



Health Work Committees (HWC) - Palestine

Research Paper

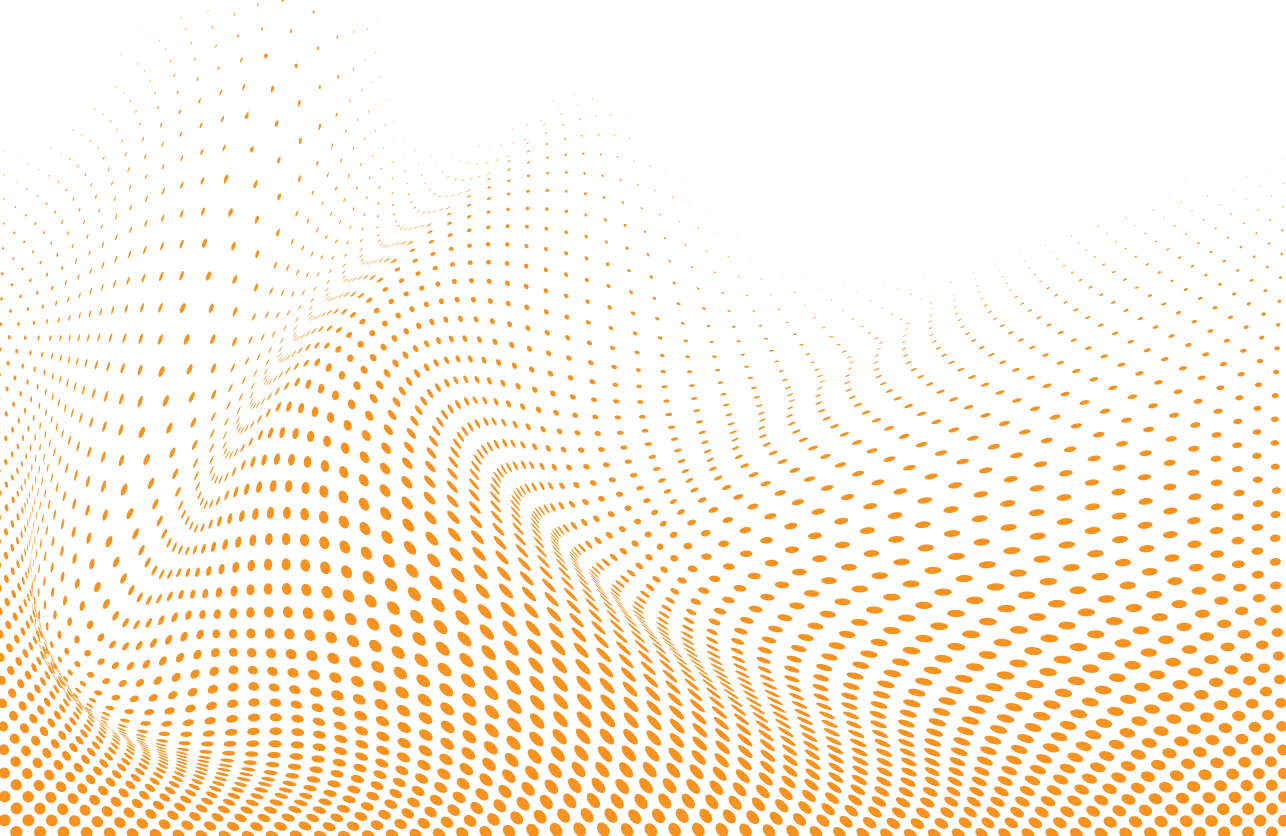
**Facts related to the Right to Equitable
Access to Health and Confronting the Pri-
vatization of Arab Health Systems**

2020/2021



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Study Terminology:

Right to Health: means the enjoyment of the highest possible level of health. The right to health includes the obtainment of acceptable, affordable and quality health care in a timely manner. It also necessitates that countries create the suitable conditions in which all persons would have access to health to the furthest extent possible, including the provision of health services and healthy and safe working conditions, as well as adequate housing and nutritious food.¹ However, a person's right to health does not mean the over-abundance of health.

Universal Health Coverage: means the ability of all people to effectively receive high quality promotive, preventive, curative, and rehabilitative health services without facing financial hardship. Universal health coverage requires the presence of robust, resilient and people-oriented health systems, and it enables a person to access basic health services covered by a comprehensive national health insurance.²

Equitable Access to Health: means that all citizens are able to receive the appropriate health services without having to pay additional costs, where everyone would have access to the highest possible level of health services based on the available resources, along with minimizing the differences among individuals and groups by facilitating their access to health services. Equitable services are characterized, inter alia, by the following features: Efficiency, quality, effectiveness, reliability, sustainability, consideration of needs, safety and coverage, flexibility, beneficiary satisfaction, and taking the prevalent culture into account. Equitable access to health also requires facilitating the provision of health services in different geographic areas, as well as enhancing the material/financial capability to enable people's access to high-quality services within the available resources in an equitable manner.³

1 World Health Organization (WHO). "Human Rights and Health." Accessed September 6, 2020. <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>

2 Health Work Committees (HWC), "Privatization in the Health Sector and its Effects on Equitable Access to Health Services" [Arabic]. 2019.

3 Ibid.

Privatization: is defined by the United Nations General Assembly as the transfer of all or substantially all the interests of a government in a public utility asset or another sector to the private sector. Meanwhile, the World Bank defines this term as: increasing the private sector's participation in managing the activities and assets controlled by or owned by the government, whereas the assets and services are transferred from the public sector to the private one as a developmental mechanism to raise the efficiency of project performance, enhance participation, strengthen market forces, improve the financial position and alleviate the burdens of the state's general budget. For the purposes of this study, and in line with its findings, Privatization was defined as the government's transfer of some health services in its facilities for the benefit of the private sector, whereas the government incurs large expenses to refer/transfer those who have health insurance to enable them to receive health services by private and non-governmental institutions.⁴

Public Sector: is a sector that aims to provide necessary basic services to ensure public order, whereas it is difficult to market these services to individuals in return for a price, such as [national] defense, internal security, and the justice sector. The Public Sector is financed by the state's general budget, and its revenues primarily originate from the taxes imposed on people to contribute to bearing the public service expenditures.⁵

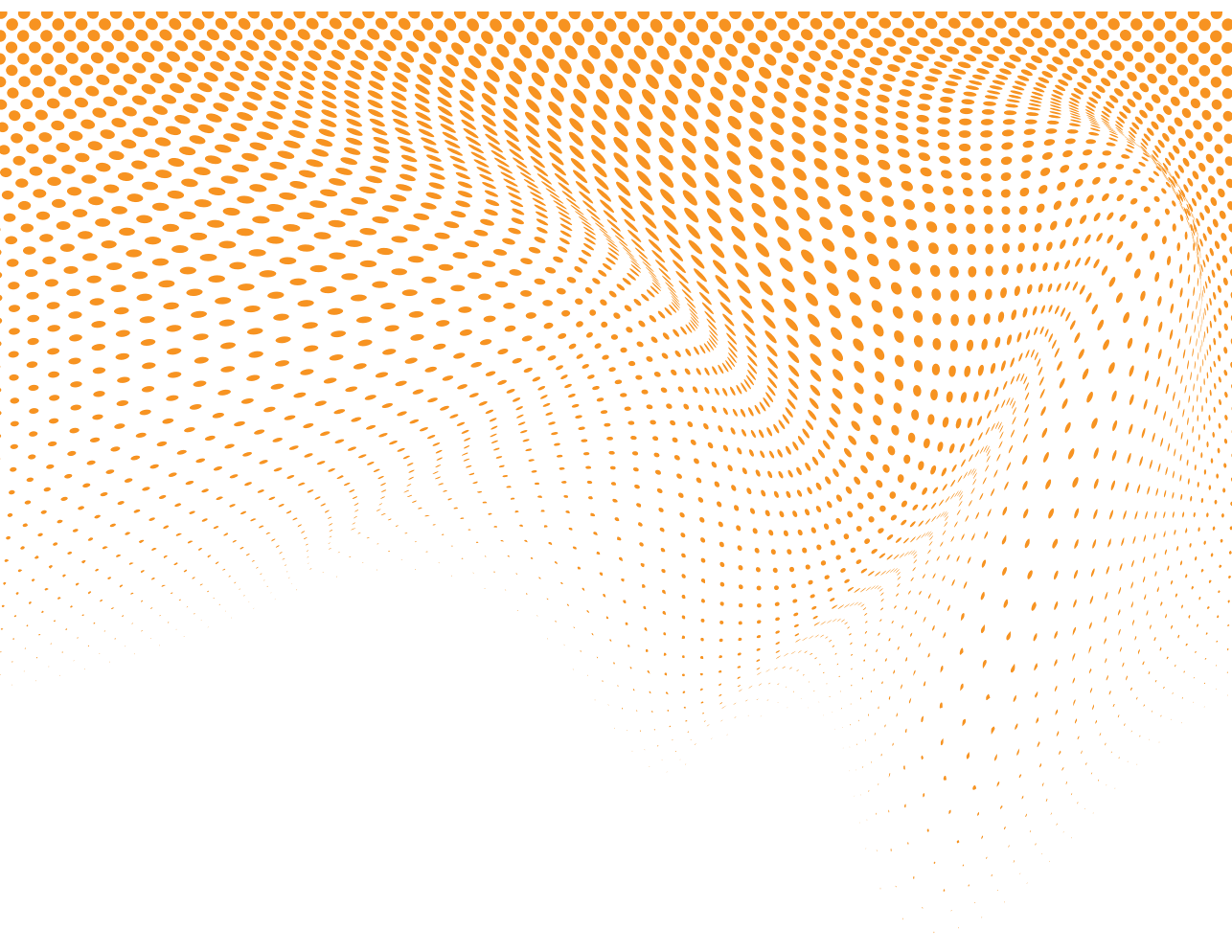
Private Sector: represents the institutions, companies and individuals who provide curative services in return for a profit. This sector is a main element for regulating economic activities and it is characterized by private ownership. In this sector, production processes are carried out on the basis of the market system and competition. Also, it is based on private initiatives and carries the risk of taking decisions separately from those of the public sector⁶.

4 *Ibid.*

5 *Ibid.*

6 *Ibid.*

Introduction



It is no secret that the most problematic issues in Arab health systems emerged as a result of certain social, economic and political circumstances. Evidence related to that were clearly seen with the outbreak of the COVID-19 pandemic, whereas the health emergency status deepened the global and regional crisis. Nevertheless, for many years, health policies [in Arab countries] were being dominated by solutions that merely deal with certain diseases and ignore the conditions that lead to more diseases and health problems. This led to the prevalence of discrimination and injustice in people's access to health care services, and the medical and pharmaceutical interventions were no longer able to effectively achieve the desired results. It is also worth noting that the "social determinants" of health help us explain the reason behind the poor and marginalized persons' suffering from diseases and premature death compared to their counterparts who enjoy better social conditions.

It became alarmingly clear that privatization in health sectors (i.e., "commodification" of health care) in the Arab world is one of the most serious challenges that restrict the citizens' access to health. Due to this privatization, all or substantially all the interests of the government in a public utility asset or another sector are transferred to the private sector.

Privatization is sometimes seen as a technical solution to manage resources and reduce the fiscal deficits suffered by the government. Nonetheless, it is also considered an integral part of a certain economic, social and political philosophy of governance. Several international actors are currently promoting privatization without considering its effects and consequences on human rights conditions. In fact, privatization frequently adopts an approach that systematically eliminates the means of protecting the citizens' right to equitable access to health. For example, a privatization arrangement may include medium-term or long-term contracting or a leasing or concession contract between the government and a private company, where the company would build and/or manage projects or services, such as hospitals, health

facilities, pharmaceuticals, medical devices and consumables, sanitation, water, communication facilities, and /or medical transportation.

The wave of privatization witnessed globally since the 1990s is not only attributed to governments and the private sector, but also to international organizations; and especially the International Monetary Fund (IMF), World Bank, and United Nations. Therefore, privatization practically became an ideology of governance and a model for redefining the public interest by “being free” from the government and benefiting from the “liberation” (so to speak) brought forward by corporate efficiency and profits.

The research papers prepared in Arab countries (Palestine, Jordan, Lebanon, Tunisia, Morocco, Yemen, and Iraq, respectively) raise some serious fundamental questions about the effects of privatization on equitable access to health. These papers thoroughly analyze a set of key issues that affect people’s access to health, including health legislations; health-related spending; health expenses by citizens and households; impact of colonialism, conflict and human security; governmental policies for developing health systems; and private companies and entities that are primarily dedicated to maximizing their non-altruistic profits.

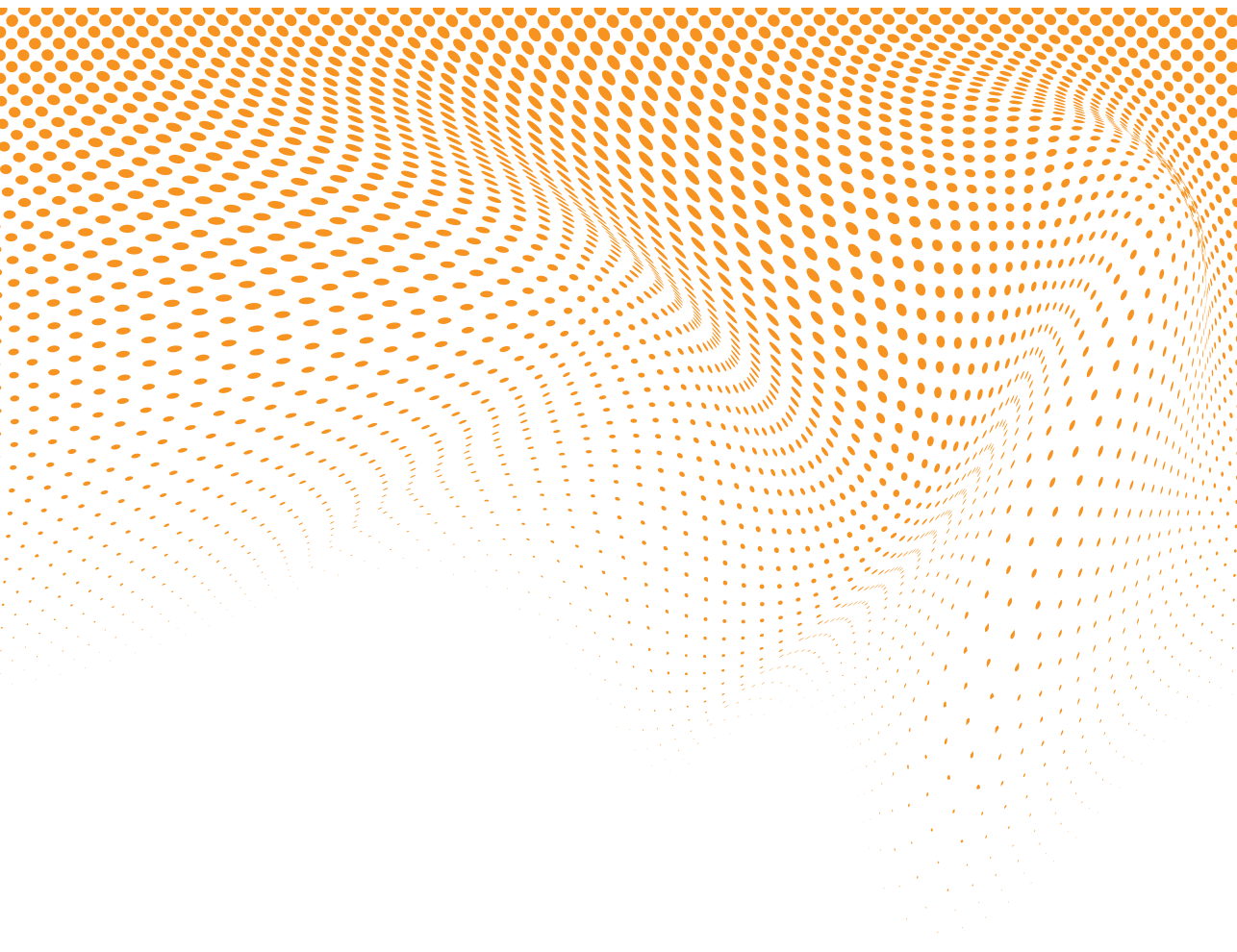
We hope that these study papers will contribute to finding policy alternatives that bring forward a rights-based vision for free societies in which citizens would enjoy justice and equity (“social justice”), as a prelude to mobilization and advocacy activities for promoting equitable access to health. This study was prepared in cooperation with partners and researchers from non-governmental institutions and civil society organizations in the Arab world.

The Health Work Committees (HWC) in Palestine extends its gratitude to all those who contributed in preparing these research papers, and especially the cherished partners and researchers from civil society organizations in the Middle East and North Africa (MENA) region, namely:

- Dr. Sabri Belqassem / Director of the Tunisian Association for Defending the Right to Health, Tunisia.
- Dr. Kamel Mohanna / Pediatric expert, Professor at Lebanese University, Director of Amel Association International – Lebanon, General Coordinator of Lebanese and Arab NGO and volunteer networks.
- Dr. Aziz Ghali / President of the Moroccan Association for Human Rights, Morocco.
- Ms. Ilham Al-Rasheedi / Executive Director of the Health for All Association, Yemen.
- Mr. Kamal Al-Mashriqi / Human rights researcher and activist, Jordan.
- Dr. Ghaith Hamid Hameed / Internal Medicine expert, specialist in Precision Medicine in respiratory and chest diseases, international consultant and trainer in the civil society sector, Advisor to the Baghdad Women Association, Baghdad.
- Mr. Mahmoud Atiyeh / legal researcher and human rights activist / reviewed the study on “Health Sector Privatization in Palestine and its Effects on People’s Equitable Access to Health” – Health Work Committees (HWC), 2019.
- Mr. Abdul-Razeq Ghazal / Supervision and review of research papers.

Ms. Shatha Odeh,
General Director of Health Work Committees (HWC)

Executive Summary



Ordinarily, the advancement of any country is measured through the progression of its health sector, wherein the more advanced the levels of health services a country provides for its individuals, and the more a government exemplifies a serious consideration in the development of the health sector by increasing its expenditure for that sector, the more it will bring about the welfare and stability of its individuals. There is no doubt that the spread of the health crises consisting of the COVID-19 coronavirus Pandemic that the world has suffered and continues to suffer from is a perfect illustration and a valid example of how substantial this statement is. After all, the developing countries – at the tail end of the healthcare system ranking – that do not spend enough on this sector or even consider health to be a fundamental human right, are now suffering from the enormous and ongoing burst of infections and death rates caused by the coronavirus. These repercussions are largely due to the inability of treatment centers, hospitals, and quarantine centers (if present at all) to receive patients.

The developing countries of the Middle East are considered to be a focal point of persistent and deadly conflicts, which only hampers the structure of health systems and stands in the way of reforming the worn-out health sectors within these countries. What hinders this process even further is the lack of government spending on health and the marginalization of the health sector from the government's public spending, in addition to the poor infrastructure of the health sector posed by the shortage of hospitals and treatment centers within these countries. Another great setback in the public health sector is the inequitable geographic distribution of hospitals and treatment centers across these countries, as hospital and treatment centers tend to exist exclusively in major cities and districts as opposed to other regions. It is rather unfortunate that the right to health as defined by the International Covenant on Economic, Social, and Cultural Rights (of 1966) as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,”^{7 8} is now sadly considered to be

7 Office of the United Nations High Commissioner for Human Rights - International Covenant on Economic, Social and Cultural Rights - Article 12. URL: <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>

8 Ibid.

a sort of luxury and privilege restricted to certain classes in societies rather than being an essential human right for all. Meanwhile, the expenses of health services are constantly on the rise which causes individuals to spend on their own health from their own money at the time where these services should be offered to them free of charge by the public health sector. Essentially, public services such as healthcare combine between being a social and economic right for individuals on one hand and having a considerable impact on the development of countries on the other, thereby making it a legal, economic, and political matter simultaneously.

The lack of potentials in the public sector of these countries accompanied by the inability to harmonize between the weak capacities and the massive increase in demand of health care services debilitates countries and transforms health from being an essential human right into a commodity in the economical sense of the word. This only paves the way to the privatization of the public health sector on the pretext of enhancing the quality of services offered by public hospitals. With that said, it is apparent through the study findings that privatization tends to make things worse in terms of widening the gaps between public and private health sectors, and adds even more financial burdens to individuals. It also incapacitates the approach towards a fair and equitable access to health, which only leads to more disparities between individuals within societies.

It is without a doubt that the approach towards fair and equitable access to health requires the activation of a universal health coverage system that would guarantee a comprehensive and mandatory health insurance for individuals in an affordable manner. This can only be regulated through legal systems within each country. As this study illustrates, it is evident that all poor countries lack the inclusivity and compulsion in their health insurance systems which would ensure everyone's equitable access to health. This is particularly true for the marginalized groups such as the elderly, patients with chronic illnesses, women, pregnant women, and persons with disabilities.

The role of civil society organizations takes effect by pressurizing, mobilizing, and advocating in efforts to form a strong public opinion aiming to influence laws and policies that reinforce the right to the equitable access to health facilities, services, and goods, and aims to promote the concept of a universal health coverage in public health facilities, goods, and services. It is in this respect that this study was produced under the cooperation and partnership of researchers and partners within civil society organizations and non-governmental institutions in the MENA region. This study includes several research papers highlighting the reality and status of health inside the Arab world and the gaps of operationalizing the right to health in marginalized countries. The Health Work Committees (HWC) in Palestine extends its gratitude to all those who contributed to preparing these research papers, and especially the cherished partners and researchers from civil society organizations in the Middle East and North Africa (MENA) region, namely:

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- Mr. Mahmoud Atiyeh / legal researcher and human rights activist / reviewed the study on “Health Sector Privatization in Palestine and its Effects on People’s Equitable Access to Health” – Health Work Committees (HWC) - Palestine, 2019.

**Lebanon: Health Policies and the
Future of Humanity:
The Decommmodification of Health
Care as a Prelude to a Safer World**

**He who has health, has hope; and he who has hope, has everything.
– Thomas Carlyle**

Introduction

Human society underwent several decades of outright arrogance, going above and beyond scientific and technological superiority and onto man's attempts to "conquer Mars" and extend influence beyond the blue planet. However, in only a few months, humanity went back to square one due to a viral microbe that caused a global pandemic which, spreading all over the world, inflicted a heavy toll. Perhaps of most significance, this pandemic exposed the fragility of the health sector, to the point that people became convinced that health is the backbone of civilization. After all, a person suffering from or threatened by a physical ailment will not be able to move towards a better future. As philosopher Will Durant puts it, civilization "begins where chaos and insecurity end." Moreover, in his book titled *On Heroes, Hero-Worship, and the Heroic in History*, philosopher Thomas Carlyle notes that "He who has health, has hope; and he who has hope, has everything". In fact, health is much more than a basic human right acquired by birth; it extends to being an essential contributor to the process of social change. Moreover, health – physical and mental – would be a fundamental objective to achieve for those who believe in advancing and transforming human societies.

The coronavirus disease 2019 (COVID-19) erupted in a world that was overwhelmed with consumer policies within the health sector, which quickly became a source of profit for agencies and companies through privatization. This contributed to deepening people's health insecurity amidst their lack of social and economic security. Alas, humankind is currently facing an acute crisis with severe and far-reaching consequences that threaten the future of humanity, and even life on Earth. The COVID-19 outbreak led to the infection of more than 24.8 million persons worldwide and the death of more than 838,000,⁹ as well as affecting the lives of billions of people around the globe. This pan-

9 World Health Organization (WHO). It should be noted that the statistical data is up to date with the most recent data bulletin issued by the World Health Organization (WHO) as of the date of this study, whereas the bulletin was issued on August 30, 2020. Link: https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200831-weekly-epi-update-3.pdf?sfvrsn=d7032a2a_4

demical also exacerbated the previous disasters, which pushed millions of people to the brink of hunger and the deprivation of livelihood, in conjunction with the loss of hundreds of thousands of jobs and the collapse of many sectors. Before the coronavirus, 2.2 billion people had suffered from severe multidimensional poverty and were unable to receive effective health care. Meanwhile, in light of the ‘snowballing’ outbreak, it seems that a major disaster is just around the corner, while no effective counter-policies are on the horizon.

A Warning to Humanity to Reconsider Health-Related Policies and Legislations

COVID-19 opened doors of controversy for many ‘First World’ countries who had deemed that pandemics were eradicated in the 20th century and therefore a thing of the past. Consequently, many European states, which claimed to be a great model for a social welfare and boasted about their provision of quality health services since the by-gone days, suddenly found themselves falling apart as the health system collapsed before their eyes. As such, the masks (so to speak) fell off and no longer obscured the recent decades’ fixation on neoliberal policies and departure from the concept of state sponsorship. This urgently calls for the need to re-evaluate the health policies globally, including the various policies for confronting environmental disasters, infectious diseases, and viruses.

This pandemic, which is considered a humanitarian and environmental catastrophe in several aspects, can be seen as a service to the world by which to reconsider health policies, plans, and procedures. This necessitates that countries adopt a new approach towards this sector, as well as a holistic developmental vision that puts humans and the environment (instead of profit and competition) at the forefront of their priorities.

It is worth noting that scientists had previously warned of pandemics similar to COVID-19 due to the ceaseless human activities and the unprecedented globalization. Also, the fact that this disease originates from animals can be seen as an indicator of the ever-increasing dysfunction and destruction caused by human activities, and their hazardous impact on land and marine habitats. Knowing that environmental and natural scientists and specialists have pinpointed a direct link between the dysfunction of the earth's ecosystems and the spread of zoonotic diseases is a call for us to seriously examine global health policies. It is no coincidence that scientists have linked the response to this pandemic with ethical guidelines, sound ecosystem management including biodiversity, as well as the need to formulate better policies, create green jobs, and make environmental education a top educational priority. This was recently affirmed by United Nations Secretary-General António Guterres, who stated that “had we been further advanced in meeting the Sustainable Development Goals (SDGs) and the Paris Agreement on Climate Change [of 2016],” humanity would have been able to respond better to such viral attacks and future crises.

The current global crisis is a good moment to rethink a number of issues in a collective manner, seeing that the entire world's societies have a common destiny in this respect. These issues are crucial to address in light of the current policies' failure to improve people's quality of life, while the climate and environment are deteriorating further. The latter actually saw a remarkable improvement during the lockdowns imposed in most countries, coupled with a decline in Carbon Dioxide (CO₂) emissions and the cessation of most industrial activities during those periods. This prompts a serious warning for human beings who are now becoming more aware of their important role in preserving life on Earth and protecting the planet for future generations, whereas the right to live in a safe, healthy and sustainable environment is an integral human right.

Is it a Crisis of Policies and Procedures?

Global health, especially amid the COVID-19 outbreak, presents a formidable challenge to the entire world today. Even the most advanced and experienced countries whose health systems have proven to be effective for many decades seem to be struggling in the global war against the pandemic. This is especially pertinent in light of what is called the “healthcare industry”, which emerged from the liberal order that soon dominated the world and contributed, in due time, to disrupting the world economy and introducing austerity policies that influenced the environment, education and health sectors. The commercialization of health care services also led to a decline in prevention and treatment systems, while prices and monopolistic competition, including in what relates to COVID-19, have increased. Investments in the pharmaceutical health care industry have become quite profitable like any other business, and especially since the for-profit private sector has not sufficiently contributed to supporting researches and studies related to diseases and pandemics. Ultimately, the “oligarchs” of this ruthless sector lost a lot of money due to the COVID-19 outbreak. Perhaps at some point, this new reality may bring forth a positive change in perception of everything.

The twenty-first century has not seen the elimination of the problems of inequality. In fact, the various developments witnessed by the world since the century’s beginning led to a growing inequality, to the point that the world’s 2,153 billionaires have more wealth than the 4.6 billion people who make up 60 percent of the planet’s population, as revealed by a report from Oxfam¹⁰.

¹⁰ Oxfam. “World’s billionaires have more wealth than 4.6 billion people.” January 20, 2020. Link: <https://www.oxfam.org/en/press-releases/worlds-billionaires-have-more-wealth-46-billion-people>

Although the planet's production of basic foodstuffs accounts for more than 110% of global needs, as many as 30 million people die of hunger every year, and more than 800 million people suffer from food shortages. It is true that the world advanced in seeking better health for all, yet the prevalence of different forms of discrimination in accessing health care has weakened those achievements.¹¹

For example, in the United States (which has been pointed to as a pinnacle of capitalist achievement), health expenditures became a huge burden on the national economy and had underlying socio-political dimensions that greatly affected the presidential elections. It was in this respect that the subject of health care became a main topic in the U.S. domestic policies and programs, thus increasing health care spending from 16% to 18% of the U.S. Gross Domestic Product (GDP). With that said, more than 50% of Americans today live without any kind of health insurance. In light of the current pandemic, the U.S. administration's health policies (also imposed on other countries) proved their inability to meet the needs and rights of people, including those in countries it sponsors. Clearly, these policies have had a detrimental impact on global health and well-being.

The issue of health in general and its cost in particular have brought the world much concern over the decades. Taking into consideration the great disparities in health service provision and deficiencies in performance methods, the World Health Organization (WHO) decided in 1977 that its main target should be to attain health for all people of the world by the year 2000. This declaration was also adopted at the International Conference on Primary Health Care (PHC) in Alma-Ata in 1978. The agenda of the World Health Organization focuses on the relationship between poor health and the lack of development, whereas poverty, illiteracy and poor infrastructure (especially in the use of wastewater) are largely responsible for the burden of ill health in many developing countries and harm the health of mothers and children in particular.

¹¹ United Nations News. "On the eve of celebrating World Food Day, the United Nations mentions the impact of hunger on the lives of millions of people around the world" [Arabic]. October 15, 2019.

According to a WHO report titled “A Billion Voices: Listening and Responding to the Health Needs [...]”, 43% of the urban population in developing regions lives in slums, whereas this percentage reaches 73% in the poorest countries. Also, the population in poor and marginalized urban slums is expected to reach about two billion by the year 2030, which represents 40% of the world’s urban population, and will increase to about three billion by 2050.¹²

Inequality is one of the distinguishing features of our contemporary world characterized by technological advancements and communication revolutions. As the United Nations Development Programme (UNDP) Human Development Report of 1994 confirms, poverty has become the rule while welfare is an exception. Our world can no longer function with a quarter of rich people and three-quarters of impoverished ones, with half of them living in democracies while the other half suffers under totalitarian regimes, and meanwhile human development is impeded by multiple forms of deprivation.

Despite the strong voices championing human rights and the Universal Declaration of Human Rights (which affirms that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care”), access to these rights is increasingly becoming difficult for a large portion of humanity, and especially in developing countries.

¹² Rida Issa, Assafir Al-Arabi. “Tombs are the best types of slums in Egypt” [Arabic]. July 25, 2012.
Link: <http://assafirarabi.com/ar/2748/2012/07/25/>

Profit Over People - Economic Globalization as an Alternative to Social Justice

The overall situation leads us to conclude that we are facing an all-out crisis. Since the World Summit for Social Development held in March 1995 in Copenhagen, the international community recurrently stated that it is impossible for humanity to survive in light of this dangerous conflict. To put it another way, we are on the verge of leaving to our children an unlivable world after states made tax-free investments their absolute priority while they ignored the legitimate humanitarian needs. The experiences of both advanced and developing countries demonstrate the gravity of this trend, which increased the demand for job opportunities to the extent that supply cannot absorb it. As a result, unemployment rates – and poverty – are on the rise. Within the same context, the marginalization of large segments of developing societies throughout the period of “economic advancement” increased the immigration influx towards advanced states, thus leading to a shortage of productive forces in Third World countries. This shows the dehumanization of economic capitalism, not to mention the spread of panhandling, child labor, and sidelining of people in the outskirts of cities and villages – all of which have perilous effects on large segments of the society and children’s safety. In fact, many of the societal issues emanate from those very segments – e.g., overpopulation, environmental pollution, illegal immigration, drug trafficking, and religious fanaticism. Although those types of dilemmas impact the entire world, yet their effects are not the same for all cross-sections of society. For example, within the national structures, the upper classes benefit from patterns of development, whereas poverty and marginalization intensify among other groups. This applies even in the Nordic countries and the global level at large. Ultimately, it is the Third World – of which the former Eastern Bloc is now in a similar situation – that suffers the most from the negative effects of this brutal pattern of growth.

