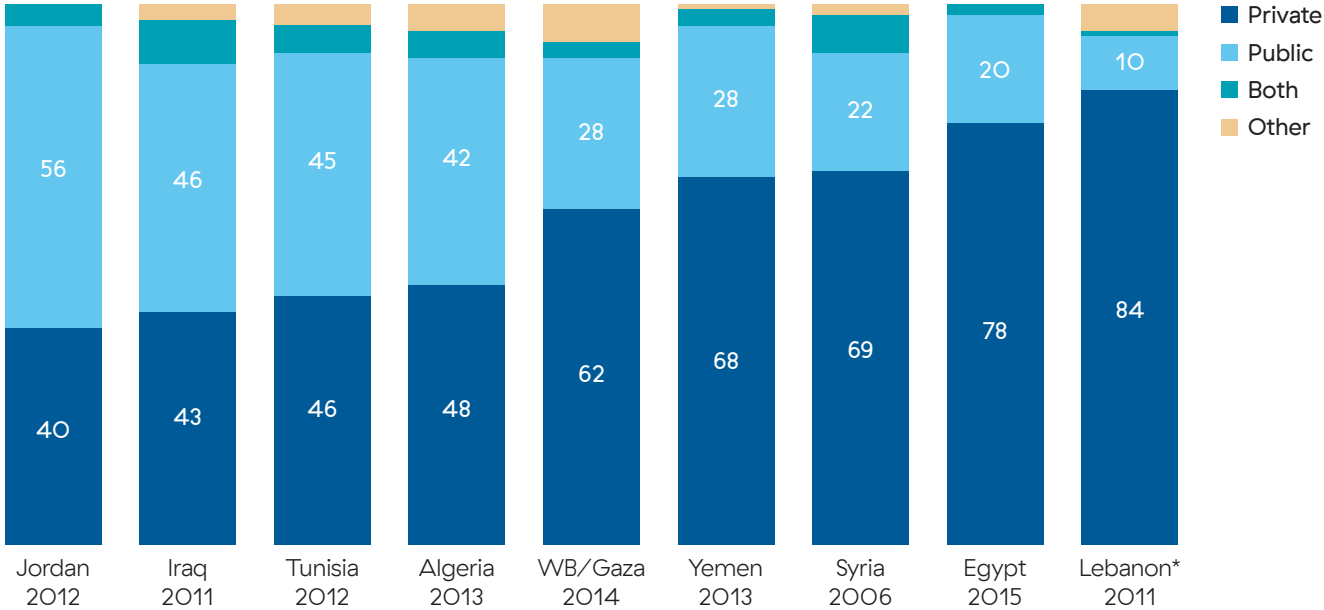
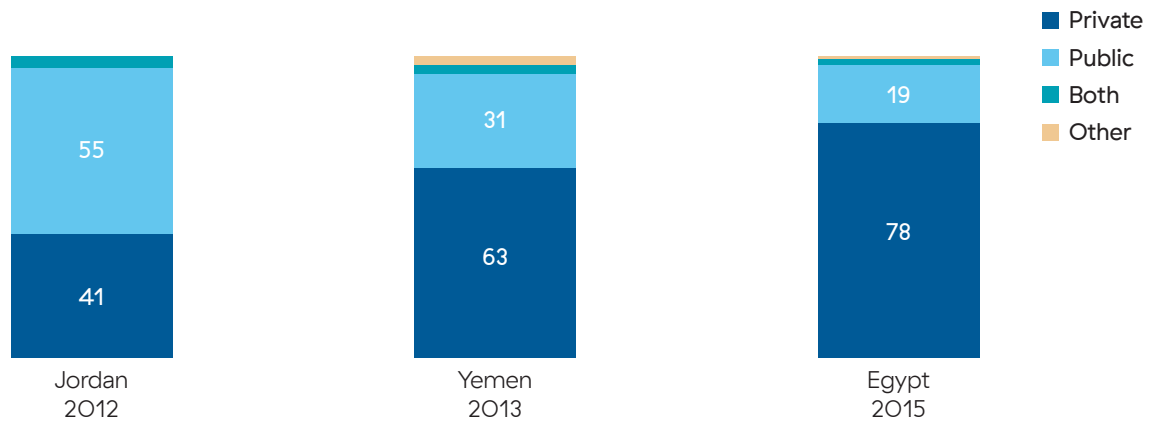


Figure 8. Source of diarrhea treatment for children under five (%)

