Engaging the Private Health Sector to Advance Universal Health Coverage: WHO Eastern Mediterranean Region Case Study

This is a discussion document commissioned by the World Health Organization and recommended by the Advisory Group on the Governance of the Private Sector to support the development of a WHO strategy.

EXECUTIVE SUMMARY

In 2018, 22 member states of the Eastern Mediterranean Regional Office (EMRO) endorsed a framework for private sector engagement. The EMRO framework recognized variation in member state contexts, alongside a dominant - and common - contextual feature: high out-of-pocket expenditure by the poor in an environment of growing private health service delivery. EMRO spent considerable time and effort to evidence this context. The process of developing the framework – from evidence gathering, consultations, to strategic discussions – has informed EMRO’s plans for engaging the private sector. The case study is instructive for other WHO regional offices and member states seeking to deepen engagement with the private sector as part of Universal Health Coverage (UHC).

INTRODUCTION

In January 2015, the member states of the United Nations adopted the 2030 Agenda for Sustainable Development Goals. In support of this and the UHC agenda, member states increasingly recognized that the private health sector has become a dominant provider of health services especially in low- and middle-income countries (LMICs). The private health sector generally includes a heterogeneous group of non-state actors in health comprising of formal and informal, profit and not-for profit, domestic and international providers. Governments in LMICs are grappling with the challenge of how to engage the private sector to advance UHC.

1Transforming our world: the 2030 Agenda for Sustainable Development. UN General Assembly. 21 October 2015
2Montague D and Chakraborty. Analysis of DHS and MICS surveys from 27 AFRO countries representing 732.7M people; and eight SEARO countries representing 1,880M people. 2019.
3David Clark et al. The private sector and universal health coverage. Bull World Health Organ 2019;
with how to work with the private health sector. A resolution to strengthen the capacity of governments to engage the private health sector was agreed by member states in the 63rd World Health Assembly in 2010. Supporting this resolution remains a priority for the WHO.

The WHO EMRO has invested in building the capacity of member states to engage the private health sector. Since 2009, EMRO has amassed a rich pool of information on the private health sector landscape in the region and held numerous consultations to develop a “Framework for Action on Effective Engagement of the Private Sector to Expand Service Delivery for UHC” (herein referred to as the Framework), which was endorsed by the 22 member states of the region in the Regional Committee 65, 2018.

Other WHO regions are also exploring partnership with the private sector, through official declarations, regional assessments, or specific interventions. EMRO’s experience of developing the Framework, and the Framework itself, contributes to this body of work. This case study aims to capture information and lessons learned from key informants who have been involved in developing the Framework and its implementation. This case study explores replicability of the EMRO approach in other WHO settings.

METHODOLOGY

The case study considered EMRO’s rationale for focusing on the private health sector, the process involved in developing the Framework, what worked and what didn’t, and lessons learned. The case study draws on primary and secondary data. Primary data was collected through stakeholder interviews (Table 1). These individuals were selected based on their role in the development of the Framework. Where quoted in the case study, key informants are referred to as respondent. Secondary data included a review of relevant documents, provided by EMRO. Study limitations included

Table 1. Key informant interviews by name and affiliation

<table>
<thead>
<tr>
<th>MEMBER</th>
<th>AFFILIATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Hassan Salah</td>
<td>Regional Advisor, Primary and Community Health Care WHO – EMRO</td>
</tr>
<tr>
<td>Dr. Fethiye Gulin Gedik</td>
<td>Coordinator of Health Workforce WHO – EMRO</td>
</tr>
<tr>
<td>Dr. Adham Rashad Ismail Abdel Moneim</td>
<td>WHO Representative and Head of Mission, Iraq WHO – EMRO</td>
</tr>
<tr>
<td>Dr. Awad Mataria</td>
<td>Director, Universal Health Coverage WHO – EMRO</td>
</tr>
<tr>
<td>Prof. Venkat Raman</td>
<td>External Consultant</td>
</tr>
<tr>
<td>Monica Villaneuva</td>
<td>Senior Health Advisor of Middle East Bureau USAID</td>
</tr>
</tbody>
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4Resolution WHA 63.27/EM/RC57/10. Resolutions and decisions of regional interest adopted by the 63rd World Health Assembly. Agenda Item 7(a). 2010;
6Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2019 update
the absence of government and private sector key informants and the small number of key informants overall, due to budget constraints.

The case study was funded by the Health Systems Governance and Financing department of WHO HQ in support of their work on governance of private health sector service delivery. The data collection and production of the document was done by Impact for Health International over a period of two months in early 2020. The WHO’s Advisory Group on the Governance of the Private Sector for UHC provided expert review of the case study.