Amidst a world order that is increasingly adopting privatization, we are witnessing the absent role of many welfare states that were built in Western Europe after World War II (which had provided great assurances to the people as reflected on the global level). Consequently, the gap has been increasing between rich and poor. After the collapse of the Soviet Union and the Berlin Wall, there were 400 million poor people and 10 billionaires in the world. Therefore, the United Nations adopted the slogan of “sustainable development” after it failed to solve the world’s security crises (that had been main reason for its establishment in 1945). Even now, in light of the prevailing global discourse on democracy, gender, human rights and social justice, the world has 2 billion poor people and 550 billionaires. This was also revealed in Oxfam’s recent report during the meeting in Davos, which pointed out that the world’s richest 2,153 billionaires have more wealth than the 4.6 billion people who make up 60 percent of the planet’s population.¹³

The United Nations focuses on holding conferences based on the priorities of its programs and activities and as per its declared principles, such as the right to health for all people by the year 2000, and the Millennium Development Goals (MDGs) to reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases, among others. However, the results of these conferences remain, for the most part, non-binding recommendations and declarations. Also, the conferences themselves are often used as tools for humanitarian and developmental work maneuvering.

13 Op. Cit, Oxfam. Link: <https://www.oxfam.org/en/press-releases/worlds-billionaires-have-more-wealth-46-billion-people>

Developing Countries are the Most Vulnerable to Health Deterioration

Health is the main challenge for developing countries (including Arab states) that have limited resources. The inhabitants of some parts of Africa face the threat of extinction similar to that which took place among indigenous societies in the past. Meanwhile in Palestine, the Israeli Occupation is implementing apartheid plans and expanding settlements, in violation of international resolutions which stipulate the legitimate rights of the Palestinian people. As such, security tensions are inflaming on the global level.

It is true that the recent decades saw a trend in incorporating a human rights-based approach for development as its fundamental basis, yet despite its theoretical significance, this approach is contrary to what is happening on the ground. The “dimensions” of development are being globally translated on the premise that the international order has reached economic stability due to adopting the market economy, reducing governmental intervention, and enhancing freedom of competition through multiple mechanisms, such as the International Monetary Fund (IMF), World Bank, and World Trade Organization (WTO).

It also seems from the outside that the world has become politically stable and is committed (albeit in an unreal manner) to the principles of democracy, yet instability is clearly visible on various social and health levels. This is apparent in the weakness of those representing the groups most vulnerable to the development process’s negative impact. For example, [legal] trading in medicines is ranked fourth in the world in terms of sales volume – only after the oil, food, and arms trade. Also, the availability of medicines in a certain country may indicate its economic prosperity, and yet the details of how the global trade is regulated demonstrates unfairness. Essentially, the pharmaceutical industry is not free of inhumane orientations that disregard the poor people’s need for medical treatment.

It should also be noted that the United Nations, led by the dominant countries, imposes its decisions on developing countries within the framework of its commercial exchange and investment policy. Therefore, if any developing country does not introduce internal policies that conform to the aforementioned decisions, it will be subject to a trade boycott. On the other hand, if the country accepts to comply with these decisions, it will suffer from unequal exchange. Whoever looks carefully at the decisions of the United Nations will realize that they are biased towards the interests of corporations and large companies owned by [influential] individuals. For example, one of the most harmful decisions in the field of health was the empowerment of private pharmaceutical companies to monopolize the manufacturing process or obtain so-called patents. This came along with enabling private medical insurance companies and multinational pharmaceutical industries to compete with their governmental counterparts.

Model of Health Care Systems in the Arab World

Most Arab countries are facing huge obstacles that impede their weak health care sector's reform and restructuring. Among their main challenges is poor infrastructure, both in terms of the great shortage of hospitals and emergency centers, as well as their inequitable geographic distribution (as most facilities are located in the large governorates and cities). This further deepens the state of injustice in the health sector.

In 2019, a report issued by the World Health Organization (WHO) showed that health care in Arab countries is ranked among the worst in the world. This includes poor medical skills and inefficiency, lack of modern methods and equipment for diagnosis and treatment, and far-away facilities; all of which make the health workforce inadequate to confront crises such as the COVID-19 pandemic. This situation is further compounded by the rising emigration of health workers to Europe and elsewhere due to the bloody wars, conflicts, and socioeconomic factors.¹⁴

In light of these wars and conflicts, some Arab countries witnessed the spread of contagious diseases such as cholera, tuberculosis, scabies, viral hepatitis, and other diseases in Somalia, Sudan, Yemen, and (recently) Syria. It should also be mentioned that Oxfam previously warned that 8 million Yemenites will lose access to clean water and that the cholera epidemic will spread in the country. Furthermore, medical sources in Sana'a showed that there were 7,364 cases of swine flu (H1N1) in Yemen in 2019; 310 of whom lost their lives.¹⁵

¹⁴ World Health Organization (WHO) report titled "Primacy Health Care on the Road to Universal Health Coverage: Executive Summary". Link:

<https://www.who.int/docs/default-source/documents/2019-uhc-report-executive-summary>

¹⁵ Noon Post, "The health sector in the Arab world... The rib of the shattered development" [Arabic]. January 13, 2020. Link: <https://www.noonpost.com/content/35545>

Many Arab countries also suffer from the phenomenon of malnutrition. A report issued by the World Food Programme (WFP) shows that more than 2 million Yemenite children suffer from malnutrition¹⁶. Also, according to the World Health Organization (WHO), the ongoing conflict in Libya led to the complete or partial destruction of 17.5% of hospitals, 20% of the primary health care facilities, and 18 specialized hospitals. Moreover, 41 attacks were carried out against health care workers between 2018-2019.¹⁷

A similar but more severe crisis is being witnessed in the Gaza Strip, Occupied Palestinian Territory (oPt). In this respect, successive warnings were issued by international envoys, who noted the ongoing collapse and deterioration of the health sector therein. The Palestinian Ministry of Health revealed that 50% of essential medicines, 25% of medical consumables, and 60% of laboratory supplies and blood banks have run out of warehouses in the Gaza Strip due to the imposed blockade and restrictions, not to mention the energy and food crisis that Gaza is suffering from.¹⁸

All of this coincides with the deterioration of mental health and the dramatic rise in suicide rates compared to previous years.

These facts show that humanity is facing an existential crisis. As Will Durant articulated: “For civilization is not something inborn or imperishable; it must be acquired anew by every generation, and any serious interruption in its financing or its transmission may bring it to an end.” This warrants us to ask: What will the next generation do with a land that is devoid of potable water or is desertified and contaminated with industrial waste? What kind of civilization could be built in a state of disruption and helplessness? The answer to these questions lies in our adopted policies and vision toward developing a system that sees health as a fateful issue that cannot be compromised or commodified.

16 World Food Programme (WFP) of the United Nations, in an article titled “Yemen” [Arabic]. Link: <https://ar.wfp.org/countries/yemen-ar>

17 Ibid. (15)

18 Palestine Return Centre, “Mladenov warns of the dire humanitarian situation in the Gaza Strip” [Arabic]. September 21, 2019. Link: <https://prc.org.uk/ar/news/345/>

Status of the Health Care System in Lebanon

50% of the Lebanese people lack health insurance

Lebanon, a country that has not witnessed a state of social, political, or economic stability for over half a century, is ranked among the worst countries in the list of nations which suffer from medical supply shortages and health-related challenges. Irrespective of the fact that medical care costs in Lebanon are the highest in the Arab World, yet over 50% of the Lebanese citizens lack health care insurance, and more than 2.5 million Lebanese citizens are currently below the poverty line. The devastating situation got worse when almost 40,000 employees lost their livelihoods within the last four months, so much so that the rising unemployment rate among the youth went up to 40%. Meanwhile, the food and health sectors¹⁹ are no longer able to function due to the daily devaluation of the Lebanese pound. Added to that, the spread of the COVID-19 pandemic accelerated the country's financial and economic collapse.

In line with the dominant trends in the patterns of global development, Lebanon adopted policies that respond to the requirements of globalization and market integration. However, this was implemented without considering the priorities needed for its particular economic characteristics and local challenges. Basically, they resorted to solving the economic crisis with the same kinds of policies that caused the crisis in the first place.

In this context, civil society organizations played a prominent role amidst the declining role of the public sector. This was especially the case during the long years of war in the country, including the Civil War of 1975-1991, Israeli aggressions of 1993 and 1996, liberation from Israeli occupation in 2000, and the Israeli war on Lebanon in summer 2006. In all of these respective periods, civil society organiza-

¹⁹ Anadolu Agency, "The triad of unemployment, poverty, and high prices compound the challenges of the Lebanese market (report)" [Arabic]. March 3, 2020. Link: <https://www.aa.com.tr/ar/1764496>

tions were the main competent party for determining and responding to the needs of the people. For example, many associations exerted substantial efforts – especially in emergency and disaster relief – to limit the devastating effects. In the early 90s after the end of the Civil War, Lebanon saw that it was imperative to move towards development, whereas the National Accord Document (Taif Agreement of 1989) stipulated the importance of equitable development. However, we have yet to see the attainment of the desired results in this field.

It should be noted that 0.3% of the Lebanese population (i.e., 8,000 persons) own half of the country's wealth, which ultimately leads to the increase in poverty rates on both the national and global levels. In this respect, approximately one-third of Lebanon's population (30%) live below the poverty threshold, of whom 7 percent are in abject poverty. Lebanon also has 1.5 million Syrian refugees (according to the Lebanese government's estimate), whereas a million of them who have been in Lebanon for eight years are registered in the United Nations High Commissioner for Refugees (UNHCR) database.²⁰ Moreover, there are significant numbers of Palestinians, Iraqis, Egyptians and Sudanese, as well as 250,000 foreign domestic workers. Clearly, the growing poverty in Lebanon is producing deplorable health consequences. Interestingly, the Lebanese National Accord Document had focused on creating a socioeconomic council for development as well as serving the citizens and meeting their needs locally. That said, the statistics indicate that no more than 50% of the Lebanese citizens have health insurance, while the others are deprived of any health coverage – apart from what is provided by the Ministry of Public Health.

Consequently, the rate of poverty is skyrocketing in Lebanon, leading to various social crises including a rise in divorce cases, drug consumption, and various other psychological effects. Notwithstanding those circumstances, the fragile Republic failed to provide the most basic services to its citizens, whose increasing numbers bring forth a new set of needs that cannot be met at this point. With this in mind,

²⁰ Human Rights Watch, Article titled "Lebanon: Events of 2018" [Arabic].
Link: <https://www.hrw.org/world-report/2019/country-chapters/lebanon>

the environmental degradation in Lebanon has other daunting ramifications on the national level.

Bearing in mind the human, material, and institutional losses that emanated from Lebanon's long-standing Civil War (1975–1991) and the repeated Israeli attacks, there were still some health improvements. Those included an increase of life expectancy at birth, a decline in child mortality, the adoption of family planning methods, and a reduction in the number of births. Those may be attributed to the following factors:

- The culture of self-reliance, increasing popular awareness, and the development of healthy behavior habits among Lebanese individuals and households.
- The active and proactive role of civil society organizations in providing health care services and responding to relief demands.
- The private sector's significant and ongoing role in supporting health care delivery.
- Continued foreign aid, especially with regard to emergencies.
- The involvement of international organizations (such as the specialized United Nations agencies such as UNICEF and WHO) in comprehensive programs by which to deal with infectious disease outbreaks. The Ministry of Public Health and civil society organizations also cooperated in these programs through immunization, prevention, and monitoring campaigns.
- It was noted that the media, national and international parties, and governmental and non-governmental bodies also had a positive role in this regard.

Irrespective of those improvements that various studies detected through a number of health indicators (despite Lebanon's long years of war), there is no way to disregard the serious challenges facing the national health system, namely: The lack of equity, low quality, high cost of health services, the demographic transition and public health, the beneficial provision of the private and NGO sectors, lack of planning, and reliance on new medical technologies.

Another obstacle is the chaos within the health care. Incidentally, the country saw a decline in death rates; the average life expectancy in Lebanon is 81.4 years. However, the lack of proper health care management has had various repercussions, including wasted resources, poor decision-making, and corruption. As an aside, those tendencies function within a sectarian regime that categorizes individuals as per their affiliation.

The overall state of chaos applies not only on relations but also on health-related investments, especially in the use of new technology. If we compare a country like Lebanon to the French Riviera (Côte d'Azur) region in France, where the population, geography and climate are somewhat similar, we will notice that Lebanon has three times more technology than that region in France. Nevertheless, no policy evaluations are made in Lebanon, no health mapping is conducted, and there is no application of the proportions between districts mentioned in the Lebanese National Accord Document (Taif Agreement). Furthermore, there are no health cards, no control over spending, and no complementary services within single health units. It should also be noted that primary health care – which was highlighted by the World Health Organization (WHO) at the Alma-Ata conference in 1978 – could be seen as the gateway to health reform in Lebanon. We proposed this already three decades ago, and – in coordination with the Lebanese NGOs, civil society organizations, and the Ministry of Public Health – those efforts culminated in the establishment of the Lebanese health care network, which includes about 205 health centers and paved the way for health reforms in Lebanon.

Health has and always will be a primary concern for people. The World Health Organization (WHO) was aware of that when it declared its intention to provide “health for all by the year 2000,” yet that statement may have not been connected to reality. It is imperative to fulfill the right to health for all citizens of the world, including Lebanon. Health, as well as education, housing, and social services are inherent rights for all citizens and must neither be done as a “favor” to anyone nor beset by “clientelism.”

In view of the conducted studies, there is a need to provide 1.5 billion dollars to cover the health coverage expenditures. However, the big question is: How can we obtain such amounts? Is it through people’s participation as is being currently proposed? How would the poor pay for their health care coverage when they have the full right to medical treatment and public health care?

Adopting the primary health care project could secure almost 70% of people’s needs due to early detection of chronic illnesses such as diabetes, high blood pressure, and cardiovascular diseases. Early screening, follow-up and the provision of home care could save between 20 to 30 percent of the health expenditures. This would also enhance medical care programs and optimize the referral system [which is discussed by everyone but not applied by anyone]. In this sense, development at the health level should be done horizontally, rather than vertically as is currently in place (wherein people are constantly resorting to hospitals). This can be done by linking the clinics, dispensaries, and health centers with hospitals and provide the currently unavailable health services at reduced prices. In this way, 70 to 90 percent of health services in these facilities will be accessible, while the remaining 10 percent will be provided in hospitals. It should also be highlighted that this health care policy should be implemented and the aforementioned referral system organized through partnership between the different health-related sectors within the health district.

Health-Related Spending and Hospitalization Costs in Lebanon

Statistical information in Lebanon is divergent and contradictory, especially in what relates to health expenditures – which are estimated at 4.5 billion dollars. Some studies estimated the cost of medicines at 2 billion dollars. Unfortunately, such crucial figures in Lebanon are often only matters of opinion. Still, it is a known fact that health expenditures increase with the advancement of medicine as well as the rising standard of living. Consequently, health has become a great burden for most countries. In Lebanon, health expenditures are approximately 9 to 12 percent of the Gross Domestic Product (GDP), which is equivalent to what Europe pays for the medical treatment of its citizens. In the United States, this rate is between 16 to 18 percent of the GDP, and it is expected to reach between 20 to 25 percent in the coming years. Therefore, although the numbers in Lebanon seem to be a bit high, they are considered logical due to the increasing health costs and the ongoing scientific advancements. This is in line with what is referred to as the “health care industry,” which highlights how everything in the world today seems to be based on material relationships amidst the degradation of morality and values.

Also contributing to the cost are the high hospitalization bills, as indicated by a 2004 report concerning Social Security. The report indicated that 30% of hospitalization cases were unjustifiable, and this is largely due to the fact that Social Security does not cover treatment outside of hospital. Insured persons, often lacking the financial ability, prefer to be admitted to hospital so as to pay a maximum of 10% of treatment costs, thus leading to an increase in hospitalization costs.

On the public policy level, there are still no legal provisions or legislations related to civil society organizations and the NGO sector, so there is no mechanism to enter a contractual relationship with this sector as is the case in hospitals. Furthermore, the licenses issued by the Ministry of Health are limited to the clinic and hospital, as there are no

legislations pertaining to health care centers, maternity centers, one day clinics, etc. We strongly recommend the stipulation of these legislations as soon as possible.

Civil society organizations could be an ideal partner in this respect, seeing that they have firsthand experience in the ways of dealing with public funds and spending for the benefit of the people. They also have expertise in developing health care programs with a culture of partnership and “esprit de corps” to strengthen the role of public hospitals.

This confirms the importance of partnership between the public and private sectors and civil society organizations, provided that the public sector (i.e., Ministry of Public Health) would be the main supervisor and regulator, and that the Ministry would not act as a bonding or insurance company. Therefore, the Lebanese Social Security should be concerned with the aforementioned aspects and roles. Moreover, the districts (mentioned in the Taif Agreement) require the participation of all health-related parties to collectively contribute to the provision of health care for all.

Role of NGOs and Civil Society Organizations

Within the framework of the Lebanese NGOs Network (which includes the largest associations), we have been working for over half a century to secure people's basic rights – especially the right to health. This was manifested by our committed work with popular groups in a nonsectarian framework and through a rights-based approach, irrespective of political, religious, or geographic considerations. This sector played a pivotal and effective role both during and after the Civil War, granted that it is the government that is responsible for the people while the civil society plays a complementary role. This sector simultaneously constituted a lobbying force to rectify public policies for the benefit of popular and marginalized groups. The statistical information issued by the Ministry of Public Health showed that of the 860 health clinics and medical centers in Lebanon, 760 were related to the civil sector and 100 were owned by the public sector. This further emphasizes the great role of the civil sector at various stages.²¹

Although some parties are involved in humanitarian work simply for personal interests, yet the Lebanese civil sector as a whole has a lot of diversity and different options. There is no doubt that this sector made some important contributions in the turbulent years by preventing the disintegration of Lebanese society; contrary to what happened in several countries that underwent war and occupation. Moreover, this sector was greatly helpful during the period of civil peace as it provided services, implemented developmental programs, as well as promoted a rights-based culture on all levels. Hence, this study highlights the role of this sector in light of the questionable policies pursued in Lebanon, which led to an economic and moral dilemma and deemed democracy unattainable in the country.

²¹ Union of Arab Banks – Article titled “Amel Association provides millions of health care services to Syrian displaced persons since 2012” [in Arabic]. URL: <https://bit.ly/3m9zKBa>

Whether at times of war or peace, civil society organizations in Lebanon played a pivotal role in different aspects. They actively participated in different programs for improving health indicators, reducing death rates, increasing life expectancy, and executing various campaigns. This role should be greatly appreciated. At the same time, all parties must work together to attain health for everyone, since this is an integral right for all.

From Diagnosis to Treatment – Towards a Strategy for Securing Equity of Access to Health Care

Based on the current situation of health systems, and in light of post COVID-19 developments, Amel Association International adopted a comprehensive vision that includes practical steps to reform the health system in Lebanon and other Arab countries, whereas the current system will inevitably collapse if it is not reformed soon. The main objective of this reform is to “provide health for all” (as declared by the World Health Organization two decades ago), within the framework of achieving equitable development and establishing district councils. The aim is to also make use of local resources to identify issues and find solutions through their active participative. Knowing there is a dire need for a more equitable, resilient, effective, integrated, and generalized health system, it becomes crucial to mobilize all efforts and capabilities in order to put human beings at the epicenter of any developmental policy.

There is no doubt that the efforts for improving the health sector are quintessential for organizing this vital field for all parties. Therefore, the following actions are highly recommended:

1. Provide reliable and pertinent information on health conditions, conduct a comprehensive survey of the health workforce, and clearly identify the future needs. It is also crucial to formulate a national health policy that ensures the development and self-sufficiency of the health workforce and thus eliminate the shortage of health workers (and especially nurses).
2. Rearrange community and public health centers by adopting a health map that specifies the role of each, in accordance with the directives of the World Health Organization (WHO). Redundancies should be avoided and eliminated, necessary actions created, and all efforts must be mobilized towards the creative implementation of a holistic national health plan that involves all active parties.
3. Adopt the primary health care approach as a major strategy to ensure that health care is provided for all. This includes developing public health infrastructure, establishing health districts, and improving primary health care projects.
4. Formulate a national pharmaceutical policy that responds to various health care needs. It is also vital to introduce appropriate legislations to implement this policy and determine the lists of essential medicines, as well as re-activate the national drug observatory as soon as possible.
5. Designate an advanced organizational structure for the Ministry of Health in a way that takes the various specializations into consideration. The structure must also apply flexible rules and regulations that will enable the Ministry's administration to duly perform their functions, appoint qualified health personnel, and expand their geographic presence to include most Lebanese regions (especially the rural ones). Furthermore, it is imperative to enhance the Ministry of Health budget and organize the distribution of public financial resources.

6. Organize the work of NGOs with a modern modus operandi and strengthen their role in primary health care through their various health centers and clinics.
7. Develop a plan for using state-of-the-art technologies and transfer the specialized cases to the private sector.
8. The Ministry of Health must supervise and recognize the civil society's distinctive role (and especially that of NGOs), as well as recruit committed personnel. In addition to benefiting from their vast experiences, NGOs should also be involved in the planning, programming, and implementation of the national health policy -in cooperation and coordination with the Ministry of Health and academic institutions. This will foster the leadership role of the Ministry of Health, as well as strengthen the active participation of NGOs while creating harmony between the public, private, and NGO sectors. With this in mind, the Ministry of Health must always be the main supervisor and regulator of the health sector. It should also be noted that privatization does not mean neglecting public institutions. Essentially, the private sector cannot succeed unless there are highly qualified state institutions that are able to properly regulate the private sector.
9. Activate the Economic and Social Council (ECOSOC) and the Higher Health Council, as well as improve the performance of sectoral committees. This can help strengthen the culture of participation, make use of national human resources, reduce health expenditures, and strive to ensure the provision of health for all (in accordance with the WHO vision).
10. The role of the NGO sector in the health system reform process should focus on familiarizing the public, private, and NGO sectors about the fact that health is an inherent human right for all individuals.

11. Replace the current health system with more equitable, resilient, effective, integrated, and generalized health services. In this respect, it should be noted that the way to improve the health indicators of poor people in Lebanon (including children, women, and overall citizens) is by going beyond the curative care approach (e.g., diseases and medications). Rather, the holistic approach of the World Health Organization (WHO) and Ministry of Public Health should be adopted instead, thereby providing primary health care for all as a main strategy. Seeing that it is crucial to consider people's economic and social conditions, there is a need to adopt an approach that goes beyond sectoral specializations. This goes in hand with exerting substantial efforts in the fields of health, education, social affairs, social security, agriculture, finance, NGOs, the private sector, and international organizations for the purpose of achieving the desired objectives of the formulated health policy.

12. Reduce hospitalization expenses so as to improve the overall health care (which happens to be one of the sustainable development goals), by:

- Adhering to a flat rate for surgical interventions approved by the Ministry of Health, as is the case in several countries.
- Finding alternatives to hospitalization (e.g., one day clinic), similar to what was put into effect in a number of countries including the United States and European countries. This established policy has cut down costs to about 30% and included approximately 50% of hospitalization services.
- Classifying hospitalization cases for various diagnoses by adopting the principle of "Diagnosis Related Groups" (DRG) within a certain financial ceiling. All amendments therein must require the approval of the sponsoring body.

- Reducing bed occupancy when there is no medical necessity for it. Implementing such a measure can reduce health expenditures by around 30 to 40 percent.
- Employing the principle of “Home Care.” In this respect, valuable help can be received from the NGO sector through their clinics and health centers that are especially prevalent in villages and rural areas.
- Choosing the family doctor as an intermediary between the patient, medical specialist, and hospital. This can help reduce the misuse of some health services. Also, if health insurance becomes mandatory as part of the solution to the health system (such as in the United States), insurance companies will start competing for the lowest prices and best services.
- For better management of this vital sector in Lebanon, there should be an introduction of a national hospitalization system. This will help unify hospitalization funds, support and activate the public hospitalization field, and activate a system for establishing public institutions to organize public hospitals in different governorates. Moreover, there a well-programmed plan must be formulated to provide health insurance to all Lebanese citizens and increase the participation of citizens in covering health care expenditures.
- The above-mentioned orientations should be considered a strategic plan for implementing the health-related Millennium Development Goals [such as reducing child mortality, improving maternal health, and combatting HIV/AIDS, malaria, and other diseases] and improving the health status of people – one of the main indicators of human development.

13. At the Level of Lebanese Non-Governmental Organizations (NGOs)

In order for the NGO sector to assume the role of a partner in development and oblige the government to recognize this role, there is a need to perform a critical internal review of its performance and programs, and to work on enhancing the democratic practices and mechanisms of its organizations. The NGO sector must also develop a general strategic vision of its role instead of running circumstantial, temporary, and incomplete campaigns. Additionally, the NGOs should give priority to the most vulnerable societal groups and respond to community-based needs instead of giving priority to donors' preferences. Furthermore, their work should not be limited to dealing with the consequences of health and social problems, for they must also exert great efforts to deal with the roots of these problems.

14. At the National Level:

The policy currently in place has led to an economic and moral dilemma within the Lebanese society and deemed the purported democracy unattainable. The country, in line with the dominant trends in the pattern of economic globalization, has also enforced policies that respond to the requirements of globalization and market integration without considering the main priorities that suit its economic characteristics and local problems and crises. As mentioned, they resorted to solving the economic crisis with the same kinds of policies that caused the crisis in the first place. In essence, the process of development requires the participation and interaction of all relevant parties. This could be done through the creation of a "social contract" for development which will enable the engagement of the civil society, private sector, and the government in introducing a future consensual project that gives priority to the country's current and future interests.

15. The Millennium Development Goals (MDGs) can be achieved through a productive economy and the encouragement of private investments. It is pivotal to put serious effort into eliminating poverty, illiteracy and unemployment; reducing emigration; minimizing the gap between different areas and social groups; and catching up with the global trends of cultural evolution. All of these points pose serious challenges for the future of Lebanon and Arab countries. They thus demand the democratization of development through involving different societal groups and actors (including civil society structures) in devising Lebanon's economic, social, and humanitarian policies and options. These policies and options should be formulated locally, while preventing the vertical approach to development (whether on the social, sectoral, or geographic level). In order to achieve this, Arab countries must cooperate between each other and the global community. We must also overcome the fear of "being dictated to" and "imposed on" by forming inclusive and reciprocal relations.

Seeing that the human and social pillars are woven into the fabric of the Millennium Development Goals (MDGs), and their attainment is contingent on them, calls for empowering the Lebanese democratic institutions by: strengthening political participation, enhancing the rule of law and institutions, activating the role of citizens, redefining the relationship between citizens and state, strengthening the judiciary's role and independence, combating corruption, creating transparency and accountability mechanisms, recognizing the role of the legislative authority, rationalizing political culture, maintaining political pluralism, ensuring the rotation of power, and expanding freedoms and civil society actions. All of these elements are prerequisites for moving the Lebanese Republic towards the path of democratic development.

16. Lebanon and the Arab world urgently need to work on those pillars that are of paramount importance towards attaining the Millennium Development Goals (MDGs). Achieving a more sustainable future is crucial, as our world has become increasingly converged, intertwined, and interdependent, while the phenomenon of “regional blocs” has become a characteristic of the 21st century. A new Lebanese and Arab system can greatly foster democratic development and empower the democratic institutions, thus influence the emerging world order.

17. Enhancing the two aforementioned pillars in Lebanon and the Arab world requires ending the cycle of violence, war, and occupation in the region (particularly in Palestine). Such conflicts have ultimately depleted the region on several levels for decades. Therefore, overcoming this dreadful situation could be a preamble for achieving progress in Lebanon and elsewhere in the Arab World.

Planning Better Health for the Future

The following can be concluded from the above-mentioned points regarding health conditions in Lebanon and the role of the NGO sector:

1. On the Level of NGOs:

The non-governmental organizations (NGOs), which demonstrated great performance during times of calamity, should transfer their effective disaster management experiences into a holistic Developmental Action Plan. Approximately 50 NGOs have implemented nationwide programs that were carried out in an impressive and responsible manner. Evidently, there is a genuine desire among civil society organizations to work under one framework, supervised by the state, and mobilize all resources to serve the country and its people. The two main associations that emerged during times of disaster were the Lebanese NGOs Network (which includes 17 organizations), and the Lebanese NGO Forum (which includes 12 organizations).

Together with the public and private sectors, these two associations have had a crucial and complementary role in working towards securing the right to health care for all.

In this context, we propose the implementation of Decree Law no. 159/83 related to establishing health districts in Lebanon and developing primary health care projects. To strengthen the contractual relationship between the Ministry of Health and NGOs (205 centers) – as is the case in private hospitals, and to meet every respective need through engaging local communities in participatory development, we recommend to:

- Endorse the following sequence:
- First, the health care clinic or family doctor.
- Second, the medical center.
- Third, the hospital.
- Reduce the hospitalization rate among the Lebanese population, which is currently between 10 and 12 percent, whereas it is about 7 to 8 percent in developed countries.
- Enhance cooperation between medical clinics, health centers and public, private, and community hospitals in different districts and governorates. This should be aligned with a unified plan that curtails improvisation, avoids the duplication and dissipation of efforts, as well as prevents the waste of budgeted amounts and the manipulation of humanitarian work for personal interests.
- Adopt the principles of specialization and complementarity between different sectors, whereas each entity should work within its own area of expertise.
- Specify the various needs to be commensurate with population numbers.
- Augment the participation of families in the conduct of activities and supervision.

2. On the level of Hospitals:

First: Private Hospitals:

1. Manage the specialized hospital units while supplying advanced technical equipment in a way that is suitable to the country's needs.
2. Apply the principle of "complementary health care specialization" among the different hospitals, under the supervision of the Ministry of Health.
3. Consider health as an inherent right for all citizens, which we (especially at the Ministry of Public Health) must work collectively to attain.

