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Government purchase of private health services in the Eastern Mediterranean region: opportunities and challenges for stewarding towards a universal health coverage focus

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ABSTRACT

Background Proliferation in government purchase of private healthcare requires stewardship support for impactful alignment to Universal Health Coverage (UHC) goals. This paper provides a synthesis of country purchasing initiatives involving the private sector from the Eastern Mediterranean region (EMR) identifying drivers, stewardship challenges and country aspirations for strengthening purchasing initiatives.

Methods Findings are drawn from 19 in-depth mixed methods country case studies commissioned by the WHO, guided by a standardised data collection tool for desk review and country stakeholder interviews. Case study synthesis approach was applied to draw on commonalities and emphasising important differences across country contexts. Extraction and analysis into country income groups allowed thematic comparisons.

Results Significant proliferation in the purchase of private healthcare has been driven by contextual opportunities provided by political momentum, local adaptive designs, unlocking of domestic financing and initial operational groundwork particularly in middle-income EMR countries. Common challenges include (1) steering constrained by conflicting ideologies, role dispersion and a focus on UHC schemes rather than the UHC vision; (2) implementation challenges of weak contract management expertise, uncertain quality compliance; and (3) private sector engagement hampered by insufficient communication and trust. Less resourced countries also face challenges of private sector fragmentation impeding purchasing. We found common interest across countries to better integrate the private sector for UHC. Prioritised future needs included (1) national Private Sector Engagement (PSE) planning to inform purchasing arrangements, (2) evidence for better understanding, (3) leadership structures, (4) formal dialogue platforms and (5) social-behavioural incentives for quality and data reporting compliance. Middle-income and high-income countries additionally prioritised payment controls, whereas lesser resourced countries emphasised sustainable fiscal mobilisation.

Conclusion The synthesis importantly highlights new directional and relational needs alongside traditional structural, and expertise needs to guide a re-imagined stewardship agenda for strengthening the purchase of private health services in the EMR. Future socio-behavioural research on private sector motivations for partnerships and behaviour under purchasing arrangements will strengthen PSE within local eco-systems.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Discourse on government purchase of private healthcare in the global south has narrowly focused on discrete financing initiatives rather than the larger stewardship ecosystem based on an understanding of the local private sector.

WHAT THIS STUDY ADDS

⇒ We focused attention on stewardship challenges of coherence across disjointed initiatives, alignment with common pro-Universal Health Coverage ideology, role fragmentation, private sector understanding and communication gaps, that are less well understood compared with traditional quality and cost concerns.

⇒ There is common future interest across Eastern Mediterranean region countries in strengthening purchasing stewardship driven by a pragmatic acceptance of the private sector in health as well as the political interest of higher leaderships.

⇒ Core needs across diverse country contexts include Private Sector Engagement planning, more evidence, stewardship structures, dialogue platforms and a greater reliance on behavioural incentives due to enforcement challenges of regulatory measures.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Urgent centrefold investment in multifaceted stewardship is required to move from purchasing to strategic purchasing.

⇒ Investment in social-behavioural research on private sector interests and converged working under purchasing arrangements will strengthen stewardship in contexts of informality seen in the global south.

INTRODUCTION

The Eastern Mediterranean region (EMR) has the greatest reliance on private providers to deliver essential health services. Private providers dominate the market for diagnostic care, constitute between 20% and 70% of hospital bed capacity and between 20% and 90% of Primary Health Care (PHC) clinics.[1] The for-profit sector is a key service provider in all EMR countries, while the non-profit sector plays a prominent role in only a few countries.[1] Weighted regional results indicate that 53% of inpatient and 66% of outpatient care takes place in the for-profit private sector.[2] Private health provision comes with a cost to households reflected in out-of-pocket expenditure of up to 50% in at least 6 out of 22 EMR countries, requiring deliberative steps by country governments to ensure affordable access.[3]

EMR countries with significant mixed healthcare systems are moving to supplement public sector services with the purchase of private healthcare to meet demands of a growing population, rise in chronic diseases with ageing and diagnostic needs to address health security concerns. EMR countries have shown a heightened policy commitment to Universal Health Coverage (UHC) in recent years, pledging to the UHC 2030 Global Impact and endorsing several regional resolutions to advance UHC by 2030 with meaningful inclusion of the private sector as part of UHC efforts.[4–8] Promisingly, a range of formal initiatives involving government purchase of private healthcare are in place in the EMR increasing access to affordable services with considerable country variations in scale of implementation. National health insurance (NHI) initiatives using pooled domestic funding are in place in many middle-income countries covering up to 30–85% of the population.[9] Additionally, standalone contracting of private health providers has long been in place in the EMR, predating insurance schemes, to increase access to specific services within underserved geographies or for specific groups such as the poor. Contracting out (CO) involves timebound contractual agreements with private providers, underwritten, managed and funded or co-funded by the state with explicit responsibilities of both state and private sector.[10] However, progress from purchasing to strategic purchasing practices in terms of what to buy, for whom and how[11] is yet to happen in most EMR countries. There are many ad hoc, parallel initiatives and a lack of robust formal assessments.[12]