The case study begins by providing a background on the Eastern Mediterranean region (EMR) and the scale of the private health sector in this region. This is followed by the findings section which outlines how EMRO responded to the growth of the private health sector and the process used to develop the Framework. The discussion section highlights the key insights and lessons that emerged from the Framework process. The case study concludes with a set of recommendations for stakeholders involved in similar work and its complementarity with the recent roadmap for governance of private sector.

BACKGROUND: CONTEXT & CHALLENGE

EMRO serves 21 member states and Palestine (West Bank and Gaza Strip) with a combined population of approximately 679 million people (Figure 1). Member states represent a range of socio-economic contexts.

- High income: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and United Arab Emirates
- Middle income: Egypt, Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Syrian Arab Republic, and Tunisia
- Low income: Afghanistan, Djibouti, Pakistan, Somalia, Sudan, and Yemen

Despite these differences, all EMR countries have mixed health systems, in which the private health sector plays a growing role, with potential to contribute to UHC. According to the global monitoring report of WHO, an average of only 53% of people in the EMR have access to basic UHC services.

In some EMR contexts, a strong public health sector operates alongside a rapidly growing private health sector.
sector. Examples include Egypt, Islamic Republic of Iran, Pakistan, and Afghanistan in which a major portion of the pharmacies or health clinics are privately owned, whereas the public sector is a major provider of inpatient care. EMRO also includes four of the six high emergency member states found globally - the Syrian Arab Republic, Yemen, Somalia, and Sudan. In these contexts, the public sector has been severely weakened due to prolonged emergency crises, which the private health sector has partly filled. Similar phenomenon of an expanding private sector amidst weak public sector are currently observed in other states in conflict; not surprisingly, the data from these countries are limited.

In the EMRO context, similar to other LMIC contexts, there is high OOP, in

Table 2: Analysis of private health sector in countries of the Eastern Mediterranean Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE)</td>
<td>Percentage of private hospital beds</td>
<td>Percentage of private health clinics</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Bahrain</td>
<td>34%</td>
<td>18%</td>
<td>88%</td>
</tr>
<tr>
<td>Kuwait</td>
<td>13%</td>
<td>15%</td>
<td>75%</td>
</tr>
<tr>
<td>Oman</td>
<td>6%</td>
<td>6%</td>
<td>79%</td>
</tr>
<tr>
<td>Qatar</td>
<td>7%</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>14%</td>
<td>23%</td>
<td>15%</td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td>18%</td>
<td>26%</td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Egypt</td>
<td>56%</td>
<td>25%</td>
<td>78%</td>
</tr>
<tr>
<td>Iran</td>
<td>41%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Iraq</td>
<td>40%</td>
<td>7%</td>
<td>na</td>
</tr>
<tr>
<td>Jordan</td>
<td>21%</td>
<td>33%</td>
<td>78%</td>
</tr>
<tr>
<td>Lebanon</td>
<td>36%</td>
<td>83%</td>
<td>82%</td>
</tr>
<tr>
<td>Libya</td>
<td>26%</td>
<td>9%</td>
<td>23%</td>
</tr>
<tr>
<td>Morocco</td>
<td>58%</td>
<td>27%</td>
<td>10%</td>
</tr>
<tr>
<td>Palestine</td>
<td>na</td>
<td>14%</td>
<td>29%</td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>54%</td>
<td>28%</td>
<td>5%</td>
</tr>
<tr>
<td>Tunisia</td>
<td>38%</td>
<td>20%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afghanistan</td>
<td>64%</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Djibouti</td>
<td>36%</td>
<td>7%</td>
<td>19%</td>
</tr>
<tr>
<td>Pakistan</td>
<td>56%</td>
<td>16%</td>
<td>92%</td>
</tr>
<tr>
<td>Somalia</td>
<td>na</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Sudan</td>
<td>76%</td>
<td>9%</td>
<td>27%</td>
</tr>
<tr>
<td>Yemen</td>
<td>76%</td>
<td>na</td>
<td>45%</td>
</tr>
</tbody>
</table>
return for unknown quality of care. The global health expenditure database reported that in EMR, USD 153 billion was spent on health in 2014. This constitutes 1.8% of the total world health expenditure. The share of OOP expenditure was highest in a low-income country, Yemen (76%), and lowest in a high-income country, Oman (6%). Although OOP is a proxy indicator of the utilization of private services, the average OOP expenditure in EMRO low-income countries was 61.6% whereas in high-income countries it was just 15.3%. Given this, poorer households in low-income contexts are more likely to face catastrophic health expenditure due to ill health and associated high OOP.

