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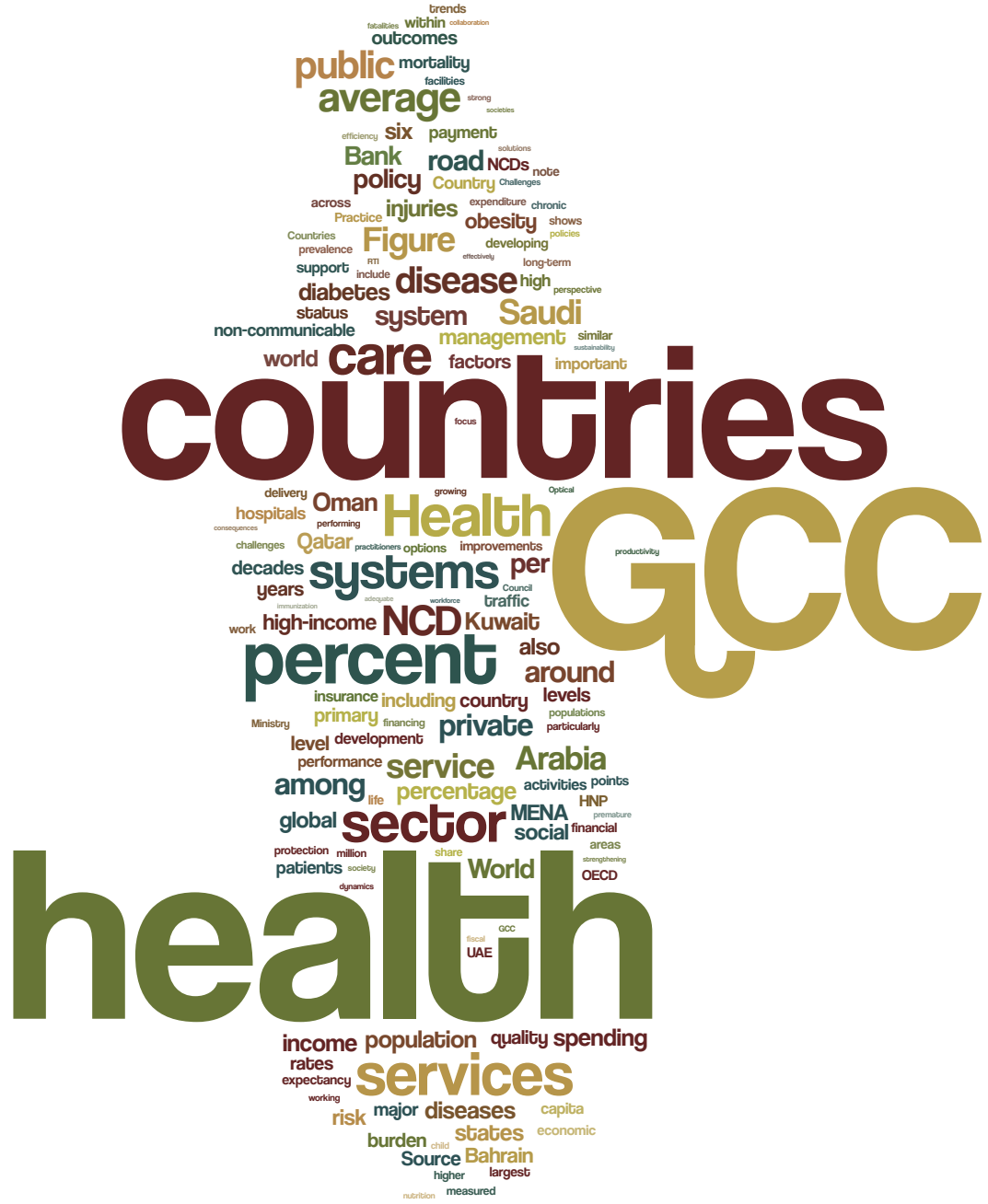
SHAPING HEALTHIER SOCIETIES AND BUILDING HIGHER PERFORMING HEALTH SYSTEMS IN THE GCC COUNTRIES

The Health, Nutrition, Population (HNP) Global Practice



APRIL, 2015

WORLD BANK GROUP

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The Health, Nutrition, Population (HNP) Global Practice

