Public-Private Partnership for Universal Health Coverage
Annual Regional Conference
November 12-13, 2017
Cairo, Egypt

Introduction

Most health systems within the developing world are characterized by mixed public and private financing and delivery of care. Improvements in quality and access therefore 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.

Private health care is not just the province of the wealthy; in many poor communities, private doctors (with varying degrees of training), pharmacists, and other service providers are the first line of response when people require care. Demographic and Health Surveys (DHS) show that the limited quality of public health services have pushed 63% to 85% of the poorest in the population to paying out-of-pocket for services from the private health sector.

This situation is mirrored in other developing countries; it is estimated that nearly 50% of those receiving health care in developing countries, even at the lowest income levels, are receiving services provided by the private sector. An analysis of Demographic and Health Survey data from 2000 to 2012 across 46 low- and 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 shows that between 27% and 30% of users in sub-Saharan Africa obtained contraception from private sector providers.

Given that many countries rely on the private sector as a significant provider of services, it is essential that it be engaged in efforts to improve health outcomes. Unfortunately, governments in most countries are unable to make the most of the potential of private health services, or to mitigate the problems that occur in a largely unregulated environment. Despite unprecedented levels of interest from donors in improving health conditions in developing countries, very few sources of development assistance help to promote or improve the relationship between the public and private sectors.

In most Eastern Mediterranean Region countries, the private sector is a dominant provider of outpatient health services, providing up to 70% of outpatient services. The private health sector therefore remains a key untapped partner in progress towards universal health coverage.

However, challenges remain concerning the private sector, including unregulated expansion; lack of accreditation programs; duality of workforce practice between the private and public sectors; irrational use of biomedical devices and technologies; non-prescription sale of antibiotics resulting in antimicrobial resistance; outdated regulations and inadequate regulatory control for quality; and limited availability of data. Additionally, there is limited capacity for ministries of health to formulate policies and fulfil regulatory responsibility. Regulation, information provision, and purchasing of services remain important tools for harnessing the role of the private sector in the move towards strategic universal health coverage goals.

Private expenditure is currently a key component of domestic financing: private expenditure on health accounts for over 50% of the total health expenditure in more than 60% of developing countries. However, it is important to note that the bulk of this is from out-of-pocket payments, which are inequitable and fall disproportionately on the poorest segments of the population; countries with the least total health expenditure per capita have the highest private heath expenditure. By working with countries on smart, scaled, and sustainable financing, both public and private financing might be harnessed in an equitable way (while reducing out-of-pocket expenses) to achieve health goals.

The private health sector presents many unparalleled opportunities to improve access and service coverage, in particular services critically needed to reach the health-related Sustainable Development Goals. It also necessitates intervention, typically by the state, to protect people by addressing the most serious shortcomings in the quality of care and health products. Health programs in most countries will only reach their objectives by engaging with the private health sector; doing so would harness and expand the benefits the sector provides. The need for such action has been clear for years, but effective policy interventions such as regulatory reform, contracting, risk-pooling, and policy dialogue are few and underdeveloped. In most developing countries, the public and private sectors of the health system work separately, to the detriment of health care outcomes. The private health sector has minimal policy direction and is rarely a major part of governments' health sector planning processes.

There is therefore an urgent need to invest in capacity building among ministries of health on designing, managing, monitoring and evaluating public-private partnerships (PPPs). Without involving the private health sector under a mutually agreed-upon national policy framework and developing effective partnerships, universal health coverage will remain an unachievable dream for many countries.

Conference Themes

A. Respective Role of Public and Private Sectors in Enhancing Access
Approaches for expanding access are becoming feasible with newly acquired capacities that allow preferential services and service delivery sources. Working models of engagement are available between major public and private sector actors to achieve public health goals and expand access.

B. Monitoring and Independent Regulation of Potential Abuse of Market Power
The importance of partnership with the private sector is increasingly being acknowledged by ministries of health, while policies for its engagement are lagging throughout the 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. The private health sector is considered something of a blind spot in most countries because of limited information, irregular reporting, and sporadic and incomplete data. Regulation and monitoring are essential to support national interests and control the extended power of both sectors.