Second: Public Hospitals:

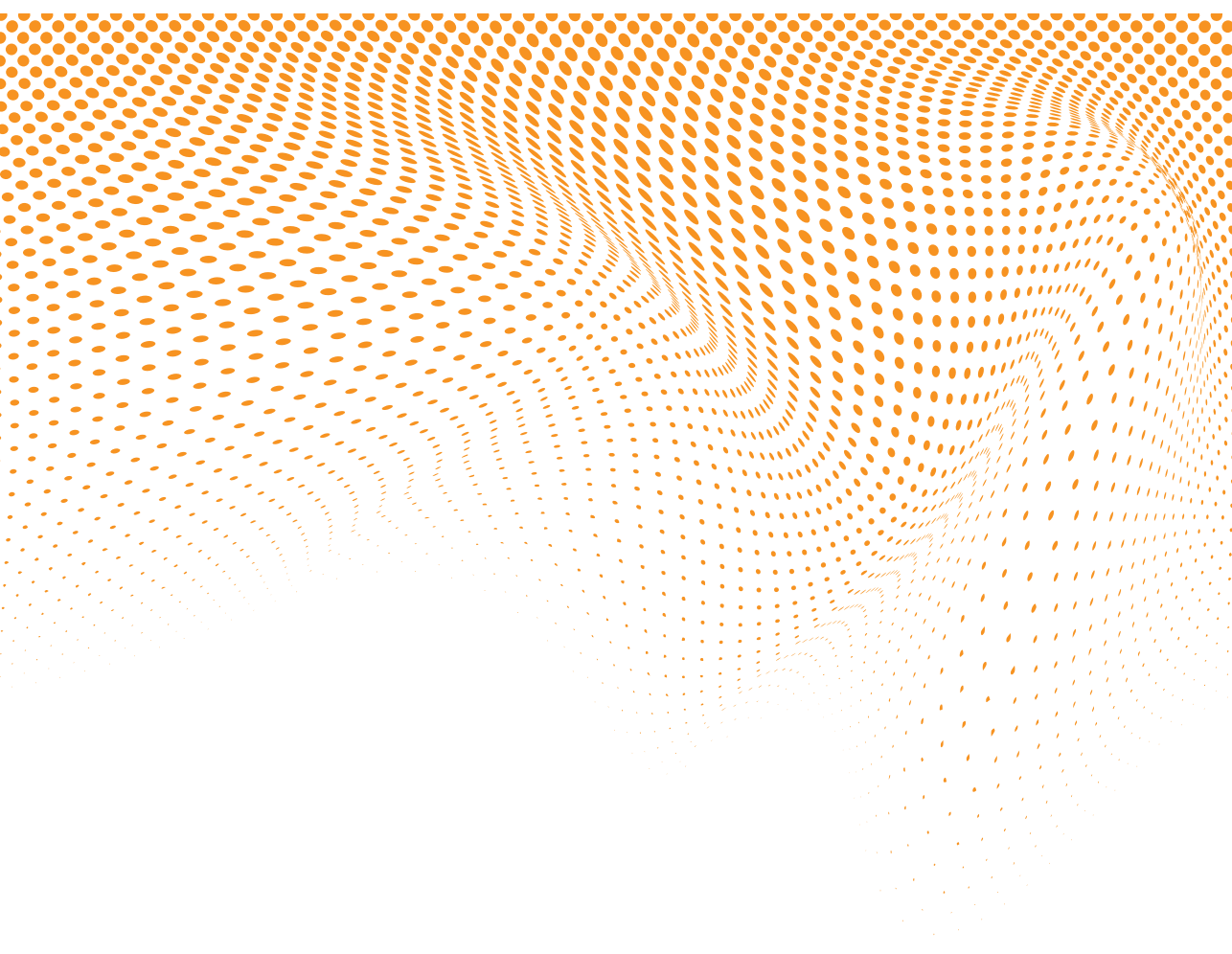
1. Support the health care delivery system that pertains to hospitalization and establishing institutions so as to manage public hospitals in different regions.
2. Highlight the importance of cooperation and complementarity between public, private, and community hospitals and foster this relationship for the interest of the country and its people.

Third: On the State Level

1. The era of the "Welfare State" (État Providence) that carries out all services is over. The state can no longer be responsible for everything and it cannot meet the different needs of citizens. Therefore, it is imperative to have a modern and advanced state wherein the different sectors cooperate effectively in bearing the national responsibility for development and improvement (as was exemplified in the cooperation between the Ministry of Public Health and non-governmental organizations during the Israeli invasion of 1982).

2. The NGOs and private hospitals undoubtedly play an instrumental role, but they should not disrupt the work of the government and must clearly specify their respective roles. In this regard, the NGO disaster response at times of war was extraordinary, and there should be lessons learned from those experiences for all parties, bar none.

Privatization of the Health Sector in Morocco



Introduction

Knowing that health care is a vital sector that concerns all citizens, we have several concerns related to RAMED²², health care coverage, and other issues related to doctors in the public and private sectors. From its end, the Ministry of Health raises the slogan of “health care coverage” merely for political purposes. Otherwise, it makes no sense to assign dates as far as six months to one year for a citizen to undergo a medical procedure or get a health screening. Unfortunately, public health care has not seen much progress in Morocco, where the traditional negative practices are still in place despite the Ministry’s responsibility for citizens’ health.

In an attempt by the Ministry to find solutions to the recorded deficiencies, the state encouraged the privatization of health care, and investors soon got on board. Privatization of the health sector certainly has some benefits, yet its disadvantages far surpass its advantages. Unfortunately, the public hospitals’ absence of essential equipment and long wait time oblige the helpless citizens to resort to the private sector and have to pay substantial amounts for health care services. As a result, citizens who do not have health coverage may need to sell all their possessions in order to receive medical treatment. This desperate situation, for some health care investors, is seen as an “opportunity.” Ideally, investments in the health field should be done by professionals and not by manipulators who seek to make profits without taking patients’ humanitarian condition into consideration. With this in mind, there is no doubt that the privatization of health care will have serious consequences, whose victims will be the poor citizens. To prevent that from happening, public hospitals must be reformed and better equipped, and the salaries of health care professionals (doctors,

22 RAMED [an acronym for Régime d’Assistance Médicale] is Morocco’s medical assistance system and one of the main components of its social development policy. This system targets the impoverished population, as well as other beneficiaries in accordance with the law, such as inmates in prisons, homeless persons, and dwellers of charitable institutions, orphanages and shelters. According to the RAMED system, these groups are exempt from the costs of treatment at public hospitals, public health institutions and state-owned health services. For more detail: <https://www.maroc.ma/ar/content/نظام-التغطية-الصحية-راميد> (Shortened URL: <https://bit.ly/3a6NHxF>).

nurses, medical professors, and practitioners) must be raised in order to safeguard the public health sector for the service of societal segments who lack health care coverage.

Before fully dismissing their right to public health care, citizens did receive services – albeit incomplete and deficient. The free health care services were average, and not fully inclusive. A significant number of residents were excluded and discriminated against on the basis of social, geographic, and gender biases. Moreover, medical and hospitalization facilities were incapable of absorbing the huge demand. This was largely due to the state's insistence to stick to cost reports by which to limit expenses of public health care activities, including constructing buildings, buying equipment, and payment of medical and paramedical wages.

The emergence of the COVID-19 pandemic and its negative ramifications and human and material losses led the international community to completely or partially suspend many vital aspects of life. Consequently, a number of preventive health care measures were issued for citizens so as to reduce risks and prevent many cases of death.

However, the hardships of some are often beneficial for others. After reviewing the governance and strategic directives and health policies of other countries, Morocco adopted the policy of privatizing this vital sector under the pressures and dictates of foreign funds. This took place despite various protests against and criticisms of health care privatization, and meanwhile paved the way for capital investments and allowed the public health sector to collapse for the benefit of expanding private clinics. On the other hand, due to the lack of purchasing power to receive treatment or hospitalization at private health care facilities, many men, women and children from vulnerable groups resorted to public hospitals, only to find a number of obstacles on their way. Those hurdles included the state's refusal to provide health care services and its imposition of the payment system as a precondition for providing treatment or hospitalization.

Withdrawing Free Public Health Care and Introducing Privatization:

Withdrawal from Free Service: The state withdrew the provision of free public health care services and treatments through the Decree of 30 March 1999 related to the ways of determining prices. Starting from May 2004, the payment requirement was endorsed in all public hospitals with regard to all various services, including medical consultations, health screenings and X-rays, biomedical analyses, surgeries, dental care, general medical services, child delivery, resuscitation, hospitalization, drugs and medications, blood bags and related products, medical equipment, hemodialysis, accommodation for patients' companions, transfer of patients inside hospitals, medical evidence delivery, and others. Consequently, the prices of services in public hospitals started applying the same logic as that of private clinics, i.e., categorized as "professional businesses".

Basic Health Care Coverage: Tying health care coverage to the six funds has been one of the main dimensions in putting people's right to public health under attack. Although this initiated as a premise to finance public health care, it was actually utilized to justify the cancellation of public health care. The basic compulsory health insurance, in this respect, falls within the scope of "social protection" because its funding comes from social contributions whose expenditures emanate from employers (and the health care received by workers is in fact part of their wages). Meanwhile, the remaining part of the coverage system has no relation whatsoever to social protection.

Therefore, the current medical assistance system for the poor is an explicit attack against free health care. This is because most of the related costs are actually borne by the poor and not by the state budget through the tax system. Several poor people pay 600 Moroccan Dirhams (equivalent to approximately \$65 U.S. according to currency exchange rates at the date of this study). This amount is considered high for large families (i.e., a five-person family), especially when com-

pared with their income. If a person fails to pay the related amounts, s/he will be removed from the list of beneficiaries of this coverage. Furthermore, the state refrained from paying any percentage of treatment costs and instead placed this burden on the medical assistance system to cover treatment expenses of prisoners, orphans, and those in nursing and old people's homes. The claim that the poor are benefiting from "free treatments" is unequivocally false because the poor people in vulnerable situations are the ones who are bearing part of these expenses through the risk-sharing system. The government also does not contribute to most other insurance systems, so individuals are the ones who have to carry the weight of the related financial burdens.

Hospital Reform: This means increasing the sustainability and self-sufficiency of hospitals so that they are able to finance themselves. Having been granted the opportunity to price their services (including for the poorest of society) through direct payments or insurance systems, this reform aims to enable hospitals to become administratively and financially independent. The premise is that bearing the operational expenses would help hospitals invest in infrastructure and equipment (i.e., reorganize their management in the spirit of entrepreneurship). This is also considered an approach for improving the "quality" of health services. However, the term "quality" in this context does not mean that the public health system will meet the medical service and hospitalization requirements in accordance with health standards. The meaning rather denotes to "commodity" – in the sense that it would meet the needed conditions for providing competitive health services in an increasingly open market economy. This can also mean that hospital equipment and services will be regarded as effective because they are essentially considered a commodity. Therefore, when hospital "reformers" claim that the aim of these reforms is to regain patients' confidence and respond to their needs by improving the quality of services, they are not talking about all patients but only those who can afford the health services. By and large, the state succeeded in widely promoting this concept, which prevailed in the discourse pertaining to public services.

Regionalism: Regionalism falls within the framework of reorganizing the state's intervention in the health sector while seeking to strengthen independence in operating public hospitals. Regional Health Directorates are considered the cornerstone for passing the different measures of the health reform program at the regional level. It is a given that they will seek to sign partnership contracts with the private sector as they aim to accelerate the privatization of public hospitals in various regions.

The Year 2011 Paved the Way for Hospital Privatization:

In July 2011, the state almost destroyed the entire public health care system by issuing Framework Law No. 34.09 related to the health system and the supply of treatments. This law undermined the premise of the right to health. It also enabled the state to avoid carrying the responsibility of sponsoring health treatments. Furthermore, it overturns all health-related concepts while favoring the different forms of privatizing public hospitals. This could well be considered a strategic turning point in the process of eliminating health care as a public service, as further demonstrated in the following:

Abandoning State Intervention to Ensure Health: Article 1 states that the right to maintain health is the responsibility of the state and society, which violates the international human rights principles and covenants. Also, Article 2 stipulates that, among the principles of attaining health objectives, is "to involve the population in the responsibility of preserving health and the prevention of and recovery from disease." This article throws the responsibility of injuries and recovery from diseases on the shoulders of citizens, which contradicts with understanding the deep causes that influence health outcomes; the social determinants of health (SDH) – as underscored by the World Health Organization (WHO).

This concept means there are several factors that determine people's physical and mental health, including housing, potable water, electricity, sewage channels, level of education and income, safety, working conditions and comfort, nutrition, environment, social and gender differences, and all factors related to income distribution.

The state's avoidance of carrying out health responsibilities was further confirmed in Article 6, which includes the private sector as a contributor alongside the state in undertaking the tasks needed to provide curative care, equipment and infrastructure, as well as training doctors and nurses.

A Radical Shift in Health Care Perception

The following concepts were introduced to justify the state's withdrawal from the responsibility of protecting citizens' health and also to legitimize privatization:

1. **Treatment Records:** This refers to the doctors, nurses, infrastructure, equipment and all means related to providing health treatments, regardless of whether they are within the scope of the private or public sector.
2. **Health Care Institutions:** Those are not limited to public facilities, but also include private clinics and hospitals. All health care institutions equally contribute to providing prevention, diagnosis and treatment services, yet private institutions were allowed to provide public health care services and treatments. Accordingly, this enabled private investors to infiltrate the public health facilities.

3. Health Map: The health map provides predictions drawn from the treatments records (mentioned above) for a ten-year period. This supply of medical treatments by both public and private sector institutions is considered reliable for responding to various population needs (such as through treatments and health care services). It will also guarantee (according to the legal provisions) fair distribution of health material and human resources and troubleshoot disruptions among agencies. Moreover, this map is a tool for controlling the growth of the offered health care services.

4. Regional Scheme of Treatments: This is a tool for the regional distribution of treatments included in the Health Map and is a basis for managing the partnership between the public and private sectors. The Regional Scheme of Treatments is also a tool for accelerating the privatization of the public health sector, whereas the Regional Health Directorates will be able to sign contracts related to various forms of privatization.

5. Legalizing the Privatization of Public Health Care Facilities, Services and Treatments: Privatization became legitimate after it was introduced by neoliberal reforms that were gradually applied for more than 10 years. For this reason, they issued the Framework Law related to the health system and the supply of treatments. After competing with public health care institutions for a long time, private investors were now given leeway to intervene as service providers in public health care facilities. This was made possible through the public-private sector partnership, which is not limited to infrastructure, equipment and the training of health care professionals, but also extends to providing essential medical services and everything related to prevention, diagnosis, and treatment.

The Framework Law introduced the following three forms of partnership as a means to enable the private sector to partake in public health care duties:

- **Delegated Management:** The list of public hospitals has now become open for private investors due to the “Delegated Management Law” and the “Public-Private Sector Partnership Law.” Basically, this authorizes private companies to manage public health care facilities in return for financial amounts from the patient, or from profits, or both. The delegated management contract might also stipulate the principle of “construction, operation, and transfer of ownership”, i.e., building facilities (such as hospitals or specialized departments) and operating them for a certain period of time, after which ownership is transferred back to the state. It is worth noting that partnership contracts that are signed in accordance with the “Public-Private Sector Partnership Law” (in effect since January 2015) are highly risky. After all, this Law gives more guarantees to capitalists. It also surpasses what was stipulated in the “Delegated Management Law” because it not only ensures private investors’ profits (by confirming the preservation of the contract’s financial balance), but it also adopts the principle of “joint and equal bearing” of the risks that the project might encounter. Additionally, it stipulates the obligation of the eligible party to assume the risks for the purpose of reducing the cost. This means that the state will bear all the risks that might lead to the loss of financial balance in the partnership contract. Moreover, in contrast with the “Delegated Management Law,” the “Public-Private Sector Partnership Law” lacks an effective monitoring mechanism in case the private health service providers breach their obligations mentioned in the partnership contract. Ultimately, this Law lacks the necessary guarantees for protecting the rights of patients and hospital personnel.

- **Partnership for Implementing Joint Activities:** This may relate to establishing a partnership between the two sectors based on the two aforementioned laws. However, there is nothing that prevents the establishment of other forms of health care services and facilities that are privatized, or public, or both. The enforcement decree of the Framework Law related to the health system and the supply of treatments stipulated the possibility to establish “a coordinated treatment network,” which is a horizontal, non-sequential entity for providing treatments in multiple specialties. This would give the means to establish – in partnership with private investors – hospital compounds whose size, number of specialties, services, equipment, and technology may well exceed those of public hospitals, even those available at university hospitals.
- **Procurement of Health Care Services from the Private Sector:** The state encouraged this form of medical service privatization before ratifying the Framework Law related to the health system and supply of treatments. As a model for this type of partnership, the state signed an agreement with representatives from private hospitals in order to purchase the kidney dialysis service [10]. One of the consequences of this was the emergence of clinics specialized in kidney failure diseases, focusing mainly on providing dialysis services (which in fact happened in a number of large cities). The state quickly conducted this kind of partnership on the premise that it lacked the needed medical and paramedical equipment and structures to carry out those functions itself. On the contrary, however, this actually increased the cost of procured services by a rate that far exceeds the expenses that could have been disbursed for taking care of patients in public hospitals. This form of privatization was like ‘double trouble’: it encouraged the growth of privately-owned health institutions at the expense of public hospitals, and it also raised the cost of the procured medical services.

Measures that Encourage Private Health Investments:

The Framework Law provided investment incentives for private health care institutions by stipulating that entering public-private partnerships would be beneficial for the latter. Also, the “Public-Private Sector Partnership Law” included even greater assurances to private investors engaged in providing services at public health care facilities. Those kinds of measures set the stage for multinational corporations to penetrate the Moroccan public health care sector. Also, Article 3 of the above-mentioned Law states that partnership contracts are to be conducted based on the principles of free access, equal treatment, objectivity, and competition. Therefore, when the different public hospitals and health care institutions are open for auction, there will be nothing to prevent foreign capital from controlling its management (whereas neither sovereign health policies nor internal laws will be able to curtail that).

Reviewing the Professional Medical Practice Law to Enhance Health Care Privatization and Commodification:

Revision of the Medical Practice Law No. 131.13 became effective in March 2015. This revision was the culmination of decades of measures to reform the public health care sector. It was necessary to amend the Medical Practice Law in order to be in line with the various reforms and to encourage private investments by offering them a wide variety of possibilities, free trade agreements, and profit incentives. In this respect, the review of the public health care reform policy took the following points into consideration:

Facilitating the Transfer of Doctors from Public Health Care Institutions: This trend was widespread for years, but it became even more prevalent today. It is now easy for any public-sector doctor to move to private clinics and facilities as soon as s/he submits his/her resignation to the Ministry of Health. They also have the possibility to work in the free-market health care after they retire, or even if they are dismissed or terminated from their public service jobs. Furthermore, it is possible for any public-sector doctor to simultaneously work in a private health care facility under the cover of “rotation at a medical clinic” for a period that may extend to two years. This clearly legitimizes the transfer of public-service physicians. As such, the revised law intensified the problems suffered by public hospitals for several decades. In the meantime, it has directly encouraged the growth of the private health care sector, which is annually supplied with state-sponsored medical staff who had received intensive training at public hospitals.

Facilitating the Entry of Foreign Doctors: It is now possible for foreign doctors to practice medicine in public hospitals and facilities based on a fixed-term work contract. This falls within the context of the conditions imposed by free trade agreements, which oblige the signatories to amend their legislations so as to authorize doctors and physicians to move to other member states (by way of recruitment). Meanwhile, we do not think this is enough of an incentive for foreign doctors (especially the specialized ones) to come and support the medical personnel of Moroccan hospitals; the opposite is probably true. As it happens, the current legislations also enable the transfer of public-sector doctors to the local private sector as well as their emigration to northern countries. It should also be noted that the Revised Medical Practice Law enables foreign doctors to work in the private health care sector, provided that they obtain permission from the Ministry of Health. Principally, the amendment of the Law aimed to elevate two issues: the first was to facilitate the entry and appointment of private foreign clinics and centers, and the second was to remove the legal obstacles for signing partnership contracts between the local public sector and foreign health care companies; and especially if they include foreign medical personnel.

Ownership of the Private Capital of Treatment Institutions: Professional Medical Practice Law No. 131.13 enabled private investors to own health care centers and clinics that provide diagnostic and curative care as well as hospitalization services, even if they are not doctors (note that the previous law did not allow this). This enhanced the commercial orientation of private clinics in a way that contradicts with treatment requirements. It also augmented the trend towards resorting to receive medical services from private clinics, whose practitioners prefer to provide financially rewarding medical services and treatments, such as having pregnant women undergo a Cesarean delivery (C-section) instead of conducting a regular delivery and medical monitoring. In most of these private clinics, it is difficult to talk about the complete independence of practitioners because they are paid by the clinics' entrepreneurs (even if the latter are doctors as well). In essence, these doctors take financial profitability into consideration whenever they make decisions about the treatment or hospitalization of their 'sick clients.'

Enhancing Business in Health Care: The revised Law also introduced two new forms of professional medical practice: 1. telehealth, and 2. medical tourism companies (which provide medical baths "hammams" and similar services). This came as a direct result of free trade agreements and in subservience to the will of the major industrial countries who worked for a long time to impose these provisions as a form of "health service trade liberalization." In this context, the Revised Medical Practice Law included a unique article about the partnership between the public and private sectors, which was justified through the premise of eliminating the shortage in medical services based on agreements between the Ministry of Health and private health care representatives.

The Privatization of Medical Schools Instilled Anger among Morocco's Doctors and Medical Students:

Since February 2019, students at the faculties of Medicine, Pharmacy, and Dentistry organized several protests and sit-ins in Morocco. Starting from March 25, there was a complete boycott of theoretical and practical lessons in medical schools. The Student Coordinator of Medical Schools stressed the desire to defend public universities and public university hospitals. They thus rejected the decisions of privatizing medical training and eliminating equal opportunities and entitlements for the benefit of students at private medical schools. Students also categorically rejected the exploitation of public university hospitals and public schools by private parties, highlighting that university hospitals have been suffering from a great shortage of professors, medical equipment, and beds. This is not to mention the overcrowded medical training workshops, which is due to the fact that each department includes about 50 medical students. Adding the private sector students to this already-high number would further jeopardize the quality of training. Therefore, the students of public medical faculties have been demanding a separation between the training and educational paths of private-sector and public-sector students.

These protests were supported by public sector doctors, who have been actively objecting for more than two years. The Independent Syndicate of Public Sector Physicians has also been championing the students' rejection of the medical training process's privatization policies (which violate the principle of equal opportunities), and they criticized the random introduction of the private medical school project.

The Government's Tendency to Privatize CNSS Clinics²³:

In 2019, the government of Saadeddine Othmani [of Morocco] moved towards privatizing all clinics of the “National Social Security Fund” (CNSS).

Through the meetings held in June 2019, with the attendance of the Prime Minister's Office, Ministry of Employment, Ministry of Finance, and the administration of the National Social Security Fund (CNSS), the government's plan has been to push the CNSS clinics towards bankruptcy in order to pass them over to private individuals, lay off thousands of CNSS employees, and deprive citizens of their distinctive services.

The above-mentioned Syndicate warned of the gravity of this step as they see that the government has no right to undermine the decisions of the CNSS Administrative Council, privatize a sector that is not owned by it, and make fateful decisions which will ultimately affect the savings of the working class.

Moreover, the Syndicate accused the government of depriving citizens of receiving the distinctive services provided by CNSS clinics and pushing them towards the health care business market instead. It is worth noting that there are about 700 male and female nurses who have been working at CNSS clinics for more than 15 years and they did not receive their basic rights.

23 National Social Security Fund (CNSS) is a Moroccan public institution established in 1959. Its mission is to ensure social security for the working class under the administrative supervision of the Ministry of Employment and Social Affairs. The Fund is a compulsory social security system for workers in the fields of industry, services, and different professions in Morocco, whereas it guarantees their protection from the risks of losing their salary in case of sickness, maternity, disability and old age through the monthly deductions from the worker's salary throughout the duration of his/her work. The Fund also provides compensations to families. In cases of death, the families which are covered by the Fund can benefit from the survivor's pension and also receive the death grant. For more details: [https://ar.wikipedia.org/wiki/الصندوق_الوطني_للضمان_الاجتماعي_\(المغرب\)#cite_note-1](https://ar.wikipedia.org/wiki/الصندوق_الوطني_للضمان_الاجتماعي_(المغرب)#cite_note-1), (Shortened URL: <https://bit.ly/3oPKGWw>)

It should be highlighted that the program for establishing multidisciplinary CNSS clinics was based on the recommendation of the United Nations and International Labour Organization (ILO) in the early seventies, whose idea was to invest workers' savings in social projects, especially in what relates to health protection (which is a form of redistributing workers' savings).

This program was adopted in the first five-year plan in Morocco at the end of the seventies, whereby it was decided to establish multidisciplinary clinics in every region. This project was funded by the surplus labor savings resulting from the earmarked amounts for family compensations.

CNSS clinics were truly a lever for improving health sector services in Morocco, as confirmed by the World Health Organization (WHO). For example, the first radiology scanner in Morocco was introduced in the Derb Ghallef clinic in Casablanca in 1979, and the working class and all other citizens benefited from the distinctive services of these clinics.

In 2018, CNSS clinics received more than 1,299,668 citizens from vulnerable groups. They also provided 161,239 days of hospitalization, 25,717 surgical operations, 40,999 days of resuscitation, 12,192 birth deliveries, and 38,049 kidney dialyses.

General Conclusions:

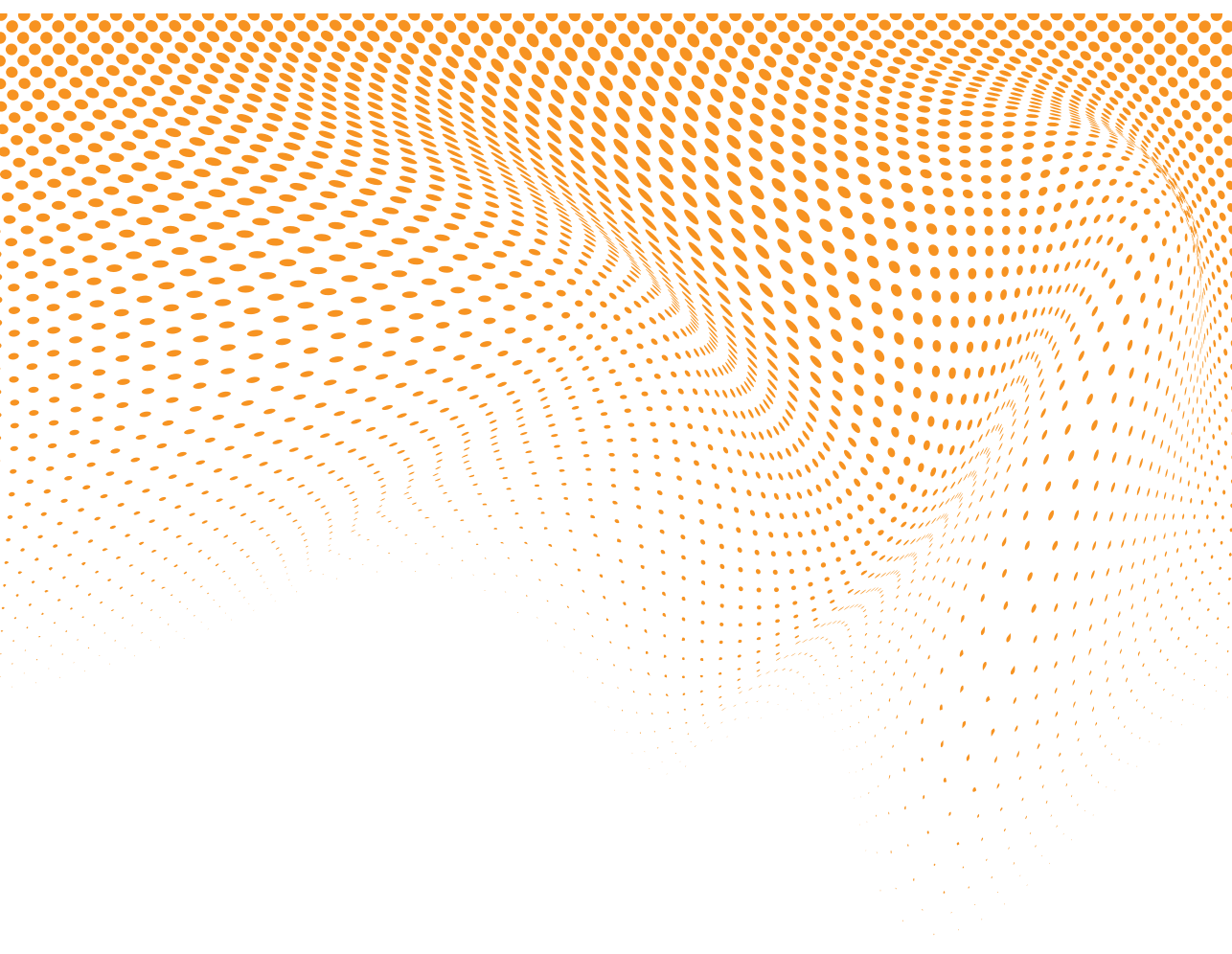
The COVID-19 pandemic exposed the truth about health systems in our country [Morocco] and revealed their encouragement of health care privatization. Health is in no way a commodity or product to be traded in return for quick profits and indecent riches. During these hard times, it was the public hospitals who received the patients infected with the novel coronavirus. The patients stayed in special quarantine rooms in public hospitals and were treated by public-service physicians, regardless of whether the patient was poor and penniless or filthy rich. It is about time to nationalize and fully liberate the public health care sector and rid it of the for-profit entrepreneurial management aspects.

In order to confront the privatization of health care and defend citizens' fundamental rights to health, it is imperative for everyone to actively oppose all forms of passing public health care institutions and services over to private investors. Moreover, we must call to abolish all legislations that stipulate privatization and to oppose the state's monopoly on public health care interventions through the following:

1. Limit the expansion of the private health care sector. This can be done by stopping the transfer of physicians from the public sector and imposing restrictions (such as taxes) on private health clinics, as well as applying a price system that does not enable free competition. Also, the licensing of private medical training institutions must be withdrawn.
2. Abolish all legislations that impose prices for services in public hospitals and put an end to estimating the cost of services related to medical work. Also, public hospitals should be prohibited from procuring medical services from private sector institutions. Also be wary of the "public hospital reform scheme" as it poses serious risks since it requires public hospitals to manage their fiscal balance based on the spirit of entrepreneurship.

3. Put an end to Framework Law No. 34.09 related to the health system and supply of treatments, as it propagates the privatization of public health care services.

Privatization of Health Care Services in Tunisia and Its Impact on Public Facilities and the Constitutional Right to Health



Introduction

Health care services have special importance as they have a direct impact on people's health, livelihood, and wellbeing. It is unsurprising that health has been regarded as one of the fundamental rights of every human being, since it is synonymous with the right to life. It is in this respect that the International Labour Organization (ILO), at its 1946 conference in the city of Philadelphia, declared a list of social and economic rights,²⁴ following the World Health Organization (WHO) which declared its constitution during its inaugural plenary session in 1944. This was further enhanced by the adoption of the Universal Declaration of Human Rights proclaimed by the United Nations General Assembly in 1948, which established a definition of "Health" as mentioned in the WHO constitution.²⁵

The Universal Declaration of Human Rights defined a set of obligations that Member States must fulfill to achieve these rights, including: Uphold economic, social, and cultural rights by refraining from committing any violation of these rights.

- Pledge to protect the economic, social, and cultural rights by preventing other parties from violating these rights.
- Commit to fulfill the economic, social, and cultural rights by taking the necessary measures to enforce these rights through legislative and administrative procedures and adopting a suitable budget for this purpose.
- Request international assistance and cooperation for the realization of these rights.

²⁴ The Philadelphia Conference was held in 1944 during ILO's 26th session. The conference included the declaration of a list of economic and social rights. For more information: <https://www.ilo.org/legacy/english/inwork/cb-policy-guide/declarationofPhiladelphia1944.pdf>

²⁵ Constitution of the World Health Organization (WHO). For more details: https://apps.who.int/gb/bd/pdf_files/BD_49th-en.pdf

Although most constitutions of regional countries included the right to health, the Member States' social roles in different sectors (such as education and health) witnessed numerous developments and revisions that had far-reaching implications for the equitable access to health care services (especially with regard to poor and marginalized groups). This was due to liberal social policies that adopted the market-based economy and patterns. The declining social role of the state within the health sector emanated from certain political contexts supported by international banking and financial institutions. This was further enhanced by the neoliberal trend, economic globalization, the weakened governmental contribution to the economy, and the financial and tax incentives given to promote private investments. Such procedures were prescribed by the Bretton Woods Agreement²⁶ regarding debtor nations, within what was called the “structural adjustment” of fiscal balances.

²⁶ The Bretton Woods Agreement is the common name for the International Monetary Conference held from July 1 to 22, 1944. The aim of this Agreement was to establish international financial stability by preventing currency exchanges between countries and reducing speculation in international currencies. The Bretton Woods Conference submitted its plans to two international organizations: International Monetary Fund (IMF) and the International Bank for Reconstruction and Development (IBRD). For more details, See: https://ar.wikipedia.org/wiki/بريتون_وودز
(Shortened URL: <https://bit.ly/2ISdeiX>).

