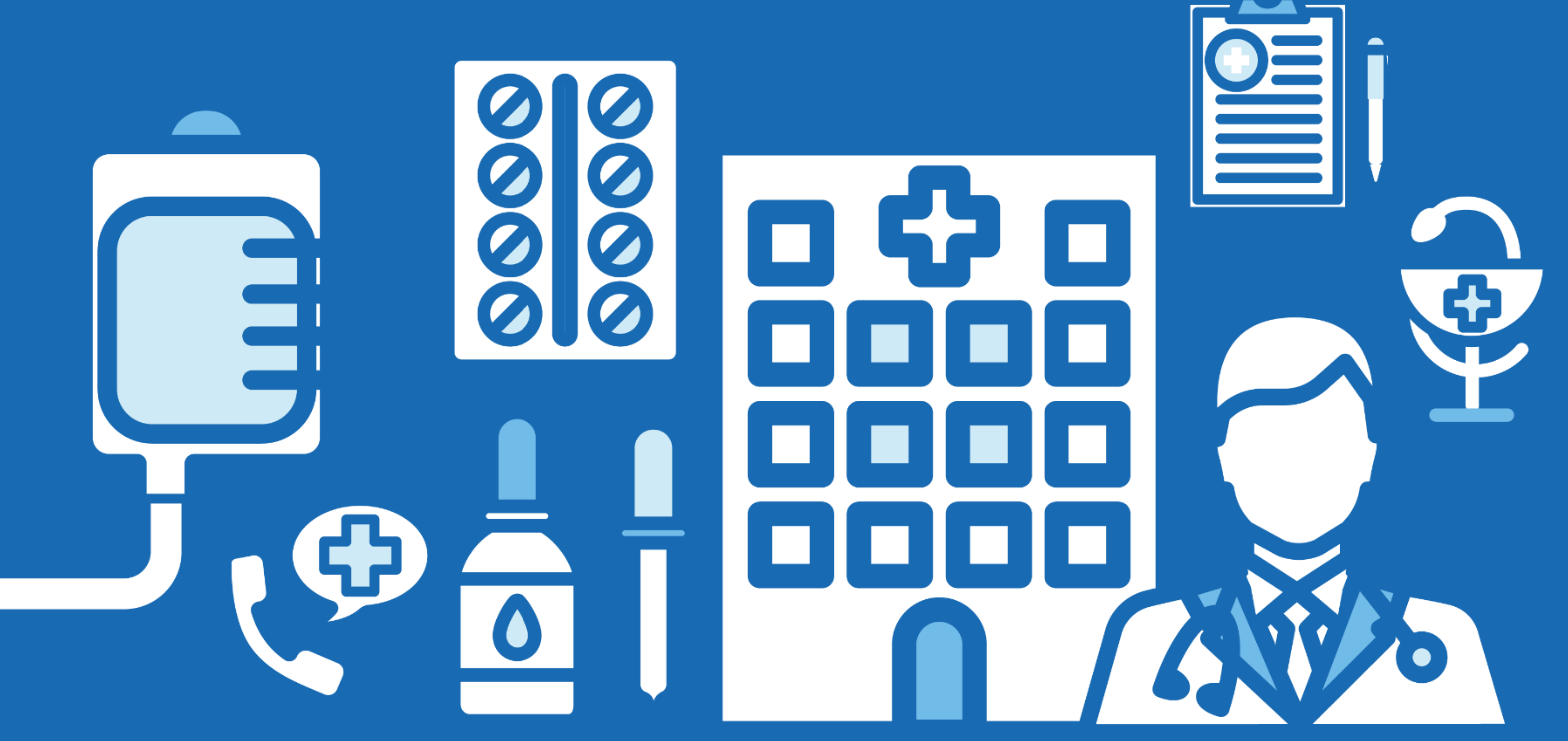

# Enhancing the Competitiveness of the Health Sector in Jordan

## September 2020

The Jordan Strategy Forum (JSF) is a not-for-profit organization, which represents a group of Jordanian private sector companies that are active in corporate and social responsibility (CSR) and in promoting Jordan's economic growth. JSF's members are active private sector institutions, who demonstrate a genuine will to be part of a dialogue on economic and social issues that concern Jordanian citizens. The Jordan Strategy Forum promotes a strong Jordanian private sector that is profitable, employs Jordanians, pays taxes and supports comprehensive economic growth in Jordan.

The JSF also offers a rare opportunity and space for the private sector to have evidence-based debate with the public sector and decision-makers with the aim to increase awareness, strengthening the future of the Jordanian economy and applying best practices.

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# 1. Context and Rational

**Context**

Jordan is classified as an upper middle-income country[1] with limited natural resources. The Kingdom has been experiencing a very high population growth rate over the past two decades, where official Census results indicate that Jordan's population reached 9.5 million in 2015, increasing by almost 86% from 2004. Meanwhile, the Jordanian Department of Statistics estimates the Jordan's population to be 10.55 million in 2019. Jordan's distinct geographic location meant that it had to cope with the repercussions of regional conflicts and instability in the region. Almost all of the country's neighbors have suffered from internal and/or external crises, and due to Jordan's stability, a large number of refugees have fled to Jordan, thereby contributing to the increased population growth rate of the country, and generating considerable pressure on the Kingdom's infrastructure including on its healthcare infrastructure. The Kingdom has built a reputation as one of the most desirable locations in the region for medical tourism receiving hundreds of thousands of patients from neighboring countries annually.

**Rational**

By the beginning of 2020, the novel COVID-19 virus outbreak took the world by a storm, impacting both human health and the economy. The short-term implications of this pandemic are evident across the globe, but long-term impacts are yet to be clear. In specific, the pandemic highlighted the fragility of health systems across the globe. Jordan was quick to act with strict measures taken to prevent the spread of the virus out of fear of a potential collapse of the healthcare system in the country. This meant that the economy had to suffer from more than 2 months of total lockdown, which adversely impacted an already fragile economy. **The healthcare system in Jordan was found to be unprepared for such a health shock, despite the high level of health expenditure in Jordan**. Consequently, more attention should be paid to healthcare systems and the healthcare sector in general to be better prepared for future shocks.

The paper aims to identify and elaborate on the main challenges facing the Health Sector in Jordan and its competitiveness, in addition to outlining a way forward for the sector. It will entail an exploration of the structure, governance, and finance of the Kingdom's Healthcare Sector. It will also investigate the main health insurance system framework in Jordan.

The paper will aim to answer the following question:

| What is the way forward for the Jordanian Health Sector to enhance its competitiveness and effectiveness? |
|---|

[1] World Bank << https://www.worldbank.org/en/country/jordan/brief/qa-jordan-country-reclassification >>

To do so, the paper will also address the following sub-questions:

- Where does Jordan rank/place internationally?
- To what extent the Jordanian health sector is efficient and effective?
- How is the health sector governed?
- What is the insurance framework in Jordan and how is it governed?
- Is Jordan's health financing sustainable?
- What are the challenges facing the Health Sector in Jordan?

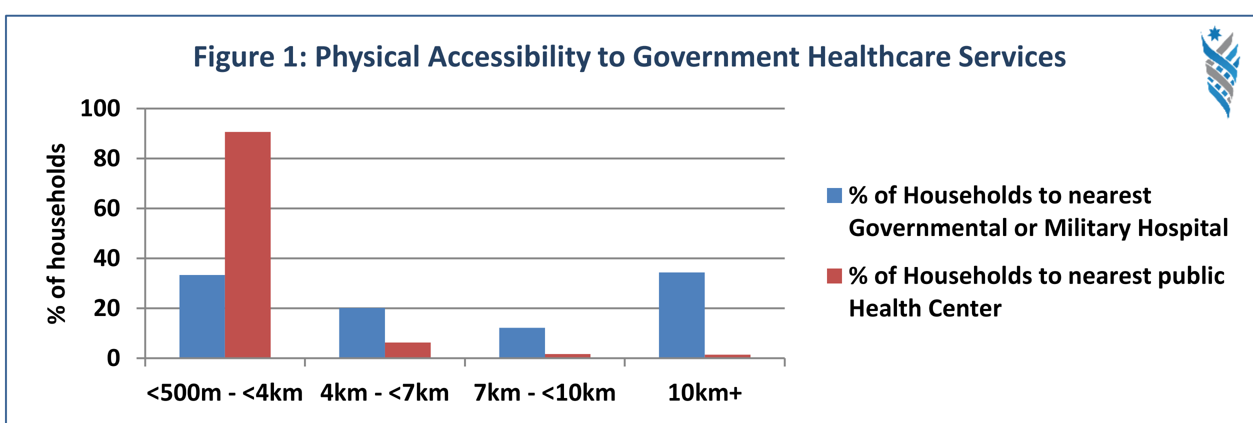
The analysis will be built on extensive desk-based research and consultations with key stakeholders to ensure practical recommendations for the way forward.

# 2. Background

**Overview of Jordan's Health Sector**

Healthcare services in Jordan can be divided into 'primary', 'secondary', 'tertiary and quaternary healthcare, with each representing increased levels of specialization and catering to smaller number of patients who would be filtered out at the lower levels. According to the **WHO**, the vast majority of patients can be fully dealt with at the Primary level.

The public healthcare system in Jordan functions on the following basis[2]: Jordanian citizens who are in need of healthcare services must first go to the Health Center in which he/she is registered in (in other words, the nearest Health Center) in order to receive treatment (i.e. Primary care). Should the doctor determine that the patient is in need of a higher level of treatment, he/she would be referred to either a Comprehensive Health Center or a governmental hospital within the governorate (i.e. secondary/tertiary care). In the event of the patient needing a service not offered in either the governmental hospital or the Comprehensive Health Center, he/she would be referred either to a Royal Medical Services (RMS) Hospital or to a University Hospital (i.e.. tertiary and quaternary healthcare). As a last resort, the patient would be referred to private sector hospitals, to the King Hussein Cancer Center in the event of the patient suffering from cancer, or health facilities outside the Kingdom (i.e.. tertiary and quaternary healthcare).
Currently, there are 112 Comprehensive Health Centers, 375 Primary Health Centers and 190 Peripheral Health Centers spread all throughout the Kingdom. In addition, the Ministry runs 505 Maternity Centers and 405 dentistry clinics[3]. It is estimated that there are 9 Health Centers for every 100,000 Jordanians, which is very close to the recommended average of 10 Health Centers for every 100,000 citizens stipulated by the World Health Organization[4]. The Ministry of Health runs these centers and clinics in addition 32 hospitals which provide secondary- and tertiary-level care




Physical access to healthcare services is not truly a problem, as most Jordanian citizens (90.6%) live at a distance of 4km or less from a health center.

