



USAID | **JORDAN**
FROM THE AMERICAN PEOPLE

POPULATION AND FAMILY HEALTH OFFICE

PRIVATE SECTOR ANALYSIS (OCTOBER 2018)

(Public Version)

OCTOBER, 2018

This publication was produced for review by the United States Agency for International Development by XL Associates Inc. under the Middle East Regional Platform (MERP) contract.

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Introduction

Background

To create a sustainable, holistic approach to improving health in Jordan requires a view of the “health sector” that encompasses both public, and private (for, and not-for profit entities). This brief analysis therefore aims (i) to capture the current role the private sector in PFH’s portfolio; (ii) outline the themes from reviewed literature; and (iii) to explore how PFH might engage and leverage private sector resources and expertise in the future.

Country Context

- Stakeholders repeatedly noted that the MOH sees itself as a provider of services, rather than overseeing regulation and/or strategic purchaser of services
- The lack of accurate costing of services is a serious impediment to understanding what might be better purchased from the private sector. For example, dialysis is contracted out, yet MOH has “no idea” whether they are getting value for money
- GOJ does not know where the market is working well and where it is failing
- There appears weak interest in engaging on preventative services
- The private sector (secondary care) is largely based in Amman
- Contracting out already works, for example in Mafrag where MOH could not recruit clinicians, they contracted the private sector to assist. They also contract out services for First Degree Government Officials (who pay 20% co-pay; and the MOH pays the balance)

I. Current engagement with the Private Sector *(see also Appendix B)*

Al-Bashir Emergency Department

\$25m tender for the renovation of the Emergency Department

Health Finance and Governance - HFG

HFG is partnering with two private health insurance companies to improve health insurance operations, with the intention of improved cost efficiency and customer satisfaction. They have leveraged around 75k JD for an outlay of 16k JD per year. They also work with the Jordan Association of Health Insurance (JAMI) for an annual two-day workshop with 80 participants, to gain the opinions from stakeholders. The event costs JAMI 60k JD/year; HFG have invested 2k JD in 2017; 10k in 2018 and anticipate 10k for each of the next three years

Key issues with the insurance system are:

- Fragmentation and the absence of appropriate risk pooling are the biggest issues
- MOH has no way of tracking patient-level expenditure in the Hakeem Patient Record System, which has no billing module, or through nationally agreed cost-per-case from other providers
- Cross-billing is vague with University Hospitals, and appears un-enforceable with RMS
- Civil Insurance premiums are capped and bear no resemblance to actual costs

Human Resources for Health in 2030 – HRH 2030

HRH 2030 is working with multiple private sector partners, including the Health Care Accreditation Council; Hikma Pharmaceuticals; Biolab; the Private Hospital Association; professional associations (medical; nursing; midwifery; pharmacists; dentists); and with an unspecified number of universities.

Areas addressed include: building best HRH practices into accreditation standards; promoting women in leadership; securing private sector involvement in national HRH interventions, and to promote to students the legal requirements for licensing and renewals based on CPD. Biolab and Hikma are both CSR initiatives; although based on available information it is unclear whether these offer value for money, for the amount of time and money invested by the project.

Other notable issues:

- Very difficult to obtain HRH data from the private sector

Health Service Delivery

The only private sector initiative HSD reported was the as-yet unsigned MoU with Pharmacy One, to support improvements in RMNCH+ services through collaboration in training private pharmacists on relevant messages and information.

In addition:

- HSD also works through General Physicians for RMNCH+, which includes using vouchers for FP and anemia screening, but they describe this as “not sustainable”. Culturally, MOH sees its role as providing “for all”, therefore “targeted programs” (such as vouchers) are perceived as “an embarrassment” and “inappropriate”
- *See Appendix A for a review of HSD’s Private Sector Engagement Strategy (2017)*

Jordan Communication and Advocacy Policy - JCAP

JCAP are currently working with Dawacom Pharmacy chain to promote anemia screening. This involves training staff in counselling; increasing reach for behavior change, and capitalizing on the pharmacy’s distribution mechanism for the roll-out of commodities. They have been unable to provide any dollar value for either Dawacom or their input, therefore value for money cannot be measured.

II. Themes from reviewed literature on working with the Private Sector

Sustainability: Global research on USAID’s PPPs shows that CSR partnerships tend not to survive more than a few years, but those building on strategic and commercial interests can produce lasting results.

PHC: The private sector can be useful in fillings gaps, although by definition the choice of supplier is often limited. In these circumstances “relational contracts” (i.e. where it is necessary to apply flexibility to make it work and keep working) will take precedence over “transactional contracts”.

Vaccination: There is conflicting evidence on whether involvement of the private sector is more efficient, accountable or medically effective. Where there is a partnership between the private sector and the government, and vaccines are provided for free, then they typically have access to more “missed opportunities for vaccination” (MOVs) than the public sector. This suggests they may be beneficial in catch-up programs but could be detrimental as a primary provider.

RMNCH+: Multi-channel approaches through community health can effectively dispel myths and improve uptake; active follow up by NGOs can increase continuity rates; private midwives can extend coverage.

Cross-subsidization and Private Patient Units: paid-for services or income generation such as running trainings or providing medical waste management can fund free or subsidized services

Insurance: Risk pooling recurs as a theme for ensuring appropriate, sustainable insurance systems

Social Franchising: meta-analysis shows it can increase client volume and satisfaction in some contexts, although it does not necessarily improve quality of care, cost-effectiveness, or equity

Hospital Autonomy in Jordan: previous USAID initiatives (1999-2002) attempted to introduce hospital autonomy; many of the issues identified then, remain problematic today.

Introducing Private Sector Management Expertise into the Health Sector: Jordan lacks management expertise in its public health sector. Lessons from the UK's introduction of private sector management expertise into the health service could be of benefit.

(For more details, and references, see Appendix C)

III. Opportunities to engage with the Private Sector

Within the current PFH portfolio

Continuing Professional Development: Opportunities exist for HRH 2030, HSD, and HFG to identify private sector partners (e.g. PHA; universities; IFH; JAFPP) who are both willing and able to develop self-financing CPD courses. This may require some initial TA and possibly pump-priming for course development, and adaptations to facilities.