The world soon witnessed a shift in perception. Having been once regarded as a fundamental human right and a societal value to be protected by the state, the concept of health turned into a business: Markets, goods, and services were at work to develop the health care industry while generating tremendous financial profits nationally, regionally, and globally. The development of the health products and services market and its revenues of over \$6 trillion USD led to the emergence of mega-corporations in the pharmaceutical industry, hospital services, as well as medical equipment manufacturers and private insurance companies. These corporations have a huge influence on shaping public opinion and making health-related decisions. Essentially, political decisions had significant negative repercussions on the provision of health care services in several countries (including economically developed ones) and a decline in the access to health care, thereby constituting a violation of international human rights and conventions.

This paper, which discusses the privatization of the health care system and services in Tunisia, is comprised of three main elements:

The first element covers the global and regional sociopolitical context and its effect on the situation in Tunisia since the country's independence. This part also highlights the impact of political orientations on the health and social conditions, as well as the social movements for maintaining the state's social obligations and confronting the adopted austerity policies. These actions were mainly performed by unions and associations, and especially the Tunisian General Labour Union.

The second element discusses the structural changes within the health system due to austerity policies and the decline of public services, including health care services. This was tackled by analyzing the main outputs of health systems and their effect on the equitable access to quality health care services, the structure of financing health expenditures, and the inclusiveness of social security coverage.

Finally, the paper's **third element** covers the significant changes that took place after the “freedom and dignity revolution.” For example, the new constitution of the Second Republic of Tunisia recognizes the people’s public and private freedoms, including their political, social and economic rights. It also requires enhancing local governance and democracy and guaranteeing the constitutional right to health care and social security coverage.

- Is there active privatization in the health sector?

Privatization comes in the context of national public policies that support the private sector’s provision of health care services. This is usually based on ideological convictions about market laws and the private sector’s efficiency in governance and administration. These policies seek to provide financial, tax and legal benefits to private sector investments. They also assist the transfer of ownership of public medical and health care institutions to private institutions, or to certain public-private sector partnerships related to investment and management. Moreover, these policies seek to privatize some services within public institutions, such as security, cleaning, patients’ subsistence, and medical equipment maintenance.

- What about negative privatization in the health sector?

Negative privatization is defined as a set of phenomena that do not necessarily result from a policy of positive privatization but emanate from the state’s reluctance to assume its political and financial duties. These include the failure to provide the required budget for public health care facilities (such as medicines and medical equipment), or not giving any pay raises to personnel. Governments, both within and outside the region, have often deliberately introduced price-shopping measures that they consider as reforms, to enable doctors to conduct for-profit care within public institutions through different means. The deterioration of public health care institutions – due to the lack of financial and human resources and the permission of dual roles – often

forces health care service users to either resort to private facilities or to suffer the consequences of receiving services within public institutions. This is a violation of the right to health and paves the way to different forms of small and medium-level corruption within the health care sector.

The generally monitored aspects in regional health care systems usually show a combination of advantages and disadvantages of privatization. This requires a careful examination of the different determinants and their impact on service delivery and financing as well as the equitable and non-discriminatory access to these services.

Global Context of Health Care Privatization:

The global trend towards privatizing health care services began in the late 1980s as a result of the economic crisis. This orientation developed with the neoliberal policies that coincide with Keynesian²⁷ economics; aiming to curtail the state's role in social sectors, including education, health, and social security. Privatization policies were driven by the intensifying financial pressures on public institutions and the rising cost of health care services. It is worth noting that global financial and banking organizations – especially the International Monetary Fund (IMF) and the World Bank – contributed to the spread of privatization policies in the social sectors of developing countries. As it happens, these countries were requesting loans from international financial institutions to reform their economy, and the privatization of health care services was often a pre-condition for receiving these loans.

²⁷ The Keynesian theory or approach to economics was developed by British economist John Maynard Keynes, who is considered one of the most influential economic theorists in the 20th century. One of his most famous publications is "The Economic Consequences of the Peace." Keynes wrote a commentary on the Treaty of Versailles in 1919. The Keynesian Theory calls for government intervention to help overcome the decline in aggregate demand, in order to reduce unemployment, increase economic growth, and achieve overall employment and price stability. See: https://en.wikipedia.org/wiki/John_Maynard_Keynes

The rising health care costs – due to epidemiological and demographic changes as well as the reduced growth (not to mention the recession of the early 1980s) – led many countries to seek to ease their burden and rationalize their spending. Different studies on health economics confirmed the increase of health expenditures (particularly in high-income countries). This is largely due to the escalating burdens of chronic and noncommunicable diseases. The steady improvement in these countries' life expectancy at birth is another factor. In fact, the rising health care expenditures of many countries outpaced their economic growth, which had an adverse impact on the cost and competitiveness of their health care services.

Regional Context of Health Care Privatization:

The areas east of the Mediterranean, and especially the Arab countries (which constitute the majority of the region's population), have some common political, cultural, and social factors. Those components have greatly impacted the history, structure, and functions of health care systems. For example, the nation states that gained their independence in the 1960s had a social orientation focusing on the concept of "welfare state." By and large, this concept provided free educational and health care services to all citizens, albeit not explicitly stating the social, economic, and cultural rights in most constitutions. In addition to being free of charge, education at various stages (primary, secondary, and higher) was compulsory, especially for females, in most countries – including Tunisia. Moreover, oil-producing countries acquired enormous gains (from the oil boom) to build their educational and health infrastructure and other vital public facilities. However, low and middle-income countries, which constitute the majority in terms of population, had comparatively meager expenditures. Accordingly, this led to the deterioration of their infrastructure and the transfer of their human resources, both internally (towards the private sector) and externally (towards regional or northern oil-rich countries).

The structure of health care systems [in those areas] was influenced by colonial legacies in terms of its financing and the ways of providing health services. For example, the former British colonies endorsed systems similar to Britain's National Health Service in terms of generating resources from state revenues, methods of tax/fee collection, provision of services in public institutions, and the delivery of health services. However, the former French and Italian colonies used multiple systems related to financing (by means of the state budget and participatory insurance system) and provided services through public and private sector personnel.

The political conditions related to the Israeli occupation and its grave consequences on the region (e.g., 1967 aggression and October 1973 war), in addition to the Iran-Iraq War and the Gulf War, had significant implications on regional economics. Among other things, they negatively affected the level of spending in social sectors (especially in the fields of education and health) and increased the debt rates – the latter of which catalyzed the already declining social role of the state. This was compounded by the inclination of most developing countries to take loans from global banking and financial institutions and accept the “structural adjustment programs” which implement neoliberal policies and call for globalized economies. Therefore, most low and middle-income countries adopted policies that encourage health care privatization and increase for-profit health-related investments.

It should be noted that substantial military spending in Arab Gulf countries in the 1990s greatly contributed to their failure to meet their social obligations. This led to a radical change in the ways of financing health care services, by introducing alternatives to the inherited systems from the colonial era (such as the British National Health Service).

For example, some Arab Gulf countries established participatory insurance systems (i.e., contributions from employees and employers) despite the objection of the World Health Organization (WHO) and the World Bank to this orientation (which primarily undermined the rights

of expatriate workers, who make up most of the population therein). Inevitably, different Gulf Cooperation Council (GCC) countries established private insurance companies, and health care services were soon in the hands of private institutions.

Certainly, there were also various organizations who aimed towards positive health care privatization in providing insurance to citizens. However, due to the World Health Organization's reservations about changing the health care insurance system and the unfair practice of excluding expatriate workers from public health care services, GCC states and other countries (such as Egypt) started resorting to experienced consultancy firms (such as McKinsey). This ended up draining a large number of countries.

GCC states and few countries in the region witnessed a rapid level of development in their private health care sector since the 1990s. For example, several diagnostic institutions (which conduct laboratory analyses, radiological tests and screenings, etc.) established. Large private hospitals were also built, such as the Saudi German Hospital, Mouwasat Hospital and others, whose investments expanded to other regional countries, such as Egypt. Arab Gulf investment companies were also growing quickly, such as the Emirati "Abraaj Group" which has investments in different countries (including Egypt, Morocco, and Tunisia) by having purchased private hospitals therein. This group plans to invest approximately \$12 billion USD in 2020.

It is worth noting that the Arab Hospitals Federation (AHF) was founded in 2004. This federation carries out scientific activities in cooperation with the Arab Administrative Development Organization (ARADO) [which is a specialized organization of the Arab League] through the funding of Mouwasat Hospital. However, excluding expatriate workers from free public health care services and upholding for-profit health care policies by allowing several investment companies to enter the private health coverage industry had its upshots. It caused several issues in expatriates' health care insurance, increased the coverage costs, and lowered the quality of health care services.

Health care privatization was not limited to Gulf Cooperation Council (GCC) states and other oil-rich countries. It also materialized in some middle-income countries, such as Egypt. For instance, in 2004, under the leadership of Health Minister Hatem El-Gabaly, the Egyptian government prepared a law to change the legal status of public hospitals and have them administered as private institutions. Concurrently, they sought to change the Egyptian health care insurance which was facing problems since the 1990s. Associations for defending the right to health saw this law as an infringement on the rights of insured members. It also evidenced the beginning of the privatization era, whereas the Minister owns a network of private institutions in the fields of radiology and medical services. Fortunately, the Egyptian Constitutional Court rejected this law following a grievance lodged by local civil society activists.

Banking and political organizations – such as the World Bank and the U.S. Agency for International Development (USAID) – endorsed privatization through different projects in support of low-income regional countries undergoing wars and political turmoil (examples include Sudan and Afghanistan). The major shift towards privatization was realized through contracting with different national and foreign associations. The idea was to provide basic health care services under the pretext of “corruption and excessive bureaucracy in public institutions.” Through the intervention of the World Health Organization (WHO), an agreement was reached to keep some governorates under the sponsorship of the Health Minister to do some feasibility comparisons and avoid taking ideological stances. After an objective evaluation by John Hopkins University, it was discovered that the medical performance of state-managed governorates was not less than that of privately managed governorates. In 2006, an article in the World Health Organization journal highlighted the importance of reforming public institutions and strengthening governance before seeking to change their ownership. Doing this would help ensure the sustainability of health care services, seeing that community organizations,

especially foreign ones, usually think of profitability and might leave the country at any point and for various reasons.

The momentum of health care privatization continued in the Middle East, and especially in GCC countries. In this regard, legal provisions were stipulated to separate the function of financing from providing health care services. The direction was to also establish governmental health bodies through which to procure services from both the private health sector and the Ministry of Health. On this subject, Allen Capital Investment Group expects that the health service market of Gulf Cooperation Council (GCC) countries will generate approximately \$104 billion USD by 2020. (This was mentioned in a study conducted in March 2018, and which was published in the company website). The reasons behind the development of the health service market are as follows: emergence of epidemiological and demographic changes with the ageing of the population pyramid, growing burdens of chronic diseases, and the expected population increase of about six million. Moreover, the programmed investments, most of which are in the private sector, have a value of about \$61 billion USD through 700 projects with different levels of completion. Furthermore, the regional political situation since 2011 (starting with the “Arab Spring”) accelerated the general trend towards privatizing different services, which will definitely exert financial burdens on citizens. In spite of these problems, the political orientation towards further privatizing health care has unfortunately not changed.

Health Care Privatization in Tunisia

The Political and Economic Context:

After Tunisia gained its national independence in 1956, it adopted progressive and socialistic political orientations, especially in terms of social, economic and cultural rights (including education, health, and social security). This happened despite the adoption of a one-party policy and restrictions imposed on political and union freedoms. For example, free compulsory public education, especially for females, was mainstreamed on the national level. Another orientation was to provide free health care services at all levels – such as primary care centers and both local and regional university hospitals – along with establishing nursing, medical, pharmacy, and dentistry schools in various governorates (wilayat). The country also saw the development of national programs for preventive services, as well as a project for improving reproductive health and family planning services. This direction continued until the end of the 1960s, when the socialist orientation was eliminated after the failure of the agrarian reforms to mainstream agricultural cooperatives in light of the stifling economic crisis. This came alongside mobilizations and protests by affluent parties against the economic orientation of then Minister Ahmed Ben Salah.

In the early Seventies, the Tunisian government changed its political orientation towards an economic policy inclined to market economy. The focus thus changed to attracting foreign investment – especially export-oriented European investments in the textile and other industries – with low added value yet high operational capacity and low labor costs. This mainly took place through incentivizing legislations, such as the Foreign Investment Law of 1972. Despite an improvement in economic growth levels, social problems resurfaced as a result of inward-looking politics and the austerity policies adopted by the government. These austerity policies sought to eliminate the food subsidy policy and reduce the budget of social ministries (e.g., ministries of health and education). They also worked toward imposing contribution payments in return for providing health care services through the

Ministry of Health; thereby no longer remaining free of charge due to the austerity measures. Social problems further intensified after disagreements between the Tunisian General Labour Union and the government following the latter's attempt to weaken the union. This culminated in a general strike in January 1978, which was suppressed in a brutal manner – by which the labour union leadership was arrested and replaced with a new leadership that was appointed by the ruling party. Then came the Tunisian bread riots of 1984 after canceling the subsidies on bread and other food supplies, following instructions from the International Monetary Fund (IMF). Despite backing down from increasing food prices, the violent suppression of these popular protests caused the death and/or injury of dozens of protestors in different Tunisian cities and villages.

The state continued adopting austerity policies whereas social problems intensified as a result of the 1980s' global economic crisis, slow economic growth, rising unemployment rates, and the growing social burdens of individuals and households (especially in paying for health care services). All of those factors led to a great deficit in public finances which took the State to the brink of bankruptcy, thus obliging it to take loans from the International Monetary Fund (IMF). However, the latter required the imposition of the structural reform policy, the endorsement of austerity measures, and the privatization of several public institutions, including the health sector with its various components. Tunisia also received a World Bank loan, which was invested in improving the primary health care infrastructure. This obliged it to impose fees on the users of health care and hospitalization services, thus ending the era of free public health care services.

This path continued in the 1990s with the trend towards economic liberalism following the impeachment of the first Tunisian President and endorsement of political approaches restricting people's freedoms. This was done in spite of the pretense of party pluralism and the holding of elections (which did not reflect the country's political reality). Consequently, Tunisia found itself burdened with World Bank

loans. This was especially the case in the field of health, largely due to the focus on governance strengthening, reforming public hospitals, and enhancing the economic efficiency of public institutions. Despite a bit of success in developing administrative methods, the financial situation prevented the fulfillment of citizens' needs. Some even considered this reform project as a first step towards privatizing university hospitals as well.

In the beginning of the 2000s, there were ongoing protests against the government's policies regarding public freedoms and democracy, as well as to counter the austerity measures and privatization of various fields. For example, there was the Revolt of the Gafsa Mining Basin in 2008, and the protests of Ben Guerdane, which were a precursor to the "Freedom and Dignity Revolution" (17 December 2010 until 14 January 2011). The slogans of the revolution – such as the desire for bread, employment, and human dignity – expressed the aspirations of broad masses of people, who led to the ousting of the authoritarian regime. The freedom and dignity revolution [also called "The Jasmine Revolution"] opened up new prospects and manifested in significant popular victories, and especially in the social field.

The Impact of Privatizing Health Care Services in Tunisia:

In Tunisia, various political and economic orientations had called for minimizing the state's role in funding health care services and for pursuing private investments. Such stances influenced the health system's functions, such as the financing and provision of health-related services and infrastructure, leading to the violation of the constitutional right to health.

Financing of Health Care Services and Decreasing Public Health Expenditures:

In the first decade after Tunisian independence, the financing of health care services generated mainly from the state budget, added to contributions from the National Pension and Social Insurance Fund. Therefore, there were no financial problems at the time in providing health care services. However, a shift towards privatization started in the 1980s and snowballed as a result of economic globalization. It is worth noting that, after the Tunisian independence, the state assumed the responsibility of assisting the poorest persons by giving them free treatment cards. This was generally done after assessing their financial condition by committees supervised by regional and local departments, in accordance with the 1958 Law and its revisions of 1991 and 1998. Through the different revisions supervised by the Ministry of Social Affairs, free medical care was classified as “white cards”; which enabled poor citizens (approximately 8%) to receive completely free treatment. Other categories (such as veterans) also received medical care cards with low rates – about 25% of Tunisian households benefited from this service.

This all changed, however, after the political changes in the late 1960s, the shift to the open market policy, and the decline of social welfare states. In due time, Tunisia introduced a set of procedures for reducing the budgets of social ministries and imposing progressive contribution amounts on the users of public health care services. Moreover, different legislations were stipulated to develop the private health care infrastructure through different financial and tax incentives. The following table shows the progressive contribution amounts of public health care users (such as the poor and other vulnerable segments) after treatment was no longer free of charge.

Following an issued decision in 1982, the Tunisian state started imposing contribution amounts to cover the health care service expenditures of the Ministry of Health. These contribution amounts were raised by means of the 1991 Law and legal orders of 1994 and 1998 as mentioned in the following table:

Contribution to the Health Care Expenditures of Public Institutions since 1991
(in Tunisian Dinars)

Contribution to Health Care Expenditures of Public Institutions since 1982				
98	94	93	91	
				Contribution amounts to outpatient clinic expenses in Tunisian Dinars
1.5	1	0.6	0.4	Primary health care centers
2	1.5	1	0.7	Clinics in local hospitals
3	2	1.5	1.5	Clinics in regional hospitals
4.5	3	2	1.5	Clinics in university hospitals
				Contribution amounts to hospitalization expenses in Tunisian Dinars
15	8	7	7	General medical and childbirth hospitalization in local hospitals
15	15	13	13	Surgical hospitalization in local hospitals
20	12	10	7	General medical and childbirth hospitalization in regional hospitals
30	18	15	13	Surgical hospitalization in regional hospitals
35	15	12	7	General medical hospitalization in university hospitals
40	20	18	13	Surgical hospitalization in university hospitals

60	30	-	-	Intensive care hospitalization in university hospitals
	***			Laboratory and radiological tests (a 10% increase for those who have health insurance)
***				.A 10% increase for low-income/poor patients, with a ceiling of 30 Tunisian Dinars

This table vividly shows the trend towards increasing the contributions of health care users who are insured in the participatory system (social security through the “Social Security Fund” for private sector procedures, and the “National Pension and Social Insurance Fund” for public sector procedures). A similar trend was seen in the health care assistance system for vulnerable persons working in the informal/marginal sector of the economy. For the purpose of euphemism, these contributions were called “adjustment contributions.” However, the continuous increase of these contributions since the 1980s transferred the burden of paying health care expenditures from the state’s budget to the personal account of public health care users.

For example, the first-level patients in outpatient clinics saw their contributions quadruple in only seven years starting from 1991. Also, the general contribution cost in outpatient clinics tripled in the same period. Moreover, the contributions to public hospitalization services increased three times at all levels (reaching five times more in the case of university hospitals). This exerts heavy burdens on poor and modest households in receiving vital health care. However, the preventive and promotive health services fortunately remained free of charge.

Simultaneously with the rising contribution amounts to outpatient clinics and public hospitalization, doctors started charging higher fees in the private sector (note that the private sector covers about one-third of outpatient clinics for those who have social security). However, the cost recovery rate remained low, which will force many patients to pay the difference at their own expense. Following the failure to update some agreements with private practice doctors for several years, a sectoral study conducted by the World Bank in 2006 showed that insured persons were only receiving one-tenth of the clinic-related costs upon reimbursing the expenses (4 Tunisian Dinars for a clinic that charges, for example, 40 Dinars - e.g., at a gynecologist or obstetrician).

Due to the increasing contributions of individuals and households in paying part of the public health expenditures, the percentage of self-generated resources (i.e., Out-Of-Pocket) saw a rise in public institution budgets. For example, the below-mentioned table shows a 50% increase in out-of-pocket costs during the period of the 10th Development Plan. Also, the Ministry of Health projections showed that state contributions did not grow beyond 38% in recent years, although the social funds are expected to double up in the Ministry of Health budget in the same period.

The establishment of the National Health Insurance Fund, which greatly reformed the health and social security system, helped mobilize resources for financing health care services. However, despite the increased contributions by the insured persons, a large part of the funds went for contracting with private health care providers. Such an orientation does not help develop the public health care system, which already has several debts from the National Health Insurance Fund.

These figures show the Tunisian state's inclination towards minimizing its role in the social and health sector and moving towards the participatory approach in social security funds. This led to the absence of universal health coverage among many people. For example, the last survey of the National Institute of Statistics showed that approximately 18% of the Tunisian population (i.e., around 2 million persons) do not have any kind of health coverage. These people belong to the most vulnerable societal segments, such as unemployed persons, private sector workers who lack any social security, workers in the informal sector, unsupported elderly persons, persons with disabilities, and immigrants.

This must urge the Tunisian state to fulfill its commitment to uphold the constitutional right to health. Also, the state must perform its sovereign functions to maintain health security and provide essential preventive and promotive services, as well as enhancing human resource training within the health sector. The country's commitment to achieve the Sustainable Development Goals (SDGs) requires the mobilization of public resources through the state budget (including taxes and other collected fees). This will enable the country to fulfill the noble goal of "achieving universal health coverage by 2030", as well as attaining other development goals that are considered social determinants of health, such as combating poverty and social marginalization, improving the environment and housing, and providing quality education.

Estimation of the Disbursed Budget of the Ministry of Public Health
(in millions of Tunisian Dinars)

Source of Funding	2001 (updated)	2001	2002	2003	2004	2005	2006
State Budget	477.8	464.8	486.8	523	565	610	660
Social Welfare Funds	144.5	144.5	174.5	200	230	265	300
Self-generated re- sources (out-of-pocket costs)	103.6	104	114.4	122	130	140	150
Total	725.9	713.3	775.7	845	925	1015	1110

Public Health Care Coverage:

There are no official statistics about the impact of the continuous financing changes on the availability and equitable distribution of health care services. However, statistics on the users of public health care facilities in the last four years (despite these facilities' shortcomings) do not show any significant decline in the demand for public health care services – as was also revealed by published indicators related to health care coverage. This matter requires an in-depth study in the case of obtaining relevant statistical data from the Ministry of Health and National Health Insurance Fund. Research results on health systems and services and household surveys can also be beneficial in this regard.

The National Survey on the Health of Tunisians in 2013 and National Survey of Households' Public Expenditures (conducted by the National Institute of Statistics in 2014), showed that 12% of the Tunisian population refrained from requesting health care services due to the lack of geographic or financial access to them, hence they have chosen other alternatives like self-treatment and traditional medicine. This figure confirms the presence of a deficiency in equitable access to health care coverage, thus constituting a violation of people's constitutional right to health.

Structure of Public Health Care Expenditures in Tunisia:
Percentages of Public Health Care Spending

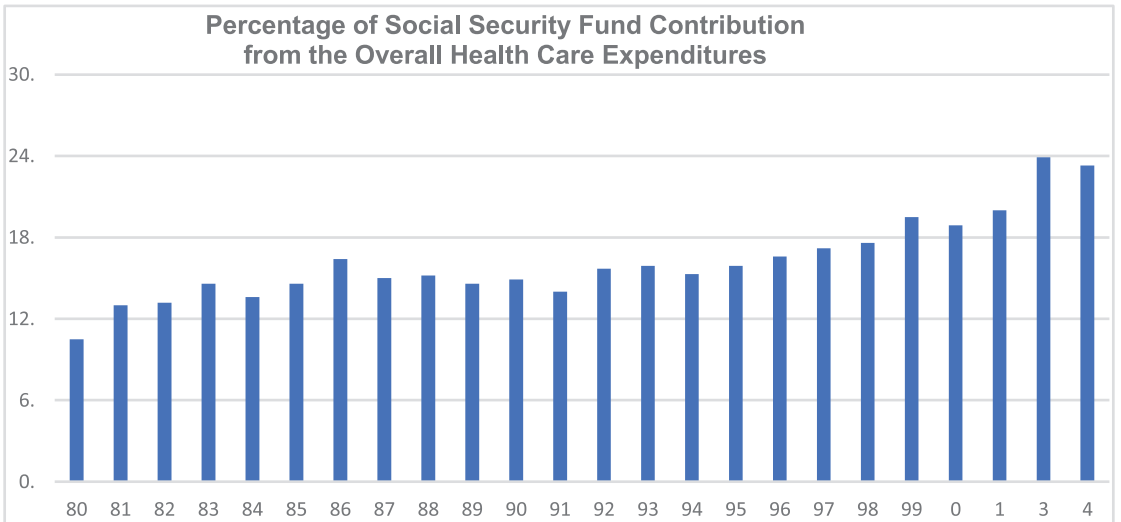
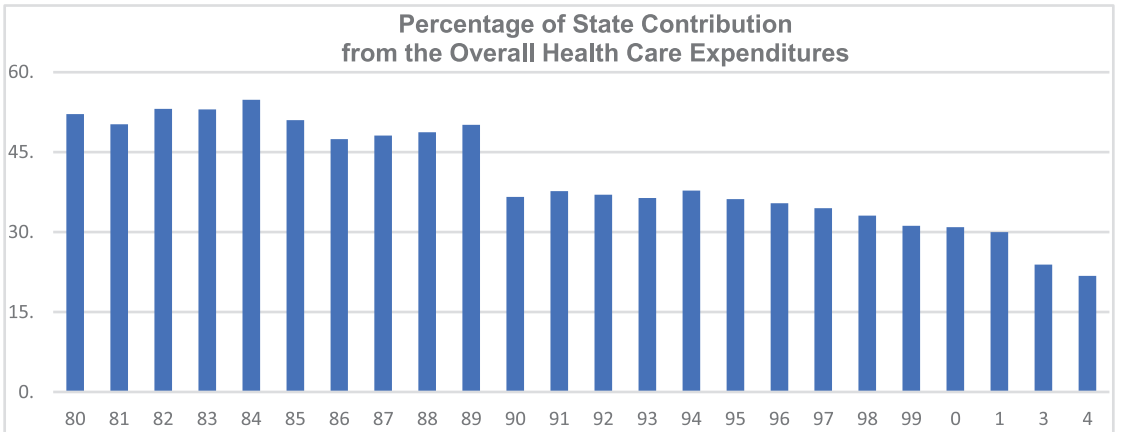
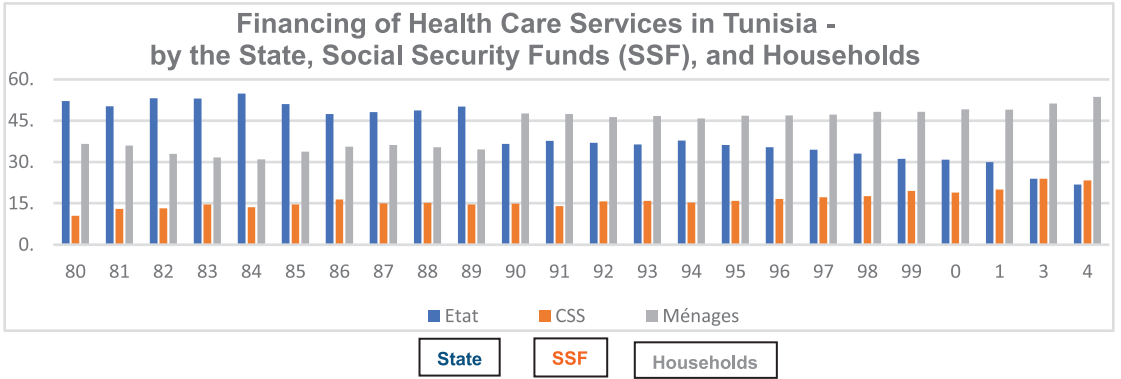
Year	1989	1988	1987	1986	1985	1984	1983	1982	1981	1980
State Contribution	50.8	49.4	48.8	48	51.6	55.4	53.7	53.8	51	52.9
Contribution of Social Security Funds	14.6	15.2	15	16.4	14.6	13.6	14.6	13.2	13	10.5
Household Contribution	34.6	35.4	36.2	35.6	31.7	31	31.7	33	36	36.6

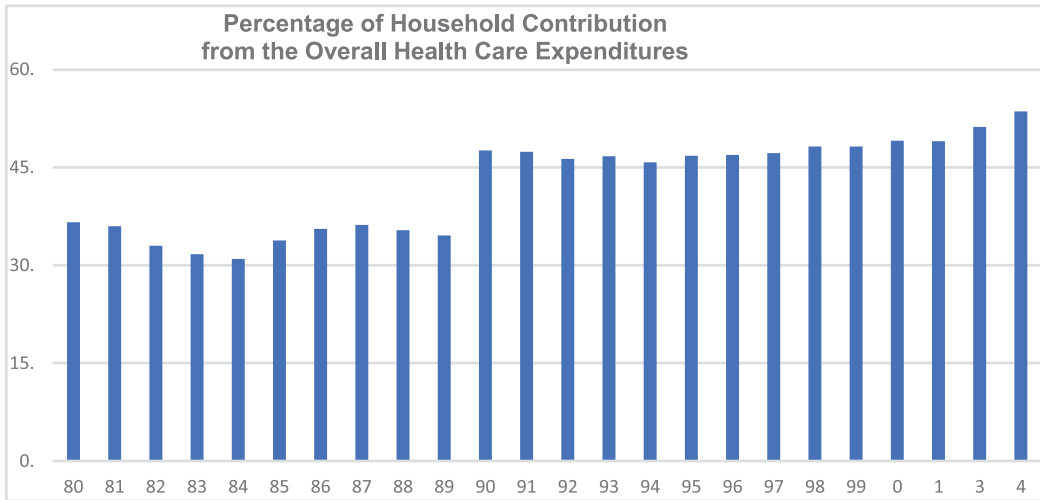
Between the years 1980-1989, the state maintained a significant level of public spending on health care services despite imposing fees on public health services (which are no longer free since 1982). Meanwhile, household contribution remained about one-third of health expenditures, and there was a slight improvement in the contribution of participatory insurance systems through social security funds. However, this positive trend in the contribution of social security funds remained below the expectation. This was in spite of the fact that those who have social security in the public and private sector constitute two-thirds of the population. This indicates some problems in registering private sector workers in the Social Security Institute and the failure of Social Security to cover the workers of vulnerable sectors, such as agriculture and fishing – not to mention the indisposed role of the informal sector in the economy.

1999	1998	1997	1996	1995	1994	1993	1992	1991	1990	Year
32.3	34.2	35.6	36.5	37.3	38.9	37.4	38	38.6	37.5	State Contribution
19.5	17.6	17.2	16.6	15.9	15.3	15.9	15.7	14	14.9	Contribution of Social Security Funds
48.2	48.2	47.2	46.9	46.8	45.8	46.7	46.3	47.4	47.6	Household Contribution

In the following decade (1990-1999), a great decline by more than five percentage points was seen in the state's contribution to health care expenditures. Meanwhile, there was a relatively small increase in the contribution by social security funds, and the households became the main financers of health care services.

2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	Year
						23.1	24.9	31	32	State Contri- bution
						23.3	23.9	20	18.9	Contri- bution of Social Security Funds
						53.6	51.2	49	49.1	House- hold Contri- bution





The above-mentioned charts show dramatic developments in the structure of financing health care services in Tunisia since the cancellation of free health care services. For example, a clear reduction was seen in the state's contribution, along with an increase in household and Social Security fund contributions. This was before the enactment of the Health Insurance Law of 2004, which only came into force in 2008 due to political and regulatory reasons. A major obstacle was that public facilities did not meet the requirements of the health care insurance system. Therefore, public facilities should be rehabilitated in terms of providing the necessary human and technical resources for competing with the private sector. Meanwhile, the private sector saw significant developments since the 1980s as a result of the positive privatization policy, provision of loans and tax advantages, and the transfer of professional human resources from the deteriorating public sector to the private one in search for better work conditions, income, and technological capabilities.