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[2] Information from 'Official Instructions on Referrals'
[3] Information taken from the Ministry of Health Strategy 2018-2022 (p.20) Note: The number 505 was provided by the Ministry of Health.
[4] The 9/110,000 figure taken from the DOS 2015 Population and Housing Census

Similarly, with economic access, Jordanian citizens do not incur significant costs when attempting to access healthcare service and out-of-pocket health payments are low. Estimates suggest that subsidized public healthcare services bring down the price of healthcare to around 20% of their cost. Moreover, multiple insurance schemes for a majority of the Jordanian population means that patients pay little when receiving healthcare. Finally, exempted patients do not pay anything to access healthcare services. All this translates into a relatively low share of Out of Pocket (OOP) Payments of households.

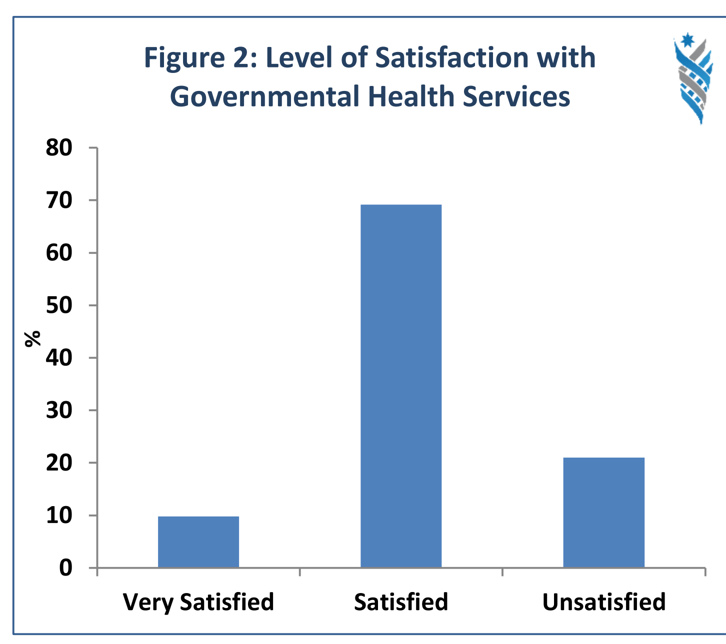


Figure 2: Level of Satisfaction with Governmental Health Services

**Accessibility of the healthcare services does not necessarily mean that Jordanian citizens are fully satisfied with the quality of the services provided.** Although there are no official studies carried out on the quality of the services provided by Health Centers, and despite the fact that most citizens (79%) are satisfied with Governmental Health Services, complaints have long been raised on the services provided in Health Centers, which forces citizens to go directly to hospitals to seek treatment – even if such high-level of care is not warranted.

The Jordan Vision 2025 document explicitly states that, among its key priorities are "improvements to the quality and cost of care in the healthcare system"[5]. Although there are few official documents containing information on the quality of the services provided, different scattered documents and reports written over the past decade give an idea as to the quality of the services provided, and the Ministry has stated that there are **disparities in the quality of the healthcare services provided between rural and urban areas**[6].

[5] Jordan Vision 2025
[6] Information provided by the Ministry of Health

# 3. Jordan's Healthcare Competitiveness

Jordan's competitiveness position in healthcare is assessed by looking at Jordan's position compared to other countries in the following indicators: health expenditure, out-of-pocket expenditure, life expectancy at birth, mortality rates (Maternal & Under 5), cause of death, universal health coverage index, service capacity (Hospital & Health Workforce Density), and finally global health security index. The table below summarizes these indicators:

| | Health expenditure | Out-of-pocket expenditure | Life expectancy at | Mortality rate | | Cause of death by NCD | Universal health coverage tracer index (0- | Service capacity | | Global health security index |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Maternal | Under 5 | | | Hospitals | Health workforce density | |
| Jordan | 8.12% | 30.43% | 74.3 | 58 | 17 | 78 | 76 | 1.4 | 2.3 | 42.1 |
| MENA Average | 6.7% | 34.26% | 74 | 57 | 22 | 75 | 68.53 | 1.6 | 1.3 | n/a |
| Upper Middle-Income Average | 5.84% | 32.87% | 75 | 57 | 13 | 83 | 74.96 | 3.5 | 2.0 | n/a |
| World Average | 9.9% | 18.21% | 73 | 211 | 39 | 71 | 65.96 | 2.7 | 1.6 | 40.2 |

Source: World Bank Development Indicators
WEF Global Competitiveness Report
Global Health Security Index Report
EDA and SDSN, Arab Region's SDG Index and Dashboard Report 2019

Overall, the ranking of Jordan in all these areas is relatively good. Out of the above indicators, the first two are most relevant to this study.

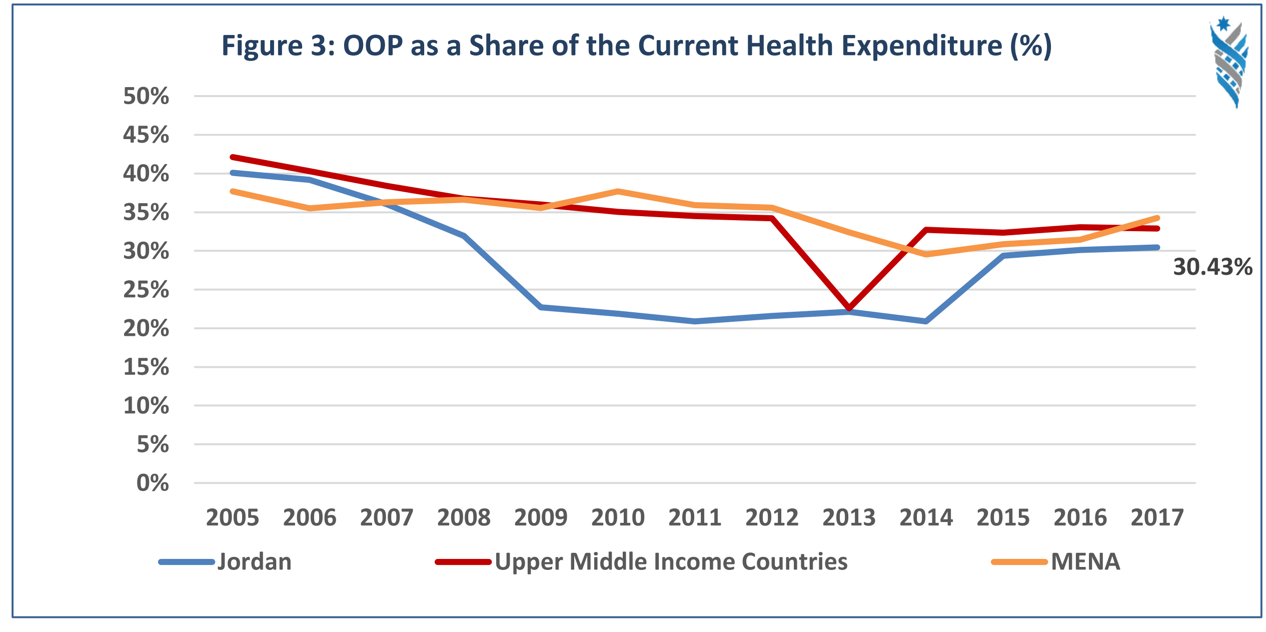


Figure 3: OOP as a Share of the Current Health Expenditure (%)

[7] 2017

Jordan spends a considerable share of its GDP on health (8.1%), higher than both the MENA average and average of upper-middle income countries. According to Jordan's Vision 2025, the high levels of health expenditure, estimated to make up 8.12% of the national GDP[8], will continue to drive growth in the sector in the short and medium term.

The country also experiences relatively low out-of-pocket expenditures at 30.4% of health expenditures which is lower than both the MENA average and the average of upper-middle-income countries. In the specific context of Jordan, the levels of out-of-pocket expenditure can be largely attributed to payments made to the private sector, given that a significant share of the population is insured and the rest are either exempted or pay a subsidized price at MoH facilities (equivalent to around 20% of cost). In other words, most of those receiving care at public sector health facilities do not incur significant payments, indicating that most of out-of-pocket expenditures go to the private sector.

With regards to the remaining indicators, Jordan fares relatively well with a relatively good life expectancy and mortality rates, as well as a good score on the universal health coverage index[9]. On the other hand, Jordan's performance is relatively worse with regards to high rates of death caused by NCDs in addition to weak service coverage in terms of number of hospitals relative to the population.

Finally, Jordan's relatively good ranking in the global health security index is worth an in-depth look. The Global Health Security Index is the first comprehensive assessment and benchmarking of health security and related capabilities across the 195 countries that make up the States party to the International Health Regulations (IHR 2005)[10].

The Index has six constituent categories. Each country is given a score and respective ranking across each of the categories and according to their performance across all indicators are placed in a comprehensive ranking. The six categories making up the GHS Index are:

1) **Prevention** of emergence or release of pathogens.
2) **Detection and Reporting** for epidemics of potential international concern.
3) **Rapid Response** to and mitigation of the spread of an epidemic.
4) **Health Systems** that are sufficient and robust to treat the sick and protect health workers.
5) **Compliance with International Norms** and commitments to improving national capacity and financing plans to address gaps and achieving and adhering to global norms.
6) **Overall Risk Environment** and country vulnerability to biological threats.

