PUBLIC-PRIVATE PARTNERSHIP FOR UNIVERSAL HEALTH COVERAGE

MENA HPF REGIONAL

11/12/2017

Conference Booklet

منتدى لسياسات صحية في الشرق الأوسط وشمال افريقيا
MIDDLE EAST AND NORTH AFRICA HEALTH POLICY FORUM

ARAB FUND FOR ECONOMIC & SOCIAL DEVELOPMENT

Contents

Introduction

The engagement of the private health sector in universal health coverage is inevitable. However, in most countries of the Middle East and North African (MENA) region, the role and workings of the private sector are not clear (WHO). In addition, its relationships and partnership modalities are poorly regulated and not well organized to support complementarity with the public health sector, due to a lack of public policy direction and planning, and a lack of a defined role delineating the sector's contribution towards the achievement of development goals.

It is estimated that nearly 50% of health care in developing countries, even for those at the lowest income levels, is provided by the private sector. An analysis of Demographic and Health Survey (DHS) data from 2000 to 2012 across 46 lower middle income countries found that the private commercial sector provided for 36% of women receiving antenatal care. Similar DHS data analyses have found that over a third of deliveries with appropriate care take place in the private sector, as well as over half of all care for children with diarrhea, fever, and cough. DHS data also showed that between 27% and 30% of users in sub-Saharan Africa obtained contraception from private sector providers. In most Eastern Mediterranean Region countries, the private sector is a dominant outpatient health services provider, and up to 70% of outpatient services are provided by the private health sector. The private sector therefore remains a key untapped partner in progress towards universal health coverage.

The private sector's role is broad, ranging from service provision, medical education, infrastructure building, and production and supply of medicines and health technologies. The sector is also linked to a variety of challenges, including unregulated expansion, lack of accreditation programmes, varying workforce practices between the private and public sectors, irrational and inefficient use of biomedical devices and technologies, non-prescription sale of antibiotics resulting in antimicrobial resistance, out-dated regulations, inadequate regulatory quality control, and limited availability of data.

The need for better quality, equity and access calls for further thinking on the role of the private sector within health systems and a broader systems perspective on how public and private sectors can work together to address the challenges of affordability, equity, quality, and availability of care.

There is an increasing need for a synergistic set of policies on this topic, which requires joint action by health and non-health sectors, public and private actors, and citizens, in service of this common interest.

CONFERENCE OBJECTIVE

The MENA Health Policy Form is organizing a conference with the overall objective of providing decision makers with policy options to expand access to quality and efficient essential health services as a core function for the achievement of universal health coverage, as delineated in the Sustainable Development Goals 2030, and taking equity into consideration.

The conference will aim to answer the question: "how can public/private interests become better aligned for the provision of equitable services toward universal health coverage?"

This will be explored by defining the role of the private sector in health systems and identifying opportunities to strengthen the public/private health systems in the MENA region, with the aim of taking advantage of the existing private sector to serve public health objectives.

Conference Approach

The conference will provide a platform for policy dialogue and experience exchange among policymakers, private sector actors, academics, researchers and development organizations, and for discussion of the experiences of Arab countries as compared with other international experiences, in order to better identify how to efficiently engage the private sector in health service delivery to improve health coverage and hence outcomes in the MENA region.

Conference Themes

The conference will focus on improving the delivery of health care services or supply-side programs, and particularly on improving coverage, expanding benefits and managing resources. Besides the presentation of several papers, its focus will be on how to improve health service provision in relation to the following pillars and subthemes:

A. The case for Public-Private Partnership in Heath Care Service Provision

Expansion of access is becoming feasible with acquired new capacities that allow preferential services and service delivery sources. Working models of engagement between major public and private sector actors in order to achieve public health goals and expanded access are available. However, a number of challenges still act as barriers to service improvement.

B. Independent Regulation to Prevent Potential Abuse of Market Power

The importance of partnership with the private sector is increasingly being acknowledged by ministries of health, yet policies for private-sector engagement lag throughout the MENA region. Conceptualizing the governance/stewardship function within public/private health systems and the role of government in the context of an expanded role for private service provision and financing is essential to minimize the abuse of market power.

C. The Role of the Pharmaceutical Sector and Technology

Expensive, cutting-edge technologies are often perceived as an indicator of high quality services. There is a high level of irrational pharmaceutical prescribing in private as well as public settings, leading to development of bacterial resistance to antibiotics, ineffective treatment, adverse effects of drugs, drug dependence, risk of transmission of infection, and economic burdens on the patient and on society more broadly. Creating appropriate products for different resource settings requires in-depth understanding of the particular needs and resource capacities of each country. Roles for controlling prices and affordability function and regulation of the pharmaceutical industry are essential in reconciling private and public interests to enhance efficiency.

D. Policy Formulation

Engagement between public and private health sectors requires deliberate, systematic collaboration with the government that goes beyond individual interventions and programs. The role of the private sector in the health reform process and in the formulation of clear policies cannot be neglected. The sector's roles and responsibilities must therefore be defined, to support effective engagement and avoid unexpected escalation to higher cost levels.

PARTICIPANTS

MENA HPF aimed to gather key stakeholders and policy-makers from all the countries in the MENA region to network and engage in discussions about public-private partnership and its applicability in their respective countries. The policy forum was well attended, with over 100 participants, including senior members of the Egyptian government such as the minister of health and population, as well as other government officials, academics, representatives of civil organizations, public and private health insurers, and international agencies including the WHO and the World Bank.

SPONSORS

The conference is supported by major financial contributions from the Arab Fund for Economic and Social Development and by the financial and technical support of the World Health Organization.

Sessions Summary and presentations

Opening Session

Chairperson: Ahmed Galal | MENA HPF
Welcome and Keynote: Lubna AlAnsary | Assistant WHO Director General
Maha El Rabbat | MENA HPF

Dr. Ahmed Galal is former Managing Director of the Economic Research Forum (ERF) and the President and Chairman of the Board of Forum Euroméditerranéen des Instituts des Sciences Économiques (FEMISE). He is a member of the Board of the Centre for International Governance Innovation (CIGI) and the MENA Health Policy Forum. Mr. Galal was Egypt's Finance Minister between July 2013 and February 2014. Previously, he worked for the World Bank for 18 years where he conducted research and provided policy advice to governments in several regions. While on leave from the Bank (2000-2006), he was the Executive Director and Director of Research of the Egyptian Center for Economic Studies (ECES). Galal authored or co-authored more than dozen books, including Welfare Consequences of Selling Public Enterprises and The Road Not Traveled: Education Reform in the Middle East and North Africa. He also authored several journal articles and book chapters. In 2004, he was awarded the prestigious regional prize for Economic and Social Sciences by the Kuwait Foundation for the Advancement of Sciences. Galal holds a PhD in economics from Boston University.

Dr. Galal welcomed participants to Cairo and to MENA HPF's annual conference. He stated that the topic under discussion, name public-private partnerships (PPPs), is both very important and often not tackled head-on. He highlighted that public and private sectors tend to provide different health services to the population, and that different segments of the health system are managed by separate groups of people, who rarely talk to one another. He added that the problem in each segment of the market is not well-defined, the boundaries are not well-drawn and the relationship between public and private is not clear-cut. He stressed that, on the ground, both the private sector and the government are very active, and both are necessary. If marriage is going to take place, Dr. Galal commented, we need to make sure it is a happy marriage.

Dr. Galal then highlighted three ideas that are relevant to public-private partnerships. The first is the issue of whether there is an optimal size for government provision of public services; should the government intervene and if so under what conditions, and where are the boundaries between the public and private sector.

He emphasized that just as there are instances of market failure, so there are also instances of government failure. In cases where markets fail, the government has a role to play, but where there is no market failure, then the private sector can provide services and there is no need for the government to intervene. He added that the balance between the degree of government intervention versus private sector participation and competition could change over time and there is no fixed optimal arrangement; as the private sector grows, the market grows and the government becomes more efficient. In summary, both the government and the private sector have important roles to play, but the question is how to manage that balance, and in particular how to adapt it as needed over time, to make sure that society is getting the most out of both.

Dr. Galal emphasized that there are three roles to be played in the process of service provision; the provider of the service, the regulator of the service and the owner of the service. He argued that the worst case scenario would be to combine all three roles. Typically, an independent regulatory agency is created to make sure that the consumer is protected and the provider is fairly compensated. He also explained the

problem of "regulatory capture", in which the regulator needs information to carry out its role and determine prices, and that information is held by the company providing the service. This information asymmetry often leads to companies "capturing" the regulator by influencing its policies. He added that it is therefore important to ensure that these different roles are not only separate but also protected.

The third point highlighted by Dr. Galal is the issue of "skimming the cream", whereby the private sector tends to provide services in wealthy areas where such provision is most profitable, a problem that he said could be particularly serious in the health sector.

Dr. Lubna El- Ansary has been appointed as assistant to WHO general Director. Originally Dr. Lubna is a Professor of Family Medicine at the College of Medicine, King Saud University (KSU). Her efforts in promoting evidence-based health care, allowed her to hold the Bahamdan Research Chair for evidence-based health care and knowledge translation at KSU. Dr. Lubna was a member of the Consultative Council (Majlis Al-Shura), which is the 'Appointed Parliament', in KSA. She joined the Council in January 2013 as one of the first women MPs ever. She was elected as the Deputy Chairperson for the Health Affairs and Environment Committee of the Council and she was selected to represent women MPs at the Inter-parliamentary Union. Dr. Lubna is a member of the board of trustees of MENA HPF.

Dr. AlAnsary focused in her introductory address on four aspects: WHO initiatives to support public-private partnerships, the situation of public-private partnerships in the Eastern Mediterranean Region (EMR), how to encourage countries to engage more in public-private partnerships, and finally how the effect/ impact of public-private partnerships can be measured.

She briefed audiences about the WHO Framework of Engagement with Non-State Actors (FENSA), adopted in 2016. The Framework endeavors to strengthen WHO engagement with non-state actors (NGOs, private sector entities, philanthropic foundations, and academic institutions) while protecting its work from potential risks such as conflicts of interest, reputational risks, and undue influence. Regarding the situation of the PPP at EMR, Dr. AlAnsary stated that the private sector is very active in the region, and recent research shows that the proportion of private sector outpatient services ranged from 33 to 86%; therefore, improving public-private partnerships would be a substantial step on the way to achieving universal health coverage. She also described the situation in the region as being diverse and lacking in strategic vision, but one which could be strengthened and expanded.

Presentation 1: Public - Private Partnership for Universal Health Coverage | Dr. Maha El Rabbat

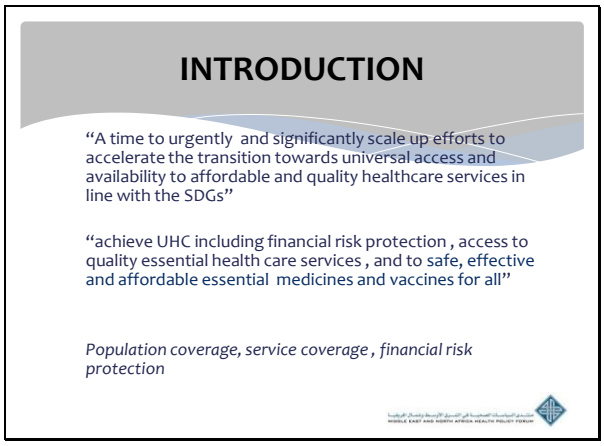
Dr. Maha El-Rabbat is a public health professor at Faculty of Medicine, Cairo University and X-minister of Health and Population for the government of Egypt. She obtained her medical degree from Cairo University, after which she pursued her postgraduate education in public health at the same institution and also abroad in the United States and United Kingdom in the fields of health sector reform, health systems strengthening and population studies. She has held high academic and technical positions in public health and worked closely with national and international organizations on national and regional programs and global studies supporting health system strengthening, community development, population issues and non-communicable diseases. She has wide experience in conducting system-wide assessments and strategic planning with an understanding of the region's challenges and opportunities that contributed to health development efforts. She currently serves as the executive director of the Middle East and North Africa Health Policy Forum (MENA HPF).

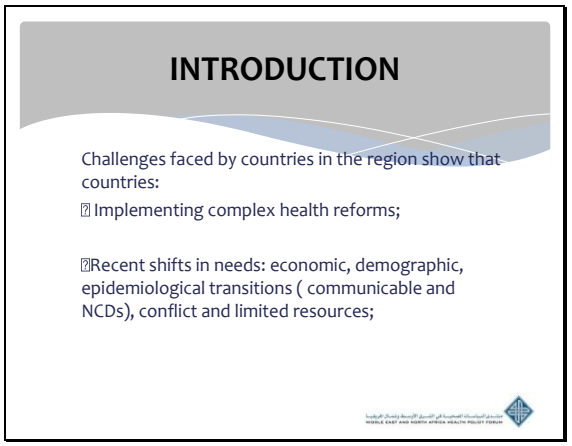
Dr. Rabbat thanked panel members and participants for attending the conference, and explained that it is one of a number of conferences and workshops organized by MENA HPF with the aim of strengthening health systems in the region and paving the way for universal health coverage. She explained that this conference addresses a new dimension, namely public-private partnerships (PPPs) for universal health

coverage. "It is a time to urgently and significantly scale up efforts to accelerate the transition towards universal health coverage in line with the Sustainable Development Goals (SDGs)," she said.

Dr. Rabbat highlighted the challenges that EMR countries are facing at present, including the implementation of complex health reforms, recent shifts in health care needs, rising health care costs, and increased demands for health care services. PPPs are one approach to address such challenges through the combined efforts of public, private and development organizations by contributing or sharing their core competencies. She also outlined the reasons for instituting PPPs in health sectors, including the desire to improve operations of public health services, the opportunity to leverage private investment for public services, and the desire to formalize arrangements with non-profit partners. She emphasized that many obstacles still exist on the path to developing effective PPPs, including lack of knowledge about this path itself. She also clarified that such partnerships do not mean getting the public sector out of service provision, and are not the same as privatization. She stressed that PPPs need effective regulation and governance.

Dr. Rabbat also highlighted the regional conference's objectives and sponsors, and thanked the WHO and the World Bank for their technical support.





INTRODUCTION

*Governments are faced with :
- Rising healthcare costs

- Increased demand for healthcare services in the face of ongoing budget constraints
**"quality of care in the public sector is poor, and accessibility and affordability to comprehensive health services is a challenge"*

Many are increasingly turning to partnerships with the private sector

Public Private Partnerships in Health

An approach to address public health problems through the combined efforts of public, private and development organizations by contributing or sharing their core competency

Why Partnerships In Health Sector?

- Desire to improve operations of public health services and facilities and to expand access to higher quality services

- Opportunity to leverage private investment for the benefit of public services

- Desire to formalize arrangements with non-profit partners who deliver an important share of public services

Public–private partnerships are essential in moving towards UHC

Filling gaps in coverage

Preventing government from overstretching its capacity in delivering for all, and

Harnessing the rapidly growing private sector towards national and state policy goals

Note

Path to partnership is not so well- known and can be challenging

Private sector growth has taken place with too little policy to guide growth

Private sector utilization is particularly high in countries in the Region where public sector spending on health is low *the private sector emergence to be a result of insufficient or underperforming public sector services*

Essential information on private sector composition, service coverage, quality and pricing continues to be patchy

What are partnerships not...?

Getting the public sector out of providing services

Privatization!

IF IT IS PROPERLY and EFFECTIVELY REGULATED

Optimum regulation of the private sector growth policies and those of the health sector

This calls for **effective governance** mechanisms

Path to partnership is not so well- known and can be challenging.

Objectives

Providing decision makers with policy options to expand access to quality and efficient essential health services

Provide a platform for policy dialogue and experience exchange

To answer the question: ***"how can public/private interests become better aligned for the provision of equitable services toward universal health coverage?"***

Sponsors

The conference is supported by major financial contributions from the Arab Fund for Economic and Social Development and by the financial and technical support of the World Health Organization.

APPROACH

Sessions are interactive we are offering opportunities for discussions at the end of each session

Please note that the issues we are addressing might be wide ranging and that discrepancies are present in and between countries

THANK YOU

Session 1: Public-Private Partnership in Healthh—Facts, Prospects and Challenges

Scene-setting

Chairperson: Hassan Salah | WHO/EMRO
Speakers: Mark Halliday | IFC (World Bank Group)
Salman Rawaf | Imperial College

Presentation 1: Partnering – From here to 2050 | Mr. Mark Halliday

Mr. Mark Halliday is the Head of Healthcare PPP advisory at the IFC, based in Washington, DC. He is originally from the UK. Mark joined the IFC from Philips Healthcare where he was the head of PPP. As well as industry experience Mark has both public and private sector experience including time at KPMG Corporate Finance, where he worked in the Global Infrastructure and Projects Group advising governments and private clients on the implementation of PPP projects worldwide. Prior to that, he worked for the National Audit Office in the UK evaluating value for money in PPP projects. Before specializing in PPP projects, Mark worked in energy project finance in London, England. Mark holds a Master of Business Administration from ESCP Europe in Paris.

Mr. Halliday, of the International Finance Corporation (IFC), presented seven major challenges facing the health care sector: change, work, workforce, quality, patient power, aging, climate change, and health care for all. For example, the World Bank estimates that to achieve SDG3, the health care workforce needs to be increased from 65 million to 80 million by 2030, and this increase in numbers should be coupled with improved distribution of that workforce. Africa, for example, faces 25% of the global disease burden, but has only 4% of the global health care workforce. Regarding quality, Dr Halliday explained that improving health care quality in each decile across the world would increase life expectancy by 4 years. Speaking of health for all, he underscored that it is only available in 40% of countries and that the World Bank Group estimates that achieving a hundred percent health for all by 2030, to meet SDG3, will require around $230 billion in annual spending. He added that currently global health care spending is $70 billion annually, of which $14 billion is spent within the private sector. Therefore, the gap of $140 billion to achieve health for all can be provided by the private sector.

He further added that there is a link between health care and economic wealth. There is an evidence that each dollar spentt on the implementation of universal health coverage will generate a benefit to the economy of about $7-9 in four to five years' time. He concluded that if this analysis holds true, each annual spend would generate $1.6 trillion in annual benefit to the community.

Presentation 2: Private Health Sector: Challenges and Opportunities | Professor Salman Rawaf

Prof. Salman Rawaf is the chair of Public Health, Director of WHO Collaborating Centre in the Department of Primary Care and Public Health at Imperial College London and Honorary Consultant Physician in the NHS. He acquired his qualification in medicine, with training in paediatrics and public health, and spent the breadth of his career in leading roles in the NHS; including 26 years as an Executive Director: County Medical Adviser, Medical Director, District Medical Officer and Director of Public Health. In the latter 23 years of his service in the NHS, he served as the Director of Health in South-West London with full responsibility for the health service in and outside the NHS, from which he then moved to Imperial College as Professor of Public Health, and the Director of the WHO Collaborating Centre for Public Health Education and Training, which supports several WHO Regions and their Member States. He is an adviser to the World Health Organization on primary care, public health, health systems, medical education and training, and human resource for health; a Fellow of the Royal College of Physicians London and the UK Faculty of Public Health; a Member of the Faculty of Public Health Medicine Ireland; and the UK Faculty of Public Health Global Health Adviser.

Professor Rawaf provided the audiences with an overview of how the health landscape will look by the year 2030. He then gave an overview of the private health sector, outlining the difference between partnership and collaboration. He defined partnership as a type of business organization in which two or more individuals' pool money, skills and other resources and share profit and loss, in accordance with the terms of partnership agreement. Collaboration, on the other hand, is a working practice whereby individuals or companies work together for a common purpose, to achieve a business benefit. He pointed out that 30-50% of the health market is wasted.

He discussed the issue of the aging of the population and raised the question of whether health systems are ready to cope with the increasing burden of non-communicable diseases. He also underscored the need for sophisticated commissioners who are knowledgeable about return on investment, Program-for-Results (P4R) instruments, risk-sharing and projections, and for better costing, data and analysis (including real world data and real world evidence), better analysis of generated evidence, and better business awareness. He shared the pillars for successful PPPs, which include the presence of national standards, strict national regulation, national priorities for PPPs, pricing policies, national workforce standards, public/private balance, increases in public funding, and the restriction of dual practice. He concluded by outlining the right balance between the public and private sectors, emphasizing that the government must take full responsibility for health (including the constitutional/human rights, social

justice aspects, as well as national emergencies), but that the private health sector has an important contribution to make. Strong regulations and their enforcement are required, but collaboration to advance health systems and maximize population benefit ("leapfrogging") is crucial.

Imperial College London

Private Health Sector: Challenges and Opportunities

Salman Rawaf MD PhD FRCP FFPH
Professor of Public Health
Director of WHO Collaborating Centre
Department of Primary Care & Public Health

Public-Private Partnership for Universal Health Coverage
MENA HPF, Cairo 12-13 November 2017

s.rawaf@imperial.ac.uk

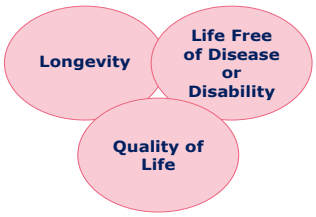
Imperial College London

Overview .....

- The main aim of Health System
- Three Challenges
- P/P General Principles
- Partnership vs Collaborations (models)
- Good, Bad & Ugly
- The solutions
- Conclusion Remarks

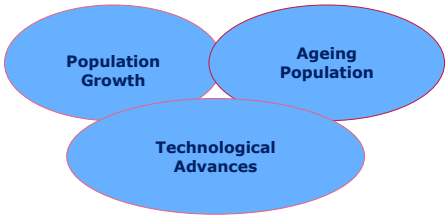
Imperial College London

Public Health / Medicine/ Health systems



Imperial College London

Three Changes: Major Influence on Health



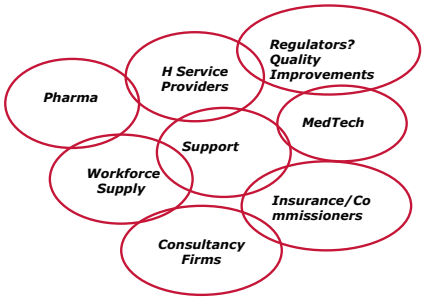
Imperial College London

General Principles

- Private Health Sector is important component of HS
- What is PHS?

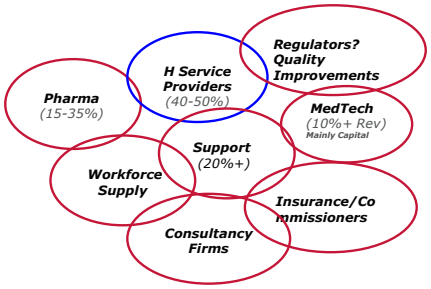
Imperial College London

'Private Health Sector Map



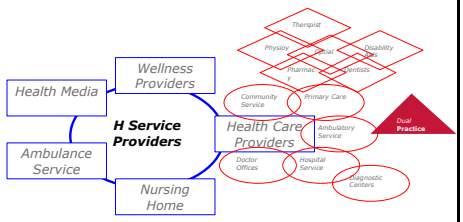
Imperial College London

'Private Health Sector Map



Imperial College London

'Private Health Sector Map



Imperial College London

General Principles

- Private Health Sector is important component of HS
- What is PHS?
- Partnership Vs Collaboration

Imperial College London

Partnership vs Collaboration

Partnership:

A type of business organization in which two or more individuals pool money, skills, and other resources, and share profit and loss in accordance with terms of the partnership agreement.

Converge Cultures / Governance

http://www.businessdictionary.com/definition/partnership.htmlPartnership

Imperial College London

Partnership vs Collaboration

Collaboration:

A working practice whereby individuals or companies work together to a common purpose to achieve business benefit.

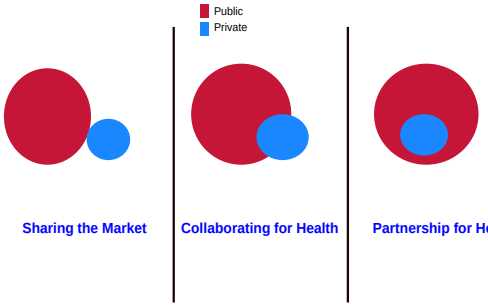
Keep different Cultures / Governance

http://www.businessdictionary.com/definition/partnership.htmlPartnership

Or

Imperial College London

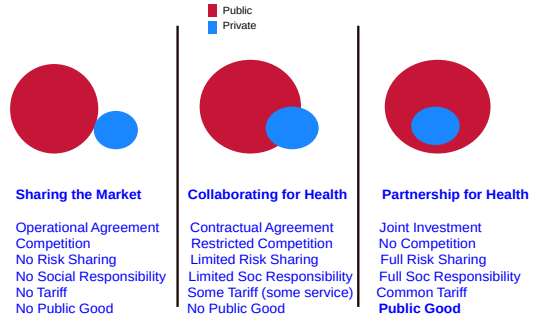
Market Share, Cooperation, Partnership



* http://www.bbc.co.uk/news/health-35008921

Imperial College London

Market Share, Cooperation, Partnership

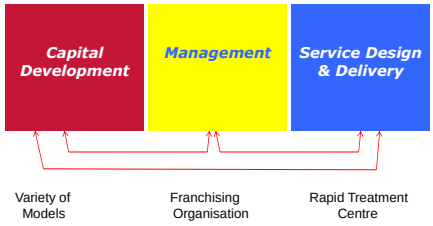


Sharing the Market	Collaborating for Health	Partnership for Health
Operational Agreement	Contractual Agreement	Joint Investment
Competition	Restricted Competition	No Competition
No Risk Sharing	Limited Risk Sharing	Full Risk Sharing
No Social Responsibility	Limited Soc Responsibility	Full Soc Responsibility
No Tariff	Some Tariff (some service)	Common Tariff
No Public Good	No Public Good	**Public Good**

* http://www.bbc.co.uk/news/health-35008921

Imperial College London

Partnership vs Collaboration: Examples in Hospital Service



Variety of Models | Franchising Organisation | Rapid Treatment Centre

Imperial College London

Models in Public Private Partnership in Hospital Provision

Model	Description
Franchising	Public authority contracts a private company to manage existing hospital
DBFO (design, build, finance, operate)	Private consortium designs facilities based on public authority's specified requirements, builds the facility, finances the capital cost and operates their facilities
BOO (build, own, operate)	Public authority purchases services for fixed period (say 30 years) after which ownership remains with private provider
BOOT (build, own, operate, transfer)	Public authority purchases services for fixed period after which ownership reverts to public authority
BOLB (buy, own, lease back)	Private contractor builds hospital; facility is leased back and managed by public authority
Alzira model	Private contractor builds and operates hospital, with contract to provide care for a defined population

Imperial College London

General Principles

- ❑ Private Health Sector is important component of HS
- ❑ What is PHS?
- ❑ **Partnership Vs Collaboration**
- ❑ **Waste of Resources**

Malaria and infectious diseases - global development professionals network

Community health care: can public and private providers work together?

The private sector has long played a role in delivering health care, but how could it collaborate with public bodies? Join us 4th Dec, 1-3pm GMT, to discuss

Sponsored by Malaria Consortium

How can a combined private-public approach to improving community care be done effectively? Photograph: Ben Curtis/AP

< 118 104

Katherine Purvis

@KatherinePurvis

Thursday 27 November 2014 18.38 GMT

Imperial College London

General Principles

- ❑ Private Health Sector is important component of HS
- ❑ What is PHS?
- ❑ **Partnership Vs Collaboration**
- ❑ **Waste of Resources**

Imperial College London

The Health Market

2016	2030	20140
7.6 Trillion	8.5 Trillion	9.5 Trillion

Imperial College London

The Health Market

2016	2030	20140
7.6 Trillion	8.5 Trillion	9.5 Trillion

7% Public Health/Prevention/Personalised Medicine

30-50% "wasted"

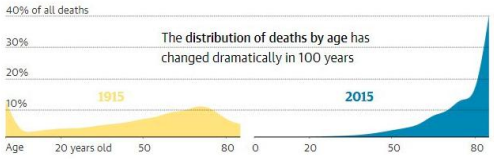
Imperial College London

General Principles

- Private Health Sector is important component of HS
- What is PHS?
- Partnership Vs Collaboration
- Waste of Resources
- **Service needs: Ageing / Technology**
- **Cherry picking**

Imperial College London

Deaths by age: 1915

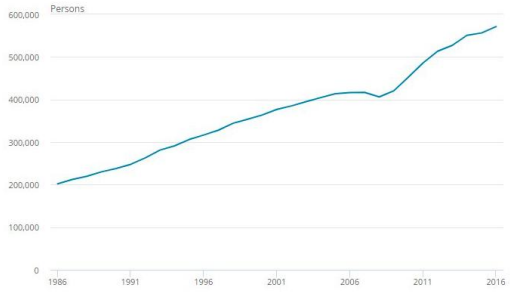


? Resources

Imperial College

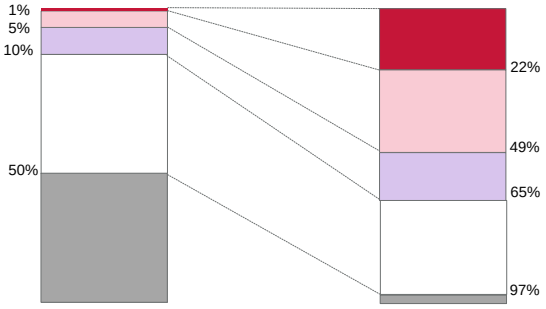
Figure 1: People aged 90 and over

UK, 1986 to 2016



Imperial College London

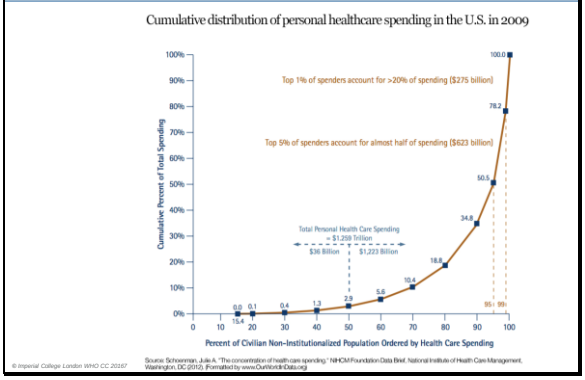
Distribution of Health Expenditure US 2013



Source: Commonwealth Fund, Sept 2016

Imperial College London

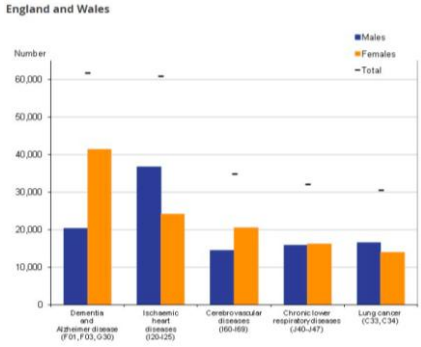
High Needs, High Costs Patients (top 5% consume 50%)



Source: Schoenman, Julie A. "The concentration of health care spending." NHCM Foundation Data Brief. National Institute of Health Care Management. Washington, DC (2012). [Formatted by www.OurWorldInData.org]

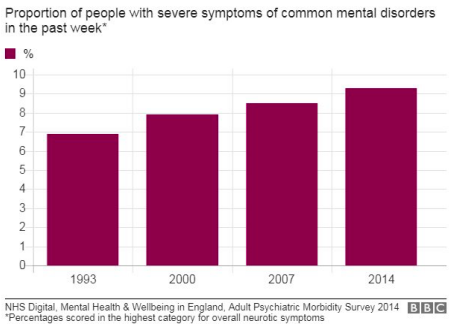
Imperial College London

Death from Dementia in the top 5 leading causes, 2015



Imperial College London

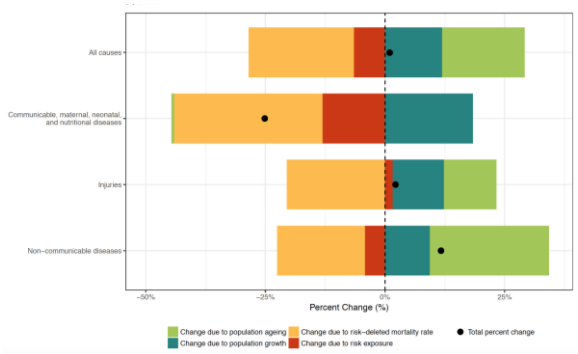
Severe Mental Illness on the rise since 1990: England



NHS Digital, Mental Health & Wellbeing in England, Adult Psychiatric Morbidity Survey 2014 BBC
*Percentages scored in the highest category for overall neurotic symptoms

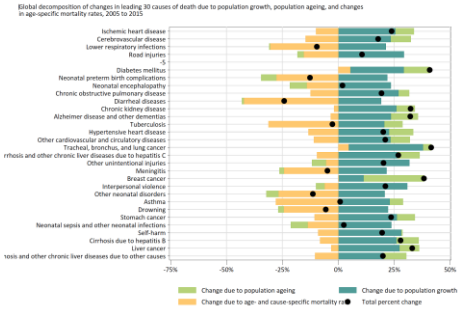
Imperial College London

Global Changes in Deaths from 2005-2016



Imperial College London

Global Burden of Disease More NCDs + Emerging Disease



Sources: IHME 2017

The Solutions

Imperial College London

Policy & Decision Makers

- Sophisticated Commissioners/HAs?/MoH
  - Tools: ROI, P4R, Risk Sharing, Projections, etc
- Better Costing
- Better Data/ Better Analysis (RWD-RWE)
- Better analysis of generated evidence
- Business Awareness /Business Cases

Imperial College London

Pillars for successful P/P 'Joint Woking" (1)

- National Standards/ Service Framework
- Strict National Regulation (both Public & Private)
- National Priorities for P/P joint working
- Pricing: National Tariff
- National Workforce Standards
  - Supply, quality, safety (appraisal, revalidation)
- Public / Private Balance (HTP – Turkey)
- Restrict /stop Dual Practice (Turkey/UK)

Resource Allocation: Public & Private Balance

NO "LAISSEZ - FAIRE"

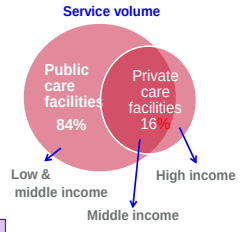
Consider country resources for citizens' needs

- *Keep public-private health care balance*
- *Don't allow for dual practice*

Ensure regulatory effectiveness

" Without adequate public funding and government stewardship, health insurance mechanisms pose a threat rather than an opportunity to the objectives of equity and universal access to health care."