With support from the Tunisian General Labour Union, health professionals from the public sector launched several initiatives to improve the work conditions of public health facilities. However, the political orientation towards supporting further privatization and commitment to the conditions of the International Monetary Fund (IMF) - within what was called "structural adjustment" of economic reforms – prevented

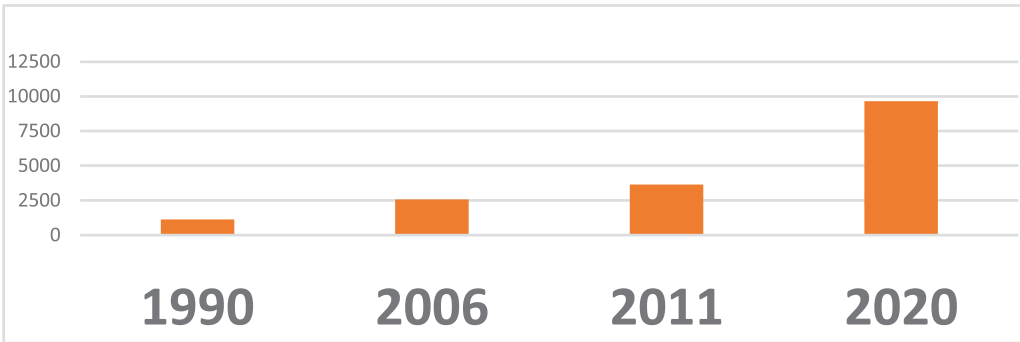
this goal's attainment. The mid-1980s was marked by a severe financial and economic crisis that prevented Tunisia from paying back its foreign debts, thus obliging the country to take loans from the IMF. Additionally, there was a change in the power hierarchy following the impeachment of the first Tunisian President and high hopes for a political breakthrough, which did not last long.

The declining state contribution in health care financing and the deterioration of public facilities coincided with the increase of household expenditures and a modest contribution by Social Security funds. This was especially true before introducing the National Health Insurance Fund, which was established to improve the health care insurance system efficiency and achieve justice for those who have social security health care coverage.

Health Care Infrastructure Development within the Private Sector:

Until the end of the 1970s, the public sector was the main health care service provider to all the population, regardless of whether one had public or private health care insurance. Meanwhile, the private health sector was mainly centered in large cities and the Tunisian coastal plain, with the main goal of maximizing profitability. In the past, private health care institutions had small hospitals with a limited number of beds (not exceeding 100 beds in most cases), as well as clinics, laboratories with screening tests, and pharmacies. Also, they mainly focused on day-care private hospitals, and especially those related to kidney dialysis, which was mainly available in cities. These private hospitals were treating patients with Social Security coverage due to limited public investments in the field of dialysis. In the early 1990s, the private sector became the main provider of kidney dialysis services for those who have Social Security. This put them in a comfortable position to negotiate agreements to cover the provided medical treatments.

Increase in the Number of Hospital Beds in Tunisia's Private Health Sector



The increasing private investments in the absence of supervision and regulation by the Ministry of Health raises several questions about the source and future of these developments and their impact on rising health care expenditures and inflation. It should be noted that the government's encouragement of private sector investments is profit-driven as it seeks to have this sector attract foreign patients, thus positively affect the country's balance of payments and hard currency.

A study conducted by Conseil Santé consulting firm in 2012, with funding from African Bank, showed that Tunisian private hospitals receive large numbers of patients from neighboring Maghreb countries (especially Libya and Algeria), as well as African and European patients (especially in the field of plastic surgery and hydrotherapy). The study also revealed that incoming patients constitute about 40% of the patients of Tunisian private hospitals. Moreover, the study indicated that hard currency revenues constituted approximately 1% of the Tunisian Gross Domestic Product (GDP). Furthermore, the Tunisian government devised a special plan to benefit from incoming patients through international trade agreements within the medical and therapeutic tourism sector. Nevertheless, the main focus of private investors is on Tunisian patients and those who have national health care insurance coverage.

In addition to dramatically increasing the number of beds in private health care facilities, the private sector attracts the professional medical staff of the deteriorating public sector. Private health care institutions also have state-of-the-art medical equipment that are sometimes not available in public university hospitals. This has often led to discriminatory actions in favor of the private sector, especially in terms of its contractual relationship with the National Health Insurance Fund (mostly in the field of cardiovascular diseases and cancer treatment), thereby increasing the quality gap between the two sectors and causing a discrepancy in the speed of work delivery. Health Insurance Regulatory Law No. 71 of 2004 refers to public-private sector “complementarity” in the provision of health care services to those who have social security coverage. However, there is no doubt that providing social security coverage to the private health sector led to its great enhancement after introducing the National Health Insurance Fund. In essence, the aim of Social Security should not be the development of the private health system.

Despite the strong development and enhanced quality of the private health sector, the [public] sector remains the main refuge of the middle-class and poor segments of Tunisian society.

Total	Private Sector	Public Sector	Medical Device
10	6	4	MRI (Magnetic Resonance Imaging)
74	54	20	CT Scan (Computed Tomography Scan)
16	3	13	Lithotripter
9	4	5	Cobalt Therapy Device
16	6	10	Angiography Device
20	10	10	Catheterization Equipment
17	5	12	Circulatory Assist Device

Privatizing Health Care Education:

Since the early 1990s, private health care education has seen great developments, particularly in nursing and auxiliary/supportive professions. However, the Ministry of Health failed to supervise and monitor the private educational institutions. The biggest dilemma arose from the absence of clear instructions and conditions and the lack of any controls on practical training inside government hospitals. Several private schools were created to maximize their profitability, flooding the market with large numbers of graduates who exceeded the local market demand, thus leading to the unemployment and disappointment of as many as 20,000 Certified Nursing Assistant graduates.

The Ministry's closure of most public schools due to high unemployment rates among graduates enabled private education providers to continue offering nursing, physiotherapy, intensive care, and other training programs. This led to having 70% of nursing students be trained and qualified in private educational institutes, albeit having no suitable job opportunities for them in the Tunisian market. Therefore, their main motive has been to work in European countries or Gulf Cooperation Council (GCC) states.

At some point, pressure groups representing influential business parties started opening private schools in Tunisia to train doctors, pharmacists, dentists, and auxiliary/supportive professionals. This happened despite the reservations of academic circles and professional unions, who had fears that this would lead to a decline in the practice level in pursuit of profit. These fears are still relevant today in light of the vague sociopolitical situation.

Privatization of Non-Clinical Jobs within Public Health Care Facilities:

The 1990s saw a wave of political measures to privatize hospice and security services in public institutions. This expanded further to include the health care sector. With profitability in mind, several contracting companies were created to perform non-medical tasks. As it happens, the owners of these companies were often influential persons with strong ties with the ruling party, i.e., the Democratic Constitutional Assembly. Consequently, this catalyzed the evolution of privatization in everything from cleaning services in public health care institutions, to patients' subsistence, laundry services, and security protection for public facilities and departments.

These for-profit institutions aimed at hiring below-minimum wage workers in unstable jobs, as well as employing outlaws with criminal records, who, according to the law, are prohibited to work in governmental jobs. And although there are no objective studies to assess the feasibility of contracting services, they nevertheless received many complaints from health professionals as well as numerous patients at public health care facilities. For these reasons, the work of these contracting companies was suspended in all organizations, and authorized workers were reassigned to their jobs after the revolution.

The Public-Private Partnership in Health Care:

In recent years, there was much talk about the feasible alternative of partnering between the two sectors instead of privatizing public institutions or changing their ownership. This method was successful in competitive business sectors, such as telecommunications, ports, and so on. However, the specificity of the health sector requires the fulfilment of certain conditions for the private-public sector partnership to succeed. This includes the need to enhance public health care facilities and upgrade their level of services to that of the private sector. Only then could there be fair competition for the contracts of the National Health Insurance Fund. Public-private partnerships in health care are advantageous when private practice doctors can take charge in moments when public health care professionals are absent for any reason, or in emergency situations.

The Impact of Privatization on Health Equity in Tunisia:

Fairness is one of the benchmarks for assessing the efficiency of health care systems. This indicator is calculated by comparing health service expenditures to people's income. To put it simply, a financing system is considered equitable if there are no differences between different societal segments in their relative expenditures. This can be detected through household health expenditure surveys.

World Health Organization (WHO) literature reviews confirm that household health care expenditures should not exceed 20% of their total expenditures. This is to avoid exaggerated health care expenditures incurred by households (such as spending 40% or more of household income on health expenditures – not to mention food expenses).

In Tunisia, household health care expenditures are approximately twice the minimum percentage recommended by WHO (38% of total expenditures in 2014).

Therefore, there are serious concerns about reaching catastrophic levels of health spending. In 2005, the World Health Organization (WHO) measured the levels of spending in Tunisia, in coordination with the National Institute of Statistics and National Institute of Public Health. The results showed that about 2% of Tunisian households have catastrophic health spending levels due to the burden of paying for medical care at their own expense. It was also revealed that 1% of Tunisian households reached below the poverty line due to their catastrophic health spending.

Impact of Health Care Privatization on Violating the Constitutional Right to Health:

The above-mentioned effects of health care privatization (including that of services, professional functions, and facilities) led to the violation of the constitutional right to health. Moreover, the state's ongoing quest for privatizing the health sector while its own role in financing it is in decline will surely intensify social problems and increase tensions and anger within the Tunisian society. After all, it is not morally acceptable to see such major disparities within the same society in terms of access to health services and to tolerate inequitable health system financing.

What has Changed since the Tunisian Revolution of 2011 and What Shall We Do?

The breakthrough in the political situation after the Tunisian revolution (17/12/2010 – 14/01/2011) led to the freedom of forming political parties, associations, and unions. The number of these entities, most of which were within civil society organizations, surpassed 20,000 after the revolution. Undeniably, the work of associations helped shape a national public opinion that supports the constitutionalization of social and economic rights, in accordance with the new constitution introduced by the democratically elected Constituent Assembly. Accordingly, the constitution of the Second Republic ensured the right to health, Social Security coverage, and a few environmental and social aspects related to health.

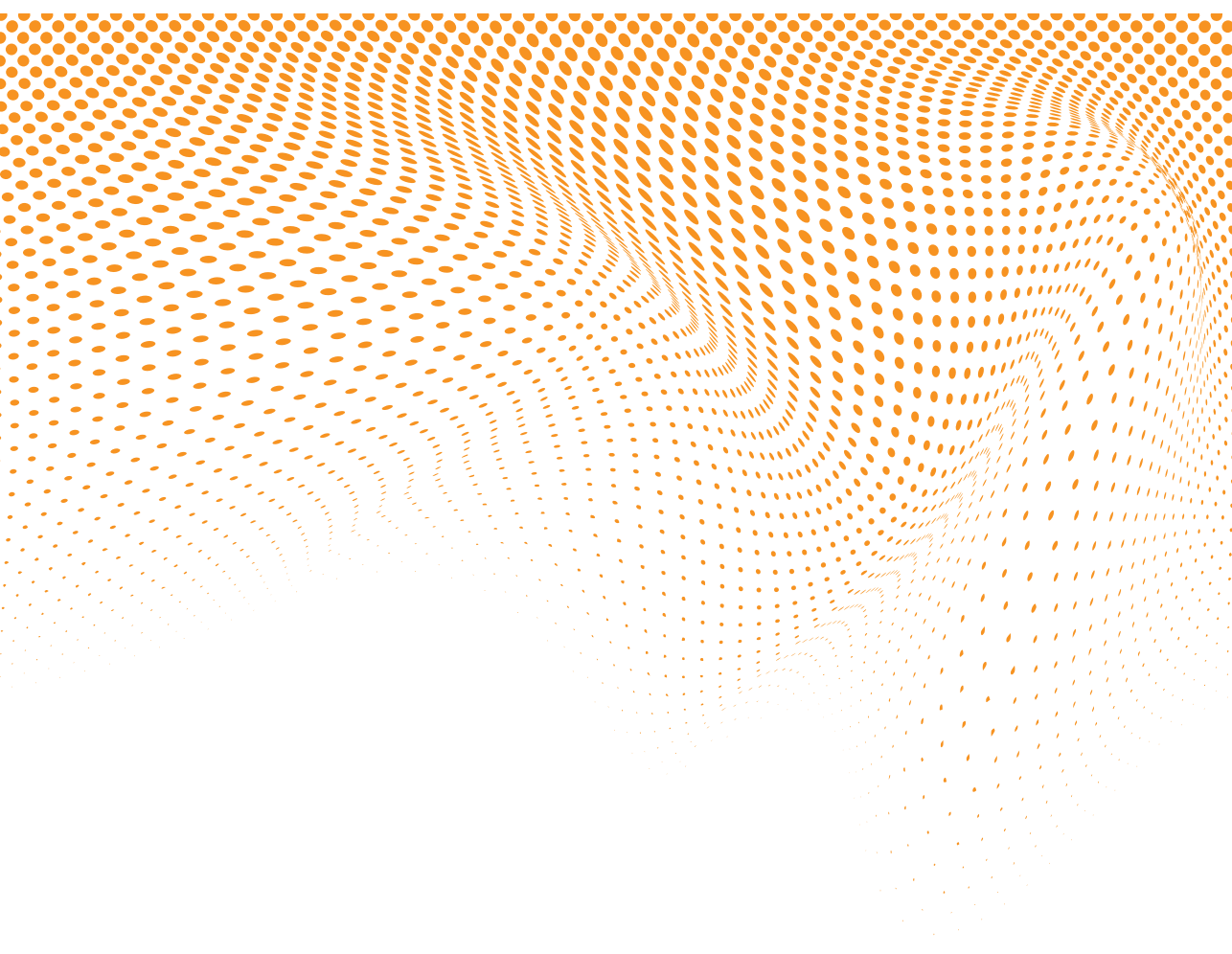
Regardless of the inclusion of the “right to health” in the constitution, many things have in fact not changed in terms of health care services. Evidently, public sector capabilities deteriorated in an accelerated manner, thus leading to a decline at all levels of public health facilities and services. Among those who paid the price were primary health care centers and first-line and second-line hospitals, as well as university hospitals and medical, pharmacy, and dentistry colleges. Regrettably, public hospitals found themselves drowning in accumulated debts from the Central Pharmacy and different suppliers. Meanwhile, the deteriorating conditions of public institutions coincided with the growth of private sector investments. In addition to attracting national banks, Tunisia’s private health care facilities gained the interest of foreign investors. One example is the Emirati “Abraaj Group”, which bought the largest private hospital in Tunisia due to its distinctive quality and services (and is visited by many patients from Arab, African, and European countries).

Various indicators highlighted the negative effects of privatization policies and submission to the dictates of the International Monetary Fund (IMF) and donor parties, including the European Union. Different legislations therefore boosted 'positive privatization', such as in the Ministerial Decree of 2018, which was put forward by one of the ministers to minimize the imposed conditions on private hospitals to focus on advanced medical devices. Unfortunately, civil society organizations failed to overturn this decision before the Administrative Court due to formal procedures.

The democratic elections of 2011 gave a clear advantage to the Tunisian liberal right represented by political Islam (Ennahda Movement), in contrast to the modest representation from social democratic movements. As a result, the state pursued similar economic and social policies that affected a number of sectors, including the health sector. Meanwhile, there was a rise in private health care investments – by reason of some banks which happen to own private hospital networks, such as "Amen Bank". Foreign financial companies also increased their investments in Tunisia. Those realities heightened the disruption of production, limited investments, plummeting of the national currency value, and increased inflation. Ultimately, they widened the gap between public and private sector institutions in light of the economic crisis.

The situation of public hospitals and primary health care centers took a turn for the worse due to the small budget allocations and the lack of drugs and medical equipment. This was one of the reasons behind acts of violence against health and medical personnel in public institutions. To make matters worse, public institutions started taking large debts, especially from the Central Pharmacy and National Health Insurance Fund, thus leading to growing rates of internal and external emigration of Tunisian human resources.

Health System Privatization in Jordan



The deteriorating situation of public health care institutions, violence against health personnel, cost of living surge and purchasing power decline all led to the emigration of many Tunisian cadres (especially the doctors and nurses) to European states, Canada, and other countries. These waves of emigration increased the shortage of competent health professionals and medical personnel, particularly in Tunisia's interior regions that greatly suffer from the lack of development and limited health care capabilities.

In light of the exacerbating conditions of public health care institutions (which constitutes a flagrant violation of the constitutional right to health), waves of protests by the health sector, civil society associations and unions erupted. These oppositions mainly prompted after the Association for Defending the Right to Health (member of the 'People's Health Movement') published its first report on the right to health in 2016.

Of relevance was the coordinating committee for civil society organizations that was formed to defend public health facilities towards attaining the constitutional right to health. In this context, a number of workshops were held in different Tunisian governorates, which culminated in introducing the list of necessary reforms by which to tackle deficiencies in the short, medium and long terms. The Health Committee of the Assembly of Representatives of the People, Tunisian General Labour Union, and the government, all reacted positively to these demands and announced a set of financial measures to meet them. However, these insufficient efforts were and are still short of the expectations.

In cooperation with progressive forces and the Tunisian General Labour Union, civil society associations will persist in the struggle to defend the constitutional right to health. This will be done by using legal mechanisms aiming to prosecute all those who violate the constitutional right to health. The parties will carefully study the best approach for the route of and involvement in transitional justice – as suggested by various human rights experts.

This approach calls for prosecuting all those who are responsible for violating economic and social rights – including banking and financial institutions (e.g., Bretton Woods), the European Union, and the World Trade Organization – due to their endorsement of austerity policies, privatization of public institutions, and signing unfair trade exchange agreements. The report of the Truth and Dignity Commission included a set of violations related to the following events: Black Thursday of 1978, Bread Riots of 1984, European Neighborhood Agreement of 1995, and the [Gafsa] Mining Basin events of 2008. They have also called for the responsible parties to apologize to the Tunisian people, compensate for the inflicted damages, and eliminate illegitimate debts. They also looked into the possibility to simultaneously and diligently file a lawsuit against the violation of the right to health.

General Conclusions:

1. The public sector privatization policy is part of a global and regional orientation towards introducing aggressive capitalism, minimizing states' social roles, and increasing the momentum of economic globalization. It has been a downhill battle for privatization policies from the Eighties and after, especially after the debts and loans from the International Monetary Fund (IMF) and World Bank, which put the country under the power of lending groups through borrowed toolkits. The lending countries require the endorsement of austerity measures, as well as the structural adjustment of public funds for the purpose of paying back the loans to donor parties.

2. The cumulative effects of more than three decades of health sector privatization policies encompassed different health functions and components, thereby undermining the health system and the equitable financing of health care services. These [privatization] policies also increased the financial burdens of households in light of the declining state contribution, private sector infrastructure development, entry of foreign investors, and the ever-increasing differences between the public-private sectors in terms of human and technological resources. These policies also led to the emergence of a health system that works on two different speeds – based on people’s income and the nature of their health coverage.

3. Amidst the deteriorating conditions of public institutions (which are the largest and most inclusive health service provider throughout the country), the civil society is continuously mobilizing its efforts to maintain people’s national health care and social security benefits for the purpose of defending the right to health; which was explicitly guaranteed by the Constitution of the Second Tunisian Republic in 2014.

The COVID-19 pandemic showed the importance of investing in health development, health security, public health programs, and the public sector at large – along with reviving the state’s social role. We believe that the post-COVID will minimize economic globalization and restore the state’s involvement in the social sector. Nevertheless, extreme caution must be exerted. We are required to collectively mobilize our efforts to uphold health as a social value and prevent its commodification. The right to health, after all, is a fundamental right to be ensured – as reflected in global charters and covenants.

Introduction

The emergence of the novel coronavirus disease (COVID-19) and the fight against the pandemic urged many countries to become more effective and responsive to different situations within the health system. This necessitated that countries develop and upgrade their health care system by which to carry out their duties more efficiently and with new methodologies. In this context, different priorities were specified to attain people's right to survival and development.

In order to confront this pandemic, it became imperative for countries to protect people's right to health, given that the state's responsibility goes beyond the idea of providing treatment, prevention, and protection. In this respect, the state could be regarded as the main driver and key source in ensuring and preserving the people's basic rights and freedoms. Certainly, this includes the enjoyment of the highest attainable standard of health, which is one of the fundamental rights of every human being. Essentially, the right to health relates to people's food; drink; clothing; housing; social and health services;²⁸ welfare; healthcare; protection; comfort; recreation; physical and mental well-being; prohibition of torture; right to education, life and privacy; development and sustainable development; solidarity rights; right to live in peace; and other human rights and freedoms. In other words, the right to health includes a long list of rights that countries must fulfill in accordance with the inherent principles of human dignity, as well as ensuring a high standard of freedom, justice and equality among all members of society.

The Committee on Economic, Social and Cultural Rights (CESCR), which is a monitoring body for the implementation of the International Covenant on Economic, Social and Cultural Rights, stressed in its General Comment No. 14 that "health is a fundamental human right indispensable for the exercise of other human rights" and that "the right

²⁸ Article (25) of the Universal Declaration of Human Rights states that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services".

to health includes certain components which are legally enforceable.”²⁹
The essential elements to be fulfilled by State parties are:

Functioning public health and health care facilities, goods and services, as well as programs, have to be available in sufficient quantity within the State party.

Health facilities, goods and services must be accessible to all without discrimination, especially the most vulnerable or marginalized sections of the population, without discrimination on any of the prohibited grounds. Also, health facilities, goods and services must be within safe physical reach for all sections of the population. Payment for health care services has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Moreover, equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, as well as being designed to respect confidentiality and improve the health status of those concerned.

Health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, as well as scientifically approved and unexpired drugs and hospital equipment and supplies.

The Kingdom of Jordan played a prominent role in countering the COVID-19 pandemic, thus becoming a good model on the global level. This is due to the adopted procedures and steps for protecting the health of individuals within its territory. However, our focus here is not to evaluate the governmental procedures nor to measure the policies' impact on other sectors including people's rights and freedoms.

²⁹ See General Comment No. 14 of the Committee on Economic, Social and Cultural Rights (CESCR) in its 22nd Session on August 11, 2000 (contained in Document E/C.12/2000/4). Its related meetings were held in Geneva between 25 April – 12 May 2000.

According to the Ministry of Health's statistical data up until this date (August 15, 2020), the number of cases of COVID-19 infection is 1,339. This includes 1,229 cases under treatment, 108 recovery cases, and 11 cases of death, whereas the Ministry of Health conducted 686,351 examinations.³⁰

This called upon the country to enhance its role of protecting the health sector and ensuring equitable access to health care services to all persons in all societal segments. This takes us to the title of this research paper, which is to ensure that health sector privatization in Jordan would not undermine the attainment of the right to health and health care accessibility, service quality, proportionality, as well as the provision of personnel, supplies, hospitals, and other elements.

Status of the Health Care System in Jordan

The Kingdom of Jordan has made significant achievements in the health sector and distinguished itself as an important center of medical tourism on the regional level. Moreover, the country increased its number of hospitals and fostered its health and medical sectors to a large extent. In fact, Jordan was on its way to becoming notable for medical tourism on the global level. With these considerable achievements in mind, it is still important to disclose some facts vis-à-vis the local population. For example, more than 25% of Jordanians do not have any form of health coverage, and the percentage of citizens' health expenditures from their personal account reached 26% of the GDP.³¹

30 <https://corona.moh.gov.jo/ar>

31 Research work paper published by the Center for Strategic Studies at the University of Jordan. This paper was presented by the former Minister of Health, Dr. Mahmoud Al-Shayyab, in a seminar held by the Center at the University of Jordan on Thursday, 24 October 2019. The paper [Arabic] was published online: <http://jcss.org/ShowNewsAr.aspx?NewsId=787>

According to the Jordanian Department of Statistics, the population of Jordan in 2019 was 10,554,000, with 5,588,000 males and 4,966,000 females. Males comprise 52% of the population. In the same year, the population density was 118.9 persons per square-kilometer, according to the Statistical Yearbook.³² Also, Jordan has been witnessing a significant increase (5.3%) in its population growth.³³

The Jordanian constitution did not explicitly and clearly mention the right to health as was the case with other rights stipulated in Chapter 2. Nonetheless, the amendment of Article 6 in 2011 by adding paragraph 5: “The law shall protect motherhood, childhood and the old-aged; and shall avail care for the youngsters and those with disabilities and protect them against abuse and exploitation”, gave a glimmer of hope regarding the inclusion of children and the elderly in public health insurance programs. However, from our point of view, this amendment is insufficient because it must be inclusive to all segments of society and to stipulate the right to health and the state’s responsibility to uphold this right.

Jordan’s National Health Sector Strategy 2016-2020, issued by the High Health Council, indicated that fertility and mortality rates, beside the immigration factors in certain age-segments, will likely increase the number of elderly persons in Jordan. This in turn will increase pressure on the government budget and inflate the country’s health spending. An example (shared in this Strategy) is that the proportion of people who are 65 years old and above will rise from 3.3% in 2014 to 4.9% in 2020. Meanwhile, the percentage of persons who are 15 years old or less will drop down from 37.3% in 2010 to 33.4% in 2020. With this in mind, the High Health Council urges to “take this demographic shift into account when planning for health services, especially those related to noncommunicable diseases, health insurance, and the provision of therapeutic, preventive and rehabilitative services,” particularly for the elderly, women and children.³⁴

32 <http://dosweb.dos.gov.jo/wp-content/uploads/2020/06/Population2019.pdf>

33 *Ibid.*

34 <http://hhc.gov.jo/uploadedimages/8f70aace-ce1e-4762-9e86-4f3d75219beb.pdf>

The health sector in Jordan consists of four main service providers:

First: The Public Sector: includes the Ministry of Health, Royal Medical Services, university hospitals, National Center for Diabetes, Endocrinology and Genetics.

Second: The Private Sector: includes diagnostic and therapeutic centers, private clinics, and private hospitals.

Third: The International and Charitable Sector: includes the clinics of charity and voluntary associations, King Hussein Cancer Center, United Nations Relief and Works Agency for Palestine Refugees (UNRWA), and United Nations High Commissioner for Refugees (UNHCR).

Fourth: Councils and Institutions: includes the High Health Council, Jordanian Medical Council, Jordanian Nursing Council, Jordan Food and Drug Administration, and the Joint Procurement Department.

It should be noted that the Public Health Law No. 47 of 2008 indicates the Ministry of Health is the competent authority accountable for all health-related matters in Jordan, including:

- Maintaining public health care by providing and monitoring preventive and curative services.
- Regulating and supervising health services provided by the public and private sector.
- Providing health insurance to citizens within the limits of financial capabilities.
- Establishing training and educational health institutes affiliated with the Ministry of Health, as well as supervising their respective administration.

• The Law also specifies the Ministry of Health tasks, responsibilities and procedures in coordination with the relevant authorities, in order to:

- Encourage and promote health lifestyle patterns and behavior, including physical activities, adoption of proper nutrition methods, promote anti-smoking, and any other pattern or behavior that proves to be beneficial for improving one's health.
- Improve people's health level by combating diseases caused by malnutrition and adding micronutrients, such as iodine, iron, vitamins and similar foodstuffs, or demanding the modification of food components and prohibiting the marketing of dangerous or harmful products.

According to official statistics in 2019, there are 118 hospitals in Jordan, divided in accordance with their respective health sector. 32 of these hospitals belong to the Ministry of Health, and they had 5,119 beds, i.e., a rate of 34.8%. This shows that the number of beds in these hospitals decreased from 2018, in which they had 5,208 beds, i.e., a rate of 35.3%.³⁵

In 2019, there were 15 hospitals in Jordan's medical service sector. These hospitals had 3,091 beds, constituting a rate of 21%. However, they also saw a decrease [in the number of beds] from 2018; in which there were 3,316 beds, i.e., a rate of 22.5%.³⁶

There are two university hospitals in Jordan:

The first is Jordan University Hospital, which, in 2019, had a capacity of 612 beds, i.e., 4.2%. This is a growth from 2018 when they had 559 beds – i.e., 4.1%.³⁷

35 https://app.moh.gov.jo:7004/greports/headermain.jsp?print_parameter=yes&lang_parameter=arabic

36 Ibid.

37 Ibid.

The second is King Abdullah University Hospital. In this educational hospital, there was a capacity of 455 beds in 2019, i.e., 3.7%. However, in the previous year (2018), they had 541 beds, i.e., 3.75%.³⁸

Meanwhile, the private sector had 69 hospitals in 2019, with a capacity of 5,334 beds, i.e., a rate of 36.3%. This is an increase from 2018, in which the private sector had 66 hospitals with a capacity of 5,077 beds, i.e., 34.4%.³⁹ The Ministry of Health statistics for 2019 indicated that there is an average of 14 hospital beds for every 10,000 persons.⁴⁰ The same source also stated that the rate of admissions in 2019 was 93.0 for every 1,000 persons, which is a decrease from 2018, when there were 97.0 admissions for every 1,000 persons.⁴¹

In 2019, there were 6,408 physicians in Jordan, including specialist, resident and general physicians, as well as dentists and veterinarians. These physicians were distributed among different central directorates, general directorates, health directorates, and hospitals. For every 10,000 persons from the local population, there were 27.39 physicians, 7.24 dentists, 11.42 pharmacists, 24.0 registered nurses, 3.51 midwives, and 1.62 assistant nurses.⁴² Also, the number of non-physician Ministry of Health medical personnel was 17,642 in 2019.⁴³

In 2019, Jordan's Ministry of Health budget was 651,033 Jordanian Dinars (JD) from the total governmental budget of 9,255,497 JD. The current budget stood at 577,443 JD. and the capital budget was 73,590 JD.⁴⁴ In 2018, the Ministry of Health budget constituted 6.6% of the total governmental budget, whereas the Ministry's budget comprised 7.0% of the total governmental budget in 2019.⁴⁵

38 *Ibid.*

39 *Ibid.*

40 <https://www.moh.gov.jo/Pages/viewpage.aspx?pageID=409>

41 *Ibid.*

42 <https://www.moh.gov.jo/Pages/viewpage.aspx?pageID=238>

43 <https://www.moh.gov.jo/Pages/viewpage.aspx?pageID=175>

44 <https://www.moh.gov.jo/Pages/viewpage.aspx?pageID=176>

45 <https://www.moh.gov.jo/Pages/viewpage.aspx?pageID=409>

Furthermore, the official data and statistics issued by the Ministry of Health show that private sector hospitals comprise 58% of hospitals in Jordan. This demonstrates crucial elements (to be highlighted later) about the framework of health care privatization. Reflecting on those indicators – especially on statistics and rates vis-à-vis hospitals – will ultimately help us understand the issues. An example is how the total number of beds in the public health sector, medical services and the two university hospitals was 9,366 beds in 2019, whereas the number of beds in the private sector was 5,334 beds. In other words, 1.75% of the total number of hospital beds in Jordan.

The ongoing population increase – and especially the growing number of females of reproductive age (aged 15-49 years) – will constitute a serious national challenge in Jordan in the coming years. For example, the women of childbearing and reproductive age will increase from about 1.6 million in 2014 to approximately 2.1 million by 2022.⁴⁶ This will require the reformulation of health plans in a way that accommodates Jordan's population growth and diversity and its demographic changes, and especially by redistributing the budget while taking inflation into consideration. Moreover, there needs to be the assignment of more health personnel to cover the different areas and populations in a way that guarantees an equitable universal health care system for all people on Jordanian lands.