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Introduction

This policy note summarizes the central health sector trends and challenges in the Gulf Cooperation Council (GCC) countries of the Middle East and North Africa region (MENA). These countries are Saudi Arabia, Kuwait, Bahrain, the United Arab Emirates (UAE), Oman and Qatar. The note also provides an overview of the GCC country context, discussing the commonalities between the six member states, and the major areas of engagement by the Health, Nutrition and Population (HNP) Global Practice of the World Bank in support of the health sector reform priorities of these countries. The areas of engagement focus on three main clusters of work: (i) developing multi-layered solutions for improving non-communicable disease and road safety outcomes; (ii) health system strengthening; and (iii) integrating health policy solutions within the wider institutional and policy frameworks in the GCC countries.

The note builds on an earlier HNP regional strategy prepared by the World Bank in 2013 focusing on the concepts of fairness and accountability. The strategy highlighted the importance of improvements in health system performance in MENA countries from an equity, accountability and fiscal sustainability perspective. The framework of the strategy covers equity in health status, financial protection and responsiveness, and the accountability of populations, payers and health service providers interacting within the health system. The fiscal sustainability of MENA health systems in the face of mounting budgetary pressures during a period of general instability and economic slowdown is also a major component of the regional strategy.

GCC Country Context

The six high-income countries of the GCC are dissimilar in terms of land territory, populations and per-income capital levels yet similar in other important political, economic and social respects. Saudi Arabia, the largest country in the Arabian Peninsula, has a land mass of 2.15 million square kilometers and a population of 28 million people whereas Bahrain has a land territory of 750 square kilometers and a population of around 1.2 million people. In between, Oman, the UAE, Qatar, and Kuwait have land areas ranging from 300,000 to 11,600 square kilometers and populations varying from 9.4 million to 2.2 million persons. In terms of gross national income levels estimated using purchasing power parity, Qatar leads the GCC countries and the world with a per capita income level of US$ 128,530 followed by Kuwait and Saudi Arabia with per capita income levels of US$ 88,170 and US$ 53,640. Bahrain has the lowest per capita income level of US$ 35,760 among the GCC countries.[1]

These differences aside, there are four important commonalities across the six countries:

- ***Rich endowments of natural resources*** - The GCC countries possess around 33 percent of the proven oil reserves in the world. Saudi Arabia, alone, has around 18 percent of global oil reserves. In term of natural gas, 17 percent of proven gas reserves are found in the four GCC countries of Qatar, Saudi Arabia, Kuwait and Oman.[2]
- ***Generous subsidy and welfare policies –*** With an abundance of natural resources, the GCC countries have established generous subsidy and welfare policies covering a range of sectors including energy, education, health, housing and social protection. The welfare policies in particular are reinforced by constitutional and legal provisions in all six countries stipulating the 'obligation' of the state to provide access to essential services including health care services.
- ***Large populations of expatriate workers –*** The labor markets in the GCC countries include a proportionately large number of expatriate workers consisting mainly of young males. The majority of

[1] Source: World Bank Development Indicators, 2013 and 2014.
[2] Sources: US Energy Information Administration, 2014, OPEC, 2013

these expatriate residents work in the energy, construction, services and domestic household sectors. The numbers of expatriate workers range from 30-80 percent of the total resident population within each GCC state.

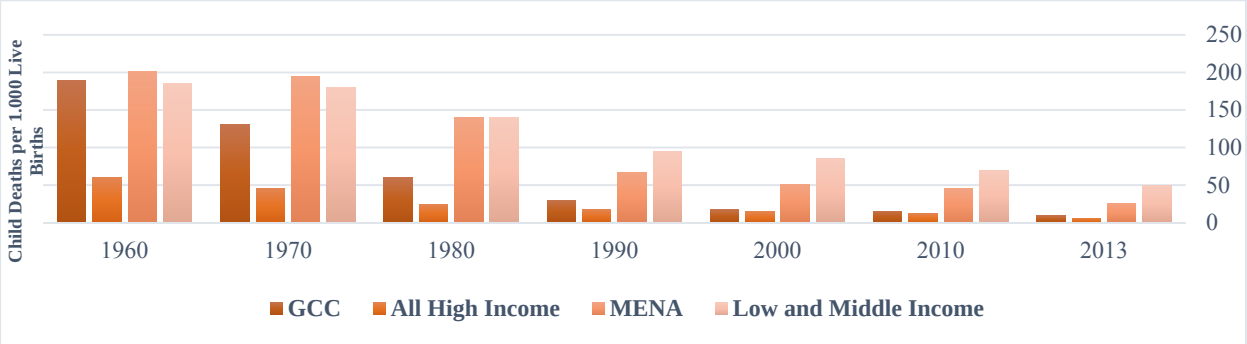
- ***Common cultural, religious and social heritage*** **–** The GCC countries share a common cultural, religious and social heritage. The Arabic language, Islam and tribalism are the defining cultural, religious and social characteristics of the societies in the GCC countries.