HRH 2030 could explore membership-fee based CPD within professional associations, although this may require regulatory change to create additional entities, because current associations/syndicates predominantly act as trade unions, rather than bodies to improve professional understanding.

Public Sector understanding of Private Sector opportunities: “Politically-driven turnover” in MOH means that more capacity building – including for contracting the private sector – should take place at devolved levels.

Insurance: Expanding a sustainable, viable health insurance to the most vulnerable is essential, and the public sector insurance model needs to factor in the private sector; this would improve risk pooling.

Accreditation and Regulation: HCAC could provide anonymised monthly benchmarks on key quality indicators if the private sector bought into this; market-testing or a funded pilot could reveal future viability.

CSR and Long-Term Partnership: Decrease the emphasis on short-term CSR and in-kind support, and instead look to identify long-term commercial opportunities that provide a win-win. For example, pharmacy opening times typically far-exceed public sector (or even NGO) clinic hours for contraception. Therefore, explore how the private sector might either partner with organizations such as JAFPP, or develop their own in-pharmacy consulting services, to fill gaps existing providers cannot/will not fill. Consider developing national campaigns, that enable buy-in from the private sector, which provide a win-win for the GOJ and private providers.

Improve PHC: Work with MOH and governorates to partner with mobile clinic providers, such as Pharmacy One and Zain to strategically reach remote or transient communities.

Improve data sharing: The Private Sector is data-rich on service/commodity provision (e.g. the amount of iron supplements supplied where/when in the past year), but lack the ability to track epidemiological data. This information sharing would greatly improve their interest and ability to provide better preventative services in primary care.

Future opportunities for PFH to work with GOJ and the private sector

Health regulation: Multiple opportunities exist that could improve private health services, such as mandatory accreditation and a medical accountability law would aid the quality of care. Pharmacy One reported multiple regulations that prevent them offering quality services; working with the private sector to identify these is essential. In addition, explore with MOH a healthcare regulatory function, similar to the UK's Healthcare Commission, which is government funded to oversee both public and private services.

Cross subsidization: Assisting organizations to generate income to fund free/heavily subsidized services, could improve access and improve sustainability. This also applies to public hospitals generating private sector income, which would require a change in national policy and regulation.

Food fortification: Childhood anemia had dropped, but anemia in women stayed roughly the same, despite flour fortification happening in 2007. Omar Dary ascribed the lack of change in women's anemia to drinking of tea with meals - less of an issue with children - which affects the bio-availability of iron in the diet. Further detailed advice should be sought during Omar's visit in October.

Vaccination: Explore long-term partnership between the GOJ and the private sector to capture Missed Opportunities for Vaccination for catch-up programs, particularly through mobile services. In other countries pharmacists can do these vaccinations; that has been resisted in Jordan.

Other possible areas to explore: Access to finance for health services (loans to private sector), such as in Bolivia, private sector partners are given land and 30-year licenses in return for building, and operating facilities that provide a defined list of free services in addition to private options

IV. Conclusion

Universal healthcare will require the private sector to fill gaps in coverage and relieve pressure on public services. However, the weakest link in Jordan is lack of vision by the GOJ to do this, and priority must be given to a coordinated plan for health and all health services, public and private. In the short-medium term, increased revenue for the public sector can only come from better pooling of insurance across the country, and the introduction of cross-subsidization.

In the medium term this requires continued attention to regulation reform; cross-subsidization opportunities, and long-term partnerships with the private sector, and less reliance on short-lived CSR.

V. Appendices

Appendix A

[Removed from the Public Version]

Appendix B – Responses from IPs as to their current engagement with the Private Sector

Name of Private Sector Partner & Nature of Their Business	Type of Agreement Sub-contractor/ CSR/PPP? Duration?	Main Aim(s) of Partnership? & How does this improve health for those living in Jordan?	Metrics?	Input and (anticipated) Value from Private Sector & Budgeted cost from IP for this activity
HFG				
Arab Orient Insurance Company Insurance company with largest market share	Partnership	To improve health insurance operations that will lead to improved cost efficiency, and customer satisfaction.	<ol style="list-style-type: none"> 1) % of operations standards met 2) Implementation of elements of the improvement plan. 	<p>Private Sector: An Estimate of JD32,000K (This includes the level of effort by 8 managers at the insurance company)</p> <p>IP: allocated around JD8,000/ year in staff, management and non-staff cost</p>
Arab Eagle Insurance Insurance company with largest market share	Partnership	To improve health insurance operations that will lead to improved cost efficiency, and customer satisfaction.	<ol style="list-style-type: none"> 1) % of operations standards met 2) Implementation of elements of the improvement plan. 	<p>Private Sector: An Estimate of JD35,000K (This includes the level of effort by 8 managers at the insurance company and the LOE of the CEO)</p> <p>IP: allocated around JD8,000/ year in staff, management and non-staff cost</p>
Jordan Association for Health Insurance JAMI (Private Association for Health insurance companies in Jordan)	Agreement between JAMI and HFG on the participation of HFG in the annual JAMI's conference. A 2-day annual conference.	<p>Getting the opinions of the participants on the most important health finance and governance issues in Jordan to improve health finance and governance and move towards achieving Universal Health Coverage.</p> <p>Disseminating, presenting, and discussing the results of the health insurance legislation review done by USAID/HFG in collaboration with concerned parties.</p>	<ol style="list-style-type: none"> 1) Total number of conference participants (~80) 2) Number of health insurance policies/legislation adopted 	<p>Private Sector: The total investment for JAMI was JD 60000/event = 120,000 JD total for FY17/18.</p> <p>IP: HFG invested JD 2000 in 2017. And 10000 in 2018. Around 10000 JD will be invested annually in the upcoming three years</p>