The Jordanian Department of Statistics (in 2015) and the Health Strategy (of 2016-2020) classified Jordanian citizens according to their health insurance providing party. For example, the civil health insurance of the Ministry of Health covers 41.7% of Jordanian citizens, the Military Insurance Fund of the [Royal] Medical Services covers 38% of citizens, and the insurance of university hospitals covers 2.5% of citizens. Meanwhile, private health insurance covers 12.5% of citizens, whereas it includes health insurance companies, the health insurance funds of associations, and some organizations. It is also worth noting that the insurance of the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) covers 2.5% of citizens but only provides primary health care services. Also, 0.4% of citizens are insured outside of Jordan, and 2.5% are insured by other types of insurance. The results also showed that there is a clear disparity in insurance coverage between different governorates. The lowest insurance coverage rates were actually found in the Amman governorate (i.e., the capital); where only %54 of Jordanians have insurance coverage and 40% of non-Jordanians have this coverage. In the Zarqa governorate, 60% of Jordanians have health insurance and 50% of non-Jordanians have it. Meanwhile, in Ajloun, 92% of Jordanians have health insurance coverage and 86% of non-Jordanians have it.⁴⁷

Status and Effects of Health Care Privatization in Jordan:

In 1985, the idea of promoting Jordan's private sector started gaining ground. The aim was to catalyze economic development in most sectors, including health and education. The privatization process started with the Jordanian government's endorsement of an economic package in the early Nineties to reform the economy and foster self-reliance. The main aspiration at the time was to raise efficiency, improve productivity, enhance the competitiveness of different economic sectors, spur and open up markets for investments, and alleviate the burdens of the government budget.

In 1996, a special unit was established by the Prime Minister's bureau to regulate the privatization process. This unit was chaired by the Prime Minister and included ministers and directors of relevant departments, whereas its mission was to supervise, select, and evaluate privatization measures and projects.

In 2000, Privatization Law No. (25) of 2000 was issued to regulate privatization processes and measures under governmental monitoring and control. Hence, the Executive Privatization Commission (EPC) was established pursuant to this law. This commission was legally assigned by the Privatization Unit to carry out studies and follow up the execution of restructuring and privatization transactions. Moreover, the Privatization Proceeds Fund was created. This fund is supervised by the Privatization Council, which is chaired by the Prime Minister and includes, inter alia, the following members: Minister of Finance, Minister of Industry and Trade, Minister of Planning, Minister of Justice, and Governor of the Central Bank.

During the aforementioned period, there was the privatization of several companies owned by the government, especially the government's ownership in public shareholding companies, such as the Jordan Phosphate Mines Company (JPMC); Jordan Telecom Group, Arab Potash Company (APC); Jordan Petroleum Refinery Company (JPRC); Irbid District Electricity Company (IDECO); several paper, cardboard [carton], tobacco, cigarette and cement companies; along with some Jordanian hotels, banks, transportation and communication companies; the Water Authority of Jordan (WJA); Royal Jordanian [airline company], and others.

Since that period, Jordan has been afflicted by a weakening economy with increasing financial burdens and budget deficits, all of which led to the accumulation of huge debts that the future generations will suffer from. Unfortunately, the adopted privatization measures were ineffective; they induced much dissipation and more deficits for Jordan, not to mention the emergence of serious corruption cases that took their toll on the society, undermining the most basic rights of individuals – including their right to health.

One of the grave concerns in health sector privatization is that it undermines the public sector's role and responsibility to protect people's health and welfare, thus widening the gap between different societal segments. This is particularly sensitive because Jordan is suffering from numerous economic, social, and demographic challenges. For example, a comparison between the censuses of 2004 and 2015 shows Jordan's significant population growth rate of 5.3%.⁴⁸ Also, Jordan's National Health Sector Strategy of 2016-2020, issued by the High Health Council, pointed out that the general poverty rate in Jordan was 14.4% in 2010, whereas the rural areas have higher poverty rates than urban ones. It was also noted that urban areas constitute about 83%, and the cities of Amman, Irbid, and Zarqa are the most populated.⁴⁹ According to what was announced by the government in April 2019 through Prime Minister Dr. Omar Razzaz, the poverty rate in Jordan has reached 15.7%. However, the current reality experienced by Jordanians might indicate an even higher poverty rate. Therefore, we call upon the government to conduct a comprehensive study on poverty in Jordan and to present more realistic percentages that reflect the reality on the ground. The 18th House of Representatives (Majlis Al-Nuwaab) has also requested the government to provide accurate poverty rates in Jordan to reflect the local situation in a transparent manner.

48 <http://dosweb.dos.gov.jo/wp-content/uploads/2020/06/Population2019.pdf>
49 <http://hhc.gov.jo/uploadedimages/8f70aace-ce1e-4762-9e86-4f3d75219beb.pdf>

In order to make sense of health care privatization and acknowledge the risks therein, we must first define it as a concept. Privatization has many definitions,⁵⁰ but we will mention the most basic elements of its definitions. These will enable researchers, readers, and concerned persons to view these pillars in light of the current practices and to come up with a formula that applies to all societies. These elements are:

1. **Ownership:** This component examines the state's ownership (or lack thereof) of the public sector. It is one of the main points that highlight the concept of privatization. There are cases when governments impose their absolute ownership and discretion – especially in undemocratic countries that lack monitoring and accountability, or in democracies with poor systems that enable the government to encroach upon other authorities.
2. **Transfer:** This second element of privatization refers to the transfer of ownership from the public sector to the private sector. This means that the government gives up the management or ownership of a project/entity and hands it over to the private sector.
3. **Control:** This means that the private sector would control and dominate over all activities after the transfer of ownership without any governmental intervention vis-à-vis work methods and operations, preparation of production-related plans and programs, etc., whereas the main goal is profit attainment and wealth accumulation.

50 Donald Stone defines privatization as “any transfer of ownership or administration from the public sector to the private sector, provided that full control by the private sector is established, which is usually achieved through the actual transfer of majority ownership to the private sector.” On the other hand, Ramanadham (1989) defines Privatization as “a broad continuum of measures extending from de-nationalization on one hand and the market system on the other.” He also describes privatization as the extent to which public sector projects and operations become subject to market forces, including liberalization and deviation from governmental regulations. Meanwhile, Lee Kuan defines Privatization as “the transfer of any activity, organization or function from the public sector to private business activity” (translated from Arabic): <https://ar.wikipedia.org/wiki/%D8%AE%D8%B5%D8%AE%D8%B5%D8%A9>

Some people see that privatization can be a tool for sharing burdens and duties between the government and the private sector. However, in our view, this approach is problematic and causes a huge burden for the health sector in Jordan. This is because the government must not neglect its responsibilities and duties towards this sensitive sector that has a far-reaching impact on all societal segments.

The government should critically examine the health sector privatization process and to urgently tackle the following aspects:

1. Enhance the competency and efficiency of all administrative and health personnel through training and qualification programs, and especially in administrative and technical aspects.
2. Reallocate and increase the health sector budget within the state budget, in a manner that corresponds with the growing need for providing health services to all persons residing in Jordan. Moreover, special budgetary allocations should be made for construction purposes and the provision of modern equipment and medications. Sufficient budgets should also be allocated for conducting and supporting scientific medical researches and procuring basic supplies for supporting the health sector in Jordan.
3. Establish cost control mechanisms and stop the waste of human and financial resources. These resources should be redistributed to include all geographic regions. It is also important to extend the health care service coverage to remote marginalized areas [i.e., far from governorate centers], as well as providing more support to smaller districts and population centers.

In light of the increasing challenges faced by the residents of Jordan, the health sector must refrain from adopting privatization frameworks as an approach to the health sector. This is especially pertinent during this critical period when the economic effects of privatization pose a tremendous challenge to the state (whereas the private sector is mainly concerned about profits while disregarding people's health).

Consequently, the following economic challenges (which greatly impact Jordan's health system) have emerged: Low GDP growth, increased total public debt, high budget deficit, rising poverty and unemployment rates, economic burden of Syrian refugees, and international donors' failure to meet their financial commitments. All of these pose a serious national issue with long-standing effects on the state's survival and inclusiveness. The Jordanian government must scientifically and practically tackle these dimensions in the framework of realistic and attainable strategic plans. These should include re-allocating the country's general budgets, combating corruption, and introducing an equitable state budget distribution. Greater financial support should be provided to health sector budgetary items, and the government should declare its responsibility to protect the health of individuals.

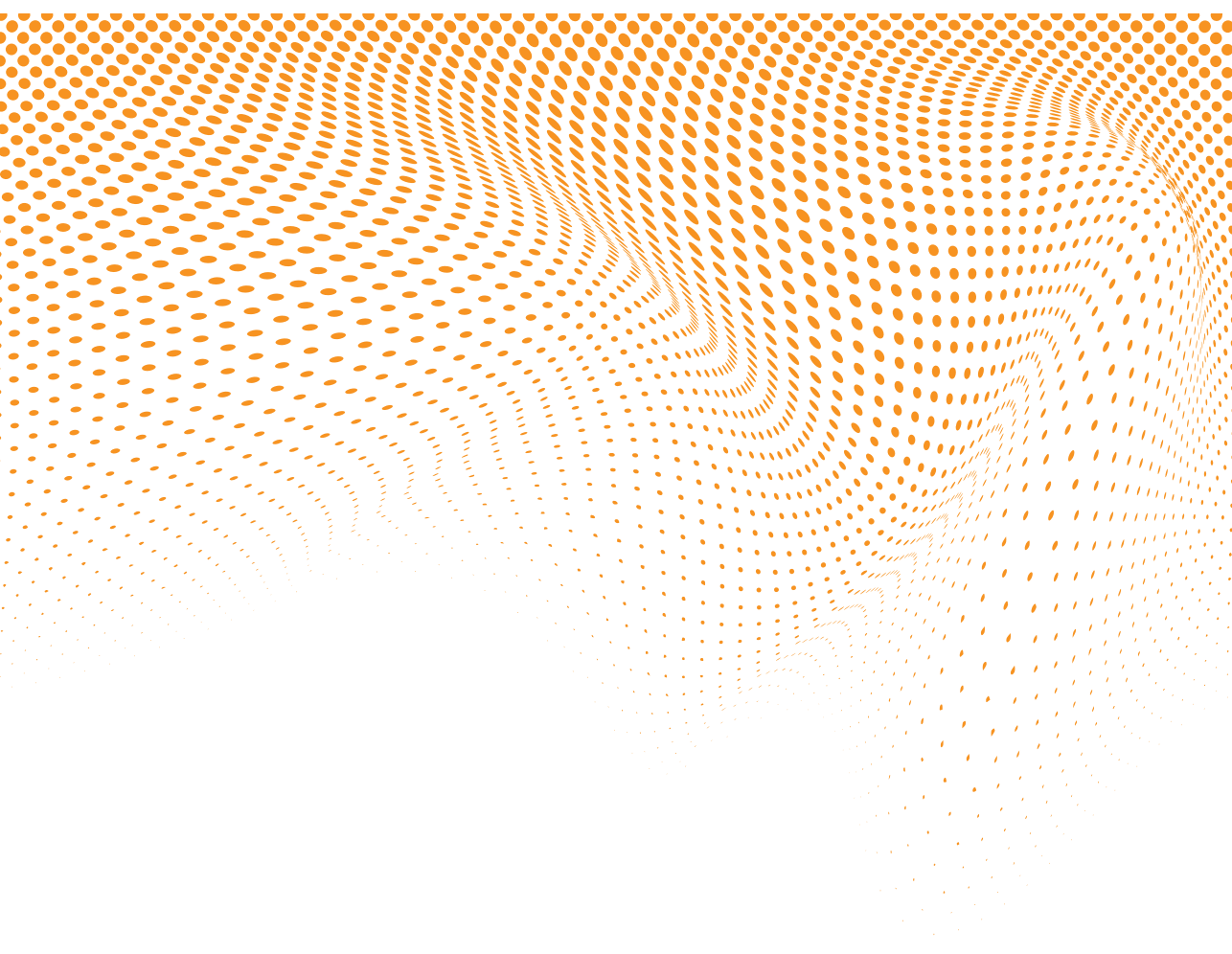
We do not see any good reason for privatizing health care. What this sector needs is to reformulate public health policies and overcome hurdles through a strategic vision focused on the equitable and inclusive distribution of health care services. Health is a vital and delicate aspect of life. Therefore, privatizing this sector will inevitably lead to major issues – such as the health system's neglect of the public's interest, private sector domination over all other sectors, and undermining people's lives and wellbeing. Citizens are the most crucial asset in all countries. Therefore, the idea of health care privatization is unacceptable from the human, social, cultural, economic, and political viewpoint.

General Recommendations

The state is the main party for achieving the right to health and it must fulfill its responsibilities as the regulator and guarantor of the right to health (which is one of the fundamental rights for all people). This paper, which discusses the effects of privatization on the Jordanian health system, hereby concludes with the following recommendations:

1. To amend the Jordanian constitution and add legal provisions that will guarantee all individuals' right and equitable access to health care. This should include marginalized and vulnerable groups such as the elderly, persons suffering from chronic diseases, women, pregnant women, children and others, in a way that ensures social justice for all segments.
2. Reallocate and redistribute general budget items and increase health sector allocations. Also, it is important to extend the comprehensive health insurance to cover all persons living in Jordan, while enhancing access to high-quality health services.
3. Strengthen health sector monitoring and control to improve health outputs; train and empower medical personnel and health sector employees; and increase the number of hospitals and health care centers to include all governorates, districts and population centers. It is also necessary to provide and upgrade medical devices and equipment.
4. Increase budgetary allocations for intergovernmental scientific research, and especially experiments related to medicines, drugs, and other treatment supplies.
5. Enhance the good governance of the health sector, provide and improve monitoring tools and mechanisms, and combat corruption.

The Health System in Yemen is on the Brink of Collapse



6. Set appropriate legislations for regulating Jordan's health sector, unify the legal reference parties, and define the respective roles in a professional, transparent and efficient manner.
7. Expand the scope of oversight, regulate the private sector, introduce specific and precise controls to manage the growth of the private health sector, and activate institutional assessment and monitoring systems.
8. Control the medical expenditures and reduce the proportion of health spending from residents' accounts. Moreover, there should be a declaration on prohibiting the imprisonment of a patient for not being able to pay his/her medical bill.
9. Foster the state's economic control and prevent the waste of health resources.
10. Strengthen the system for training, equipping, and empowering medical and health personnel. Also, it is important to develop and update a national strategy for the elderly, and to provide suitable financial resources for this strategy's implementation.
11. Be inclusive of all individuals and groups within the comprehensive public health program.
12. Augment the provision of health services to the elderly, e.g., medical services related to high blood pressure, diabetes, cancer, and other diseases.
13. Expand the scope of health courses and specializations related to treating and nursing the elderly.
14. Increase support for the civil health insurance fund that covers groups classified as poor by the Ministry of Social Development and exempt them from paying health-related fees.

15. Expand the curative services covered by the Ministry of Health, especially those that have substantial costs, while enhancing the inclusivity of all citizens. It is also important to reintroduce a system of exemptions from various parties in order to include all citizens and individuals without exception; and especially those who suffer from contagious diseases, cancer, kidney diseases, pulmonary and non-pulmonary tuberculosis, AIDS, alcohol and drug addiction, and other dangerous diseases. These services must also include people in refugee camps, as well as persons from the Gaza Strip.
16. Create a national mechanism/reference point for issuing accurate statistical data and studies related to health sectors and insurance coverage.
17. Advocate for compulsory and comprehensive health insurance for all, including the 25% of Jordanian citizens who do not have health coverage. Moreover, it is necessary to provide health insurance to non-citizens living on Jordanian territory, especially the children of Jordanian women, refugees from different nationalities, persons in refugee camps, and persons coming from the Gaza Strip.
18. Establish an independent national health insurance commission as a reference point for providing and regulating health services and organizing individuals' use of medical services.
19. Reassess the work of the private sector within the health system and distinguish between private health sector parties that primarily seek profits and commercial interests and those who are committed to providing health services for the public's benefit. The latter parties should be encouraged.
20. Expand the scope of exemptions and encourage organizations and charitable associations to carry out their tasks for supporting the health sector.

21. Strengthen the parliament's role in carrying out their oversight, accountability and disclosure tasks related to Jordan's health system.
22. Link the Jordanian health system with the collected taxes and reduce tax evasion to maximize spending on the health sector.
23. Increase budgetary allocations to achieve the Sustainable Development Goals (SDGs), especially Goal 3 which is related to providing health care for all and access to quality health services without facing financial difficulties.

Introduction

The humanitarian catastrophe in Yemen is the worst on the global level. Yemen has been suffering from more than five years of ceaseless conflict between belligerent parties, amidst a sharp economic decline that led to famine and a growing need for humanitarian assistance in all public and private sectors. Consequently, approximately 80% of Yemen's 24 million population (19.2 million) ache for some kind of humanitarian assistance to protect them from this heinous conflict, including 14.3 million Yemenites who are in acute need for this assistance. It is quite unfortunate that the escalating crisis is further aggravating the humanitarian needs. Evidently, the number of people who are in urgent need of assistance has increased by a staggering 27% from the previous year. Also, two-thirds of all districts in the country signal warning indicators that predict famine (i.e., are in "pre-famine"), and one-third face a convergence of multiple acute vulnerabilities.⁵¹

What exacerbates the health situation in Yemen is that its public health sector has not seen any real infrastructure development in the last 35 years. For example, the total government spending on health care in 2011 was 5.4% of the Gross Domestic Product (GDP), and it was only 3.7% of GDP in 2002. Also, the per-capita government spending on health care in Yemen is very low compared to other Middle Eastern countries. The situation got much worse after the horrendous events and aftermath of the 2015 War. The political conflict on the one hand, and the government's failure on the other to adopt policies for providing medical equipment or paying health care professionals, damaged and completely destroyed health care facilities. Moreover, the country's sharp economic deterioration led to the spread of several epidemics at an accelerated pace.

51 Website of the United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA): <https://www.unocha.org/yemen/about-ocha-yemen>

Equitable Access to Health Care – Yemen’s Health System in the Past and Present:

Prior to 1990, individuals in Yemen received public health care services in return for symbolic prices. These services were based on social contributions provided by the state to its citizens, while the prices were largely proportionate to citizens’ income. At the time, the right to health care access was available to everyone. However, the outbreak of war and the ongoing conflict constituted a dilemma in both public and private health facilities. Hospitals and public health centers, in this respect, started providing simple medical services for exaggerated prices that were disproportionate to citizens’ income. Citizens’ income levels also plummeted in comparison with the high cost of living and the incessantly rising prices of health goods and services. Another thing worth noting is that prior to the crisis, some important medications for treating widespread chronic diseases (whose prices were high) were provided free of charge to Yemeni patients on the basis of social solidarity.

Currently, the Ministry of Health does not provide any treatment to the people since it is unable to do so. Nevertheless, there are some non-governmental organizations – such as World Health Organization (WHO) and Doctors Without Borders – who contribute, through Yemen’s Ministry of Health, in the procurement of some medicines for chronic diseases (e.g., diabetes and cancer medicines) and provide them free of charge to patients. However, these organizations lack good organization and correct distribution, as there could be shortages of medicines for two or more months due to the donors’ failure to import or deliver them to patients.

Due to the aforementioned reasons, the right to access health care became (unfortunately) the responsibility of citizens instead of that of the state. Consequently, citizens must now pay for all their medical examinations, drugs, treatments, and rehabilitation at their own expense. The situation exacerbated with the lack of monitoring medication sales. As a result, one would find that medicine prices differ from one pharmacy to another, and examination costs change from one laboratory to another. This happens within the same directorate – not to mention disparities in prices between the different governorates. To make things more complicated, the current exchange rate in the capital Sana'a and northern areas is 599 Yemeni Rial per 1 USD, whereas the rate in Aden and southern areas is above 750 Yemeni Rial per 1 USD, thereby increasing the financial burden on citizens' shoulders.

Deterioration of the Health Sector and Human Security due to the Ongoing War:

The Ministry of Health and its offices in different Yemeni districts have the responsibility to provide, develop, and improve public health services. However, the successive wars and conflicts paralyzed the Ministry of Health (and the Yemeni government in general) of their duties, thus leading to the deterioration of the health sector. Although there are some non-governmental organizations that provide humanitarian aid to the population, yet those do not establish health infrastructures, seeing that they do not formulate future developmental plans alongside the government. It is also worth noting that belligerent parties destroyed most of the country's infrastructure, including many health facilities. To make matters worse, an imposed blockade by the Saudi-led coalition in 2015 led to restrictions on imports and price inflation, thus preventing Yemenites' access to health care and other essential services. Additionally, many of Yemen's health personnel – 50,000 in total – had their salaries stopped since August 2016. As a result, they left the public health system and were forced to search for other sources of income. Simply put, the Yemeni health system is in serious trouble and is on the verge of total collapse. In this conundrum, Yemenites

are facing great difficulties in accessing health care facilities; some of which were destroyed and many of which are dysfunctional. Therefore, preventable diseases like measles (a highly contagious viral disease) have been spreading and became the main cause of child mortality in the country. Doctors Without Borders (MSF) mentioned that they have cured 1,787 persons from the measles disease in Yemen in 2018.⁵²

The conflict in Yemen has greatly intensified since the events of March 2015, which pushed the country's health system to the brink of collapse. On this account, human insecurity, power shortages, and lack of fuel to power generators and ambulances have led to the closure of almost 1 in 4 health facilities. Moreover, many health workers have fled the country, while drug and medical supplies have been disrupted. Limited funding is taking a toll on the government's capacity to continue operating health facilities, as well as on patients' ability to pay for services.⁵³ The health system in Yemen is in shambles and is heavily dependent on international support. Even the basic health care services are currently unavailable in a country of more than 14.8 million people, where less than 45% of health facilities are still functioning and 17% of health facilities do not perform their work at all. This is because 274 health care facilities were destroyed or damaged during the current conflict, and health care workers have not received their salaries on a regular basis in the last six months. Additionally, there is a great shortage of medical supplies despite the significant support of World Health Organization (WHO) and other health organizations, thus the inability to save many lives due to insufficient health care services. There are also direct injuries inflicted on Yemeni individuals due to armed conflict, many of whom die in silence and are among the missing – with no one noticing or recording their death.

52 Doctors Without Borders (Médecins Sans Frontières/MSF): Shortened Link: <https://bit.ly/3haHi67>.

53 World Health Organization (WHO). Link: <https://www.who.int/news-room/feature-stories/detail/insecurity-drives-health-workers-out-of-yemen>

In the meantime, many youth, women and men are dying because of malnutrition or due to easily preventable and curable diseases. Also, people suffering from chronic diseases (e.g., high blood pressure, diabetes, kidney failure) are dying slowly due to the unavailability of treatments that can keep them alive.⁵⁴ As many as 95 percent of foreign medical personnel, all of whom were highly specialized, departed from Yemen due to the war and blockade. Moreover, there is an absence of 12 types of medicines for treating chronic diseases (especially cancer), and challenges in transporting 362 types of medicines. In addition, there was the prohibition or prevention of entry for essential deliveries pertaining to pharmaceutical industries, as well as hampering the arrival of shipments of drugs and medical supplies despite the obtainment of import authorization documents. Arbitrary measures were also imposed on the entry of ships and cargo vessels loaded with drugs, hence causing damages to medicines and preventing 320,000 patients from receiving treatment abroad due to the closure of Sana'a International Airport. This included 230,000 officially registered patients urgently in need of treatment abroad. Among these patients, 32,000–43,000 have passed away; of whom 30% were children. Also, 30,000 patients with cardiac problems may die due to the malfunction of the only cardiac catheterization device located at Al-Thawra General Hospital in Sana'a. Seven kidney dialysis centers were also shut down due to the lack of dialysis devices.⁵⁵

54 Source: <https://www.who.int/hac/crises/yem/appeals/speech/ar/>

55 Source: Annabaa Information Network, April 2020. Article titled "Health Sector in Yemen: Shocking Facts and Figures" (Arabic). Link: <https://annabaa.org/arabic/health22874/>

Impact of the COVID-19 Pandemic on the Health Sector in Yemen:

The eruption of the COVID-19 global pandemic, which started at the end of 2019, exposed the weakness and fragility of the health sector in Yemen, as follows:

The preliminary measures for dealing with the novel coronavirus varied between north and south Yemen. In the north, information about the real number of infected and dead persons was being concealed, and hospitals were receiving COVID-19 patients in complete secrecy. Meanwhile, the situation was different in the south, where two special centers were created to treat coronavirus patients: The first center was located at Al-Amal Hospital in Al-Buraiqeh, whereas the second was inside the Republic Hospital in Khormaksar. The treatment of COVID-19 patients in these hospitals was conducted with the participation of the Ministry of Health, and the hospitals received all coronavirus cases inside and around the Aden governorate. However, during the height of the pandemic, the two quarantine centers could not function properly due to political conflicts and the absent role of the Ministry of Health and its unpreparedness for this exceptional situation. This led to the intervention of Doctors Without Borders (MSF) to help manage the two above-mentioned centers. It is also worth noting that one of these centers recently closed down as a result of irresponsible practices by some state parties.

According to statistical data issued by Yemen's Supreme National Emergency Committee for COVID-19, the figures of injuries as of August 7, 2020 were as follows:

There was the detection of 1,796 COVID-19 infection cases, 907 recoveries from COVID-19, and 502 deaths from it. It should also be noted that some vulnerable areas lack treatment facilities altogether, so they witnessed countless deaths whose cause could not be determined due to the presence of several epidemics besides COVID-19. Also, the statistical data and information from official government agencies have been inaccurate. For example, the last population census was conducted in 2004, hence it is normal to see growing pressure and inequity in newly opened health facilities (due to the population growth).

Indicators of the Weakness and Fragility of the Health Sector in Yemen:

1. The closure of public and private hospitals – due to their inability to cope with the rising number of infected patients. This led to an increase in death cases. It is worth noting that the closure of public hospitals does not only affect COVID-19 patients but also those suffering from chronic diseases such as heart diseases, diabetes, and strokes.
2. Absence of physicians – due to the infection or death of several physicians and health personnel and the lack of safety measures within public hospitals (especially because of the absence of the state). Some people attempted to provide assistance through social media platforms. However, those contributions were quite limited and insufficient to counter a pandemic so dangerous that it led to the collapse of some well-developed health systems around the world.
3. Absence of basic diagnostic examinations: The France-based Doctors Without Borders (MSF) confirmed, through their main officer in Yemen,⁵⁶ that, in many cases, people have died because they arrived late at quarantine centers as a result of the following reason/s:

⁵⁶ According to an article titled “For this reason, it is impossible to know the extent of COVID-19’s spread in Yemen” (Arabic). Shortened URL: <https://bit.ly/37PuLSI>

- Loss of confidence in the provided health services;
- Deterioration of individuals' financial condition;
- Poor awareness regarding health and preventive methods, whereas most people become aware of a disease only after its occurrence and not at earlier stages;
- The free movement of ill and infected persons within and between governorates without any monitoring.

These factors contributed to the spread and expansion of epidemics in the country. As a result, Yemen is still categorized among the countries suffering in large part from exacerbating health problems and diseases. This is due to the low share of health spending from the public budget, thus prompting shortage of equipment, resources, and specialized technical staff in health facilities.

The population of Yemen in 2011 was 26,988,900, i.e., 40 persons per every square-km, and it is estimated that Yemen's population reached 32,080,300 in 2016. In 2012, the Yemeni Ministry of Health had 241 hospitals in different governorates (in both cities and villages). Also [according to the last count], the Ministry had 3,880 health centers, including the National Epidemiological Monitoring Center; Malaria Center; emergency centers; and kidney transplantation, cardiology, and cancer treatment centers. Yemen has 60 public health centers with beds, in addition to 813 centers that do not have beds for conducting medical examinations. Also, there are 3,007 health units that provide health care in various Yemeni governorates, and 2,466 centers for reproductive services. In 2012, there were about 6,570 officially appointed physicians in Yemen, but there are many practitioners who were not officially appointed. Also, there are 2,885 nurses, 4,370 midwives, and 2,741 pharmacists as part of the health sector's essential employees. It should be noted that all the aforementioned groups were greatly affected by the war and its consequences, as demonstrated in the following:

1. Most health centers and hospitals became ineffective due to the scarce resources and equipment and lack of monitoring.
2. The low revenues and non-payment of salaries amidst the rising prices led to the emigration of many medical personnel (physicians, nurses, and pharmacists) to work abroad or move to private hospitals.
3. Closure of a number of health centers due to the unstable security situation.

It should be highlighted that the World Health Organization (WHO) announced that they detected about 113,000 suspected cases of the cholera epidemic in Yemen since the beginning of 2020. Also, the United Nations Office in Yemen noted in a tweet [on Twitter] that “since last January, the number of suspected cases of cholera in Yemen was 112,851”, and that “among these cases, there were 56 laboratory-confirmed cases and 29 death cases related to cholera.” The UN Office added that “these cases were detected in 200 directorates in Yemen (from a total of 333)”⁵⁷.

In May 2020, Major-General Sanad Jamil, the Head of Personal Status Unit in Aden [which is the party that issues death certificates], informed AFP (Agence France-Presse) that “in the last 24 hours, more than 80 people died in Aden as a result of spreading epidemics and fevers in the city.” MG Jamil added that his unit usually issues only seven death certificates each day, but the number of death cases since May 7 reached 607 [i.e., from 7 May until 18 May 2020]. This was confirmed by the Civil Affairs Authority who stated, on Saturday, May 16, 2020, that dozens of people died from undetected diseases (i.e., it was not known whether the deaths were related to COVID-19 or not).⁵⁸

57 Anadolu Agency, Article titled “Global Health: We detected 113,000 suspected cholera infections in Yemen” (Arabic). URL: <https://bit.ly/3prMwNQ>

58 International Monte Carlo Agency (Arabic website). Article titled “Southern Yemen: The rising number of deaths is an indication of a possible outbreak of COVID-19 pandemic”. Shortened URL: <https://bit.ly/38QCf7d> Full URL: <https://www.mc-doualiya.com/articles/20200518-جنوب-اليمن-ارتفاع-عدد-الوفيات-مؤشر-على-احتمال-تفشي-كورونا-المستجد-20200518>

The most affected marginalized groups' situation in light of the deteriorating health system in Yemen

The Yemenites' incomes significantly decreased after the eruption of the war in 2015, in which [dangerous] military and economic weapons were utilized. Indicators revealed the weakness of the Yemeni health system in the face of these circumstances and the total disregard of equitable access to health care. Among these indicators were the following:

- The inability of individuals to conduct diagnostic tests, especially during the surge of COVID-19. The price of a laboratory examination was between 20,000–30,000 Yemeni Rial (approximately 80–120 U.S. Dollars). Also, the price of a digital diagnosis examination was around 35,000 Yemeni Rial (as high as \$140 USD).
- Many individuals were unable to complete their treatment by antibiotics and vitamins, as their prices per course ranged between 15,000 – 20,000 Yemen Rial (i.e., between \$60–\$80 USD).
- Many citizens were reluctant to receive treatment and resorted to the use of nonevidence-based medicine within a highly illiterate and uneducated society. This exacerbated the humanitarian and health catastrophe and allowed the spread of different epidemics. It also prompted the re-emergence of some diseases which had previously disappeared (according to WHO), such as pulmonary tuberculosis, leprosy, and others, along with the emergence of diseases that have not been diagnosed until now.

- Vulnerable and marginalized groups were the most affected by the war and the poor level of health care. For example, according to the Yemeni Coalition for Monitoring Human Rights Violations (“Rassd Coalition”), the number of disabled persons reached 4.5 million⁵⁹ due to the war that erupted in 2015 (as of March 2020). These persons lack the most basic elements of the right to health. Moreover, this increased the disabled persons’ poverty levels due to the lack of job opportunities. In fact, there is no governmental party that is concerned with disabled persons due to the absence governmental monitoring after the war. Many other vulnerable groups were also largely affected by the war, such as the elderly and patients with chronic diseases and dangerous epidemics, amidst the deteriorating health status and the lack of concern about them.