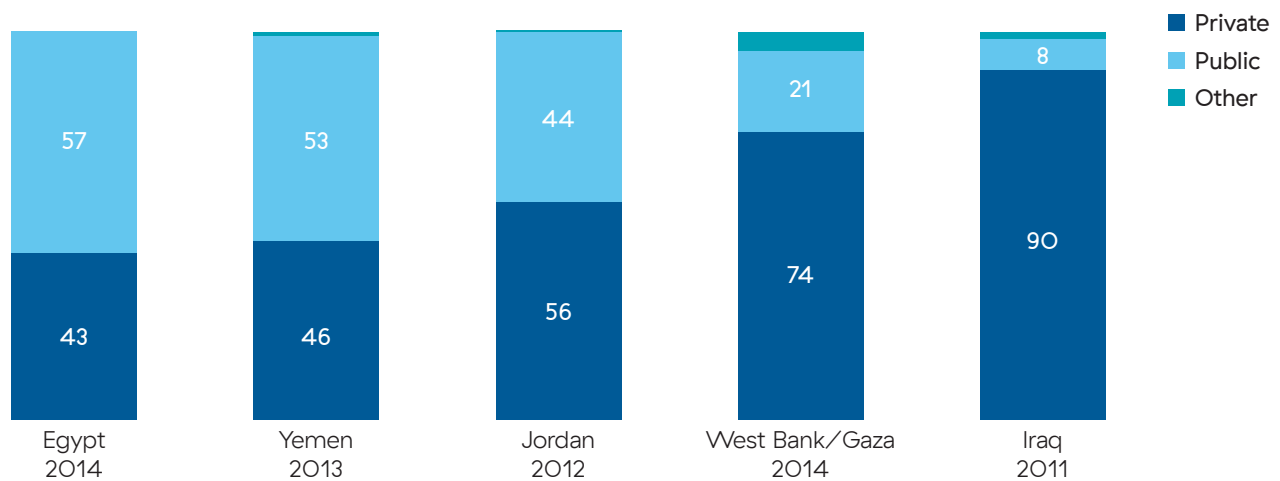


Sources: Egypt, Jordan, Yemen from DHS. Years as noted.

Note: Bars add to more than 100 percent because patients sought care in multiple sectors.

Data also show that the private sector is a significant source of modern contraceptive methods among women currently using a modern method, ranging from 43 percent of women obtaining their method from the private sector in Egypt to 90 percent in Iraq (Figure 9). In Egypt, Yemen, Jordan, and Iraq, pharmacies are consistently one of the top two sources of modern contraception. Other common private sources vary by country; these include private physicians in Iraq and private clinics and NGOs in Jordan. In the West Bank and Gaza, the UN Relief and Works Agency for Palestine Refugees health centers and hospitals are the most common source.

Figure 9. Source of modern methods of contraception among married women currently using modern contraception (%)

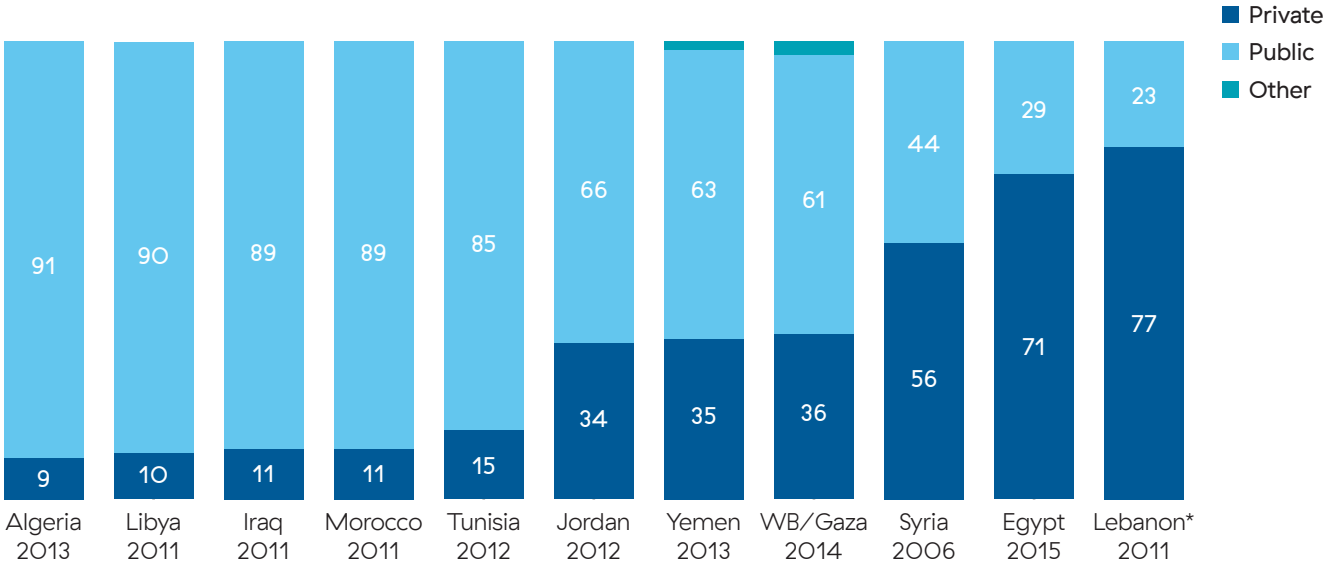


Sources: Iraq and West Bank/Gaza data from MICS. Egypt, Jordan, and Yemen data from DHS. Years as noted.

