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PROVISION OF BASIC HEALTHCARE SERVICES BY NON-STATE ACTORS IN ARAB COUNTRIES: BENEFITS AND RISKS

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Preface

Basic social services such as education, water and sanitation, healthcare and housing are intended to meet essential human needs. States are given the task of guaranteeing equal access to these services, either through direct provision or through the regulation of services provided by other institutions, such as businesses or civil society organizations.

Following independence, most Arab countries built comprehensive systems of social services, which the State provides to the population free of charge. With population growth, however, and in the wake of socio-economic crises and armed conflict, these systems were pushed beyond their capacity. Private sector and civil society organizations began addressing the gaps in coverage and quality deficits that characterized state service provision.

In order to assess the extent of this change, and to support countries in assessing their current welfare mix, ESCWA's Social Development Division has started to research the distribution of responsibilities between the State, the market and civil society in the provision of social services and social protection. In a series of technical papers we will look at the patterns of service provision by non-state actors. Questions that need to be explored include: Is the involvement of non-state actors increasing access to essential services, in particular for vulnerable groups? How does the State regulate standards and ensure the quality of services provided by market-based or non-profit organizations? How can synergies between different institutions be optimized, and duplication avoided?

The current paper is the first in this series. It looks at non-state provision of basic healthcare services, seeking to highlight the benefits and the risks that emanate from non-state provision of social services. It largely draws on case studies of Bahrain, Egypt, Iraq, Jordan, Lebanon, Sudan, and Tunisia. Papers covering education as well as water and sanitation are planned to follow.

The paper was authored by Ms. Katherine Brooks and Ms. Allison Minor under the supervision of Ms. Gisela Nauk, Chief, Social Policy Section, Social Policy Division of ESCWA and the overall guidance of Mr. Frederico Neto, Director, Social Development Division, ESCWA. The paper also benefitted from comments and support by Emilie de Keyzer, Salwa Mohammed, James Pinho, Tanja Sejersen, and Vanessa Steinmayer. ESCWA would also like to express special thanks Ms. Melani Cammett, Associate Professor of Political Science, Brown University, Providence, USA, who reviewed the paper and provided valuable feedback.

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Definitions

Although delineations are not always clear, the present research applies the following definitions: 'Private sector provision' is defined as the provision of social services on a commercial basis, be it for profit (as in the case of private or shareholder companies) or on the basis of full cost recovery. 'Public-private partnership' is treated as a special form of private sector provision. 'Civil society provision' is defined as provision of social services by social groups that seek to advance common interests, operating on a non-profit basis. These may take the forms of charities, private foundations, religious groups, women's groups, or non-governmental organizations. Funding mostly comes from donations, and organizations may also draw on voluntary work and public engagement.

Introduction

Across the diverse countries that make up the ESCWA region, there is a growing trend toward non-state actors participating in the provision of basic social services, including healthcare. While some countries in the ESCWA region have long traditions of non-state participation in this sector, recent increases in participation may be considered a response to limited state budgets, growing populations and increased demand for social services.

This non-state participation includes private, for-profit organizations as well as not-for-profit organizations, generally identified as civil society organizations. Whether in post-conflict, developing, or high-income countries, governments are showing greater interest in the additional capacity and investment that the private sector can bring to healthcare provision. This represents a shift in ideas about the role of the government in a region where, in the era following independence, countries espoused a strong ideological commitment to government provision of social services, including recognizing healthcare as a citizen's right.

The Universal Declaration of Human Rights first affirmed the right of access to basic healthcare in 1948. Article 25 calls for an adequate standard of living, including medical care and necessary social services.[1] National constitutions in several ESCWA member countries also identify access to healthcare as a basic human right that the government is responsible for protecting.[2] Globally, the human right to basic healthcare was reaffirmed and elaborated upon in one of the foundational documents framing the government's responsibilities for healthcare, the Alma Ata Declaration (1978). This declaration upheld health as a human right and set forth basic goals and strategies for their achievement. It states,

"The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector".[3]

Unlike other human rights, the right to basic healthcare can only be provided by a small and highly trained group of professionals, and it is often difficult for non-professionals to judge what represents high-quality care. These factors make the Government's role in ensuring that citizens receive both equitable and quality care especially important. Another perspective on healthcare suggests that health is an individual's responsibility. This perspective is grounded in the fact that it is ultimately individual behavior and choices that affect one's health, and that the individual has ultimate responsibility for his or her own body. This perspective can be used to justify a more limited government role in healthcare provision and is prominent in countries where healthcare is primarily private.[4]

Until the late 1980s, most Arab countries had embraced the idea that the Government should take a dominant role in the planning, financing, delivery, monitoring and regulation of healthcare.[5] Due to rising healthcare costs, growing populations and fiscal constraints, Governments began to move away from this strategy. Periods of conflict and instability also prompted the expansion of both the private and non-profit health sectors, including during the civil war in Lebanon and in Iraq under the sanctions regime.[6] These examples serve as a reminder that health is not an isolated domain, but one that is interconnected with the broader social, political and economic context.

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1 United Nations, 1948.

2 Jabbour et al, 2012, p. 374.

3 International Conference on Primary Health Care, 1978, chapter I.

4 For a deeper discussion of this issue, see Minkler, 1999.

5 Stephen, 1993, pp. 458-459.

6 WHO, 2006f, p. 57, WHO, 2010a, p. 25.

Different countries within the region have established a variety of public systems in an attempt to guarantee rights to healthcare and to assure sufficient access to healthcare provision, to the extent possible given each country's limited resources. All of these systems struggle with similar, well-known problems of duplication, overconsumption, and cost effectiveness. Methods for dealing with these issues may create new issues: out-of-pocket payments are often used to limit over-consumption, but can also reinforce inequality. Private sector and civil society participation can exacerbate these issues, but can also create new opportunities.

With such an influential shift in social service provision, it is an important time to conduct a broad, critical, and comparative evaluation of the role of non-state actors in healthcare, including private sector participation, either independently or in coordination with the public sector. That is the purpose of this paper. It examines trends and issues associated with the role of the private sector and civil society across selected countries in the ESCWA region, ranging from least developed to high-income countries. While each example is distinct and rooted in a unique country context, there are important patterns and continuities across countries which may yield lessons applicable in a broader context.