Purposeful steering of the private health sector to improve access to affordable services is now emphasised by the WHO as integral for progression towards UHC.[13] Although government purchase of private healthcare by governments in EMR countries provides a potentially powerful lever to steer private providers towards UHC goals, we contend that the strengthening of purchasing arrangements must go beyond the dos and do not of the payment and financing functions of discrete funding schemes. Instead, a wider process-based understanding must be developed of the stewardship ecosystem necessary for engaging and finding common ground with private providers under national health goals to guide purchasing arrangements. Stewardship according to the WHO is about how government actors exert responsibility and coordinate across multiple stakeholders, typically exercised through legal frameworks, institutional arrangements, connections between decision-making structures, processing of data and charting pathways to sustainable resourcing under strategic health systems goals.[14] Investing in the larger stewardship ecosystem is particularly necessary for southern contexts where formal transactional systems are less salient.[15]

This paper contends that future efforts to shift from purchasing towards more strategic purchasing must be preceded by building an understanding of multifaceted stewardship challenges in harnessing the private health sector within local purchasing ecosystems. It presents findings from a synthesis of country case studies with the aim to examine the nature and depth of stewardship efforts being exerted within existing purchasing arrangements, ascertain foremost stewardship challenges and identify country aspirations and needs to strengthen stewardship. The political juncture in EMR countries is particularly opportune for lesson learning on enhancing stewardship as several countries are re-calibrating existing purchasing initiatives for better delivery or contemplating the introduction of the purchase of private healthcare. The lessons extracted are meant to contribute to a regional stewardship agenda to support the purchase of private services as part of the UHC 2030 commitment, building on existing local entry points.

METHODS

The paper presents findings from a synthesis of country case studies commissioned by the WHO's Eastern Mediterranean Regional Office of 19 out of 22 countries in the region. The synthesis is guided by three objectives: (1) to explore modalities and scale of purchasing arrangements for private healthcare underway in EMR countries; (2) to identify what stewardship measures have been introduced by country governments to support the purchase of private healthcare; (3) to examine aspirations, challenges and capacity needs for stewarding the purchase of private health services. A case study synthesis approach is applied for the regional analysis and is useful for drawing on commonalities across case studies as well as emphasising important differences that can be explained by the local context.[16 17] The case studies are drawn from a range of low, middle and high-income countries that included Afghanistan,[18] Djibouti,[19] Egypt,[20] Iran,[21] Iraq,[22] Jordan,[23] Kingdom of Saudi Arabia (KSA),[24] Lebanon,[25] Libya,[26] Morocco,[27] Oman,[28] Pakistan,[29] Palestine,[30] Qatar,[31] Somalia,[32] Sudan,[33] Syria,[34] Tunisia[35] and Yemen.[36] These 19 case studies provided the basis of this synthesis.

The country case studies attempted to understand the role and contribution of the private sector in health and to identify challenges and opportunities for engagement

of private healthcare within the context of UHC. Mixed methods were applied by the case studies involving desk review of country policies, legislations, programmatic reports, quantitative data on private health markets and national health expenditure, published literature as well as key informants interviews with government, private sector, development partners and experts with informed consent. Data collection was undertaken by local researchers based on a standardised tool provided by the regional office to guide desk reviews and interviews. The tool was designed to elicit private sector characteristics, utilisation within the national health system, status of formal government arrangements with the private sector for health service delivery, operational environment to oversee Private Sector Engagement (PSE) and key challenges, future needs for PSE. Country stakeholders provided input on case study priorities, tool adaptation, contextualised data sources, identifying key findings and acknowledged the use of data for regional knowledge sharing and research. Data collection, collation and analysis processes were guided and reviewed by the regional office for standardised reporting on all components of the study.

Key information categories were developed under the guiding objectives of this synthesis as a basis for extracting contextualised descriptive data. Information categories comprised of (1) private healthcare purchasing arrangements managed and funded by the state, (2) features of the operating environment for overseeing purchasing arrangements such as planning, legislation, purchasing, payment, quality control, (3) key challenges expressed by countries in the purchase of private healthcare and (4) interests and priority capacity needs expressed by countries for better/future purchase of private health sector and/or for PSE arrangements (table 1). Data from individual case studies were extracted to an excel spreadsheet based on key categories of information collected.

Details on level of interest, approach, efforts, processes were noted for each category. Deductive content analysis[37] approach was applied to synthesise the descriptive data using the information categories as the key thematic constructs while leaving room for other emerging themes. For analysis of findings, the countries are classified into the three income groups comprising low-income-conflict affected countries having resource challenges and weaker governance; low-upper-middle income countries with better resourcing and governance; high-income countries having sufficient resourcing and strong governance. This facilitated comparisons across country groups and within countries in each group.

Table 1 Thematic categories

Private healthcare purchasing arrangements managed and funded by the state	Modalities Scale Financing Beneficiaries Services
Operating environment for overseeing purchasing arrangements	Policy support, planning Roles, leadership, structures Legislative support Management of purchasing Payment systems Quality control
Key challenges in purchase of private healthcare	Government related challenges Private sector related challenges Larger systemic challenges Other challenges/threats
Country interests	Interest for purchasing arrangements vs general PSE Extent of interest Key drivers
Capacity priorities for future/better purchase of private health sector and/or for PSE future arrangements	Directional priorities How-to priorities Private market-related priorities Other priorities

PSE, Private Sector Engagement.