Health Insurance in low-income countries, Joint NGO Briefing Paper, May 2008



Resource Allocation: Public & Private Balance

NO "LAISSEZ - FAIRE"

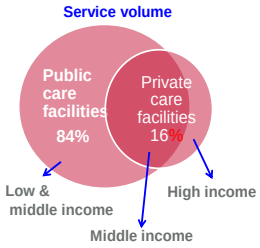
Consider country resources for citizens' needs

- *Keep public-private health care balance*
- *Don't allow for dual practice*

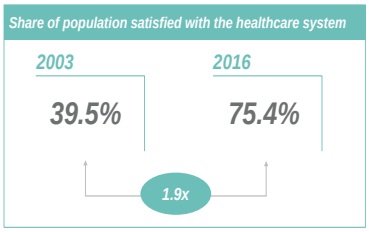
Ensure regulatory effectiveness

" Without adequate public funding and government stewardship, health insurance mechanisms pose a threat rather than an opportunity to the objectives of equity and universal access to health care."

Health Insurance in low-income countries, Joint NGO Briefing Paper, May 2008



Citizen satisfaction with healthcare has almost doubled



Source: TSI Life Satisfaction Survey 2015

Financial Protection

	2002	2015
Share of "out-of-pocket" health spending *Percent*	19.8%	17.8%
Catastrophic health expenditure *Numbers of household in ten thousand*	81	31
Universal health coverage *Share of population under coverage*	65%	99%

- Free of charge services for emergency transport and PHC
- No extra charges for services by public hospitals
- No extra charges for emergency, intensive care and some high-cost services, but limited extra charges for other services by private hospitals.
- Minimized co-payments for drugs, orthesis and prosthesis

Source: Ministry of Health, Turkey

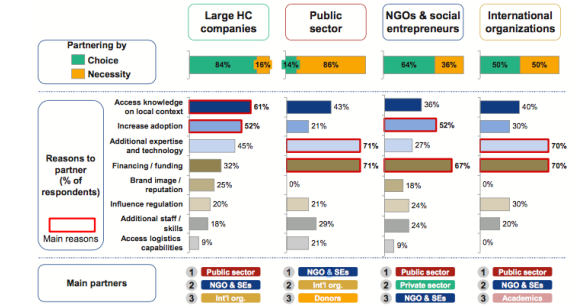
Imperial College London

Pillars for successful P/P **'Joint Woking"**

- National Standards/ Service Framework
- National Priorities for P/P joint working
- Pricing: National Tariff
- National Workforce Standards
  Supply, quality, safety (appraisal, revalidation)
- Restrict/Stop Dual Practice
- **Choice vs Necessity**

Imperial College London

Reasons for Public / Private Engagements



Note: Each respondent could mention up to three reasons; Numbers of respondents: Large HC companies: 49, Public sector: 14, NGO & social entrepreneurs: 33, International organizations: 10
Source: Leapfrogging survey, BCG analysis

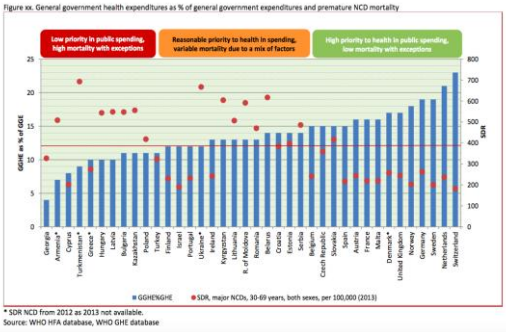
Imperial College London

Pillars for successful P/P **'Joint Woking"**

- National Standards/ Service Framework
- National Priorities for P/P joint working
- Pricing: National Tariff
- National Workforce Standards
  Supply, quality, safety (appraisal, revalidation)
- Restrict/Stop Dual Practice
- Choice vs Necessity
- **Increase Public Funding** (Intervention costs)

Imperial College London

General Government Health Expenditure



* SDR NCD from 2012 as 2013 not available.
Source: WHO HFA database, WHO GHE database

Imperial College London

Pillars for successful P/P **'Joint Woking"**

- National Standards/ Service Framework
- National Priorities for P/P joint working
- Pricing: National Tariff
- National Workforce Standards
  Supply, quality, safety (appraisal, revalidation)
- Restrict/Stop Dual Practice
- Choice vs Necessity
- Increase Public Funding (Intervention costs)
- **Leapfrogging system through collaboration**
  (Tech/Expertise/Finance/Management)

Imperial College London

In Conclusion

- **Government takes full responsibility for health** (Constitutional / Human rights/ Social Justice/ National Emergencies)
- **Private Health Sector important contribution**
- **Strong Regulations / Enforcement**
- **Collaboration, No Competition**
- **Culture of Health before Profit**
- **Collaboration to Advance Health system & Maximise Population Benefit** (Leapfrogging)

Session 2: Alternative Models of Public-Private Partnership in Health—Experiences from the Region

Panel discussion
Moderator: Raeda Alquotob | MENA HPF
Panelists: Alaa Hamed | World Bank
Mohsen George | HIO, Egypt
Nabil Kronfol | LHCM, Lebanon

Presentation 1: MAKE OR BUY" Role of Private Sector in Health | Dr. Alaa Hamed

Dr. Alaa Hamed is a Senior Operations Officer at the World Bank since 1998, with more than 30 years of experience working in health and human development on regional and country projects in the Middle East/ North Africa and Sub-Saharan Africa. He is a Medical Doctor and has a Doctorate Degree in Public Health. Dr. Hamed specialized in designing service delivery solutions and managing projects in areas related to health systems, public health, population, nutrition, health financing, public private partnerships, results-based financing and social protection. He worked as integrator in multi-sectoral programs. He was the Team Leader for Egypt and Yemen and currently the Team Leader for Sudan.

Dr. Hamed presented on the "make or buy" role of the private health care sector, sharing his experiences in engaging the private sector in both Egypt and Yemen. He pointed out that in the twentieth century, governments became central to health policy, often both financing and delivering care, and this engagement was justified to secure both efficiency and equity. However, he argued, weaknesses in the core functions of health systems—financing, generation of inputs, and provision of services—leads to policies and programs that fail to reach the poor.

He further elaborated on the nature of government failure, including problems with public accountability and asymmetry of information in the public sector that lead to higher transaction costs and the potential for corruption. He explained that the large, inefficient public sector produces goods and services that could be bought from nongovernmental providers, and could benefit from greater private sector participation in both factor markets (production of inputs) and product markets (provision of services). This would take time, accompanied by capacity building in contracting, regulation and coordination of non-governmental providers.

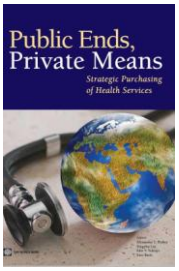
He explained the goods that the private sector can best provide are goods of high contestability and high measurability. He presented the standard policy instruments for goods/inputs. He illustrated that inputs with few market imperfections are best produced within competitive markets with minimal government intervention, while inputs with considerable market imperfections require a mix of strong regulation and in-house production to ensure adequate generation. Finally, inputs with moderate contestability and measurability, skilled use of regulations and contracting mechanisms are needed for purchasing. He added that PPPs involve setting priorities, mapping goods and services, and decisions about who can produce what and from whom to buy. He also pointed out that moving from a public sector monopoly to a more effective balance between public and private roles is not easy.

"MAKE OR BUY" Role of Private Sector in Health

Alaa Hamed

MNA Health Policy Forum, November 12, 13 2017

Based on the chapter: Political Economy of Strategic Purchasing



The Question

Is it possible to know which goods, services better produced by public sector, which services bought efficiently from nongovernmental, private providers?

The question is how to get from here to there

Not a question of deciding if private sector can contribute to broader health objectives, already does so

Moving from a public sector monopoly to a more effective balance between public and private roles is not easy

- Large, inefficient public sector produces goods and services that could be bought from nongovernmental providers
- Could benefit from greater private sector participation in both
  - **factor markets** (production of inputs)
  - **product markets** (provision of services).
- Takes time, accompanied by capacity building
  - contracting
  - Regulation
  - coordination of nongovernmental providers

Public Sector Participation in Health

Weakness in core functions of health systems—*financing, generation of inputs, and provision of services*—leads to policies and programs that fail to reach the poor

Core Functional Components and Performance Measures

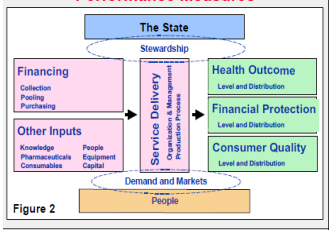


Figure 2

In the 20th century, governments became central to health policy, often both financing and delivering care

Such an engagement was justified to secure:

- ***efficiency***—since significant market failure exists in the health sector
- ***equity***—since individuals and families often fail to protect themselves adequately against the risks of illness and disability on a voluntary basis

To improve efficiency or equity, governments can choose from an extensive range of actions—from least to most intrusive

What we expect governments to do

- **Provide information,** influence behavioral changes
- **Develop/ enforce policies & regulations,** influence public/ private sector activities
- **Issue mandates**
- **Purchase services,** from public/ private providers
- **Provide subsidies**
- **Produce preventive and curative services**, in certain cases

However governments often try to do too much with too few resources and little capability

What well-intending governments often fail to do

- **Develop effective policies**
- **Make available information** about personal hygiene, healthy lifestyles, and appropriate use of health care
- **Regulate/ contract** private sector providers
- **Ensure adequate financing** for whole population
- **Secure access to public goods with large externalities** for whole population

THE NATURE OF GOVERNMENT FAILURE

Problems Relating to Public Accountability

Good public accountability secured through intersection between homogeneous social values, political agenda reflecting such values, vested bureaucratic interests

Accountability will be imperfect, aggregates never perfectly homogeneous individual values

The Authorizing Environment Needed for Good Public Sector Accountability

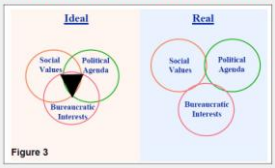


Figure 3

Information Asymmetry in the Public Sector

Information asymmetry can occur in three major ways

- ***Between patient and provider***
  - Patients know symptoms; doctors know causes, prognosis, effectiveness of treatments. Patients and Doctors may not communicate clearly
- ***Between patient and administrator***
  - Patients conceal pre-existing conditions; Administrators lack transparency in rationing of scarce resources
- ***Between provider and administrator***
  - Providers have better understanding of legitimate needs or demands of patients; Administrators have better understanding about supply, cost of resources, know little about intervention's appropriateness or effectiveness

Information Asymmetry in the Public Sector

Leads to:

- Higher Transaction Costs
- Potential for Corruption

Abuses of Public Monopoly Power

Exhibits negative features:

Leads to reduction in output, quality, while raising prices with incentives to lower expenditures

Failure of Critical Policy Formulation

Government is needed for these goods:

- public goods (policymaking and information)
- goods with large externalities (disease prevention)
- goods with intractable market failure (insurance)

However

- Governments busy producing curative services that private sector can provide
- Spending public funds on poorly targeted public production
- Leaving few or no resources for strategic purchasing of services for the poor from nongovernmental providers

The Nature of Goods

An optimally functioning market will result in a welfare-maximizing situation

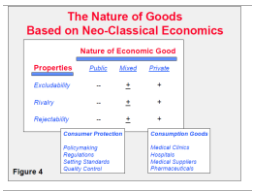
The Assumption

- Competitive forces will lead to a more efficient allocation of resources than nonmarket solutions
- For that to happen:
  - Goods involved behave like private goods
  - Rights can be perfectly delineated
  - Transaction costs are zero

Goods: What is Public and What is Private?

Private goods exhibit

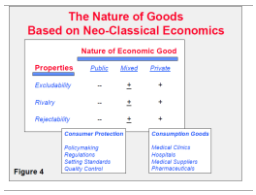
- **Excludability:** consumption by one individual prevents consumption by another— no externalities
- **Rivalry:** competition among goods based on price
- **Rejectability:** individuals can choose to forgo consumption



Goods: What is Public and What is Private?

True publicgoods have significant elements of nonexcludability, nonrivalry, and nonrejectability

Mixed goods have some but not all of characteristics of private goods



A breakdown occurs in both efficiency and equity when

- Public goods or services with significant externalities are allocated through competitive markets
- Private goods are produced or provided by a public sector monopoly

- Many public health activities generate significant externalities, not pure public goods (sanitation services, control and prevention of communicable diseases, and health promotion)
- Expensive diagnostic and therapeutic care—often provided in publicly owned inpatient facilities at highly subsidized rates—is private good, hence marketable, same is true for ambulatory, community-based care
- When governments try to control market for such services, preventing their sale in informal economy is difficult

Production Characteristics of Goods and Services

Contestability & Measurability

- **Contestability,** where firms (their goods) can enter market freely without resistance, exit without losing investments
- **Measurability,** precision with which inputs, processes, outputs, outcomes of a good or service can be measured
- Difficult to measure output and outcome of health services characterized by high degree of information asymmetry

Health care goods and services, categorized on a continuum

high-contestability/ high measurability services, low-contestability/ low measurability services

Addition to significant information asymmetry

"MAKE OR BUY"

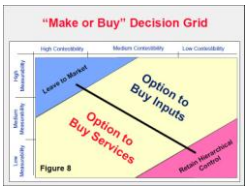
Set Priorities First …

- Priorities specify range of interventions to finance through public resources, ensure public subsidies appropriately targeted
- Countries, not to rush into "make or buy" decisions before setting priorities

…Then Decide Who Can Produce What

Map goods and services:

- can be bought
- where coordination is enough
- better produced by the public sector



…Finally Decide From Whom to Buy and How

- Once "make or buy" options have been settled, the next questions relate to:
  - whom to buy from
  - how to structure the purchase

Whom to buy from

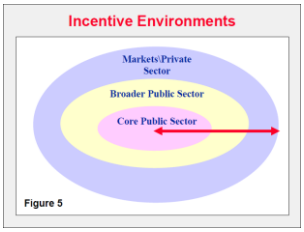
- Consider all possible producers
- Base purchase on best product at lowest price responsive
- **No market**, stimulate demand rather than in-house production.
- **No competitive market** (low contestability), use benchmark purchasing (estimated reference costs)
- **Dysfunctional market**, improve function through appropriate incentives (strategic subsidies) or regulations (antitrust)

And how to buy

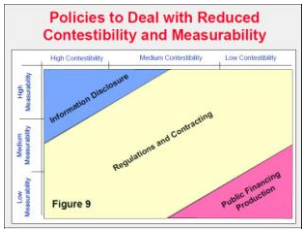
- Choose contractual arrangement most suitable for a given purchase
- All potential producers to be treated alike

POLICY LEVERS AVAILABLE TO GOVERNMENTS

Incentives for efficient production, higher moving toward the periphery, where service delivery is better



Standard Policy Instruments



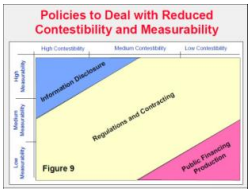
Standard Policy Instruments

Factor markets (Inputs/Goods)

Inputs with few market imperfections, best produced within competitive markets, minimal government intervention (information disclosure, quality or safety standards)

Inputs with considerable market imperfections, mix of strong regulation, in-house production to ensure adequate generation of inputs

Inputs with moderate contestability, measurability, skilled use of regulations, contracting mechanisms needed for purchasing



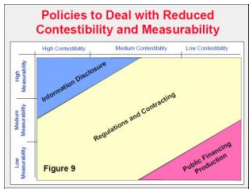
Standard Policy Instruments

Product markets (Services)

Production of interventions can be "contracted out" (purchased), not produced in-house

Which to make in-house, which to contract out is complicated

- Some outputs harder to specify than inputs
- Contestability often reduced
- Complex health problems require strategic coordination among interventions (integrated care, continuity of care, appropriate and timely referrals)



Other Policy Levers

- ***Governance:*** relationship between owner (governments), health care organizations
- ***Market environment:*** competition for goods, services markets
- ***Purchasing mechanisms:*** funding, payments arrangements for goods or services

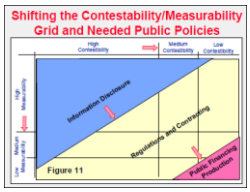
Governance and Internal Incentive Regime

Changes in *governance* influence characteristics of health care goods, services characteristics by enhancing nature of their contestability and measurability

Market Environment

Policies influencing competitive environment through regulations or contracting can alter contestability of health care goods and services

Information asymmetry can be reduced by
- increasing availability of good information on services,
- enhancing health care providers' institutional capacity to deal with information
- improving patients' understanding about health problems



Market Environment

Market Imperfections In Service Delivery

- Two related problems in market structure of service delivery in most segments of health sector
  - Little or no competition may emerge—reducing pressures on provider to deliver "value for money" to maximize profits
  - Alternatively (or in addition), competition may emerge, but may be dysfunctional

Market Environment

Market Imperfections in Service Delivery

Information asymmetry in the health sector exacerbates these problems, can be corrected through appropriate regulations and contracting arrangements

Market Environment

Market Imperfections In Service Delivery: Examples

- Medical treatment is a "bundled" good where doctor guides patients' consumption decisions
- Providers use their information advantage to control a rigid, lucrative referral chain
  - Doctors may "**forward integrate**" into diagnostic labs, pharmacies; steer patients toward consumption where a financial stake
  - Hospitals may "**backward integrate**" creating strong links with doctors, cornering part of market where little or no competitive pressure
  - Medical professionals able to create cartels, limiting competitive pressures that strengthen influence of patients and purchasers

Market Environment

Market Imperfections In Service Delivery: Examples

- Patients/ payers know less than providers about value or cost of health services, providers can cream-skim, select patients who cost less to treat
- Providers increase profits, not by delivering better service to capture market share or cutting costs but by choosing more profitable patients.

Market Environment

Market Imperfections In Service Delivery: Examples

- Equal access to capital and antitrust legislation, limiting the power of professional cartels, can significantly decrease the entry barriers for some segments of the health care market, especially for clinical services that fall in the middle band of the contestability/ measurability grid.
- Same would be true for contracting practices that are open to both public and private providers and which leave open possibilities for choosing alternative providers or exercising "exit" strategies.
- In other instances, supplier cartels, combined with low quality-control standards, shift activities such as retail sale and distribution of pharmaceuticals and medical equipment into the lower right corner, even though such activities belong in the upper left area of high contestability and measurability.

Market Environment

Market Imperfections of Private Health Insurance

- Private voluntary health insurance prone to market imperfections, many related to information asymmetries
  - Insurance may protect some people against selected risks, fails to cover everyone, excludes individuals needing health insurance the most or who greatest risk of illness
  - Insurers have strong incentive to enroll healthy or low-cost clients (risk selection or cream-skimming), excluding costly conditions, minimizing financial risk using caps, exclusions limiting protection against expensive/ catastrophic illnesses

Market Environment

Market Imperfections of Private Health Insurance

- **Adverse Selection**, at risk individuals conceal underlying medical condition
- **Free-riding,** healthy individuals pay low premiums, deliberately underinsure themselves, hoping free or highly subsidized care be available when ill, preventing insurers from raising funds for expenses incurred by sicker or riskier members
- **Moral Hazard,** when third-party insurers pay, both patients and providers become less concerned about costs, become careless about maintaining good health leading to more use of care, less effective care, or not needed care

Purchasing Mechanisms

- Provider payment systems influence goods properties
- Service providers respond differently to alternative funding and payment mechanisms.

GETTING FROM HERE TO THERE

When large private sector present

Public sector recognizes its existence, increase its use through better coordination, contracts, positive regulatory environment

Once learning, transfer positive lessons to priority areas where nongovernmental providers are not active

Where public sector is engaged in inefficient activities

Buy from private sector

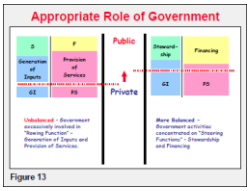


Figure 13

GETTING FROM HERE TO THERE

Public sector to be involved in areas of strategic importance: securing financial protection against cost of illness, providing sectoral oversight in terms of stewardship function

Parallel to moving out of production of goods and services, move to integrated approach and greater public sector involvement in health care financing, sectoral coordination, regulation, monitoring, and evaluation

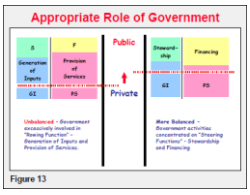


Figure 13

THANKYOU

Dr. Mohsen George is a medical doctor, the Vice President of Health Insurance Organization (HIO) in Egypt since January 2014, before which, he was the Chief Medical Officer of HIO for a previous three years. He has several areas of experience in addition to Health Insurance systems, as training and education, quality in health care, and health financing. He studied management at American University, Harvard School of Public Health, Indian Institute of management and Flagship Program by World Bank Institute. In the same time, he is general and laparoscopic surgery consultant, and member of the General Surgery Scientific Council of both; the Egyptian Fellowship Board and the Arab Board of Health Specializations. He is also a member of the European Pathway Association, the Editorial Board of the International Journal of Care Pathway, and the Advisory Board of the Journal of the Arab Board of Health Specializations.

Dr. George, of the Health Insurance Organization, provided an overview of the current system of health insurance in Egypt, the new social health insurance (SHI) scheme, and models of partnership with the private sector in the two systems. He stated that the current system stared in the 1960s and at present covers nearly 60% of the population, via an integrated model (service financing and provision). This has led to many challenges in service accessibility, quality, financial efficiency, accountability and responsiveness to patients' needs. He presented examples of PPP in the current system, such as contracting with hospitals to provide services and reimbursement of beneficiaries who get their services from the private sector. In addition to collaboration with the private sector in service provision, collaboration involves the supply of pharmaceuticals, medical supplies and devices, maintenance services, catering, cleaning and security services.

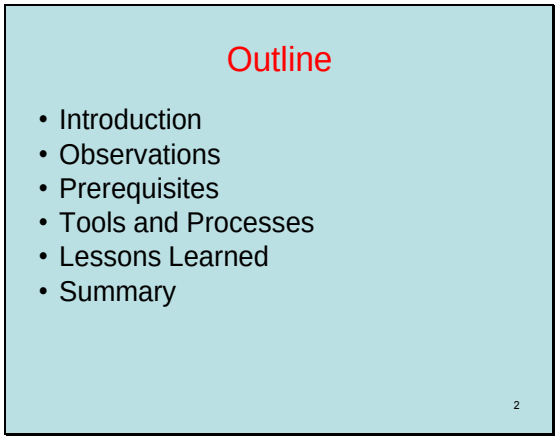
He added that the new social health insurance scheme will broaden the collaboration with the private sector as it will cover the entire population, and will require a larger network of health service providers. The new law will also permit both duplicate and supplementary health insurance provided by the private sector.

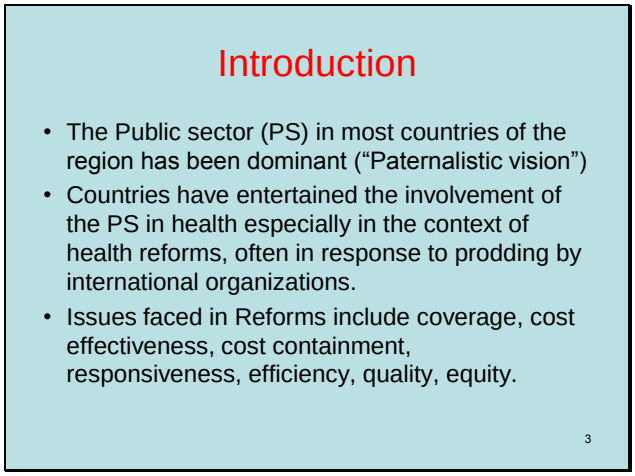
Presentation 2: Private Sector and the Health Services | Dr. Nabil Kronfol

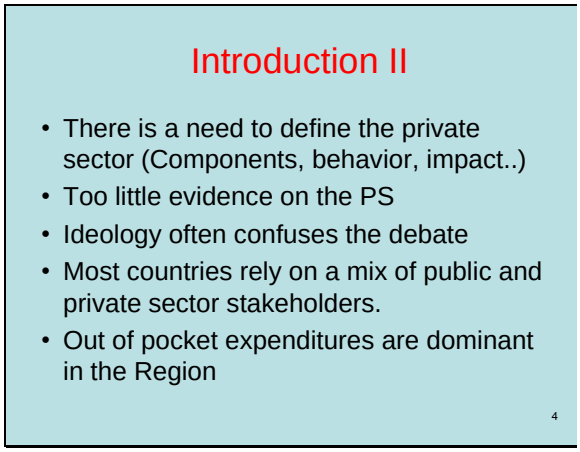
Dr. Nabil Kronfol is a Professor of Health Policy and Management and the President of the Lebanese HealthCare Management Association that focuses on the further development of policies and health systems in Lebanon and the MENA Region. He is also a co-founder of the recently established "Center for Studies on Ageing" in Lebanon and the MENA Region. He received his B.Sc. degree in 1965 and the medical degree with the Penrose Award from the American University of Beirut (AUB) in 1969 and became a diplomat of the American Board of Pediatrics in 1972. He then received a Doctorate degree in Public Health in Health Services Administration from Harvard University. Dr. Kronfol joined the American University of Beirut in 1974 and while on the professional tenure he established the College of Health Sciences in the State of Bahrain, four schools of nursing in the United Arab Emirates and the Planning Unit at Lebanon's Ministry of Health. He also played a key role in the establishment of several faculties of Medicine and Public Health in the MENA Region. Dr. Kronfol received the International McGaw Award in 1984, the Fulbright International scholar Award in 1985 and lately the Shusha Award from the World Health Organization (2007). He is a member and past president of the Alpha Omega Alpha Honor medical society and the Sigma Phi science society.

Dr. Kronfol, president of the Lebanese HealthCare Management Association, reiterated in his presentation that the public sector in most countries of the region has been dominant, in what he attributed to a "paternalistic vision", and that countries have entertained the involvement of the private sector in health care in the context of health reforms, often in response to prodding by international organizations. He added that the private provision of care has increased in social and home care recently, and that privatization is not an end in itself; it is rather being promoted as one of the means to achieve societal goals and values.

He observed that private providers have captured a significant and growing share of the health care sector. He also clarified that private funding includes private health insurance, out-of-pocket payments, direct and informal payments and formal cost-sharing, and that dual practice is rampant. He highlighted key prerequisites that could be used to get the private sector more involved in health care such as the need to change attitudes towards the private sector, accurate information on the capabilities and resources of the private sector, and the focus on policy-making and regulation. He also outlined several policy instruments that governments can use to involve the private health sector including contracting; regulation; information dissemination, education and persuasion; subsidies; conversion, which consists of turning over public services to the private sector; public private initiatives ; private health insurance; provision of public health services; and resource creation. In his view, key lessons learned include reforms that increase the role of the private sector in financing health care will increase expenditure; policy-makers should cease to ignore private health providers; and the negative impact of the private sector has its origins in absent or ineffective financing and regulatory mechanisms, not the ownership of the service delivery itself. He summarized his presentation by emphasizing that decision-makers should look at the resource mix and its impact on societal goals, the need to disentangle values and ideology, and assess evidence on the impact of the private sector on society's goals. Health systems with mixed delivery systems enabled by strong government funding have better performances, he said, and privatization can only succeed in meeting society's goals when the state exercises strong stewardship.