By focusing on the effects of non-state actor participation on the equity and quality of services, this paper provides a rights-based perspective on private sector participation. It is a perspective that is often lost in reports on the ability of non-state actors to relieve pressure on public systems or improve efficiency and economic gains, or those that look at civil society actions in isolation from the larger service system. This paper also seeks to fill in the gaps in the existing literature on civil society provision of social services in the ESCWA region.

I. CURRENT FORMS OF PRIVATE SECTOR PARTICIPATION

Private sector participation in healthcare delivery (and to some extent financing) is both a reality and a necessity for most ESCWA countries, given limited state resources and increasing healthcare demands. As introduced previously, the nature of health as a human right necessitates an examination of the effects of private sector provision of healthcare on the equity and quality of services. This includes analyzing the current role of the private sector and assessing how the risks and challenges resulting from this participation can be minimized, while benefits and advantages are maximized.

The private sector's role in healthcare provision is multifaceted and complex. One common form of private sector participation is outright private provision, which is often done independently by the private sector without the direct involvement of the public sector. This can include everything from family doctors to private pharmacies and private hospitals. When it comes to private delivery of services, the private sector tends to be more active in pharmacies, outpatient care and specialty care, like dentistry. This is the case in Tunisia for example, where 72 per cent of the country's dentists were working in the private sector in 2004.[7]

There are also many private hospitals offering in-patient care in the region. This is especially common in Lebanon. Lebanon is a unique case in that public sector in-patient facilities have been quite limited, a legacy of the civil war. The result is that non-state-run facilities have now become more prevalent than public clinics and hospitals. However, in recent years, increased public investment in facilities may contribute to a shift in this trend in Lebanon.[8]

A. PUBLIC-PRIVATE COOPERATION

Often, the private sector and the public sector collaborate. A common form of partnership is contracting between the Government and private hospitals or clinics to provide care for individuals covered

[7] WHO, 2006d, p. 26.

[8] Ammar, 2009, p. 2.

by public insurance or subsidies. This is especially prominent in the Lebanese healthcare system, which is largely based on public financing of private care. In 2005, 64 per cent of the income of private hospitals was from the Ministry of Public Health (MOPH).[9] Jordan also engages in some contracting with private facilities, and Tunisia incorporated private care into public coverage in 2004 (with higher copayments than public sector care).[10] In Egypt, only a very limited amount of public funding goes towards private healthcare. However, in some other countries under study, private healthcare is excluded from government funding and comes entirely from households (as in Iraq) or from a mix of households and private insurance plans (as in Bahrain and Egypt).

Another common form of public-private cooperation occurs in a system where semi-private providers use some public resources, but also collect private fees. This system is in use in Iraq (box 1) and Egypt.[11] The use of public resources helps to reduce the costs of private services. Revenues will often be shared between the State and the staff.[12] This kind of partnership in healthcare can serve a variety of purposes. In particular, it can provide an incentive for doctors to stay in the public sector and help Governments cope with limited budgets and high demand for services. These lower-cost, semi-private services also provide an alternative source of care. Especially after working hours, when normal public clinics are closed, individuals do not have to resort to private care (with high out-of-pocket payments) or turn to unnecessary, high-cost inpatient care in public hospitals. In this way, semi-private care has the potential to limit costs for patients and to improve the overall efficiency of the system. This arrangement does, however, bear some risks. It is a fairly complex system that may create conflicts of interest and inefficiencies, especially if patients have access to the same doctors through both the public and private sectors.

Box 1. Alternative forms of public-private collaboration in Iraq

Given limited public resources, public primary healthcare clinics in Iraq can only stay open until 2pm. However, after 2pm, the state opens public facilities to approved private providers. The profits are then split between the Government and the staff.

Another private-public blend in Iraq is the "consultant clinic". Doctors who work in the consultant clinics receive a government salary. These clinics, open in the evening and night, charge fees that are higher than the nominal fees charged by primary health care clinics, but are far below the fees charged by private clinics (a consultation costs US$1 in consultant clinics, compared to US$0.20 in primary health care clinics and an estimated US$2 to US$7 in private clinics). The state hopes that the consultant clinics will offer additional incentives to doctors to curb the drain on human resources, while also keeping costs at a reasonable level.

Some countries are also pursuing increased private control of public facilities. In Iraq, for example, some public hospitals and other healthcare facilities are seeking contracts with private companies for their management, or in some cases even full privatization.[13]

B. HEALTHCARE FINANCING THROUGH PRIVATE HEALTH INSURANCE

Another possible form of private sector involvement in healthcare services is financing of healthcare through private insurance. Private health insurance is most prominent in GCC countries like Oman, Saudi Arabia, and the United Arab Emirates, primarily as a result of their large expatriate populations. In Saudi Arabia, the requirement that all non-nationals be covered by private insurance has pushed up the cost of

[9] WHO, 2006c, p. 20.

[10] International Social Security Association; WHO, 2006b, p. 45.

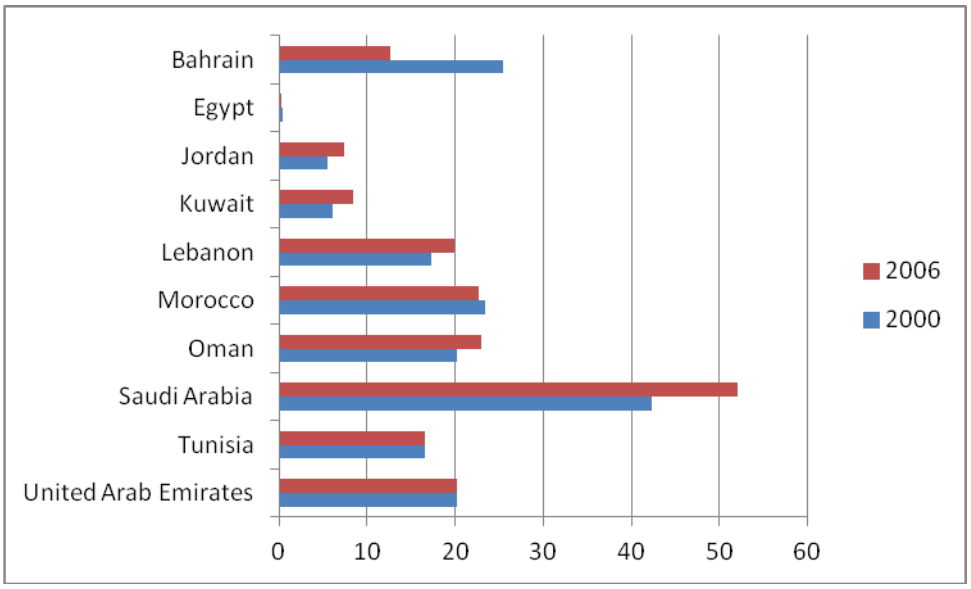
[11] WHO, 2006a, p. 25.