Table 2 overleaf presents further analysis of member state health systems using the WHO’s six health-system building blocks\textsuperscript{12} and grouped based on economic status.

**FINDINGS: THE FRAMEWORK**

Figure 2 presents the chronological process that was followed by EMRO to produce the framework. Three distinct phases were noted: data collection, sensitization, and consensus building (Figure 2).

**Phase 1 – Data Collection**

The first and longest phase focused on collecting data to understand the private health sector landscape. As a respondent explained, the “private sector is a blind box. We use private health services, but we do not know much about them.” Assessments began in 2007 and collected data on the private health sector from 12 countries in the EMR. Additional data was collected in 2012 from 11 more countries and the data collected in the first phase was also updated. The data from these 22 countries were analyzed in 2013 and revealed that
the private health sector was delivering a large portion of PHC, contributing to high OOP health expenditure and was inadequately regulated. This was the first time that EMRO had analyzed the private health sector to this extent: “We [EMRO] looked at this reality and looked at what we were involved in. There was a total misalignment in our focus and that was a critical lever to help start the conversation.” Previous to this, EMRO had prioritized other aspects of service delivery to improve access\(^{13}\) and had been working exclusively with ministries of health (MOH).\(^{14}\)

**Phase 2 – Sensitization**

With the data and evidence in hand, EMRO still had to convince other stakeholders of the importance of private sector engagement; as noted by a respondent, “despite the data and evidence, the staff still (didn’t) feel it.” A high-level consultation meeting in 2014, with senior ministers and subject experts from across the globe, was used to build understanding that the private sector needed to be engaged to improve service delivery. A resolution was passed after the 63rd regional committee session to strengthen public-private-partnership in service delivery by scaling up family practice\(^{15}\). Capacity-building workshops were held in various EMR countries to raise awareness among health policy implementors on the importance of effectively engaging the private health sector and as a means of sharing analytical tools, mechanisms for engagement and best practices\(^{16}\).

Concurrently, the importance of the private health sector was also emphasized in EMRO frameworks for action on advancing UHC\(^ {17}\) and health workforce development.\(^ {18}\) Although these efforts were well received, countries still struggled to formulate an evidence-based policy to engage the private health sector. As a respondent noted “…a strategic pathway to pursue this agenda was still absent as EMRO remained predominantly public with no internal platform to start talking to about the private sector.”

**Phase 3 – Consensus Building**

To define a strategic pathway, additional in-depth analyses were conducted during the period 2015-17. The findings of these analyses were presented to the member states at the 64th regional committee meeting in 2017. This approach once again evidenced the prominence of the private health sector in the region and created demand from member states for a technical paper. This request triggered internal discussions among a team of experts at the EMRO office who led the process. Most of the budget of the EMRO PHC Unit for 2018-2019 was directed to private health sector assessments. EMRO also drafted an initial Framework outlining how countries could engage the private sector. The goal of the framework was “to simplify the complex environment that we are working in”, but it also helped in tracking...
progress and identifying challenges. The “Framework for Action on Effective Engagement of the Private Sector to Expand Service Delivery for UHC” was validated with support of an external expert and member state feedback was also incorporated. The Framework was presented as a resolution at the 65th Regional Committee meeting in October 2018 and endorsed by the 22 EMR countries. This endorsement offered a legal and political commitment for work on the private health sector.

**The Framework**

The data collection, sensitization and consensus building phases resulted in a Framework with four overarching objectives:

1. Expanding and improving equitable access to health services;
2. Establishing a national health service for UHC with the participation of the private health sector;
3. Assuring improved quality of services provided by the private health sector through agreed standards, regulation, and incentives; and
4. Enhancing the financial protection goal of UHC through strategic purchasing from the private health sector.

The Framework proposes five strategies for action to engage the private health sector to expand service coverage for UHC.

1. Develop a policy framework, organizational systems, and financing strategies for engaging private health sector providers in national health systems.
2. Develop strategic options for private health sector engagement, including strategic purchasing, and facilitate and institutionalize private health sector engagement, including capacity-building.
3. Improve the quality of services in the private health sector.
4. Ensure that regulatory mechanisms for health systems are enforced effectively in the private health sector; and
5. Develop monitoring and reporting mechanisms for private health sector providers.