Note: Bars add to more than 100 percent because patients sought care in multiple sectors.

In most countries, less than half of women choose a private sector facility for delivery. The majority of women across the region deliver in health facilities, except for in Yemen where only about a third of women do so.³ Only about 10 percent of women who delivered in a facility reported using private facilities in Algeria, Libya, Iraq, and Morocco, and about a third used private facilities for delivery in Jordan, Yemen, and the West Bank and Gaza. However, use of the private sector for deliveries is high in four countries; over half of deliveries in Egypt, Lebanon, Syria, and Tunisia were in private facilities (Figure 10).

Figure 10. Place of delivery for births among women who delivered in a health facility (%)



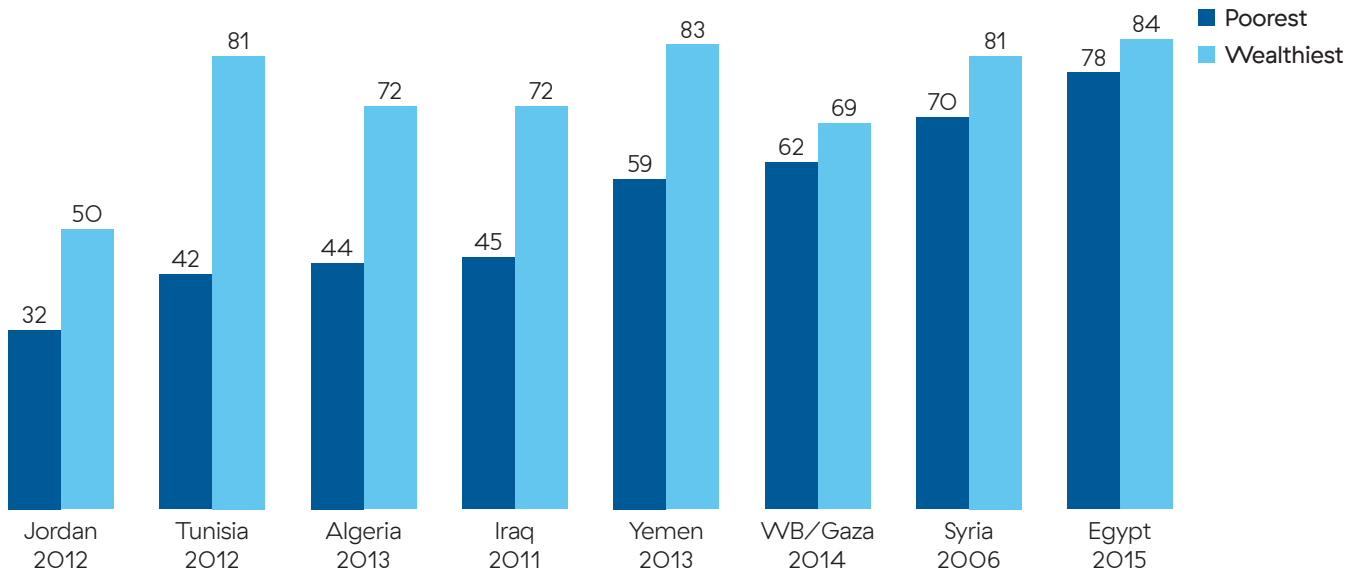
Sources: Algeria, Iraq, Lebanon, West Bank/Gaza, Syria, and Tunisia data is from MICS and is for delivery within two years prior to survey. Libya and Morocco data from PAFAM surveys and for delivery within five years prior to survey. Egypt, Jordan, and Yemen from DHS surveys and for delivery within five years prior to survey. Years as noted.

*Lebanon data is only for Palestinian refugees.

Use of the private sector for MCH is common for both the wealthy and poor. In all countries for which data is available, it is more prevalent among the wealthy, likely because they have the ability to pay. In Jordan, Tunisia, Algeria, and Iraq, ARI data show that health markets are well segmented, as use of private sector services among those in the wealthiest quintiles is higher than in the poorest quintile (Figure 11). Still, across all countries shown, over one-third of people in the lowest wealth quintile use the private sector for both ARI and diarrhea treatment (Figures 11 and 12).