[12] IRIN, 2004.

[13] National Investment Commission.

these plans to over half of all private health expenditures in the Kingdom (figure I).[14] In Bahrain, the Government encouraged employers to cover insurance for non-Bahrainis, which led to a reduction of private expenditure for insurance between 2000 and 2006.[15] In non-GCC countries of the ESCWA region, private insurance is not a major source of private healthcare expenditure, with the exceptions of Lebanon and Morocco. The limited role of private insurance in many ESCWA countries is due to a combination of factors: laws and regulations are often not favorable to insurance companies, government coverage may limit demand for private insurance, and high risks may restrict profitability. These factors tend to limit the industry and make private insurance fairly expensive, such that only large companies can achieve the scale necessary to make it affordable.[16]

Figure I. Private prepaid plans as a percentage of private expenditure on health, 2000 and 2006, selected ESCWA countries



Source: *World Health Organization Database, updated 19 November 2010.*

C. Current forms of civil society participation

In many Arab countries, as part of culture and tradition, there is a longstanding religious commitment to the provision of healthcare for the sick and disadvantaged. Many of the Arab region's most prestigious hospitals and health centres owe their existence to charitable organizations, predating the establishment of health ministries and other state-level institutions. One such facility is the *Al Noor* Hospital in Damascus, which has been in operation for seven centuries. It is not surprising, therefore, that civil society is considerably involved in providing healthcare to large parts of the population in some of the countries under study.

The current level of civil society involvement in healthcare provision is not, however, merely a result of this tradition; it is also a response to the difficulties incurred by both the Government and the private sector in attempting to provide quality, affordable healthcare to large numbers of citizens, such as in the case of Egypt (box 2).

[14] Colliers International, 2012.

[15] WHO, 2007, p. 34.

[16] UNDP, 2009b, p. 158.

Civil society involvement in social services has a long tradition in Lebanon. The civil war enhanced this trend, as various militias became the main providers of healthcare in the territories they controlled.[17] As a result of this legacy, civil society, including political parties, is still involved in the provision of healthcare. To date, about one third[18] of the country's 147 private hospitals are run by charitable organizations and religious congregations, and they have a determining role in the powerful Association of Private Hospitals.[19] In addition, several political parties and movements operate independent health networks, with their own hospitals, clinics and dispensaries. For example, various agencies linked to Hezbollah operate four hospitals and at least 24 clinics, while the Shi'ite Amal Movement administers approximately 13 clinics. The Sunni-dominated Future Movement effectively runs over 40 clinics through its affiliate, the Hariri Foundation Health Directorate.[20]

Box 2. Civil society and faith-based organizations (FBOs) in Egypt

Egypt is an example of a country with a highly developed civil society healthcare sector. NGO health providers vary greatly in terms of their size and resources. This includes clinics with a single doctor resembling dispensaries, to large facilities with 200 doctors. The larger, more sophisticated clinics often provide a range of specialized services like surgery, cardiology, ophthalmology, gynecology, and dentistry. Some clinics belong to larger networks, but others are individual providers affiliated to a particular mosque or community.

While the distribution of civil society providers is diverse, there are a number of large-scale organizations which are worthy of note. These include the Muslim Brotherhood, which ran 24 hospitals in Egypt in 2011, through the Islamic Medical Association. Of the roughly 5,000 legally registered NGOs and associations in Egypt in 2006, an estimated 20 per cent were affiliated with the Muslim Brotherhood.

Studies which have been conducted into the civil society healthcare sector in Egypt suggest that the client groups of many NGOs tend to be from the same social groups as the providers and organizers, which are typically middle class Egyptians.[21]

The extent of provision by civil society actors varies enormously across the ESCWA region, from low involvement of civil society actors in the countries of the Gulf Cooperation Council (excepting informal provisions among communities of foreign contractual workers), to the traditionally high levels of involvement of religious organizations in Egypt and Lebanon[22] (box 2). Unfortunately, there is very little by way of reliable and quantifiable data[23] on the proportion of healthcare services provided by civil society groups, whether in the countries under study or in the ESCWA region as a whole.

The nature of the groups providing healthcare within the ESCWA region is extremely varied. The following list outlines the different kinds of organizations that exist in the region, although it is not exhaustive:

- **Socio-political movements**: Many socio-political movements in the region provide certain social services to their target demographic, including healthcare. Examples include Hamas, Hezbollah and the Muslim Brotherhood. In order to provide social services, socio-political movements often fund

[17] Harik, 1994, pp. 15-16.

[18] Cammett, 2013, figure 2.4.

[19] Ammar, 2003, p. 11.

[20] Chen and Cammett, 2012, p. 2.

[21] Clark, 2003, pp. 3-4, 146.

[22] Ibrahim, 2009, p. 7.

[23] Ibrahim, 2009, p. 2.

NGOs that deliver those services. One example is the Islamic Health Society in Lebanon, which is affiliated with Hezbollah.[24]

- **Religious communities**: Religious communities can run different levels of healthcare, ranging from full-service hospitals to clinics and dispensaries. Frequently, mosques or churches run their own small clinics directly attached to the mosque or the church. These are typically organized by the community, paid for through user fees and community donations and, although nominally available to all, primarily service that community.

- **Women's groups**: The primary example of this would be the the *murshi'dat* in Yemen, female primary healthcare providers who have received basic training and run clinics providing maternal and pediatric care.

- **Religious endowments (awqaf)**: The tradition of awqaf within the ESCWA region has meant that, throughout history, clinics and hospitals have been founded by religiously motivated endowments. Many of these facilities continue to operate today.

- **Local NGOs**: Local, non-political, secular NGOs also provide social services. Some provide healthcare to communities or individuals who otherwise have difficulty accessing it, such as refugees, unmarried pregnant women, and persons living with HIV and AIDS.

- **International NGOs**: A number of international NGOs are very active in the countries of the ESCWA region. These include the Red Crescent, which provides a substantial portion of the healthcare services in Palestine; Médécins Sans Frontières; and Oxfam, which has significant operations in Yemen and the Sudan.