Limited additional details are noted, although three levels of engagement are proposed: consultation, involvement, and partnership.\(^{19}\)

**Post-Framework Implementation**

The development of the Framework was followed by private health sector assessments in selected countries using a standard assessment tool. These assessments are in the final stages of analysis and will be published in quarter 4 of 2020. These will be instrumental in guiding member states on options for private sector engagement and capacity building.\(^{20}\)

The focus of 2019 was to create awareness among member states on utilizing the Framework for effective engagement of the private sector. Despite the endorsement of the Framework, the implementation by member states as well as the regional office has been limited.\(^{16}\) As a respondent explained, “We are drowning in frameworks.\

\(^{20}\)Key informant interview with Prof. A. Venkat Raman on 20 February 2020
Many frameworks are sitting on shelves collecting dust.” The reason, there are many theoretical frameworks and guidelines that come from WHO but national MoHs do not have the capacity to put them to action.

United States Agency for International Development (USAID) is supporting implementation of the Framework in a few countries. The assessment of the private health sector in the region by USAID through their Sustaining Health Outcomes through the Private Sector Plus (SHOPS Plus) initiative supported their decision to invest in policy dialogue in a subset of EMR countries, Iraq, Libya, Morocco, Tunisia, and Yemen. Oman is planning to host one of the workshops, and, as a by-product of hosting, they have become interested in the work as well. The policy dialogues are expected to help to support the development of a country action plan to operationalize the regional framework for action on effective engagement with the private health sector.

Alongside plans for public-private policy dialogue, consultation with other departments of WHO is underway. For example, EMRO has engaged focal persons of ‘The Global Action Plan’ on EMR health matters, including private sector engagement. EMRO will also be launching a ‘Regional Health Alliance’ by partnering with development partners for several accelerators and private sector engagement is one of them. The private health sector became part of the regional joint collaboration work plan for EMRO with United Nations partners, including United Nations Program on HIV/AIDS (UNAIDS), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), United Nations Children’s Fund (UNICEF) and World Organization of Family Doctors (WONCA) to help ensure the engagement of the private health sector in response to COVID-19.

DISCUSSION

From the chronology presented in the findings section, we have identified key insights of relevance to regional WHO offices and member states, to reflect on the process of the Framework development and its application.

The process to develop the Framework was protracted and relied upon successive private health sector assessments. The number of assessments conducted as part of the process to develop the Framework took significant resources and time. As these are done as discrete assessments, they tend to become outdated, and require reassessment given evolving contexts and dynamic private health sectors. While they are useful to inform private sector engagement, they are not intended to be a tool for public-private partnership dialogue. In place of one-off analyses through large assessments other, less resource-intensive tools and metrics, should be developed and applied consistently across countries and over time.

EMRO had to navigate institutional
biases against the private health sector within WHO country offices and ministries of health. Most WHO resolutions and frameworks were centered around the public sector and did not align with private sector engagement. As a result, promotion of the Framework was met with resistance, “I really had a hard time over the past two years. So many people questioned my focus on the private sector” (Respondent). Resistance was less ideological, and more pragmatic, grounded in concerns with institutional capacity, “It is not an ideological position but more of apprehension about the change without appropriate capacity” (Respondent). The data and analyses were not sufficient to overcome these apprehensions, which were overcome through persistence and teamwork, “Joint work across teams made it more acceptable” (Respondent). Member states and other organizational champions also helped. Additional creative advocacy facilitated member state support. This included a documentary film from senior policy makers of Jordan, Pakistan, Saudi Arabia, Morocco, Lebanon and Libya about the importance of private sector, played prior to the presentation to the 64th regional committee meeting. This set a positive tone during the 2017 meeting and helped overcome some political resistance to private sector engagement.

The process to develop the Framework required WHO to be an interlocutor for the public and the private sectors, a role it had not assumed before. As a single coordinating body working with ministries of health and development partners, WHO was well positioned to play the role of interlocutor. However, since WHO has not traditionally engaged with private sector partners, considerable effort was needed to establish and nurture public-private dialogue. An external respondent recognized the efforts of EMRO, “WHO put lot of time in building relationships.” They let the ministries call the meetings and promote robust participation from the private sector.

RECOMMENDATIONS

Based on the EMRO experience, the following recommendations are proposed for other regions and member states interested in more effective private sector engagement.

Resource and develop WHO’s role as convener of private sector engagement and public-private partnership dialogue. WHO is well placed to play a convening role given its unique and long standing relationships with governments and other stakeholders, including development partners. To do this, WHO needs to build the trust of private health sector stakeholders and facilitate their engagement and perspectives in governance processes. To play this role effectively, WHO must resource the role with dedicated staff.

Appraisal of the political economy should inform engagement and Framework development strategies.

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Private sector engagement should be informed by political economy analysis and underpin strategic engagement. This form of analysis would facilitate understanding of the institutional biases that may exist within and between key stakeholders – including the private sector, ministries of health, development partners and WHO offices. This analysis should inform stakeholder engagement and framework development, early in the process. In the EMRO case, the early phases of the process were focused on technical assessment, which did not adequately consider political economy analysis, or existing mechanisms of engagement.