RESULTS

Contextual architecture: private sector purchasing modalities

The two main modalities of government-supported purchase of private healthcare seen in EMR countries are insurance initiatives for hospital healthcare and standalone contracting for specific health services to fill gaps in public sector provision. Nine EMR countries have national insurance schemes that purchase services from private and public hospitals for provision of inpatient services—eight of these are implemented in middle-income countries, one in a low-income and one in a high-income EMR country (table 2). Private providers under EMR insurance schemes include both for-profit hospitals as well as non-profit hospitals ranging from medium-sized unregulated hospitals to - internationally accredited well-established hospitals. Standalone contracting of private providers for health services is practised by at least 15 EMR countries with prominent examples in middle-income countries of Egypt and Iran, as well as in low-income countries of Pakistan and Afghanistan (table 2). Contracted private providers include hospitals, specialty centres, diagnostic centres, family practitioners and non-governmental organisations (NGOs). There are very few instances of demand-side initiatives such as voucher schemes. These are funded and managed by international agencies and have not been transitioned to government management. Contextual variations in scale, and modalities are seen across low-income, middle-income and high-income countries.

Low-income and fragile countries

Large established initiatives involving purchase of private health services are seen in only two of the seven countries (table 2). Sudan's compulsory health insurance scheme purchases primary care and limited secondary care from private providers for all enrolled beneficiaries,

Table 2 Landscape of purchasing initiatives involving private healthcare

	Low-income/conflict-afflicted countries	Low-middle to upper middle-income countries	High-income countries
Scale and type of initiatives	Large established initiatives Sudan: ► Purchase of private primary care and limited secondary care under National Health Insurance Fund; beneficiaries; one-off joint venture contract for cardiac hospital Afghanistan (pre-conflict): ► Long established history of contracting NGOs for delivery of basic and essential healthcare packages	Large established initiatives Egypt: ► Purchase of specialist hospital care from private hospitals/specialised centres for beneficiaries of national health insurance scheme ► Standalone contracts with private hospitals for dialysis, urgent surgery, joint venture contract for hepatitis C/NCDs screening centres Iran: ► National health insurance allows private hospital care with 70% patient copayment ► Widespread standalone contracting of family practitioners/NGOs for Community Health Cooperative Centres in urban areas Lebanon: ► National Social Security Fund largely reliant on purchase of private inpatient/maternity care Pakistan: ► National health insurance (Sehat Sahulat Programme) purchases private health hospital care for all beneficiaries ► Extensive use of management contracts with private organisations for operating basic health units/rural health centres/secondary hospitals/regional blood centres	Emerging initiatives KSA: ► Joint venture projects under planning for imaging, laboratory, rehabilitation and primary care Oman: ► Small scale contracting of private hospitals for dialysis; wider PPPs under consideration Qatar: ► Compulsory social health insurance under planning to purchase private sector; occasional standalone contracts private healthcare for labourers in high-risk occupations/cancer screening for high-risk populations
	Nascent initiatives Libya, Syria, Somalia, Yemen: ► No major purchasing initiatives; informal engagement for healthcare ► Purchase of ancillary hospital services from private providers	Progressing initiatives Morocco: ► Social Health Insurance (AMO) purchases private hospital care restricted only to formal sector employees ► Standalone contracts of MoPH with few private hospitals for dialysis services Tunisia: ► National health insurance for the poor (AMG) supports referral to private hospitals for chronic care hospital treatment that cannot be provided at public sector hospitals ► Routine private sector inpatient and outpatient care is restricted to government officers in the social health insurance scheme (MHI); standalone contracting not practiced Jordan: ► Civil Health Insurance Programme purchases supplementary emergency care from the private sector for all beneficiaries ► Standalone contracts with few private/autonomous public sector hospitals—previous contracts for C-sections, cardiac surgery, cancer therapy discontinued and replaced with dialysis ► Contracting of private hospitals for dialysis, medical imaging, laboratory, pharmacy and emergency care services Emerging initiatives Iraq: ► MoPH contracts with two private specialty hospitals involving dialysis and cardiology services; private healthcare purchased for insured employees of Ministry of Oil Djibouti: ► One-off joint-venture contract for HIV/AIDS prevention centre Palestine: ► Purchase of hospital ancillary services from private sector	

AMG, Assistance Médicale Gratuite" (Free Medical Assistance); AMO, Assurance Maladie Obligatoire (Mandatory Health Insurance); KSA, Kingdom of Saudi Arabia ; MHI, Mandatory Health Insurance ; MoPH, Ministry of Public Health ; NCDs, Non Communicable Diseases ; NGO, non-governmental organisation; PPPs, public–private partnerships.

with the poor and disadvantaged financed through government subsidy.[33] Afghanistan, up until the recent conflict, had relied on contracting NGOs for delivery of basic and essential healthcare packages.[18] Other countries such as Libya, Syria, Somalia and Yemen[26 32 34 36] are at a nascent stage, having occasional examples of non-monetary engagement with private health providers with purchasing arrangements so far restricted to ancillary hospital support services from the private sector.

Low-upper middle-income countries

Large established initiatives involving purchase of private healthcare are seen in Egypt, Iran, Lebanon, Pakistan involving both NHI and standalone CO modalities[20 21 25 29]

(table 2). NHI schemes in Egypt, Iran, Lebanon and Pakistan provide choice of private hospital care for all beneficiaries and are supported by government subsidies for the poor. In Lebanon, the predominant reliance is on private hospitals which outnumber public sector hospitals (ref). Patient co-payment for insurance-supported private healthcare is in place in Iran,[21] whereas Egypt and Lebanon reimburse private hospitals on standard insurance tariffs and any difference with private tariff is picked up by the patients.[20 25] In Pakistan, there are no restrictions for patients for private healthcare on NHI.[29] Fairly extensive standalone contracting initiatives have proliferated over time for privately delivered free or subsidised healthcare. Prominent examples include the Egyptian Ministry of Health's (MoH's) purchase of specialty inpatient services from private hospitals to decongest government hospitals,[20] delivery of primary healthcare packages through Cooperative Health Centres in deprived urban areas in Iran,[21] contracts with private providers to manage radiology and pharmacy services for public sector hospitals, management contracts to operate poorly functional primary and secondary government health centres in Pakistan.[29]