D. FINANCING FOR CIVIL SOCIETY CARE

The sources and extent of funding for civil society healthcare provision vary widely between countries and between organizations within particular country settings. In countries where civil society involvement is strong or where the Government partners with civil society organizations out of limited state capacity to provide comprehensive healthcare services, there are instances of partial government funding of civil society groups, such as the funding of the community midwives in Yemen.

Some civil society provision of healthcare is fully funded by charitable donations. One example is the Cairo Children's Cancer Hospital, which opened in 2007 and where treatment is free of charge. The hospital and its operations are entirely funded by charitable donations.[25] Similarly, in Lebanon, several private foundations provide healthcare services free of charge to disadvantaged groups. One example, among others, is the René Moawad Foundation in Lebanon, which provides health services to those living in poor remote villages in Northern Lebanon.[26]

Many civil society organizations provide their services on a fee-for-service basis. This is particularly the case in the well-developed clinics and hospitals of Egypt and Lebanon, which charge users service fees far lower than those charged by private hospitals, and frequently at rates that are competitive with government hospitals.[27] These payments may be partially or totally funded by state or employer health insurance, or funded privately.

Due to the dearth of available data, the proportion of civil society provision of healthcare which is provided without charge is difficult to estimate. In many middle-income countries within the region, where

[24] Flanigan and Abdel-Samad, 2009, p. 124.

[25] Grant Thornton International, 2009, p. 14, Children's Cancer Hospital Egypt.

[26] Ibrahim, 2009, pp. 124-125.

[27] Clark 2003, p. 60.

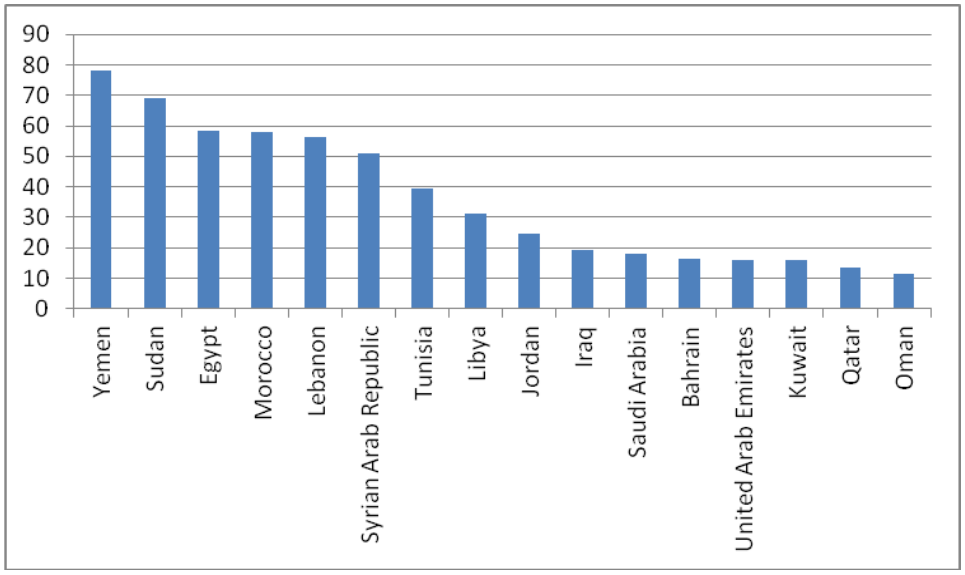
civil society is most involved in healthcare provision, fee-for-service tends to be the most common method of funding civil society healthcare.[28] However, in some of the lower income countries included in the study such as Palestine, Sudan, and Yemen, the inability of large segments of the population to finance their healthcare needs means that civil society healthcare provision is heavily dependent upon international funding.

II. RISKS OF NON-STATE ACTOR INVOLVEMENT IN THE PROVISION OF HEALTH SERVICES

A. HIGH OUT-OF-POCKET-PAYMENTS: A BURDEN ON HOUSEHOLDS

Out-of-pocket payments are mainly associated with the for-profit private sector; however they are also relevant when civil society provides healthcare. In the case of outpatient or inpatient care, these out-of-pocket payments are often fee-for-service payments due at the time of treatment or shortly thereafter, which can be difficult for households to manage. Another important source of out-of-pocket payments is pharmaceutical costs, which, for a variety of reasons, tend to account for a large proportion of health spending in the ESCWA region and represent a significant strain on household budgets. According to Gericke, "out-of-pocket payments are the most regressive type of contribution to health care", because the burden is higher for poor households than for wealthier households.[29] Out-of-pocket payments were very high in several countries of the ESCWA region in 2011, being highest in least-developed countries such as Yemen (78 per cent of total health expenditure) and the Sudan (69 per cent), but also high in Egypt and Morocco (58 per cent) (figure II).

Figure II. Out-of-pocket payments in the ESCWA region, 2011 (as a percentage of total health expenditure)



Source: World Bank, World Development Data, 2013. Data for Palestine has not been available.

Although most Governments operate some form of health insurance, this is frequently limited to certain sectors of the population, such as civil servants and the armed forces, or provides only partial payment for services. As a result, many citizens in countries of the ESCWA region remain without health insurance. For example, in Egypt, only formal sector workers benefit from social insurance, but even that

[28] Clark 2003, p. 60.

[29] Gericke, 2005, pp. 1082-1083.

coverage excludes their spouses and children.[30] In Jordan, recent reforms have expanded coverage of social health insurance to cover up to 60 per cent of the population.[31]

While publicly provided care is often covered or subsidized through government insurance programs, protection plans, or subsidies, the public sector tends to offer more limited financial assistance for private sector or civil society care, or none at all. This has become an issue in Egypt, where private care has become a dominant or necessary form of care to cover gaps in public care, leading to out-of-pocket payments of 58 per cent in 2011 (figure II).[32] In the majority of European countries and North America, private insurance, whether supported by employers or purchased by individuals, covers the costs of private care. However, because the private insurance sector is less comprehensively developed in the ESCWA region, most or all of the costs of private sector care fall on households. For this reason, out-of-pocket payments in several countries of the ESCWA region are high, with over half of total health care spending coming from out-of-pocket payments (figure II). Many countries in the region, including Egypt, are also witnessing a trend in increasing out-of-pocket payments as a percentage of total health expenditures (box 3).[33]