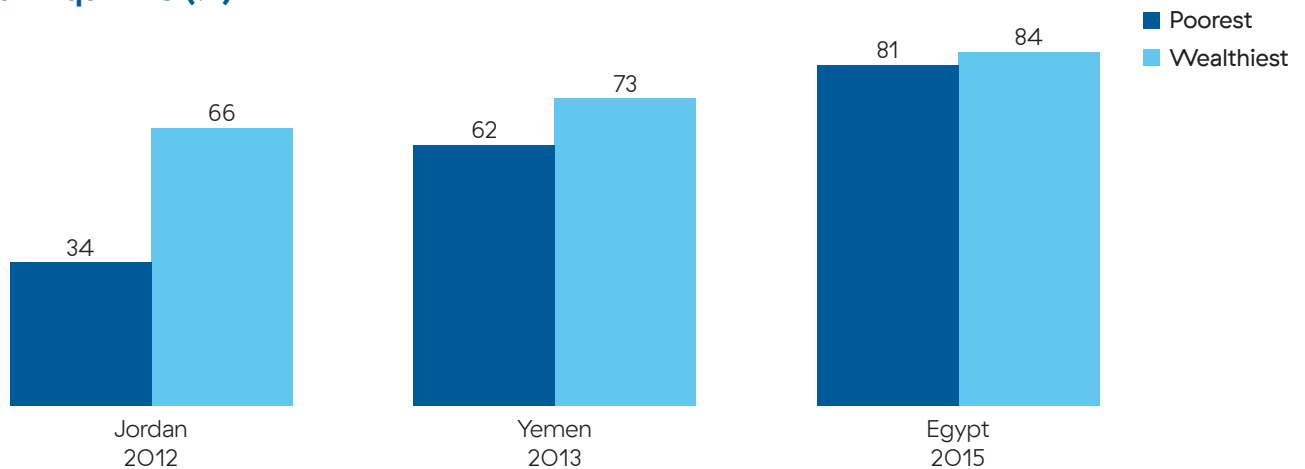
³ In Algeria, Libya, Jordan, the West Bank and Gaza, Lebanon, and Tunisia, over 90 percent of women deliver in facilities. In Egypt, Iraq, Morocco, and Syria, over 70 percent of women deliver in facilities and the remainder deliver at home. Yemen is the exception, as only a third of women deliver in facilities and the majority deliver at home (DHS 2012).

Figure 11. Use of the private sector for acute respiratory infection treatment in children under five, by wealth quintile (%)



Sources: Algeria, Iraq, Lebanon, West Bank/Gaza, Syria data from MICS. Egypt, Jordan, Yemen data from DHS. Years as noted.

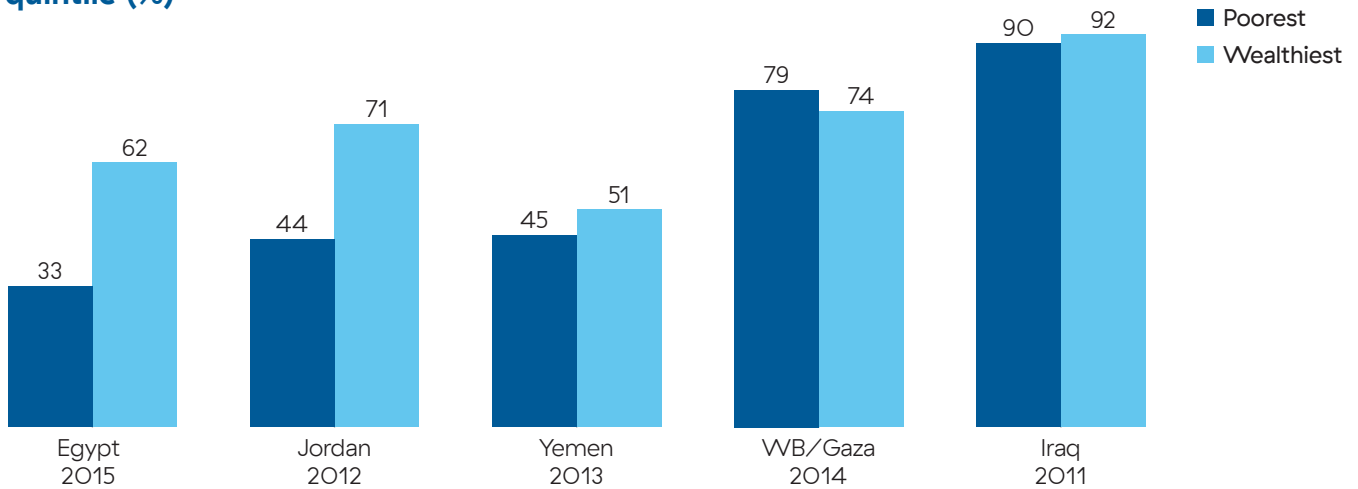
Figure 12. Use of the private sector for diarrhea treatment in children under five, by wealth quintile (%)



Sources: Egypt, Jordan, Yemen from DHS. Years as noted.

The private sector is a common source for modern family planning methods among people in both the lowest and highest wealth quintiles (Figure 13). Use of the private sector is high among the wealthy and poor in the West Bank and Gaza and Iraq. In the West Bank and Gaza, this may be because NGOs, particularly the UN Relief and Works Agency for Palestine Refugees, play such a large role in health service provision. In Iraq, this may be because of weakened public service delivery due to the conflict. However, data are not sufficient to draw conclusions about reasons for higher private sector use in certain countries or for certain health services. The market appears to be better segmented in Egypt and Jordan, with fewer people from the lowest wealth quintile using private sources for modern family planning.