Progressing, fairly significant initiatives of purchase of private healthcare are seen in Jordan, Morocco and Tunisia as part of NHI or social health insurance schemes, as well as smaller-scoped standalone contracting initiatives. NHI programmes in Tunisia[35] and Jordan,[23] supported by government subsidies for low-income beneficiaries, purchase private healthcare for discrete health conditions that cannot be provided in government hospitals, whereas in Morocco the government-supported insurance beneficiaries are restricted to public sector hospitals but formal sector employees enrolled in social health insurance have access to private inpatient and outpatient care.[27] Discrete standalone healthcare contracting with private hospitals is seen in Morocco[27] and Jordan[23] for dialysis services, but not practiced in Tunisia (table 2).

Other middle-income countries, Djibouti and Iraq, have emerging examples involving one-off contracts and are not part of a sustained initiative. Examples include joint-venture contracts with the private sector for cardiology and dialysis centres (Iraq),[22] HIV prevention centre (Djibouti) involving co-financing by the government to expand access through additional health infrastructure.[19] Palestine as yet has no purchasing arrangements for private healthcare; the NHI is limited to public sector facilities.[30]

High-income countries

High-income countries of KSA, Qatar, Oman have emerging initiatives with the private sector. These include planning for a series of joint venture projects for medical imaging, laboratory, rehabilitation and primary care in KSA,[24] small-scale contracting of private hospitals for dialysis in Oman[28] with wider projects under consideration and compulsory social health insurance under planning in Qatar drawing on both private and public healthcare facilities[31] (table 2).

Stewardship eco-system for government purchase of private healthcare

Purchasing of private healthcare in EMR has proliferated under different laws, organisational structures and self-tried best practices (table 3). Several of these have grown opportunistically in response to different political drivers. This has created challenges of fragmentation, but at the same time, the existing groundwork and growing policy interest provide huge opportunities for more strategic and systematic stewardship efforts.

Policy and planning

Growing political recognition to engage with the private health sector is seen across several EMR states. However, even in countries where significant examples of the purchase of private healthcare are seen, national health policies have remained disappointingly vague. Explicit strategies or policy guidelines on PSE for health are only seen in Afghanistan (pre-conflict), Sudan, Iran, Oman and Qatar,[18 21 28 31 33] whereas a PSE strategy is being drafted in KSA.[24] In the absence of strategic direction from MoHs, existing initiatives are driven by different ideologies that include pro-poor financial protection, de-congesting public sector hospitals by supplementing with private healthcare, better functioning of public sector health facilities with private sector management and economic growth for health infrastructure expansion through public–private partnerships (PPPs). It is important to note that national health targets have not been the starting point of purchasing initiatives. Financial protection allowing purchase of private healthcare has been operationalised under NHI schemes in most middle-income countries, at least one low-income country (Sudan).[33] Larger PPP policies for collaborative financing and better delivery of public goods have provided the umbrella for standalone contracting across high-income, middle-income and low-income countries. Most initiatives exist as discrete operational initiatives disjointed from national health reform agendas and with little attempt to cohesively link them with UHC targets. Integration into national health reform planning has only been undertaken in two countries (Egypt, Iran).[20 21]

Legal frameworks

Four countries have no supportive legislation in place as yet to support the purchase of private healthcare (Iraq, Palestine, Somalia, Yemen)[22 30 32 36] and significant initiatives have not started in these countries. Other EMR countries have some legislation in place, but not always well adapted to the health sector. Health insurance legislation for purchase of private healthcare is seen in Sudan[33] and middle-income countries (Egypt, Iran, Jordan, Lebanon, Morocco, Pakistan, Tunisia)[20 23 25 29 35] and under drafting in two high-income countries (Oman, Qatar).[28 31] Additionally, some middle-income countries