[8] World Bank Data
[9] This index is concerned with all people and communities receiving the quality health services they need without incurring financial hardship.
[10] Global Health Security Index Report, 2019

| GHS INDEX | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Overall | Prevention | Detection and Reporting | Rapid Response | Health Systems | Compliance with International Norms | Overall Risk Environment |
| Jordan | 80th | 97th | 83rd | 50th | 79th | 96th | 99th |
| | 42.1 | 31.8 | 42.9 | 47.8 | 27.8 | 48.6 | 55.8 |
| Average Score | 40.2 | 37.8 | 41.9 | 38.4 | 26.4 | 48.5 | 55.0 |

Jordan's scores across the six categories of the Index are mirrored and reflected in their response to the COVID-19 pandemic. Examining the Index, we see that Jordan ranks poorly in the 'Prevention' Category but ranks relatively well in the category concerned with 'Rapid Response'. This becomes evident upon examining recent events and Jordan's response and measures in relation to COVID 19. Although characterized by relative high health expenditure and health worker density, Jordan's health system is fragile and easily overwhelmed with a hospital bed availability of merely 1.4 beds per 1,000 of the population. Hence, **the health system may find it challenging to deal with the large case load that would accompany a sharp rise in COVID-19 cases.** This is also attributed to the fact that Jordan is a relatively poor country with high budget deficit and relatively high reliance on public health services.

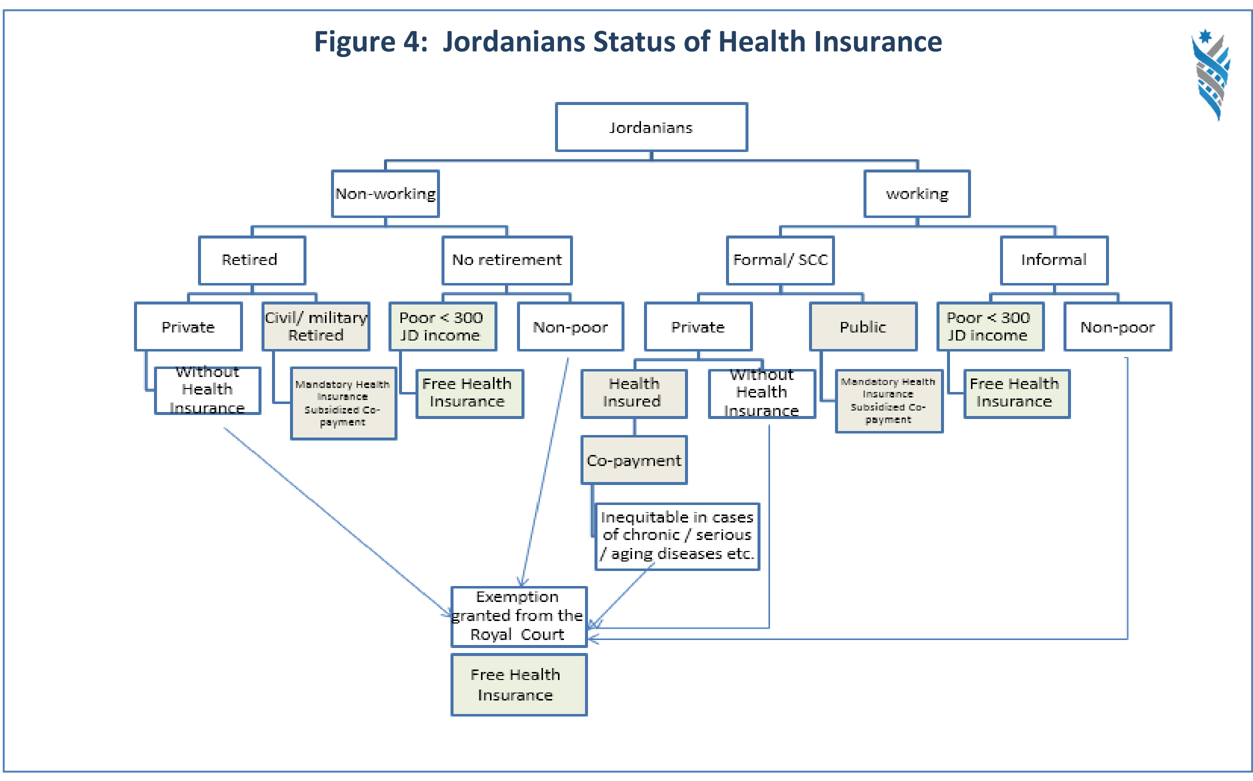
# 4. Healthcare in Jordan: Insurance & Financing

## Universal Health Coverage and Health Insurance

A number of different health insurance schemes exist in Jordan, rendering the overall framework for health insurance fragmented and inefficient in its use of resources. Not only this, but the provision of healthcare services at below-market prices (20% of cost), in addition to exemptions of healthcare fees granted to many Jordanians, increases the complexity of analyzing the situation of health insurance in Jordan and its financing. According to a World Bank review[11], this system makes it difficult, if not **impossible, to assess or measure the actual cost of providing services**.

A significant share of Jordanians are health insured, or receive free healthcare. A comprehensive illustration of the status of health insurance for Jordanians is shown in the figure below. It shows how a large number of categories of Jordanians are health ensured or receive exemptions from healthcare fees. This, as explained earlier, contributes to comparatively lower out-of-pocket expenditures.

**Figure 4: Jordanians Status of Health Insurance**




According to the Housing and Population Census carried out in 2015, 64% of Jordanians are insured by at least one type of health insurance, and 4.7% receive free health care services, putting the total at 68.7% of Jordanians. Moreover, health coverage is relatively decent as per the World Bank, the Universal Health Coverage service coverage[12]. Jordan scored 76 out of 100, above the average MENA score 68.53 and the average global score of 65.96.

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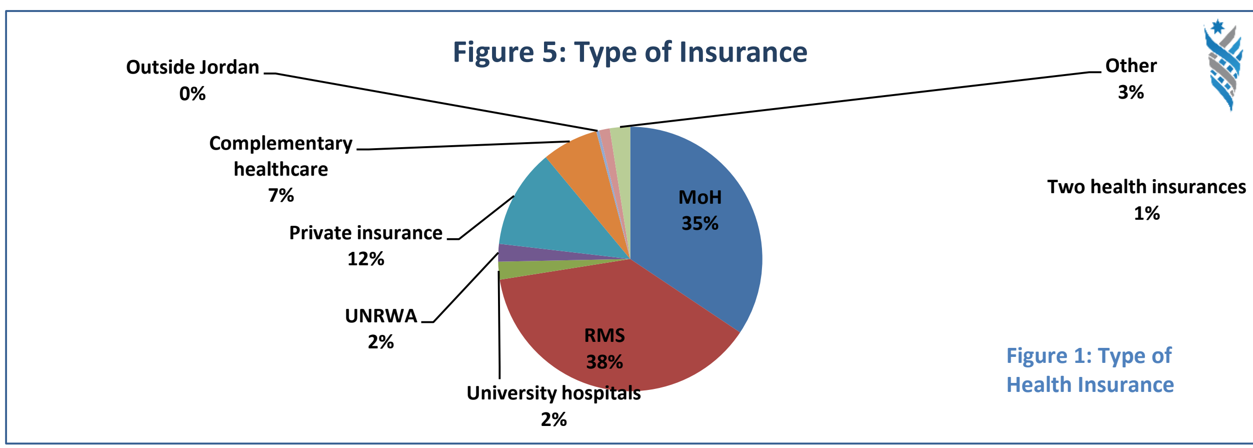
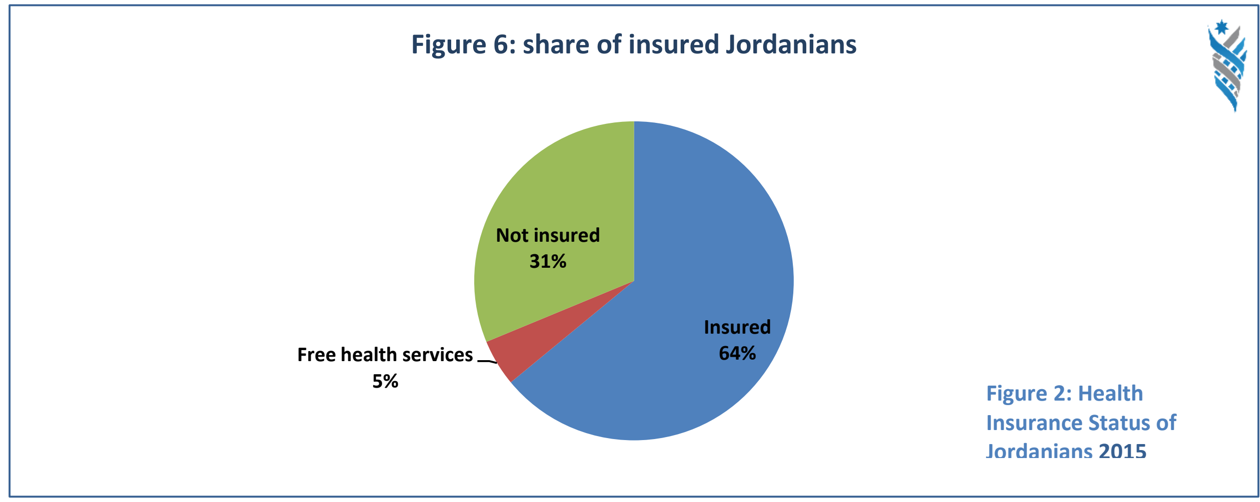
[11] World Bank (2014) "Towards Universal Health Coverage: A Comprehensive Review of the Health Financing Systems in Jordan"
[12] World Bank (2017) "Tracking Universal Health Coverage: 2017 Global Monitoring Report"

The majority of insured Jordanians are covered through the Civil Insurance Program (CIP) administered by the Ministry of Health (MoH), the Military Insurance Program (MIP) administered by the Royal Medical Services (RMS) under the Jordan Armed Forces, and private insurance. 38.1% of insured Jordanians are covered by the RMS, 34.4% by the CIP/MoH, and 12.1% are covered by private insurances. In addition to this, 6.9% receive 'complementary healthcare' which puts the total Jordanians covered by CIP/MoH at 41.3% of insured Jordanians. This means that t**he government is the principal financer of health services, operating the two major insurers in Jordan**.