Figure 13. Use of private sector sources for modern methods of contraception, by wealth quintile (%)

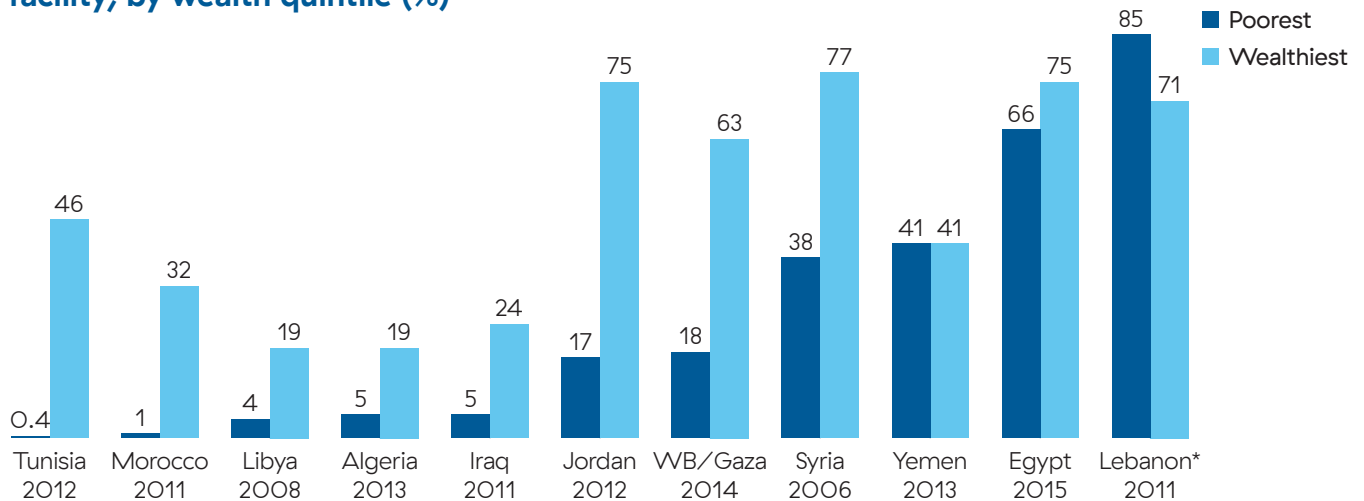


Sources: Egypt, Jordan, Yemen from DHS. West Bank/Gaza from MICS. Years as noted.

In most countries, use of the private sector for deliveries is less common among the poor than the wealthy (Figure 14). This is likely because of the high cost of facility delivery. Many women may choose to use the public sector, especially if public and private health schemes commonly cover delivery there. Typically, treatment for ARI and diarrhea as well as buying family planning methods is less costly than a delivery in a facility.

In Lebanon, the data used in this analysis only covers Palestinian refugees. The high number of refugees from the lowest wealth quintile (85 percent) who delivered in private facilities used NGO sector facilities, mostly Palestine Red Crescent Society hospitals.

Figure 14. Use of private sector facilities for delivery among women who delivered in a facility, by wealth quintile (%)



Sources: Algeria, Iraq, Lebanon, West Bank/Gaza, Syria, and Tunisia data are from MICS and are for delivery within two years prior to survey. Libya and Morocco data are from PAFAM surveys and for delivery within five years prior to survey. Egypt, Jordan, and Yemen data are from DHS surveys and for delivery within five years prior to survey. Years as noted.

*Lebanon data is only for Palestinian refugees.

While reports suggest that many people perceive higher service quality in the private sector than in the public sector, there is little reliable evidence on this issue. Existing data suggest that quality in the private sector is uneven, given limited regulation and oversight. There are many private sector facilities recognized for excellence throughout the region, particularly hospitals accredited by international standards in Egypt, Jordan, Tunisia, and East Jerusalem that are renowned for quality secondary and tertiary care. However, in some service areas—often where there is limited oversight of the private sector—service quality is inconsistent. In a recent study of private sector family planning services in Egypt, most providers reported that they had received no family planning training for 10 years (Abdel Tawab et al. 2016). These issues are not unique to Egypt. In many countries, there are limited opportunities for continuing medical education for private providers of any cadre. Key informant interviews highlighted this issue for pharmacies in particular. Pharmacies often act as primary care providers in several countries and are a key source of care for MCH and family planning, yet many pharmacists had little training or knowledge in counseling patients on how to properly use medications or on their side effects (Amin 2016; Amin and Chewning 2016). In most countries, enforcement of prescription drug regulations is limited.⁴

Box 3. Syrian field hospitals

Over half of public hospitals and health centers in Syria are closed or partially functioning (WHO 2016b; Coutts et al. 2015). This has led to restructuring of health facilities to meet the medical and humanitarian needs of those affected. These new facilities include field hospitals administered by NGOs and communities. Established in locations including factories, farms, caves, and basements, the so-called field hospitals have saved the lives of countless patients and health workers, although they often lack the necessary equipment and staff to be as effective as they could be and are targeted by armed forces (Alahdab 2014). Field hospitals increase opportunities for care, help to prevent displacement, and, when fortified, can ensure the protection of equipment (Fallon and Kieval 2017).