Table 3 Stewardship eco-system for government purchase of private healthcare

	Low-income countries/conflict-afflicted countries	Low-middle to upper-middle income countries	High-income countries
PSE strategy/ framework/guidelines	Policy guidelines for PSE: Sudan, Somalia Private health sector strategy: Afghanistan (pre-conflict) Absence of PSE health framework/ guidelines: Libya, Somalia, Syria, Yemen	All countries: absence of PSE health framework	PSE policy drafted, under review: KSA Absence of PSE health framework: Oman/ Qatar
Stewardship structure	Dedicated unit in MoH: Afghanistan (pre-conflict) MoH does not have a dedicated unit: Libya, Sudan, Somalia, Syria, Yemen	Dedicated unit in MoH: Egypt, Morocco, provincial units in Pakistan MoH does not have a dedicated unit: Djibouti, Iran, Iraq, Jordan, Lebanon, Pakistan, Palestine, Tunisia	Dedicated unit in MoH: KSA MoH does not have dedicated unit: Oman, Qatar
Legal cover	Insurance law for purchasing private healthcare: Sudan Wider PPP laws allowing healthcare contracts with private sector: Afghanistan, Libya, Syria Absence of supportive legislation: Somalia, Yemen	Insurance law for purchasing private healthcare: Egypt, Iran, Jordan, Morocco, Tunisia Health specific PPP laws: Morocco, Pakistan, Lebanon (drafted) Wider PPP laws allowing healthcare contracting of private sector: Djibouti, Egypt, Iran, Jordan, Tunisia Absence of supportive legislation: Iraq, Palestine	Compulsory insurance law being drafted to purchase healthcare from private and public providers: Oman, Qatar Wider PPP laws allowing healthcare contracts with private sector: KSA, Oman
Management of purchasing	Independent insurance fund: Sudan Semi-autonomous insurance funds: Not seen Standalone contracting managed by MoH: Afghanistan, Syria Purchasing mechanism not established: Libya, Somalia, Yemen	Independent insurance funds: Egypt, Iran, Lebanon, Morocco, Tunisia Semi-autonomous insurance funds: Jordan Standalone contracting managed by MoH/ line ministries: Egypt, Iraq, Morocco, Palestine, Pakistan, Djibouti	Standalone contracting managed by MoH: KSA, Oman, Qatar
Payments	Standard fee for service tariffs/ case tariffs: Sudan	Standard fee for service tariffs/case tariffs: all insurance schemes Hospital contract using prospective/ retrospective budgets/negotiated fee: Egypt, Jordan, Morocco PHC contracts using capitation: Iran, Egypt Management contracts using global budgets: Pakistan	Line-item budgets: standalone contracts
Quality regulation	Elementary facility registration by MoH: Libya, Somalia, Sudan (one province), Syria Accreditation centre, non-functional: Libya, Afghanistan (pre-conflict) Absence of quality regulatory laws: Yemen	Functional accreditation agency: Egypt, Iran, Jordan, Lebanon Registration and licensing unit: Iraq, Morocco, Pakistan Elementary facility registration laws: Djibouti, Palestine, Tunisia	Accreditation board within MoH: KSA Accreditation, licensing and Registration unit in MoH: Qatar Registration and licensing department in MoH: Oman

KSA, Kingdom of Saudi Arabia; MoH, Ministry of Health ; PPE, public–private partnerships; PSE, Private Sector Engagement .

(Morocco, Pakistan) have also enacted health-specific PPP legislation to support standalone contracting of private healthcare.[27 29] Other countries still draw on wider cross-sectoral PPP frameworks to provide a legal umbrella for the purchase of private healthcare (table 3).

Although legislation has paved the way for the purchase of private healthcare in many countries, there are legislative gaps related to risk management within contracts, early contract termination, linking purchasing to pre-qualified providers and compliance for data reporting.[20 24 29 31] Countries with significant purchasing arrangements in place have not refreshed legislation to better regulate the purchase of healthcare. Attempt at regulation of purchasing is only seen in Egypt where new legislation was introduced to establish a healthcare organisation for regulation of health insurance and establish links between accreditation and purchasing of healthcare.[38]

Structural arrangements

Despite visible spending on the purchase of private health services in several EMR states, there has been less investment in establishing stewardship units within the MoHs. Purchasing functions are typically fragmented across different sections of the health ministry or in some countries delegated to different line ministries. PSE units within ministries of health have been established in only five EMR countries that include one low-income country (Afghanistan pre-conflict),[18] two middle-income countries (Egypt, Morocco),[20 27] set-up subnationally but not in central MoH (Pakistan)[29] and one high-income country (KSA)[24] (table 3). These units, however, are narrowly focused on the operation of standalone health contracting initiatives failing to provide a larger directional focus across all purchasing initiatives involving private healthcare. The structures are also commonly constrained in terms of staff and expertise and roles are being reviewed in two countries for more effective delivery.[24 27]

Management of purchasing

Separation between purchasing and provision has been established in very few EMR countries. Even within the same countries, there exist multiple approaches to the management of purchasing—purchasing private healthcare under insurance is usually managed by separate insurance organisations reporting to the MoH, whereas standalone contracting is managed directly by MoH rather than separate structures. Independent insurance organisations are seen in five EMR countries (Egypt, Iran, Morocco, Sudan, Tunisia), a semi-autonomous body in one country (Jordan) whereas insurance is directly managed by the ministry of health in one country (Pakistan). Coordination issues have been reported between the MoH and autonomous insurance funds that have dual reporting to labour or social security ministries, involving a trade-off between financial protection priorities of other ministries vs attention to more cost-effective health services by MoHs.[21 25 35]

Standalone contracting in most EMR countries is directly handled by MoHs and in some cases by the line ministries, with the exception being Iran where a dedicated Ministry of Cooperatives manages healthcare contracting. Competitive selection of private providers, a hallmark for contracting to provide value for money, is practiced in Iran, Afghanistan and Pakistan.[18 21 29] Most countries do not have healthcare-specific purchasing guidelines with reliance on traditional government procurement rules, which makes the process cumbersome, heavily administrative and prolonged.

Payments

Insurance initiatives in EMR (Egypt, Morocco, Lebanon, Jordan, Pakistan, Sudan, Tunisia) apply predetermined tariffs for making fee-based or case-based payments to private providers (table 4). Lebanon is the only country to introduce performance-based payments tariffs linked to quality-of-care indicators to decrease inappropriate billing and incentivise private providers to build critical care capacity but faces challenges in implementation.[39] Payment mechanisms for standalone contracts vary extensively across countries. Use of line-item budgets (Egypt, Iraq)[20 22] agreed daily bed rates for dialysis (Jordan),[23] flat monthly rate per patient for dialysis (Morocco)[27] is seen for supplementary specialty services paid through standalone contracts. Primary healthcare contracts rely on either capitation payments as seen for family practice in (Iran and Egypt[20 21]), or global budgets as used in Pakistan for managing weakly performing basic health units and secondary care centres.[29]

Quality regulation

Quality regulation of private healthcare facilities has been introduced by a growing number of EMR countries, particularly middle and high-income countries, but varies extensively in depth, enforcement capacity and links with purchase of healthcare (table 3).