Introduction III

- The private provision of care has increased in social and home care recently
  A "melting of public-private boundaries" is observed (Saltman)
- Privatization is not an end by itself; It is being promoted as one of the means to achieve societal goals & values

5

Observations

- Private providers capture a significant and growing share of the HCS, even in LDC.
- In rural areas, NGO are main providers
- Overall, PS is mainly in ambulatory and dental care, less in inpatient and almost absent in Public Health. In a sample of 40 developing countries, an average of 55% of physicians were in the PS along with 28% of hospital beds (Hanson and Berman)
- Scanty information on PS

6

Observations II

- Perception of greater privacy, speed of service, quality of care promote the PS (Paler, Mills)
- Private funding include private health insurance, out-of-pocket payments, direct and informal payments and formal cost-sharing
- Dual practice is rampant

7

Prerequisites

- Attitudes towards PS is changing
- The Notion of "buyability": Gvt should contract for goods and services that it can buy; Gvt should focus on goods that are not "buyable" (Preker and Harding)
- Accurate information on the capabilities and resources of the PS
- Focus on Policy making and regulation

8

Policy instruments

I - Contracting

- Powerful tool to harness the resources of the PS to achieve society's goals
- Contracting requires substantial government capacity to lead the process
- Contracting requires financial resources
- Making profit is not illegal
- Need for ethical values

9

Contracting II

- Clinical services: Usually Primary and Tertiary Care are contracted for
- Auxiliary services: Catering, cleaning
- Purchase services rather than assets (Jordan)

10

II - Regulation

- Considered as a means to improve quality, reduce inequality and disparities in access, improve efficiency, reduce waste and contain cost
- Types of Regulation: Legislation, Price, Market entry, Licensing, Accreditation, Credentialing, Utilization Reviews, Audit, Guidelines, Protocols
- Incentives: More complex but effective. Can be economic and non-economic;

11

Regulation II

- Regulatory Agents: Government, Professional Orders, Civil Society lately
- Regulatory institutions are of many types and complexity
- Scope of regulation can be very vast
- Is dynamic. Needs constant changes.
- A study by EMRO (Egypt, IR Iran, Jordan, Lebanon, Pakistan, Sudan, Syria, Tunisia)

12

III – Information

- Outreach mechanisms include information dissemination, education and persuasion
- Information to patients: Raise awareness of quality (MD and hospital profiles, Internet) and consumer rights.
- Publish information on maximum permitted prices
- Empower the public. Role for the media

13

IV - Subsidies

- Common with NFP and NGOs
- Subsidies to serve public interest
- Subsidies may include tax exemption
- Subsidies may be in kind (Training, Medications, IT packages)

14

V - Conversion

- Consists in turning over public services to the PS
- Existing public facilities: Sell outright, Lease, operate under a management contract.
- Capital investment required: For expansion or Rehabilitation. (Lease-Build-Operate)
- Construction of new facilities: Build-Transfer-Operate contract; Build-Operate-Transfer. (Private Finance Initiative in the UK)
- Divesture: Government ceases operations in case of excess capacity in certain localities

15

VI - Public Private Initiatives (PPP)

- Refers to virtually any relationship between the public and the private sector
- Involves PS in the delivery of public services
- Need for Purchasing tools and contracts, Regulation and Financial allotments

16

VII - Private Health Insurance

- When private insurance is voluntary and without adequate regulation, it will fail to meet societal objectives, whether in terms of equity, access, efficiency or cost containment (Maynard and Dixon)

17

VIII - Provision of Public Health Services

- Community-Based services such as water chlorination, salt iodization
- Individual preventive services such as Immunizations
- Promotion activities such as information on screening (Breast cancer, Prostate, Tobacco, Nutrition, Breastfeeding,
- Special priority campaigns: HIV/AIDS, Substance abuse, Malaria, Tuberculosis

18

IX- Resource Creation

- Development of Human Resources: Physicians, Nurses, Technical and Administrative Staff
- Development of Facilities: Private clinics, hospitals, diagnostic centers, imaging centers, physiotherapy centers, home care
- Technology: Medical Equipment, Pharmaceutical Plants, Telemedicine
- Research, Legislation, Education: Academia, Civil Society, Research Institutions.

19

Lessons Learned

- Reforms that increase the role of the PS in financing health care will increase expenditures
- Systems that rely heavily on private finance for health care tend to be less progressive
- Increase in private finance need not lead to the evolution of the public sector into a “poor service for the poor”. Public expenditures may continue to increase
- Evidence is needed for better decision making

20

Lessons Learned II

- Policy makers should cease to ignore private health providers. They should pursue options for working with the PS in order to achieve sector objectives
- The negative impact of the PS has its origins in the absence or ineffective financing and regulatory mechanisms not the ownership of the service delivery itself.

21

In Summary

- Decision makers should look at the resource mix and its impact on societal goals
- Disentangle values and ideology and assess evidence on the impact of PS on society’s goals (incl. values)
- HS with mixed delivery systems enabled by strong Government funding have better performance
- Privatization can only succeed in meeting society’s goals when the State exercises strong stewardship.

22

The WHO Paradigm of HCS

The building blocks
Service Delivery
Health Workforce
Information
Medical products and technologies
Financing
Leadership and Governance

THROUGH
Access
Coverage
Quality
Safety

Goals and Outcomes
Improved Health (Level & Equity)
Responsiveness
Social and Financial Risk Protection
Improved Efficiency

23

References

- EURO Regional Committee, 2002
- MAYNARD, A. & DIXON, A. Private health insurance and medical savings accounts: theory and experience. *In: Funding health care: options for Europe*. Buckingham, Open University Press, 2002 (European Observatory on Health Care Systems series).
- MOSSIALOS, E. & THOMPSON, S.M.S. *Voluntary health insurance in the European Union*. (a policy brief)
- FIGUERAS, J. ET AL. *Purchasing for health gain*. Buckingham, Open University Press (European Observatory on Health Care Systems series) (in print).
- SALTMAN, R.B. Melting public-private boundaries in European health systems. *European journal of public health* [in press].
- SALTMAN, R.B. *Regulating the private sector*. Copenhagen, European Observatory on Health Care Systems [in press]. (European Observatory on Health Care Systems policy brief)
- Paulo Ferrinho, Wim Van Lerberghe, Inês Fronteira, Fátima Hipólito and André Biscaia; "Dual practice in the health sector: review of the evidence" *Human Resources for Health* http://www.human-resources-health.com/content/2/1/14
- Hanson K, Berman P: Private health care provision in developing countries: a preliminary analysis of levels and composition. *Health Policy Plan* 1998, **13(3):**195-211.
- Natasha Palmer, Anne Mills, Haroon Wadee, Lucy Gilson & Helen Schneider; "A new face for private providers in developing countries: what implications for public health? Bulletin of the World Health Organization 2002;80:292-297
- Carol Propper; "A LARGER ROLE FOR THE PRIVATE SECTOR IN HEALTH CARE? A REVIEW OF THE ARGUMENTS", Centre for Market and Public Organization, April 1999- CMPO Working Paper No. 99/009

24

Session 3: Evidence and Knowledge for Strengthening PPPs—Country Experiences

Chairperson: Maha El Adawy | WHO/EMRO
Speakers: Fadi El-Jardali | AUB, Lebanon
Mohamed Farghaly | Health ministry, Dubai
Aziz Yahya | Health ministry, Morocco
Raja AlYusuf | Health ministry, Bahrain

Presentation 1: Lebanon Experience | Dr. Fadi El-Jardali, MPH, PhD.

Fadi El-Jardali is a Professor of Health Policy and Systems and the Chairman of the Health Policy and Management Department (HMPD) at the Faculty of Health Sciences (AUB). He is also the Founder and the Director of the Knowledge to Policy (K2P) Center; Co-Director of the World Health Organization (WHO) Collaborating Center for Evidence-Informed Policy and Practice; Co-Director of the Center for Systematic Reviews in Health Policy and Systems Research (SPARK); and Co-Director of the Nodal institute at the American University of Beirut, Lebanon. He is an adjunct professor at the Department of Health Research Methods, Evidence, and Impact at McMaster University in Canada. Dr. El Jardali holds a PhD in Public Policy (2003) from Carleton University in Canada. Dr. El Jardali held senior positions with policy analysis related organizations such as the Ontario Ministry of Health and Long-Term Care (as Hospital Consultant), Federal department of health / Health Canada (as Senior Policy Advisor) and the Health Council of Canada (as Health Economist and Program Manager). He is a recipient of the Global Health Leadership Award and has been elected twice to the Board of Health Systems Global Society. He is also a recipient of the Fellowship on Evidence Informed Policy from the Alliance for Health Policy and Systems Research. He is the founding member of the MENA Health Policy Forum.

Dr. El-Jardali, the American University of Beirut (AUB), presented the experience of Lebanon, including the integrated knowledge translation model deployed, the role of evidence, and lessons learned from this experience. He addressed questions such as how to combine evidence with the current context, how to produce feasible policy solutions, how to raise interest in evidence and ensure greater influence of reliable evidence on policy-making, what constitutes good evidence for policy and its usage within policy processes, and how to create "evidence-advisory institutions" that embed key principles of both scientific evidence and real world context.

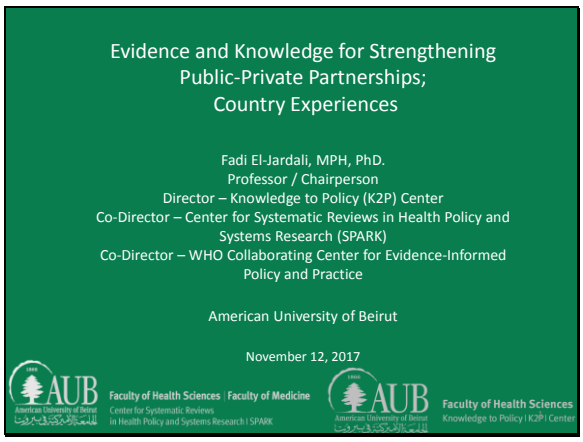
He provided an overview of the Center for Systematic Reviews of Health Policy and Systems Research (SPARK), the first center in Lebanon and the Eastern Mediterranean Region to specialize in the production of systematic reviews and other evidence-synthesis products that respond to health policy and systems' priorities. The centre was founded in 2013 with funding from the Alliance for Health Policy and Systems Research, and competitively selected to host the Secretariat of the Global Evidence Synthesis Initiative (GESI).

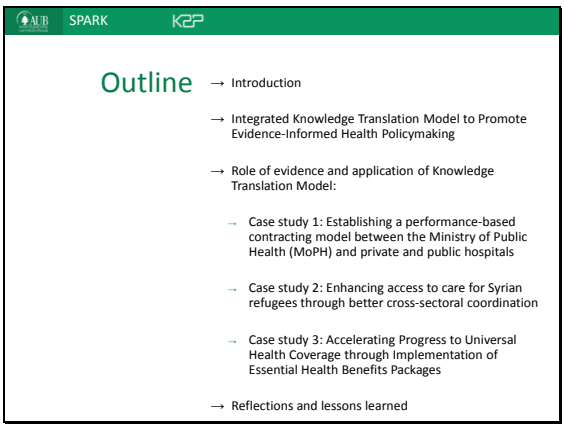
Dr. El-Jardali also provided an overview of the Knowledge to Policy (K2P) Center, describing it as a forerunner in synthesizing evidence, contextualizing knowledge and engaging stakeholders to impact health policy and action in Lebanon and the region. It was founded by the Faculty of Health Sciences (FHS) at the American University of Beirut (AUB) with seed funding from the International Development Research Centre (IDRC) and designated since 2015 as a WHO Collaborating Center for Evidence-Informed Policy and Practice.

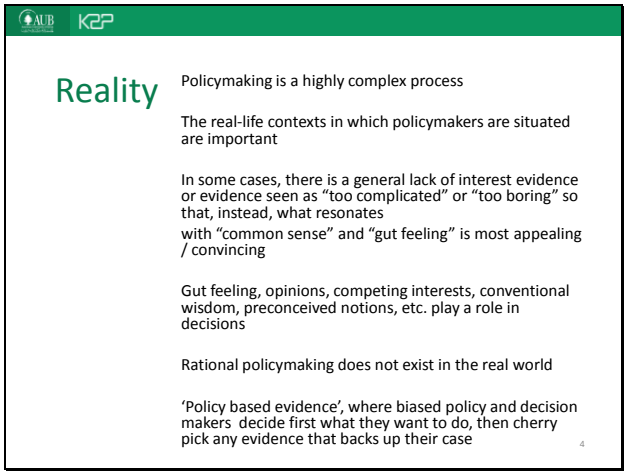
Dr. El-Jardali also presented the Integrated Knowledge Translation Model to Promote Evidence-Informed Health Policymaking, as well several case studies: the establishment of a performance-based contracting model between the Ministry of Public Health (MoPH) and private and public hospitals; the enhancing of

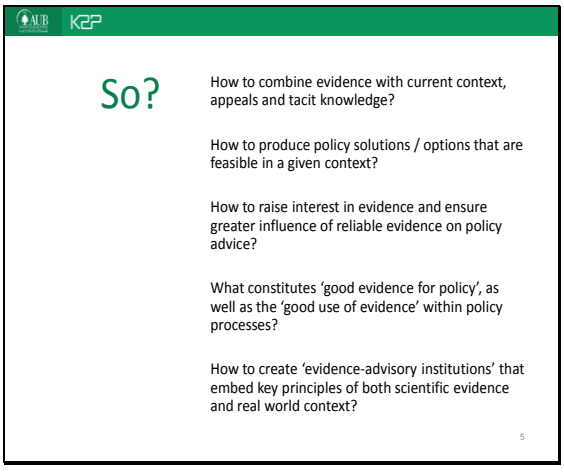
access to care for Syrian refugees through better cross-sectoral coordination; and a project titled Accelerating Progress to Universal Health Coverage through Implementation of Essential Health Benefits Packages.

He concluded that health policy-making and health system strengthening need to be informed by robust research evidence, and responsive to a country's specific needs, given that health systems are highly context-specific. He added that evidence-synthesis and knowledge translation centers/platforms have critical roles to play in bridging the gap between research and policy and in promoting evidence-informed policy-making. Finally, leveraging pre-existing research evidence and systematic reviews can enhance efficiency and minimize research waste.









SPARK K2P

Center for Systematic Reviews of Health Policy and Systems Research (SPARK)

Faculty of Health Sciences | Faculty of Medicine
Center for Systematic Reviews in Health Policy and Systems Research | SPARK

→ The first Center of its kind in Lebanon and the Eastern Mediterranean Region that specializes in the production of systematic reviews and other evidence synthesis products that respond to health policy and systems priorities

→ Founded in 2013, with funding from the Alliance for Health Policy and Systems Research.

→ Competitively selected to host the Secretariat of the Global Evidence Synthesis Initiative (GESI).

SPARK K2P

Knowledge to Policy (K2P) Center

→ A forerunner in synthesizing evidence, contextualizing knowledge and engaging stakeholders to impact health policy and action in Lebanon and the Region.

→ Modeled after McMaster Health Forum

→ Founded by the Faculty of Health Sciences (FHS) at the American University of Beirut with seed funding from the International Development Research Centre (IDRC)

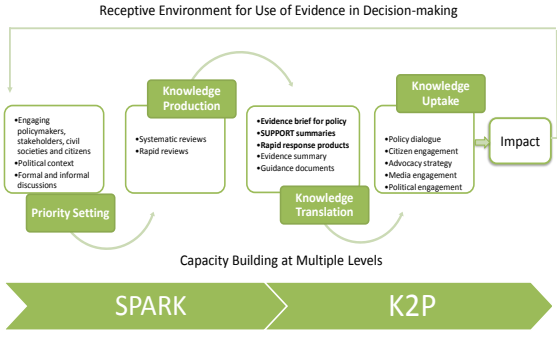
→ Designated since 2015 as a WHO Collaborating Center for Evidence-Informed Policy and Practice

SPARK K2P

K2P Knowledge Translation Products

SPARK K2P

Integrated Knowledge Translation Model to Promote Evidence-Informed Health Policymaking



El-Jardali, F., & Fadlallah, R. (2015). A call for a backward design to knowledge translation. Int J Health Policy Manag, 4, 1-5.

Case study 1:

Establishing a performance-based contracting model between Ministry of Public Health & private and public hospitals in Lebanon to improve quality of care, patient outcome, and system performance

SPARK K2P

Context

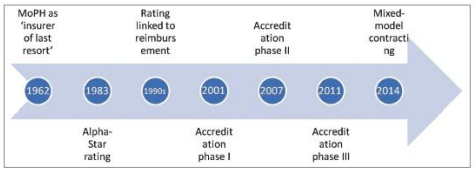
→ The health care system in Lebanon is pluralistic due to the public–private mix involved in the financing and provision of health services.

→ The Ministry of Public Health (MOPH) contracts with 105 private hospitals and 26 public hospitals to deliver healthcare services to uninsured citizens, thus providing hospitalization coverage to about 53% of the Lebanese population.

→ The MOPH is considered the main financier of private hospitals, allocating about 64% of its total annual budget for hospitalization coverage.

SPARK

Hospital Contracting Reforms



→ In 2001, accreditation system was introduced and was linked to reimbursement rate for hospitals. The accreditation- reimbursement link was evaluated and found to be inappropriate.

→ In 2014, the MOPH implemented a new reimbursement formula that is based not only on accreditation but also on additional criteria / indicators. **However there is a risk that this arrangement may not reflect hospital's actual performance and not be optimal for improving patient outcomes.**

SPARK

Hospital Contracting Reforms

Performance-based Contracting is currently a priority for the MOPH in Lebanon:

→ Establishment of a reimbursement model fully based on performance indicators to include higher payments for hospitals with higher quality of care and better health outcomes.

→ Performance-based contracting is a form of pay for performance (P4P).

SPARK

Pay for Performance (P4P)

→ P4P is defined as the "transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target" (Eichler 2006).

→ While some arrangements allow that providers get paid equally regardless of the quality of care they are providing, pay-for-performance adjusts the fee-for-service model to include higher payments for higher quality care.

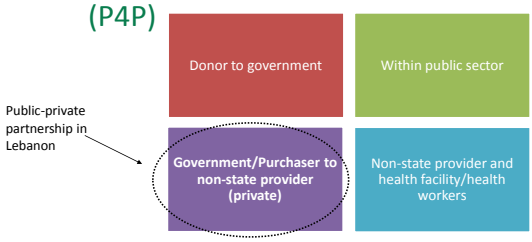
→ P4P is increasingly being used to drive improvements in health care quality and safety.

→ Pay-for-performance programs are being implemented in a growing number of developed countries, including the United States (US), United Kingdom (UK), Canada, Australia, New Zealand, and in a number of developing countries including now Qatar.

SPARK

Pay for Performance (P4P)

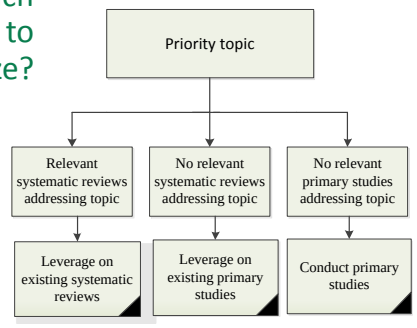
4 P4P models have been identified in the literature:



Source: Eldridg & Palmer, 2009

SPARK

Which Evidence to Prioritize?



SPARK

Evidence from Systematic Reviews

→ A systematic review (SR) is a high-level overview of primary research that aims to identify, select, synthesize and appraise all research evidence addressing a particular research question in order to answer it.

→ SRs rely on systematic, explicit and accountable research methods.

→ SRs provide policymakers, stakeholders and professionals with the most reliable evidence to inform their decisions and practices.

SPARK

Evidence from Systematic Reviews

SRs constitute a more appropriate source of research evidence than individual studies:

→ Probability of being misled by research evidence is lower with a SR than with an individual study .

→ Confidence in an intervention's effectiveness is higher with a SR than with an individual study.

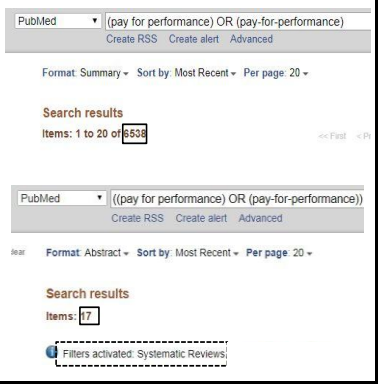
→ SRs provide a summary of the best quality studies, so drawing on an existing SR constitutes a more efficient use of time.

→ SRs summarize the findings of studies conducted in different settings so they make it easier for users to assess the applicability of a certain option.

18

SPARK

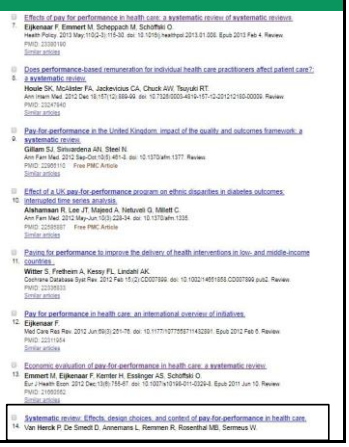
Existing Evidence on P4P

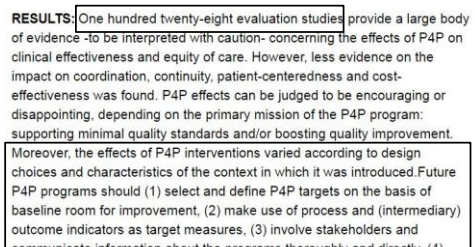


SPARK

SPARK

Sample Systematic Reviews on P4P





RESULTS: One hundred twenty-eight evaluation studies provide a large body of evidence -to be interpreted with caution- concerning the effects of P4P on clinical effectiveness and equity of care. However, less evidence on the impact on coordination, continuity, patient-centeredness and cost-effectiveness was found. P4P effects can be judged to be encouraging or disappointing, depending on the primary mission of the P4P program: supporting minimal quality standards and/or boosting quality improvement. Moreover, the effects of P4P interventions varied according to design choices and characteristics of the context in which it was introduced.Future P4P programs should (1) select and define P4P targets on the basis of baseline room for improvement, (2) make use of process and (intermediary) outcome indicators as target measures, (3) involve stakeholders and communicate information about the programs thoroughly and directly, (4) implement a uniform P4P design across payers, (5) focus on both quality improvement and achievement, and (6) distribute incentives to the individual and/or team level.

CONCLUSIONS: P4P programs result in the full spectrum of possible effects for specific targets, from absent or negligible to strongly beneficial. Based on the evidence the review has provided further indications on how effect findings are likely to relate to P4P design choices and context. The provided best practice hypotheses should be tested in future research.

SPARK

Interpretation of Evidence from Systematic Review

→ How should this evidence be interpreted?

→ Can it be used to inform decision-making?

- Yes it can and it should.
- Policy decisions will be made regardless of whether or not evidence is present.
- Health systems are complex in nature and health systems strengthening is not an easy or quick task ➔ Sometimes, the existing research evidence is not very robust, but it is the best available research evidence to inform the decision at that time.

SPARK

Effectiveness of P4P	Findings
clinical effectiveness	• Effects of P4P ranged from absent to positive (1 to 10%) or very positive (above 10%), depending on the target and program. • In general, there was about 5% improvement in quality of care and performance due to use of P4P, with wide variations depending on the measure and program.
Access and equity of care	• P4P did not have negative effects on patients of certain age groups, ethnicity, or socio-economic status, or patients with different comorbid conditions.
Cost effectiveness	• Cost-effectiveness of P4P use was reported in several studies.

Important role of evidence in answering many different types of questions which policymakers need to inform their decisions.

Summary of findings from systematic review by Herck et al, 2010

SPARK

Interpretation of Evidence from Systematic Review

→ Is this evidence adequate to inform policy decisions related to P4P?

- Evidence on the effectiveness of interventions should be supplemented by evidence on how contextual factors (e.g. health systems characteristics, target population, culture) can affect the size of such effectiveness.
- Relying on only what can work – as opposed to understanding how, why, when and for whom interventions work – has contributed to the uneven progress towards the achievement of the Millennium Development Goals, and to the weak health systems responses to Ebola and refugee crisis.

SPARK

Implementation Considerations

Level	Barrier	Counterstrategies
Patient	--	--
Professional	- **Cherry-picking**: selecting healthier cases to achieve better outcomes - **Dependency on financial incentives**: Provider may stop on improving performance when the incentives end - **Demoralization**: occurs if short-term professionals receive more financial incentives than those who have established long-term practices	- Use of a combination of process and outcome measures - Alignment with norms and values to keep providers' intrinsic motivation. - Involvement of stakeholders, particularly providers, in designing the program - Provision of a relatively high incentive - Provision of incentives of a purely positive nature - Selecting and defining targets based on baseline room for improvement
Organizational	- **Free-riding:** in group settings performance payments may not be effectively distributed to group members, and it may be tempting for members to free ride, especially in large groups. - **Bureaucratization** - **Limited Resources**	- Minimizing delay between care delivery and pay- out - Use of absolute targets
System	- **Gaming the system:** improving on reporting/documentation rather than improving performance	- Use risk adjustment to even playing field across providers with respect to severity of patient mix - Supply data via an online tool enabling auditing and checks - Impose penalties on hospitals failing to meet data accuracy targets

SPARK

Summary of the Evidence on P4P

→ P4P can improve quality of care.

→ Effectiveness of P4P depends on the **design** of the scheme and the **context** in which it is implemented.

→ Findings suggested:

- →Selecting and defining P4P targets based on baseline room for improvement.
- →Using a combination of process and outcome measures
- →Involving stakeholders in designing the program
- →Providing a relatively high incentive size
- →Implementing a uniform P4P design across different payers at a national level rather than fragmented initiatives

SPARK

Implications for Countries in the EMR

→ Is P4P a fit for all purpose? Can we develop one P4P program that can be implemented across countries of the EMR?

→ Magic bullets do not exist.

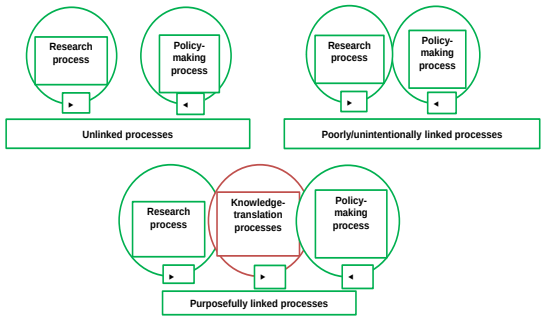
→ Each country has to:

- → Agree on the payment formula, the mix and size of incentives & list of metrics.
- → Define the goals that a health care purchaser wants to accomplish through the incentives
- → Develop capacity including enforcement and monitoring strategy

→ **Knowledge translation** becomes critical to **contextualize** the evidence and **promote its uptake in policy decisions**.

SPARK

Missing Link: Knowledge Translation

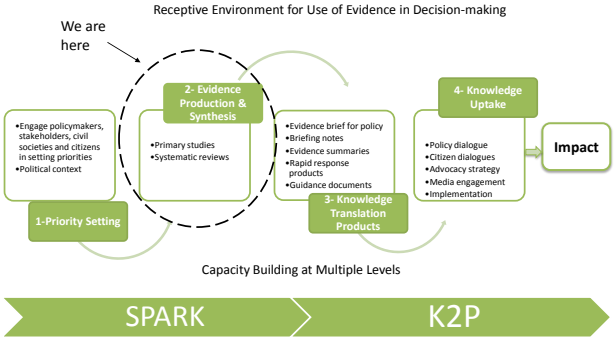


Source: Lavis, 2006

29

SPARK

Integrated Knowledge Translation Model to Promote Evidence-Informed Health Policymaking



El-Jardali, F., & Fadlallah, R. (2015). A call for a backward design to knowledge translation. Int J Health Policy Manag, 4, 1-5.

30

SPARK

Knowledge Translation Product

→ The creation of new knowledge does not, on its own, lead to widespread uptake, implementation or impact on health.

→ Knowledge translation (KT) products allow evidence generated from the systematic reviews to be packed in a user-friendly format and written in an understandable language which would increase the likelihood to be used by policymakers.

SPARK

Knowledge Translation Product

→ The findings from existing systematic reviews are incorporated into a knowledge translation product known as policy brief.

→ Policy Briefs bring together:
- → Global research evidence (numerous systematic reviews)
- → Local evidence (from primary studies, reports, indicators)
- → Context-specific knowledge (key informant interviews with targeted policymakers and stakeholders)

→ To inform deliberations about health policies and programs.

K2P Policy Brief
Establishing performance-based contracting for hospitals in Lebanon

SPARK

Knowledge Translation Product

→ **Outline**:
- → Problem and underlying causes
- → 3-4 options to address the problem
- → Implementation consideration

→ **Format**:
- → Key messages (1 page)
- → Executive summary (3-5 pages)
- → Full brief (25-30 pages)

K2P Policy Brief
Establishing performance-based contracting for hospitals in Lebanon

SPARK

Knowledge Uptake

→ Policy dialogue meeting about "Performance-based contracting for hospitals in Lebanon" being planned

→ Dialogue to include policy-makers, stakeholders, civil societies and researchers to deliberate about a policy issue

→ Dialogue to be informed by Policy Brief

→ Dialogue brings research evidence together with the views, experiences and tacit knowledge of participants to agree on an ideal P4P model that would fit the context of Lebanon

SPARK

Policy Dialogue

35

SPARK

Desired Impact

A re-modeled pay for performance model to provide the right incentives to improve patient outcomes and value for money

Model currently being pilot-tested by the MOPH. The model is based on the following indicators:

1. Accreditation
2. Patient satisfaction
3. Readmission rates

} Patient level impact

4. Case-Mix Index (CMI) } Health system/ hospital level impact

A new reimbursement rate will be applied based on the performance scores.

Case study 2:

Enhancing access to care for Syrian refugees through better cross-sectoral coordination and Partnerships

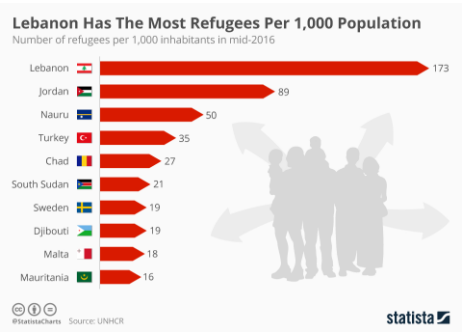
SPARK

Refugee Crisis

Syrian conflict erupted in 2011

Large influx of refugee to neighboring countries (mainly Turkey, Lebanon and Jordan), as well as to distant countries

SPARK



SPARK

Refugee Crisis

→ Major burden on different levels, including the economy, jobs, education system, and healthcare system in Lebanon

→ Health policy makers were struggling with how to respond to the needs of refugees in the context of an already strained health system

→ A number of local and international NGOs, UN agencies and governmental bodies and agencies provide humanitarian, assistance to Syrian refugees.

→ Poor coordination of efforts & partnerships between the different entities providing or financing health services led to inefficiencies and duplication of efforts and hindered optimal access of refugees to care.

SPARK

Systematic Review Production

PLoS One. 2015; 10(9): e0137159. PMCID: PMC4558048
Published online 2015 Sep 2. doi: 10.1371/journal.pone.0137159

Effectiveness of Mechanisms and Models of Coordination between Organizations, Agencies and Bodies Providing or Financing Health Services in Humanitarian Crises: A Systematic Review

Elie A. Akl,[1,2,*] Fadi El-Jardali,[2,3,4,5] Lama Bou Karroum,[3] Jamale El-Eid,[6] Hneine Brax,[7] Chaza Akik,[8] Mona Osman,[9] Ghayda Hassan,[10] Mira Itani,[11] Aida Farha,[12] Kevin Pottie,[13,14] and Sandy Oliver[15]

Version 1. PLoS Curr. 2016 August 3. 8. PMCID: PMC4999356
ecurrents.dis.95e78d5a93bbf99fca68be64826575fa
Published online 2016 August 3.
doi: 10.1371/currents.dis.95e78d5a93bbf99fca68be64826575fa
Research Article

Coordinating the Provision of Health Services in Humanitarian Crises: a Systematic Review of Suggested Models

Tamara Lotfi, Lama Bou-Karroum, Andrea Darzi, Rayan Hajjar, Ahmed El Rahyel, Jamale El Eid,* Mira Itani,* Hneine Brax, Chaza Akik, Mona Osman, Ghayda Hassan, Fadi El-Jardali, and Elie Akl

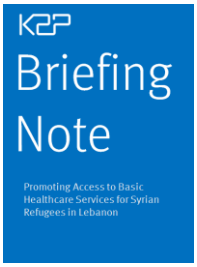
41

SPARK

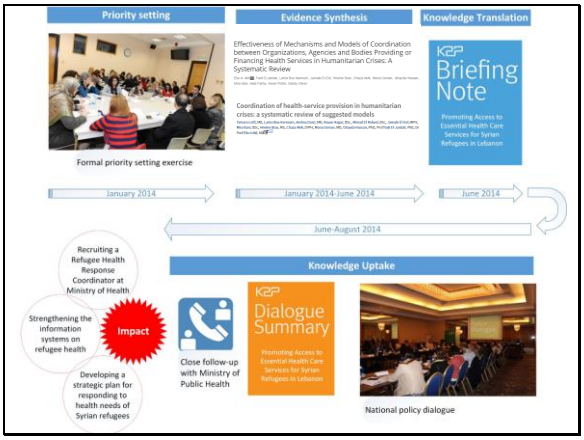
Knowledge Translation

Preliminary findings from systematic reviews were incorporated into a Briefing Note

**Do not wait till the systematic review is published to disseminate findings!*



42



Case study 3:

Accelerating Progress to Universal Health Coverage through Implementation of Essential Health Benefits Packages

SPARK

Leveraging on the UHC agenda

→In January, 2016, the Ministry of Public Health in Lebanon launched the "Comprehensive Primary Health Care Project, a Step toward Universal Health Coverage".