⁴ Understanding the supply and availability of health products is a key part of the private health sector. However, examining this was beyond the scope of this review, so this information is not included.

The private health sector in conflict settings

In conflict settings, health systems become fragmented between areas controlled by governments and opposition forces. Security issues also make national data collection challenging or impossible. In this context, data on the private health sector is scarce in conflict and post-conflict settings.

While already limited, oversight of the private sector weakens further in conflict or post-conflict settings when health systems and government functions fragment. In countries affected by protracted conflict, including Iraq, Libya, Syria, and Yemen, health sector governance varies geographically and over time depending on the intensity of fighting. Prior to the start of their respective conflicts, Iraq, Libya, and Syria had strong public health sectors and budding private sectors. The private sector, though less developed, also played an important role in Yemen. Professional associations that included the private sector were strong in Syria, for instance. National health policies and strategies still exist and are implemented to varying degrees in parts of these countries that are under government control. Monitoring of the private sector, which was limited before conflict, has declined, especially as ad hoc or informal private health providers and facilities may emerge to fill gaps left by destruction of the pre-conflict health system. In Iraq, Syria, and Yemen, international organizations and NGOs play a strong role in governing and monitoring service quality in the private, nonprofit sector through the humanitarian cluster system, under which international and local NGOs, usually vetted by the UN, coordinate efforts to make sure needs are met and to avoid duplication. In areas of these countries not under government control, some local and international NGOs have taken over running and supplying formerly public health facilities.

In conflict and post-conflict settings, the private sector develops ad hoc in response to changing health needs, locations of violence/destruction, and the weakening of health systems, among other conflict-related factors. Ad hoc field hospitals, for instance, are one response in Syria (Box 3). The role of UN organizations and NGOs such as the International Committee of the Red Cross, the International Rescue Committee, and International Medical Corps has increased in order to fill gaps left by the weakening and destruction of parts of the public and for-profit private sectors, particularly in primary and secondary service delivery. While international NGOs offer swift responses to acute health needs, experience, and funds, they may not remain in-country for long or have clear accountability mechanisms; they may lack local knowledge or disregard local capacity. Local NGOs also operate amid conflict. While these organizations tend to possess local knowledge and credibility, they may lack resources.

In conflict settings, for-profit providers, typically located in urban settings, tend to provide primary and secondary care and pharmaceutical supply (Witter and Hunter 2017). Their relative strengths may include capacity, flexibility, and perceived higher quality (Witter and Hunter 2017). However, these providers may lack regulation, charge high fees, and many may leave in response to worsening violence (Witter and Hunter 2017). In Iraq, Libya, Syria, and Yemen, the private for-profit sector has been greatly weakened as the uncertain economic and security environment increases the challenges of running a business. Foreign workers played a critical role in the Libyan for-profit sector prior to the civil war but many have left since it began.

When conflicts limit local medical resources, patients may travel to other parts of the region to seek private care. For example, thousands of Iraqis

In Iraq, Libya, Syria, and Yemen, the private for-profit sector has been greatly weakened as the uncertain economic and security environment increases the challenges of running a business.

travel to Beirut and Amman each year for weeks or months to seek treatment in the private sector. This has a high cost, particularly for people with chronic diseases such as cancer that require multiple costly treatments (Dewachi 2013). Many patients sell properties and belongings, or borrow money to cover travel and treatment expenses (Skelton 2013).

PPPs between local and international NGOs and the government are important to service delivery in conflict and post-conflict settings. For instance, MSF partners with the Iraqi Ministry of Health to expand access to mental health care in public health facilities (MSF 2012). In Yemen, the NGO community serves as an intermediary between the public and private for-profit sectors, supporting the former by acquiring some resources from the latter. Donors fund these PPPs, so they may not be sustainable in the long run.

Private sector care for refugees

Available data show that the private sector, both for-profit and nonprofit, is a key source of health care for refugees living both inside and outside camps. UN agencies, namely UNHCR, typically provide primary and secondary services to refugees living in camps, referring them out to the public or private sectors as needed for tertiary and chronic care. Refugees living outside camps may access care from NGOs or from the private for-profit sector, depending on their ability to pay for services. A 2017 UNHCR survey found that 64 percent of Syrian refugees (registered with the UNHCR) in Egypt seek care in the private sector. In Egypt, Syrian refugees are entitled to access primary health care in the public sector; many did not due to limited awareness of the benefit and other factors (Nielsen 2017). A 2014 survey of Syrians living outside camps in Jordan found that 39 percent of health services sought by Syrian refugees were in the private for-profit sector and 10 percent were in the private NGO sector (Doocy et al. 2016b). The largest barrier to private sector care for refugees is cost.