Establishment of private health facilities has proliferated historically under multiple laws and legal requirements distributed across the MoH as well as other ministries dealing with companies or charities. Registration of private health facilities with MoH is based on elementary health infrastructure parameters without quality-of-care requirements in most low-income conflict-affected countries (Libya, Somalia, Syria)[26 32 34] and few of the middle-income countries (Djibouti, Palestine, Tunisia).[19 30 35] Yemen is the only country that does not have healthcare regulatory criteria for private facility establishment,[36] whereas Afghanistan recently introduced health facility legislation, but these are not implemented.[18]

Quality of care criteria for private facility registration and licensing is importantly in place in middle-income countries of Iraq, Morocco, Pakistan, supported by legislation and units in the MoH, but enforcement remains weak.[21 27 29] Some middle-income countries have expanded from licensing to accreditation with prominent examples being Egypt with a recently established independent accreditation body,[20] Lebanon with a long-standing independent accreditation board,[25] Jordan with an accreditation department within the MoH and Iran with an accreditation unit within the MoH.[23] Compliance by private health facilities remains uneven. High-income countries have established accreditation systems with better quality compliance. Examples include an accreditation board within the MoH in KSA, an[24] accreditation unit within the MoH in Qatar[31] and a registration-licensing unit within the MoH in Oman coordinating with international bodies for accreditation.[28]

Links of quality assurance with the purchase of private healthcare remain weak. In the absence of well-established licensing and accreditation systems, insurance initiatives rely on separate empanelment exercises for enrolling private providers. Lebanon has led in attempts at introducing quality scores for insured providers and building capacity for accreditation. On the other hand, standalone contracting is often underwritten by government procurement rules for lowest cost bids and not linked with pre-licensed quality assured

Table 4 Country interest and existing stewardship challenges

	Low-income/conflict-afflicted countries	Low-middle to upper middle-income countries	High-income countries
MoH interest	High, established interest: Sudan Initial cautious interest: Libya, Somalia, Syria, Yemen Uncertain interest: Afghanistan (moderate interest re-conflict)	High established interest: Egypt, Iran, Lebanon, Morocco, Pakistan Progressing interest: Djibouti, Iraq, Jordan, Palestine, Tunisia	High established interest: KSA, Qatar Progressing interest: Qatar
Existing challenges	Directional challenges ► Unclear policy direction, roles and modalities ► Fiscal constraints How-to challenges ► Inadequate quality regulation framework ► Legislative framework not in place ► Insufficient contract writing and management skills, navigating risks ► Insufficient know-how to design payments to incentivise private sector while countering over-billing Private sector challenges ► Insufficient private provider mapping, information flow and reporting ► Small sized private sector ► Weak communication with private sector, lack of mutual understanding, trust gaps ► Security issues and political instability to attract the private sector ► Countering conflict of interest from dual practice	Directional challenges ► Unclear policy direction, roles and modalities ► Lack of leadership and clear roles within MoH ► Insufficient public sector funding to uphold government commitment to contractual agreements How-to challenges ► Insufficient know-how to design payments to incentivise private sector while countering over-billing, issues of escalating expense ► Bureaucratised payment systems causing delayed payments ► Weak enforcement of quality regulations, poor compliance, few accredited facilities Private sector challenges ► Insufficient information flow and reporting ► Trust gaps, attitudinal resistance by MoH employees, weak communication with private sector representatives ► Countering conflict of interest from dual practice	Directional challenges ► Unclear policy direction, roles and modalities How-to challenges ► Legislative framework not purpose-fit ► Insufficient contract writing and management skills, navigating risks ► Lengthy administrative processes involved Private sector challenges ► Insufficient information and reporting systems ► Disconnects between government design and private sector interest

KSA, Kingdom of Saudi Arabia.

providers. Iran has introduced post-contracting periodic assessments of minimum quality standards for contracted health providers with growing stakeholder demand to make scores available online and searchable facility wise.[40] Facility score-carding examples also previously seen in Afghanistan during the delivery of basic and essential health service packages.[41]

Country aspirations, challenges and capacity needs for stewarding purchase of private health services

All countries showed pragmatic acceptance of the private sector role as integral for expansion towards UHC. Motives ranged from use of complementary or supplementary services from private providers, use of purchasing as an additional lever to direct rational growth of the private sector and exploration of potential co-financing with the private sector. Initial cautious interest was seen in less resourced countries or those with debilitated healthcare systems (Libya, Somalia, Syria, Yemen), progressing interest in better resourced countries already having initiatives in place (Djibouti, Iraq, Jordan, Palestine, Tunisia, Qatar) and established high interest in countries that had significant initiatives either in place or under planning (table 4).

EMR countries outlined existing challenges faced for PSE as well as specific challenges for the purchase of private healthcare. These were grouped into directional challenges, implementation challenges and private market-related challenges. Directional challenges of insufficient critical understanding, multiple narratives and roles for PSE were commonly voiced across low-income, middle-income and high-income countries (table 4). Fiscal constraint to purchase private healthcare was an additional concern in low-income countries, whereas insufficient government funding to uphold purchase of private healthcare was a concern in middle-income countries already contracting. Finally, the death of local evidence from private healthcare purchasing arrangements was a common challenge reported by EMR countries for overseeing.