C. Role of Pharmaceutical Sector and Technology
Private hospitals are introducing sophisticated marketing campaigns to attract patients, and the focus of such campaigns is often on expensive, high-tech technologies, meant to indicate high-quality services. There is a high level of irrational pharmaceutical prescribing in private as well as public settings, leading to the 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 society. Creating appropriate products for different resource settings requires in-depth understanding of the particular needs and resource capacities of each country. Regulations of the pharmaceutical industry, including price controls and a focus on affordability, are essential in reconciling private and public interests to reduce tension between net affordability and profit.

D. Policy Formulation
Engagement between public and private health sectors requires clear policy formulation and deliberate, systematic collaboration between the government and the private health sector, according to national health priorities, in a way that goes beyond individual interventions and programs. The role of the private sector in affecting the health reform processes and policy formulation cannot be neglected. Definition of roles and responsibilities is thus needed to support effective engagement and avoid unexpected escalation to higher cost levels.

Outline of the Conference

- 2 days
- 7 plenaries

Conference Objectives

Developing countries typically rely on a mix of public and private health delivery systems, but government health system stewards mostly lack essential information, know-how and mechanisms to create effective engagement with private providers to deliver primary health care services. In order to obtain full access and better quality, the engagement of the private sector with the public health system must be considered, through stronger partnerships that are based on clear objectives within a well-defined regulatory mechanism. The benefits of establishing a broader system must also be evaluated. This will help address the challenges of affordability, availability, and quality of care.
The MENA Health Policy Forum organized this conference to answer the question: "how can public/private interests become better aligned for the provision of equitable services toward universal health coverage?"
This was elaborated on 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.

Approach

The conference provided a platform for policy dialogue and experience exchange among policy-makers, private sector actors, academics, researchers and development organizations, to identify better, more efficient engagement of the private sector in health service delivery, in order to improve health coverage and hence outcomes in the MENA region.

Sponsors

The Middle East and North Africa Health Policy Forum (MENA HPF) conducted the conference in collaboration with Arab Fund for Social and Economic Development and the World Health Organization (WHO).

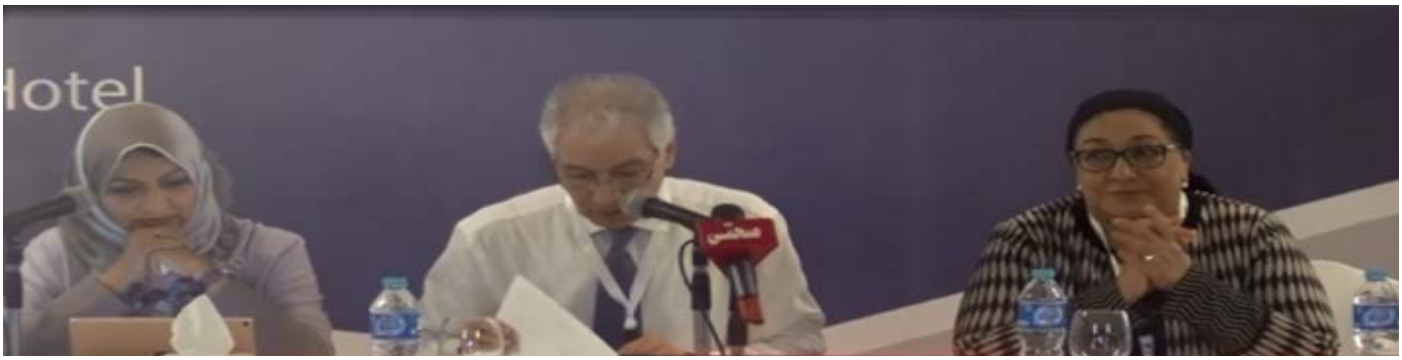
Participants

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.

Opening Session

Chairperson: Ahmed Galal | MENA HPF

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



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 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. 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.

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.

Session 1: Public-Private Partnership in Health—Facts, Prospects and Challenges | Scene-setting

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

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.