The close societal bonds, common historical experience and shared space on the Arabian Peninsula prompted the six countries to form an alliance in 1981 and to establish the 'Gulf Cooperation Council' (GCC). The objectives of the GCC are to deepen relations and strengthen cooperation between the member states at all levels, particularly in the economic, social and infrastructure sector. Over the past twelve years, the GCC worked on creating a customs union and common market for goods, services and labor. Since 2009, efforts by some member states have been exerted towards establishing a monetary union.

Health Sector Trends and Challenges in the GCC Countries

The vast investments by the GCC countries over several decades in health service infrastructure have yielded impressive improvements in overall health status outcomes[3]. The health systems established by the GCC states focused on fulfilling the core public health functions of childhood immunization, food safety, environmental health and essential child and maternal health services. Figure I below shows the trends in under-five mortality rates between the GCC states, the MENA region as a whole, all developing countries and all high-income countries. In 1960, child mortality rates in the GCC countries were similar to those in MENA and those in the low and middle income countries; and were around three times higher than the average child mortality rate in the high-income countries. Over five decades, child mortality in the GCC countries declined rapidly down to a level almost equaling the average rate in high-income countries.

Figure I: Trends in Child Mortality from 1960-2013 by Groups of Countries



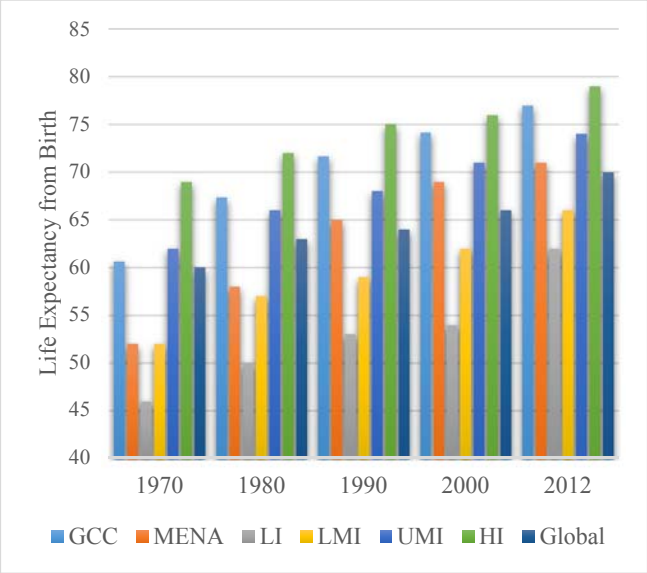
Source: World Bank Development Indicators, 2014.

Similar improvements in health status outcomes related to infant, maternal and adult health are observed across all six GCC countries. Average life expectancy from birth in the GCC countries increased from 62 years in 1970 to around 77 years in 2012 – an increase of 24 percent in four decades. In 1970, as shown in Figure II below, life expectancy in the GCC countries approximated the global average and was slightly below the average for upper-middle income countries. By 2012, it well-surpassed the upper-middle income country average and was only slightly behind the average for high-income countries. Between the GCC countries, there was also variation in life expectancy during 1970-1990 with Oman and Saudi Arabia

[3] Note: The health status outcomes reported in the following sections are for GCC nationals only and do not include expatriate workers.