Name of Private Sector Partner & Nature of Their Business	Type of Agreement Sub-contractor/ CSR/PPP? Duration?	Main Aim(s) of Partnership? & How does this improve health for those living in Jordan?	Metrics?	Input and (anticipated) Value from Private Sector & Budgeted cost from IP for this activity
HRH 2030				
Health Care Accreditation Council (Jordan and the region's only non-profit, ISQua accredited institution)	Collaboration (not specified)	To ensure facility accreditation standards reflect the best practices and developments of HRH in Jordan and promote enforcement of HRH-related standards throughout the Kingdom's health facilities	Proposed: number of standards revised HRH2030 will track accreditation standards as one policy-level change, as well as any training conducted for surveyors/quality facility directors	Private Sector: 30,000 JOD in kind support (staff time and space for revising standards and training) IP: budgeted around 5,000 JOD/year in staff and other direct costs (some training costs anticipated)
Hikma Pharmaceuticals (International pharmaceutical company based in Jordan, that manufactures non-branded generic and in-licensed pharmaceutical products)	CSR April 2018-August 2020	To create broad support and interest in promoting women leaders in health, including private sector contributions for sustainability of a women's health leadership network	n/a HRH2030 monitors the number of women in leadership positions at the MOH, but not for the health sector as a whole. HRH2030 will also track the number of events, participants trained, policies changed, and tools/resources created by the network through other indicators.	Private Sector: 5,000 JOD lump sum cash donation + in kind support (staff time for supporting the Women in Health Leadership Network, pledged donation of space at Hikma Academy for training, estimated at 15,000 JOD over 2 years) IP: budgeted around 50,000 JOD/year in staff and other direct costs
Biolab (Medical diagnostic laboratories that offer a full range of laboratory services in Jordan)	CSR June 2018 – August 2020	To create broad support and interest in promoting women leaders in health, including private sector contributions for sustainability of a women's health leadership network	n/a HRH2030 monitors the number of women in leadership positions at the MOH, but not for the health sector as a whole HRH2030 will also track the number of events, participants trained, policies changed, and tools/resources created by the network through other indicators.	Private Sector: TBC, but anticipated in kind support estimated at 5,000 JOD over two years IP: budgeted around 50,000 JOD/year in staff and other direct costs (same as above)

Name of Private Sector Partner & Nature of Their Business	Type of Agreement Sub-contractor/ CSR/PPP? Duration?	Main Aim(s) of Partnership? & How does this improve health for those living in Jordan?	Metrics?	Input and (anticipated) Value from Private Sector & Budgeted cost from IP for this activity
Private Hospital Association (Member-based organization representing private hospitals in Jordan)	Stakeholder support January 2017-August 2020	To ensure private sector involvement in national level interventions, including the national HRH strategy, women's leadership, CPD, and HRH data	No specific indicators for work with PHA directly, but progress on interventions tracked through various HRH2030 program indicators	Private Sector: TBD, but anticipated at in kind support estimated at 5,000 JOD over three years IP: Multiple areas of budget
All professional associations (medical, nursing/midwives, pharmacist, dentists)	Stakeholder support January 2017-August 2020	To ensure professional associations' involvement in national level interventions, including license renewal/CPD, the national HRH strategy, women's leadership, and HRH data	No specific indicators for work with PHA directly, but progress on interventions tracked through various HRH2030 program indicators	Private Sector: TBD IP: multiple areas of budget
Universities	Stakeholder support January 2019-August 2020	To ensure health education institution students understand the legal requirements of licensing and renewing licenses based on CPD.	No specific indicators for work with PHA directly, but progress on interventions tracked through various HRH2030 program indicators (such as number of CPD awareness sessions)	TBD
HSD				
Pharmacy One (Not yet signed; currently with USAID for clearance).	Memorandum of Understanding (Not yet signed: Sept 2018-August 2019)	To support improvements in RMNCH+ services through collaboration in training private pharmacists to deliver RMNCH+ messages and information.	Training information: A template will be developed to report on training including: <ul style="list-style-type: none"> • Training topics • Duration • Number of attendees • Feedback 	Private Sector: Training materials, trainers, evaluation materials for training activities. Review of RMNCH+ messages for pharmacy clients. Implementation of messages to clients at Pharmacy One branches. (In kind only) IP: Technical support for the capacity of Pharmacy One pharmacists relative to their role in primary health care through identification of priority topics and review of training materials. Provision of logistical support for training venues as needed. In addition to staff time, estimate JD150 per training session (assuming 20 participants), but total number of trainings not yet fixed.

Name of Private Sector Partner & Nature of Their Business	Type of Agreement Sub-contractor/ CSR/PPP? Duration?	Main Aim(s) of Partnership? & How does this improve health for those living in Jordan?	Metrics?	Input and (anticipated) Value from Private Sector & Budgeted cost from IP for this activity
JCAP				
Dawacom (Chain of Pharmacy retailers)	CSR (MoU or ?) during Anemia prevention campaign wave (3 months)	Display of campaign materials in pharmacies for counseling/anemia prevention JCAP print materials, and plastic bags with campaign logo	# of pharmacies enrolled # bags distributed	Private Sector: In kind IP: Materials and costs

Appendix C – Summary of the literature reviewed

Public Private Partnerships

Globally, USAID has averaged \$1.18bn annually in public-private partnerships (2001-2014), of which 29% came from US resources and 70% from non-USG sources. Health accounted for 21% of all PPPs, yet represents 47% of the total value of all PPPs. The MENA region accounts for just 3% of all of USAID's PPPs, of which only Jordan and Egypt have secured 22 each, worth \$311m and \$86m respectively. Experience suggests philanthropic partnerships tend not to survive, but those building on commercial interests produce lasting results.¹

In 2017 KPMG published lessons learned from working on PPPs. Issues that they identified as reasons why some PPPs do not succeed included:

- Selecting the wrong kinds of priorities and projects as applications for PPP
- Setting objectives that incentivize an overly narrow focus on service targets rather than high-value healthcare
- Choosing the wrong partners to work with
- Making erroneous or overly restrictive assumptions about the future
- Failing to generate sufficient competition and contestability.

