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Prospects and Experiences

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Health Sector Reform in the Middle East and North Africa: Prospects and Experiences

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The mass protests that swept the Middle East and North Africa (MENA) region since December 2010 called for social justice and a dignified life and well-being for all citizens. Beyond the political and economic dimensions, these popular uprisings were also fueled by a strong sense of discontent with struggling health systems that have not delivered on the promise for better, more affordable, and equitable healthcare.

MENA countries have some of the lowest levels of public spending on health, which continue to translate into high levels of out-of-pocket (OOP) expenses. This high OOP has forced many citizens of MENA countries to either forgo care or face impoverishment due to medical expenses. Further, access to care is inequitable and quality is capricious and inconsistent, with long waiting times coupled with high absenteeism rates among providers. With a rising burden of non-communicable diseases, and a double burden of malnutrition characterized by the coexistence of undernutrition along with obesity, these factors have been adding to the strain falling on MENA health systems with serious consequences on future health spending and labor productivity. These challenges to health systems, in terms of financial burden, disease profiles, and access to equitable quality care, would likely defy hopes for realizing the aspirations of the many who took to the streets during the Arab Spring and thereafter.

Confronting MENA's health system challenges will require concerted efforts and bold reforms together with strong political commitment to meet population needs, especially at a time of shrinking fiscal space. The recent plummeting of oil prices, which have dropped by some 60% since the middle of 2014, has added more pressure on already stagnating economies. The situation is further complicated by the ongoing conflict in parts of the MENA region, which has resulted in wide-spread political instability, diminishing economic activity, and huge reductions in government revenues.

Many MENA governments are highly cognizant of these challenges, and have taken active steps to renew and revive the social contract to meet citizen expectations and demands using the Arab Spring as a catalyst for long-term change.

This special issue of *Health Systems & Reform* examines government efforts that have been adopted since 2011 to address imminent health system challenges in the MENA region. It attempts to capture some of the fundamental health sector reforms that have been adopted by MENA countries to address their population's demands for better health care service delivery, access, and equity. The articles included in this special issue relate to projects that have been financed by the World Bank in the last six years, or where technical assistance was provided by the World Bank to MENA governments. Therefore, it does not constitute a comprehensive assessment of health system performance across all MENA countries, but focuses on a select group of country experiences where the World Bank was involved in this time period. The findings, interpretations and conclusions expressed herein are those of the authors and do not necessarily reflect the view of the World Bank Group, its Board of Directors or the governments they represent.

Framework

A useful way to pull together some of the themes impacting the health sector in MENA and reflected in the articles in this issue is to think systematically about the policy levers typically used in addressing health sector performance and reform. A framework increasingly used for organizing health systems thinking is the Flagship Framework which describes a health system as having three ultimate outcomes---improving health status, financial protection, and citizen satisfaction---that are influenced by three intermediate outcomes---access, quality, and efficiency.^{1,2} In order to influence the intermediate or ultimate outcomes of a health system, a policy maker has five policy levers (or “control knobs”) at her disposal---financing; payment; organization; regulation; and behavior (Figure 1). This framework provides a useful heuristic through which to understand the articles in this issue. Each article either evaluates a health system based on the ultimate outcomes or describes a set of policy reforms implemented in MENA which use one of the policy levers.

The Flagship Framework argues that the final aim of a health system is to achieve three outcomes---improve health status, provide customer satisfaction, and assure financial risk protection. In reality, even within the three categories of performance goals there are several different outcomes which can be considered. Health

status, for example, can be measured by a variety of mortality-based globally reported data such as infant mortality, child mortality, adult mortality, life expectancy, and years of life lost. Health status can also be measured by variables that combine mortality and morbidity such as disability-adjusted life years or quality-adjusted life years. This complex challenge of measuring health sector performance is tackled in two articles in this special issue and applied to the region. Wang and Yazbeck take a regional approach to benchmarking health performance with a focus on health status and financial protection. Pande, El Shalakani and Hamed develop a novel diagnostic method to measure progress towards social justice using all three performance measures and apply it to the case of Egypt. Both articles highlight the importance of setting up and systematically measuring health sector performance as a means to identify and develop policies to eventually improve outcomes.