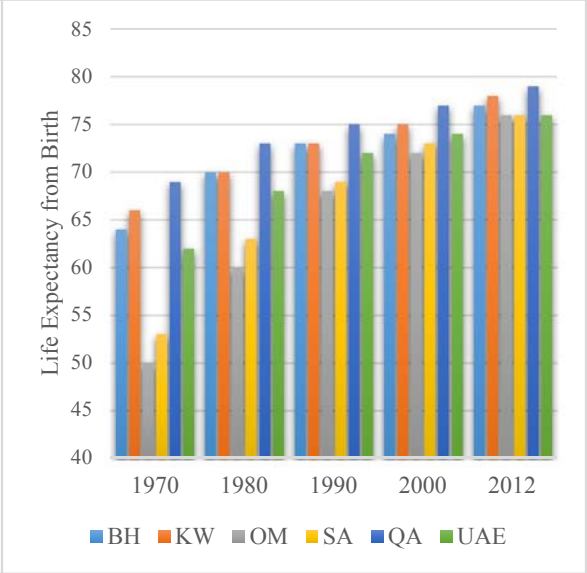
lagging significantly behind the other GCC countries – as shown in Figure III. This gap in health status narrowed substantially over the latter two decades.

Figure II
Life Expectancy by Regions[4] 1970-2012



Source: WHO, WDI 2014

Figure III
Life Expectancy by GCC Country 1970-2012



Source: WHO, WDI 2014

One GCC country, in particular, made exceptional improvements in health system performance during the period from 1970-2000. The Sultanate of Oman was ranked among the top ten performers in the world by the World Health Organization (WHO) in 2000 for its accomplishments in improving the health system performance outcomes of health status, financial protection, and responsiveness. In 1970, Oman had only 2 hospitals and 13 physicians on staff; and a life expectancy at birth of around 50 years. Over five decades, life expectancy improved by almost 80 percent - a remarkable achievement reflecting an abiding commitment by the Omani Government towards improving the human development conditions of the population.

These substantial improvements in health status in recent decades stemmed from the development of an extensive health service infrastructure by the public sector. The GCC states early on adopted a traditional 'national health service' model under which health facilities providing services to the general population were largely owned and administered by the public sector. Within the public sector, large health sector networks emerged under the Ministries of Health, Defense, Interior and other public entities.

Over time, parallel health services emerged in the private sector particularly in the area of outpatient care. The introduction of mandatory health insurance initiatives after 2000 in several GCC countries ushered in an era of rapid expansion in private care facilities. The private sector share of health infrastructure capacity and service utilization is now substantial in most GCC countries. In Abu Dhabi, 31 percent of hospital beds and 93 percent of primary care centers and clinics are now in the private sector.[5] In Saudi Arabia, 23 percent of all hospital beds in the country are owned by the private sector.[6]