They identify six factors they have identified which are pertinent to successful initiatives:

This report concludes with six insights from KPMG's global leaders:

1. Sweat small stuff — be obsessed with the detail of the deal
2. Active market management - don't retreat into 'tender mode' (*i.e. don't take a job-done approach after a tender is awarded*)
3. Scaling up capacity in the public sector – the importance of a well-resourced, specialized PPP unit
4. Embrace, rather than resist, the politics of UHC
5. Data systems you can trust – PPPs are only as good intelligence which it is built
6. From clarity of objectives to clarity of requirements — goals, behaviors and expectations are often implicit and assumed, but a stable partnership requires as much as possible to be discussed and set out clearly.

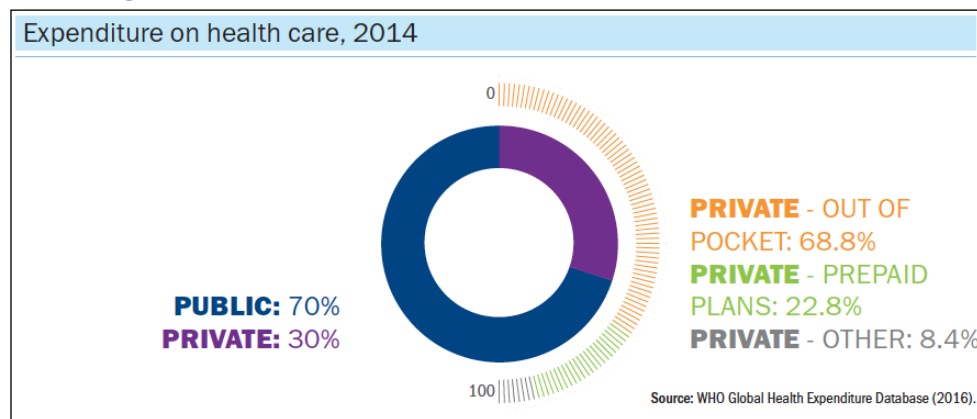
Naturally there is some concern about engaging for-profit providers to be partners in reaching the most vulnerable. Robust evidence for what actually works remains relatively scarce.² In a paper for UNICEF (Montagu 2010), a simple benchmark test was proposed: 'Does this initiative help to "Respect", "Protect" and "Fulfill" the health needs of poor children? If yes, how will it work? How much difference will it make?'³

¹ George M Ingram, Anne E Johnson, and Helen Moser, "USAID's Public-Private Partnerships: A Data Picture and Review of Business Engagement" (Washington D.C.: Brookings Institute, 2015), www.brookings.edu/global

² Dominic Montagu and Catherine Goodman, "Prohibit, Constrain, Encourage, or Purchase: How Should We Engage with the Private Health-Care Sector?," *The Lancet* 388, no. 10044 (August 6, 2016): 613–21, [https://doi.org/10.1016/S0140-6736\(16\)30242-2](https://doi.org/10.1016/S0140-6736(16)30242-2)

³ Dominic Montagu and Abby Bloom, "The Private Sector and Health Services Delivery in the EAP Region" (2010), https://www.unicef.org/eapro/3_Market_decentralization_and_Health_Services_delivery.pdf

Healthcare Financing in Jordan



Financing

- Public/private health expenditure analysis (2014) shows Jordan has a 70:30 ratio, similar to Turkey (77:23) and the OECD average of 73:27, but very different to Egypt (38:62)
- Public health care is funded by multiple insurers
- The role of voluntary health insurance (supplementary) is expanding
- Private health expenditure is predominantly via OOP payments

Delivery

- Primary care, secondary and tertiary care, clinical support services and long-term care are all mixed
- Jordan's private health sector is large, with more than half of the country's hospitals privately operated

Key challenges and/or reform agenda

- The trend has been towards decentralization of health care organization and financing.
- The current reform programme focuses on improving access to medicine, enforcing the regulations covering clinical trials and increasing the number of hospitals and insurance coverage.⁴

Primary Health Care

The use of the private sector in primary care is often to fill gaps from the public sector. A key paper by Natasha Palmer (2000), describes the different types of contracting arrangements available. Crucially, she observes, that where a contract is to fill a gap, then often by definition the choice of supplier may be limited to either a handful, or even just one potential supplier. In these circumstances "relational contracts" (i.e. where it is necessary to apply flexibility to make it work and keep working) will take precedence over "transactional contracts" (which are strictly defined).⁵

In 2015, the Joint Learning Network for Universal health Coverage formed a Private Sector Engagement collaborative to share knowledge and experiences in working with the private sector. Resources include

⁴ Pavel Dvorak et al., "The Health Care Sector in EBRD Countries of Operations" (London, U.K.: European Bank for Reconstruction and Development, November 2016), <https://www.ebrd.com/documents/manufacturing-and-services/overview-of-the-health-care-services-sector.pdf>

⁵ Natasha Palmer, "The Use of Private-Sector Contracts for Primary Health Care: Theory, Evidence and Lessons for Low-Income and Middle-Income Countries," *Bulletin of the World Health Organization*, 2000, 9, <http://www.who.int/iris/handle/10665/268154>

manuals that address issues such as engaging the private sector, regulation, stewardship and working with the private sector to achieve Universal Health Coverage.^{6 7}

Vaccination

There is conflicting research on the benefits of using the private sector. GAVI, for example, in 2014 claimed that the private sector was a vital partner in the poorest countries, despite only providing around 5% of vaccinations in wealthier provinces.⁸ Meanwhile a systematic review that compared public and private healthcare systems in low and middle-income countries concluded that the 102 research papers reviewed did not support claims that the private sector is more efficient, accountable or medically effective.⁹

A more recent study by WHO (2017) identified differential approaches to engaging the private sector, taking a more positive view of what is both achievable and beneficial. The authors suggest a more nuanced approach that begins with a review of their existing contribution to immunization, program monitoring, adverse events, disease surveillance and the quality of service delivery. Based on discussions with private sector partners, an optimal model could be developed, leading to an MoU.¹⁰

Involvement of the private sector has the potential to increase inequity (Nahad, 2018), as private vaccination services improve the health of the wealthy, particularly when they can access vaccines not available through publicly-funded services. Yet, where there is a partnership with the government and vaccines are provided for free, then they typically have access to more “missed opportunities for vaccination” (MOVs) than the public sector. This requires training and reporting to be harmonized.¹¹

The researchers go on to point out that common issues encountered when working more closely with the private sector include poor cold-chain and vaccine management, and limited understanding of government immunization policies or national vaccination schedules. These can be mitigated by regular supervision, close monitoring and mandating a suitable accreditation system.