Health Financing Reforms

The health sector finance policy lever in the Flagship Framework refers to how money is raised, risk pooled, and allocated in order to change the performance of the health sector. As noted earlier, overall public spending on health in the region has tended to be on the low side standing at 3.2% as a share of GDP in 2014, and has been recently further challenged by political instability in some countries and declines in the price of oil and gas in others. An important set of reforms in the region have focused around building or reforming health insurance systems for both generating money for the sector, as well as for pooling risk across populations. Most Gulf Cooperation Council (GCC) countries, for example, are exploring or have recently implemented some form of insurance. The United Arab Emirates has a single quasi-publically run Emirate wide insurance system in Abu Dhabi, and a mandated private health insurance in Dubai (the two largest Emirates in the country). Qatar, on the other hand, is currently exploring shifting from a single payer public insurance to a competitive private health insurance system. In this issue, Al-Mazrou and co-authors explore how private health insurance for expatriate workers in Saudi Arabia grew after a labor law was passed 16 years earlier, and how it dramatically influenced how health services are financed, organized, and delivered.

Payment Reforms

The payment policy lever focuses on what and how various health sector institutions and care providers are paid and how those payments can create incentives for changing behavior. Unlike financing, which tends to be fairly difficult to reform, provider payment reforms are mostly within the control of the health sector and therefore easier to change. Two articles in this issue touch on provider payment in instructive ways. The article on Lebanon (Khalife and co-authors) addresses an area that will increasingly play an important role in health sector reform in the MENA region---provider payment from the public sector to the private hospital sector in the country. Given the dominance of public finance for health care in the region and the policy push for private sector delivery, the Lebanon article presents important lessons for the design and management of payments systems. The article on Saudi Arabia also offers important lessons in this area. The expansion of private health insurance in the Kingdom was originally dominated by indemnity-type insurance instead of health maintenance insurance, leading to a fee-for-service payment system focused on curative care. The private hospital sector in the Kingdom consequently grew in ways that emphasized curative services, instead of preventive care, and focused on intervention based-medicine such as surgery with implications for health care cost and quality.

Organizational Reforms

The organizational reform policy lever in the Flagship Framework covers a range of issues which include policies to define and manage public and private entities and relationships, the challenging range of issues around the role of the public sector versus markets, and how health systems are organized around centralized and decentralized agencies, clinics, and hospitals, as well as internal management issues. Several articles in this issue address issues linked to the organizational policy lever. For two articles, organizational issues are central. The article on Palestine (Alaref and co-authors) focuses on policies to deal with dual practice among physicians and in doing so addresses an issue that is on top of the agenda of many MENA countries as well as elsewhere in the world. The Morocco article (Le Pape and co-authors) looks at the central role of information

and communications technology (ICT), as well as health management information systems (HMIS) in how the health sector is organized and functions. The Morocco article also looks at how to engage stakeholders in organizational reforms from inception to planning to implementation.

Articles in this Issue

Each article in this issue addresses an important aspect of a health system presented in the Flagship Framework---from understanding health performance by evaluating final outcomes to bringing about reform through influencing one or many policy levers. The lessons learnt from each experience are relevant, not only to other MENA peers, but also to other countries globally which are grappling with similar challenges.

The first article of this issue, by Wang and Yazbeck, looks across the MENA region to benchmark the health sector and introduce readers to both high and low performing health systems. The authors use existing global data bases on health status and health financing to extend previous work on benchmarks in the health sector^{3,4} by updating the data and applying it to MENA. In terms of health status, the article finds three clusters of countries with specific patterns of achievement relative to levels of national income and educational stock, two variables highly correlated to health outcomes. The three clusters are: (1) countries that underspend on health, in some cases substantially, and under perform in terms of life expectancy; (2) countries with slightly higher than expected spending on health but substantially higher than expected life expectancy; and (3) countries with slightly lower spending and slightly better than expected health status. Another interesting finding is that many of the countries that did very well on health status did not do well on financial protection. By identifying high, low and average performers on two dimensions of health system performance in the region as well as some apparent tradeoffs between health status and financial sustainability, the article begins to identify targets for countries to use as they reform their health sectors. A potential use of the findings of this article is the identification of countries where further and deeper analysis is needed to better understand good and low performance.