Further, estimates indicate that a significant share of those who are insured (around 8%) are insured by more than one type of health insurance. For the uninsured Jordanians, they pay a subsidized price (20% of cost) for select inpatient and outpatient services at the MoH facilities or pay full cost at private facilities.

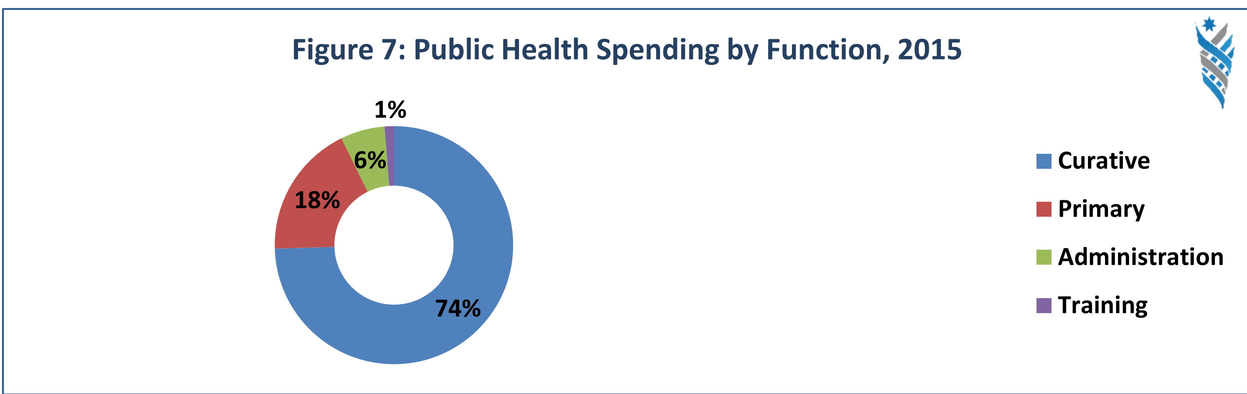
The below charts have been prepared from the 2015 Census results and illustrate the share of insured Jordanians as well as the type of health insurance covering them. Together, both RMS and CIP insurance schemes cover 72.5% of insured Jordanians.



## Health Financing

According to the latest available National Health Accounts (2015), Jordan's healthcare expenditures more than doubled in nominal terms, in the period 2007 and 2015, rising from




JD1.02 billion in 2007 to JD2.2 billion in 2015. As a share of GDP, total health expenditures increased 8.3% of GDP in 2007 to 8.9% of GDP in 2017[13].

While the system is providing effective health protection and lessening the burden of healthcare costs on the general population in general and on the poor in specific, **the financial implications have been burdensome and the economy is facing a severe financial crisis in attempting to meet the health care needs of the population** mainly due to inefficiencies in service delivery, fragmented insurance and delivery systems, inability to control utilization, and growing demand from refugees among other things[14]. Furthermore, curative care dominates over other health spending functions, illustrating the inefficiencies in the system and thus the higher costs involved. This means that there is scope to increase the allocative efficiency through shifting spending towards health promotion and disease prevention, that can be managed by primary health centers.

Due to all these issues**, health arrears have been accumulating over time.** By the end of 2017, Jordan had a **health services debt exceeding JD442 million**, including JD342 million accumulated though the end of 2016 with an additional JD100 million added in 2017 alone (30% increase)[15]. This means that the health sector lost JD100 million in 2017 alone, and has added this figure to an already mounting pile of health arrears.

Given the above overview of Jordan's health insurance system and its relative positive outcomes over the past decade, it is clear that the most problematic issue stemming out of the system is its **weak financial sustainability** resulting from a mix of different factors.

As can be concluded from the above analysis, the financing of Jordan's healthcare system is largely unsustainable and is leading to the accumulation of significant arrears. This is largely

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[13] Jordan National Health Accounts for (2016-2017) Fiscal Years, High Health Council (JO)
[14] USAID Health Finance & Governance Activity (2018) "Diagnostic Study of Selected Public Insurance Payers: Equity and Sustainability
[15] UNICEF (2017) "The cost and Financial Impact of Expanding the Civil Insurance Program to Vulnerable Jordanians and Syrian Refugees"

due to the governance and complexity of healthcare financing in the Kingdom that include large inefficient insurance schemes coupled with subsidized prices and exemptions. The prices of public healthcare services have been frozen since the 1990s and currently make up around 20% or less of the full cost of the service[16]. As an example, the MoH fee for normal delivery is set at an average of JD50, whereas a delivery at the King Abdullah University hospital is charged at JD500[17]. Such discrepancies meant that the MoH misses out on substantial needed revenues. For example, in 2016, the MoH lost out on more than JD32 million in revenues[18]. And for most Jordanians who lack any formal insurance coverage or do not have the means to pay for healthcare (even at subsidized prices), they can receive exemptions for medical treatments by the Royal Court and the Prime Ministry.

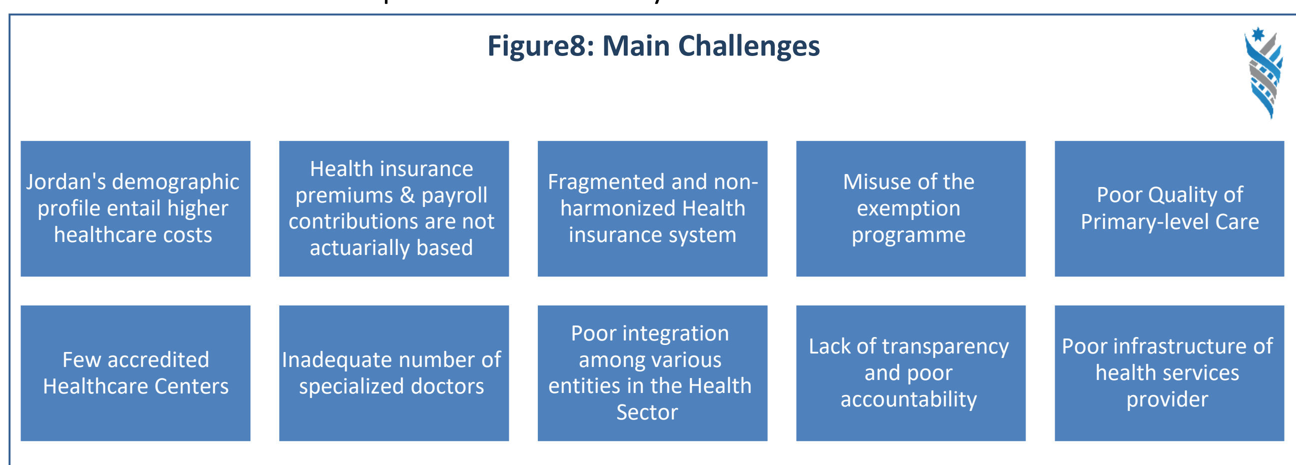
According to the National Health Accounts (2015), the government is the main source of healthcare financing, **with the Ministry of Finance contributing JD893 million in 2015, or 38.1% of total financial flows.** The second largest source of funding is **households, contributing JD731 million or 31.1%**, which is the share of out-of-pocket payments. On the receiving end, private facilities receive most of the healthcare financial flows in Jordan, reaching JD735 million in 2015, making up 32.7% of total financial flows. After private facilities, MoH facilities and RMS facilities received JD573 million and JD383 million respectively, making up 25.5% and 17% of total financial flows. It is interesting to note that the majority of funds flowing into MoH facilities originate from MoH, ***showing how MoH is both a purchases and provider of services. Given that the CIP is under the MoH, then we can consider the MoH to be the insurer, purchaser, and provider of services. The case is similar to the RMS.*** Such a governance structure entails large ramifications regarding the quality and financial sustainability of public healthcare in Jordan.

[16]IMF (2018) "Public Expenditure Review and Rationalization: Issues and Reform Options"
[17]USAID (2018) "Health Financial Flows, Revenue, and Cost Optimization: Efficiency Strategies to Support Financial Sustainability of the Health System in Jordan.
[18]MoH Statistics Book 2016

# 5. Challenges

This section will present the challenges of the overall healthcare system as well as of the health insurance framework in Jordan. For the healthcare system as a whole, the main challenges are related to **the quality of healthcare**, **poor utilization of primary healthcare services**, and an overall sub optimal quality of services provided. The main challenges faced by the health insurance framework lie in its **weak financial sustainability** along with **equity issues**. In contextual terms, the main challenge will be to meet higher health spending over the medium and long term, given Jordan's demographic profile. In terms of the health insurance framework itself, fragmentation and lack of planning and proper management have driven inefficiencies and inequities across in the system.

**Figure8: Main Challenges**




- **Jordan's demographic profile entail higher healthcare costs in the medium to long run which are unsustainable given the status quo of the system.**
  The demographic profile of the Jordanian population will entail rising health costs on the medium to long term, translating into higher healthcare financing needs. The proportion of elderly population over 60 (who are granted free health insurance by the CIP) is projected to grow to 13% in 2050 compared to only 3% of the Jordanian population in 2010[19]. Also, since the decision to include the elderly aged 60 or above into CIP is relatively new, more and more elderly people will be joining the CIP in the coming years. All this means that health financing pressures will only increase with time, and will bear a greater influence on overall public financial management and contribute to an expansion in debt levels.