One study that used demographic health survey data from 29 countries in sub-saharan Africa estimated that newborns delivered in private-for-profit facilities were ten-percentage points less likely to have received their BCG vaccination, than those born in public facilities. These differences were “more pronounced” among poorer children and in rural areas”.¹²

⁶ Joint Learning Network, “Public-Private Partnership and Engagement,” 2018, <http://www.jointlearningnetwork.org/resources/topic/public-private-partnership-and-engagement>.

⁷ Cicely Thomas et al., eds., “Engaging the Private Sector in Primary Health Care to Achieve Universal Health Coverage” (Joint Learning Network for Universal Health Coverage Primary Health Care Technical Initiative, 2016), <http://www.jointlearningnetwork.org/resources/PHC-Engaging-the-private-sector-in-PHC-to-Achieve-UHC>

⁸ GAVI. “Private Sector Partnerships Prove Critical to Vaccinating Children in Poorest Countries,” 2014. <https://www.gavi.org/library/news/gavi-features/2014/private-sector-partnerships-prove-critical-to-vaccinating-children-in-poorest-countries/>

⁹ Sanjay Basu et al., “Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review,” ed. Rachel Jenkins, *PLoS Medicine* 9, no. 6 (June 19, 2012): e1001244, <https://doi.org/10.1371/journal.pmed.1001244>.

¹⁰ Rachel Mitrovich et al., “A Review of the Private Sector’s Contribution to Immunization Service Delivery in Low, Middle, and High-Income Countries” (World Health Organization, 2017), http://www.who.int/immunization/sage/meetings/2017/april/2_Review_private_sector_engagement_Mitrovich_et_al.pdf

¹¹ Nahad Sadr-Azodi, Denise DeRoeck, and Kamel Senouci, “Breaking the Inertia in Coverage: Mainstreaming under-Utilized Immunization Strategies in the Middle East and North Africa Region,” *Vaccine* 36, no. 30 (2018): 4425–4432, <https://doi.org/10.1016/j.vaccine.2018.05.088>

¹² Zachary Wagner, Peter G. Szilagyi, and Neeraj Sood, “Comparative Performance of Public and Private Sector Delivery of BCG Vaccination: Evidence from Sub-Saharan Africa,” *Vaccine* 32, no. 35 (July 31, 2014): 4522–28, <https://doi.org/10.1016/j.vaccine.2014.06.020>

RMNCH+

Based on the Jordan Population and Family Health Survey (2012) private sector providers were the source of modern FP methods for 56% of all users. Private doctors, clinics, and hospitals accounted for 20% and private pharmacies for 15%; 21% was provided by UNRWA and NGOs.¹³ In the years running up to 2012, the Private Sector Project (PSP) for Women had focused upon improving access to contraception; raising standards of care through Enhancing Quality in Private Providers (EQuiPP); awareness raising of domestic violence, and breast cancer awareness. Results included 17 private hospitals institutionalizing domestic violence training for detection and referral; and over 1,700 private clinicians attending at least one of PSP's training sessions.¹⁴

SHOPS sought to build on this, through the creation of the *Coalition of Private Associations*, facilitated in 2014 by Ta'ziz.¹⁵ However, the initiative proved unsustainable without ongoing support from SHOPS.

The 2016 report by the Institute for Reproductive Health pointed away from contraceptive *use* and access being the primary issue for the previous decade's plateau in the TFR, instead suggesting contraceptive *effectiveness* has been the key issue, with women switching to less reliable methods.¹⁶ The authors recommended a shift towards behavior change communication and outreach activity, aimed at securing better understanding of methods, tied with reduced rates of discontinuation.

In Uganda USAID's ASSIST project applied two approaches to addressing myths and misconceptions about birth spacing and contraception in one district in western Uganda. The first was a facility-based approaching, using midwives to ask mothers about their thoughts on contraception. These were noted down on flip charts, and over the next few weeks each myth or misunderstanding was systematically addressed. The flip charts were then placed on the walls of the waiting room. Later the same messages were displayed in counselling rooms for both clients and health providers to see. Family planning usage increased from 17% in March (the start of the initiative) to 52% in June.

This was then supplemented by community-based initiatives, through Village Health Team (CHWs) members addressing gatherings including in places of worship, village meetings and immunization outreach sessions. The village volunteers talked about their experiences of using different methods, and midwives also talked about the benefits. This helped push uptake to 63%. A subsequent stage provided short-term methods during outreach sessions, which pushed uptake to 78%. Midwives were also then assigned to work with NGOs who provided contraception. By March 2015, uptake had reached 95%.¹⁷

In the Philippines, the USAID FP program faces challenges. They have found that many young women do not want to access public services. Preferring instead something more discreet, they frequently turn to private sector midwives. In response, the program has worked to develop a public-private mix for the sector in some parts of the country. This involves training, monitoring, and mentoring midwives and development of a referral system in the private sector. Midwives submit a performance report and in

¹³ Department of Statistics (Jordan) and ICF International, "Jordan 2012 Population and Family Health Survey" (Calverton, Maryland, USA: Department of Statistics and ICF International, 2013), <https://dhsprogram.com/pubs/pdf/SR202/SR202.pdf>

¹⁴ Reed Ramlow, "Private Sector Project for Women's Health" (Maryland, USA and Amman, Jordan: Abt Associates Inc., 2012).

¹⁵ Luis Rivera, "Strengthening Family Planning Project: SHOPS Final Report 2010-2015" (Amman, Jordan: Abt Associates Inc., 2015).