→The project is considered a stepping stone to accelerate progress towards universal health coverage in Lebanon.

45

SPARK

Determinants of Universal Health Coverage

→ One of the key requirements for successful UHC programs is the design and **implementation** of Essential Health Benefits Packages (EHPs).

→ EHP is defined as a set of essential health services that population have access to.

→ A basket of six EHPs has been designed to be provided for free to 150,000 citizens of limited incomes through 75 primary healthcare centers selected according to the geographical location of the targeted groups

→ MOPH needs research evidence on the factors that are critical to the successful implementation of EHPs within PHC.

46

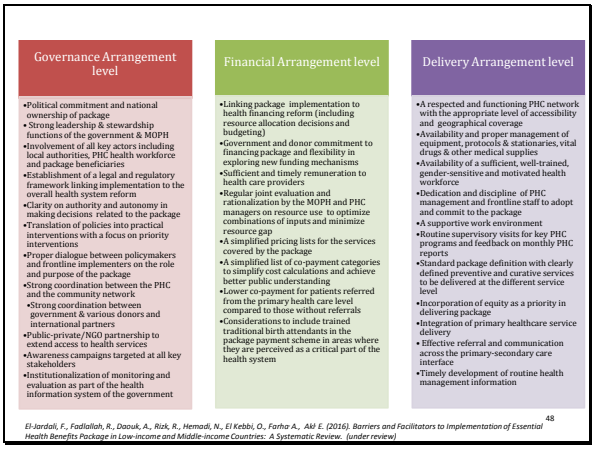
SPARK

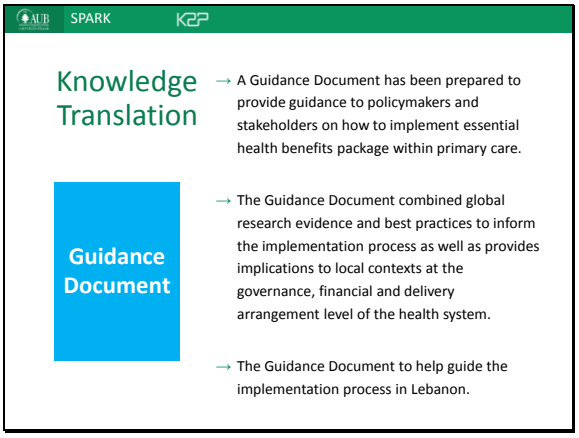
Evidence Synthesis

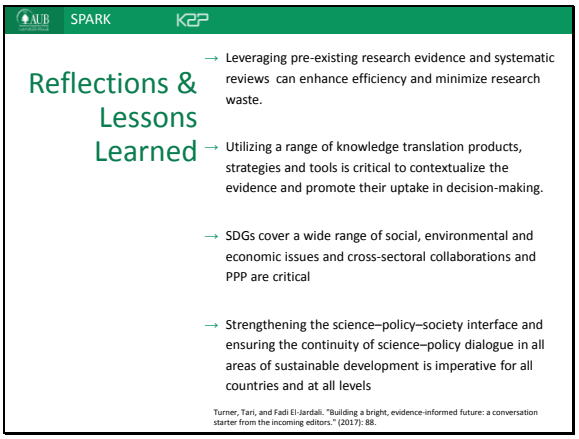
→ A search of the literature revealed a lack of systematic reviews addressing this priority.

→ Accordingly, we conducted a systematic review of factors critical to the implementation, uptake and sustainability of health benefits package in low- and middle-income countries

→ Factors critical to implementation are presented at the governance, financial, and delivery arrangement levels of the health systems







Presentation 2: Health Insurance Systems in Dubai | Dr. Mohamed Farghaly

Dr. Mohamed Fargaly is a Professor at Dubai Medical College, senior specialist at Dubai Health Authority, member of UAE technical committee for diabetes, member of UAE National Diabetes Guideline Committee, Member of DHA diabetic board, accredited trainer in family medicine by the Royal College of General Practitioners in United Kingdom and accredited examiner for MRCGP (INT). He is a senior tutor and module lead for Leicester University Diabetes Diploma. He is the Chairman of Family Medicine scientific committee EMA, General Secretary of WONCA EMR.

Dr. Farghaly provided an overview of the health insurance systems in Dubai, explaining that the current systems involve partnership between the government and the private sector. He described the SAADA health insurance program, which is provided for citizens of the Emirate and is under the supervision of the Dubai Health Authority. It aims to provide coverage for those citizens who do not currently benefit from any government health program. He also mentioned a recently developed program for geriatric care called Hospital at Home Services. The program uses telemedicine for provision of services and includes referrals for cases that require hospital care. The program is expected to markedly reduce the costs of health care for this group.

Dr. Farghaly highlighted some of the key features of the SAADA system, including the availability of data on the private sector; the use of Ejada indicators to assess the quality of care; the development of the Dubai Standards of Care, which are evidence-based guidelines on chronic disease management, in 2017; and changing the payment system in Dubai for services to the international refined diagnosis-related group (IR DRG) system. Finally, he presented developments in 2017, including the activation of the use of health insurance via the Emirate identity card for all those insured in Dubai, the health insurance program for visiting tourists, and the inclusion of early detection of cancers and hepatitis C treatment in the basic insurance benefits package.

Presentation 3: The Role of the Public vs. the Private Sectors: The Moroccan Experience | Dr. Aziz Yahya

Yahia Aziz; MD; MPH, is advisor at the General Secretariat of the Ministry of Health, Morocco. He was the Provincial Head of Primary Health Care, Regional Planning Officer, Regional Hospital Director and Teacher at National School of Public Health. He has experience in management of health programs; hospital management and Planning and contracting. Dr. Aziz is an auditor; teacher and coach in public health. He was awarded a certificate in "Strategic Management" by the Institute of Tropical Medicine in Antwerp/Belgium; certificate in "Capacity Development Workshop for Hospital Managers"; EMRO/Cairo/Egypt and certificate in "Strengthening Policies and Health Systems" "CARPeSS".

Dr. Yahya presented the Moroccan experience in PPPs, providing an overview of key health achievements in Morocco, such as the decrease in morbidity due to infectious and perinatal diseases from 33% to 18%. He then highlighted the key challenges facing health care in the country, including decreased access to treatment, a decreased health care workforce, poor health care financing, poor quality health care, and increased patient expectations. He also outlined the changes that are influencing medical practices, such as the rapid advancement in medical sciences, the cost of health care, and the quality of medical education. He described the key features of the Moroccan Health Sector Development Strategy for 2017-2021, and presented the legal framework that governs the relationship between the public and private sector in Morocco, the system for licensing, and the Moroccan health map.

تذكير بأبرز المكتسبات 2/2

- تحسن الولوج إلى خدمات المستشفى العمومي
  - ارتفاع نسبة ارتفاق المستشفيات العمومية بـ 80% (10.77 مليون مرتفق حاليا مقابل 6 مليون في 2008).
  - ارتفاع نسبة الاستشفاء (Hospitalisations) بـ 61%، ارتفاع نسبة الاستشارات الطبية المتخصصة بـ 78%.
- تحسن الولوج إلى الأدوية والمستلزمات الطبية
  - خفض ألفة أكثر من 3600 دواء ومستلزم طبي، ارتفاع نسبة استعمال الأدوية الجنيسة: 39% حاليا، مقابل 30% في 2012.
- تطور مؤشرات الحماية المالية للمرضى والأسر:
  - انخفاض الانفاق المباشر للأسر المستفيدة من نظام المساعدة الطبية (RAMED) بـ 38%.
  - انخفاض معدل النفقات المباشرة للأسر على الصحة بـ 6% (من 53.6% في 2010 إلى 50.7% في 2016).
- ارتفاع الطاقة الاستيعابية الاستشفائية العمومية بـ 2440 سريرا إضافيا:
  - 14 مستشفى عمومي (1880 سرير)، ومستشفى جامعي (وجدة: 560 سرير). في انتظار 04 م ج و 36 م ع
- انخفاض الوفيات:
  - ارتفاع متوسط العمر المتوقع عند الولادة (EVN) من 71.1 عاما في 2004 إلى أكثر من 74.8 حاليا.
  - انخفاض نسبة وفيات الأمهات بـ 35% : من 112 وفاة لكل 000 100 ولادة حية في 2010 إلى 72.6 وفاة لكل 000 100 ولادة حية في 2016.
  - استمرار انخفاض نسبة وفيات الأطفال دون سن الخامسة، من 47 وفاة لكل 1000 ولادة حية سنة 2004 إلى 30.5 سنة 2011.

أهم التحديات

- استمرار النقص في الولوج إلى العلاجات:
  - ضعف نسبة الولوج إلى الطبيب العام: 0,6 استشارة طبية لكل مواطن سنويا، مقابل 2,7 بتونس، 6,4 بفرنسا ...
  - ضعف نسبة مراقبة الحمل ونسبة الولادة تحت إشراف طبي: 75%،
  - ضعف التأطير الطبي بالعالم القروي والمناطق الجبلية،
- نقص حاد في الموارد البشرية:
  - حاليا 1,51 ممثي الصحة لكل 1000 مواطن (يجب الوصول إلى 4,45 لكل 1000 مواطن)،
  - إشكالية تحفيز الموارد البشرية الصحية،
- ضعف الموارد المالية:
  - حاليا الانفاق المباشر للأسر يقدر بـ 50,7% (ويجب خفضه إلى حدود 25% لاجتناب النفقات الكارثية)،
- خدمات صحية في حاجة إلى تجويد.
- انتظارات المواطنين متزايدة، متسارعة وملحة.

المجلس الاقتصادي والاجتماعي والايكولوجي
التغييرات التي تحدث وتؤثر على ممارسة الطب

- التطور السريع للعلوم الطبية، تقنيات التشخيص والعلاج، تنويع المهن ومجالات عمل الطب.
- تكلفة الرعاية والإجراءات الطبية وتسويق وسائل التشخيص الجديدة، علاجات جديدة وارتفاع تكلفة الدواء على الرغم من الانخفاض الأخير في أسعار الأدوية.
- الحق في الولوج ، الحق في العلاج، الحق في المعلومة، الحق في الجودة.
- جودة التعليم الطبي، ودوره الحاسم في الممارسة السليمة للطب ، نقل المعرفة والمهارات والقيم.

الترسانة القانونية

ظهير شريف رقم 1.11.83 صادر في 29 من رجب 1432 (2 يوليو 2011) بتنفيذ القانون إطار رقم 34.09 المتعلق بالمنظومة الصحية ويحرض العلاجات.

مرسوم رقم 2.14.562 صادر في 7 شوال 1436 (24 يوليو 2015) بتطبيق القانون إطار رقم 34.09 المتعلق بالمنظومة الصحية و بعرض العلاجات. فيما يخص تنظيم عرض العلاجات والخريطة الصحية والمخططات الجهوية لعرض العلاجات.

ظهير شريف رقم 1.15.26 صادر في 29 من ربيع الاخر 1436 (19 فبراير 2015) بتنفيذ القانون رقم 131.13 المتعلق بمزاولة مهنة الطب.

مرسوم رقم 2.15.447 صادر في 6 جمادى الأخرة 1437 (16 مارس 2016) بتطبيق القانون رقم 131.13 المتعلق بمزاولة مهنة الطب

ظهير شريف رقم 1.14.192 صادر في فاتح ربيع الأول 1436 (24 ديسمبر 2014) بتنفيذ القانون رقم 86.12 المتعلق بمعقدي الشراكة بين القطاعين العام والخاص.

مزاولة مهنة الطب بالمملكة المغربية(1/2)

- التعليم المستمر الإلزامي لجميع الأطباء(مشروع مرسوم)
- طرق ممارسة الطب للقطاع الخاص
- تحديث أحكام العيادة الطبية الفردية
- الممارسة الطبية الجماعية والمزاولة المشتركة
- قواعد ممارسة الطب بالعيادة الطبية الفردية
- تعريف للمصحة، تقنين الخدمات بمصلحة الاستعجال الطبي، مستشفى النهار،

والمؤسسات المماثلة للمصحات: القانون بالمصحة : مراكز تصفية الدم، ومراكز أمراض الدم السريرية، ومراكز العلاج الإشعاعي، ومراكز العلاج الإشعاعي الموضعي، ومراكز العلاج الكيميائي، ومراكز الفسطرة، ومراكز النقاهة أو إعادة التأهيل ومراكز الاستجمام من أجل العلاج وأي مؤسسة صحية خاصة تستقبل المرضى للاستشفاء.

مزاولة مهنة الطب بالمملكة المغربية(2/2)

- تحديد وضع المصحات ومديريها وإطلاق الاستثمار في القطاع الصحي (المادة 60)

  يمكن أن تكون المصحة في ملكية شخص ذاتي شريطة أن يكون طبيبا، أو في ملكية مجموعة من الأطباء أو في ملكية شركة تجارية أو شخص اعتباري خاضع للقانون الخاص لا يهدف إلى الحصول على الربح، وذلك وفق الشروط التالية :

- اللاذن بإنشاء المصحات و استغلالها
- قواعد تسيير المصحات و تنظيمها: اللجنة الطبية للمؤسسة ولجنة الأخلاقيات، المدير الطبي للمصحة، شروط المزاولة داخل المصحة، افتحاص المصحات و تفتيشها(نص تنظيمي)
- ممارسة الطب الشغل؛ طب المراقبة؛ طب الخبرة

الشراكة ما بين القطاع العام و القطاع الخاص

المادة 103 ق131-13

تحدد علاقات الشراكة بين القطاع العام و القطاع الخاص من أجل سد الخصاص في الخدمات الطبية بموجب اتفاقيات بين الإدارة وممثلي القطاع الخاص المعني، مع مراعاة النصوص التشريعية الجاري بها العمل.

مشروع إحداث الهيئة الوطنية الاستشارية للتنسيق بين القطاعين العام والخاص

الطب عن بعد

المادة 99 من القانون

يمكن للأطباء المزاولين في المصالح العمومية للصحة وللأطباء المزاولين في القطاع الخاص وكذا المؤسسات الصحية العمومية والخاصة، أن يلجؤوا في إطار عرض العلاجات والخدمات الصحية إلى الطب عن بعد في إطار احترام أحكام هذا القسم والنصوص المتخذة لتطبيقها وكذا المقتضيات التشريعية و التنظيمية المتعلقة بحماية الأشخاص الذاتيين تجاه معالجة المعطيات ذات الطابع الشخصي، خاصة المحافظة على سرية المعطيات و التقارير المضمنة بالملف الطبي للمريض و المتعلقة بإنجاز العمل الطبي عن بعد.

- مشروع مرسوم و دراسته مع الشركاء المعنيين بالأمر

استراتيجية النهوض بالقطاع الصحي 2017-2021

- تجاوز إكراهات نقص الموارد البشرية الصحية:
  - تشجيع التعاقد مع أطباء القطاع الخاص لسد النقص الراهن،
  - انتداب أطر طبية من القطاع الخاص أو العام للاشتغال على الأقل مرة في الأسبوع بالمراكز الصحية القروية المغلقة، في إطار عقد محدد الأجل.

تعزيز التأطير القانوني والتنظيمي:

- بلورة وإصدار حوالي 95 نصا تشريعيا وتنظيميا:
  - 20 مشروع قانون (6 منها معروضة حاليا على أنظار البرلمان)،
  - 25 مشروع مرسوم،
  - و50 قرار،
- إحداث الوكالة الوطنية للصحة العامة،
- إحداث الهيئة الوطنية الاستشارية للتنسيق بين القطاعين العام والخاص،
- إحداث الوكالة الوطنية للأدوية والمنتجات الصحية

12

هيئات التشاور في المجال الصحي

المادة 30 ق 34-09

من أجل ضمان انسجام أعمال المنظومة الصحية وتحسين حكامتها وتمكين مختلف الشركاء من المساهمة الفعالة في هذه المنظومة، تحدث الهيئات التالية :

- مجلس وطني استشاري للصحة ؛
- لجنة وطنية للأخلاقيات ؛
- لجنة وطنية استشارية للتنسيق بين القطاع العام والقطاع الخاص ؛
- لجنة وطنية ولجان جهوية لعرض العلاجات ؛
- لجنة وطنية لليقظة والأمن الصحي ؛
- لجنة وطنية للتقويم و الاعتماد.

11

قانون رقم 86.12
يتعلق بعقود الشراكة بين القطاعين العام والخاص

يهم كل المجالات بما فيها قطاع الصحة

وفي هذا الصدد، فإن تطوير الشراكة بين القطاعين العام والخاص، يمكن تحت مسؤولية الدولة، من تعزيز :

- توفير خدمات وبنيات تحتية اقتصادية واجتماعية وإدارية ذات جودة وبأقل تكلفة ؛
- يتولى الشريك الخاص تقديم الخدمات موضوع مشاريع الشراكة مع التقيد بمبدأي المساواة بين المرتفقين واستمرارية المرفق ؛
- تقاسم المخاطر المرتبطة بها ما بين القطاعين العام والخاص ؛
- تنمية نماذج جديدة لحكامة المرافق العمومية داخل الإدارات العمومية على أساس الفعالية ؛
- وكذا إلزامية المراقبة والتدقيق في عقود الشراكة خاصة شروط وأحكام الإعداد والإسناد والتنفيذ.

علاوة على ذلك، وتطبيقا لمبدأ الشفافية والحق في الولوج إلى المعلومة، فإنه أصبح من الواجب نشر أهم البيانات المتعلقة بعقود الشراكة.

14

مرسوم رقم 2.12.507 صادر في 28 من ربيع الأول 1436 (20 يناير 2015) يتعلق بوضعية الأطباء وأطباء الأسنان بالقطاع الخاص المتعاقدين مع وزارة الصحة.

المادة الأولى

يجوز لوزارة الصحة، عندما تدعو حاجة المصلحة إلى ذلك، أن تلجأ عن طريق التعاقد إلى أطباء عامين أو متخصصين و إلى أطباء أسنان من القطاع الخاص لمزاولة مهنهم لبعض الوقت بمؤسسات صحية تابعة للوزارة، واقعة في دوائر إدارية حيث يكون عرض العلاجات غير كاف إما من حيث أعداد الأطباء أو أطباء الأسنان أو من حيث المؤهلات الطبية.

المادة 2

تحدد بقرار لوزير الصحة الدوائر الإدارية وكذا لائحة المؤسسات الصحية المعنية بالتعاقد.

المادة 3

يتم اللجوء إلى الأطباء وأطباء الأسنان بالقطاع الخاص بعد إعلان وزارة الصحة عن طلب لتقديم الترشيحات.

13

نظام الترخيصات و التنسيق المؤسساتي: آليات التنسيق

- نظام الترخيصات
- "يحدث نظام للترخيص لجميع هذه المنشآت". المادة 27 من القانون 34-09
- التنسيق المؤسساتي
  - هيئات الحكامة:
    - لجنة استشارية وطنية للتنسيق بين القطاع العام والقطاع الخاص؛
    - لجنة وطنية ولجان جهوية لعرض العلاجات؛
  - آليات لتنسيق العلاجات: شبكات ومسالك العلاجات، مصالح المساعدة الطبية الاستعجاليةSAMU

"تحدث آليات خاصة لتنسيق الخدمات العلاجية بين مؤسسات القطاعين العام والخاص، وبين مختلف مستويات التكفل الطبي الاستشفائي والخارجي والمتنقل، ولاسيما:

* مسالك ومستويات العلاج المنظمة على أن تبتدئ من أطباء الطب العام بالنسبة للقطاع الخاص ومن مصالح الخدمات الصحية الأساسية بالنسبة للقطاع العام؛
* شبكات منسقة للعلاج تهم بالخصوص المرضى المصابين بمرض يستوجب تكفلا شاملا متعدد التخصصات؛
* أنظمة لضبط مصالح المساعدة الطبية الاستعجالية SAMU." المادة 16 من القانون 34-09

الشراكة بين القطاعين العام والخاص

-"يجوز للمؤسسات الصحية التابعة للقطاع الخاص أن تساهم، بناء على دفتر تحملات، في أعمال الصحة العمومية في إطار التكامل بين القطاعين العام والخاص.

وفي هذا الصدد، سيتم وضع أنماط للشراكة بين القطاعين العام والخاص لتمكين القطاع الخاص من المشاركة في مهام المرفق العمومي للصحة، لاسيما عن طريق التدبير المفوض والمشاركة لتنفيذ أعمال مشتركة أو عن طريق شراء خدمات صحية من القطاع الخاص تكون غير متوفرة أو غير كافية في المؤسسات الصحية التابعة للقطاع العام." المادة 15 من القانون 34-09

-"يجوز الترخيص بالاستغلال المشترك لهذه المنشآت أو لبعض التجهيزات من قبل عدة مؤسسات صحية." المادة 27 من القانون 34-09

-"يمكن أن يستفيد من تدابير مشجعة على الاستثمار في مجال الصحة، طبقا للشروط المنصوص عليها في المقتضيات التشريعية والتنظيمية الجاري بها العمل، مع مراعاة دفتر تحملات تضعه الإدارة... مؤسسو المؤسسات الصحية الخاصة الذين يقبلون الانخراط في شبكة علاجات ذات منفعة عامة التي تحددها الإدارة، في إطار مشروع شراكة بين القطاعين العام والخاص." المادة 29 من القانون 34-09

قيمة الخريطة الصحية

- الغرض منها
  - -القدرة على أجرأت السياسات الصحية العمومية (الوقاية، الصحة بالعالم القروي، الإشراف الطبي...)
  - -القدرة على تيسير ولوج الساكنة الفعلي إلى مجموعة من العلاجات والخدمات الصحية.
- شروط نجاعتها
  - مستويات الإنصاف والقرب؛
  - التكامل بين القطاعات المعنية (بالنشاط)؛
  - درجة مشاركة الساكنة وإشراك أصحاب المصلحة؛
  - الأثر على التحكم في النفقات الصحية؛
  - المساهمة في التنمية الجهوية / الإقليمية؛

دور الخريطة الصحية
والمخطط الجهوي لعرض العلاجات

المادة 20 من القانون 34-09

"الخريطة الصحية والمخطط الجهوي لعرض العلاجات [SROS] يهدفان إلى:

- توقع التطورات الضرورية لعرض العلاجات العمومية والخاصة وتحفيز أجرائها، (دور تخطيطي)
- وذلك قصد (دور تنظيمي):
  - الاستجابة على النحو الأمثل، لحاجيات الساكنة من العلاج والخدمات الصحية،
  - وتحقيق الانسجام والإنصاف في التوزيع المجالي للموارد المادية والبشرية،
  - وتصحيح الاختلالات بين الجهات وداخل كل جهة،
  - والتحكم في نمو العرض."

البعد الدستوري للخريطة الصحية
الملاحظة العامة 14 (2000)PIDESCوفقا للمادة 12 من العهد الدولي الخاص بالحقوق الاقتصادية والاجتماعية والثقافية

- الحق في الصحة يعني، ضمنياً، وجود العناصر المترابطة والأساسية التالية:
  - التوفر (الكفاية)
  - الولوجية: تشتمل على 4 أبعاد متداخلة بعضها:
    - عدم التمييز،
    - الولوجية المادية،
    - الإمكانية الاقتصادية (القدرة على تحمل التكاليف)،
    - إمكانية الحصول على المعلومة.
  - المقبولية (الاعتماد الثقافي).
  - الجودة (الاعتماد التنظيمي والعلمي).

أبعاد الخريطة الصحية

- بعد "وصفي" يخص القطاعين العام والخاص:
  - وظيفة "الدليل": BOSS (المغرب)؛ FINESS (فرنسا)
  - "تحدد الخريطة الصحية، على المستوى الوطني وبين الجهات وعلى مستوى كل جهة، مجموع البنية التحتية الصحية الموجودة ؛ ..." المادة 23 من القانون 34-09
  - "... يحدد المخطط الجهوي لعرض العلاجات، بالنسبة إلى كل عمالة أو إقليم، مع مراعاة الخريطة الصحية وتبعا للتقطيع الصحي داخل الجهة وكذا على أساس تحليل الحاجيات، ما يلي: جرد البنية التحتية الصحية الموجودة؛ التوقعات المرتقبة للمؤسسات الصحية والأسرة والأماكن والتخصصات والمنشآت العمومية والخاصة الثابتة والمتنقلة والتجهيزات الثقيلة وكذا توزيعها المجالي."
- بعد "معياري" يخص القطاع العام:
  - "يتم إحداث وتوطين كل مؤسسة صحية عمومية طبقا للخريطة الصحية والمخطط الجهوي لعرض العلاجات." المادة 26 من القانون 34-09
- بعد "تحفيزي" يخص القطاع الخاص:
  - « يتم إحداث وتوطين المصحات والمؤسسات الخاصة التي تدخل في حكمها، وعيادات الفحص بالأشعة ومختبرات التحاليل الطبية بالاستناد إلى توجيهات الخريطة الصحية والمخططات الجهوية لعرض العلاجات» المادة 26 من القانون 34-09
  - يمكن أن يستفيد من تدابير مشجعة على الاستثمار في مجال الصحة، طبقا للشروط المنصوص عليها في المقتضيات التشريعية والتنظيمية الجاري بها العمل، مع مراعاة دفتر تحملات تضعه الإدارة: مؤسسو المؤسسات الصحية الخاصة، الذين لا تهدف إلى الربح، الذين يقبلون احترام الخريطة الصحية؛ الأطباء وأطباء الأسنان الذين يقبلون الخضوع للخريطة الصحية والمخططات الجهوية لعرض العلاجات؛ مؤسسو المؤسسات الصحية الخاصة الذين يقبلون الانخراط في شبكة علاجات ذات منفعة عامة التي تحددها الإدارة، في إطار مشروع شراكة بين القطاعين العام والخاص." المادة 29 من القانون 34-09.التوزيع المجالي والتوقعات المرتقبة في إعداد الموارد البشرية..." المادة 24 من القانون 34-09

Presentation 4: Healthcare PPP Opportunities in the Kingdom of Bahrain | Dr. Raja Al Yusuf

Dr. AlYusuf presented an overview of the structure of the health care system in Bahrain, and the challenges facing it. The major challenges she cited included demographic changes, the increase in the prevalence of chronic non-communicable diseases, and the sustainability of financing health services (high cost of care vs. limited financial resources). She highlighted how the government of Bahrain had turned those challenges into opportunities for PPPs, adding that enhancing the role of the private health sector is a national priority and the regulatory framework is being revised to facilitate health sector investment. An aging and growing population and changing lifestyle trends are driving a demand for health services and the involvement of the private sector. She outlined a number of PPP opportunities, including partnerships in management of specific areas of health care, such as hospices for geriatric and palliative care; provision of public health services whenever the capacity of the public sector is saturated; contract management, especially locums or staff involved in job-sharing or flexible hours, or on demand; skill development in specific areas; asset management and investment; social marketing and re-branding; home-care teams; telemedicine and mobile health; management of leases of major services to the private sector; outsourcing of support services; partnerships in pharmaceutical procurement and supply; operation of private wards; and "front desk" management. Finally, she discussed Bahrain's National Social Health Insurance Program, one of the key priorities of the National Health Plan (2016-2025).

Kingdom of Bahrain

Healthcare PPP Opportunities in the Kingdom of Bahrain

November 2017

Healthcare in Bahrain

Health Service Providers	28 Government Primary Health Centers 3 Government Hospitals 18 Private Hospitals
Hospital Beds	1,500 Public Sector Beds 600 Private Sector Beds
Health Sector KPIs	25.3 Physicians per 10,000 population 50.1 Nurses per 10,000 population
Health Expenditure	3.3 % of GDP 461.4 Total Health Expenditure (BHD m) 129.7 Private Health Expenditure (BHD m)

MAJOR CHALLENGES

- **Demographic changes**
  - Increasing life expectancy
  - Increase in population
  - Increase in the geriatric population group
- **Increase in the prevalence of chronic non-communicable diseases**
- **Sustainability of financing health services**
  - High cost of care vs Limited financial resources

Investment and Partnership Opportunities

Competitive advantages

Government support	Enhancing the role of the private health sector is a national priority and the regulatory framework is being revised to facilitate health sector investment
Demographic trends	An aging and growing population and lifestyle trends are driving demand for health services
Access to regional market	Bahrain's strategic location enables access to the GCC market
National Cadres	Bahrain has a strong national health workforce in terms of doctors, nurses, and allied health professionals.

Investment opportunities

Specialist health services

- National Diabetics Center
- National Dialysis Center
- Drug Rehab Facilities
- Pediatric Hospital
- Neurosurgery Center

Utilization of surplus capacity in government

PPP Opportunities at Hospital Level..1/3

- Partnership in management of specific areas of healthcare such as hospices for geriatric and palliative care
- To provide public health services whenever the capacity of the latter is saturated.
- Contract management especially locums or staff involved in job sharing or flexible hours or on demand, etc…



PPP Opportunities at Hospital Level..2/3

- Skill development in specific areas, example: financial skills, business development, etc…
- Asset management and investment
- Social Marketing and re-branding
- Home Care Teams
- Telemedicine and mobile health

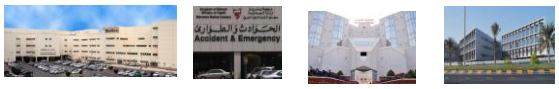


PPP Opportunities at Hospital Level..3/3

- Management of leases of major services to the private sector (Example: MRI services, Central laboratory services, etc..).
- Outsourcing of support services
- Partnership in pharmaceutical procurement & supply
- Operation of private wards
- "Front Desk" management

Current Health Sector Structure

Monitoring and Policy Setting	Supreme Council of Health / National Health Regulatory Authority	Ministry of Health	Bahrain Defense Force (BDF)	
Financing	Ministry of Finance		Private Health Insurance Companies	
Service Delivery	MOH Hospitals and Primary Healthcare Centers	BDF Hospital & Mohamed bin Khalifa Cardiac Center	King Hamad University Hospital	Private Hospitals and Clinics



National Social Health Insurance- SEHATI

The National Social Health Insurance Program is one of the key priorities of the National Health Plan.

Key Elements

Enhance the health system's structure	Change the funding mechanism	Enhance health services	Change service provider's operational mechanisms
•Separate the service providers from MOH •Establish the Health Insurance Fund to collect payments and contract with service providers •Establish a center for health information and knowledge «HIKMA», to operate under the SCH	•Mandatory financing by the government for Bahrainis and by employers for residents •Replace the current funding system with one based on an annual per capita actuarial value	•Ensuring access to health services for all based on the basic services package •Provide a patient safety net for citizens and residents and reduce the need for direct spending	•Enhance the operational autonomy of public service providers •Encourage competition among service providers to provide the best quality and most affordable services •Boost private sector involvement in healthcare

Review Health Laws

National Health Plan (2016-2025)

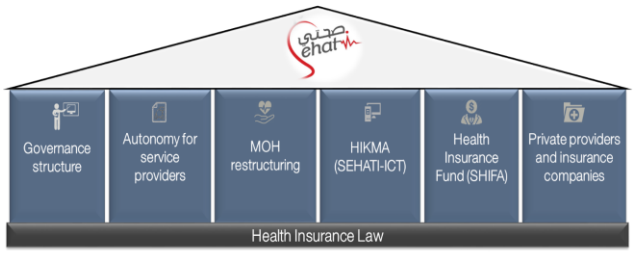
Vision: A Healthy Bahraini Society with access to just, competent, and high quality healthcare.