- **Health insurance premiums and payroll contributions are not actuarially based; MoH charges on the 'uninsured' are very low and do not reflect the true cost, resulting in substantial arrears.**
  The CIP and MIF are mainly financed through low payroll contributions, premiums and copayments that do not reflect the cost of services provided and which were not revised to account for price increases over the years. This is a main driver behind the accumulation of health debt over the past years, and is a main obstacle in front of the financial

[19] World Bank (2014) "Towards Universal Health Coverage: A Comprehensive Review of the Health Financing Systems in Jordan"

sustainability of the public health insurance schemes. In fact, a significant source of health funding in Jordan are general tax revenues raised by the Ministry of Finance, as payroll contributions, premiums, copayments, and charges are too low to cover the necessary expenditures[20].

Low premiums, copayments and charges not only fall short of covering the total costs involved, but also encourage excessive usage and waste of medical resources[21]. Furthermore, copayments are considered to be very low for individuals who have the financial means to cover expenses, a matter which undermines equity of the system[22]. Charges remain at 20% of the full cost, and have not been updated since the 1990s[23]. According to the World Bank review[24], the subsidized services are comparatively generous and not based on assessments of evidence of cost-effectiveness. All this is in spite of the fact that relevant legislation requires authorities to regularly update rates and charges.

- **Health insurance system in Jordan is fragmented and non-harmonized, which yields an inequitable system. No reconciliation of revenues and costs takes place, and no reimbursement accountability.**
  The nature of Jordan's health insurance system is fragmented and complex, with various insurance schemes in operation including the two main insurers (CIP and MIP) as well a number of other schemes by universities, syndicates, UNRWA, and private firms. Estimates indicate that about 8% to 10% of the population have multiple insurances, as a Jordanian can be both a CIP principal member and MIP dependent member at the same time[25]. Therefore, there are significant overlaps due to this fragmented system, and thus, opportunities for abuse or arbitrage across different insurance schemes emerge[26].

  The fragmentation results in inefficiencies in the production of health care services due to lack of appropriate contracting between the different players. In other words, this situation involves different payers and providers trying to find effective ways to reimburse one another, but in Jordan, the transfer of funds between public providers is not done on the basis of formal contracting, but rather by ad-hoc transfers through budget line items[27]. There is no commitment control system.
  The fragmentation in the system also leads to a range of separate revenue mobilization policies. This fragmentation on the revenue side entails additional fragmentation on the pooling of revenues and on the provision of services. This translates into revenue mobilization policies that are inadequate to sustain funds.[28]

[20] World Bank (2014) "Towards Universal Health Coverage: A Comprehensive Review of the Health Financing Systems in Jordan"
[21] IMF (2018) "Public Expenditure Review and Rationalization: Issues and Reform Options"
[22] USAID (2018) "Health Insurance Legislative Review"
[23] IMF (2018) "Public Expenditure Review and Rationalization: Issues and Reform Options"
[24] World Bank (2014) "Towards Universal Health Coverage: A Comprehensive Review of the Health Financing Systems in Jordan"
[25] IMF (2018) "Public Expenditure Review and Rationalization: Issues and Reform Options"
[26] IBID
[27] World Bank (2014) "Towards Universal Health Coverage: A Comprehensive Review of the Health Financing Systems in Jordan"
[28] Ibid

Furthermore, the benefits packages offered by the CIP, MIP and some other public programs are broad, generous, and non-harmonized, which further contributes to the overall fragmentation of the system[29]. Packages vary widely not only across but also within public providers, reinforcing the fragmentation of the system, and making the system less equitable. For example, high ranking officials get much better access and benefits than the poor or other vulnerable categories.

The two main public insurance schemes in Jordan entail the same purchaser and provider of health care services (MoH/CIP and RMS/MIF). The CIP does not pay the providers in its home network (i.e. MoH hospitals) for the provided services and collections from other players is not directly reimbursed to the providers. This means that the revenues collected are not being used to cover the providers' costs, which translates into revenues and costs not being reconciled[30]. In other words, the public system is designed to avoid pricing and reimbursement accountability through a lack of separation between payers and providers[31].

- **Misuse of the exemption programme, which contributed to the bulk of health arrears and hinders expansion of formal coverage**

  Almost all recent studies conducted on the Jordanian health insurance landscape point towards the unsustainably large value of exemptions provided to uninsured Jordanians. As stated earlier, Jordanians who lack any health insurance or means to pay for healthcare can receive medical assistance through the Royal Court and other agencies. In 2013, this assistance or exemptions reached JD180 million to treat 110,000 cases, mostly outside of MoH facilities. Costs related to this exemption program have escalated well above the allocated amounts in recent years, and has therefore become another main source of health arrears.

  Such a lax exemption program undermines efforts to expand formal coverage through other more structured and effective programs[32]. It also acts as a disincentive for people to remain uninsured. A major drawback of the program is that much of the spending by the Royal Court and Cabinet on medical treatment exemptions occurs on an ad-hoc basis and goes to non-poor persons[33]. According to the IMF[34], the program was originally intended to support poor uninsured Jordanians who cannot afford healthcare costs, but it has been misused due to lack of controls over quality and costs. To further illustrate the problem, Jordanians with private insurances use this program, and some public sector employees temporarily drop out of the CIP to obtain exemption before re-instating membership later[35]

[29]Ibid
[30]USAID (2018) "Review of Medical Fee Schedules: MOH (Civil Insurance Fund) and Jordan Medical Association"
[31]Ibid
[32]Number of studies arrived to this conclusion including IMF and USAID studies
[33]UNICEF (2017) "The cost and Financial Impact of Expanding the Civil Insurance Program to Vulnerable Jordanians and Syrian Refugees"
[34]IMF (2018) "Public Expenditure Review and Rationalization: Issues and Reform Options"
[35]Ibid

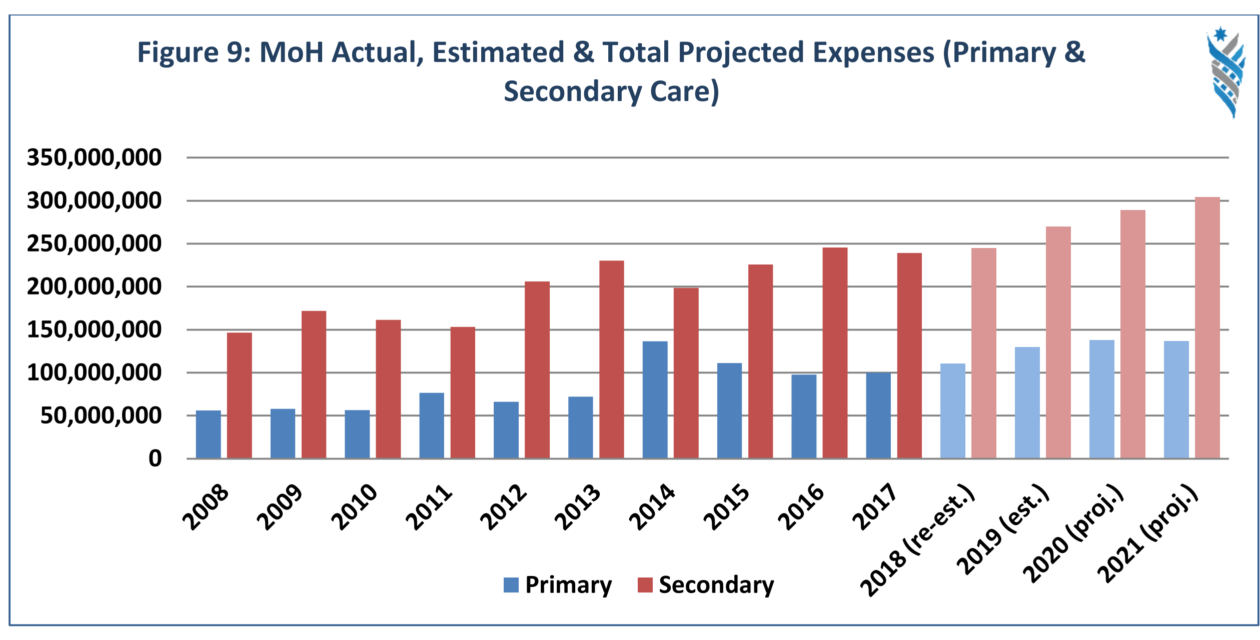
In the beginning of 2018 and in order to halt the escalation of costs, authorities decided that the Royal Court will be the only institution allowed to grant exemptions, to be valid for six months for regular disease and up to one year for chronic illness. Moreover, under another decision made in 2017, exempted Jordanians will be eligible to be treated first at MoH hospitals, and if the relevant treatment is not available, they can be referred to other non-MoH facilities. While these decisions will contribute to slowing down the growth of expenses, the IMF review estimated that such measures may not be sufficient to prevent the accumulation of new arrears[36].

- **Poor Quality of Primary-level Care due to less Priority of expenses on Primary-level care as opposed to Secondary- and Tertiary-level Care:**

The National Strategy for the Health Sector 2016-2020 called for "increasing allocations to primary health services by containing hospital expenses", while the Jordan Vision 2025 called for a "well-planned geographic expansion of healthcare facilities and services based on the principles of partnership, coordination and integration". In the SWOT analysis of the Ministry of Health's Strategy 2018-2022, "poor investments in primary care when compared to secondary care and a focus on more expensive secondary care at the expense of primary care"[37] is highlighted as a weakness, with one of the strategy's broad objectives being "improving primary healthcare".