Box 3. Increase in out-of-pocket payments in Egypt

In Egypt, out-of-pocket payments are on the rise. Over the past several years, Egypt's rates of these payments have been consistently high and increasing, but data from the most recent National Health Account (NHA[34]) suggests that out-of-pocket payments rose substantially – almost 12 per centage points – between 2007-08 and 2008-09, bringing out-of-pocket payments to 71.8 per cent of total healthcare expenditures. Part of this increase may be due to changes in the methodology of the NHA in 2008-09, which provides more comprehensive data on care and a shift in how household financing is counted. These changes may have uncovered out-of-pocket payments that past NHAs failed to capture (MOHP and Health Systems 20/20, 2012, p. 3). But part of the increase is also triggered by changes in the user fees of those covered by public health insurance. Egypt attempted to expand the proportion of the population covered by the Health Insurance Organization (HIO), but this was done by reducing the insurance plan's benefits. As a result, fees for medical treatment in 2009 were pushed to levels that many HIO beneficiaries cannot afford.[35]

When out-of-pocket payments reach a certain level of household income, they begin to have serious consequences that extend beyond the health of household members, affecting overall household vulnerability and poverty. Different households use different strategies to cope with high out-of-pocket payments. One coping strategy is not to seek care from higher-cost non-state providers, even in cases where public care is poor or lacking. This marks the development of a two-tier system, where only the more affluent population strata can afford healthcare services of acceptable quality.

Another coping strategy is to accept what are called 'catastrophic payments' to cover private care, as in the cases of Egypt and Iraq (box 4). When out-of-pocket payments exceed a certain threshold level, they may force households to make detrimental reductions in other expenditures or increase household vulnerability to shocks. Many studies set this threshold at between 5 and 20 per cent of household income.[36] Protection against healthcare costs is considered insufficient when more than 5 per cent of households suffer

[30] Gericke, 2005, p. 1083.

[31] Holst & Gericke, 2012, p. 216.

[32] Egypt, Ministry of Health and Population and Health Systems, 2010, p. 34.

[33] Elgazzar et al., 2010, pp. 3-4.

[34] National Health Accounts are comprehensive surveys of all resource flows related to a country's health system over a limited period. They are particularly concerned with the mobilization and allocation of resources, insurance, care, and the distribution of benefits in both the public and private sectors. See http://www.who.int/nha/en/.

[35] Jabbour et al., 2012, p. 484.

[36] Xu et al., p. 112; Elgazzar et al., p. 15.

from catastrophic payments. In the ESCWA region, the percentage of households struggling with catastrophic payments is much higher, ranging from roughly 7 per cent in Lebanon and Egypt[37] to 22.6 per cent in Iraq (box 4).[38]

Box 4. Catastrophic payments in Iraq

A Family Health Survey conducted in Iraq in 2007 presents a troubling picture of health financing. It looks at out-of-pocket payments as a proportion of household income and a household's capacity to pay (non-subsistence income). The average household spends 13.2 per cent of all its expenditures on out-of-pocket payments (above the 10 per cent catastrophic payment benchmark), representing 24.6 per cent of their capacity to pay. Overall, this means that 22.6 per cent of all out-of-pocket payments were catastrophic. Compared to other countries in the region, where 7 to 13 per cent of households faced catastrophic payments, this number is quite high. These payments, which went primarily towards outpatient care, are distributed inequitably; the rates are even higher in rural areas, for poor populations, and in the south and central regions of the country. For poor populations in these areas, out-of-pocket payments reach 28 per cent of their capacity to pay. This level of out-of-pocket payments can have far-reaching negative consequences. Looking only at non-poor households across the country, the survey finds that 10 per cent of the population surveyed will actually be pushed into poverty due to catastrophic out-of-pocket payments, with even higher rates in rural areas. The northern Kurdistan region of Iraq is less vulnerable to the effects of these payments.

Catastrophic payments are not found exclusively among the poor. More affluent groups are also struggling with catastrophic payments in considerable numbers, including 20.4 per cent of the non-poor households surveyed. These non-poor households spend 3.5 times more on healthcare than poor households. The numbers suggest that insufficient government services and support are forcing all segments of the population to spend more than they can afford on healthcare. Not only are households spending huge portions of their income on care, they are taking out loans and selling assets as well. One third of households studied borrowed money to pay for healthcare. This number jumps to 45.5 per cent for households in which a person has been hospitalized, reflecting the serious burden of inpatient costs. Given that households of a variety of income levels are spending more than they have on healthcare, it is highly likely that both poor and non-poor groups are forgoing significant amounts of care because of cost.

B. Other risks of private sector participation

A major concern regarding private sector provision of healthcare services is that it may negatively affect equity of access to healthcare and especially the quality of healthcare. The private sector's primary goal is generally not to secure human rights or to provide services on an equitable basis; rather, it is focused on profits, or at least covering costs. Thus private healthcare facilities tend to concentrate in areas where profits promise to be higher. Unfortunately, the poorest and most marginalized groups, which are often in the greatest need of healthcare also offer the least promise of profit for private companies.

There are two primary conceptions of equity in healthcare. According to the egalitarian model, care should be distributed according to need, and payment should be arranged according to ability to pay, while health outcomes should be the same across the population. According to the market-oriented model, an agreed-upon basic standard of care should be available to all, while care of higher quality and standard can be accessed by those willing to bear higher costs.[39] Based on commitments in national constitutions, most countries in the ESCWA region seem to aim for the egalitarian model, but in reality, the market-oriented model dominates. A private sector that offers superior care at a higher cost is not problematic in the market-oriented model, so long as the public sector continues to meet basic standards of care, or alternatively, if the State ensures that all citizens can access necessary private care. If, however, public care is considered sub-par, countries risk developing a two-tiered system, where those who can afford the higher private sector payments receive superior care, while others are limited to lower quality public sector care.

[37] Elgazzar et al., 2010, p. 12.

[38] Iraq, Ministry of Health, 2008, p. 27.

[39] Wagstaff and Van Doorslaer, 1998, p. 8.