Seven key strategic thrusts

Health Service Delivery Methods: Integrated and Sustainable Healthcare Methods, Focused on Health Promotion	Health Service Funding: Controlling and Directing Health Service Expenditure and Funding	Capacity Building: Recruiting Qualified Staff and Developing Human Resources	Leadership and Governance: Setting Leadership Roles for Governmental Health Institutions in the Kingdom
Health Service Quality and Safety: Raising Quality and Safety Standards of Healthcare Services and Ensuring their Continuity	National Health Insurance Program: Sustainable Financial System that Guarantees Freedom of choosing health provider	Health Information Systems: A strong and effective infrastructure for operating different health information systems and E-Health	

The plan aims to boost support to the Private Sector and Public-Private partnerships, to make the Kingdom a leading regional healthcare destination

National Social Health Insurance Program (SEHATI): Key Pillars



Kingdom of Bahrain

Thank You

Session 4: Pharmaceutical Industry and Technology Profitability

Chairperson: Nagla Altigani | Health ministry, Saudi Arabia
Speakers: Adham Ismail | WHO/EMRO
Sarbani Chakraborty | Roche, EMEA
Ashraf El-Khouly | ESPR, Pfizer

Day two started with a wrap-up by Dr. Rabbat of the key messages delivered on day one, including:

1. The need to harness the rapidly growing private sector towards national policy goals;
2. Governance is an important step in public-private engagement;
3. There are many forms and models of PPP. It could involve service provision, information and education, infrastructure or capacity building;
4. Successful public-private partnership necessitates the presence of a strong public sector.

Presentation 1: Health Technology Industry and Profitability: *A WHO Perspective* | Dr. Adham Ismail

Dr. Adham Ismail is a senior biomedical engineer with over 20 years of experience as an international healthcare technology professional. Dr. Ismail is currently in charge of the essential medicines and health technology program in the Eastern Mediterranean Regional Office of WHO. His current duties involve assisting Member States in developing national strategies and programs in the area of health technologies (including medical devices and assistive products); designing regional tools/guidelines; promoting intersectoral collaboration with relevant institutions; and strengthening national capacity in developing Health Technology Assessment (HTA) and Management (HTM) systems. Dr. Ismail is a graduate of: (1) Alexandria University, where he earned a BS in Electrical and Communications Engineering in 1991 and an MSc in Biomedical Engineering in 1994, (2) University of Miami - USA, where he earned his Ph.D. degree in Biomedical Engineering in 1998, and (3) Arab Academy for Science and Technology, where he complemented his managerial abilities by obtaining an MBA in 2004. Dr. Ismail has published many articles in renowned engineering journals and has participated in many national and international conferences.

Dr. Ismail gave a presentation the health technology industry and profitability from the WHO's perspective. He started his presentation by defining key concepts such as universal health coverage, health technology assessment (HTA), and private sector, and looked at the role of technology in contemporary health systems, where it forms the foundation for prevention, diagnosis and treatment of illness and disease. Thousands of new technologies are introduced each year, and technology and health systems are interdependent: a sustainable supply of technologies requires functional health systems and vice versa. He then highlighted key roles that the private sector could play, including managing innovations, complying with national regulatory authorities (NRAs), lowering costs to fit into health care technology assessment requirements, adhering to national health technology (supply chain) management requirements, and discussing PPP options that will provide win-win situations. Dr. Ismail added that through such partnerships, developing countries can strengthen capacities to design and locally produce medical products. Furthermore, successful partnerships should stimulate new ideas, from concept to manufacture, marketing, and uptake, although to avoid rejection these new ideas should take into account local values and culture. He concluded his presentation by reiterating that expensive, cutting-edge technologies are often perceived as an indicator of high quality services; however, they may lead to a disproportionate escalation in health care delivery costs and he argued that creating appropriate products for different resource settings requires in-depth understanding of the particular needs and resource capacities of each country.

Health Technology Industry and Profitability:

A WHO Perspective

Adham R Ismail, MSc, MBA, PhD
Coordinator a.i.. Essential Medicines and Health Technologies (EMT)
Regional Adviser, Health Technology and Biomedical Devices (HMD)
Department of Health Systems Development (HSD)
Eastern Mediterranean Regional office (EMRO)
World Health Organization (WHO)

2017

Introduction

"He who has health, has hope; and he who has hope, has everything"
Thomas Carlyle (1795-1881)

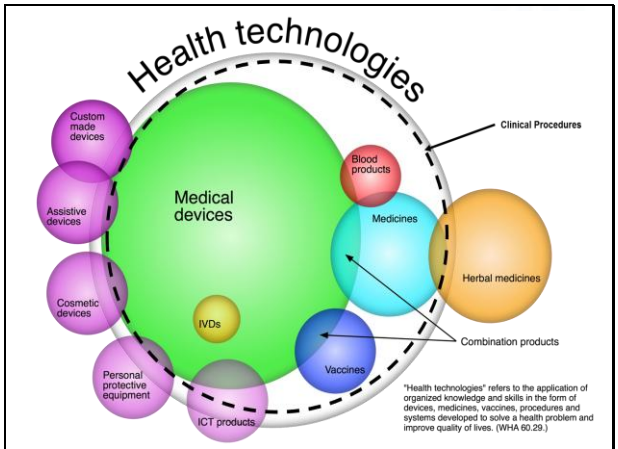
- **MS**: •This simply means that authorities have the responsibility to promote and protect population health.
- **UHC**: • This can be materialized through UHC, the leitmotif for the coming decade.
- **HT**: • Polices, Regulation, HTA, and HTM are government functions that provide the rules of the game.
- **Private**: • Private sector may be competing with the public health sector but rules should be applied to both sectors.

What is a Health Technology (HT)?

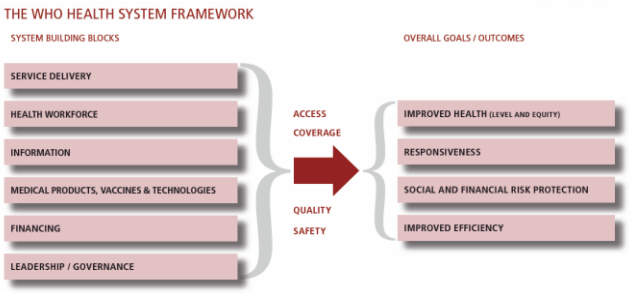
- WHO experts define HT as;

" The application of organized knowledge and skills in the form of devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve quality of lives".

- This definition also encompasses traditional medicine, health promotion & prevention activities and information systems.

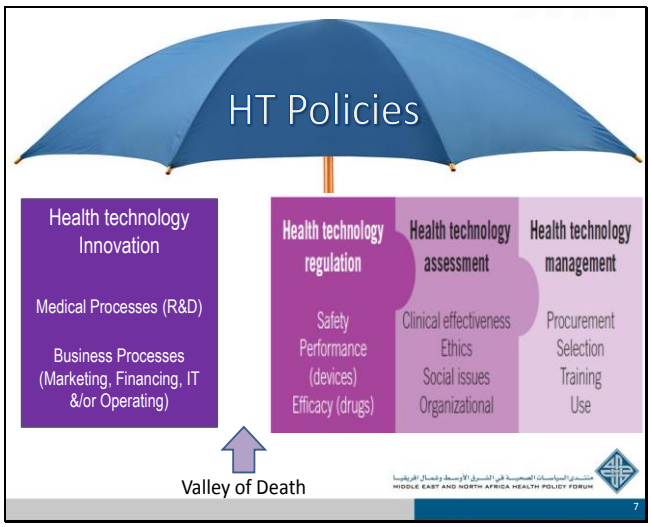


HT in WHO Health System Framework



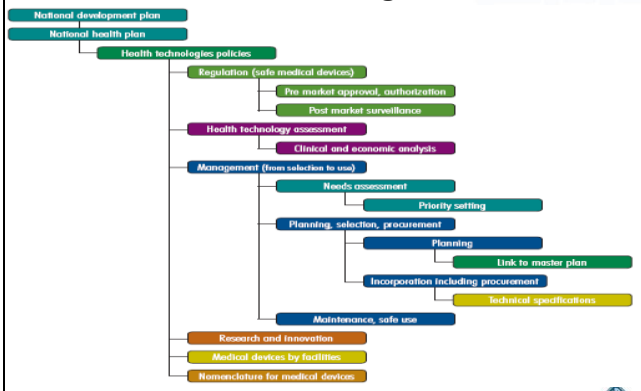
HT in Contemporary Health Systems

- They form the foundation for prevention, diagnosis and treatment of illness and disease.
- Thousands of new technologies are introduced into practice each year.
- Technologies and Health Systems are interdependent: *Sustainable supply of technologies require functional health systems and vice-versa.*

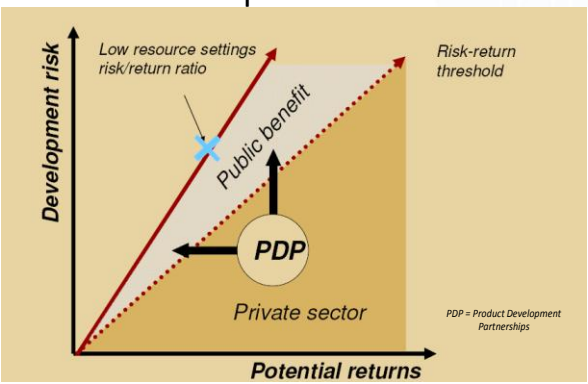


Achieve safety, quality, equity and universal coverage

From Plan to the strategies and actions



Partnerships for Public Benefit

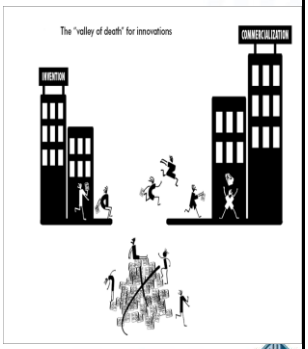


Private Sector and Innovations:
Partnership for Local Innovation

- Local innovation is possible in settings where they are needed, provided that infrastructure is available locally to:
  - Attract competent personnel;
  - Link invention and design to health-related needs;
  - Use local materials and expertise; and
  - Launch the product into appropriate networks for distribution to populations.
- Through partnerships, developing countries can strengthen capacities to design and locally produce medical products.
- Transparency, rule of law, business conduct and IP to be addressed.
- Successful partnerships should stimulate new ideas from concept to manufacture, marketing, and uptake.
- To avoid rejection, these new ideas should take into account local values and culture.

Private sector and Innovation:
The Valley of death

- Lack of funding can kill good ideas before hitting the market.
- At this stage, risk for innovators is high & profit is uncertain.
- Private sector stay away and prefer to fund more mature projects.



Private sector and Innovations:

Out-of-Context Situation

- Health professionals, especially in low-resource settings, often develop ideas for improving medical products.
- Difficulties faced in moving innovations forward can be due to:
  - Lack of local research infrastructure
  - Little encouragement for local innovations
  - Lack of marketing mechanisms
- This leads to an out-of context situation where:

"Medical Products for low-resource settings are developed in high-resource settings".

Private sector and Regulations:

Is it a hurdle?

- Regulations ensure safety but can also be a financial burden on designers and manufacturers, especially in low-resource settings.
- For example:
  - Immunodiagnostic tests incur low development costs; however, costs are doubled or tripled when they are submitted to regulatory process for licensing.
- High regulatory costs can prompt companies to elude regulatory oversight and market their products in unregulated markets, thereby compromising patient safety.

Private Sector and Regulations:

The need for NRAs

- International standards vary from one local conditions to the other.
- Manufacturers are usually asking perplexing questions :
  - Should the same standards be applied everywhere?
  - Could standards be adapted to local conditions?
  - Could lowering standards lead to lowering overall HC standards?
  - What body could authorize such exceptions?
  - Would compliant manufacturers suffer a comparative disadvantage with respect to those who bend the rules?
  - Could compliant manufacturers be permitted to market their products at lower safety, quality, and/or performance than those necessary for other devices?
- National Regulatory Authorities (NRAs) at national, regional and global levels are required.

Private sector and Product Design:

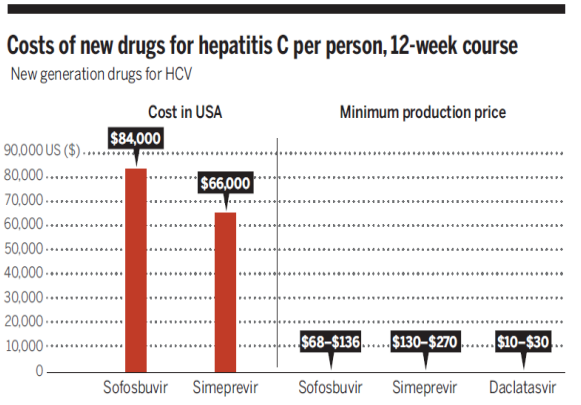
A balance is needed

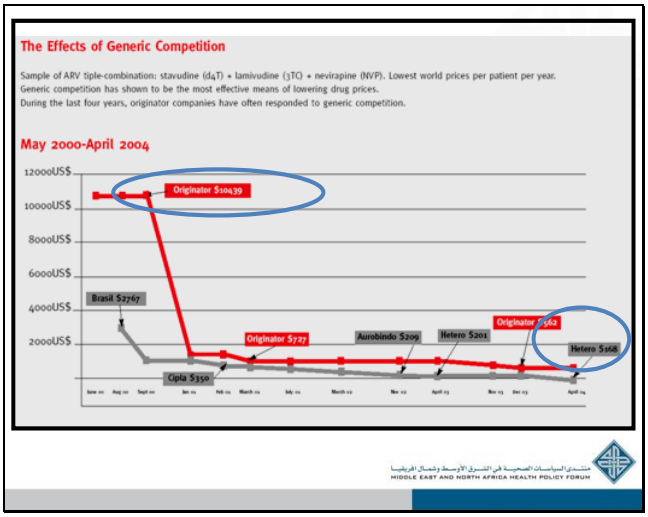
- Sometimes it is difficult to strike a balance between solving problems & creating new needs.
  - Disposable batteries may solve electricity shortage, but may require a supply chain and waste management.
- An example of inappropriate design is the failure of affordable wooden-seat wheelchairs to achieve widespread use among users in Nicaragua.
  - Though appropriate to local conditions (narrow doorways, high pavements and lack of access to buildings for wheelchair users), it required a cushion to prevent ulcers in people with spinal cord injuries.
  - Although cushions were provided during the first year of use, most people in Nicaragua could not afford a replacement once the cushions wore out.

Private sector and Pricing:

Diffusion and uptake

- Though their main purpose is to improve health, in many times medical products lead to escalation in HC expenditures.
- Efforts to reduce costs mean that some products will diffuse, while others will not.
- Conversely, inappropriate uptake can lead to overuse of products that may not meet urgent clinical needs.





Private sector and HTA:
The Thai Experience

In Thailand:
HTA uses <0.01% of health budget, and results in >$100 million/year savings from price negotiations alone.

Medicine	Original price (THB)	Reduced price (THB)	Potential saving (THB per year)
Oxaliplatin (injection 50 mg/25 ml)	8,000	2,500	152 million

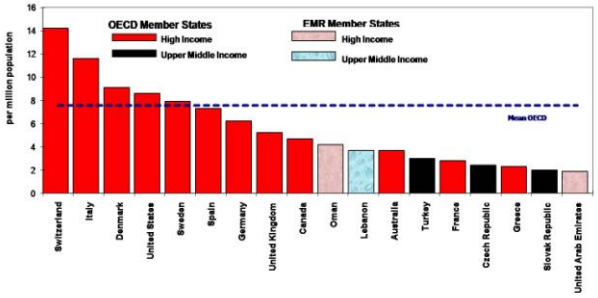
20

Private sector and HTA:
Investment Decisions

- Support in production of evidence to support decision making regarding investments made by the public sector.
- Examples of situations where HTA had to take decisions on cost-benefit of some drugs:
  - Exemestane for treating breast cancer
  - Pregabalin for neuropathic pain management
  - Combination therapy vs. intensification of stain monotherapy
  - Trastuzumab Adjuvant Treatment for Breast Cancer HER2+
  - Positron Emission Tomography (PET) Scanners
  - 3-Tesla Magnetic Resonance Imaging (MRI)
  - CT Scan 64 slice (single and dual)
  - Femto-second laser

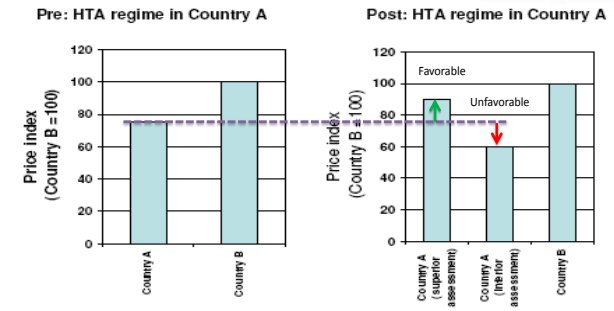
21

Will HTA decisions affect the private sector?
Procurement of MRI in EMR



22

Will HTA decisions affect Private Sector?
Pricing of Cancer Drugs



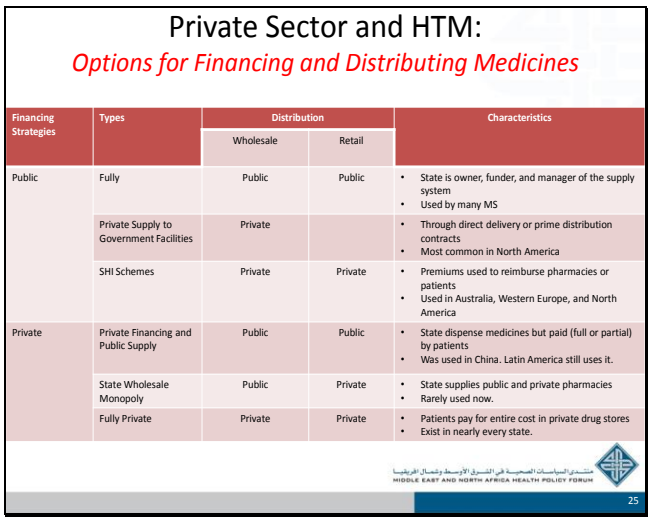
Source: CRA analysis

23

Private sector and HTM:
Is there a role to play?

- Focus will be on activities related to supply chain management; namely:
  - *Needs Assessment, Selection of priority and essential products, Procurement, Nomenclature, Donations, Safe Use, HR requirements, User Training , Inventory, Maintenance, CMMS and Waste Management*
- HT management, or clinical engineering can be located at the national, regional, or local (hospital) level.
- In some countries the national HT management team is part of a center of national excellence.
- It is of interest to the private sector to ensure that their products are adequately used for many reasons (user-related errors, vigilance, downfall times, proper storage, etc.)

24



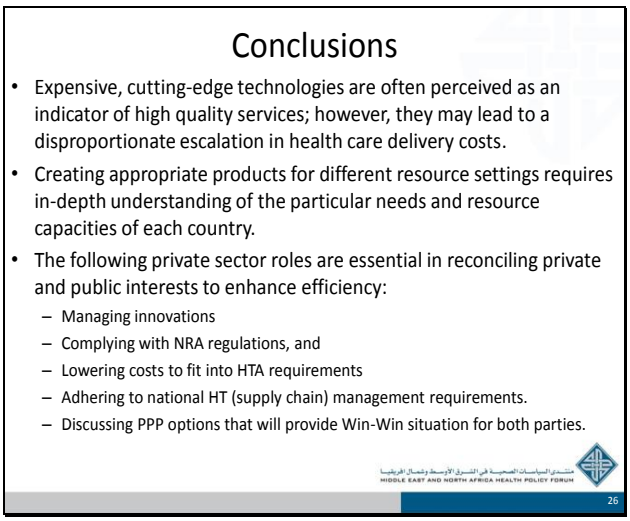
Private Sector and HTM:

Options for Financing and Distributing Medicines

Financing Strategies	Types	Distribution		Characteristics
		Wholesale	Retail	
Public	Fully	Public	Public	• State is owner, funder, and manager of the supply system • Used by many MS
	Private Supply to Government Facilities	Private		• Through direct delivery or prime distribution contracts • Most common in North America
	SHI Schemes	Private	Private	• Premiums used to reimburse pharmacies or patients • Used in Australia, Western Europe, and North America
Private	Private Financing and Public Supply	Public	Public	• State dispense medicines but paid (full or partial) by patients • Was used in China. Latin America still uses it.
	State Wholesale Monopoly	Public	Private	• State supplies public and private pharmacies • Rarely used now.
	Fully Private	Private	Private	• Patients pay for entire cost in private drug stores • Exist in nearly every state.

منتدى السياسات الصحية في الشرق الأوسط وشمال إفريقيا
MIDDLE EAST AND NORTH AFRICA HEALTH POLICY FORUM

25



Conclusions

- Expensive, cutting-edge technologies are often perceived as an indicator of high quality services; however, they may lead to a disproportionate escalation in health care delivery costs.
- Creating appropriate products for different resource settings requires in-depth understanding of the particular needs and resource capacities of each country.
- The following private sector roles are essential in reconciling private and public interests to enhance efficiency:
  - Managing innovations
  - Complying with NRA regulations, and
  - Lowering costs to fit into HTA requirements
  - Adhering to national HT (supply chain) management requirements.
  - Discussing PPP options that will provide Win-Win situation for both parties.

منتدى السياسات الصحية في الشرق الأوسط وشمال إفريقيا
MIDDLE EAST AND NORTH AFRICA HEALTH POLICY FORUM

26

Presentation 2: Access to Innovative Medicines in UHC: Advancing the Dialogue | Dr. Sarbani Chakraborty

Sarbani Chakraborty is currently Head of Public Policy for Eastern Europe, Middle East and Africa (EEMEA) Region, F. Hoffman La Roche, based in Basel, Switzerland. In this capacity, she is responsible for working with Roche country policy staff on access to medicines, oncology policy and public-private partnerships. She is also responsible for Roche's regional engagement with international organizations and NGOs. Prior to joining Roche in May 2017, Sarbani worked as Head of Global Health Policy for Merck, based in Darmstadt, Germany (2013 – 2016). Prior to joining the pharma sector, Sarbani worked for 16 years with the World Bank as a Senior Health Specialist. At the Bank, she worked on health financing, public expenditure management and universal health coverage. Sarbani has Ph.D. in Health Policy from Johns Hopkins University. She is currently guest lecturer in global health policy at the Center for International Health, Ludwig Maximillian University, Munich.

Dr. Chakraborty addressed the topic of access to innovative medicines in universal health coverage. She mentioned that, with a growing middle class, public expectations of emerging markets' health systems are rising. Furthermore, universal health coverage and implementation is weakest for noncommunicable diseases, even though they represent the bulk of the disease burden in emerging markets. She added that governments and industry have different views on access to innovative medicines, but they need convergence for sustainability. She clarified that transparent methods to assess the value of health technologies (i.e. health technology assessments), real world data/evidence, and outcome-based payment approaches are all needed to improve the dialogue between governments and the private sector. She further explained the difference between micro- and macro-level health technology assessments, explaining that micro-level HTAs usually focus on short-term cost containment rather than any system-wide focus on achieving value, while macro-level HTAs are about the efficiency of the organizational system or architecture of the health care system, remuneration systems and provider incentives. She concluded that a stronger focus of limited health technology assessment resources on "macro" aspects of health system architecture may yield higher gains in the mid- to long-term.

Access to Innovative Medicines in UHC: Advancing the Dialogue

Sarbani Chakraborty, Head, Public Policy, Eastern Europe, Middle East and Africa, (EEMEA), Roche

Do Innovative Medicines matter for UHC?

Growing middle class, public expectations for emerging markets' health systems are rising.

UHC coverage and implementation is weakest for NCDs, in spite of the fact that they represent the bulk of the disease burden in emerging markets.

Better option than traditional treatments – inclusion of patented medicines on WHO EML

But people are worried about price

Sources:

Governments

Industry

My biggest challenge in providing more access within limited budget

Paying for outcomes sounds complicated. It will take too long to implement

We have so many needs – why would I reinvest my savings into innovative medicines

But investing in health care is securing social and economic value

It is important to look beyond medicines – improving efficiency of the system

Governments can easily reinvest savings into innovative medicines

GOV./PAYERS and INDUSTRY have different views on access to innovative medicines but we need convergence for sustainability

Move to Value Based Approaches can improve the dialogue between Governments and the Private Sector

- Transparent Methods to assess the value of health technologies (HTA)
- Real World Data/Real World Evidence
- Outcomes based payment approach

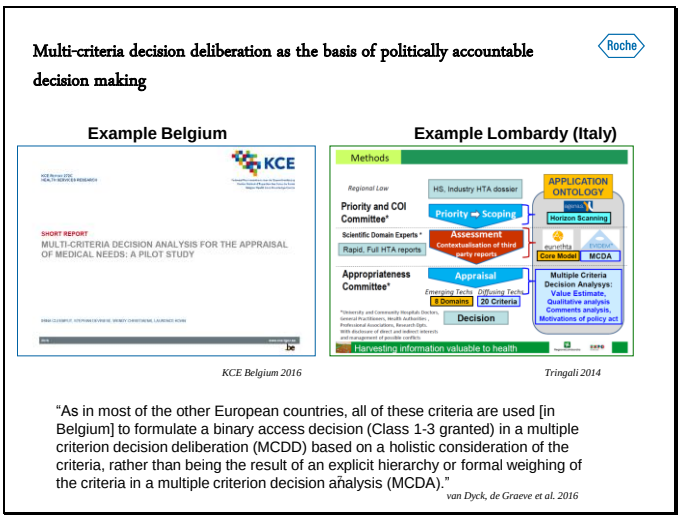
Micro- and macro-level HTA

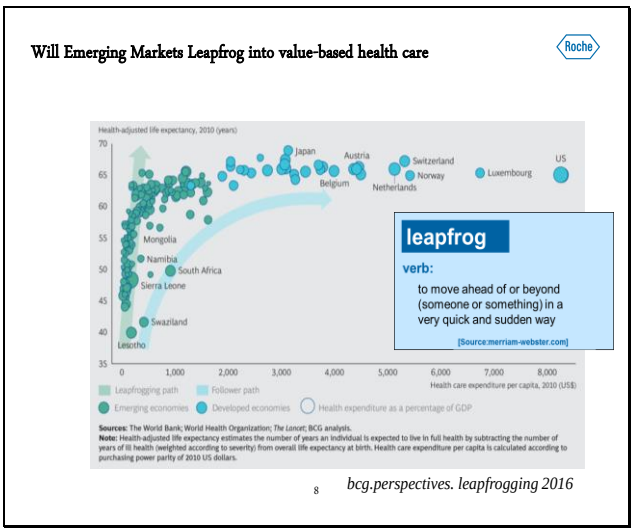
Towards a more efficient use of scarce HTA resources

- **micro-level" HTA** usually with focus on short term cost containment rather than any system wide focus on achieving value
  - appraisal of individual technologies, or groups of related technologies
- **"macro-level" HTA** which is about the efficiency of the organizational system or architecture of the health care system e.g.
  - primary care and hospital infrastructure (size, accessibility, quality standards)
  - public/private contribution in health care provision and regulatory options
  - renumeration systems and provider incentives

→ A stronger focus of limited HTA resources on "macro" aspects of health system architecture may yield higher gains mid- to long term

6





Presentation 3: Presecription Medicines: Cost in Context | Dr. Ashraf El Khouly

Dr. Ashraf Ahmed ElKhouly has nearly 29 years experience constantly working in multinational pharmaceutical companies mostly in senior management positions. He is currently filling the position of Corporate Affairs and Communication Director of Pfizer Egypt and Sudan from May 2013. Dr. ElKhouly is the chairman of the Egyptian Society of Pharmaceutical Research (ESPR). He is a board member of the Industrial Chamber of Pharmaceuticals, Cosmetics and Appliances. He was the Country Manager of Bayer Pharmaceutical for Egypt, Lybia, Sudan, and Yemen from April 2007 to February 2013 and the Country Manager of Schering AG for the Gulf countries from January 2001 to March 2007. He was the head of marketing of Schering AG for Saudi Arabia from January 1999 to January 2001. Dr. ElKouly has In Market experience in pricing, agents (distributors) agreements, marketing & sales covering major markets in the Middle East (Saudi, Gulf countries, Bahrain, Qatar, Kuwait, Emirates and Oman, Egypt, Libya, Sudan and Yemen).

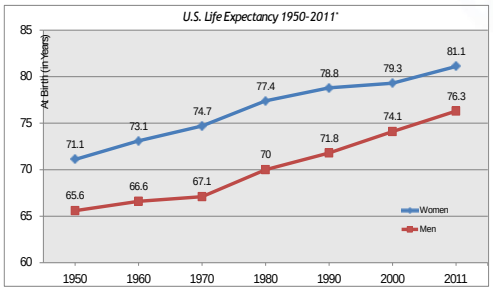
Dr. El Khouly presented on the context of prescription medicine costs, arguing that low investment in health care and innovative medicines contributes to lagging health outcomes. It takes on average 10 to 15 years to develop a new medicine from drug discovery to regulatory approval, and the process costs around $2.6 billion. He noted that the cost of developing new medicines has more than doubled over the past decade, and biopharmaceutical companies have invested billions to bring innovative therapies to the market. Biopharmaceutical companies use today's revenues to invest in tomorrow's treatments, he stated, emphasizing the need for a public policy environment that recognizes and rewards risk-taking. He added that key MEA markets have been starved of innovation and that lower relative income and higher out-of-pocket contributions translate into lower pharmaceutical sales in most cases. He concluded by affirming that reforms can make medicines more affordable and accessible. This should include a modernization of the drug discovery and development process, empowering consumers and lowering out-of-pocket costs, and promoting value-driven health care.

Prescription Medicines: Costs in Context

Increases in U.S. Life Expectancy

"While nutrition, sanitation, other public health measures, and expanded access to care have been major sources of increasing human health, innovative medicines have also played a profound role in this progress."

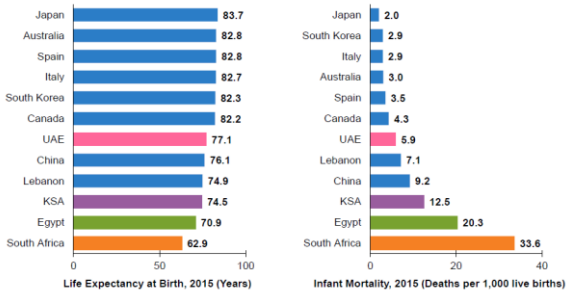
— The President's Council of Advisors on Science and Technology[1]



1. President's Council of Advisors on Science and Technology. "Report to the President on Propelling Innovation in Drug Discovery, Development, and Evaluation." Washington, DC:PCAST,September 2012.
2. U.S. Department of Health and Human Services (HHS), CDC, National Center for Health Statistics (NCHS) "Health, United States, 2009 with Chartbook," Hyattsville, MD: HHS, 2009. 1950-2006 data from M. Heron and "Deaths: Final Data for 2006," *National Vital Statistics Reports* 2009; 57(14): 5. Hyattsville, MD: NCHS. Available at www.cdc.gov/nchs/data/nvsr/nvsr57_14.pdf#page=5 (accessed June 2010). 2007 data from J.Xu, et al. "Deaths: Final Data for 2007," *National Vital Statistics Reports* 2010; 58(19): 13. Hyattsville, MD: NCHS. Available at www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf (accessed June 2010). 2008-2009 data from K.Kochanek, et al. "Deaths: Final Data for 2009," *National Vital Statistics Reports* 2011; 60(3): 9. Hyattsville, MD: NCHS. Available at www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_03.pdf (accessed March 2013) 2010–2011 data from D.L.Hoyert and J.Xu. "Deaths: Preliminary Data for 2011," *National Vital Statistics Reports* 2012; 61(6): 5. Hyattsville, MD: NCHS. Available at www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf (accessed December 2012).