The graph below showcases the actual, estimated and projected expenses (running costs and capital expenses combined) by the Ministry of Health on Primary and Secondary care[38]:

[36] IMF (2018) "Public Expenditure Review and Rationalization: Issues and Reform Options"
[37] Ministry of Health Strategy 2018-2022 (p.13)
[38] Successive budgets of the Ministry were obtained from the General Budget Directorate (source) (study comparison of budgets – source)




As becomes immediately apparent, apart from the year 2014 where expenses on primary care were significantly increased while expenses on secondary care were reduced compared to the preceding years, the recommendations calling for the Ministry to focus and invest more on primary care as opposed to secondary care have not been heeded. Since 2015, the objectives stipulated in the *Executive Development Plan 2018-2020* have largely not been achieved[39]:

| | Percentage that primary health expenses took up of the Ministry's total budget (%) | Objectives to be achieved (as per the Executive Development plan 2018-2020) (%) | Achieved (Yes/No) |
|---|---|---|---|
| 2014 | 22.25 | 21 | Yes |
| 2015 | 18 | 18 | Yes |
| 2016 | 16 | 18 | No |
| 2017 | 18 | 22 | No |
| 2018 (re-est.) | 18.5 | 23 | No |
| 2019 (est.) | 22.4 | 24 | No |

Despite the fact that the numerous national and institutional strategies have called for shifting the Ministry's focus to primary-level care, it appears that the government has not

[39] Executive Development Plan 2018-2020

taken this orientation, as among the stipulations of the *Nahda Programme – Government Priorities 2019-2020* are the building of three new governmental hospitals in Tafileh, Ajloun and Irbid by the end of 2020[40].

- **Few accredited Healthcare Centers**

The importance of accreditation has been mentioned in the numerous national and institutional strategies, as an accredited health center provides high-quality health services, is equipped with proper functioning equipment and is staffed with the qualified medical cadres expected to be serving in it. However, the targets outlined in these strategies have not always been met, as the below table highlights:

| Year | Actual number of accredited Health Centers[41] | Target (*Executive Development plan 2016-2019*)[42] | Target (*Executive Development plan 2018-2020*) [43] | Target (*Nat. Strat. For the Health Sector 2016-2020*)[44] | Target (*Jordan Vision 2025*)[45] | Target (*Ministry of Health Strategy 2018-2022*)[46] |
|---|---|---|---|---|---|---|
| 2011 | 11 | N/A | N/A | N/A | N/A | N/A |
| 2012 | 39 | N/A | N/A | N/A | N/A | N/A |
| 2013 | 41 | N/A | N/A | N/A | N/A | N/A |
| 2014 | 93 | 90 | 90 | N/A | N/A | N/A |
| 2015 | 96 | 102 | 90 | 90 | N/A | N/A |
| 2016 | 91 | 130 | 90 | 106 | N/A | N/A |
| 2017 | 92 | 150 | 91 | 130 | 180 | 98 |
| 2018 | 97 | 170 | 95 | 150 | N/A | N/A |
| 2019 | N/A | 180 | 100 | N/A | N/A | 110 |
| 2020 | N/A | N/A | 105 | N/A | N/A | |

It is apparent that the targets outlined in the Executive Development Programme 2016-2019, the National Strategy for the Health Sector 2016-2022 and the Jordan Vision 2025 are very far from being achieved. The targets in the more recent documents – namely the Executive Development Plan 2018-2020 and the Ministry of Health Strategy 2018-2022 – are far more reasonable and highlight the reality of the situation when it comes to accreditation.

[40]Nahda Programme – Government Priorities 2019-2020. Note that in Tafileh there is only 1 RMS hospital in the whole governorate and no MoH hospital while in Irbid there are 8 MoH hospitals, in addition to 1 university hospital and 1 RMS hospital in the governorate.
[41] National Social Protection Strategy (2019-2025) - background papers
[42] Executive Development Programme 2016-2019
[43]Executive Development Programme 2018-2020, p. 183. Note: The numbers in the PowerPoint presentation were from the EDP 2016-2019 which had more ambitious targets (e.g. for 2016: 130 Health Centers accredited).
[44] High Health Council - National Strategy for the Health Sector (p.73)
[45] Jordan Vision 2025, p.126
[46] Ministry of Health Strategy 2018-2022, p.31

In 2014, the number of accredited Health Centers increased dramatically, but has been increasing at a slow pace since then mainly due to inadequate resources at the Higher Council for Accreditation and at the Ministry of Health's Department of Quality Control. In addition, the Ministry usually starts the accreditation process with Health Centers that are already well-run, well-maintained and are in need of only some work to become accredited[47].

- **low incentives to medical cadres in the Ministry and inadequate number of specialized doctors**

For a while now, the Ministry of Health has been suffering from a serious 'brain drain' problem[48]: Specialized doctors in Jordan prefer working either in RMS, University Hospitals or in the private sector in Jordan or abroad as opposed to working in the Ministry, as the pay and working conditions in the former are far superior to in the latter.

Although the Ministry of Health has recently announced that salaries of all its cadres will be increased by 30% in an attempt to make the Ministry a more attractive work environment[49], other recent decisions adopted by the Ministry have proven to be very unpopular and have generated a lot of controversy, with doctors staging protests in front of the Royal Court and accusing the Ministry of violating their rights[50].

In addition, the Ministry faces difficulties in staffing Health Centers in certain areas which it dubs 'Areas Difficult to Employ in'. Financial and non-financial incentives (such as accommodation, transportation and meals) are provided for medical personnel (doctors, nurses, radiologists and laboratory technicians) who work in these areas. However, these incentives are not very enticing and are seen more as 'rewards' than actual incentives, and it is unclear whether this policy has been successful or not[51].

- **Poor integration among various entities in the Health Sector**

Ineffective and inequitable application of the referral system between health-care facilities:

The National Strategy for the Healthcare Sector 2016-2020 stated that among its objectives are "reaching a level of synergy [تكامل] between primary, secondary and tertiary health services" and the "implementation of an effective referral system for patients between the different levels of care and between the public and private sector entities"[52]. As for the Executive Development Programme 2018-2020, it states that it is necessary to "reduce as much as possible duplication and unorganized expansion of health services, and increase coordination between the public and the private sectors" and calls for "establishing effective

[47] National Strategy for the Health Sector, p.28
[48] In 2011, a doctor working in the Ministry anonymously penned an article pointing out that specialized doctors tend to prefer working outside of the Ministry (source). In 2014, an article in Al Rai shed light on this brewing crisis in the Ministry, stating that the 'brain drain' that the Ministry is experiencing is a major challenge (source). In 2018, around 400 specialized doctors working in the Ministry sent an open letter to the Prime Minister airing their grievances and explaining why the Ministry has become a 'no-go' zone for specialized doctors (source).
[49] Al Rai (2019). (source)
[50] These decisions namely significantly increase the fines that specialized doctors in-training must pay should they decide to leave the Ministry and work in other sectors. These decisions are aimed at increasing the number of years that specialized doctors spend in the Ministry. Numerous press reports on this issue have been reported, especially given that the issue is still ongoing. Sources used: Al Mamlaka TV; Dr.Maen Qatamin (source)
[51] National Social Protection Strategy (2019-2025) - background papers
[52] High Health Council - National Strategy for the Health Sector

partnerships between all relevant health services-providing sectors and increase coordination between them"[53].

As previously mentioned, the health system in Jordan functions on the basis of referrals from primary-level care provided in health centers to higher levels of care, depending on the needs of the patients. Theoretically, such a system should be effective and allow for patients to receive the care they need at the primary level, and only be referred to higher levels of care if they truly need it, which would reduce stress and demand for services on hospitals. There are two types of referrals[54]:

- **Referrals within the Ministry of Health:** A patient would attend a health center (Peripheral or Primary) and would be referred to a Comprehensive Health Center or to a governmental hospital directly. Should the service required be unavailable at the Comprehensive Health Center or the governmental hospital, the patient would be referred to another governmental hospital that provides the services that the patient needs.
- **Referrals from the Ministry of Health to other entities**: When a patient is in need of a service that the Ministry cannot provide, he/she would be referred to hospitals with which the Ministry has agreements with. The patient would first be referred either to the Prince Hamza Hospital, RMS Hospitals or University Hospitals, and, should the services required not be available at either of these sectors, the patient would be referred to private sector hospitals or specialized health centers.

However, the system does not function this way in Jordan. There are numerous loopholes which allow patients to bypass the lower levels of care and go directly to higher levels, even if they do not truly necessitate it[55]:

- Governmental employees can directly go to a governmental hospital to receive treatment, bypassing the need to go to a Health Center and be referred to a hospital should he/she necessitate such a level of care
- High-ranking governmental employees can go directly to RMS Hospitals, University Hospitals and hospitals in the private sector, bypassing the need to go to a Health Center and be referred to a hospital should he/she necessitate such a level of care
- Patients who have received an exemption from the Royal Court were capable of going directly to whichever health services providing entity that they wish. However, since January 2018, they must go first to a governmental hospital[56]

The inadequate working hours in Health Centers, as well as the lack of specialized doctors and adequate medications, forces patients to resort directly to hospitals. This further causes stress on hospitals and overworks the staff. The limited number of specialized doctors in

[53] Executive Development Programme 2018-2020 (p.175; p.177)
[54] National Social Protection Strategy (2019-2025) - background papers
[55] National Social Protection Strategy (2019-2025) - background papers
[56] Khaberni (2018) (source)

governmental hospitals forces the Ministry to refer patients extensively, which is costly and takes a toll on patients[57].

Given that an estimated 95% of health cases in Jordan can be treated at the primary level[58], it is clear that the referral system in Jordan and the quality of services provided at the primary care are in need of significant overhauls.

Inadequate provision of emergency services for patients in need of reaching secondary-level care during emergencies:

Given the inadequate working hours of Health Centers, many patients find themselves forced to go to Hospital Emergency Units to receive treatment, simply due to the fact that the Health Center is closed[59]. This has caused tremendous pressure on doctors in Governmental Hospitals. For instance, it is estimated that the Al Bashir Hospital in Amman welcomes one new patient every 23 seconds[60]

- **Lack of transparency and poor accountability:**

  Poor mechanisms for collecting data and publishing it, weak ability of local communities to call for accountability and determine priorities based on actual need:

The National Strategy for the Health Sector 2016-2020 calls for “collecting data do ensure transparency and accountability”, a “system of monitoring and evaluation “evidence-based policymaking” and “empowering citizens to demand governmental accountability”[61]. The Executive Development Programme 2018-2020 on the other hand calls for “providing health services […] to all citizens on a just and fair basis”, for “the participation of local communities in the planning of developmental projects”, and for the “development of evidence-based policies and decisions”[62].