Indeed, in several countries under study, private sector healthcare facilities are concentrated in relatively wealthy urban areas and are mainly used by the wealthier income groups. In Tunisia, 80 per cent of private general practitioners are concentrated in the Greater Tunis and east-central regions. As a result, in 2007 the ratio of inhabitants per specialist doctor (both public and private) was over ten times lower in Greater Tunis than in the Kasserine Governorate (855 inhabitants per specialist doctor in Greater Tunis, compared with 8,980 in Kasserine).[40] Similarly, two-thirds of private hospitals in Iraq are in Baghdad, with all of the remaining third found in other major urban areas.[41] The same trends are also reported in Egypt[42] and the Sudan.[43] Surveys from Egypt based on data from 1994/1995 showed that the richest income quintile used mostly private sector facilities, with 42.8 per cent of private health expenditure being from the wealthiest households.[44] As income inequality has barely decreased over time, it is likely that this has not changed significantly. Public hospitals are often underused; in 2003 the occupancy rate of hospital beds in government-run hospitals was only 35 per cent.[45] Citizens typically cited hygiene concerns and a low level of staff morale as reasons for choosing not to frequent government hospital facilities.[46]

Some countries in the Gulf Cooperation Council are facing unique equity issues as they change regulations regarding insurance for the large expatriate communities. For example, the growth of private insurance in Saudi Arabia is a result of a law requiring health insurance for all non-nationals. With such growth and broad dependency on private health insurance, the concern now is to keep insurance costs at a reasonable level and ensure that the few insurance companies dominating the market do not gain a monopolistic advantage over healthcare providers.[47] Bahrain, on the other hand, seeks to assure full, equitable access to healthcare for its entire population, including non-nationals. In the past, non-Bahrainis had to pay only small fees for services that were highly subsidized by the Government. However, it is now reconsidering its responsibilities to its non-national population. This involves a five-step plan for compulsory insurance for all non-nationals.[48] Non-Bahrainis make up over half the population of the country and also tend to be among the lower income groups.[49] If they do not receive coverage through an employer and are subject entirely to the private insurance market, there is concern that especially high-risk individuals will face unaffordable insurance rates or be excluded entirely if their premiums are not paid by their employer.

Although it is often expected that the private sector will operate more efficiently than the public sector, another risk of private participation in the overall health system is that it may increase total healthcare spending and thus reduce the overall efficiency of the healthcare system. Private companies often have an incentive to overinvest in high-cost technologies and brand name drugs, because consumers are likely to associate them with quality care. Additionally, private providers often have incentives to over-test, over-diagnose, and over-treat. This trend is notable in several ESCWA countries, including Bahrain, Jordan, Lebanon and Tunisia.[50]

[40] WHO, 2010b, p. 30.

[41] WHO, 2006f, p. 22.

[42] WHO, 2006a, pp. 46, 78.

[43] WHO, 2006e, p. 19.

[44] Rannan-Eliya et al., 1998, p. 22.

[45] Salah, 2007, p. 71.

[46] UNDP, 2005, p. 2.

[47] Colliers International, 2012, p. 3.

[48] Bahrain, Ministry of Health, 2009, p. 1.

[49] Hediger et al., 2007, p. 57.

[50] Ammar, 2003, p. 5, Bahrain, Ministry of Health, 2010, pp. 5-6, Jordan, Ministry of Health, 2011, p. 53, Tunisia, Ministry of Public Health, 2007, p. 46.

In Lebanon, the private sector dominates healthcare delivery, but financing is mostly public. As a result of over-investments,[51] Lebanon's public health expenditure as a share of total government expenditures was very high, reaching 11.8 per cent in 2005.[52] Several reforms, including introducing flat rates for certain procedures, helped to reduce government expenditure.[53] In Tunisia, which has been praised in the past for its highly efficient and primarily public healthcare, increasing private sector participation in outpatient care has tended to undermine the overall efficiency of the system.[54] Between 1980 and 2005, total healthcare expenditures in Tunisia grew annually by an average of 11.6 per cent, which is twice the average growth of GDP over the same period. Despite the fact that the private sector accounted for less than 20 per cent of hospitalizations and 25 per cent of outpatient visits, and that it had no role in preventative care in 2005, it consumed roughly half of total healthcare expenditures in the country.[55] Households are bearing most of these costs, with over 80 per cent of household health expenditures flowing into private healthcare.[56]

Additionally, the growth of the private sector can negatively affect the quality of public sector care by siphoning off financial and human resources from the public sector. This was the case in Iraq post-2003, when the public health sector experienced a large shortage of doctors[57] and other personnel because they preferred to work in private sector facilities with better pay. A similar problem is developing in Tunisia, where specialist doctors are moving to the private sector, to the detriment of the public regional hospitals.[58]

C. Risks of civil society participation

It is often assumed that civil society groups target populations in need, and that they can reduce some of the equity concerns in public and privately provided care. However, this is not always the case, as civil society groups are guided by diverse interests. While the poorest countries, such as the Sudan and Yemen, typically have the greatest need for improved healthcare, it appears that civil society provision is actually most developed in middle-income countries such as Lebanon and Egypt (specifically urban Egypt). In Egypt, not only do civil society groups run numerous clinics, there are also sophisticated hospital networks managed and funded by groups like the Muslim Brotherhood, as outlined in box 2.[59]

Many civil society organizations providing social services argue that their work is about bringing affordable healthcare to the poor. However, when one examines the client groups of civil society providers in countries such as Egypt and Jordan, it is found to be mostly middle class citizens who benefit from such services. There are of course many civil society groups who do cater to the needs of the poor. However, they frequently provide only primary and basic healthcare and are often run with the assistance of international providers. The more sophisticated aspects of civil society healthcare, such as hospitals and specialized clinics, tend to be located in middle class areas with the express aim of serving the local inhabitants.[60]

The explanation for this trend is that in many countries of the ESCWA region, civil society organizations tend to be set up by groups who themselves wish to utilize the service. The only sector of society with both the need for such services and the capacity and expertise to establish and run them is the

[51] Ammar, 2003, p. 4.

[52] World Bank, 2013.

[53] Ammar, 2009, p. 1.

[54] WHO, 2010b, p. 31.

[55] WHO, 2010b, p. 31.

[56] Tunisia, Ministry of Health, 2007, p. 57.

[57] WHO, 2006f, p. 20.

[58] WHO, 2010b, p. 27.

[59] IRIN, 2006.

[60] Clark, 2003, pp. 11, 31, 38, 44.

middle class. Participation tends to be most prevalent among the more religiously active components of the middle class, as it is within religious communities that most services are based. The key motivating factor behind the establishment of these clinics is not usually the lack of access to any healthcare, but the desire to access better quality healthcare than that provided by the State and at a more affordable rate than that of the private sector.[61] Given these observations, it would appear that the main circumstances which lead to the development of extensive civil society provision would be the existence of a well-educated and religiously active middle class, and a State that is struggling to supply quality affordable healthcare of a standard corresponding to the country's level of wealth.