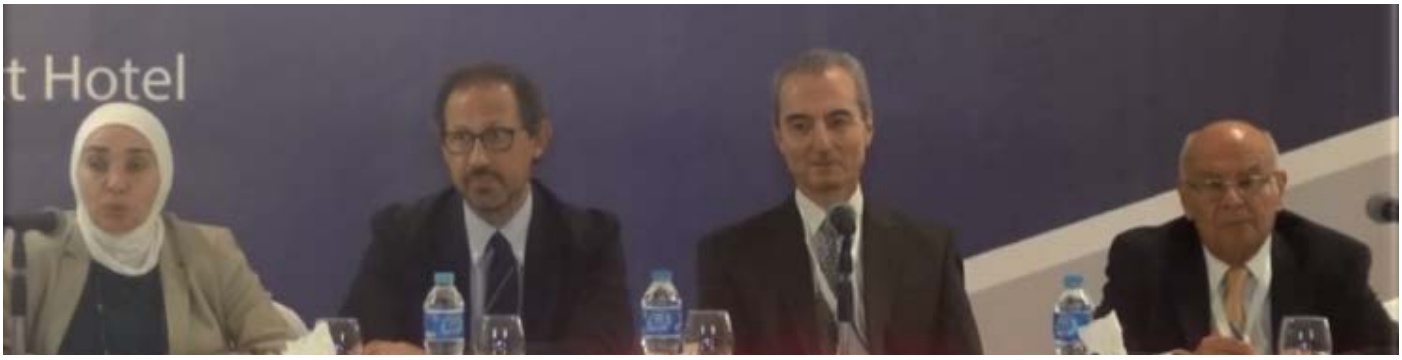
He further added that there is a link between health care and economic wealth. There is an evidence that each dollar spent on the implementation of universal health coverage will generate a benefit to the economy of about $7-9 in four to five years' time. He concluded that if this analysis holds true,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

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 noncommunicable 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.

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



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.

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.

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.

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
Open discussion

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 center 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.

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(KPIs used by Dubai system) 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.

Dr. Yahya presented the Moroccan experience in PPPs, providing an overview of key health achievements in Morocco, such as the decrease in 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.

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 noncommunicable 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).

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
Open Discussion

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.

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 require 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.

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.

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.

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
Open Discussion

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.

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.

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.

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
Open Discussion

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.

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.

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.

Key Discussion Points

1. NGOs' support of countries heading towards universal health coverage should be aligned with countries' main strategies and national plans.
2. Government can enroll NGOs and contract them to achieve national health goals.
3. Effective PPP requires a strong public health sector, and that PPP must be a win-win situation.
4. Dual practice and reduced capacity of the health workforce in the public sector were raised as obstacles to social health insurance.
5. Political economy and health - how can we revitalize this to advance universal health coverage?
6. Egypt's plans in the transition period from the old to the new social health insurance.
7. PPP and its taxonomy, such as participation and engagement.
8. The existence and extent of corruption in the health sector, and how PPP can reduce corruption.
9. The role of the private sector in the provision of preventive and the curative services.
10. Accountability as an important aspect of PPP and the need to address this in future forums.
11. The importance of national pooling, which creates economies of scale.
12. Universal health coverage and the inclusion of preventive services at the individual and population levels.
13. 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.
14. The new social health insurance in Egypt and the challenges facing its implementation.

Key Conclusions and Recommendations

1. 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.
2. Mixed public and private financing and delivery of care characterize most health systems in the developing world.
3. 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.
4. There is an urgent need to invest in capacity building among ministries of health to design, manage, monitor and evaluate PPPs.
5. 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.
6. Many obstacles still exist on the path to developing effective PPPs, including lack of knowledge about their implementation.
7. PPP is not about getting the public sector out of service provision, and it is not privatization.
8. Countries need a secure, predictable, stable, consistent and commercially oriented framework of law and regulation in order for PPP to flourish.
9. PPP requires effective regulation and governance.
10. 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.
11. The private sector can best provide goods of high contestability and high measurability.
12. 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.
13. Health policy-making and health system strengthening need to be informed by robust research evidence, and re sponsive to a country's specific needs, given that health systems are highly context-specific.
14. 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.
15. Leveraging pre-existing research evidence and systematic reviews can enhance efficiency and minimize research waste.
16. 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.
17. PPPs in the health sector are in the very early stages; market power abuse must be prevented.
18. 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.
19. 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.
20. 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.

21. 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.
22. 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.