¹⁶ Institute for Reproductive Health, and FACT Project. "Jordan Family Planning Assessment. Final Report." Washington D.C.: Georgetown University, March 2016. www.irh.org/projects/FACT_Project

¹⁷ Rosette Birungi and John Byabagambi, "Addressing Myths and Misconceptions to Increase the Uptake of Contraceptives : The Experience of Bukuuku Health Center IV" (Kampala, Uganda: University Research Co. LLC, 2015). <https://www.usaidassist.org/resources/addressing-myths-and-misconceptions-increase-uptake-contraceptives-experience-bukuuku>

return for their engagement with the process, they are allocated certain free commodities from the city's budget.

A recent study in Pakistan, where discontinuation rates are around 37% for long acting methods (LAMs), compared passive, telephone, and home-based follow-up following commencement of a new method supported by NGO staff. Their results found a slight advantage in phone-based follow-up (89% continuation at 12 months) compared to home-based follow-up (87% continuation at 12 months). Active client follow-up overall generated a five percentage-point improvement in discontinuation rates compared to passive follow-up.¹⁸

In Zambia in 2011, one NGO program employed 18 dedicated providers of LAMs to educate women in waiting room, and to provide services on-site. In 14 months, the program initiated 32,000 women onto a long-acting method, with approximately one third choosing an intrauterine device (IUD) and two thirds opting for an implant. Of these, around 38% had been using no method prior to starting with a long-acting method. One third of sites involved offered these as an option post-partum (within 48 hours of delivery).¹⁹

Cross-Subsidization

In Nairobi, the Kenya Women's Hospital was supported by GIZ to purchase a much larger incinerator than the hospital itself needed. The spare capacity was then sold to multiple smaller providers who previously had no adequate arrangements for medical waste management. The income initially funded a free clinic for survivors of sexual and domestic violence. In recent years the number of clinic locations has expanded, and has become a free-standing charitable entity.²⁰

Prosthetics NGO Exceed Worldwide recognized a market state-of-the-art prosthetics and orthotics among many wealthier clients led the organization to develop their own social enterprise. With initial assistance from Australia's DFAT, they established "Exceed Social Enterprises" to create up-scale private prosthetics and orthotics clinics and a prosthetics and orthotics distribution business, to generate profits purely for social impact. Profits go back into Exceed Worldwide's free services for poorer clients.^{21 22}

Private Patient Units

In the UK's National Health Service, public hospitals are permitted to earn up to 49% of revenue from their private patient units (PPUs), which is additional income to cross-subsidizes their free service, while also helping monitor private medical standards.

Two major hospitals in London generate around \$143m from their private patient units each year, although more typically hospitals would expect revenues of \$1.5m - \$6.5m per year. Collectively, NHS PPUs are the third largest provider of private medical care for the major insurance companies.²³

¹⁸ Waqas Hameed et al., "Comparing Effectiveness of Active and Passive Client Follow-Up Approaches in Sustaining the Continued Use of Long Acting Reversible Contraceptives (LARC) in Rural Punjab: A Multicentre, Non-Inferiority Trial," ed. Charlene S. Dezzutti, *PLOS ONE* 11, no. 9 (September 1, 2016): e0160683, <https://doi.org/10.1371/journal.pone.0160683>.

¹⁹ Neukom, Josselyn, Jolly Chilambwe, Joseph Mkandawire, Reuben Kamoto Mbewe, and David Hubacher. "Dedicated Providers of Long-Acting Reversible Contraception: New Approach in Zambia." *Contraception* 83, no. 5 (May 2011): 447–52. <https://doi.org/10.1016/j.contraception.2010.08.021>

²⁰ Paula A. Johnson and Rachel Gordon, "Dr. Sam Thenya: A Women's Health Pioneer" (Harvard Global Health Institute, June 23, 2014), https://caseresources.hsph.harvard.edu/files/case/files/2014_samthenya-cs.pdf

²¹ DFAT. "Disability-Inclusive Development Initiatives." Department of Foreign Affairs and Trade. Accessed October 5, 2018. <http://dfat.gov.au/aid/topics/development-issues/disability-inclusive-development/Pages/disability-initiatives.aspx>

²² "Exceed Social Enterprises," n.d., <https://avpn.asia/deals/exceed-social-enterprises-ese/>

²³ Philip Housden, "Tie-up with NHS Is Boundless," *Independent Practitioner*, April 2016, 18–19, <http://www.housdengroup.co.uk/files/IPAPR16-p18-19.pdf>

PPUs help make best use of valuable assets, including land and clinical facilities, for example by working three session days, seven days/week. They offer economies of scale, through shared access to high-tech equipment for the public and private patient, as well as immediate support through intensive care units if there are complications with routine surgery.

Insurance

Civil Insurance only covers Jordanians. 2015 Census data indicates that 68% of Jordanians and 55% of the Kingdom's overall population, including children under six years old, are covered by various types of health insurance.²⁴

The World Bank report for the GOJ in 2014 indicates that Jordan's health system is highly fragmented and across both the public and private sector. This revenue-fragmentation leads to a mis-match between costs and risk pooling. In the private sector this is managed by offering insurance packages that are relatively limited in scope and financial protection.²⁵

HFG have explored short, medium, and long-term opportunities for improving public insurance. These are documented in the Diagnostic Study from earlier in 2018.²⁶ They have also explored the legislative framework for insurance in Jordan, to better understand what can be done within existing legislation, and what needs to change.²⁷

A major study in the *Lancet* (Reich, 2016) looked at lessons from 11 countries that are moving towards Universal Health Coverage. The need to risk-pool health insurance was a repeated theme, although "open-ended fee-for-service payment systems typically lead to cost-escalation." Countries tended to respond by introducing measures to contain costs, although this risked eroding coverage, undermining financial protection.²⁸

Medical Tourism

The Private Hospitals Association indicates that there are 69 private hospitals in Jordan, of which 10 are accredited by Joint Commission International (JCI) and 25 by Jordan's Healthcare Accreditation Council (HCAC). The site describes "[o]ne of Jordan's primary assets in the medical services sector is its workforce, as the country boasts over 28,000 physicians most of whom are board certified in the United States, United Kingdom, Canada or other European countries and a growing team of nurses that are experienced in state-of-the-art patient care."²⁹ (*This level of foreign-trained medical workforce is disputed by others.*)