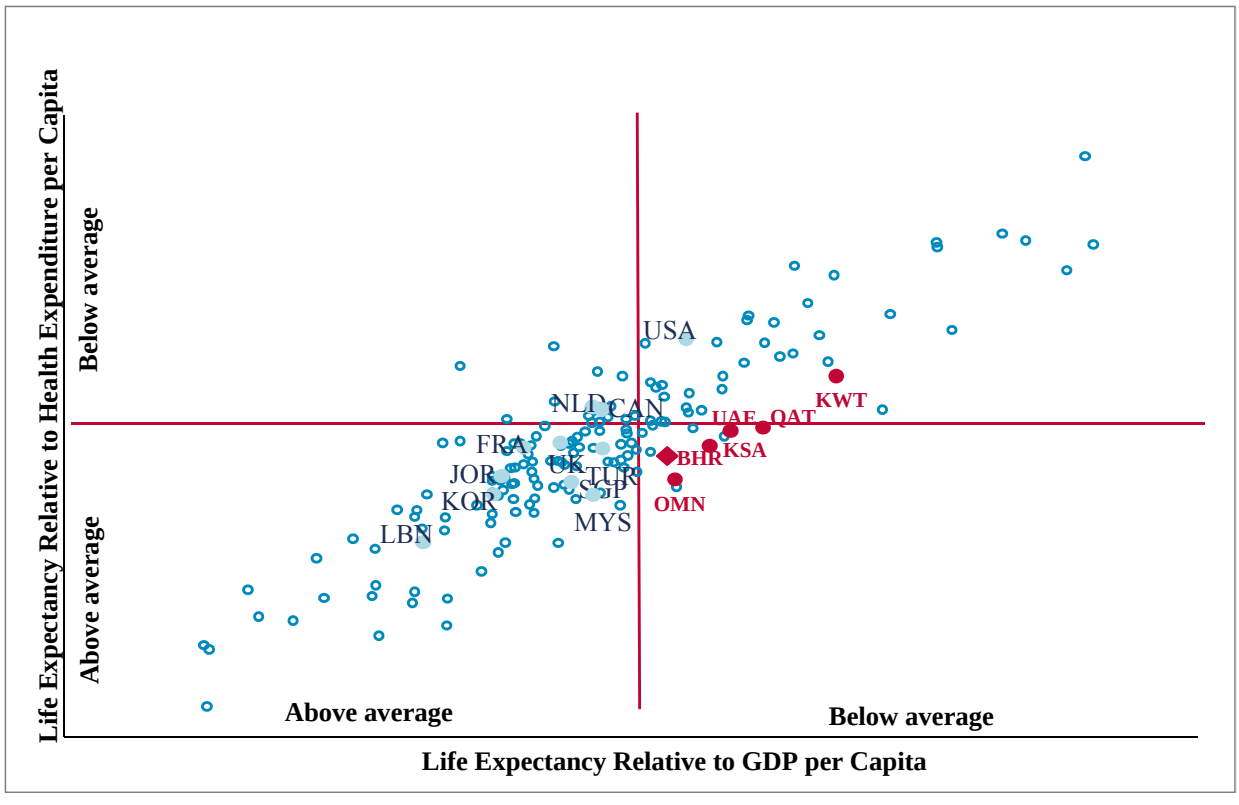
[4] Note: LI: lower income countries; LMI: lower-middle income countries; UMI: Upper-middle income countries; HI: High-income countries. The Y-axes in both graphs begin at 40 to reveal the in-between differences in life expectancy from birth more clearly.
[5] Source: Health Authority of Abu Dhabi (HAAD), 2012.
[6] Source: Ministry of Health, Saudi Arabia, 2014.

The advent of mandatory health insurance schemes in the GCC countries has driven up expenditure on private health insurance as a share of total private health spending. In Qatar, spending on private insurance as a percentage of total private health expenditures increased from 7 percent in 1995 to 47.8 percent in 2012. In Saudi Arabia, the percentage increased from 27.7 percentage to 45.3 percent during the same time period – and a similar increase was observed in Bahrain.[7]

Within the framework of the GCC, an Executive Board for the Health Ministers' Council was established in 1991 to strengthen the harmonization of health policy agendas between the six member states.[8] The Executive Board has focused on promoting cooperation in the areas of infectious disease control, health promotion, emergency medical services, organ donation and transplantation. On the financing side, the Board also launched an initiative for the bulk purchasing of drugs generating substantial efficiency gains for the individual states.

Notwithstanding significant historical achievements in recent decades, health status outcomes in the GCC countries still lag behind the outcomes of countries with comparable per capita income and health expenditure levels. As Figure IV shows below in the case of life expectancy, all six GCC countries perform below average relative to countries with similar per capita income levels – but slightly above average relative to per capita health expenditure levels. Kuwait performs below average relative to both indicators, particularly with respect to GDP per capita.

Figure IV: Life Expectancy Relative to Health Expenditure and GDP per Capita, 2012

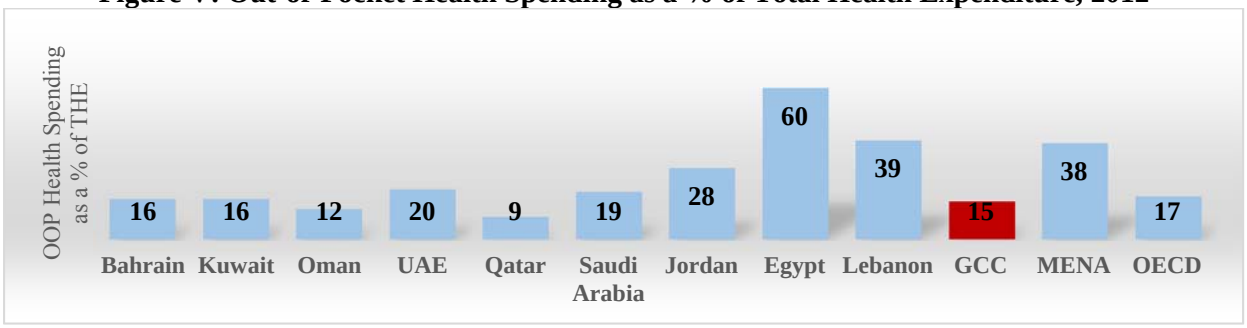


Source: World Bank, WHO, IMF 2014

[7] Source: World Bank, WDI 2015.
[8] Note: Yemen joined as the seventh member of the Health Ministers' Council in 2003