ME&A Life Expectancy And Infant Mortality Rates Are Behind Developed Nations

Low investment in healthcare and innovative medicines contributes to lagging health outcomes



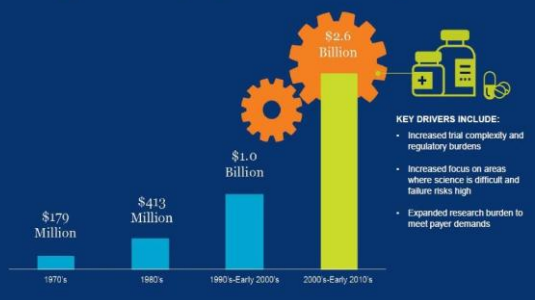
Source: Health Advances analysis; WHO Global Health Observatory Database (accessed September 2016).

The Biopharmaceutical Research and Development Process

From drug discovery to regulatory approval, developing a new medicine on average takes 10 to 15 years and costs $2.6 billion

The Cost to Develop a New Medicine More Than Doubled Over the Past Decade

Average Cost to Develop an Approved Medicine – Including Setbacks

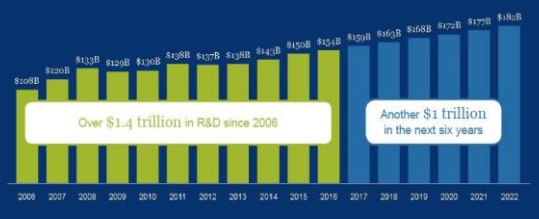


KEY DRIVERS INCLUDE:

- Increased trial complexity and regulatory burdens
- Increased focus on areas where science is difficult and failure risks high
- Expanded research burden to meet payer demands

Biopharmaceutical Companies Have Invested Billions to Bring Innovative Therapies to Market

Worldwide Pharmaceutical R&D Investment[1]



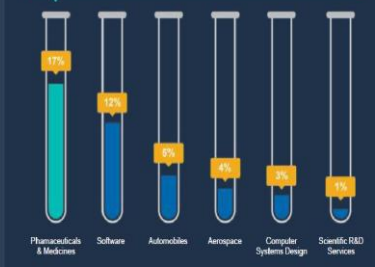
"The most important challenge facing the global research community is ensuring that populations regard its contributions as positive, responsible and legitimate. R&D policy is not just about throwing money at scientists and engineers – it is also about ensuring that their innovations can be brought into use, which is a quite different challenge."
– DOMESTIC CORPORATION, UK (DECEMBER 2013)[2]

Biopharmaceutical companies use today's revenues to invest in tomorrow's treatments and cures.

Invested about
$75 Billion
in R&D in 2015

And
20%
of revenues are reinvested into R&D

Industry invests **17%** of all domestic research and development funded by U.S. businesses



We need a public policy environment that recognizes and rewards risk taking.

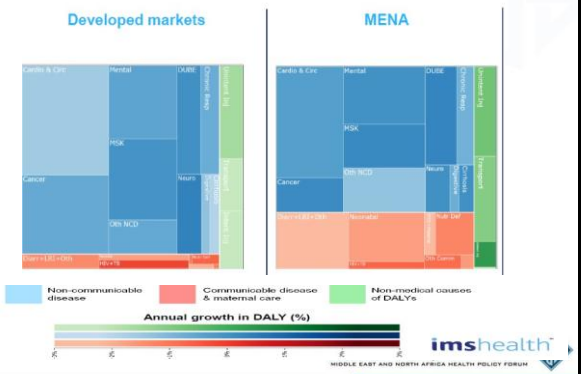
On average, it takes more than
10 years and $2.6B to research and develop a new medicine.

BETWEEN 1998 AND 2014

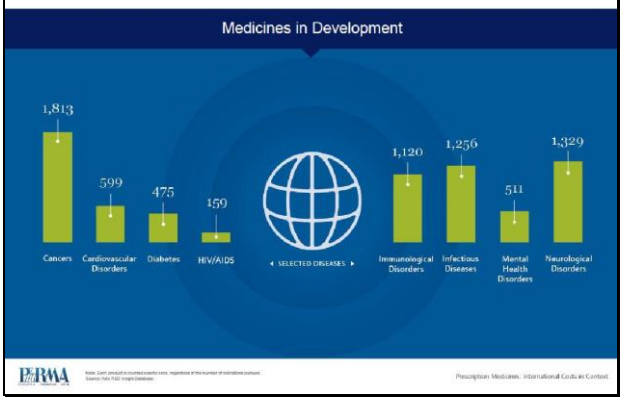
Unsuccessful Attempts		Successful Attempts
123 Alzheimer's Disease	Just **12%** of drug candidates that enter clinical testing are approved for use by patients	4 Alzheimer's Disease
96 Melanoma		7 Melanoma
167 Lung Cancer		10 Lung Cancer

Communicable disease burden in MENA

DALY: Disability-Adjusted Life Year



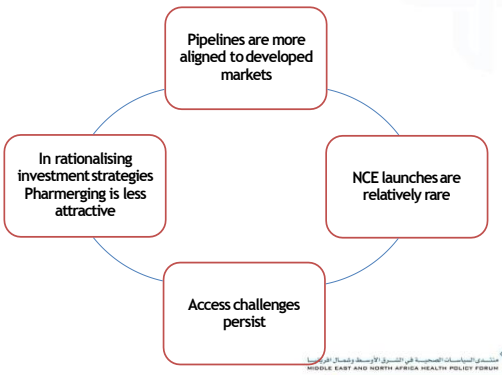
More Than 7,000 Medicines Are in Development Around the World



We are in a new era of medicine where breakthrough science is transforming care with innovative treatment approaches...

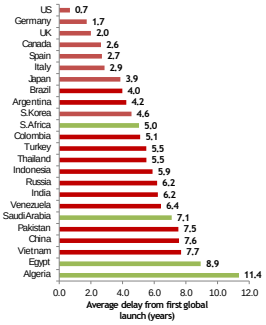
Then	Now
Medicines made of chemical compounds	Medicines made from living cells
Medicines treat broad diseases	Medicines targeted to specific patient based on genetic makeup
Radiation and chemotherapy to treat cancer	Immunotherapy that harnesses body's own immune system to fight disease
	CAR T-cell therapy
	CRISPR

Pharmerging risks being marginalised as Pharma shifts strategic focus



Key MEA markets starved of innovation (NCEs)

Delay between NCE global launch and local launch (Years)



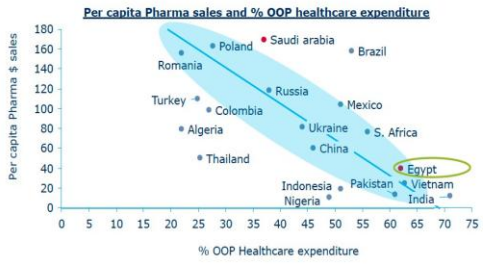
Top MEA markets NCE Launch

MEA	NCE's launched 2006-2010	NCE's launched 2011-2015
US	90	144
SAUDI ARABIA	13	13
EGYPT	6	9
ALGERIA	2	0
SOUTH AFRICA	18	5
UAE	19	30
MOROCCO	6	2

Increase in NCE launches

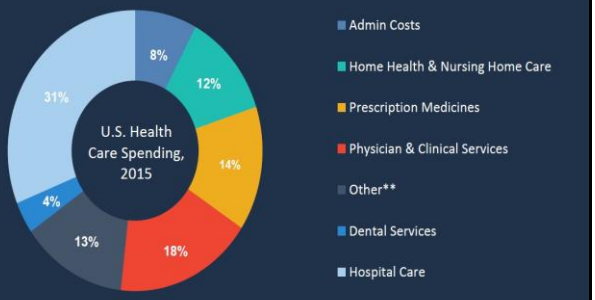
Decrease in NCE launches

Lower relative income and higher OOP contributions translates into lower pharma sales in most cases



Source: World Health Organization WHOSIS database; IMS analysis, IMS Global market prognosis 2012-2016

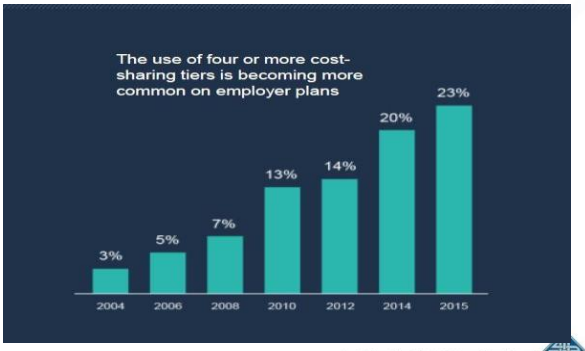
Spending on retail and physician-administered medicines continues to represent just 14% of spending…



Spending on prescription medicines is a small percentage of total health care spending around the world.

Prescription Medicines as a Percentage of Total Health Care Spending

Patients in the United States are facing rising out-of-pocket costs and other barriers to care.



More than 1/3 of the list price is rebated back to payers in US

Brand companies retain just 63% of list price spending on medicines

Rebates, discounts and fees keep increasing

In fact, after discounts and rebates, brand medicine prices grew just 3.5% in 2016.

Patients share the costs for their medicines. They should share the savings, too

- **Negotiated discounts for medicines are not shared with patients with high deductibles or coinsurance.** A new analysis from Amundsen Consulting found more than half of commercially insured patients' out-of-pocket spending for brand medicines is based on the full list price.
- **Insurers should share more of these rebates with patients.** Providing access to discounted prices at the point-of-sale could dramatically lower patients' out-of-pocket costs.

Your insurer doesn't pay full price for medicines.

So why do you?

Patients share

Reforms can make medicines more affordable and accessible.

MODERNIZE THE DRUG DISCOVERY AND DEVELOPMENT PROCESS

- Modernize the authorities to keep pace with scientific discovery and increase efficiency of generic approvals
- Promote and incentivize generic competition.

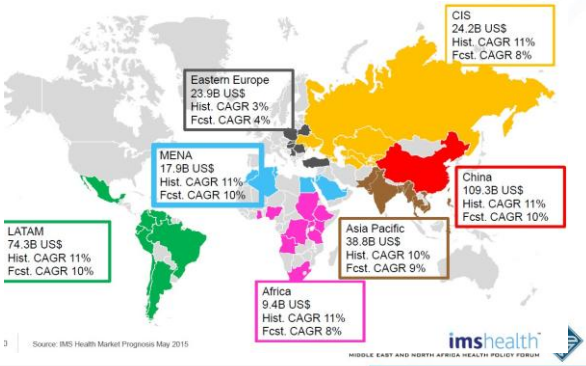
EMPOWER CONSUMERS AND LOWER OUT-OF-POCKET COSTS

- Provide patients with access to negotiated rebates.
- Address affordability challenges in the deductible.
- Make more information on health care out-of-pocket costs and quality available to patients.

PROMOTE VALUE-DRIVEN HEALTHCARE

- Remove barriers restricting information companies can share with insurers.
- Reform regulations discouraging companies from offering discounts tied to outcomes.

At a macro level MENA is not the largest but it has attractive growth rates



Session 5: Regulation to Prevent Abuse of Market Power

Chairperson: Ibrahim Aqel| IFH, Jordan
Speakers: Hala Abou-Taleb| WHO/EMRO
Chokry Arfa| University of Carthage, Tunisia
Sherine Shawky| AUC-SRC, Egypt

Presentation 1: Regulation of Public-Private Partnerships to Advance towards Universal Health Coverage

Dr. Hala Abou Taleb is an advisor at the Eastern-Mediterranean Regional Office (EMRO) of the World Health Organization. She holds a Master degree in Public Health and Epidemiology and a Ph.D. in Community Medicine and Social Science from the Kasr Al Aini medical school and the London school of hygiene and tropical medicine. She works on issues related to the strengthening of health system governance to progressively achieve universal health care coverage (UHC). Her research also covers the promotion of the right to health and equity, public health law, health diplomacy and policy planning, and development. Since 1999 Dr. Abou-Taleb worked for various United Nations organizations including UNFPA, and UNAIDS Regional Office for Middle East and North Africa.

Dr. Abou-Taleb presented on the regulation of PPPs in order to advance towards universal health coverage. She defined PPP as a long-term partnership in the form of a legal contract between the public sector and the private sector. Under the contract, a public asset is managed or service provided while the private party bears significant risk and management responsibility, and remuneration is linked to performance. She highlighted the governing rules for successful PPP contracts and that PPP contracts typically allocate each risk to the party that can best manage and handle it. She underscored that risk transfer to the private party is not a goal but is instrumental for full transfer of management responsibility and for the alignment of private interests with the public interest. She also outlined key challenges, including weak national institutional and human capacities to prepare and develop PPP contracts, inadequate policy, legal and institutional frameworks, lack of government guidelines and procedures on PPP, lengthy delays because of political debate, addressing affordability constraints and managing long-term fiscal risks and project operation challenges. She also addressed possible approaches to PPP, the PPP lifecycle and PPP in health care. She described health care PPP advantages e.g. less constraint on public funds, access to private financing, higher quality of public health care services and standards, innovation, know-how and best industry practices in public sector services, increase in profits for the private sector, social responsibility and risk-sharing. She underscored the importance of mitigating the risk of corruption in PPPs, and concluded by emphasizing that countries need a secure, predictable, stable, consistent and commerciallyy oriented framework of law and regulation in order for PPPs to flourish.

Public-Private Partnership For Universal Health Coverage
Middle East and North Africa Health Policy Forum
Regional Conference 12-13 November, 2017

Regulation of Public-Private Partnerships to Advance Towards Universal Health Coverage

Dr. Hala Abou -Taleb
Medical Officer
Policy and Health Planning
Governance and Finance
Health System Development Department
WHO/EMRO

What is a Public Private Partnership (PPP)?

There is no single, internationally accepted definition of Public-Private Partnership

There is a widespread confusion between PPP in the public health and private healthcare network, which inevitably lead to incorrect debates. In many states both coexists, but never overlap

What is a Public Private Partnership (PPP) ? Cont.

- PPP is a **long-term** partnership in the form of a **legal contract** between the public sector and the private sector
- PPP encompass a long-term contract **for providing a public asset or service** in which the **private party bears significant risk and management responsibility** and **remuneration is linked to performance.**

Characteristics of PPP

- Risk Allocation
- The obligation is output based not input based
- The "availability payment" is based on the standard quality for the available service
- The contract is long-term regulating a network of relationships
- Key supervisory role for the financing authorities
- Selection of best value for Money and not the cheapest
- Contractual Services and facilities

Forms and Types of PPPs

Typical mechanisms of the conventional Partnership.

- Government owned assets Government bears capital and commercial risks
  - Service contracts
  - Management contracts (Maintenance and operation)
  - Lease contracts
- Government owned assets Private sectors bears capital and commercial risks
  - Public utility obligation
- Private sector owned assets Private sector bears capital and commercial risks
  - Build, own, operate and transfer of ownership
  - Build, own and operate (privatization)

Forms and Types of PPPs (Cont'd)

PPP Mechanism	Ownership of project assets	Maintenance and operation	capital Investment	Commercial risks	Timeframe of partnership
Service and management contracts	Public sector	Public sector and private sector	Public sector	Public sector	1 - 2 years
Lease contracts	Public sector	Private sector	Public sector	Public sector and private sector	8 - 15 years
Concession contracts	Public sector	Private sector	Private sector	Private sector	20 - 30 years
Build, own, operate and finance	Private sector then public sector	Private sector	Private sector	Private sector	20 - 30 years
Privatization*	Private sector	Private sector	Private sector	Private sector	

Governing Rules for successful PPP Contracts

- PPP contracts typically allocate each risk to the party that can best manage and handle it.
- Risk transfer to the private party is not a goal

but is instrumental for full **transfer of management responsibility** and for the **alignment of private interests with the public interest.**

World Health Organization
Regional Office for the Eastern Mediterranean

7

Risk allocation

- Commercial risks
- Performance/Technical risks
- Operation risks
- Market risk
- Financial risks
- Regulatory risks
- Political risks
- Economic risks

World Health Organization
Regional Office for the Eastern Mediterranean

8

PPP for Public Benefit

- In PPPs, key stakeholders will have conflicting objectives -private parties seek to maximize **profits** while minimizing risk, whereas the government pursues improvement of access and quality of **services** i.e. **public benefit**.
- Within the government, sector agencies seek to maximize **service delivery**. This may conflict with **ministries of finance that seek to prudently manage financial obligations and risks**.

The best way to address this conflict is to define the objectives and priorities of the PPP program clearly and up front

World Health Organization
Regional Office for the Eastern Mediterranean

9

PPP Challenges

- Weak national institutional and human capacities to prepare and develop PPP contracts
- Inadequate Policy, Legal and Institutional Frameworks
- Lack of government guidelines and procedures on PPP
- Lengthy delays because of political debate
- Addressing affordability constraints and managing long-term fiscal risks
- Project operation challenges

World Health Organization
Regional Office for the Eastern Mediterranean

10

PPP Possible Approaches

- •PPP policy supported by clear rules and dedicated experts on both sides to allow for smooth planning and transition.
- •High skills to well define each partner's risks and responsibilities, fix the terms in advance, and define expectations in a service-level agreement
- •Sufficient time should be built in for partners to transition into new roles and arrangements created under the PPP
- •Private partners should have a proven-track record and well evidenced expertise in the subject matter

World Health Organization
Regional Office for the Eastern Mediterranean

11

PPP Possible Approaches

- •Quality assurance and performance monitoring should be ongoing and feed into improved management
- A well-thought out implementation plan, including detailed definitions of business processes and management functions.
- Piloting the PPP concept and structure can save time overall and help ensure success.
- •Early securing of funding for the pilot and the start of implementation.

World Health Organization
Regional Office for the Eastern Mediterranean

12

PPP Possible Approaches

- Involvement of all the key stakeholders in a well-defined consultation and project development process early on.
- A well defined communications, buy-in and change management.
- Continuity within the planning team, transparency and communications between partners.
- Careful definition of targets and budget constraints for each project phase.
- Coordination and milestones throughout implementation

World Health Organization
Regional Office for the Eastern Mediterranean
13

PPP in healthcare

- Access to public healthcare services is constitutionally a fundamental right to citizens, whereas private healthcare services is a business.
- PPP in the healthcare thus relates only to the public service area, and doesn't have anything to do with private care.
- PPP is a way to improve provision and access of cost-effective health care nothing to do with privatization

World Health Organization
Regional Office for the Eastern Mediterranean
14

Healthcare PPP Advantages

- Less constraint on public funds.
- Access to private financing.
- Higher quality of public healthcare services and standards.
- Innovation, knowhow and best industry practices in public sector services.
- Increase in profits for the private sector
- Social responsibility
- Risk sharing

World Health Organization
Regional Office for the Eastern Mediterranean
15

Healthcare PPP challenges

- Affordability
- Risk allocation
- Legal, policy and institutional regulations
- Political environment
- PPP management capacity

World Health Organization
Regional Office for the Eastern Mediterranean
16

The PPP lifecycle

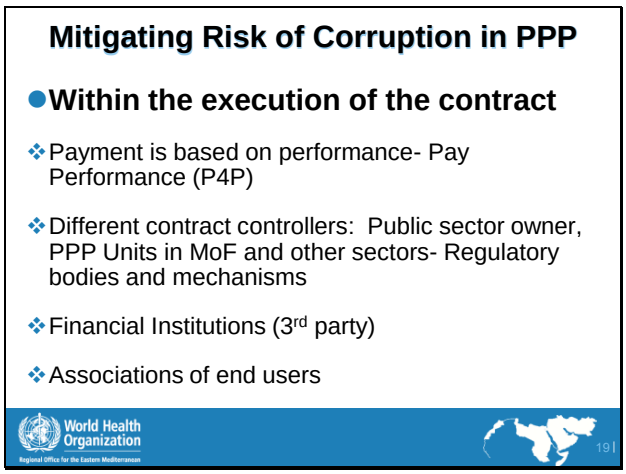
- Project appraisal and identification.
- Tendering and selection.
- Contract award.
- PPP project implementation.
- Monitoring and compliance.
- End of project term.

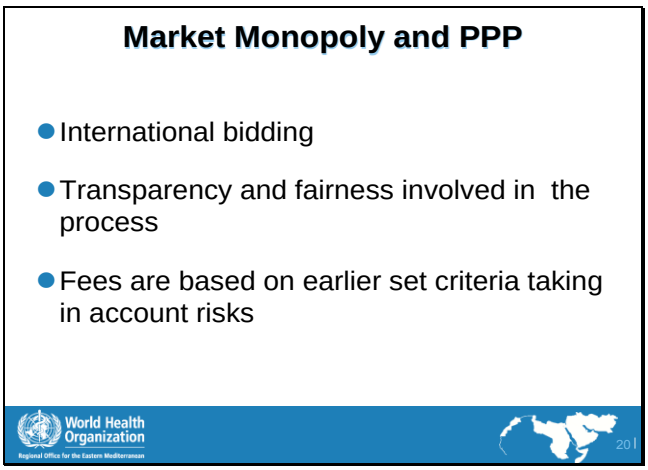
World Health Organization
Regional Office for the Eastern Mediterranean
17

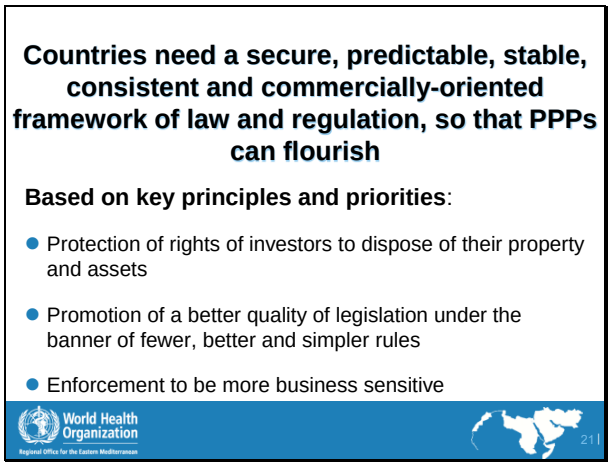
Mitigating Risk of Corruption in PPP

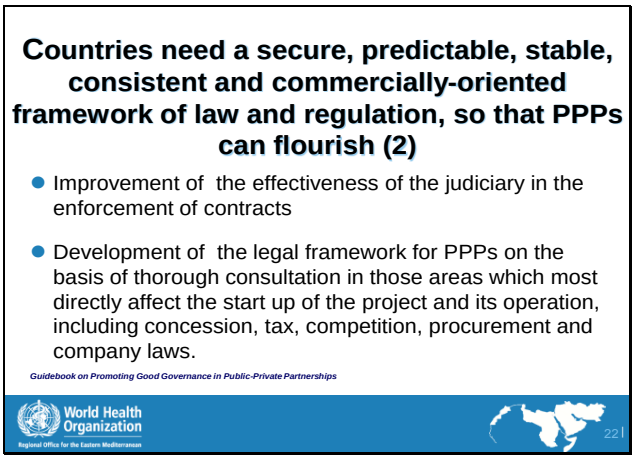
- PPP is usually not a local but international allowing for a **wider competition space** with fairer consequences of the tender.
- **Prequalification criteria** and **intent of interest** followed by **rehabilitation and revision** of the PPP proposal to allow for better competition
- **Competitive dialogue** allows public sector to listen to private sector and accommodate concerns

World Health Organization
Regional Office for the Eastern Mediterranean
18







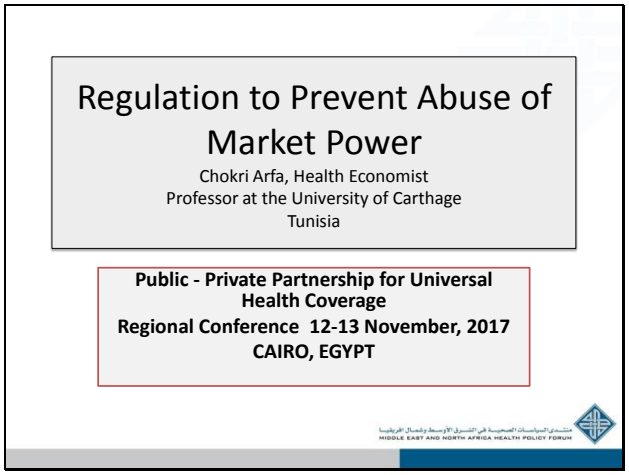


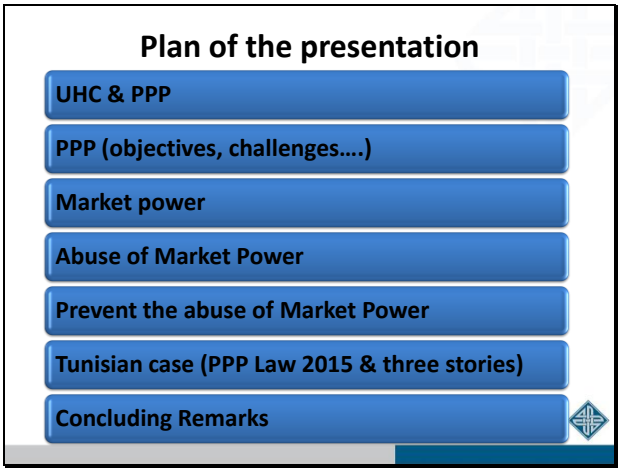
Presentation 2: Regulation to Prevent Abuse of Market Power | Dr.Chokri Arfa

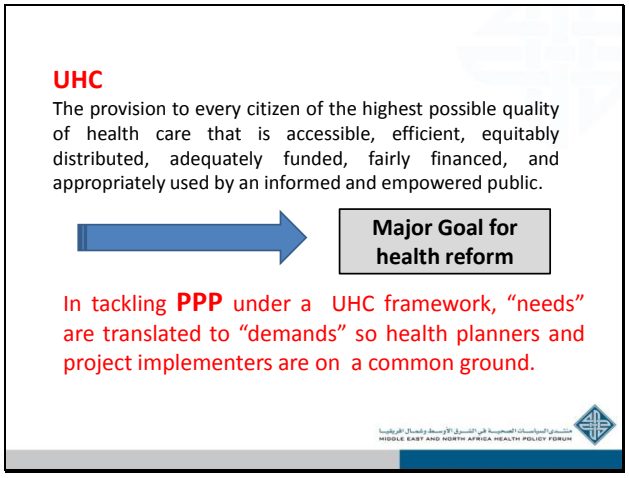
Dr.Chokri Arfa holds a Ph.D and HDR in health economics from Tunis Faculty of Economic Sciences and Catholic University of Lille in France. He is currently associate professor, ex-director of research department at the National Institute of Labor and Social Studies, University of Carthage and secretary-general of the national observatory of social inequality in health. He has 18 years of experience in management of public health, teacher and trainer as well as international consultant. He has published in numerous journals and coauthor of book "Economie et Santé: Evaluation et Stratégies de mise en oeuvre". His research activities and publications are focused on health financing and equity, social protection in health, efficiency and productivity of health facilities etc. His last published paper was titled "Monitoring and Evaluating Progress towards Universal Health Coverage in Tunisia

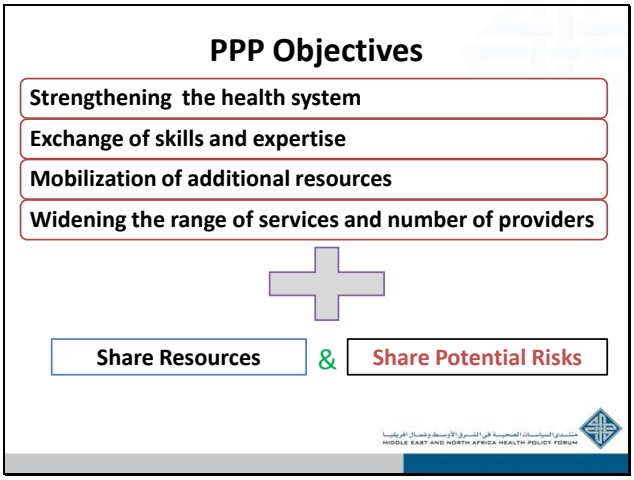
Dr. Arfa spoke on the role of regulation to prevent abuses of market power. He explained that market failure occurs due to a number of factors: firstly, an imbalance of information—health professionals have more information than patients, and pharmaceutical companies know more about their products than public officials; secondly, uncertainty in health markets—not knowing who will fall ill, when illness will occur, what kind of illness people will get, how effective the treatment is; and thirdly, the complexity of the health system—the large number of actors involved, and the relationships between medical suppliers,

health care providers, health insurance and policy-makers. He highlighted that PPPs in health are in the very early stages and in order to prevent abuse, significant institutional development is required, in terms of financial analysis capabilities, monitoring and evaluation systems and appropriate regulations to check the unintended outcomes of private sector growth. He added that anti-corruption measures must be tailored to fit the particular context of a country's health system under the PPP framework, including rule of law, transparency, trust, effective civil service codes and strong accountability mechanisms. Strong role of civil society and Preventive measures such as procurement guidelines, codes of conduct for operators in the health sector – both individual and institutional and transparency and monitoring procedures, are helpful. He emphasized that these measures are crucial to protect the public from fraud, manipulation, and abusive practices related to the sale of health care services, and to foster open, competitive, and financially sound commodity futures and option markets.









Key factors PPP for health sector improvements

Desire to improve operation of public health services and facilities and to expand access to higher quality services

Opportunity to leverage private investment for the benefit of public health services

Desire to formalize arrangements with private sector who deliver an important share of health services

More potential partners for governments as private

What we should Benefits from PPP

Crowding in investment and expertise from the private sector to the delivery of public goods and services.

Advantages in off-budget funding,

Mechanism of modern governments regularly turn to in order to fulfill their responsibilities on public infrastructure and services.

Seeking alternative methods of meeting the increasing demands for investment in public sector development.

- Improving quality, accessibility, availability, acceptability and efficiency
- Universal coverage and equity for primary health care

RHS → PPP → UHC

PPP Challenges

Involving private providers in managing various components of the health sector

Developing joint ventures or inviting private capital

Contracting out services (Catering, Cleaning, Security, Laboratory…..)

Consumer Protection Act (Safeguarding the interest of consumers)

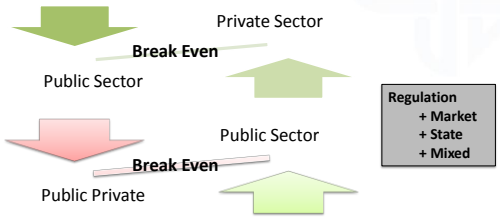
Regulation and Accreditation of private providers by Government

PPP Challenges

- Poor understanding of PPP concept and role
- Weak institutional capacity of public sector
- Limited sustainability of resources
- Lack or weak monitoring
- Prevalence of moral hazards and political influences and practices
- Public good (health) limit the market capacity to optimize the actors relationships

Lack of appropriate regulatory and monitoring mechanisms raised doubts about PPP in health sector

More Challenges



Free Provision of Products and Services
Unsustainable for Government

Profit Maximization
Unsustainable for Consumers

Health System vulnerability to market abuse

- **Imbalance of information – health professionals have more information than patients; pharmaceutical companies know more about their products than public officials**
- **Uncertainty in health markets – not knowing who will fall ill, when illness will occur, what kind of illness people get, how effective the treatment is**
- **Complexity of the health system – large number of actors involved; relationships between medical suppliers, health care providers, health insurance and policy makers**

Market Failure

Market Failure occurs where

1. Knowledge is not perfect - ignorance
2. Goods are differentiated
3. Common access Resource
4. Services/goods would or could not be provided in sufficient quantity by the market
5. Existence of external costs and benefits
6. Inequality exists
7. Market power
    1. Existence of monopolies and oligopolies
    2. Collusion
    3. Price fixing
    4. Abnormal profits
    5. Rigging of markets
    6. Barriers to entry

Market Power in the economic sense

Market power refers to a company's relative ability to manipulate the price of an item in the marketplace by manipulating the level of supply, demand or both.