Social Franchising

Social Franchising is based on the idea that organizing private sector health-care providers under a standardized, branded set of services will improve the quality and accessibility of services. This could be a whole clinic that is franchised (e.g., PSI's Sun Quality Health clinics) or individual healthcare providers,

²⁴ Dana Al Eman, "55% of Population, 68% of Jordanians Covered by Health Insurance," *Jordan Times*, February 22, 2016, <http://www.jordantimes.com/news/local/55-population-68-jordanians-covered-health-insurance/>

²⁵ Tamer Samah Rabie, Bjorn Ekman, and Ece Amber Özçelik, "Towards Universal Health Coverage: A Comprehensive Review of the Health Financing System in Jordan (Draft for Consultation)" (Washington D.C.: The World Bank, June 2014).

²⁶ USAID - Health Finance and Governance Program, "Diagnostic Study of Selected Public Insurance Payers: Equity and Sustainability" (Amman, Jordan: Palladium, 2018)

²⁷ Nicole Serfontein, Khaldoun Younis, and Julian Simidjijiski, "Health Insurance Legislative Review in Jordan" (Amman, Jordan: USAID - Health Finance and Governance Activity, 2018)

²⁸ Michael R. Reich et al., "Moving towards Universal Health Coverage: Lessons from 11 Country Studies," *The Lancet* 387, no. 10020 (February 20, 2016): 811–16, [https://doi.org/10.1016/S0140-6736\(15\)60002-2](https://doi.org/10.1016/S0140-6736(15)60002-2)

²⁹ Private Hospitals Association Jordan, "Healthcare System Overview" (PHA, Jordan, n.d.), <http://www.phajordan.org/EN-article-3809->

such as community health workers who are trained to understand the clinical criteria for a particular product, how it should be stored, and dispensed.

Sun Quality Health clinics have been deployed by PSI in multiple countries. Evidence suggests that women living in communities with between 1-5 years of social franchise had 4.7 higher odds of using a modern contraceptive device when compared with women living in communities with no IUD program. These gains appear to increase with the number of franchisees within the town. Areas with 6-12 franchises were 1.5 times more likely to use a modern contraceptive method.³⁰ Franchisees like the model because it offers access to cheap, high quality drugs and enhances their sense of social responsibility.³¹

In Uttar Pradesh, Matrika is a multi-faceted social franchising model that aimed to improve both the quality and coverage of health services on the continuum of care for maternal, newborn, and reproductive health. The model was part of a research initiative (Tougher, 2017) that studied 60 clusters (wards/villages) and matched them with 120 comparison cluster sites, with a primary aim of seeing whether there was an increase in the proportion of women giving birth at a health facility. The study found that there was a slight increase in facility births but it was not statistically significant, and evidence of improvements in delivery practices were also weak.³²

The study was published in the *Lancet*, which provided additional comment highly critical of the quality of studies that assessed social franchising to date. Specifically, they identify 24 previously published studies, that “have failed to provide any evidence of a positive impact of social franchises on population health” (except for Aung et al. (2014) in Myanmar). They go on to note that in most of the studies “franchising increased client volume and satisfaction in some contexts, it did not necessarily improve quality of care, cost-effectiveness, or equity” before concluding that the quality of most of these studies was so poor that none met the criteria for inclusion in a Cochrane review, “despite these criteria being broad”.³³ In contrast, they observed that the most recent study by Sarah Tougher et al. did meet a high benchmark for research quality, and should be taken seriously.

The one exception referred to was a social franchise model in Myanmar run by PSI, that was initially developed as a randomized control trial to test the efficacy of training community health workers in the supply of oral rehydration salts (ORS) with zinc. One year after the research commenced, “ORS plus zinc” was being used in 13.7% of the most recent cases of diarrhea in the intervention households, compared with 1.8% in the control group.³⁴

³⁰ Aung, Tin, Nang Mo Hom, and May Sudhinaraset. “Increasing Family Planning in Myanmar: The Role of the Private Sector and Social Franchise Programs.” *BMC Women’s Health* 17, no. 1 (December 1, 2017): 46. <https://doi.org/10.1186/s12905-017-0400-4>

³¹ Huntington, Dale, Gary Mundy, Nang Mo Hom, Qingfeng Li, and Tin Aung. “Physicians in Private Practice: Reasons for Being a Social Franchise Member.” *Health Research Policy and Systems* 10, no. 1 (December 1, 2012): 25. <https://doi.org/10.1186/1478-4505-10-25>

³² Tougher, Sarah, Varun Dutt, Shreya Pereira, Kaveri Haldar, Vasudha Shukla, Kultar Singh, Paresh Kumar, Catherine Goodman, and Timothy Powell-Jackson. “Effect of a Multifaceted Social Franchising Model on Quality and Coverage of Maternal, Newborn, and Reproductive Health-Care Services in Uttar Pradesh, India: A Quasi-Experimental Study.” *The Lancet. Global Health* 6, no. 2 (December 20, 2017): e211–21. [https://doi.org/10.1016/S2214-109X\(17\)30454-0](https://doi.org/10.1016/S2214-109X(17)30454-0)

³³ Mumtaz, Zubia. “Social Franchising: Whatever Happened to Old-Fashioned Notions of Evidence-Based Practice?” *The Lancet. Global Health* 6, no. 2 (December 20, 2017): e130–31. [https://doi.org/10.1016/S2214-109X\(17\)30501-6](https://doi.org/10.1016/S2214-109X(17)30501-6)

³⁴ Aung, T., D. Montagu, H. Su Su Khin, Z. Win, A. K. San, and W. McFarland. “Impact of a Social Franchising Program on Uptake of Oral Rehydration Solution Plus Zinc for Childhood Diarrhea in Myanmar: A Community-Level Randomized Controlled Trial.” *Journal of Tropical Pediatrics* 60, no. 3 (June 1, 2014): 189–97. <https://doi.org/10.1093/tropej/fmt108>