Gaps in Health Coverage and Health Insurance in Yemen:

The Yemeni state does not impose compulsory health insurance on its citizens and does not care much about them or their development. However, there are some organizations with limited health care facilities that do provide different health insurance services to their employees. For example:

The Electricity Company provides health coverage to its employees by enabling them to obtain medicines and treatment from certain physicians determined by the company. These physicians are employed by the company, and their medical examinations are conducted in centers that belong to the company. However, most organizations prescribe that, if the treatment amount surpasses a certain value, the employee will have to pay the additional cost at his/her own expense. Also, this amount does not cover employees’ major operations or their treatment abroad.

⁵⁹ Akhbar Alyom (Yemen). Article titled “Human Rights Coalition: 4.5 million Yemenis are disabled and the mines of Houthi militias exacerbate the disaster” (Arabic). Link: https://akhbaralyom-ye.net/news_details.php?sid=119915

Oil companies and Doctors Without Borders (MSF) provide comprehensive health insurance through an agreement with private hospitals both within and outside the country, and they cover all medical bills for the employee and his/her spouse, children, and parents.

Some public facilities, such as the Water Authority, provide health insurance by paying a lump sum to the employee regardless of his/her health condition. However, these facilities do not exceed 2% of state facilities, whereas the vast majority of state employees and public and private health sector employees do not have health coverage.

It is also worth noting that there are two main laws that regulate health insurance work in Yemen. The first law is Social Health Insurance Law No. (9) of 2011, whose executive regulation was issued by the Republican Decree No. (165) of 2012. The second law is Order No. (154) of 2012 for Establishing the Public Authority for Social Health Insurance. It is also worth pointing out that there is Law No. (25) of 1991 concerning Insurances and Pensions, of which Chapter Two on Health Insurance stipulates in Article (40) that patients' health insurance is financed from the following resources:

1. Monthly contributions that are deducted by the employer from the total shares of employees and transferred to the [relevant] fund on a monthly basis.
2. Proceeds from investing these funds.
3. Regulations related to the health care system are issued by a presidential decree after approval from the Council of Ministers and Presidential Council based on the Minister's proposal. These regulations must include the various rules and detailed provisions related to [health] insurance, medical care and contribution percentages.

Article (42) of the same law stipulates that:

“Insured persons do not benefit from the provisions related to medical treatment and care during their secondment outside the Republic.⁶⁰

In Republican Decree No. (125) of 1992 concerning the executive regulation for the Law on Insurances and Pensions,⁶¹ the legislator mentioned the following two fields of insurance in Chapter Four under Article (12):

1. Old-age, disability, and death insurance.
2. Work injury insurance.

In Article (2) of Republican Decree Law No. (25) of 1991 concerning Insurances and Pensions, the legislator stated (under the definitions) that a disability is a case in which a person suffers from an illness or accident other than a work injury. Later, in Amended Law No. (26) of 1991 concerning Social Security, Article (2) stated that a non-occupational disability is one which results from a disease or accident that is not related to one’s work. Also, in Chapter Three titled “Work Injury Insurance” and Section IV titled “Old Age, Disability and Death Insurance”, health insurance was not mentioned as done in the previous law because the legislator did not stipulate health insurance and failed to issue an internal regulation as stated in Article (40), paragraph (3).⁶²

The branches of social security are as follows:

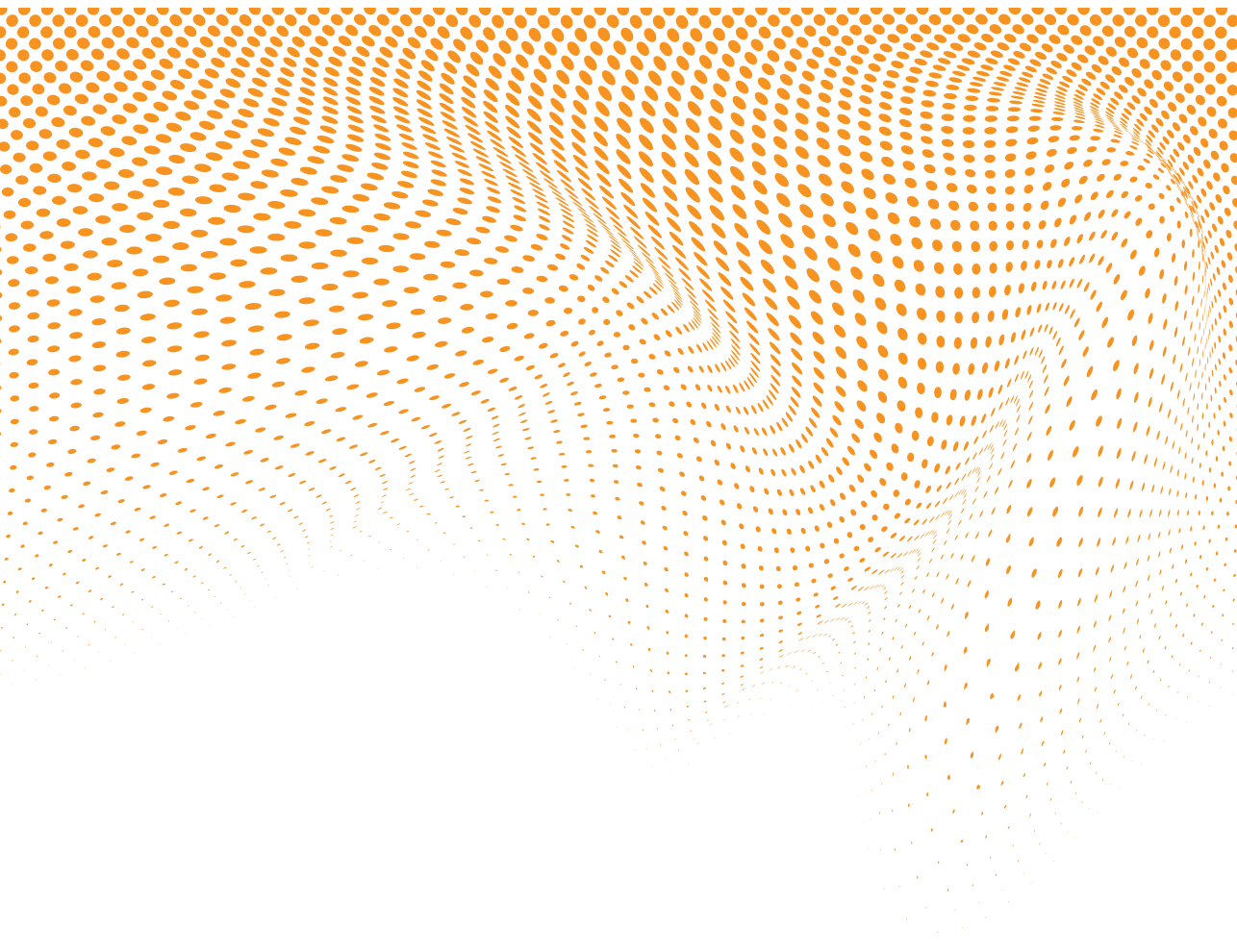
- Work injury insurance;
- Old-age insurance;
- Disability and death insurance;
- Health insurance for workers, pensioners and eligible persons;
- Unemployment insurance;
- Benefits insurance.

60 Republican Decree Law No. (25) of 1991 concerning Insurances and Pensions. Source: National Information Centre/Yemen. (In Arabic). Link: https://yemen-nic.info/db/laws_ye/detail.php?ID=11311

61 Republican Decree No. (125) of 1992 concerning the Executive Regulation for the Law on Insurances and Pensions. (In Arabic). Link: http://gasspyemen.org/userfiles/file/laws/related/ind_proc.pdf

62 Republican Decree No. (26) of 1991 concerning Social Security. Source: National Information Centre/Yemen. (In Arabic). Link: https://yemen-nic.info/db/laws_ye/detail.php?ID=11294&print=Y

Overview of the Health Situation in Iraq



All indicators show that the health insurance system in Yemen is not functioning properly despite its importance in people's lives. Therefore, it is not being implemented at all although it has been under review for the last 20 years. Health insurance was mentioned in Law No. (25) but was not stipulated in Law No. (26) due to several factors. These include the insurance systems' failure to fully implement the different types of social security. For example, the social security system did integrate old-age insurance and disability and death insurance, but it did not include work injury insurance and occupational disease insurance despite the fact that the laws stipulated them as well. This is because the mentioned laws and health insurance are not mandatory for individuals, thereby confirming that there is no real health insurance in Yemen and that the state is not concerned about insurance and does not impose it.

The absence of comprehensive and compulsory health insurance for individuals is the main reason for citizens' lack of equitable access to health. As mentioned above, the state does not require insurance for its citizens (i.e., is not mandatory), and it is not concerned about developing and improving health insurance. This was due to the low level of health spending in the public budget (as mentioned previously) and the conflicts and wars taking place in Yemen (which greatly harmed citizens, drained the public budget, prevented the provision of health services to individuals, and led to overcrowded hospitals and health care facilities). Moreover, due to the low income of individuals and rising prices of health goods and services, many people started avoiding public and private hospitals and resorted to alternative medicine – which is not founded on any medical or scientific facts.

Conclusions and Alternatives:

The humanitarian catastrophe in Yemen is clearly exacerbating, which in turn restrains the right to equitable access to health care, especially among marginalized groups such as the poor, disabled, women, pregnant women, and persons with chronic diseases. In addition to the detrimental effects of war on the health situation, funding from non-governmental organizations is very limited and is sometimes absent. In order to improve the general health situation, here are our main recommendations and solutions:

1. End the wars and conflicts in the region. The ongoing state of war since March 2015 has been the main cause of health status deterioration. Hence, it is crucial to urgently eliminate all forms of conflict and prevent the exacerbation of Yemen's humanitarian catastrophe.
2. Swift intervention to save the economic situation which is on the brink of collapse: The current war led to the economic decline of Yemen, thus increasing the number of impoverished persons and widening the health-related gaps in the country. The international community must immediately intervene to save the economic situation and protect Yemen from the catastrophes of famine and extreme frailty.
3. Increase health spending by the government. As explained earlier, health-related spending in Yemen is very low and does not match the severe health crisis witnessed in the country. The absent role of the Ministry of Health and the Yemeni government has also further aggravated the crisis.
4. Quickly formulate emergency plans that can be implemented in these two years. The health system in Yemen has seen a decline in the level of health services because it is no longer able to receive large numbers of patients affected by the war. Hence, international and local non-governmental organizations (NGOs) must rapidly formulate emergency plans to reduce health problems in the country.

5. Urgent improvement of health center and hospital infrastructure. Hospitals and other health centers have a great shortage of vital components, such as hygiene-related ones. Also, their level of services is not up to par with the minimum recognized standards, thus exacerbating the health crisis instead of solving it.

Alternatives for Improving the Condition of Marginalized Groups (the poor, elderly, disabled, women, pregnant women, and persons suffering from chronic diseases):

1. Elevate the quantity and quality of programs organized by humanitarian NGOs, such as Doctors Without Borders (MSF), World Health Organization (WHO) and other international and local organizations. Although they do not build health infrastructures, these organizations can nevertheless greatly reduce the aggravating crisis.
2. Pay urgent and particular attention to people with chronic diseases and persons at risk, by providing medicines to cardiac/renal/diabetes/stress diseases and offering these medications free of charge due to the deteriorating economic conditions as a result of war.
3. Reactivate the work of public hospitals that were shut down due to their inability to cope with the increasing number of patients during the war, and oblige private hospitals to accept all patients and provide them with medical care.
4. Provision of electricity, water and other basic needs, especially in light of increasing temperature levels, which may affect medicines that must be properly stored in suitable temperatures. Otherwise, these medicines – which are used for treating people with chronic diseases – might be damaged and could also be harmful to the above-mentioned marginalized groups.

Historical Context of the Health Situation in Iraq:

The Republic of Iraq was among the most advanced countries in terms of health in the Middle East and North Africa (MENA) region. This was especially true during the 1970s and 1980s, when Iraq had modern health institutions with advanced medical equipment, distinctive scientific and practical know-how, health management systems, and robust technical training curricula. However, Iraq's long-lasting wars and the ensuing economic blockade (which lasted for more than 13 years) led to the deterioration of its health sector, such as the declining health sector development and the shortage of hospitals, specialized medical centers, and primary health care centers. Moreover, its medical equipment became obsolete, medicines became scarce, health care personnel started emigrating. The number of the health work force soon plummeted in comparison with the population, while prevention and awareness programs became weaker.

The deteriorating health conditions further aggravated after the invasion of Iraq in 2003, eruption of sectarian armed conflicts, administrative and financial corruption, and a set of political and economic crises which coincided with numerous terrorist attacks in most Iraqi governorates.

Among the most ferocious and despicable terrorist groups was ISIS, which occupied three large Iraqi governorates and threatened different provinces. These brutal events led to the death, injury and disability of many persons, along with millions of internally displaced persons (IDPs) and emigrants to foreign countries.

The health situation in Iraq was also affected by catastrophic economic and social conditions in the country. For example, according to official statistical information and international organizations' reports, the illiteracy rate in Iraq skyrocketed to more than 25% of the population, whereas the poverty rate and unemployment rate rose to approximately 30%. This exacerbated the adverse living conditions in Iraq,

reduced the opportunity of receiving adequate health care, increased exposure to different diseases (especially those related to malnutrition and infectious diseases), prevented the suitable treatment of chronic diseases, and affected people's mental and physical health and well-being.

This situation also lowered the residents' level of health and environmental awareness and led to poor services (especially in terms of water, sanitation, and waste removal services), thus contributing to the spread of communicable diseases.

It is worth noting that health spending in Iraq remains among the lowest in the world despite its rich natural resources. Unfortunately, the said resources are not being invested properly for a number of reasons, including political conflicts, poor management, and widespread corruption in different institutions at all levels.

Legal Framework of the Right to Health in Iraq:

Although the Iraqi Constitution clearly stipulates citizens' right to receive health care, the constitutional provisions and relevant laws are not being enforced to elevate the health situation to aspired levels. For example, the Iraqi Constitution of 2005 recognizes the right to health, whereas Article (31) states that:

“First: Every Iraqi citizen has the right to health care. The State shall maintain public health and provide the means of prevention and treatment by building [different types] of hospitals and health institutions. Second: Individuals and entities have the right to build hospitals, clinics, or private health care centers under the supervision of the State, and this shall be regulated by law.”

Moreover, Article (33) of the Constitution mentions that “Every individual has the right to live in safe environmental conditions” and that “The State shall undertake the protection and preservation of the environment and its biological diversity.”

It is worth noting that Iraq has ratified several international human rights conventions and covenants, such as the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). These agreements include important provisions that clearly and explicitly support citizens’ right to obtain universal health care without discrimination based on gender, age, race, and political and intellectual orientation. Iraq also adopted the Millennium Development Goals (MDGs), which include vital health-related goals, such as Goal 4 (Reduce child mortality), Goal 5 (Improve maternal health), Goal 6 (Combat HIV/AIDS, malaria, and other diseases) and Goal 7 (Ensure environmental sustainability). The Iraqi Republic also sought to attain the Sustainable Development Goals (SDGs), including SDG 3 (Good health and well-being), SDG 5 (Gender equality), and SDG 6 (Clean water and sanitation). However, there is still a long way to go to achieve these goals in light of the deteriorating health conditions and absence of a clear vision. The Iraqi health system provides services to citizens equally without discrimination, but these services are poor and do not respond to the needs of many patients. Therefore, if a patient resorts to the private health sector or receives medical treatment abroad, s/he will notice substantial differences at the level of provided health care services. Hence, people from poor and vulnerable groups do not have access to such treatments, thereby constituting a violation of the “universal health care” principle.

In order to gain a better understanding of the health situation in Iraq, we will mention a set of relevant demographic facts and statistics. It is also worth noting that this research paper uses the official statistics of the Central Statistical Organization (which is part of the Ministry of Planning) and those which were included in the Ministry of Health

Annual Statistical Report of 2017. The latter report allowed us to gain good insight into the current health situation, whereas we do not believe that there were tangible differences in recent years (i.e., from 2017 until today). Moreover, we will quote some information from a relevant report issued by former Iraqi Health Minister, Dr. Alaeddin Alwan, in July 2019.

Health Indicators in Iraq:

The population of Iraq is about 40 million, with an almost equal male and female ratio. 69.8% of Iraqis live in urban areas, and 30.2% reside in rural areas. The Iraqi society is a very youthful one: 40.5% of the population are below 15 years old, while the number of citizens over 60 years of age is 5%. The Iraqi population growth rate is among the highest in the world (2.4%), and the average life expectancy per capita is 70.3 years (68.3 years among men and 72.2 years among women). The median age of the population is 20.9 years.

After examining health service indicators based on official Iraqi sources – including the Ministry of Health Annual Statistical Report of 2017⁶³ - and in line with progress assessment indicators related to achieving SDG 3 targets, the following results were concluded:

- With regard to maternal and child health, the Iraqi birth rate is 28.05 per 1,000 inhabitants. Women's fertility rate is 4 per woman, and the maternal mortality rate during childbirth is 31 per 100,000 births. Also, 93.7% of births in Iraq were attended by a skilled birth attendant, and 35.2% of births were via Caesarean delivery ("C-section"). The neonatal mortality rate is 13.6 per 1,000 births. Mortality rate for children under one year old is 18.6 per 1,000 live births, while mortality rate for children below five years of age is 23.1 per 1,000 children. Furthermore, the rate of birth defects ("congenital malformations") is 2.9%, and the rate of newborn children weighing less than 2.5 kilograms is 6.6%.

- Regarding indicators of communicable diseases, the rate of HIV/AIDS infection in Iraq is 0.26 per 100,000 population, incidence of tuberculosis is 21 per 100,000 population, and the rate of infection with viral hepatitis B is 5.2 per 100,000 population.
- The general death rate in Iraq is 4.1 per 1,000 population, and the mortality rate of those between 15-60 years old is 2.2 per 1,000 population. The rate of premature deaths from major non-communicable diseases among persons aged 30-70 years is 3 per 1,000 persons. Furthermore, the rate of emergency deaths from the overall number of deaths stood at 11%, and the suicide mortality rate was 0.53 per 100,000 population. Also, death from fatal traffic accidents was 15 cases per 100,000 population.
- The top ten causes of death (from highest to lowest) in terms of percentages were as follows: Cerebrovascular diseases (10.38%), Ischemic heart diseases (9.34%), malignant tumors (9.28%), heart failure (8.48%), kidney failure (6.06%), high blood pressure diseases (5.54%), respiratory and cardiovascular disorders during the neonatal period (4.84%), diabetes (3.79%), combat operations (3.68%), and traffic accidents (3.47%).
- As for the indicators related to primary health care centers, the total number of primary health care centers throughout Iraq was 2,685 centers covering 135 sectors. This included 1,295 main centers, 1,363 sub-centers, and 180 specialized centers. Also, there were 117 primary health care centers for family medicine. Vaccination coverage rates among children were as follows: BCG (Bacillus Calmette–Guérin) vaccine against tuberculosis: 94%, polio vaccine: 86%, and single measles vaccine: 83%.
- As mentioned above, there are 180 specialized centers in Iraq, including 21 for pulmonary diseases, 9 for allergies and asthma, 50 for dentistry, 31 for training, and 100 for other health specializations.

It should also be noted that there are 379 outreach clinics, 254 health insurance-related clinics, 502 health homes [which usually provide physical, mental and/or addiction treatment], and 284 birth and death registration offices.

- With regard to secondary and tertiary medical services, there are 273 public hospitals and specialized centers that include beds, with a total of 44,527 government-owned beds. In these hospitals and centers, there is an average of 1.2 beds per 1,000 population, sleepover rate of 74 per 1,000 population, and death rate of 18.4/0.184 for every 1,000 recumbent patients. The occupancy rate of prepared beds is 49%. Also, there are 1,821 caregivers for premature babies.
- With regard to health personnel in Iraq: In 2017, there were 252,723 health sector personnel from various specializations and levels, including those who are part of the Ministry of Higher Education. Among these personnel, there were 31,451 doctors, with an average of 9.4 doctors for every 10,000 persons. Among these doctors, there were only 11,585 specialized doctors. The number of pharmacists was 10,939, with a rate of 3.3 pharmacists for every 10,000 inhabitants. Additionally, there were 64,297 nurses (at a rate of 20.3 nurses/10,000 population), an average of 2.3 nurses alongside each doctor, and 59,961 other health professionals, i.e., 19 health professionals for every 10,000 inhabitants.

Gaps in Health Education in Iraq:

With regard to health education in Iraq, there are 28 medical schools, 43 schools of dental medicine, 37 schools of pharmacy, 53 health technical schools, 16 nursing schools, 28 health and technical institutes, 59 preparatory schools for nursing, and 18 preparatory schools for midwifery. These schools and institutes are located in different Iraqi regions and governorates. Thousands of medical and health students graduate from them before working in the field, as they get employed by the government in accordance with the law. However, in recent years, due to the small budget and austerity measures, there was a delay in employing many health school graduates, which urged them to demonstrate and demand the fulfillment of their right to be appointed.

As demonstrated in the indicators and official statistics above, we conclude that Iraq has a poor level of health services. Unfortunately, this does not at all correspond with its great economic potential and decades-long history in the field of medical services. The level of services does not meet citizens' needs, and thus fails to achieve the goal of universal health for all. Essentially, the low level of health care services forces many patients to resort to medical clinics and private hospitals or receive treatment abroad, which can cost huge sums of money that poor and low-income patients cannot afford to pay.

Decline in Health Care Services and Health Spending in Iraq:

In July 2019, an important document titled Health Situation in Iraq: Challenges and Priorities of Action was published. This document includes an introduction, several chapters, and a roadmap for universal health coverage, along with strategic orientations for reforming the health system in Iraq. The document also mentions the reasons behind the decline in Iraq's health services. According to the document,

“this deterioration was due to several factors, such as the fact that successive Iraqi governments since 2003 did not consider health as a strategic priority, and budgetary allocations did not meet the needs and aspirations of the population.” The document also states – in an explicit manner - that Iraq failed to achieve the Millennium Development Goals (MDGs) by 2015 with regard to maternal and child health and mortality, due to the poor level of primary health care services.

In addition, the document highlights the urgent need to enhance the water and sanitation sector and reduce environmental pollution. For example, approximately 5 million cubic meters of sewage and wastewater is discharged daily into rivers without undergoing any treatment. The document also states a well-known fact in Iraq, which is that five million citizens (i.e., 14% of the population) lack access to potable water services.

The aforementioned document also discusses the challenges of financing the Iraqi health system. For example, it mentions the dramatic changes in health sector financing within the last decades, such as the transformation from the “welfare state” model (in which the public sector provides free health care to all citizens) to the “self-financing system” (which collects fees from citizens in return for a wide range of health services). In this respect, the document concludes that “the failure to consider health and the environment as main priorities in the programs of successive governments largely contributed to the exacerbation of the health situation in Iraq.” It is also worth noting that government investments in health and environmental aspects is nowhere close to meeting the great challenges and reform requirements of the health system. Moreover, the health sector’s share from the current governmental budget does not correspond with citizens’ needs, whereas the level of Iraq’s spending on health-related matters is among the lowest in the world.

Also noted is the shortage of the health care workforce (such as doctors and nursing staff), poor personnel distribution, insufficient training, and unsuitable working conditions that lead to staff discontentment and aversion.

The said document also provides details about the Iraqi health infrastructure, provision of health services to internally displaced persons (IDPs), and preventive health services (especially those that can reduce major diseases in Iraq, such as chronic communicable and non-communicable diseases and behavioral and environmental risks). For example, it discusses the issue of vaccines, where as many as one-third of Iraqi children do not receive essential vaccines.

The Health Situation in Iraq: Challenges and Priorities of Action document goes on to examine reproductive health and maternal and child care services in Iraq. For example, the presented data shows that about a third of Iraqi women of reproductive age did not receive adequate health care during pregnancy. The document also assesses Iraq's emergency preparedness and extent of meeting the requirements of international health regulations, blood transfusion services, food safety, health information systems, and medicines and medical technologies. It asserts that only 12% of essential medicines were constantly available in 2018, whereas half of these medicines were completely unavailable in different hospitals and health centers in 2019. The document also shows that there is a problem in providing medicines in the private health sector, in a way that is "severe, disorderly, and causing great concern".

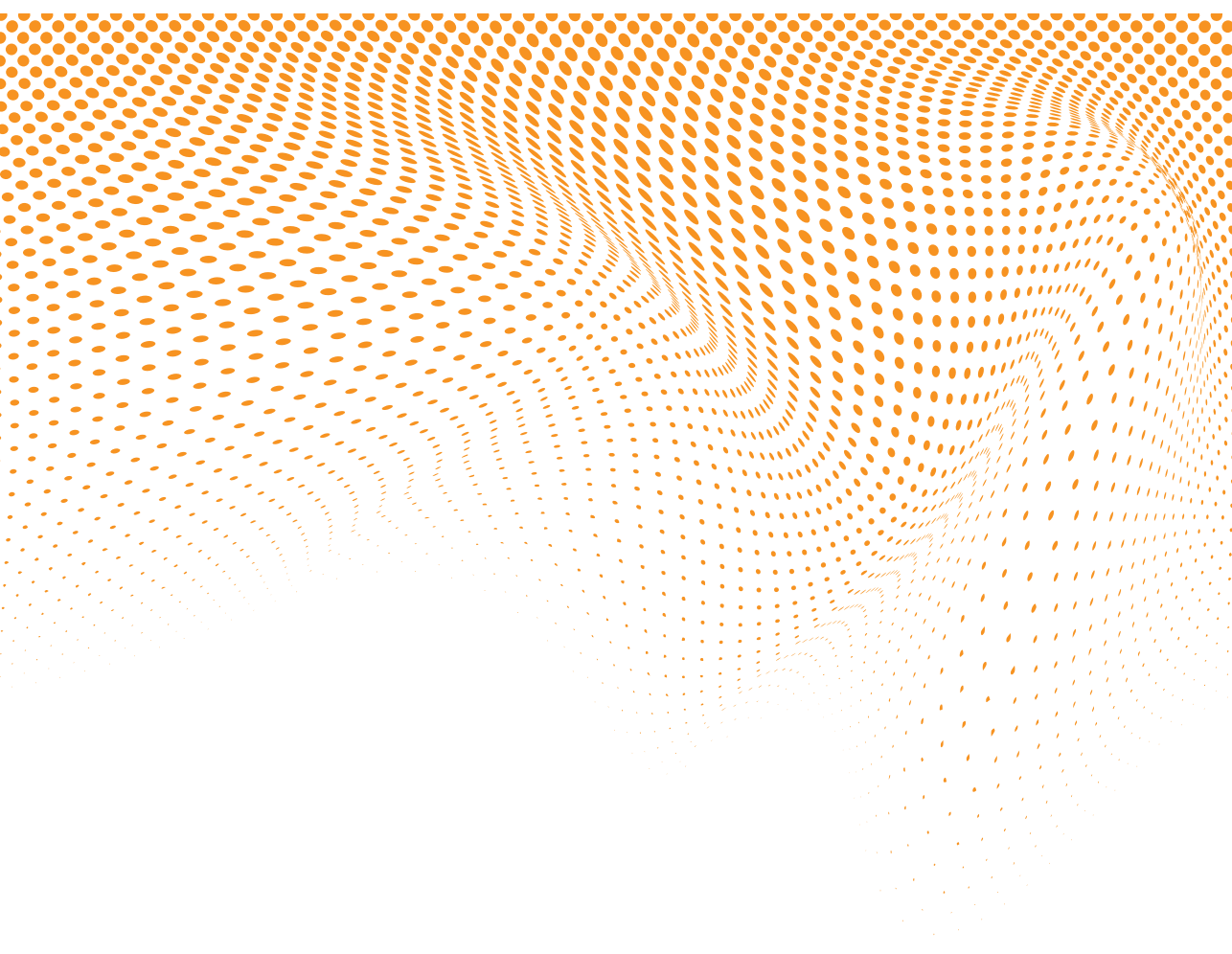
With regard to formulating a roadmap for universal health coverage and strategic orientations for reforming the health sector, the document recommends enhancing citizens' access to high-quality basic health care without bearing any financial burdens. Not less importantly, it recommends reviewing the health financing mechanisms, as well as raising their level and adopting a new approach to preparing governmental budgets. It also suggests the creation of a project for devising a health insurance plan that would be discussed with the Council of Representatives. Furthermore, it calls for increasing the imposed taxes on harmful products, especially tobacco and alcohol.

The above-mentioned roadmap also stresses the need to bridge the health personnel gaps (especially in terms of poor distribution), as well as formulating a crystal-clear action plan for human resources. Principally, it underlines the importance of eliminating the medicine crisis and proposes recommendations in this regard. Moreover, it suggests expanding and upgrading hospital services, reorganizing the pharmaceutical sector, and updating the policies and systems of supplying, storing, and distributing medicines.

Impact of COVID-19 Pandemic on the Iraqi Health System:

Iraq's preventive and health measures did not manage to adequately confront the severe COVID-19, neither at the official/governmental level nor on the societal level. The current health system proved to be unequipped to receive the growing numbers of patients. Many individuals, even those with moderate cases of COVID-19, were forced to continue their treatment at home due to the shortage of suitable beds in health institutions, poor supply of oxygen, and lack of ventilators and intensive care devices. Furthermore, isolation and quarantine measures were not properly applied, and the crisis management team fluctuated between imposing total curfew and opening up some public facilities. On the other hand, many citizens did not adhere to social distancing, quarantine, or other preventive measures. Conversely, false

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rumors were spreading, leading to disbelief in any information about the pandemic. Many people thus resorted to unscientific treatments and methods and refrained from contacting governmental institutions – either out of frustration from the poor services or due to the tendentious parties' discredit of the said institutions. This is not to mention the fear of social stigma with respect to COVID-19 infection, which caused much suffering and ostracism of infected individuals within some communities. All of these reasons combined led to rising infection rates, with up to roughly 5,000 new infection cases each day. The total number of confirmed and declared COVID-19 cases at the date of writing this report (September 12, 2020) was 286,778, with 7,941 deaths and 221,283 recoveries. Currently, there are no signs of any decline in the number of infections. In fact, the number of cases is expected to grow exponentially, especially after removing the curfew and lockdown and people's return to their work in markets, public facilities, government offices, and the private sector.

General Conclusions:

- We are still very far from achieving the goals and targets of Universal Health Coverage (UHC). There needs to be a lot of work to reform the Iraqi health system and to upgrade and geographically expand health care services. This can be done by providing primary health care services to all parts of the country, as well as developing these services vertically in terms of sub-specializations and advanced examinations. Such measures basically require putting health-related aspects at the forefront of governmental priorities, increasing financial allocations for the health sector, ensuring the effective and wise management of resources, and eliminating corruption, squandering, and mismanagement.
- The improvement of the health situation in Iraq requires health infrastructure rehabilitation and expansion; personnel recruitment, training and development; providing health institutions with modern equipment and devices; enhancing preventive measures; and introducing

health promotion and awareness programs for citizens and involving them in health system governance. This can be done in cooperation with civil society organizations, volunteer groups, and unions and professional associations – especially those pertaining to physicians and other health professionals.

- It is also important to put effort in the private medical sector towards improving its related legal, economic and investment environment. It is crucial to give this sector the opportunity to play a supportive role to public sector institutions instead of merely being scattered entrepreneurial projects.
- It is vital to activate the health insurance system for employees (both within the public and private sector) and support vulnerable groups, especially women, children, the elderly, persons with disabilities, displaced persons and those below the poverty line. This can be done by introducing free health care programs and economic empowerment initiatives to improve these groups' quality of life and prevent their infection with many diseases.