Market power leads to Economic Inefficiency and Loss of Economic Welfare

Sources of Market Power
- Exclusive control over inputs
- Patents and Copyrights
- Government licenses or franchises.
- Economies of scale
- Network economies

Monopolists (or firms with significant market power), are both productively and allocatively inefficient, since without competition, such firms are able to charge higher prices and produce smaller quantities!

The Abuse of Market Power

- Setting higher prices
- Offering less choice
- Restricting competition
- inefficient allocation of resources

The Fallout!

- The government costs can be increased because in some situation it should compensate the risk of private firm.
- The Limited number of private entities might limit the competitiveness required for cost effective partnering.
- Profits of the projects can vary depending on the assumed risk, competitive level, complexity, and the volume of the project being performed.
- The government might be unable to accurately assess the proposed costs.

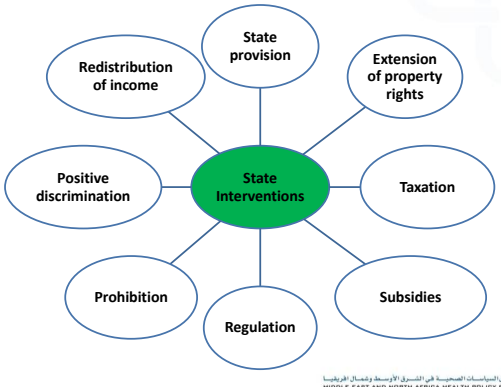
Complexity, challenges and market abuse !

Corruption

- in procurement
- in payment systems
- in the pharmaceutical sector
- at the point of health service delivery
- Etc…

Embezzlement and theft

Measures to correct Market Failure



To Prevent the abuse

- Set up common goals and objectives
- Joint decision-making process
- Relative equality between partners
- Accountability and responsibility set out for each partner
- Understanding the strengths and weakness of the partners among themselves
- A high level of trust and confidence
- Benefits to both the stakeholders
- Monitoring and evaluation (Govt or Independent Agencies) based on
  - Standardized scale
  - the simple criteria of pass and fail
  - the feedback received from the beneficiaries.

PPP Law 2015 in Tunisia

- **The Law establishes the general framework of PPP contracts, fundamental principles, their methods of conclusion and determines the methods of their control.**
- AIMS
  - Diversify the satisfaction of the public orders and its sources of financing
  - Develop and strengthen infrastructure
  - Encourage public investment in PPP framework
  - Benefit from professionalism and private sector experience.

The Institutional Framework Presidency of the Government

- **Strategic PPP Council**
  - For establishing national strategies in the area of partnership and to set priorities in accordance with strategic directions of the development plan.
- **General Authority of PPP**
  - For assessing of PPP contract
  - For providing technical assistance to public entities and assist them in the preparation, conclusion and follow-up of PPP contracts.
  - For insuring transparency, competition and equal opportunities

The Law framework

- Three years maximum duration of the contract
- The public entity may contribute to the private firm capital than obligatorily represented the firm management, notwithstanding the % of participation.
- The contract must indicate the methods of calculation and compensation review.
- In all case, the private firm remains directly responsible to the public entity, the fulfillment of all obligations imposed by the contract (yield, sub-contracting…)
- The occupation and use of public domain is limited in time

The Monitoring

Private firm is required to communicate periodically all legal documents, accounting, financial and technical aspects of the project the plans and the standards required by the public body

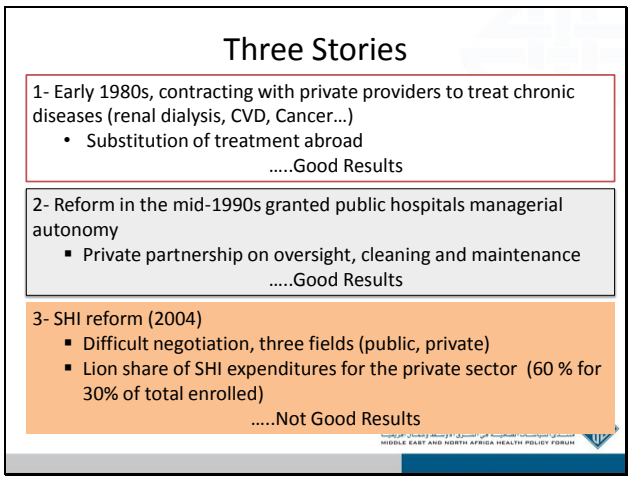
- Public entity :
  - Monitor of the advanced state of the project
  - Verify the validity of the documents and the commitments of the firm 's project
  - carry out on-the-spot checks of the works for check their progress
  - Control of the firm's compliance and if any the subcontracting
  - Recruit a specialist and independent experts to control the execution of the contract
- AND with the support of the new institutional framework
- The audit and control reports should be published

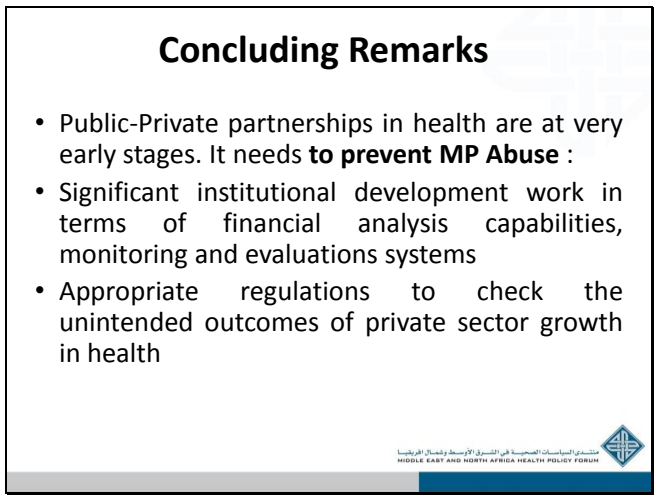
Tunisian case

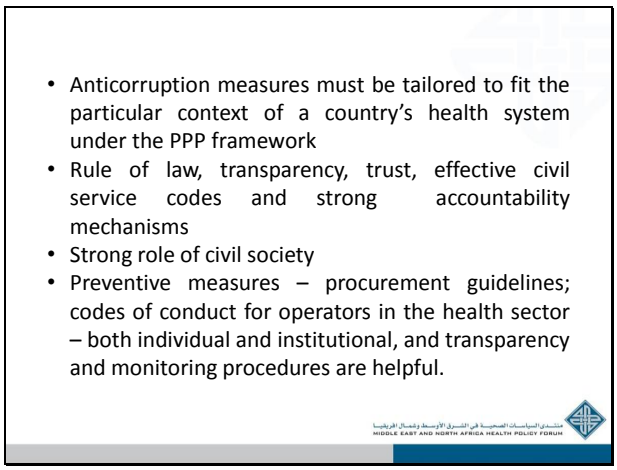
More Franchising
involves a franchisor–franchisee relationship built on standardized contractual arrangements which requires :

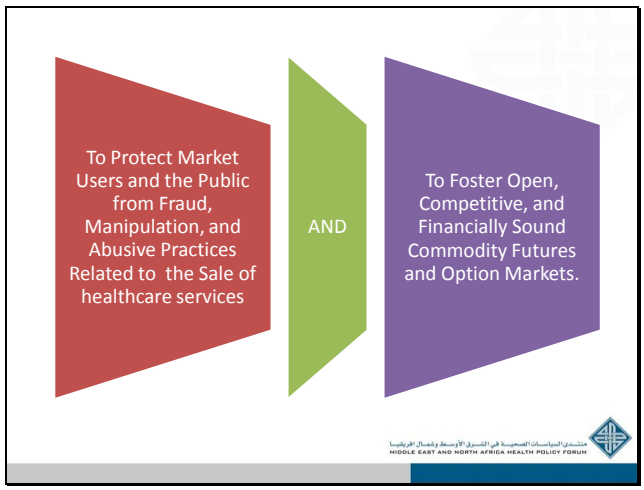
- standardization of products and services;
- standardized procurement, packaging, and distribution;
- standardized accounting, billing, and payment system; and
- common branding.

Less Joint ventures
involve sharing of profits, losses, and risks and are either corporatized (a joint-venture stock corporation is formed) or covered by an executive joint-venture agreement and PPP institutional arrangements









Presentation 3: Private health sector regulations in low and middle-income countries of The Eastern Mediterranean | Dr. Sherine Shawky

Dr. Sherine Shawky has medical degree from Egypt, Doctorate in Public Health; MPH in Epidemiology and MPH in Statistics from Belgium. Since 2003, she works as Research Professor at the American University in Cairo. Previously, she was Associate Professor in Faculty of Medicine, King Abdulaziz University, Jeddah; Expert in Rwanda among the Egyptian-Rwandan Cooperation Program. She has 30 years of experience in research and capacity-building. Her areas of specific interests include MCH, HIV/AIDS, viral hepatitis, NCDs, health systems, SDH and health equity. She serves as consultant for international agencies and has over 40 peer-reviewed publications and national and regional reports.

Dr. Shawky spoke about private health sector regulations in low- and middle-income countries in the Eastern Mediterranean Region. She stated that the private health sector in EMR countries is expanding as the government's relative share in total health expenditure decreases, and as public demand for private health care provision increases. She outlined the results of national surveys conducted in Egypt, Lebanon and Yemen which aimed to assist in engaging the private health sector in moving towards universal health coverage. Her key messages were that the private health sector is complex, multifaceted and intermixed and regulating it to allow for PPPs is not an easy mission. Regulation is hindered by the conflict between

older and more recent laws and from the fragmentation between older and more recent ministerial resolutions, whereas public-private contracting requires a set of harmonized regulations to define the relationship between the public and private health sectors, as well as the relationships within the private health sector. Furthermore, the regulatory instruments focused on market entry are full of gaps and pitfalls that hinder progress on PPPs. The irrelevant enforcement system and the lack of information on the private sector's performance and impact are true obstacles to effective, efficient and sustainable health care.

Public – Private Partnership for Universal Health Coverage
November 12-13, 2017

PRIVATE HEALTH SECTOR REGULATIONS IN LOW AND MIDDLE INCOME COUNTRIES OF THE EASTERN MEDITERRANEAN

Sherine Shawky, MD, DrPH
Social Research Center
The American University in Cairo

PRESENTATION OUTLINE

- Background
- Private health sector regulatory system
- Perception of overall regulatory effectiveness
- Key Messages

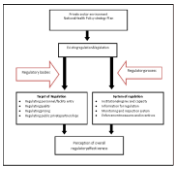
BACKGROUND

- Expansion of the private health sector in EMR countries, with decreasing government relative share in total health expenditure and increasing public demand on private healthcare providers
- Regulation is one major pillar for governments to harness the private health sector
- Knowledge gap in private health sector regulations and regulatory system

THREE COUNTRY SURVEY: EGYPT, LEBANON AND YEMEN

Does the existing regulatory system provide a promoting environment for Public Private Partnerships?

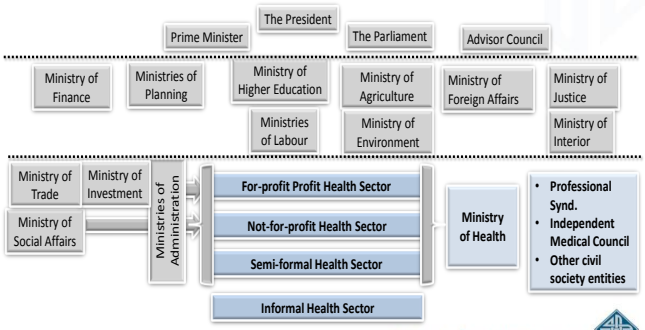
- **Goal**
  - Assist in engaging the private health sector in moving towards universal health coverage in EMR countries
- **Objectives**
  - Understand the private health sector complexity
  - Recognize the private health sector regulations and regulatory system
  - Assess the effectiveness of the private health sector regulatory system as perceived by the various stakeholders
- **Method**
  - Desk review
  - Key informants in-depth interviews (policy makers, regulators, healthcare managers/professionals)
  - Focus group discussions (service beneficiaries)



PRIVATE HEALTH SECTOR

- **Economic**
  - For-profit: sole owners, partnerships, companies, private academia
  - Not for-profit: mosques, churches, NGOs, civil society
- **Therapeutic**
  - Formal
    - Individuals, institutions
  - Semi-formal:
    - Medical doctors providing alternative/modern medicine: Chinese acupuncture, Oxygen therapy, Ozone therapy
    - Other healthcare professionals: pharmacists, nurses, technician
  - Informal sector
    - Informal traditional healers: dayas, barbers, as well as herbal, Quran, spiritual and hegama therapists

REGULATORY BODIES FOR THE PRIVATE HEALTH SECTOR



EXISTING LEGISLATIONS/REGULATIONS GOVERNING THE PRIVATE HEALTH SECTOR

- **Constitution**
  - Values health
- **Laws**
  - Mostly recent horizontal laws: market entry and administration arrangements for private sector employees/institutions
  - Mixture of old and recent vertical laws: healthcare professionals, private healthcare facilities, professional syndicates, services, pharmaceuticals
- **Mixture of huge package of old and recent resolutions**
  - MOH resolutions to enact vertical laws, organize and manage health sector
  - Other Ministries resolutions to enact horizontal laws, organize and manage private sector
- **National health policy**
  - Universal health coverage, private sector expansion, public-private partnership, commercialized care

TARGET OF THE PRIVATE HEALTH SECTOR REGULATIONS

- **Healthcare facilities**
  - Clinics: Private medical clinic, specialized clinic,
  - Specialized Medical Center (laboratories, X-ray centers, ….
  - Private hospital: inpatient, outpatient
  - Specialized units (renal dialysis, cardiac cauterization, operation theater)
  - Pharmacies
  - Convalescence homes, health clubs, optician shops,
- **Healthcare professionals**
  - Physicians, dentists, nurses
  - Biochemistry, bacteriology and pathology specialist
  - Physiotherapists and medical massage
  - Midwives, assistant midwives, psychologists, dental makers, opticians
  - Pharmacists, assistant pharmacists, medicine brokers
  - Professional acts (FGC, …..)
- **Pharmaceuticals and other products (beyond the scope of the study)**
  - Drugs, cosmetics
  - Medical equipment and supplies
  - Food, food products and milk formula
  - Drug factories, drug stores, advertisement agencies, brokers office, importing/exporting agency

REGULTORY FRAMEWORK FOR THE PRIVATE HEALTH SECTOR

	Facilities	Healthcare Practitioners
Market entry	• Registration, licensing • Relicensing (one country)	• Registration, licensing • Relicensing, work permit (one country)
Quality/safety	• Non-mandatory accreditation	• Code of ethics • Certification
Quantity/distribution	• None	• None
Pricing	• Approval of facility proposed fee schedule • Reference non-obligatory fee schedule	• Non-mandatory fee schedule • No salary scale
Public-private partnership	• Contracting	• Contracting
Private-private partnership	• None	• None

PRIVATE HEALTH SECTOR REGULATORY ENFORCEMENT

- **Method:**
  - Control-based
- **Target:**
  - Target the formal providers
- **Tools**
  - MOH inspection on technical aspects and structural measures
  - Ministry of administration for administrative aspects
  - Other Ministries for horizontal measures
  - Formal/informal beneficiaries complaints
- **Actions**
  - Penalties

PERCEPTION TOWARDS THE REGULATORY EFFECTIVENESS

Policy Makers and Regulators

- Promoting environment, organized market entry and better quality than public sector
- Weak organization, limited resources and insufficient incentives, conflicting laws and fragmented resolutions and uncontrolled semi-formal and informal providers
- Inspection is challenged by insecurity and disrespect
- Monitoring is challenged by absent or incomplete information/databases
- Outdated non-standard and non-realistic fee schedule
- Public-private partnership opens door for manifold practice and patient drain to private sector

PERCEPTION TOWARDS THE REGULATORY EFFECTIVENESS

Healthcare Mangers and Practitioners

- Bureaucratic environment with informal influences
- Irrelevant conflicting regulations
- Work overload and patient violence
- Irregular ineffective inspection with informal payment
- Outdated non-standard fee schedule, no salary scale
- Low salaries, irregular payments with public employer and no contracting arrangements with private employer

PERCEPTION TOWARDS THE REGULATORY EFFECTIVENESS

Healthcare Beneficiaries

- Money making business
- No regulations and if exists are not enforced
- No inspection, weak complaint system
- Loose for unqualified individuals and poor quality institutions
- Manifold practice, crowdedness and long waiting time, lack of services
- Expensive and unaffordable
- Public sector lacks resources and private sector has informal arrangement for money making

KEY MESSAGES

- The private health sector is very complex, multifaceted and intermixed and regulating it to allow for PPPs is not an easy mission
- The private health sector is mainly governed by the Ministry of Health, yet other ministries are still involved in the regulatory system and they need to be considered in PPPs
- The regulations suffer from conflict between old and recent laws and mixture of huge fragmented old and recent ministerial resolutions while public private contracting requires a set of harmonized regulations to the define the relation between the public and private health sectors as well as the relation within the private health sector
- The regulatory instruments focus on market entry and the regulatory framework is full of gaps and pitfalls that hinders progress on PPPs
- The irrelevant enforcement system and the lack of information on the private sector performance and impact are true obstacles to ensure effectiveness, efficiency and sustainability
- The voice of all sectors of the population provides a comprehensive picture for the regulatory reform

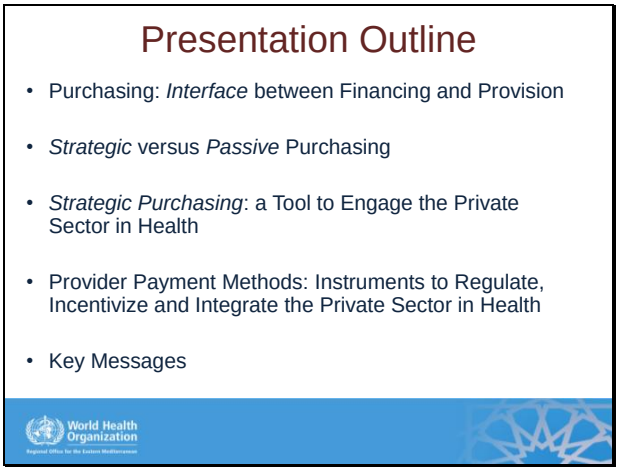
Session 6: Partnerships for Resources for Health Service Delivery

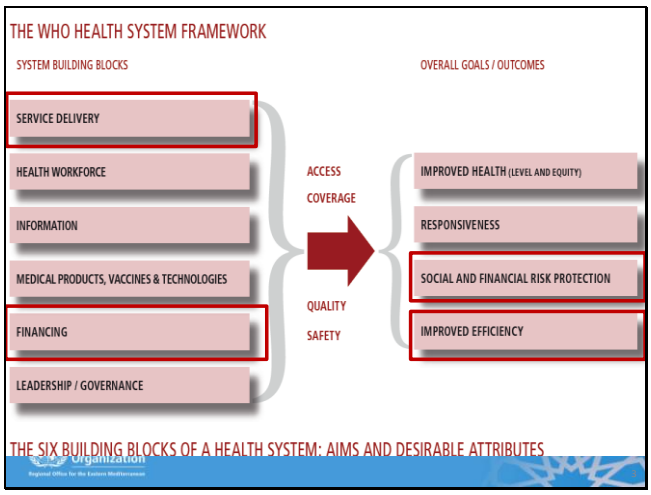
Chairperson: Seif Al Nabhani | Health ministry, Oman
Speakers: Awad Mataria | WHO/EMRO
Laila Iskandar | CID Consulting, Egypt
Ehab Abul-Magd | Private insurance

Presentation 1: Using Strategic Purchasing to Leverage the Role of Private Sector in UHC, Lessons for the MENA Region | Dr. Awad Mataria

Dr. Awad Mataria is the Regional Adviser for Health Economics and Financing at the WHO Regional Office for the Eastern Mediterranean. Dr. Mataria has more than ten years of experience in health system strengthening and health financing. For the last six years, he has been supporting the countries of the Eastern Mediterranean Region to reform their health financing systems to move towards Universal Health Coverage. Dr. Mataria has a Masters in Health System Analysis and a Ph.D. in Health Economics. His areas of expertise are: Universal Health Coverage; health systems' financing and organization; Social Health Insurance; using economics in health care priority setting; measuring the benefits of health care mainly using stated preferences techniques; economic evaluation of health care interventions (cost-effectiveness analysis, cost-utility analysis and cost-benefit analyses); and National Health Accounts. Dr. Mataria has several publications in high impact journal.

Dr. Mataria presented on the use of strategic purchasing to leverage the role of the private sector in universal health coverage. He discussed passive versus strategic purchasing, defining passive purchasing as when providers are reimbursed for services and national governments allocate budgets to various levels of administration based on the previous year's funding, and strategic purchasing as purchasing that is based on evidence-informed decisions and promotes quality and efficiency. He also outlined the provider payment methods and the advantages and disadvantages of each method, emphasizing that there is no perfect payment method, as all can create undesirable incentives and adverse consequences, and all can be useful at different times, depending on objectives. However, he said, it is always preferable to move from input-based to output-based payment. He concluded that strategic purchasing is an effective mechanism for engaging the private sector for quality and efficiency, that different provider payment methods can be a way to regulate, incentivize and integrate the private sector, and good governance is key for ensuring effective engagement of the private sector.





What is Purchasing?

- **Revenue collection** is the process by which the health system receives money – households, organizations, donors;
- **Pooling** ensures that the risk of having to pay for health care is borne by all members of the pool and not individually;
- ***Purchasing*** is the process by which pooled funds are paid to providers in order to deliver a set of health interventions.

Source: World Health Report 2000

Purchasing – Passive vs. Strategic

- ***Passive purchasing*** - providers are ***reimbursed for services*** and national governments ***allocate budgets*** to various levels of administration based on previous year's funding
- ***Strategic purchasing*** – is extent to which purchasing is based on evidence informed decisions and promotes quality and efficiency by asking explicit questions:
  - What interventions and services to purchase?
  - For whom to purchase?
  - From whom to purchase?
  - How to pay the providers?

Source: World Health Report 2010

Strategic Purchasing, Purchaser-Provider Split, and Private Sector

		Provision	
		Public	Private
Financing	Public	Public hospitals and network of PHC facilities [All countries]	***Outsourcing, contracting, grants to non-state providers [most countries]***
	Private	***Building trust hospitals [UK]*** **BOT, BOOT, Etc.**	Private providers paid directly by users [most countries]

Provider Payment Methods

The way in which money is distributed

- From a source of funds [fund holders]:
  - government
  - insurance company
  - other payer
- To:
  - health care facility (including laboratory, pharmacy) [Public or Private]
  - individual provider (physician, nurse, physiotherapist) [Public or Private]
- Each PPM carries a set of **incentives** that encourage providers to behave in specific ways in terms of the types, amounts, and quality of services they offer

Major Payment Methods: Advantages and Disadvantages

Payment mechanism	Unit of Payment	Advantages	Disadvantages	Financial risk
Line item budget [salaries]				ovider = W yer = LOW
Global b				ovider = GH yer = LOW
Capitatio				ovider = GH yer = LOW
Case bas payment - Diagno Related Groups)				ovider = ODERATE yer = ODERATE
Per diem				ovider = W yer = HIGH
Fee for service	Per unit of service	High accessibility, high quality, competition	Overprovision who can pay, under service poor	Provider = LOW Payer = HIGH

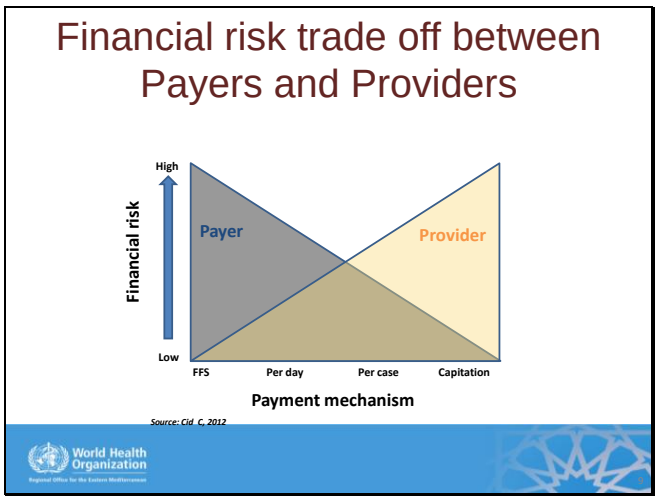
There is no perfect payment method.

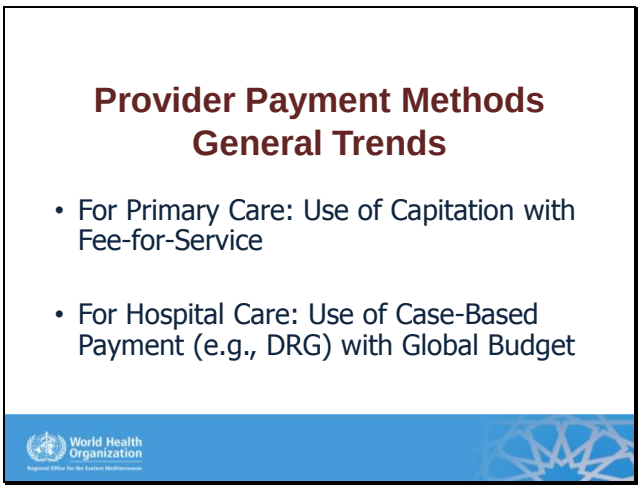
They all have strengths and weaknesses.

They all can create undesirable incentives and adverse consequences.

They all can be useful at different times depending on the objectives.

However, it is always preferable to move from ***input-based*** to ***output-based*** payment



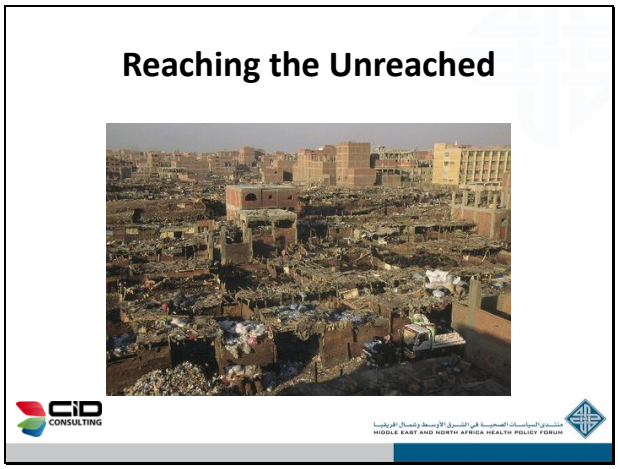


Presentation 2: Community Partnerships for Social Justice in the Health Sector | Dr. Laila Iskandar

Dr. Laila Iskandar was the Minister of State for Urban Renewal and Informal Settlements in Egypt from July 2014-September 2015 and before that served as Minister of State for Environmental Affairs in the two cabinets following the June 30th Revolution. Prior to holding public office she was a leading member of civil society both nationally and internationally, working with grass roots communities in informal urban settlements and deprived villages in Upper Egypt as well as being part of global networks addressing issues of Urban Poverty. She was Chairperson of CID Consulting from 1995 - 2013, which was awarded the "Social Entrepreneur of the Year" award in 2006 at the World Economic Forum by the Schwab Foundation for the sustainable recycling school established in partnership with UNESCO. She studied economics, political science at Cairo University, Near Eastern studies and international education development at UC Berkeley (Masters of Arts in Teaching), California and Columbia University, N.Y (Doctorate in International Education Development). Her international assignments have included serving as jury to UNESCO's International Literacy Prize, acting as UNESCO's Resource Person for the Arab region since 2005 on the United Nations Literacy Decade - UNLD - and Education for Sustainable Development (ESD) Decade, and served as CIDA's Education Advisor in Egypt. She worked on issues of informality of dwelling and livelihood for over 30 years, with a focus on the informal waste sector

building on recycling SME's and value chain analysis. Her work links up to global networks of recycling organizations and informal settlements.

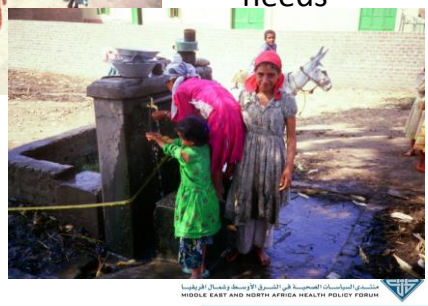
Dr. Iskandar discussed community partnerships for social justice in the health sector. She shed light on key concepts such as reaching the un-reached, addressing non-medical aspects of health, home-based family health, gendered approaches to power over resources, financing non-medical home-based health needs, and non-formal education on health issues, both urban and rural. She spoke about the organization Care with Love (CWL), which was established to fill a gap in providing home-based health care. CWL started the first program in Egypt for training and employing home health care providers, to provide needed health care in communities through a system ensuring affordable and accountable health care for those who need and desire it. CWL was founded in 1996 as a program under an NGO, and then became an independent entity in 2003. It started with expatriate health trainers, and then began selecting and training graduates of the program to be CWL trainers. It transferred its experience to other NGOs in partnership, not competition. Dr. Iskandar summarized prospects for PPPs with non-profit organizations, discussing the need to expand the space available for NGOs to operate, to remove barriers to funding, to link them to medical regulatory authorities, the need for monitoring while allowing them to maintain some autonomy, and to recognize their contributions. She also stressed the recognition of the non-medical needs which contribute to improved health, as well as the potential to design PPPs for social justice and then for universal coverage, as the un-reached and the un-served constitute a major segment of the population, particularly in rural and slum areas.



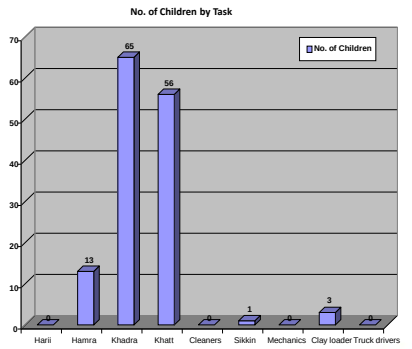
Addressing non medical aspects of Health

Home Based Family Health – Gender approach to power over resources

Financing non medical home based health needs



Children in Brick Factories



Issues Identified by Brick Factory Workers

1. Water Supply and Quality
2. Upgrading the Waste Water System
3. Improving and Paving Main Roads
4. Establishing Emergency Health Services
5. Providing Telephone Lines (Infrastructure)
6. Toilets
7. Living Conditions/Accommodations for Workers in Factories
8. Children's Education (Vocational and Academic)

Non Formal Education on Health Issues - Urban and Rural

This requires mobilizing, training, and managing people and resources

Linking to Government Services

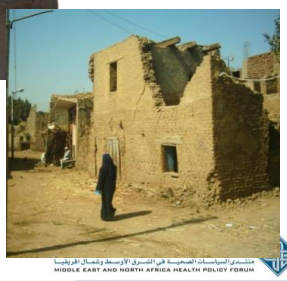
Home Based Rural focus

Who Finances these?

Health Related Housing Improvements

منطقة الاشراف - المنيا

منطقة الجنيدي - المنيا



HOME BASED CARE

Care with Love (CWL) was established to fill a gap in providing home based health care. CWL started the first program for training and employing home health care providers to provide needed health care in communities through a system ensuring affordable and accountable health care for those who need and desire it. CWL started in 1996 as a program under an NGO, and then became an independent entity in 2003. It started with expatriate health trainers, and then started selecting and training graduates of the program to be CWL trainers.