In terms of the impoverishing effects of catastrophic health expenditures, either due to sudden illness or long-term chronic diseases, the GCC states afford their resident populations a relatively broad level of financial protection. Out-of-pocket (OOP) health spending as a percentage of total health spending is below 21 percent in all six GCC states while it is much higher in other countries in MENA and other regions of the world. As Figure V shows below, average OOP health spending in the GGC as a percentage of GDP is 15 percent – two percentage points lower than OECD average and 23 percentage points below the MENA average. OOP spending below the 20 percent threshold set by WHO indicates a relatively good level of financial protection from the unpredictable costs of treating human illnesses.

Figure V: Out-of-Pocket Health Spending as a % of Total Health Expenditure, 2012



Source: WHO health financing indicators, 2012.

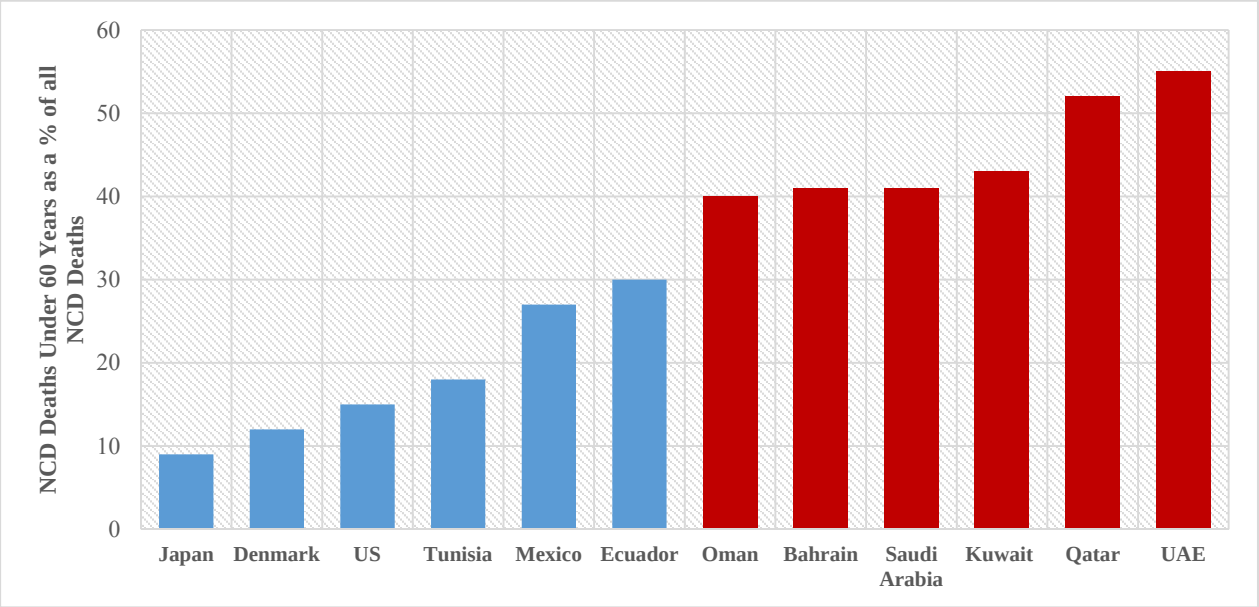
The Escalating Crisis of Non-Communicable Diseases and Injuries

Among the most pressing health system challenges facing countries around the world including the GCC countries is the escalating crisis of non-communicable diseases (NDCs) and injuries. After tackling and controlling infectious diseases over the past half century through immunization services, public health surveillance and essential health services, countries are now grappling with the rising burden of chronic conditions and injuries – and their risk factors. Globally, the five major types of non-communicable diseases and injuries are cardiovascular diseases, diabetes, cancers, chronic respiratory diseases and road traffic injuries and the major adult risk factors for non-communicable diseases are obesity, physical inactivity, tobacco use, alcohol consumption, and raised blood pressure[9].