Recommendations and Knowledge Gaps



Recommendations and Knowledge Gaps

Recommendations for USAID investment

The following recommendations support USAID's plan for "strategic transitions"—moving select middle-income countries to a model of US engagement that relies less on traditional development assistance and more on other forms of cooperation. This includes a shift from service delivery to capacity building, drawdown of grant funding, and a prudent reduction in USAID's physical presence.

General recommendations

- Help implement USAID's strategic transition from service delivery and grant funding to capacity building and technical assistance. This should use a phased approach and a realistic timeline, taking into account gaps in public finance and local capacity.
- Continue contributing to multilateral development banks and UN agencies, whose lending, investment programs, and technical assistance tend to be better matched to middle-income countries' financial and technical needs.
- Focus grant resources on capacity building in partner countries to ensure the sustainability of USAID investments (e.g., family planning and primary health care in Egypt and Jordan). Each country-specific strategy should identify the appropriate menu of technical assistance to be implemented, and a realistic timeframe for implementation.

Health financing recommendations

- Support a shift from passive purchasing to active and strategic purchasing by sharing experiences, tools, and best practices of other countries, and providing mid-term support to tax-based and health insurance entities to introduce new purchasing arrangements and to manage the transition.
- Strengthen countries' capacity to (1) expand and manage social health insurance schemes and prepayment mechanisms and (2) implement, monitor, and evaluate the universal health coverage agendas and plans.
- Promote domestic revenue mobilization for social services in general and health in particular. Strengthen partner countries' revenue administration and collection, advise on tax reform, encourage a culture of tax compliance, and strengthen pro-poor policies and public financial management, including health expenditure review and monitoring.
- Provide strategic advice, tools, and information on key health policy issues and particularly on health technologies and human resources for the 21st century, health information platforms, contractual arrangements, equity-oriented policy, health system governance, health service management and evaluation, priority setting and benefit package design, results-based financing, economic evaluation methodology, and evidence-based decision making.

- Help countries institutionalize the National Health Accounts exercise and use of the results to inform policy dialogue and decision making on health policy and financing.

Private health sector recommendations

- In priority countries where USAID would like to invest in working with the private health sector, it may be necessary to conduct more detailed assessments to better understand the size and scope of the private sector and to find private sector partners. Conducting private sector assessments or censuses in key countries, such as Jordan or Egypt, is one way to do this. An assessment captures key information such as who comprises the private sector, which services and products they provide and to whom, where private providers are located, and more. Assessments can focus on a specific health area or they can cover a range of health priorities. Having this information can help local stakeholders to more effectively harness the private sector's strengths in their health systems.
- On a country basis, establish a formal platform such as a technical working group that functions to initiate or support dialogue between the public and private sectors to support the implementation and regular updating of regulations and procedures, the development of private sector components of national health strategies, and the identification of opportunities for PPPs.
- Support existing private provider associations to advocate for themselves in policy making to strengthen governance of the private sector.
- On a country basis, support collaboration between the public and private sectors to build a total market approach for increasing access to priority health products and services. A total market approach (TMA) is a lens or process for

developing strategies that increase access to priority health products and services. It involves taking into account free, subsidized, and commercial delivery methods as well as clearly defining the roles and target populations of the public and private sectors to increase access for all segments of a population.

- The private health sector is a critical provider of care for NCDs across the region. Governments are advised to prioritize PPPs for NCDs, particularly for NCD prevention, building on successful models in Egypt and Lebanon.
- Facilitate collaboration between the public and private sectors to strengthen referral systems. This will help to increase efficiency by ensuring the private sector complements the public sector in service provision.
- Support provider associations or other possible training venues to provide continuing medical education to private providers.
- Focus on training and organizing private pharmacies to improve the quality of MCH and family planning services, including counseling on the use of child health treatments and family planning methods, including possible side effects.

Recommendations for fragile states

For countries experiencing prolonged conflict, different types of investments are necessary to support and rebuild health systems. Guidance on health interventions in fragile states advocates sequencing for maximum effectiveness. This means that donors, including USAID, should focus on short-term, urgent relief to save lives during conflict. This may require large financial and technical support for several years, delivered in close collaboration with other donors and partners. As the country stabilizes, donors can focus on longer-term development goals and make investments

similar to those recommended above for stable states (Management Sciences for Health 2007). During post-conflict transitions, it is important to consider how to advise countries so that they can take advantage of rebuilding to rethink their health system design, governance, and management.