Implementation challenges of quality assurance and contract management were dominant across all country groups, whereas payments, incentivisation and value for money were particularly reported by middle-income

countries with significant purchasing initiatives in place. There was growing disenchantment with state-led quality enforcement where practiced, reported issues of prolonged bureaucratic process for registration, weak capacity for criteria assessment, absence of digital systems for transparent reporting and even instances of corruption for quality registration.[20 21 23 29] Positive imaging and medical tourism were reported to be more successful in driving the private sector towards accreditation.[20 23 24 28] Payment-specific challenges included absence of data systems to monitor case mix and length of stay to counter over-billing issues, little familiarity with the full range of payment modalities to design tariffs and slow administrative disbursement in case of direct payments by the MoH.[42 43] At times, even the discontinuation of contracting driven by value for money concerns was seen, as, for example, in Jordan where contracts were discontinued and reset.[23] While there was little systematic assessment of private provider participation in government-led purchasing initiatives, there were reported instances of weak interest from the private sector, as seen, for example, in Iran the family practitioner drawing few bidders as contractual terms were considered private providers to be unfavourable to.[40]

Private market-related challenges were particularly salient in lesser resourced countries, with small sized fragmented private sector, insufficient private sector data and political instability preventing meaningful partnerships. Some countries suggested reorganising private providers into associations to facilitate engagement[22 23] as seen in Egypt where the private market was re-shaped into healthcare organisations for purchase of healthcare.[21] Dual practice creating a conflict of interest for the purchase of private healthcare was a concern shared by both low-income and middle-income countries, whereas inadequate information reporting was commonly experienced in high-income and middle-income countries. Finally, weak communication, poor understanding of the private sector and long-standing mistrust of the private sector by mid-level staff within health ministries was highlighted as a threat to new PSE directions, across low, middle-income and high-income countries.

EMR countries articulated future needs to steward the purchase of private healthcare under the larger umbrella of PSE. The most expressed need across low-income, middle-income and high-income countries was establishing a planning direction for PSE supported with evidence and practical demonstrable examples (18 countries) (table 5).

The next frequent set of responses related to quality regulation (15 countries), contract management (15 countries) and dialogue with private sector (14 countries). Introduction of quality assurance mechanisms was expressed by low-income/conflict-affected countries, whereas linking quality regulation with purchasing was emphasised by middle and high-income countries (table 5). This was followed by the need for contract and risk management expertise commonly expressed across low-income, middle-income and high-income (14 countries). Establishing dialogue platforms to engage with the private sector for understanding, design and implementation of purchasing initiatives was emphasised by nearly all middle-income countries, some of the low-income countries and one high-income country (Qatar).

The third frequent set of responses related to building expertise with payment modalities (nine countries), introduction of legislative framework (nine countries), establishment of stewardship units (nine countries), information databases and reporting (nine countries) and mobilising sustainable finance (nine countries).

Table 5 Stewardship aspirations and priorities for purchasing private healthcare

Country aspirations and priorities	Low-income countries and conflict-afflicted countries	Low-middle to upper-middle income countries	High-income countries
Planning direction, lesson learning, evidence	Afghanistan, Libya, Somalia, Sudan, Syria, Yemen	Djibouti, Egypt, Iran, Iraq, Jordan, Lebanon, Libya, Pakistan, Palestine, Tunisia	KSA, Oman
Stewardship structure in MoH	Yemen	Iran, Jordan, Lebanon, Pakistan, Palestine, Tunisia	KSA, Oman
Quality regulation and accreditation	Afghanistan, Libya, Somalia, Sudan	Djibouti, Egypt, Iran, Iraq, Jordan, Lebanon, Morocco, Pakistan, Palestine, Tunisia	Oman
Supportive legal framework	Afghanistan, Libya, Somalia, Syria, Yemen	Djibouti, Iraq, Tunisia	Oman
Contract management and risk mitigation expertise	Somalia, Syria, Yemen	Djibouti, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Pakistan, Palestine, Tunisia	KSA, Oman
Payment systems and pricing expertise		Egypt, Iran, Jordan, Lebanon, Morocco, Palestine, Tunisia	KSA, Oman, Qatar
Dialogue, communication with private sector, attitudinal shift	Libya, Somalia, Syria, Yemen	Egypt, Iran, Iraq, Jordan, Morocco, Lebanon, Pakistan, Palestine, Tunisia	Qatar
Private sector information database, reporting	Afghanistan, Libya, Sudan, Syria	Iraq, Morocco, Pakistan, Tunisia	Oman
Mobilise sustainable financing	Afghanistan, Libya, Sudan, Syria, Yemen	Djibouti, Egypt, Lebanon, Pakistan, Palestine	

KSA, Kingdom of Saudi Arabia.

Responses varied across country groups contexts and by level of country advancement in the purchase of private healthcare. Payment expertise and stewardship units were a common aspiration mainly of middle-income countries and high-income countries already undertaking purchasing initiatives. Establishment of a legal framework and private sector information databases was emphasised by low-income conflict-affected countries and the few middle-income countries that did not have significant purchasing initiatives.