Develop tools and metrics that enable more nimble and generative understanding of the private health sector and their role in mixed health systems/whole society approach. EMRO relied upon technical assessments in the development of the framework, which were time consuming and costly and did not allow for more dynamic appraisal of mixed health systems. In place of one-off analyses through large assessments it is recommended that other, less resource-intensive, tools and metrics are developed and applied consistently across countries and over time.

Establish the EMR Private health sector advisory group (PHSAG). PHSAG will carry out strategic sectoral analysis and identify high-priority health areas and promising approaches for private sector regulation and engagement in the context of the WHO GPW13 goal of 1 billion more people benefiting from UHC.

CONCLUSION

Both the technical and political elements of EMRO's experience in developing the private sector engagement framework are aligned with the private sector governance behaviors outlined in WHO's draft roadmap. This outlines six governance behaviors that are critical to align private health sector service delivery with UHC goals. They include build understanding, deliver strategy, enable stakeholders, foster relations, align structures, and nurture trust.

The governance behaviors were present in the EMRO process, however, they were not evenly addressed and relied heavily on technical assessments, creating a protracted process of engagement and Framework development. EMRO sought to build understanding through the country technical assessments and consultations. The discussions around the creation of the Framework helped to create an agreed sense of direction and openness to change for member states to deliver strategy. The decade long work on evidence gathering and discussions nurtured trust between stakeholders and fostered relationships to support the work (but may not have been the most efficient or effective way to approach this). As EMR member states work to implement the Framework, they will, no doubt, work more closely with private sector service delivery partners to further articulate the roles and responsibilities that will help...
deliver strategy, enable stakeholders and align structures.

Governance systems need to be calibrated to mixed health systems. These systems must be flexible enough to adapt to innovation, including private sector service delivery through digital health and self care, which challenge traditional boundaries of health systems. As much as systems need to adapt so do system users, policy makers and technical partners, including the WHO. Frameworks for public-private sectoral engagement and dialogue, may not convey the importance of change management and behavior change needed across stakeholder groups for effective engagement and UHC.
REFERENCES

Transforming our world: the 2030 Agenda for Sustainable Development. UN General Assembly. 21 October 2015

Montagu D and Chakraborty. Analysis of DHS and MICS surveys from 27 AFRO countries representing 732.7M people; and eight SEARO countries representing 1,880M people. 2019.

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Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2019 update


Key informant interview with Dr. Hassan Salah on 05 February 2020


Key informant interview with Prof. A. Venkat Raman on 20 February 2020

SHOPS Plus. Health Trends in the Middle East and North Africa. A Regional Overview of Health Financing and the Private Health Sector. USAID. July 2018


Key informant interview with Dr. Awad Mataria on 20 February 2020


ABOUT THE PROJECT

For more information about the work, please contact Dave Clarke, clarked@who.int

This document was commissioned by the World Health Organization and recommended by the Advisory Group on the Governance of the Private Sector for UHC as part of its ongoing work to develop a strategy for the World Health Organization and member states to effectively engage the private sector for the governance of mixed health systems.

Additional documents in this series include the following:

- International Organizations and the Engagement of Private Healthcare Providers
- Measuring the Size of the Private Sector: Metrics and Recommendations
- Principles for Engaging the Private Sector in Universal Health Coverage
- Private Sector Utilization: Insights from Standard Survey Data
- Private Sector Accountability for Service Delivery in the Context of Universal Health Coverage

The Advisory Group on the Governance of the Private Sector for UHC was convened in February of 2019 to act as an advisory body to the WHO about developing and implementing governance and regulatory arrangements for managing private sector service delivery for UHC. The group was formed with the primary goal of providing advice and recommendations on the regulation and engagement with the private sector in the context of the WHO GPW goal of 1 billion more people benefiting from Universal Health Coverage, and in particular outcome 1.1.4 of this goal – “Countries enabled to ensure effective health governance”. Members of the Advisory Group include: Dr. Gerald Bloom, Mr. Luke Boddam-Whetham, Ms. Nikki Charman, Dr. Mostafa Hunter, Mrs. Robinah Kaitritimba, Dr. Dominic Montagu, Dr. Samwel Ogillo, Ms. Barbara O’Hanlon, Dr. Madhukar Pai, Dr. Venkat Raman, and Dr. Tryphine Zulu.

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WHO also thanks those who were involved in commenting on this document. Financial support for this work was provided by the European Union as part of its support for the UHC Partnership.