Recommended investments related to health financing and the private health sector include:

- Sponsor applied research and interventions related to health financing in conflict, as little is known about this area. Possible research topics include the mix and sequencing of financing mechanisms, regulation and public financial management, payment systems and incentives at the facility and health worker levels, and possible contributions of overall health financing strategies to wider state building.
- Sponsor applied research on effective interventions for providing chronic NCD care through the private sector in conflict and post-conflict settings. There is little research on this topic, but the need for NCD care is high among Syrian refugees in Lebanon and Jordan, and among people living in unstable situations in Iraq, Libya, Syria, and Yemen.
- Promote focused approaches to improve service quality in conflict settings, possibly through financial incentives or substitutes for state regulation where state oversight has broken down or become fragmented in conflict. These approaches could include external and self-accreditation, franchised service provision, and community monitoring of health service availability and quality.
- Consider contractual non-state partners to provide basic health services, including those for NCDs. These activities should be accompanied by the implementation of innovative ways to build or rebuild the capacity of ministries of health to manage and administer funds to NGOs and other partners, set policy, regulate the market, and contract services.
- Where mobility is limited due to security, support remote, video- or phone-based training and supportive supervision for providers in areas that are not physically accessible to improve service quality.
- Where health systems have become fragmented or destroyed, explore the feasibility of creating health service directories that are accessible via mobile phones for refugees or internally displaced persons who are moving frequently or living in unfamiliar areas.
- In more stable areas of conflict and post-conflict states, train and organize private pharmacies to improve the quality of counseling and services, particularly for MCH and family planning services.
- Establish a transition mechanism and well-defined financing rules for shifting from humanitarian aid to development aid. This is critical to avoid maintaining dependency and state-avoidance practices.
- After conflict ends, focus on rebuilding private health sector infrastructure, providing medical supplies, and helping to rebuild private provider associations or networks. Continue to provide health personnel salaries while assisting with the transition to sustainable revenue models.

Key knowledge gaps

There are substantial gaps in existing knowledge about health financing and the private sector in the region. USAID would be well advised to invest in more detailed reviews in priority countries to help fill these gaps.

Health financing

There is little information available on how revenue is collected and how various public and private contributions to health systems are structured. In addition, there is little detailed information on levels and sources of OOP payments among different populations, especially by socioeconomic status. Better understanding of revenue collection and contributions has important implications for promoting equity in health financing.

Knowledge is limited on how policymakers define benefits packages. There is little information on what tools are used for priority-setting, structuring benefits packages, funding them, and evaluating their effectiveness. Understanding how policymakers decide on benefits packages is important for structuring health financing mechanisms.

There is limited information on the effects of different active purchasing arrangements and payment methods on service quality and cost in the public and private sectors. Several countries have piloted different purchasing arrangements or initiatives aimed at separating providers and payers, but little is known about the results of these pilots.

There is limited information on the population coverage of different financing regimes in these 11 countries, as well as on people's access to basic or specialized health services and their household health expenditures. Population-based health surveys are needed to gather reliable data in this area.

For countries bordering Syria, little is known about the impact of refugees and the Syrian crisis on health financing and performance in Jordan, Lebanon, and other countries. Data are lacking about the extent to which alternative providers and donors have stepped in to fill widening financial gaps in Syria as the conflict has unfolded.

Few sources have examined lessons learned on financial protection from countries previously in conflict and reconstruction efforts that could be applied to Middle Eastern countries in conflict. These lessons could help to inform post-conflict rebuilding to improve health financing systems.

Private health sector

Little is known about the size and scope of the private health sector, types of providers in it, services they offer, and populations they serve. Existing government, professional association, syndicate, or other records of private providers are inconsistent and usually out of date. It is unclear how the private sector complements or competes with the public sector in most countries.

There is little information on lessons learned and successful policy models for supporting the private sector in the Middle East. Certain countries have dedicated PPP units within government, contract extensively with the private sector for certain services, and have made efforts to include the private sector in policy making. However, it is unclear what the effects of these policies have been and whether they are successful in supporting private sector development or increasing public-private dialogue.

Data are extremely limited on the use of private sector health services. As discussed above, few reliable, recent population-based surveys ask about the use of health services. The surveys that do exist are often designed for low-income countries

and focus on family planning and MCH services. While small-scale studies gather data on NCD service use among specific populations, such as refugees, nationally representative data on sources of health care, particularly for NCDs, are rare.

A lack of reliable data exist on how the private sector evolves during conflict, which makes it challenging to know how to support the private sector in conflict and post-conflict settings. Reports suggest that the private health sector changes substantially during conflict, with instability causing for-profit providers to close or move, new types of providers to open due to changing demand, increased roles for local and international NGOs, and deterioration of public health systems.



Two children await medical care in Iraq.

Photo: DVIDSHUB/
Sgt. Daniel West

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