How does one achieve social justice in health care? This question is relevant to several governments that came to power in the Arab world on calls for social justice during the period of the Arab Spring in 2011. In the second article in this issue, Pande, El Shalakani and Hamed, tackle this question by proposing a novel diagnostic method and then applying it to the case of Egypt, a country with a stated goal of achieving social justice in health care. By conducting a comprehensive analysis of primary and secondary qualitative and quantitative data sources, they first identify six disadvantaged groups in Egypt and then analyze the status of these groups with respect to the three objectives of a health system as defined in the Flagship Framework---improving health outcomes, financial protection, and public satisfaction. Their results suggest that Egypt faces 11 challenges to achieving social justice in health care, including; poor maternal and child health indicators; high out of pocket spending; and poor quality of care in certain sub populations. These challenges can be addressed through 14 short and medium policy reforms drawn from global best practice including supporting a family health model of primary care; separating providers from payers; and creating avenues for citizen's participation. Implementing these actions can improve social justice in health care in Egypt.

The third article in this issue focuses on financing. Al-Mazrou and co-authors document an interesting and not so well studied phenomenon of how changes in one sector, specifically labor laws, can and do, dramatically impact the development of the health sector. Saudi Arabia, like all other GCC countries, has been transforming how health care is financed and delivered in part due to the large percentage of expatriate workers in the country. The article analyzes the 16-year history of a labor law that put the responsibility on private employers to ensure that expatriate workers are covered by private health insurance instead of relying on an overburdened public system of facilities and hospitals. This law led to a steady growth in private health insurance, which drove an unprecedented and dramatic growth in private hospitals in the country. A second and more recent labor law focuses on increasing Saudi workers in the private sector by setting up targets for employment. Given that the health sector is highly labor intensive but requires highly skilled workers, the law on national quotas is the biggest threat to continued growth in private sector delivery and has had an impact on Saudi doctors working in public hospital (exit and dual practice). Lessons from this article apply to other

GCC countries and offer important insights on the unintended consequences of labor laws on the health sector.

The fourth article focuses on the payment policy lever. In an important article on the long-term experience of contracting between the public sector and private hospital services in Lebanon, Khalife and co-authors present the history of the contracting experience and how a recent reform is starting to produce positive results for the health system. Lebanon's experience is somewhat unique in the Middle East given the large private sector for health in the country, but aligns well with a regional push towards stronger public-private partnership and the development of the private sector for hospital care. The article describes the technical nature of the contracting reform and also the open process with which it was developed and implemented. The authors identify important lessons about provider payment methods, linking payments to accreditation and different measures of quality, the effective use of data and information technology, the active use of community engagement and committee approaches, and the nature of public-private partnerships (including political dimensions). Other important lessons from the article relate to the use of smart stewardship in a fragmented sector and how data intensive reforms can be used in a potentially politicized context.

The fifth article focuses on the role of organizational reforms. It examines the potential impact of banning dual practice, which is defined as the practice of a health worker engaging simultaneously in both the public and private sectors, on access and quality of service delivery in the Palestinian territories. Dual practice is not unique to Palestine, and many countries in MENA and globally have experimented with different policies to manage it. However, there is no widely accepted policy approach; some countries have attempted to institute a complete ban while others have permitted it without restriction. In between these two extremes, some have applied different restriction modalities, including: licensure restrictions; restrictions on earnings; allowing private provision in public facilities; and even using self-regulation. This article analyzes the experience of the Palestinian territories, demonstrating that a complete ban on dual practice would result in a number of negative consequences. This includes the risk of a 'brain drain' with the loss of rare specialties in the public

sector. The authors also argue that while dual practice is negatively associated with poorer quality of care in the Palestinian territories, instituting a ban is not likely to improve quality given the many structural challenges that the country faces. Finally, the article emphasizes the implications associated with the enforcement of such a policy, which would be fiscally unsustainable, and not likely to realize the intended objectives of access and quality.

The sixth article looks at another aspect of the organization of a health system---the information technology platform on which it is built. Information technology is an important element of a modern health sector but is challenging to develop and implement. Unlike many other sectors, the health sector in most countries is slow to adopt information technology, and as a consequence misses out on ways to become more efficient. In their analysis of the health sector of Morocco, Le Pape and co-authors present important lessons on how information technology can be brought in to help make the sector more effective and more productive. The article explores the introduction of a nationwide health management information system through the “*urbanisation*” of its information systems. The authors examine both technical and operational dimensions of the challenge and draw out important lessons for other countries. The article also brings to life how a well-functioning and well-used information system can help decision makers at all levels of the system. Such success, however, requires engagement at all levels of the system in all aspects of planning and rolling out, from inception to phasing, to full implementation.