Other risks may emerge because civil society service provision can be organized along sectarian or factional divides. In Iraq and Lebanon, these factional divides can exert themselves in the healthcare system in potentially harmful ways, as certain groups receive better quality healthcare while other groups feel themselves excluded. For example, a study on Lebanon found that political affiliation and level of involvement were significant determinants of the care and financial assistance one received.[62] Even private or public institutions are often affiliated with a specific faction, politicizing that institution and negatively affecting its ability to work with other actors or institute reforms.[63]

III. BENEFITS OF NON-STATE PARTICIPATION IN THE PROVISION OF HEALTHCARE SERVICES

While the risks of non-state participation are important, they should not overshadow the potential benefits of such participation. Looking at both the private sector and civil society, the combined ability of these sectors to fill in gaps in public coverage is highly important, especially in conflict situations.

Participation of non-state actors can relieve some of the burden on the Government to simultaneously serve as the dominant planner, financer, deliverer and regulator of healthcare. For example, Bahrain is pursuing guided expansion of private sector healthcare provision in order to allow the State to shift its focus away from providing and towards planning and regulating. As stated by Amal Akleh, a management advisor of the Ministry of Health of Bahrain, "Right now we provide healthcare, but that should change…the Ministry of Health will be focusing on policy-making while outsourcing clinical and non-clinical services. Regulation will be carried out by an independent regulator".[64] Bahrain is encouraging a high-quality private sector that can support medical tourism as well as private sector insurance.[65] In addition to these shared benefits, private participation and civil society participation can each offer benefits to a country's healthcare system.

A. BENEFITS OF PRIVATE SECTOR PARTICIPATION

One important benefit of the private sector is its ability to offer much-needed financial resources for healthcare. In addition, the private sector enjoys a comparative advantage over the public sector in certain areas. For example, the private sector tends to be more capable of offering greater diversity of care options, which may appeal to different populations. Moreover, it tends to encourage greater innovation, which is highly important in healthcare.[66]

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[61] Clark, 2003, p. 57.

[62] Chen and Cammett, 2012, p. 6.

[63] Tarantino and Jawad, 2007, p. 30.

[64] Oxford Business Group, 2008, p. 195.

[65] Oxford Business Group, 2008, p. 194.

[66] Mehrotra and Delamonica, 2005, p. 145.

As a result of its financial capacity, the private sector is often able to provide more specialized care with more specialized equipment, which the public sector would not be able to provide. In Tunisia in 2004, the private sector was generally better furnished with heavy equipment. While there were 54 computerized tomography scanners in private healthcare facilities, there were only 20 in public healthcare facilities.[67] Similarly, in Jordan, the advanced equipment used by the private sector is considered to be one of the private sector's strengths.[68]

The private sector can also be important in relieving some of the burden of investment and financing for healthcare. In Jordan, for example, increased public contracting with private providers could help resolve issues of excess supply and inefficiency. At 9.5 per cent of GDP, total health expenditures were unsustainably high in Jordan in 2009.[69] This is partly because of an excess supply of private sector care. While public facilities have high usage rates and are in need of greater capacity in several areas, the average patient levels of private sector facilities are far below capacity, which drives up costs for individual users. On the other hand, the public health sector is overburdened and in need of new facilities. This disconnect emerges because different groups of people seek out public versus private care, given that many are not able to afford the fees in the private sector. However, the public sector may be able to take advantage of the excess private supply, reducing the cost of additional government investment in public sector facilities in the process, by contracting with private sector providers that are lacking patient volume. In some ESCWA countries, the State has already begun contracting with private hospitals on a limited basis, succeeding in controlling costs and registering positive results for both the State and private hospitals.[70]

B. Benefits of civil society participation

Civil society has its own advantages for healthcare provision. It may serve populations to whom for-profit providers do not usually cater, provide services at lower costs than private providers (and thus contribute to avoiding catastrophic payments), or provide services like maternal care that are less common among private providers. Civil society provision of healthcare is fulfilling a substantial segment of the healthcare demands in several countries of the ESCWA region, in many cases responding directly to the needs of the population.

Indeed, far from constituting only basic or rudimentary care, civil society clinics and hospitals are often the provider of choice for many Lebanese and Egyptians as well as others in the region. Those who choose to frequent such providers cite better hygiene standards, cheaper fees, more responsive physicians, and greater trust as their reasons for doing so.[71]

Moreover, especially in the poorest countries of the region, such as in Yemen, civil society healthcare providers can take some of the credit for the reductions in maternal and child mortality rates through their provision of primary and maternal healthcare, otherwise sparsely provided by the State.[72] However, it also has to be noted that sometimes government involvement can improve the services provided by civil society. For example the *murshidat* (community midwives) in Yemen initially had only limited success in reducing maternal and child mortality, as they did not have sufficient skills to deal with complications during birth. It was only when the Government launched a programme to promote substantive training for community midwives that these groups were able to reduce maternal and child mortality rates.[73]

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[67] WHO, 2006d, p. 73.

[68] WHO, 2006b, p. 40.

[69] World Bank, 2013.

[70] WHO, 2006b, p. 59.

[71] Clark, 2003, pp. 47, 72-73.

[72] De Regt, 2007, pp. 295-298, also see WHO 2009, p. 24.

[73] De Regt, 2007, pp. 295-298.

IV. MONITORING AND REGULATION OF NON-STATE ACTORS

Considering these threats and opportunities alongside the necessity and inevitability of private sector involvement, it becomes clear that private sector participation in healthcare financing and delivery requires careful, coordinated planning, regulation and monitoring by the State. The private sector emerged with little to no regulation in many countries in the region, and improvements in the regulatory environment are not fully developed in some countries.