Care with love transferred its experience to other NGOs in partnership and not in competition

Various levels of Community Based Tertiary Care

State of the Art Tertiary Care Raei Misr Hospital in Beni Mazar,

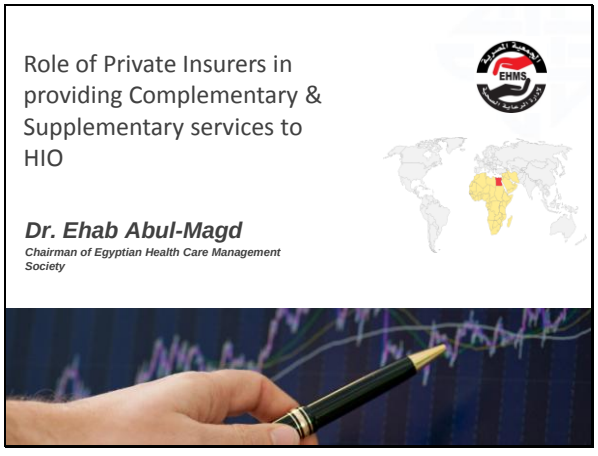
Prospects for PPP with Non Profits

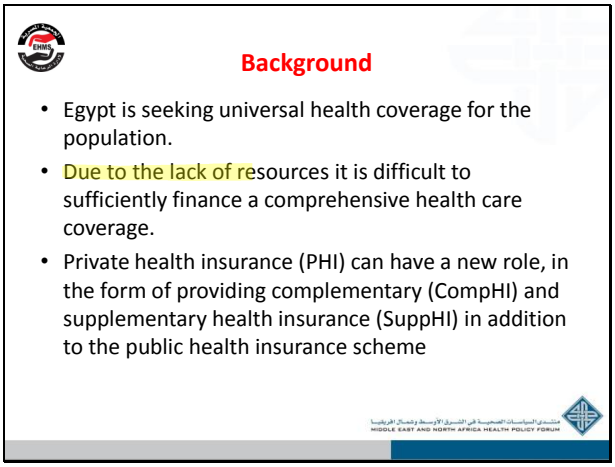
- Expand the space available for NGOs to operate: remove barriers to funding, link to medical regulatory authorities, monitor but allow them to maintain some autonomy, recognize their contributions
- Recognize the non medical needs which contribute to improved health
- Design PPPs for Social Justice and then for universal coverage - the unreached and the unserved constitute a major segment of the population particularly in rural and slum areas

Presentation 3: Role of Private Insurers in Providing Complementary & Supplementary Services to HIO | Dr. Ehab Abou El Magd

Dr. Ehab Abou El Magd is the Chairman and Managing Director of Platinum Healthcare Holdings Group. Founded in 1999 ,it includes the largest group of companies engaged in the field of medical insurance, health care and various insurance consultancy. Dr. Ehab is founder and president of the Egyptian Federation of Health Care Management Companies. He is sdvisor and insurance expert and a member of the American Health Insurance Planners (AHIP) as well as head of medical insurance studies at the Egyptian Institute of Insurance.

Dr. Abul-Magd presented on the role of private insurers in providing complementary and supplementary services to Egypt's Health Insurance Organization. He stated that supplementary and complementary private health insurance can play a significant role in the Egyptian health care system, and argued that private health insurance should be aligned with the development of universal health coverage. He described the structure of the public health care system and Health Insurance Organization coverage in Egypt, explaining that health insurance is mandatory for all employees working in the government sector, certain public and private sector employees, pensioners, students and infants under one year of age, and that, as of 2017, 63% of the population was covered by the Health Insurance Organization. However, he highlighted that in reality medical services are often inaccessible, and that only 6% of the population utilizes HIO coverage. He further stated that public sector services are usually not satisfactory. Egyptians who can afford to, prefer to pay for care out of pocket instead of using public services, and over 70% of total health expenditure is borne by individuals (i.e. out-of-pocket payments). The current role of private health insurance is marginal and there is a duplicate system for certain employer schemes. He also shared experiences from other countries. He underscored health gains, sustainability of health care financing, efficiency of health care delivery, and financial protection of the health system as the reasons why supplementary and complementary private health insurance are important to the Egyptian health care system. He concluded by emphasizing that the development of supplementary and complementary private health insurance should be aligned with the development of universal health coverage, and that strategic review of countries that face similar challenges to Egypt but are more advanced in implementing universal health coverage, e.g. South Africa or Thailand, may deserve more attention.





Different types of current Private Health Insurance

- **Substitutive PI**: An alternative to statutory insurance and is available to sections of the population who may be excluded from public cover or who are free to opt out of the public system
- **Duplicate PI**: PHI that offers coverage for health services already included under government health insurance, while also offering access to different providers (e.g. private hospitals) or levels of service (e.g. faster access to care). It does not exempt individuals from contributing to government health coverage programs.

way to reach universal health coverage

- Supplementary and complementary private health insurance can play a significant role in the Egyptian healthcare system based on:
  - large proportion of out of pocket payments
  - small proportion of private health insurance expenditures
  - incomprehensive basic benefit package

Definitions of supplementary and complementary

WHO definitions:

Supplementary: Offers faster access to service, greater choice of health care provider or enhanced amenities

Complementary services: covers services excluded from the publicly financed benefit package

way to reach universal health coverage

- Private health insurance should be aligned with the development of universal health coverage (UHC)
- Objectives of PHI development should be determined by the government
  1. Political: satisfaction of different subgroups of Egyptian citizens (and expatriates)
  2. Direct financial: provide promising business model for private health insurance companies
  3. Indirect financial: reduce the financial pressure on the implementation of UHC
- Special pilot areas (e.g. disease area, special technologies or services, geographical region) may be selected to facilitate alignment on the short run

Role of private health insurance (PHI)

Packages	Public health insurance	Private health insurance
Minimum package	• Population: all citizens • Restriction: no copayment and waiting list	
Essential package I.	• Population: all patients with insurance • Restrictions: copayment, waiting list , low quality, no choice	• Supplementary: Immediate access, better quality • Complementary (user charges): copayment • Complementary (services): Choice
Essential package II.	• Population: all patients with insurance • Restrictions: coverage only for subgroup, copayment, waiting list, second-line	
Equity package	• Population: selected patients with insurance • Restrictions: strict diagnostic criteria, monitoring	• Complementary (services): coverage for patients with no access
Non-reimbursed services		

Egypt

Structure of the public health care system – Egypt

Governmental sector

MOHP (Ministry of Health & Population) facilities

- Highly subsidized care
- 20% of services require OOP

Revenues

- Taxes
- Funding from donors
- OOP

Parastatal sector

- Main actors
  - Health Insurance Organization (HIO)
  - The Curative Care Organization (CCO)
  - Teaching Hospitals and Institutes Organization (THIO)

Health Insurance Organization coverage – Egypt

- **Beneficiaries**
  - Mandatory to all employees working in the government sector, certain public and private sector employees, pensioners, students and new-borns (children under yr. 1)
  - 63% of the population (2017) is covered through HIO
- **Benefit package**
  - Officially comprehensive
  - In reality: Inaccessible medical services, only 6% of the population utilizes HIO coverage

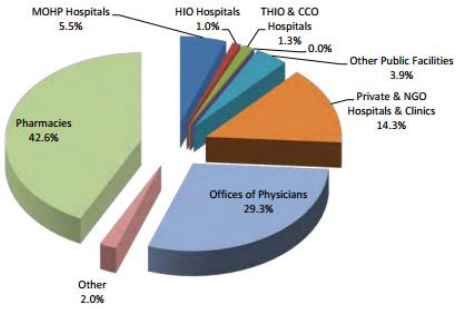
Health Insurance Organization funding – Egypt

Beneficiaries usually have to pay only a marginal contribution to utilize the HIO services:

Beneficaires	Extent of contribution
Students	4 EGP/year & co-payment(1/3 of the medication costs*)
Newborns	5 EGP/ year
Pensioners	1% of the monthly pension
Widows	2% of the monthly pension
Public sector employees	1% of the monthly salary
Private sector employees	3% of the monthly salary collected from the employer

*Except for chronic medications

OOP household spending's by providers – Egypt



Role of private sector – Egypt

Public sector services are usually not satisfactory

- Egyptians who can afford, prefer to pay for care out of pocket instead of using public services
- Over 70% of THE is borne by individuals (i.e. OOP)
- Private purchasing of public services is available in some cases

  e.g. economic departments where public providers are permitted to generate their own income by charging user fees for better accommodation (e.g. private room instead of community room)

Market of PHI – Egypt

Duplicate system

- Employees in private companies often have mandatory duplicate coverage
- Both social security contribution and private insurance premiums are deducted from employee salaries

Coverage

- 5% of the population

Types of contracts

- Group and company insurances are frequent and affordable
- Individual insurances are rare and more expensive

Summary – Egypt

- The public health insurance coverage is not satisfactory for the beneficiaries
- The current role of private health insurance is marginal
- There is a duplicate system for certain employer schemes
- Complementary and supplementary health insurances have a potential role to support the „real" coverage of the basic benefit package
- Pharmaceutical, outpatient and inpatient care, the main drivers of OOP expenses, have to be targeted by the PHI schemes

Country	Type of coverage available	Number of covered lives or number of policyholders	Voluntary or mandatory insurance	Individual or group policies (% of market if both policy types exist)	Life insurance products including health elements	Long- term care insurance (LTC)
Australia	Duplicate and supplementary.	Covered lives	Voluntary	Individual	Yes. Lump sums for medical conditions, serious illness, injury or permanent disability. Monthly benefits if unable to work due to illness or injury.	No
Austria	Complementary	Covered lives	Voluntary	-	-	-
Belgium	Complementary (primary small-risks coverage for self-employed)	Covered lives	- Voluntary (private companies and mutuelles) - Mandatory (long-term care in Flanders)	- 100% individual (mutuelles) - 25% individual and 75% group (private companies)	N.a. (private companies), No (mutuelles)	Yes (for Zorgverzekering in Flanders)
Private insurers	-	-	Voluntary		-	-
Mutuelles	-	-	Voluntary	Individual	No	Only if LTC treatment in hospitals, in framework of in-patient treatment
Hospitalisation						Only if LTC treatment in hospitals, in

Country	Type of coverage available	Number of covered lives or number of policyholders	Voluntary or mandatory insurance	Individual or group policies (% of market if both policy types exist)	Life insurance products including health elements	Long- term care insurance (LTC)
						framework of in-patient treatment
Zorgverzekering (Flanders only)	-	All population in Flanders	Mandatory	Individual	No	LTC only
Canada	Supplementary	Covered lives	Voluntary	10% individual and 90% group	Yes (e.g, critical illness insurance, disability insurance)	Yes
Chile	1 Primary PHI	3.196.477 (number of covered lives) in 2013	Mandatory or Mandatory plus a part voluntary to upgrade services	18.2% in 2013 (both groups)	-	-
	2 Complementary PHI	3.781.135 (number of covered lives) in 2013	Voluntary	21.7% in 2013 (both groups)	-	-

Country	Type of coverage available	Number of covered lives or number of policyholders	Voluntary or mandatory insurance	Individual or group policies (% of market if both policy types exist)	Life insurance products including health elements	Long- term care insurance (LTC)
Czech Republic	Supplementary. Primary: for foreigners who are not eligible for public health insurance coverage.	-	Voluntary	Individual	Life insurance products do not generally comprise coverage for health care services. - Disease specific and critical illness products, - Income replacement and cash products, Temporary or permanent disability.	No
Denmark	Complementary, supplementary	Policyholders (number of policies taken out. Information on covered lives is n.a.).	Voluntary	Group and individual (% is n.a.)	No. Life insurance products generally do not include health elements.	No
Estonia	-	-	-	-	-	-
Finland	Supplementary	-	Voluntary	-	-	-
France	Complementary	Covered lives	Voluntary	Individual and group	-	-

Country	Type of coverage available	Number of covered lives or number of policyholders	Voluntary or mandatory insurance	Individual or group policies (% of market if both policy types exist)	Life insurance products including health elements	Long- term care insurance (LTC)
Germany	Primary, complementary and supplementary	Covered lives	Voluntary and mandatory	Individual and group (% of n.a)	Yes (e.g. permanent disability insurance)	Yes
Greece	Duplicate	-	Voluntary	-	Yes	-
Hungary	Supplementary	-	Voluntary	-	Yes	No
Iceland	Primary	Covered lives	Voluntary	Individual	Yes	Yes, but just recently offered
Ireland	Duplicate	2 million covered lives (including children)	Voluntary	Individual and group policies combined	Yes. Life companies offer products (critical illness, hospital cash, income replacement etc).	Yes. Life companie s may offer long term care insurance.
Israel*	Complementary, Duplicate and Supplementary	Covered lives	Voluntary	Both	-	Yes, in addition to the health insurance.
Italy	-	-	-	-	-	-

Country	Type of coverage available	Number of covered lives or number of policyholders	Voluntary or mandatory insurance	Individual or group policies (% of market if both policy types exist)	Life insurance products including health elements	Long- term care insurance (LTC)
Japan Source: Financial Services Agency	Complementary and supplementary	-	Voluntary (except the compulsory automobile liability insurance)	Individual and group	Yes (e.g. cancer insurance, specified disease insurance, etc.)	Yes
Korea	Complementary and supplementary	-	Voluntary	Individual	Yes	Yes
Luxembourg	-	-	-	-	-	-
Mexico	Duplicate	-	Voluntary	-	-	No
Netherlands						
Up to 2005	Primary and supplementary	5.834 million, of which: - Policies entirely pertaining to private law (4.130 million)	Voluntary	48% individual, 52% group	No	No

Country	Type of coverage available	Number of covered lives or number of policyholders	Voluntary or mandatory insurance	Individual or group policies (% of market if both policy types exist)	Life insurance products including health elements	Long- term care insurance (LTC)
		- Standardised policies regulated under the WTZ scheme (0.817 million) - Policies for civil servants (0.888 million)				
2006 onwards	Supplementary	Covered lives: approximately 15 million.	Voluntary	Individual and group (group max. 44%, but from the total insured population of 16.5 million)	No	No
New Zealand	Complementary and Supplementary	Covered lives	Voluntary	Individual and group	Yes	No
Norway	Duplicate	-	Voluntary	-	-	No
Poland	-	-	-	-	-	-
Portugal	-	-	Voluntary	-	-	-

Country	Type of coverage available	Number of covered lives or number of policyholders	Voluntary or mandatory insurance	Individual or group policies (% of market if both policy types exist)	Life insurance products including health elements	Long- term care insurance (LTC)
Slovak Republic	-	-	-	-	-	-
Slovenia	Complementary	Insured persons and dependents	Voluntary	-	Yes	No
Spain	Primary, duplicate	Covered lives	Voluntary	Individual	-	Yes
Sweden	-	-	-	-	-	-
Switzerland	Supplementary	Covered lives	Voluntary	-	-	-
Turkey	Complementary and supplementary	Policy holders	Voluntary	-	Critical illness	-
United Kingdom	Duplicate	Covered lives	Voluntary	Individual and group (% is n.a.)	Critical illness	-
United States	Primary and complementary	Covered lives	Voluntary	-	No	Yes

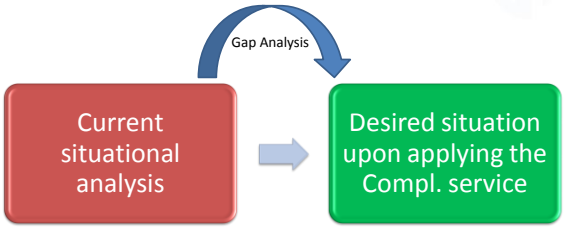
Project Milestones
Product features

Generalization:
- The product should be able to be generalized to large segment of patients

Replication
- The product should be subjected to replication to further disease areas or interventions

Traceability
- The product and process should be easily traceable and tracked for KPIs efficiency and control

Project Milestones
Methodology



Project Milestones
Roadmap

Why Supplementary and complementary private health insurance are important to the Egyptian health care system :

- Health gain
- Sustainability of health care financing
- Efficiency of health care delivery
- Financial protection of the system

Recommendations

Perspectives of SHI and CHI in Egypt

- Supplementary and complementary private health insurance can play a significant role in the Egyptian healthcare system based on:
  1. large proportion of out of pocket payments
  2. small proportion of private health insurance expenditures
  3. incomprehensive basic benefit package

Questions before the design of the PHI system cont.

CHI and SHI design

- What type of services should be offered?
  - all in-kind benefits
  - co-payment (CHI)
  - higher quality care (SHI)
  - better access (SHI)
- What type of methods should be used?
  - to incentivise
  - to finance , e.g. collect premiums, MSAs
  - to contract
  - to prevent adverse selection
- What is the level of control the government want to gain?
  - Free market competition
  - Managed competition
  - Strict government control

How to implement the new healthcare system?

- Development of supplementary and complementary private health insurance should be aligned with the development of universal health coverage
  1. Strategic team of multidisciplinary stakeholders should develop mid-term and long-term policy framework to adjust the role of private health insurance to universal health coverage
  2. Special pilot areas (e.g. disease area, special technologies or services, geographical region) may be selected to facilitate alignment on the short run
- Strategic review of countries with similar challenges to Egypt, but more advanced in implementing universal health coverage. E.g. South Africa or Thailand may deserve more attention

Session 7: The Way Forward—Panel Discussion

Moderator: Ahmed Galal | MENA HPF
Panelists: H.E. Ahmed Emad Rady| Minister of Health and Population, Egypt
Mostafa Nabli | Former Governor of the Central Bank, Tunisia
Zafar Mirza | WHO/EMRO
George Gotsadze | Health Systems Global

Dr. Nabli shared with audiences three key observations. First he pointed to the scarcity of discussions on the empirical evidence for PPP, which he attributed largely to an absence of research in the MENA region in this area. He underscored the important role that MENA HPF can play in addressing this gap, by gathering evidence and informing policy-makers. He further added that the political economy of PPP has not been addressed. His second observation was the importance of strengthening the public sector in order to achieve successful PPP, and that some forms of informal PPP can weaken both public and private sectors. Finally, he commented that influencing decision-making in relation to PPP could be done by cross-regional coordination, including health technology assessment coordination, preparing policy briefs, and pooling of procurements, especially for medicines.

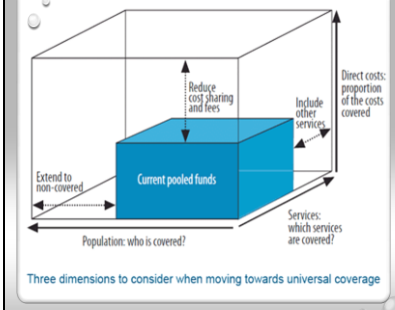
Presentation 1: Public-Private Partnership for UHC: THE WAY FORWARD | Dr. George Gotsadze

Dr. George Gotsadze is one of the founders and executive director of the Curatio International Foundation (CIF), a not-for-profit Georgian Think Tank established in 1994 and working on health systems and policy issues of Eastern Europe and Central Asian Countries for more than two decades. Since March 2015, CIF in Tbilisi, Georgia hosts the secretariat of Health Systems Global (HSG), the first international membership organization dedicated to promoting health systems research and knowledge translation and Dr. Gotsadze is an executive director of HSG. HSG is an owner and organizer of biennial Global Symposiums on Health Systems Research, the fifth one to take place this year in Liverpool, UK during October 8-12th. Dr. Gotsadze is an associate professor and teaches health care financing at the School of Public Health at Tbilisi Medical University. He has authored over 40 scientific papers and several books and book chapters. He is also known for his contributions to the Global Health serving as a vice chair of the Technical Review Panel of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Geneva-based innovative financing institution. Throughout his career, Dr. Gotsadze also served on the Boards of non-profit with global reach and on international panels dealing with health issues on a global scale.

In his presentation, ***Dr. Gotsadze*** listed potential ways forward, including expanding service coverage by the use of existing capacities within the private sector when public capacities are overstretched, and engaging NGOs and including other services or alternative approaches, such as developing new capacities through PPP. He added that PPP can also reduce costs and increase value. This can be achieved through complimentary or basic insurance to pool the risks and reduce out-of-pocket payments, engagement with technology providers to secure better pricing, assessing the value afforded by new technologies using health technology assessments, and through more efficient production via economies of scale. Finally, he shared the gaps in policies and regulations, which include the lack of understanding of why PPP is needed, what triggers a need for PPP and when, the lack of willingness to engage the private sector, the lack of capacity or weak capacity within public sector entities/organizations, a lack of information, rule of law and corruption-related issues, a lack of capacity to develop contracts, and a lack of templates on how things are being done. He concluded by inviting participants to Health Systems Global's 2018 Global Symposium in Liverpool, the UK.

PUBLIC-PRIVATE PARTNERSHIP FOR UHC THE WAY FORWARD

NOVEMBER 13TH, 2017



Three dimensions to consider when moving towards universal coverage

LET'S BE CLEAR WHERE PPP COULD HELP UHC?

PLANNING HORIZONS FOR UHC AND HEALTH SYSTEM

5 years of

20-30 years?

POTENTIAL AREAS FOR PPP (INCOMPLETE LIST)

EXPAND SERVICE COVERAGE

- USE EXISTING CAPACITIES WITHIN PRIVATE SECTOR, WHEN PUBLIC CAPACITIES ARE OVERSTRETCHED
- REACH HARD TO REACH POPULATION BY ENGAGING NGOS (SUDAN, JORDAN, LEBANON, ETC.)

INCLUDE OTHER SERVICES OR ALTERNATIVE APPROACHES

- DEVELOP NEW CAPACITIES THROUGH PPP E.G. SCREENING CENTERS IN SHOPPING MALLS, DIALYSIS CENTERS, ETC.
- HOSPITAL INVESTMENTS IN UK
- ELDERLY CARE – HOME MANAGEMENT E.G. DUBAI
- GOOGLE SURVEILLANCE IN US

REDUCE COST SHARING AND/OR COSTS AND INCREASE VALUE

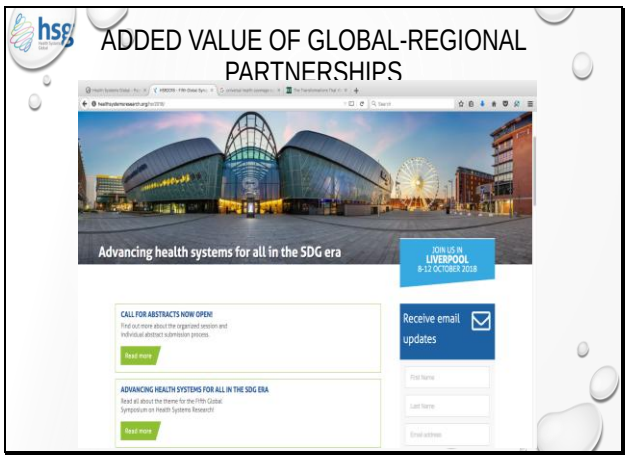
- COMPLIMENTARY OR BASIC INSURANCE TO POOL THE RISKS AND REDUCE OOPS
- ENGAGEMENTS WITH TECHNOLOGY PROVIDERS FOR SECURING BETTER PRICING
- ASSESS THE VALUE AFFORDED BY NEW TECHNOLOGIES USING HTA
- MORE EFFICIENT PRODUCTION THROUGH ECONOMIES OF SCALE (IF FEASIBLE AND REALISTIC????) TELEMEDICINE, ETC.

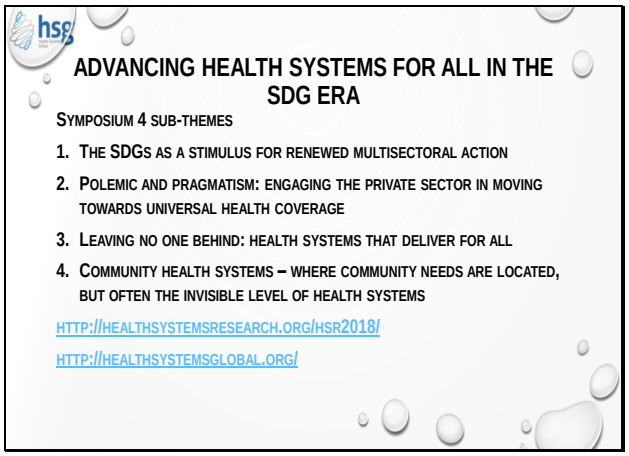
WHAT ARE GAPS IN POLICIES AND REGULATIONS?

A LOT SUCH AS (INCOMPLETE LISTING):

- LACK OF UNDERSTANDING
  - WHY DO WE NEED PPPS?
  - WHAT TRIGGERS NEED FOR PPP AND WHEN?
- LACK OF WILLINGNESS TO ENGAGE PRIVATE SECTOR
- LACK/OR WEAK CAPACITY WITHIN THE PUBLIC SECTOR ENTITIES/ORGANIZATIONS
- LACK OF INFORMATION BUT (SOLVABLE) WITH INFORMATION TECHNOLOGY
- RULE OF LAW AND CORRUPTION RELATED ISSUES
- CAPACITY TO DEVELOP CONTRACTS, LACK FOR TEMPLATES ON HOW THINGS ARE BEING DONE?

ADDED VALUE OF GLOBAL-REGIONAL PARTNERSHIPS





Dr. Galal stressed that the term public-private partnership might be confusing and suggested using "public-private participation" instead, with the hope that this terminology might broaden the concept of the relationship between the government and the private sector, and at the same time preserve the independent role each party plays. He further shared another insight related to the difficulties facing PPP implementation, noting that different countries vary in the conditions/aspects of their health services and thus there is no one model of PPP that fits all countries.

Dr. Mirza thanked MENA HPF for selecting this theme for their annual conference and shared some reflections from the perspective of the WHO. The WHO is currently using the term "effective engagement" with the private health sector, which gives the government the leadership role. He shared two general considerations: firstly, he highlighted the importance of establishing clearly how the public sector will engage the private sector in health care by defining the regulatory role of the public sector and the health care quality standards that should be met by the private sector. Secondly, it is important to determine the framework of engagement with the private sector. He cited the WHO Health Systems Framework as a good example. This framework starts with governance; the government has the responsibility to develop national health policies/ strategies/plans with clear inclusion of the private sector and regulating relevant institutions e.g. private medical colleges. In financing, he underscored that it is not the problem of resources but rather that health services are not the priority of the government. Thus it is

important to first define the benefit package of services that will be delivered, to cost them, and then to decide what would be the role of the private sector in service delivery. He emphasized that from the WHO perspective, the best way of engaging the private sector is to purchase services from the private sector. In this way the public sector can decide the quality of service, the standards and the cost i.e. the public sector defines the terms of engagement with the private sector.

He also discussed the idea of pooling and creating economies of scale, stating that political economy determines if this strategy will be successful. The WHO has done a systematic evaluation of six global pooling procurement arrangements and out of the six (including one in North Africa: Morocco, Libya, Tunisia, and Egypt) only two succeeded.

He also invited MENA HPF to partner with the WHO in conducting national forums in four countries to promote universal health coverage.

Dr. Rady outlined the progress that Egypt has made on the road towards universal health coverage, and gave some updates on the new social health insurance (SHI) system. He stated that the SHI law is in the final stages and has been submitted to parliament for approval. He explained that Egypt has had social health insurance since 1964; however, it covers only the formal sector (around 7 million Egyptians). The insurance system has expanded to include students (22 million) and female-headed households, so the total coverage is currently around 30 million. Dr. Rady added that 65% of health expenditure in Egypt is out-of-pocket and that the current relationship between the public and private sector entails minimal engagement. This includes, for example, purchasing renal dialysis services from the private sector, and reimbursement of patients who receive some health services from the private sector. He emphasized the importance of collaboration with the private sector and affirmed that the new SHI addresses this. He said that it is expected that the private sector will cover 35% of health services under the new SHI, through the purchasing of services from the private sector. He further stated that the main focus of the government is to strengthen the public sector to deliver quality services and to regulate the private sector. He added that the role of NGOs in supporting universal health coverage needs to be strengthened and aligned with the strategic directions of the Ministry of Health and Population.

Conclusion and way forward

Key Discussion Points

- NGOs' support of countries heading towards universal health coverage should be aligned with countries' main strategies and national plans.
- Government can enroll NGOs and contract them to achieve national health goals.
- Effective PPP requires a strong public health sector, and that PPP must be a win-win situation.
- Dual practice and reduced capacity of the health workforce in the public sector were raised as obstacles to social health insurance.
- Political economy and health - how can we revitalize this to advance universal health coverage?
- Egypt's plans in the transition period from the old to the new social health insurance.
- PPP and its taxonomy, such as participation and engagement.
- The existence and extent of corruption in the health sector, and how PPP can reduce corruption.
- The role of the private sector in the provision of preventive and the curative services.
- Accountability as an important aspect of PPP and the need to address this in future forums.
- The importance of national pooling, which creates economies of scale.
- Universal health coverage and the inclusion of preventive services at the individual and population levels.
- Proper mapping and assessment of the private sector as an important initial step in PPP development, to find out its strengths and how the public sector can engage them effectively. The methodology of assessment was developed by the WHO and states can use that as a tool for assessing their private sectors.
- The new social health insurance in Egypt and the challenges facing its implementation.

Key Conclusions and Recommendations

- PPP is a long-term partnership in the form of a legal contract between the public sector and the private sector. Under the contract, a public asset is managed or service provided while the private party bears significant risk and management responsibility, and remuneration is linked to performance.
- Mixed public and private financing and delivery of care characterize most health systems in the developing world.
- Improvements in quality and access require further thinking about the role of the private sector within health systems and a broader systems perspective on how the public and private sectors can work together to address the challenges of affordability, quality, and availability of care.
- There is an urgent need to invest in capacity building among ministries of health to design, manage, monitor and evaluate PPPs.
- Without involving the private health sector in a mutually agreed-upon national policy framework and developing effective partnerships, universal health coverage will remain an unachievable dream for many countries.
- Many obstacles still exist on the path to developing effective PPPs, including lack of knowledge about their implementation.

- PPP is not about getting the public sector out of service provision, and it is not privatization.
- Countries need a secure, predictable, stable, consistent and commercially oriented framework of law and regulation in order for PPP to flourish.
- PPP requires effective regulation and governance.
- The government should take the full responsibility for health, but the private health sector has an important contribution to make. Strong regulations and their enforcement are required, but collaboration can advance health systems and maximize population benefit.
- The private sector can best provide goods of high contestability and high measurability.
- Policy instruments that governments can use for PPP include contracting, regulation, subsidies, public-private initiatives, private health insurance, provision of public health services, and resource creation.
- Health policy-making and health system strengthening need to be informed by robust research evidence, and responsive to a country's specific needs, given that health systems are highly context-specific.
- Evidence-synthesis and knowledge translation centers/platforms have critical roles to play in bridging the gap between research and policy and in promoting evidence-informed policy-making, and knowledge translation is critical to facilitate uptake of evidence in policy decisions.
- Leveraging pre-existing research evidence and systematic reviews can enhance efficiency and minimize research waste.
- Successful partnerships should stimulate new ideas from concept to manufacture, marketing, and uptake, although to avoid rejection these new ideas should take into account local values and culture.
- PPPs in the health sector are in the very early stages; market power abuse must be prevented.
- Expensive, cutting-edge technologies are often perceived as an indicator of high quality services; however, they may lead to a disproportionate escalation in health care delivery costs. Creating appropriate products for different resource settings requires in-depth understanding of the particular needs and resource capacities of each country.
- A stronger focus of limited health technology assessment resources on "macro" aspects of health system architecture may yield higher gains in the mid- to long-term.
- Strategic purchasing is an effective mechanism for engaging the private sector and promotes quality and efficiency; different provider payment methods can be a way to regulate, incentivize and integrate the private sector in health, and good governance is key for ensuring effective engagement of the private sector in health.
- The development of supplementary and complementary private health insurance should be aligned with the development of universal health coverage and strategic review of countries that face similar challenges to Egypt but are more advanced in implementing universal health coverage, e.g. South Africa or Thailand, may deserve more attention.
- The WHO Health Systems Framework is a good framework for engagement with the private sector.

Future Directions

1. MENA HPF will continue to address gap areas, which include gathering evidence and informing policy-makers.
2. MENA HPF is to partner with the WHO in conducting national forums in four countries to promote universal health coverage.