Concluding Remarks

Each article in this special issue showcases the ways in which different countries in MENA have grappled with universal challenges in improving the performance of health systems---high health spending; large uninsured populations; and poor data for decision making, among others. Overall, this special issue serves three purposes. First, the issue presents ways that the health sector can tackle current health challenges, and brings forth important lessons for all countries across the globe, not just MENA. Second, the experiences of MENA demonstrate the dynamism of health systems in this region, highlighting their capability to adapt and

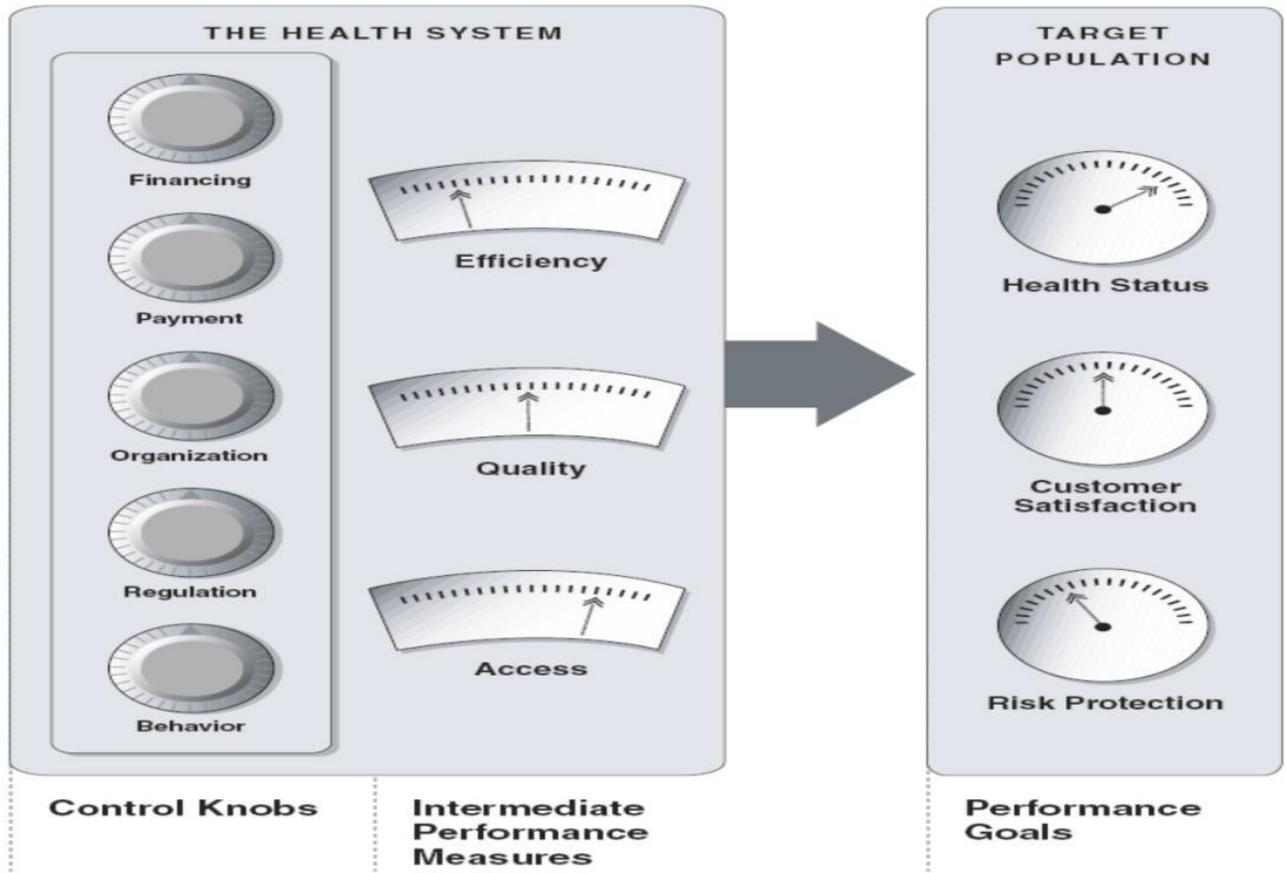
innovate in the face of external shocks. Third, studies on the health systems in MENA have been under represented in the global health literature, and this issue augments the published literature on efforts to improve health system performance in the Middle East by sharing the experiences of several countries from this region.

The MENA region remains one of the most dynamic regions globally---full of both challenges as well as opportunities. We hope that this issue helps readers see the opportunities in the challenges and how they can be applied to help advance the cause of Universal Health Care around the world.

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Source: Roberts et al. [1]

Figure 1. The Flagship Framework