The mounting tide of non-communicable diseases and injuries in the GCC countries will not only place upward pressure on health financing but will also affect economic productivity due to the growing rates of premature mortality and morbidity among the working population. The changing patterns of disease burden in MENA including the GCC countries have largely mirrored global trends over the last 20 years, especially those in Europe and North America. These changes, combined with population aging, will necessarily dial up the pressure on health spending as the share of NCD disease burden continues to grow. NCDs are projected to account for 81 percent of all deaths in MENA and 87 percent of all deaths in the GCC countries by 2030.[10] Premature deaths due to NCDs among the working population are particularly high in the GCC countries as Figure VI shows below.

[9] Note: Raised blood pressure is also often viewed as a 'risk marker' -- rather than a 'risk factor' -- such as in the case of hypercholesterolemia whose own risk factors include obesity, smoking and physical inactivity.
[10] WHO, 2014.

Figure VI: Under 60 NCD Deaths as a Share of all NCD Deaths, 2013



Source: Economic Intelligence Unit, 2014, 'Health Outcomes and Cost: A 166 Country Comparison.

The share of NCD deaths among individuals aged 60 years or younger out of total NCD deaths in the GCC countries is the highest in the world. Figure VI above shows the estimates for several OECD countries including Japan, Denmark and the United States with figures below 15 percent. On the other side of the graph are the six GCC countries all equal to and above the 40 percent level. The problem in Qatar and the UAE is exceptionally acute with the percentages reaching above the 50 percent level. This high level of premature mortality among the working age population has non-negligible implications for labor force productivity. The high rate of premature NCD mortality in the GCC countries stems from both unhealthy lifestyles and perhaps inappropriate treatment options to manage NCDs and their complications.

There are also noticeable gender differentials in premature NCD mortality rates under the age of 70 in the GCC countries – with males dying much earlier than females. The largest differential is in Qatar (21.8 percentage points) and the lowest differential is in Kuwait (10.1 percentage point). Oman is closer to Qatar with 16.9 percent points and Bahrain and Saudi Arabia are closer to Kuwait with 12.7 and 11.9 percentage points respectively.[11]

The leading contributors to disease burden in GCC countries are a mix of non-communicable diseases and road safety injuries. Mental health disorders, diabetes, low back pain, road injuries and heart disease were the largest contributors to the burden of disease in the GCC countries in 2010 as measured by the composite measure of disability adjusted-life years (DALYs) lost.[12] Mental health disorders are ranked as the highest contributors to disease burden in Bahrain, Qatar and the UAE whereas road injuries are the top contributors in Saudi Arabia and Oman. In Kuwait, the non-communicable disease with the largest impact is heart disease.[13] Explanations for the major contribution of mental health disorders to disease burden in these high-income countries include changing household, gender, and social dynamics in the GCC countries.

[11] Source: WHO 2010 'Global Status Report on NCDs'.
[12] Note: Disability-adjusted life years (DALYs) quantify both premature mortality (years of life lost) and disability (years lived with a disability) within a population.
[13] Source: Institute of Health Metrics and Evaluation, Global Burden of Disease GCC country profiles, 2010

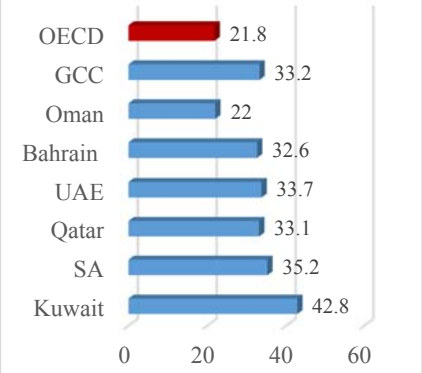
The major NCD risk factors in all GCC countries were obesity, dietary risks, high fasting blood sugar, high-blood pressure and physical inactivity. The number one risk factor in all GCC countries in 2010 was clearly obesity (high body-mass index). Around 8-12 percent of all DALYs in the GCC countries were attributable to the risks associated with obesity. Dietary risks were the second largest contributor to disease burden in Oman, Kuwait, Saudi Arabia and the UAE while high fasting blood sugar levels were the second largest contributor in Bahrain and Qatar. Physical inactivity was also among the top five risk factors in the GCC countries while tobacco use was among the top 15 risk factors.[14]

Obesity, Diabetes and Road Traffic Injuries: Is the GCC a High-Income Outlier?