When it comes to ensuring that Health Centers are properly run, Directors of the Health Directorates in the Governorates organize check-up visits. There is no schedule for these visits and are decided by the Director. Often they are carried out after complaints are received from citizens or from Centers’ staff. Upon discovering a gap in a Health center (for example, a machine is broken), the Director contacts the Ministry in Amman which would act on the matter and ensure that the gap is filled. However, there is no database containing information on what are the ‘staffing gaps’ or missing or broken equipment that Health Centers across the Kingdom suffer from[63].

In addition, the Ministry has not carried out any Kingdom-wide assessment of the Health Centers to determine which ones are functioning properly, which ones are in need of being

[57] Press reports (source ; source; source)
[58] Al Rai (2019) (source)
[59] National Social Protection Strategy (2019-2025) - background papers
[60]Addustour (2019) (source)
[61] High Health Council - National Strategy for the Health Sector
[62] Executive Development Programme 2018-2020
[63] National Social Protection Strategy (2019-2025) - background papers

upgraded, which ones should be shut down due to inactivity etc.[64]. In 2014, the 'Parliamentary Initiative' Bloc in the Jordanian Parliament submitted a detailed report to the Ministry containing information on (i) which Health Centers are in need of being upgraded (e.g. turning a Peripheral Health Center to a Primary Health Center) due to the demands of the local communities, and (ii) which Health Centers should be shut down as they have very little demand for services and are located very close to other Health Centers etc.[65]. However, the report's recommendations have not been heeded, as it is very difficult for the Ministry to close down Health Centers – even the ones that are not very much used – as it would need the full approval of the local community, which is not easily obtained[66].

The Ministry of Health has very recently developed an application on the Apple Play Store, the "Health Map", which allows citizens to know what are the closest hospitals and health centers. This application is an excellent and much-lauded first step in encouraging e-governance and citizens to demands accountability. However, it will need to be improved, as the subsequent recommendations section will showcase.

- **Poor infrastructure of health services providers**

A study carried out by the Civil Service Bureau in 2009 highlights that one of the challenges faced by the health sector in Jordan is the **poor infrastructure of health services providers**, especially in regards to **communications** and **health technology**[67]. In addition, a report prepared by DOS in 2011 on 13 Poverty Pockets showed that when it comes to the main problems that households in these areas face when attempting to access healthcare services, 38.23% cited **'poor services'** (سوء الخدمة) and 27.27% cited '**lack of specialized doctors'** as the major obstacles[68]. The 'State of the Country Report' conducted by the Economic and Social Forum, in addition to several articles published in numerous media outlets, have criticized the infrastructure of the governmental health centers and the quality of services provided.

The major complaints tend to relate to short working hours, lack of sufficient medical cadres (especially specialized doctors), poor shape of the health centers, ***non-functioning medical equipment***, and a ***lack of an adequate supply of medicines*** (which can be especially dire for citizens with chronic diseases, such as diabetes patients who are in constant need of insulin)[69]. In other words, despite the fact that most citizens live relatively close to Health Centers as was previously highlighted, ***primary care seems to be only partial and not particularly useful in certain areas, which prompts citizens to travel long distances to the nearest hospitals to receive the care that they should have otherwise received at the health center.***

Over the past several years, Health Centers and Hospitals were built by the Ministry of Health on an unplanned, haphazard fashion which was determined less on the basis of actual need

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[64] ibid
[65] ibid
[66] ibid
[67] Civil Service Bureau (2009), Primary Study on the Conditions of Healthcare Services and Human Resources in MOH, p.18
[68] Department of Statistics (2011), Poverty Pockets in Jordan, p.47
[69] Information retrieved from the 'State of the Country Report' as well as numerous articles published in local press outlets, such as Al Madena News (2014) (source), Al Rai (2019) (source) and Al Ghad (2019) (source)

and more on the basis of demand. This has resulted in difficulties for the Ministry to adequately staff the centers and hospitals and provide healthcare services[70]. Out of the 677 Health Centers and the 32 Hospitals that the Ministry runs, only 93 and 12 are accredited respectively by the Higher Council for Accreditation. The Ministry has not done any country-wide assessment of the Health Centers, and its Department of Quality Control, which is responsible for overseeing the accreditation process, is severely understaffed and underfunded[71].

[70] National Social Protection Strategy (2019-2025) - background papers
[71] Ibid

# 6. Concluding Remarks and Way Forward.

- **Enhance Transparency, Accountability, and Overall Quality of Governmental Healthcare Services at the Primary Level**

In order to improve transparency, accountability and the overall quality of healthcare services provided by the Ministry of Health in its Health centers, the following action plan composed of three concrete steps is proposed:

1. The standards of the three different types of Health Centers that the Ministry runs should first be publicized widely, with citizens being asked to identify through a smartphone application (such as the aforementioned 'Health Map' application, for example) what are the problems they face when accessing Health Centers based on these standards. Following a two-week period, the Ministry would review the numerous comments and feedback received, and would prepare a plan to investigate and address citizens' concerns. The plan would be publically announced and progress would be publically reported on a monthly basis. This recommendation is aimed at **establishing transparency and accountability[72].**

2. Require that all referrals be made electronically (through a smartphone application) that includes the patient's National ID number, insurance number (if relevant) and the medical reason for the referral. After several months, the data from these referrals can be analyzed to assess the fairness and efficiency of the system. Given that the Ministry of Health has already launched a 'Health Map' application, it is recommended to expand this application to make it a wide-ranging app which (apart from serving a role as making referrals electronic), can allow citizens to submit complaints, know exactly where they can access governmental healthcare services and received general information on health-related issues. This recommendation is aimed at **implementing an effective referral system.**

3. Within six months, the Cabinet would:
   - Review the findings of the first two actions
   - Review existing Health Center standards and budget allocations
   - Revisit the principle of "locally available primary care with referral to higher levels of service" and determine any changes to be made in the system such as: reducing the standards to a level that the Government is willing to be held accountable for; shifting budgets; combining several peripheral centers into a single comprehensive center; making greater use of mobile clinics or telemedicine, etc.

   This recommendation is aimed at improving the overall quality of the health care system based on **evidence and fairness.**

[72] Note: A modification on this proposal would be to start with an initial but limited period of time during which the heads of each Health Center would be asked to report on any problems that they face based on the standards, with the Ministry then devoting a period of time to address the problems

- **Enhance cooperation with non-Ministry of Health entities to ensure adequate provision of healthcare services, especially at the Secondary Care Level**

As previously mentioned, the Ministry of Health is struggling with attracting qualified specialized medical cadres to work in its Hospitals and Health Centers, which is forcing the Ministry to refer patients to other health services providers. The following actions are proposed:

1. Carry out a thorough study of the 'Prince Hamza Hospital' experiment with decentralization, in order to determine to what extent was it successful or not and what are pros and cons to be accrued by providing such a level of administrative independence to hospitals. Based on this study, the Ministry would be able to determine the extent to which hospitals should be given administrative and financial independence, and how this would allow them to provide better services and attract specialized medical cadres[73]
2. Cooperate with Health services-providers outside of the Ministry (such as the RMS, University Hospitals or the Private Sector) in order to subcontract specialized doctors based on the needs of the hospitals[74]
3. Currently, there are no clinical guidelines in Jordan, which poses a big problem in the health sector as a whole. Doctors in Health Centers are the decision-makers when it comes to referring patients to higher levels of care, and do not have to follow any specific clinical guidelines[75]. Having official clinical guidelines which doctors need to follow will likely reduce the numbers of referrals from primary-level care to higher-levels of care, and thus reduce the pressure on hospitals. In addition, these guidelines will allow doctors to immediately determine the level of care that the patient needs, and would be able to refer the patient to the relevant entity (for instance, a cancer patient at a Health Center would be thus directly referred to the King Hussein Cancer Center or another entity specialized in treating cancer and not have to go to a governmental hospital where he/she would be then referred to the specialized center – thus saving both time, pressure and referral costs on all parties involved)

- **Develop Monitoring, Evaluation and Data Collection**

The Ministry of Health should develop a widespread database to monitor and track health outcomes (i.e. NCDs, communicable diseases etc.), measure impact of policies and guide decision-makers. This database would include:

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[73] Currently, the 'Prince Hamza Hospital' experiment has generated both praise and criticism from different stakeholders. In an op-ed published by Al Ghad (2017), MP Jamil Al Nimri mentions that a measure of decentralization for hospitals is essential, while he is skeptical of providing complete administrative and financial independence (source). Salma Jaouni (HCAC) states that the Prince Hamza Hospital experiment has been a failure, as the hospital does not have 'independence' when it comes to providing healthcare services, while Ahmad Awad (Phenix Center) criticizes the experiment, stating that the Prince Hamza Hospital now functions as a private sector hospital – which means that the costs that citizens incur when accessing healthcare services there are higher than in regular Governmental Hospitals – without the quality of the services truly improving. However, an interview from Al Rai (2018) held with the former Director of the Hospital, Dr. Mazen Naghwi, showcases the benefits of the 'experiment' (source). These divergent opinions show the need for the Ministry to carry out an in-depth study on the Prince Hamza Hospital and to learn the pros and cons from the 'experiment'

[74] The Jerash Governmental Hospital has managed to solve the 'brain drain' problem and employ specialized medical cadres by subcontracting specialized doctors from the RMS and from University Hospitals (Al Rai, 2019 – source).

[75] Information taken from meeting with Dr. Ammar Al Shurafa on the 25th of February

1. The physical needs of the Health Centers and Hospitals run by the Ministry, compared with the needs, cost estimations and optimization. In other words, this database would contain the exact number of medical equipment (e.g. laboratory equipment, medicines etc.) needed in the Health Centers and Hospitals, and it would allow decision-makers to know exactly which Centers and Hospitals should be prioritized and how to properly allocate resources.
2. The needs in terms of human resources that Health Centers and Hospitals require (such as technical and administrative staff, specialized medical cadres, nurses etc.), which will allow decision-makers to plan in advance and be able to quickly and effectively fill in the gaps.