DISCUSSION

We set out to explore stewardship challenges faced across diverse country initiatives in the EMR that are purchasing services from the private sector and identify country appetite and prioritised needs for strengthening stewardship of future purchasing arrangements. Our contention was that a shift is required from the narrow emphasis on individual healthcare purchasing schemes as a means to UHC. We focused attention on the wider multifaceted stewardship challenges of building coherence across purchasing initiatives as well as anchorage with national planning and health systems functions. There are critical knowledge gaps on stewardship requirements within southern contexts where legal risk-minimising transactional architecture to support strategic purchasing is not present.[44 45]

The EMR region demonstrates significant state-supported initiatives involving the purchase of private healthcare to supplement public sector provision in middle-income countries, with progressing initiatives in high-income countries and nascent initiatives in less resourced countries. Purchasing arrangements have been driven by contextual opportunities provided by political momentum, local adaptive designs, unlocking of domestic financing and initial operational groundwork for stewardship. Operational groundwork is more advanced in middle-income countries, emerging in high-income countries and under deliberation in less resourced countries. Our synthesis also highlights key stewardship challenges as well as prioritised country needs for strengthening purchasing stewardship.

Stewardship eco-system across all EMR countries is faced by common challenges. First, the purchase of private healthcare is based on disjointed operational initiatives and conflicting ideological imperatives, not unified under national planning for affordable accessible, quality care goals. Second, the dispersion of roles across multiple entities created a leadership vacuum in several countries. Third, weak understanding of the private sector, mistrust and slow-changing attitudes of MoH staff have not kept pace with higher political support for PSE. Fourth, although independent purchasing is established for national insurance initiatives in several countries, but standalone contracting continues to be directly managed by the MoHs with administrative red-tape slowing down payments as well as creating potential conflicts of interest.

Differences by country groups are seen for other stewardship features of payments and quality assurance. Middle-income countries have introduced legislative support for purchasing, quality licensing-accreditation systems and payment systems but struggle with over-billing concerns and failure of traditional quality enforcement systems in ensuring compliance. High-income countries are better advanced with accreditation and compliance but still to establish payment systems and health-specific purchasing legislation. Less resourced countries, except for Sudan and pre-conflict Afghanistan, have not established payment systems but have basic facility infrastructure registration and wider PPP laws yet to be adapted for healthcare services. Fragmented private sector is an additional constraint faced in lesser resourced countries.

High interest from executive leadership and supra-ministries of finance and planning is driving a pro-private sector policy environment in nearly EMR countries, with MoHs cautiously re-pivoting driven by pragmatic acceptance to better integrate the coexisting private sector for UHC progression. MoH's expressed capability needs to better optimise future or ongoing purchasing initiatives. Common needs include PSE planning, building understanding with evidence, stewardship structures, dialogue platforms and new socio-behavioural approaches for performance compliance. Middle-income and high-income countries additionally prioritised payment controls for cost containment and improved data reporting, whereas lesser-resourced countries emphasised fiscal mobilisation and adequate private sector databases as starting points.

Our empirical findings of directional needs, implementation needs and relational dialogue needs provide critical evidence for placing stewardship at the centrepiece of private sector purchasing efforts in the EMR. The findings also underline the importance of re-imagining purchasing stewardship as a process-centred approach, aligning with pro-UHC national ideologies and managing the interface dynamics of public–private engagement. Weak anchorage of financing initiatives within national planning has been cautioned by global experts to be detrimental to UHC stewardship.[46] Purchasing insights from Africa underline similar needs for clearer roles, guidelines, data system, a mix of incentives and regulations[47] and re-organising the fragmented private sector for a strong unified voice.[48] Support for dialogue platforms is articulated from country contexts of Guatemala, India, Kenya.[49] Centrality of goal alignment while countering conflicts of interest is highlighted from other low-middle-income countries (LMICs),[50] whereas the need for deliberative coordination and trust-building efforts is seen from both upper-middle-income and high-income countries.[51 52] The findings come at an opportune time when a global perspective on private sector governance has for the first time been articulated by the WHO. Although the ambit of WHO's progression pathway on PSE goes beyond purchasing, the proposed measures of aligning structures, delivering strategy, better data for understanding, enabling fostering relations and building trust are also central to

building better stewardship to guide purchasing initiatives.[53 54]

The synthesis's strength lies in in-depth contextual details, a distinctive pattern of findings across country income groups and evidence in an area where little regional collation had been earlier attempted. A limitation of the synthesis is insufficient data on private sector motivations and process-related behavioural insights from the purchase of private healthcare, to design impactful models based on converged interests towards UHC. Another limitation is the reliance on existing case studies that may have varied in the level of detail on the PSE context. This was countered by the use of a similar thematic frame to extract details, and peer review of case studies to ensure sufficient methodological information, compliance with approved methods, identify inconsistencies and reduce subjective content.

CONCLUSION

The substantial proliferation in government purchase of private healthcare in EMR countries requires urgent centrefold attention to investing in stewardship for coherent alignment to UHC goals and to progress from purchasing to strategic purchasing.

The synthesis importantly highlights new directional and relational needs alongside traditional structural, and expertise needs to guide a stewardship agenda for strengthening the purchase of private health services in the EMR. UHC-focused PSE strategies, leadership units within MoH to counter role dispersion, formal dialogue platforms and calibrated behavioural incentives across payments, quality and risk management emerge as new needs in the EMR. Future socio-behavioural research on private sector interests for partnerships and converged working under purchasing arrangements, will be beneficial for stewarding within local eco-systems.

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