For example, in Tunisia state regulation of private facilities or personnel is limited to a job description registry.[74] Because the State does not have control over the prices of medical care in clinics, it is difficult to implement cost-containment measures in the private sector. Further, the supply of facilities, care, and personnel are not regulated to correspond with the needs of all portions of the population, but rather respond freely to market mechanisms. The relatively low level of state regulation of private facilities stands in stark contrast to the careful state planning and regulation in the pharmaceutical industry.[75]

Other countries have started to introduce regulation and quality control mechanisms. Egypt used to have no formal mechanism to monitor or evaluate the fee schedules of private providers, or to assure the quality of private care.[76] However, ongoing reforms plan to introduce an independent regulatory and accreditation body that is supposed to regulate quality. Continuous quality is to be ensured by accreditation follow-ups every 3 years.[77]

Lebanon has started a voluntary accreditation programme, which has become a prerequisite for hospitals to contract with the Ministry of Public Health. The accreditation system examines the quality of medical care and hospital management. The Ministry of Public Health also terminates contracts with hospitals that do not meet minimum quality and safety standards. In the future, the Ministry of Public Health seeks to link accreditation to other incentives, to avoid quality standards being improved for the sole purpose of achieving accreditation.[78]

In many countries in the region, civil society groups are typically regulated similarly to for-profit clinics, especially in cases where countries lack special tax and other benefits for non-profit organizations, or classification of organizations working for the public good.[79]

In order to address equity concerns, Lebanon introduced reforms to public financing mechanisms for private hospitals. The Ministry of Public Health lowered expenditures by switching from a fee-for-service system to flat rates for surgeries, and introducing a cost ceiling in every contract with a hospital. Additionally, the Ministry instituted a beneficiary database that simplified administrative procedures and reduced wait times for pre-authorization for hospital admissions.[80]

Ideally, healthcare regulation would be performed by an independent, neutral public body; one that is separate from the planning, provision and, crucially, the financing of healthcare provision. This regulation would be guided by consistent, reliable reporting mechanisms and a set of publicized, internationally consistent standards. Countries such as Bahrain and the United Arab Emirates are moving or have already moved towards this model. For example, Bahrain recently created an independent body, the National Health

[74] World Bank, 2006, p. 37.

[75] World Bank, 2006, p. 35.

[76] WHO, 2006a, p. 20.

[77] El Hosseiny, 2010, p. 9.

[78] Ammar, 2009, pp. 2-3, Akoun, 2012, slides 2 and 27.

[79] ESCWA, 2013, p. 12.

[80] WHO, 2010a, p. 26; Ammar, 2003, pp. 124-125.

Regulatory Authority, that is supposed to carry out all monitoring and regulation activities in the health sector. This is to ensure that those regulating the health sector are separate from those financing and providing healthcare. Improved regulation is becoming increasingly important in Bahrain as well as in Egypt, as the State encourages the growth of the private sector.[81]

V. CONCLUSION

In general, the role of both the private sector and civil society in healthcare, especially healthcare delivery, has increased in recent years. Lebanon, coming from a situation where care had been almost entirely in the hands of the private sector, is one of the few examples of a country where the public sector has grown vis-à-vis the private sector. Growing populations, increasing demand for healthcare, limited state budgets and, frequently, inefficient, inadequate public healthcare options all make this participation essential. However, increased private sector participation carries its own risks, particularly in situations with little government regulation.

High-cost, technology-intensive private care tends to drive up healthcare costs across the region, especially in countries where there are no regulations of private fees. An increasingly dominant private sector is directing attention and human resources away from the public sector. This is especially problematic given the strain on government budgets following the global financial crisis. Two-tier systems are increasingly common in the region, and the effectiveness and efficiency of public systems are being undermined. The threat this poses to the health of the population, especially the poorest and most marginalized groups, is underlined by high and in many cases catastrophic out-of-pocket payments in the region.

The key to mitigating these threats is coordinated planning, monitoring, and regulation by the State. As the role of the private sector in healthcare continues to grow, it is increasingly important that the State embrace these responsibilities in order to maintain an efficient and equitable healthcare system. Coordinated planning entails a strategy for how the private and public health sectors can complement each other. This could also entail a strategy where the public sector focuses on basic and essential care, while the private sector focuses on specialty care. Monitoring and regulation should cover both the costs and quality of healthcare and be performed by an independent regulatory body. Countries across the ESCWA region are adopting these strategies. Bahrain is actually taking steps to shift the State's role to that of planning and regulation, rather than delivery. Other countries are pursuing various regulations to limit costs and improve equity in private care.

Recognizing that private sector participation had driven up out-of pocket-payments, Lebanon and Iraq have pursued reforms to curtail these payments. Their experiences demonstrate the effectiveness of key reforms in post-conflict situations. Particularly important reforms include the application in Lebanon of common standards and improved contracting and financing mechanisms. Pharmaceutical reform further helped to bring down out-of-pocket payments and overall expenditures in both Lebanon and Jordan. Bahrain and the United Arab Emirates have also taken steps towards more effective regulation of the private sector. A variety of additional options are available to Governments. They can offer greater means-tested support and health insurance, potentially including private care. This can help ensure that assistance goes to those who need it most and that quality essential care is accessible to all, regardless of income. In this effort, avoiding catastrophic payments is particularly important. However, contracts with private providers should be well-managed and emphasize the efficiency of private care and financing, potentially excluding certain services to limit costs.

At the same time, Governments may consider continuing to enhance public healthcare services in both quality and coverage. Even with regulation, private care may not be equitably distributed according to need,

[81] Bahrain, Ministry of Health, 2009.

so it is important that the public system offer quality services to those who cannot access private care, in order to avoid a two-tier system.

Civil society provision of social services does not automatically address issues related to inequitable access to healthcare; in some cases it rather reinforces and perpetuates existing inequality in service provision. Many civil society healthcare initiatives in the region are set up within specific social, political, ethnic and religious communities and may serve primarily the members of their own community. This is usually not a result of the implementation of a formal policy, but of a combination of factors including geographical location, fees-for-service requirements, and the tendency of various communities within the region to self-segregate. As a result, many of the poorest, most isolated and most vulnerable members of society often remain without sufficient access to healthcare. Moreover, this frequently leads to the development of horizontal inequalities between communities regarding access to healthcare, creating the possibility of sectarian tensions.

This does not mean that civil society involvement in healthcare should be discouraged. Indeed, it has contributed to improved healthcare for many. However, if the contributions of civil society to social service provision are to be maximized, countries may need to regulate and support such organizations in order to reduce inefficiencies, reach out to other groups within society and encourage them to see promoting equality as a primary goal.

The coming decades will bring many opportunities for governments in the ESCWA region to diversify and reform their healthcare systems. This paper has highlighted that there are numerous benefits to the involvement of non-state actors in healthcare provision, but also that there are many risks. Coordinated planning by the state can help ensure that increased non-state participation complements, rather than conflicts, with the public health system. Robust monitoring and regulation systems can also help minimize the risks associated with non-state participation, while maximizing their benefits.

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