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Introduction

This research paper delves into the subject of health care in Palestine. Seeing that health is a fundamental right of every human being, the paper sheds light on the gaps and obstacles that prevent many Palestinians from accessing health and medical services. Another point of focus is the status of Palestinian health services in terms of the size of health care facilities and extent of governmental health spending. These elements are critical for examining the Palestinian health infrastructure's condition and its ability (or inability) to cope with the growing demands and ongoing pressures. This is of utmost importance in light of the COVID-19 health crisis, which presents a significant challenge to the Palestinian health system. Evidently, the pandemic caused serious issues for health systems around the world in light of the ongoing surge in death tolls and infection rates – to the point that public and private hospitals could no longer keep up with the accelerating numbers of new infections.

Those difficulties prevented the Palestinian government from properly carrying out the tasks of developing primary health care services. This, in turn, impeded the ability to upgrade health infrastructures and enhance human resources.

In describing the Palestinian health sector's situation, the study also stresses on the obstacles emerging from the Israeli occupation which obstruct the development of the health sector amidst the challenging economic and social conditions. After all, the health system in the occupied Palestinian territory is under immense pressure due to the effects of colonization; the number one obstacle for Palestinian access to health

As such, we will discuss the restrictions imposed by the Israeli occupation on different Palestinian health institutions (such the monopoly over resources and revenues), which have exacerbated the Palestinian health crisis. We will also highlight different factors that boosted the Palestinian private health sector and weakened individuals' right to

access health services. In this context, we will focus on health sector privatization, its growing influence, and negative effect on people's equitable access to health (especially vis-à-vis marginalized and vulnerable groups in Palestine). In this respect, the different forms and experiences of Palestinian health sector privatization will be set forth.

The Health Sector in Palestine:

Estimates of the Palestinian Central Bureau of Statistics (PCBS) show that the population within the State of Palestine in 2020 was approximately 5.1 million (2.59 million males, and 2.51 million females). According to the same source, children below 14 years of age made up about 38% of the total population (36% in the West Bank and 41% in the Gaza Strip). On the other hand, a decline was noted in the percentage of people aged 65 years and above, whereas they comprised about 3% of the Palestinian population in mid-2020 (4% in the West Bank and 3% in the Gaza Strip).⁶⁴ These percentages indicate that the Palestinian society is very young and requires great efforts for service sustainability of preventive health care.

It is important to note that the population receives curative health services at three levels: I. Health care centers, II. Public hospitals, and III. Specialized hospitals. Health care services are provided by centers belonging to the Ministry of Health, non-governmental organizations (NGOs), United Nations Relief and Works Agency for Palestine Refugees (UNRWA), and Military Medical Services (MMS). The following table demonstrates the distribution of primary health care centers according to the different parties of supervision⁶⁵:

64 Palestinian Central Bureau of Statistics (PCBS), PCBS presentation of Palestinian population statistics on the occasion of the International Population Day. July 11, 2020.

Link: <http://pcbs.gov.ps/post.aspx?lang=en&ItemID=3774>

65 Annual Health Report – Palestine 2019, Ministry of Health, issued on June 2020 (Arabic source). Wafa Palestinian News and Information Agency. Link: https://info.wafa.ps/ar_page.aspx?id=20082

Supervising Party	No. of Centers	Percentage
Ministry of Health (Government)	475	63.4%
Non-governmental organizations	192	25.6%
UNRWA	65	8.7%
Military Medical Services (MMS)	17	2.3%
Total	749	100%

These centers provide general medical services, family planning, medical specialties, oral and dental care, and health screenings and X-rays. However, it is worth noting that most of these services are provided by a small number of facilities and are not covered in all population areas.

We also deduced from the above-mentioned table that the private sector does not invest in primary health care centers (which provide preventive and diagnostic services). Rather, it mainly focuses on complementary examinations, specialized treatments, and distribution of highly profitable medicines and medical goods. Meanwhile, secondary and tertiary health care services are provided in 85 hospitals. The following table shows the distribution of hospitals that are not affiliated with the Ministry of Health according to the sector of ownership:

Sector of Ownership	No.	Percentage
Private Sector	16	28.0%
Non-governmental Sector	38	66.7%
UNRWA	1	1.8%
Military Medical Services (MMS)	2	3.5%
Total	57	100%

Source: Palestinian Health Information Center, Ministry of Health, Palestine, 2019

It should be highlighted that the Palestinian Ministry of Health has 28 hospitals, with a total capacity of 3,531 beds. Hence, the Ministry owns and manages 54.9% of the total number of hospital beds in Palestine. However, all the beds of rehabilitation and physiotherapy centers in Palestine are owned and administered by non-governmental parties.

There are 15 Ministry of Health hospitals in the West Bank, with a capacity of 1,749 beds; which is equivalent to 49.5% of Ministry of Health hospital beds. On the other hand, there are 13 hospitals owned by the Ministry of Health in the Gaza Strip, with a capacity of 1,782 beds (which is equivalent to 50.5% of Ministry of Health hospital beds).⁶⁶

The above-mentioned data indicates that the Palestinian Ministry of Health is the main provider of secondary health care services. In essence, its hospitals provide general surgeries, pediatric services, and treatment of internal diseases, mental disorders, etc. Meanwhile, rehabilitation and physiotherapy services are solely provided by non-governmental organizations. Currently, there are four rehabilitation centers in Palestine, all of which are non-governmental, with a total capacity of 135 beds, i.e., 2.1% of total hospital beds in Palestine.

We also noticed an overlap between secondary and tertiary health care services in several hospitals based on the degree of specialization. For example, there are public hospitals that provide a range of services at different levels, and those comprised 56.6% of West Bank hospitals in 2019. On the other hand, specialized hospitals that provide advanced and holistic secondary and tertiary health care services made up about 18.9% of West Bank hospitals. Maternity hospitals comprised 18.9% of West Bank hospitals in 2019, and rehabilitation and physiotherapy centers comprised 5.7% of West Bank hospitals in the same year. The aforementioned percentages show the range of different services that are provided by public, private, NGO, and UNRWA-owned centers (whereas the latter mainly provide primary health care services to Palestinian refugees).

⁶⁶ Palestinian Ministry of Health, Annual Health Report for 2019, June 2020. <https://rb.gy/wcs0wk>

The Palestinian Ministry of Health covers a large proportion of the provided health services. Evidently in 2019, the bed occupancy rate in Ministry of Health hospitals was 103.4% in the West Bank and 100.1% in the Gaza Strip. Within the same context and in the same year, the total number of visits by patients of outpatient clinics to Palestinian Ministry of Health hospitals was 1,322,056 visits.⁶⁷ However, these figures do not give us insight about the quality of health services in light of the growing demand for such services and the decline of health development budgets.

Health Expenditures in Palestine:

Based on official statistics, the Palestinian health expenditures in 2017 were approximately 1.466 billion USD. However, the following year saw a decline in health expenditures: According to the data of the Ministry of Health Department of Financial Affairs, the budget of the Ministry of Health in 2018 was 1,767,295,225 Shekels.⁶⁸

It is worth noting that the Palestinian government and health care financing systems cover about 33% of health expenditures, whereas Palestinian households contribute the largest percentage of health expenditures (45.5%).

This percentage is considered quite significant, and it is a point of concern as per World Health Organization (WHO) recommendations. Moreover, foreign organizations cover 15.2% of Palestinian health expenditures, and the remaining percentage is covered by non-governmental organizations (NGOs).⁶⁹ It is worth noting here that curative care services constitute the largest share of health expenditures, as

67 Palestinian Ministry of Health, Annual Health Report of 2019, June 2020. Link: <https://rb.gy/wcs0wk>

68 Palestinian Ministry of Health, Annual Health Report of 2018, issued in July 2019. Shortened URL: <https://bit.ly/3aWU9Yr>, Full URL: <https://info.wafa.ps/userfiles/server/202018%السنواتي%20الصحى%20التقرير.pdf>

69 Palestinian Central Bureau of Statistics (PCBS), 2018. National Health Accounts – 2016. Link: www.pcbs.gov.ps. It is also recommended to see the following link: http://www.pcbs.gov.ps/site/lang_en/797/default.aspx?lang=en

they account for 71.7% of total health spending. On the other hand, the lowest percentage of expenditures was for preventive and supportive health services.⁷⁰

In 2016, the Palestinian society spent a total of \$260 million USD on retail and other services provided by suppliers of medical goods; constituting 18.3% of total health expenditures. These figures and percentages clearly show that Palestinian citizens bear the brunt of treatment costs in private clinics and hospitals. Nevertheless, medical care is one of the lowest expenses of the Palestinian society if we compare it with other costs. For example, the monthly expenditure of a Palestinian family of six is approximately 350 Jordanian Dinars (J.D.) for food, 110 J.D. for transportation, 70 J.D. for cigarettes, and 60 J.D. on transportation. On the other hand, a six-person family spends only 50 J.D./month⁷¹ on health care; the greatest part of which is spent on treatment and the purchase of medical supplies.⁷²

It is worth noting that the aforementioned data and figures were not updated to reflect the occurring changes after the COVID-19 pandemic. Although these data and statistical figures are not quite recent, yet they are actually the last data issued by the competent authorities, i.e., the Palestinian Ministry of Health and the Palestinian Central Bureau of Statistics, whereas the latter has not issued any subsequent data or information.

We also do not know when the Ministry of Health will issue a new report about health expenditures in light of the spread of the coronavirus. However, after noticing the divergent health spending rates in 2018, 2019, and 2020, it is possible to predict an increase in Palestinian health spending to confront the global pandemic. As it happens, we have seen a rise in health sector employment rates to alleviate the current health crisis. With that said, it is difficult to make calculations

70 Health Work Committees, Privatization in the Health Sector and Its Effects on Equitable Access to Health Services. URL: <http://hwc-pal.org/files/server/Publications/102معدلة٢٠٠٠نسخة٢٠٠٠الخاصة٢٠٠٠>.
pdf

71 *Ibid.*

72 *Ibid.*

and assumptions due to people's reluctance to go to hospital in fear of contracting the contagious disease in overcrowded areas. Unfortunately, Palestinian hospitals are still suffering from over-crowdedness and congestion due to a health staff shortage of about 2,000 persons. Therefore, based on the need to fill budgetary gaps and increase health personnel expenditures, we expect an increase in health-related expenditures this year. Nevertheless, we hope that the official authorities will release updated data and information on this matter in the near future.

Medical Transfers for Treatment Outside Ministry of Health Facilities:

In 2018, there were 109,818 transfers for the procurement of medical consultation and treatment services outside Ministry of Health facilities, i.e., an increase of 7.15% from 2017. The total cost of these transfers was 725 million Shekels, which is an increase of 68% from the previous year. This is considered a large share from the Ministry of Health budget and expenditures.⁷³ These transfers included medical consultations (31.8% of transfers) and overnight treatment (68.2% of transfers).

The procurement of health services from NGO and private hospitals was as follows: Jerusalem: 38.4%, West Bank: 30.1%, and Gaza Strip: 5.7%, respectively. There were also small procurements from Jordan, Egypt, and Turkey. However, the percentage of procurements from Israeli hospitals was as high as 25%. Despite the GDP slowdown and rising unemployment rates in 2018, health and other services increased to constitute about 61.7% of GDP, whereas vital productive sectors – such as agriculture, industry and construction – did not exceed 21% of GDP.⁷⁴

73 ibid.
74 ibid.

This sharp and unjustified increase in medical transfer expenditures and services negatively affects the ability of public hospitals and health centers to retain qualified employees and provide patients with quality services, medications, and supportive tools.⁷⁵

In light of the rising costs of medical referrals and Israel's withholding of Palestinian clearance revenue, the Palestinian government has been seeking to localize its health and medical services by developing the current health system for the realization of equitable health care and medical services for all citizens. The current political, economic and health conditions – as well as the significant challenges and available capabilities – are also being taken into account, especially in light of the COVID-19 pandemic and its impact on different aspects of life in Palestine.

On this basis, the National Health Committee – established by the Council of Ministers Decision No. (5/7/18/MoH) of 2019 – considers that equitable access to universal health coverage for meeting the basic needs of Palestinian society is a desirable goal that all health sector partners should pursue. Within the framework of achieving universal health coverage in Palestine, it was agreed that the health insurance system should become more holistic, inclusive and mandatory, and must contribute more effectively to health financing. It also urged to formulate executive plans to develop and localize health services at various levels, enhance partnership and integration mechanisms by different health service providers, and provide human, financial and technical resources to implement these plans. It was also agreed to introduce and expand relevant initiatives to systematically raise the level of health care by all service providers, as well as implementing the household health methodology as a practical tool for developing the primary health care system in Palestine.⁷⁶

75 Ibid.

76 As mentioned in the Executive Summary of Decision No.5/07/18 MOH. القرار (القرار 5/07/18/م.و.أ) of 2019.

Factors contributing to the expansion of Palestine's private health sector in light of the poor access to the fundamental right of health care:

There are several factors that led to the growth of private sector investments in health services⁷⁷ and privatization of curative services, such as:

1. Limited government resources: The Palestinian Authority (PA) took charge of the public health services in 1995 when this sector was in a deteriorating condition (similar to those in the poorest developing countries). This was due to the fact that the Israeli Civil Administration had not established any hospitals or health centers. Prior to that, the few medical facilities that were built during the Jordanian rule were in dire need of several additions, such as expansion, maintenance, equipment, and qualified staff. In the absence of financial resources, the PA was unable to finance the investment of major infrastructure projects without obtaining sufficient tax revenues from the private sector. This was vital in order to secure finances for establishing and operating service-providing facilities, particularly in a society that endured long years of occupation, poverty, and oppression, and which could not pay the costs of high-quality medical services. Added to that, the sums that were being collected from health insurance and other fees were relatively small and did not sufficiently cover the developmental needs.⁷⁸

2. Poor quality of services: The lack of material resources led to a shortage of qualified personnel and suitable equipment, thus generating great pressure on public services. For example, public hospitals are still operating with a bed occupancy rate that exceeds their maximum capacity. Basically, the main reason for choosing private health care services has been the weak public sector personnel – who are often unable to perform correct diagnoses and treatments. This is not to mention the negative feedback of many public service recipients,

⁷⁷ Health Work Committees, Op. Cit.

⁷⁸ Ibid.

such as poor diagnoses, countless medical errors, low-quality health services and lack of equipment and medicines. Hence, many citizens feel forced to receive treatment in private or NGO-owned facilities.⁷⁹

3. Pressure to liberalize the economy due to the demands of donors to rationalize expenditures, enable private sector participation in development, raise the level of supply to increase workforce employment, and obtain revenues for boosting performance. This is because health service trade liberalization is an adopted policy of the World Bank, International Monetary Fund (IMF) and World Trade Organization (WTO). The general agreement with WTO also encourages private sector investments in the field of social services.

4. “Brain drain” of medical personnel: Many qualified health personnel have left public hospitals. This is largely due to the fact that the public service system failed to retain distinctive and specialized health sector employees who are seeking better job opportunities in the private sector, both in Palestine and abroad.

Manifestations of Privatization in the Palestinian Health Sector

The statements and results of interviews in the Health Work Committees (HWC) study titled Privatization in the Health Sector and Its Effects on Equitable Access to Health Services⁸⁰ showed the manifestations of privatization in the Palestinian health sector. These include the following:

1. Rising amounts of referrals to procure health services from external facilities (i.e., outside the Ministry of Health). Although the Palestinian government provides these health services to insured persons, their cost in the private sector is much higher than that of the public sector. This comes at the expense of developing public health services and prevents the provision of these services to uninsured poor and marginalized groups.
2. The growing role of the private sector in providing basic services that the public sector is supposed to deliver to all citizens. A large number of private hospitals, health facilities, and laboratories were established in this regard. Meanwhile, the public sector is lacking development funds due to the transfer of a large segment of the public health budget to the private sector.
3. Significant contributions of insured citizens have been going to health care services in both the public and private sector. For example, citizens are paying additional fees and exorbitant prices for examinations and medicines that are not available in public sector facilities.
4. Lack of many necessary medicines and examinations in the public sector. Consequently, many patients are required to undergo complementary medical examinations in external facilities (i.e., outside MOH) and purchase essential medicines at their own expense.

80 Health Work Committees, Op. Cit. Shortened URL: <https://bit.ly/3htXgZf>
Full URL: <http://hwc-pal.org/files/server/Publications/102معدلة20نسخة20-20الخصخصة20دراسة.pdf>

5. The current health insurance system provides a package of services that does not meet patients' needs. For example, private insurance does not cover the treatment of cardiac operations, blood disorders, and other common health problems in the Palestinian society .
6. Citizens' low level of trust in public health services, whereas the prevalent view is that private health care services are much better than public ones.
7. Malfunction of many important diagnostic devices in several public hospitals and health centers.
8. Lack of strategic planning to develop specialized staff and provide adequate facilities and equipment.
9. The relatively few specializations in many public hospitals force many citizens, especially the elderly, to resort to the private sector.
10. Delays and slowdowns in public health services push many citizens to resort to the private sector.
11. Existence of prior agreements between the government and the private sector to provide advanced services in the field of diagnosis and treatment.
12. Many public health professionals also work in the private sector. Therefore, it is possible to visit their private clinics to speed up the obtainment of health services instead of waiting for a long time in public facilities.

Conclusions:

- There is a general trend towards privatization due to the government neglecting its duty to provide some health services (especially secondary services). Although the government procures services for those who have insurance coverage, yet the cost of delivering them through the private sector is much greater than that of the public sector. This substantially diminishes the availability of vital resources and impedes equal access to health care for all citizens (especially for impoverished groups who have no health coverage).
- Despite its efforts, the Ministry of Health failed to raise the quality of its services well enough to curtail privatization policies. Therefore, privatization has grown in many implicit ways. This seriously undermines Palestinian citizens' equitable access to universal health coverage, as well as compels them to incur additional payments for basic health care services.
- Privatization is inflicted upon poor and marginalized groups, as access to quality health care services has become based on citizens' ability to pay. Even services that are covered (directly or indirectly) by the government now necessitate large contributions and fees from insured persons. In other words, all medical procedures, examinations, and screenings now require the payment of additional fees, with an additional contribution requested upon receiving the medical referral. Meanwhile, many treatments are not available at all, and citizens are obliged to buy them at their own expense.
- Privatization negatively affects the quality of services, as it seriously constrains equitable access to health services (which is a most basic quality standard). The situation is expected to further deteriorate in light of the rising poverty and unemployment rates, high cost of treatment in private institutions, departure of qualified personnel from public hospitals, and increased overcrowding of patients over a small number of health professionals. These factors will certainly intensify

the levels of stress and pressure within public health facilities, and inevitably lead to more medical mistakes and communication problems with patients in need of urgent medical care.

- Privatization enhances profit-driven domination over the health sector. The Palestinian government's failure to endorse correct investment mechanisms for developing its hospitals and diagnostic centers and providing adequate personnel training and technologies certainly amplifies the profit-seeking private sector. This often happens under false pretexts (such as "localizing services" or "dispensing with others"). In this context, the privatization alternative is usually presented as "the lesser of two evils," whereas citizens will (unfortunately) be forced to succumb to the new monopolies.

- The absence of laws and legislations to govern the public-private relationship enables a number of influential people in high-ranking positions to privatize some public sector services. This is intentionally done to generate maximum profits at the expense of citizens' right to receive quality health care services.

- The ramifications of the health care privatization deplete a huge part of the Ministry of Health budget instead of investing it for developing public facilities and enhancing personnel capabilities. Privatization also leads to the departure of qualified public health care personnel due to numerous medical transfers to other sectors, both locally and abroad.

- Privatization leads to inequitable access to health services. In for-profit health care, rich and well-connected persons have more access to medical treatment than poor and marginalized patients. Indicators reveal that the ongoing trend toward privatization is also widening the gap between the different groups.

Consequently, you will find that cancer patients and those with genetic diseases are dying from the lack of medical treatment. In the meantime, elderly persons are battling with complications from irregular

treatment and poor access to suitable services (such as in the case of eye and urinary tract problems, osteoporosis, fractures, and chronic diseases). Only a real partnership between all relevant sectors can guarantee a sustainable health system for a people who are struggling for liberation. It must be possible to provide services through an insurance system that involves all related parties.

Recommendations:

1. Create a real partnership between the public, private, NGO and UNRWA sectors, where the private sector would not deliver the same services as those provided by the public or NGO sector. Also distribute services to all different sectors, geographic areas and population centers in an organized manner. The private sector must mainly focus on providing specialized curative services and rare cases, while applying a cost ceiling on hospital treatment (i.e., maximum amounts) that corresponds with the local economic situation.
2. Manage cooperation with the private sector by forming an independent national insurance commission that includes all types of health coverage under a single entity and with a common administrative council. Insurance contributions should be mandatory for all citizens, while taking the income levels of citizens who are paying fees into consideration. Also, establish a single national fund for universal health insurance – to be supplemented with collected government taxes.
3. Fortify the culture of scientific research and development (R&D) among all relevant parties. This should be a precondition before providing a license to all health organizations so that we steer away from the profit-driven culture. Also, it is important to introduce follow-up and accountability mechanisms to know the progress level in [health-related] production.

4. Improve the services of primary health care centers in various governorates in order to reduce the phenomenon of medical transfers. The poor services in primary health care centers were a main focus of this study. It is thus crucial to develop the services therein in a decentralized manner as a first step towards reducing the need for secondary and tertiary health services. This requires the society's willingness to switch to a more effective health model in a way that enhances community involvement in all sectors.
5. Raise the level of citizens' awareness so that they transform their perceptions and strengthen their trust towards public services. This can be achieved by introducing channels of dialogue and discussion based on the principles of respect, transparency, and human dignity.
6. Separate the public-public roles, prevent conflicts of interest (which constitute a violation of the professional code of conduct), and enable legal and human rights parties to hold responsible persons accountable in cases of poor performance.
7. Promote people's health (to the highest extent possible) at relatively low costs and enhance their resilience and steadfastness in the face of challenges emanating from the ongoing occupation of Palestine.
8. Increase the awareness of citizens about their health rights and the available services. It is also important to constantly exert pressure on decision-makers in order to keep improving the quality of public sector services.
9. Develop the services of primary health care centers to reduce the rates of transfers to private hospitals, augment public facilities, and allocate qualified personnel to better regulate overcrowding in departments. Moreover, it is important to increase the work hours of specialized doctors so that they are able to provide health services to patients in need of care in a timely manner.

10. Accelerate efforts for the attainment of social justice in the context of health care. This requires that all societal groups receive health services and can be enhanced by preparing a holistic and mandatory health insurance system.

11. Introduce laws and legislations that define the relation with the private sector and specify its role in providing health services.

12. Conduct a survey about beneficiaries' opinions (i.e., the citizens who received health services) to gain a greater understanding of the occurring privatization and its harmful impact on equitable access to health services.

General Conclusions and Alternatives:

1. Privatization and health: Privatizing this sector affects people's ability to access health care services and facilities and to obtain medical supplies, goods, and medicines. It also presents the risk of departing from the principles of justice, social protection, and health for all. Basically, it paves the way for companies, transnational corporations and international financial organizations (such as World Bank and International Monetary Fund/IMF) to commodify health within the business market. The cumulative effects of several decades of health sector privatization policies (with its various components and functions) have significantly degraded the health scene in terms of inequitable financing of health services and growing financial burdens of households. This degradation was further aggravated by declining state contributions, private health infrastructure developments, and entry of foreign investors. Also harmful was the growing disparity between the public and private sectors in terms of human and technological resources, and the emergence of a new service delivery system that operates at two different speeds based on individuals' income and status of health coverage. The current policy of health sector privatization is part of a global and regional orientation towards brutal capitalism, by which social role of the state is declining, and the momentum of economic globalization is taking precedence.

The Alternative:

- Countries and governments should assume the primary responsibility of guaranteeing all people's equitable access to basic services, especially health care. Accordingly, they must safeguard the access of marginalized and vulnerable groups to health and other social services, provided that they are of good quality, correspond with people's need, and not be based on their financial capabilities.

- It is also pertinent to reform and upgrade health-related systems and services. Primary health care services must expand geographically and become available in all countries. It is also quintessential to develop health services vertically in terms of sub-specializations and advanced examinations. These procedures require prioritizing the health sector in governmental frameworks and increasing their budgetary allocations. It is also important to ensure that these resources are managed wisely and effectively so as to avoid cases of mismanagement and squandering and to eliminate corruption.

- It is imperative for states to reclaim their social role in the health sector. This requires changing the orientations and priorities of political regimes in terms of their view of health and social protection, debt crisis, and funds from the World Bank and IMF. It is also crucial to refrain from putting poor countries under the clout of donor parties and their austerity toolkits and conditions (i.e., structural adjustment policies for the purpose of returning donors' loans).

2. Health under Colonization and Conflict: The health sectors in the Arab world are operating in extraordinary conditions in the face of the Israeli occupation in Palestine and the different wars and conflicts such as in Yemen and Iraq. These factors pose a great threat to human health and the environment. Among other things, the systematic methods have caused impoverishment and displacement, restrictions on food and medicines, and disrupted the implementation of health measures in different areas. These strenuous circumstances, in conjunction with movement restrictions on citizens and goods and the extreme shortage of electrical and fuel supplies, exacerbated economic and health conditions while undermining living standards. This in turn affected health facilities and sewage networks, generated a shortage in medical personnel and vacancies, and hampered the recruitment of qualified professions. All of those stood in the way of properly tackling health challenges in light of the COVID-19 pandemic.

The Alternative:

- Boosting social and health development and eliminating the root causes of health disorders require expanding solidarity networks and social movements (such as anti-colonization movements in Palestine and calls to end the internal strife and armed conflicts in Yemen, Iraq, and other countries).

- Health sector development necessitates the ending of war and conflict and requires rapid intervention to save the economic situation from further deterioration. This will enable countries to increase public health budget allocations, seeing that their economic collapse stemmed from wars and bloody conflicts that clearly exacerbated citizens' suffering and crises. It is also worth noting that war and conflict increased the number of impoverished persons and expanded the level of health inequality in different countries. Therefore, the international community must intervene to save the economy of several countries – especially in Yemen, which suffers from the disaster of famine and the convergence of acute vulnerabilities.

3. The COVID-19 pandemic revealed the truth about health systems in our countries. The eruption of this deadly pandemic exposed the various problems of health sector privatization. On this account, it became crystal-clear that health should not be a commodity to be sold or to generate egregious profits. During moments of hardship, public hospitals were the only ones who admitted COVID-19 patients in different quarantined rooms. Public sector doctors and nurses attended to infected individuals – regardless of whether the patient was a poor citizen or an affluent bourgeois who can afford to receive treatment in or outside the country.

The Alternative:

- It is time to nationalize the public health sector and liberate it completely. In order to confront health sector privatization and defend citizens' basic rights to health, the government must be in charge of services that were assigned to or handled by other parties and actively oppose all forms of handing over public health institutions and services to private investors. Moreover, we must call for the removal of all legislations which stipulate health sector privatization, so that the state is not cornered for public health sector interventions.

4. Health Spending: It has become a common trend for developing Arab countries to throw the burden of health spending on their citizens' shoulders. For example, the percentage of household spending on health in Arab countries ranges between 40% (in the case of Palestine) and 58% (in Morocco). Therefore, Arab citizens and households are now incurring substantial expenditures on health, medical treatments, and medicine. Simultaneously, the role of states in providing equitable access to health has greatly diminished. For example, the amount of annual household spending on health for a family of five in Tunisia is 600 Dirhams (approximately \$65 USD), which is a large amount compared to their low income. Meanwhile in Palestine, the monthly expenditure of a family of six is approximately 350 Jordanian Dinars (J.D.) for food, [more than] 100 J.D. for transportation, 70 J.D. for cigarettes, 60 J.D. on transportation, and 50 J.D. (approximately \$70 USD) on health-care. This shows that Palestinian citizens bear the greatest burden of health expenditures. Evidently, all developing countries carry similar economic burdens while states and governments are giving up their social responsibilities and throwing the health expenditure burdens on their citizens. These policies greatly affect the marginalized groups, and especially the poor persons who cannot afford to pay for medical treatment and stay alive.

The Alternative:

- In order to improve the health situation, governments must increase their health expenditures and avoid marginalizing health care in their general budget. Governments ought to develop and sustain this sector, which is crucial for development, and improve the health services and infrastructure of public hospitals and health facilities in a way that ensures equitable access to health for all societal groups and segments.
- Expand alliances between civil society organizations, social movements, and health and human rights activists to push states to fulfil their social welfare duty and provide basic services (particularly health care) to their citizens for free – or at least with affordable prices that correspond with citizens' financial condition.
- States must rehabilitate and expand public health service infrastructure as well as recruit, train, and develop more professionals. They must also provide equip health institutions with the necessary modern equipment and devices, while focusing on prevention and implementing health promotion and awareness programs for citizens. Citizens must also participate in health system governance through the involvement of civil society organizations, volunteer groups, unions and professional associations, especially those related to the health work force.

5. Health-related legislations and constitutions: Regional countries differ in terms of considering health as a basic human right to be guaranteed by local constitutions and legislations. However, if we look at some countries' health legislations – such as in Morocco, Tunisia, Yemen, Jordan, Lebanon, and Iraq – the right to health was actually stipulated in special legislations on this matter. In fact, all these countries officially acceded to international human rights conventions and covenants. The Iraqi and Tunisian constitutions, for example, mention the right to health, yet the Palestinian Basic Law still did not stipulate this right. Apart from Public Health Law No. (20) of 2004, Palestine also does not have any special legislations that stipulate the right to health. Nevertheless, the various provisions – whether in the framework of the constitution or special legislations – were enforced on the ground in a way that elevates the health status to aspired levels. With all this in mind, we see that there is still a long way to go for these countries to enforce, achieve and facilitate the right to access health services in light of deteriorating health conditions and the absence of a clear vision. In the meantime, however, health systems are providing low-quality services to citizens in an inequitable manner.

The Alternative:

- To amend the constitutions of developing countries and stress in the provisions that the state has the duty to ensure citizens' right to health. Equitable access to health should also be explicitly mentioned in different laws, legislations and regulations, while eliminating the private sector's monopoly over quality health services. Furthermore, the state must accelerate all efforts to strengthen public health care and be the sole party of responsibility to attain citizens' health. The fundamental right to health care must not in any way be compromised, and households should not be forced to incur significant health expenditures from their limited income.

- Provision of universal health coverage, where the state would assume the role of providing comprehensive and mandatory health insurance for all. Accordingly, it would promulgate laws which guarantee the right to equitable access to health care for all individuals, especially the marginalized and vulnerable groups (e.g., the elderly, patients with chronic diseases, women, pregnant women, and children) in a way that ensures social justice for all.

- Strengthen the role of civil society organizations and international coalitions in monitoring and accountability for the enforcement of equitable health care legislations and policies. It is also crucial to develop a clear vision regarding the documentation of health rights violations in the Arab world.

6. Absence of the “universal” and “mandatory” features in actual health insurances: The absence of universal health coverage in most Arab countries and the lack of a mandatory health insurance system for all people is an obstacle for individuals’ equitable access to health. This is particularly the case for the marginalized and vulnerable groups (i.e., the poor, elderly, disabled persons, women, and pregnant women).

The Alternative:

- It is necessary to create a true partnership between the public, private, NGO and UNRWA sectors, where the private sector would not deliver the same services as those provided by the public or NGO sector. Services should be distributed among different sectors, geographic areas, and population centers in an organized manner. Also, the private sector must put its focus on providing specialized curative services and rare/exceptional cases, while applying a cost ceiling on hospital treatment (i.e., maximum amounts) that correspond with countries’ economic conditions.

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- Establish a universal and mandatory health insurance system that corresponds with the financial condition of individuals and groups in order to fulfill states' social responsibilities. Evidently, the absence of a universal and mandatory health care insurance for individuals is a common denominator in the region's developing countries and is the main reason behind depriving citizens of equitable access to health care.
 - Establish independent national insurance commissions in all countries, in a way that includes all types of insurance under a single entity with a common administrative council. Contributions should be mandatory for all citizens, but fees should take the income levels of citizens into consideration. A single national fund must also be established for universal health insurance, to be supplemented with collected government taxes and subject to a formal system of accountability.

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