Hospital Autonomy in Jordan

Twenty years ago, USAID's Partners for Health Reform Plus Project explored how to develop and roll out hospital autonomy. The GOJ expressed an interest in developing at least partial autonomy for 22 MOH hospitals, and agreed to identify (Phase 1) and pilot (Phase 2) the process in two, the Princess Raya Hospital, in the Irbid governorate, and Al-Karak Hospital in the Karak governorate.³⁵

During Phase 2 a number of laws and regulations were identified that needed to be amended or rescinded to allow for hospital autonomy. Most of these related to the requirement and deployment of staff, and also the purchase and disposal of equipment.³⁶

Phase 3 involved analysis of the distribution of such costs across hospital costs centers for both sites. In addition, the PHRplus report made recommendations on various areas for policy intervention, such as the establishment of a cost-reporting system that tracks and coordinates hospital expenditures throughout the MOH.³⁷

Twenty years on, many of those recommendations and discussion points, such as having an accurate cost-reporting system, are being raised again.

Introducing Private Sector Management Expertise into the Health Sector

Feedback from multiple stakeholders indicate that MOH is staffed predominantly by medics, and few have any substantive training or expertise in strategic planning, management or purchasing. Similarly, HSS pillars such as Human Workforce issues are poorly understood and this is reflected in weak retention of staff and management of the health system in general.

In 1983, the British government similarly found its National Health Service was not fit-for-purpose. The then Prime Minister appointed Sir Roy Griffiths, Chair of the UK's largest supermarket chain to lead a small team to review the health sector. In his most famous quote, he imagined the founder of modern nursing's view of a poorly run health service: " .. if Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge".³⁸

After one year, Griffiths delivered a succinct 18-page report, which fundamentally transformed the Health Service. He recommended a National Board to determine the purpose, objectives, direction and budget for the health service. The Board would also receive performance reports and evaluations. Also, at a national level would be a small management executive to carry on the Board's direction. This would include a Head of Human Resources, and a "property function" for the acquisition and disposal of health real estate.

At a regional authority level, one general manager (regardless of discipline), would be tasked with the general management function and overall responsibility for achieving the objectives set by the authority. They were given greater freedom to organize the management structure of the authority in the way best suited to local requirements and management potential.

At a hospital/ "health unit" level, Griffiths recommended the identification of a general manager (regardless of discipline) to plan "*for all day to day decisions to be taken in the main hospitals and other*

³⁵ Dwayne Banks, "Implementing Hospital Autonomy in Jordan: The Selection Process" (Amman, Jordan: Abt Associates Inc., April 1999).

³⁶ Dwayne Banks et al., "Implementing Hospital Autonomy in Jordan: Changing MOH Operating Procedures" (Maryland, USA and Amman, Jordan: Partnerships for Health Reform Project, Abt Associates Inc., March 2000).

³⁷ Ayyoub S K As-Sayaideh et al., "Implementing Hospital Autonomy in Jordan: An Economic Cost Analysis of Al-Karak Hospital" (Maryland, USA: The Partners for Health Reform Plus Project, Abt Associates Inc., June 2002).

³⁸ Martin Gorsky, "'Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry," *Medical History* 57, no. 01 (January 2013): 87–107, <https://doi.org/10.1017/mdh.2012.82>

units of management".³⁹ Ultimately 12% of those appointed as general managers came in from the private sector.

Reflecting on lessons learned from the introduction of general management, Gill Morgan noted one of the most significant was that doctors withdrew from the leadership process, and felt out of place in an "environment where the talk seemed to be more about money than patient care".⁴⁰ Balancing the macro understanding of the needs of a health service, with the professional training that views the individual patient as paramount, requires very careful introduction, yet is fundamental to ensuring an efficient service that is fit for purpose.

Richard Lewis adds "... leaders must look beyond the walls of any single institution and discover how to reshape whole health and care systems. They need to understand the interdependencies between hospitals, primary and social care and how the demand for services may be shaped through new information shared with patients and citizens."⁴¹

All of these have parallels with the current shortage of management skills in the Jordanian public health sector, and the move to decentralization. Some of them have been addressed in previous programs such as PHRplus, although reforms have been reversed in Jordan in recent years due to perceptions that the Arab Spring included a backlash against privatization of public services.

³⁹ British Medical Journal, "NHS Management Inquiry. Small, Central Management Board Recommended.," *BMJ* 287, no. 6402 (November 5, 1983): 1391–93, <https://doi.org/10.1136/bmj.287.6402.1391>

⁴⁰ Gill Morgan, "We Need to Manage Griffiths' Unintended Consequences," *Health Service Journal*, July 21, 2014, accessed October 3, 2018, <https://www.hsj.co.uk/future-of-nhs-leadership/gill-morgan-we-need-to-manage-griffiths-unintended-consequences/5073058.article>

⁴¹ Lewis, Richard. "Thirty Years on, the Griffiths Report Makes Interesting Reading." *Health Service Journal*, July 21, 2014. <https://www.hsj.co.uk/future-of-nhs-leadership/thirty-years-on-the-griffiths-report-makes-interesting-reading/5072885.article>

Appendix D – Stakeholder Interviews

Interviewees included all four Implementing Partners; HCAC; Dr. Fawzi for Private Hospitals Association (PHA); the Institute for Family Health (IFH); Jordan Association of Family Planning and Protection (JAFPP); UNICEF, and the Chief Executive of Pharmacy One.

Questions were tailored to each entity, but all had four main sections:

1. Country Context – this explored the government’s willingness to engage with the private sector
2. Sector specific questions – relating to use of and opportunities to connect with, the private sector
3. Equity – whether greater use of the private sector would improve or hinder equity
4. Sustainability – whether greater emphasis on the private sector would improve sustainability

Questions were forwarded to all interviewees in advance. The format was semi-structured and, in some cases, interviewees opted to talk around the topics rather than follow the questions directly. Where this was perceived to be beneficial, this was permitted.