As of the time of writing, the Ministry of Health does not have a database containing patients' medical records [سجل طبي], despite the fact that the *Electronic Health Solutions*' 'Hakeem' programme – which is intended to provide governmental hospitals and health centers with an online network to allow medical cadres to easily be able to share and access patients' records – has been active since October 2009[76]. The Ministry should Carry out a thorough study on the effectiveness of the Hakeem programme and determine what are the reasons as to why the gaps persist, and how they may be filled rapidly

- **Improve Health Awareness and Healthy Lifestyles**

As the data on tobacco consumption has shown, high rates of smoking affect Jordanian citizens from all walks of life, and virtually all aforementioned strategies highlight the dangers that NCDs pose to Jordanians and their high cost of treatment. NCDs can be prevented through proper health-awareness and through the adoption of healthy lifestyles. The NSP proposes the following cross-cutting recommendations to limit the spread of NCDs and raise health awareness:

1. Focus on carrying out health-awareness raising initiatives through Primary-level care (i.e. Health Centers). Health Centers should be provided with the ability to carry out such activities in their local communities (for example, hosting lectures on the dangers of tobacco consumption)
2. Carry out a study of the Healthy Villages programme to determine its pros and cons, and incorporate the program's 'grassroots-based' approach[77] and the study's findings into future awareness-raising activities
3. Enhance and strengthen cooperation and coordination with civil society organizations seeking to promote healthy lifestyles and raise awareness on health-related issues when planning and carrying out awareness-raising activities[78]

- **Achieve Universal Health Coverage**

[76] National Social Protection Strategy (2019-2025) - background papers
[77] ibid
[78] ibid

Jordan strives to achieve universal health coverage in the long run. But any country wishing to achieve UHC should carefully assess whether it has the required fiscal space to secure the necessary funding without impacting the sustainability of the country's fiscal position[79]. International evidence suggests that overall health financing in any given country is strongly determined by the overall macroeconomic environment[80]. And many countries were able to create the necessary fiscal space through a mix of policies that include (i) raising revenues, (ii) reprioritizing health expenditures, and (iii) achieving efficiency gains, noting that each of these policy options are associated with costs and benefits.[81]

For a country in pursuit of fiscal consolidation like Jordan, raising extra revenues to finance additional healthcare expenses would be challenging given the current difficulty in mobilizing domestic resources and given the Kingdom's high level of indebtedness. Nevertheless, sustained economic growth will be necessary to create the required fiscal space of health in Jordan in the coming years. Therefore, the recommendations in this section will focus on how Jordan can achieve efficiency gains, and reprioritize healthcare expenditures. In addition, the recommendations were formulated in a way to directly tackle the above-mentioned challenges, and are supported by most recent studies on the topic. It is also worth noting that all recommendations fall within the overarching objective for Jordan of moving away from generalized subsidies towards effectively targeted subsidies.

As mentioned in the challenges, the current status quo of the health insurance system (including exemptions to the uninsured) is financially unsustainable, especially given Jordan's demographic profile. Already, Jordan has accumulated large and significant health arrears. Therefore, there is a dire need to restructure and modernize the system before expanding coverage in order to make it sustainable. In other words, it is not recommended to expand coverage without first addressing the inefficiencies currently present in the system.

1. Charges on uninsured patients need to be revised to reflect major part of the real cost; all poor would remain protected from the increase under health insurance

   Healthcare fees charged on uninsured patients need to be revised upwards to reflect the true cost of medical services, as fees have remained stagnant since the 1990s and are currently on average 20% or lower than the actual cost. Subsidizing healthcare fees creates distortions and is considered regressive as poorer segments of the population end up paying a higher share of their expenditures on healthcare compared to richer segments of the population. Instead of offering non-targeted healthcare subsidies, the government is encouraged to subsidize the insurance premium of the poor and vulnerable groups of the population, thereby avoiding distortions, and aligning with Jordan's strategic objective of targeting subsidies.

[79]World Bank (2014) "Towards Universal Health Coverage: A Comprehensive Review of the Health Financing Systems in Jordan"
[80]ibid
[81]ibid

Presumably, the poor would be protected from the increase in healthcare fees for the uninsured, given that the government already provides free health insurance for citizens classified as being poor by the Ministry of Social Development (i.e. family earning JD300/month or less) and citizens eligible for safety net benefits (i.e. citizens with annual individual expenditures not exceeding JD1,000). The increase in charges will contribute to the financial sustainability of offering free health insurance for the poor.

Nevertheless, the government should make sure that no poor Jordanian is charged the updated higher price when receiving treatment at MoH facilities.

2. Carry out a comprehensive actuarial and technical study to determine new levels of payroll contributions and copayments, and harmonized equitable benefits packages. Authorities should consider introducing pooling[82] arrangements based on income to increase equity of the system.

   The government is strongly encouraged to restructure the main public insurance schemes. The first step would be to conduct a comprehensive actuarial and technical study to set new payroll contribution and co-payment rates, which have remained stagnant for a long period of time and are currently well below the actuarial cost. Failure to appropriately design and price premiums and copayments according to benefits covered undermines the entire health insurance system[83]. Furthermore, benefits packages must be determined in a way that corresponds with the contribution and copayment rates to ensure equity.

   The idea is to incorporate a model for insurance that includes a risk pool approach and is linked to actuarial analysis. It is recommended that the new actuarially-based premium methodology be based on income rather than gender or health risks, in order to protect the poor. This would require an income-based classification of all health insurance beneficiaries. For example, the monthly cap for premiums of JD30/month for civil servants may be removed, and the premium rate of 3% and copayment rates may be reconsidered if needed, based on actuarial results and to protect the poor. A methodology and pooling arrangement that is based on income will increase equity, and increase access to healthcare services by all segments of the population. Contributions that are based on the capacity to pay rather than health risk can facilitate cross-subsidization and can significantly increase financial protection for all members of the pool[84].

[82]According to the World Bank, pooling is defined as the accumulation and management of sufficient and sustainable revenues to ensure that all members of the pool have access to an essential

[83]USAID (2018) "Health Insurance Legislative Review"

[84]World Bank (2006) A Practitioner's Guide: Health Financing Revisited, chapter 2

According to the IMF[85], if government gradually raised charges closer to the 'unified price', and if copayments could be increased and become dependent on income, an estimated 0.2% of GDP of additional revenues would be raised in around 3 to 4 years, making health financing more sustainable.

3. Separate payers and providers in public insurance systems, and work towards a single public insurer model with harmonized benefits packages; build capacity of single insurer or regulatory body in actuarial science.

   There is a dire need to address the current system's inefficiencies and complexity. As a first and immediate step, public insurers should be made independent of public health providers. This will make formal contracting or strategic purchasing the norm, and will allow for pricing and reimbursement accountability through a separation between payers and providers.

   As a next step, public insurance operations should be standardized with a harmonized benefits package to ensure equity and sustainability of the system. Such a harmonized benefits package should be determined based on its cost-effectiveness and responsiveness to health priority needs. This will also act as a prerequisite for the future need of unifying the multiple existing public insurance schemes into a single scheme (i.e. single payer model) which would allow for more effective pooling arrangements and eliminate overlaps and related inefficiencies. A single public insurer needs to become a reality in the medium term as the demographic profile of Jordan shifts towards a higher share of elderly citizens.

   The public health system should be modernized and the capacity of the single insurer or a regulatory body should be built in the relevant technical skills, including actuarial studies. Currently, the capacity to produce reliable cash projecting and rolling periodic cash plans is limited. In specific, the administrative structures and financial procedures need to be strengthened through automating the systems and processes, maintaining separate and full records for the insured and uninsured citizens, and strengthening mechanisms and processes for budgetary controls, internal audit, periodic reporting and monitoring of arrears. Moreover, commitment controls should be strengthened, and the credibility and realism of the budget should be enhanced. Cash-flow planning need to be strengthened and integrated with commitment controls.[86]

4. Phase out the exemption program to control and reduce growth in health arrears, and reallocate resources to expand formal coverage
   As illustrated earlier, much of the public spending through the Royal Court and the Cabinet ad-hoc systems go to non-poor persons, meaning that this large government subsidy is not being effectively targeted to those who need it, and represents a clear

[85]IMF (2018) "Public Expenditure Review and Rationalization: Issues and Reform Options"
[86]IMF (2018) "Public Expenditure Review and Rationalization: Issues and Reform Options"

inefficiency that could be addressed. Furthermore, the exemption program acts as a strong disincentive to Jordan's strategic objective of achieving universal health insurance. In fact, the World Bank review indicated that it would be financially feasible to extend health insurance coverage under the current level of financing, through reallocating resources from these ad-hoc resources to formal coverage[87]. This would also help in harmonizing pooling arrangements.

It is therefore recommended to phase out the exemption program completely, which will result in substantial savings that will limit future health arrears and divert resources to harmonize benefits packages and expand formal coverage. In specific, saved resources could be diverted to improving the health insurance benefits offered to low income groups through for example allowing them to be easily referred to non-MoH hospitals for needed treatment.

[87]World Bank (2014) "Towards Universal Health Coverage: A Comprehensive Review of the Health Financing Systems in Jordan"

**Annex**

Main insurance terms and concepts, presented in the following table:

**Table 6-1: Insurance terms and concepts**

| Term | Definition |
|---|---|
| Premium | An amount of money that an individual has to pay for an insurance policy. |
| Payroll contribution | The amount deducted from an individual's salary for an insurance policy |
| Copayment / Coinsurance rate | A cost sharing mechanism where the insured pays a specified amount or share of incurred medical expenses, and the insurer pays the remainder. |
| Healthcare fees/charges | The amount needed to be paid by non-insured individuals in return for receiving any healthcare service |
| Actuarially | The computation of premium rates, copayments, risks... etc according to probabilities based on statistical records. |
| Actuarially fair | An insurance contract is considered actuarially fair if the premiums paid are equal to the expected value of the compensation received. |

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