Are the GCC countries a global outlier among high-income countries around the world with respect to obesity, diabetes and road traffic injuries? Current epidemiological evidence indicates that indeed the GCC countries do much worse than other high-income countries. The prevalence rates of obesity and diabetes in GCC countries are the highest in all high-income countries and second highest among all countries of the world. Only the lower-income Pacific island nations of Polynesia (e.g. Tonga, Samoa, Fiji) have higher rates of obesity and diabetes. Similarly, average death rates from road-traffic accidents are markedly higher in the GCC countries than the average rates among the high income countries of the world.

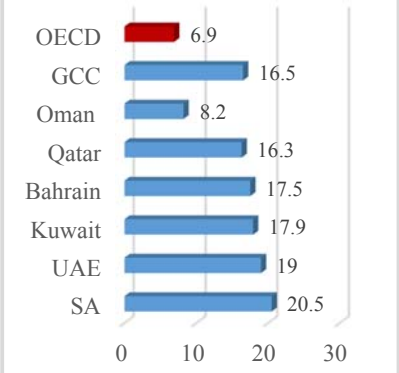
Figures VII, VIII and IX

Adult Obesity Prevalence (2013)



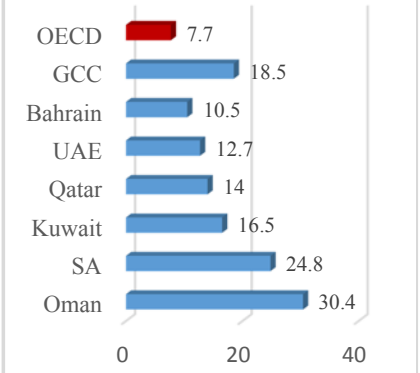
Source: WHO Indicators, 2014

Adult Diabetes Prevalence (2012)



Source: WDF, 2014. OECD Report 2013

Road Traffic Death Rates (2013)



Source: WHO Indicators, 2014

Figures VII, VIII and IX illustrate these differences in graphic form. The average prevalence of adult obesity among individuals aged 20-79 years in the GCC in 2013, as shown in Figure VII, was 33.2 percent whereas in the OECD it was 21.8 percent - around 12 percentage points lower. A similar gap is noticed in Figure VIII. The prevalence of adult diabetes in the GCC countries in 2012 ranged from 8.2 percent in Oman to a high of 20.5 percent in Saudi Arabia – and the average adult prevalence of diabetes was around 16.5 percent. The OECD average of diabetes prevalence was 6.9 percent.[15] The death rates from road traffic accidents, measured as the number of road traffic fatalities per 100,000 population, ranged well above the high-income country average of 7.7 fatalities per 100,000 persons – as indicated in Figure IX. It is worth noting that Oman is an 'outlier within the outliers' in all three graphs. Its indicators for obesity and diabetes are comparable to the OECD figures yet its indicator for road traffic fatalities is significantly higher than

[14] Ibid.
[15] OECD Health at a Glance, 2013

most of its neighboring GCC countries. The impressive achievements in combatting obesity and diabetes in Oman stem from decades of significant investments in primary care and health promotion activities. The less impressive road safety outcomes, as indicated by 2012 data, are likely the result of risky behaviors among the youth and possible under-investments in required emergency medical services.

These alarming trends warrant strong and sustained policy actions by the GCC countries. Obesity affects other important NCD risk factors (i.e. hypertension, cholesterol) and is a major risk factor for heart disease, diabetes and certain types of cancer (e.g. breast, colon, and kidney). Diabetes, if uncontrolled, leads to major complications including kidney failure, eye damage, foot damage and the onset of cardiovascular disease. Mental health diseases, similarly, have significant social and economic consequences for GCC societies. NCDs and road traffic injuries will have an increasingly greater impact on the GCC states and their societies in the absence of effective prevention and management strategies. These trends will continue to: (i) drive cost escalation in the health sector and (ii) lower workforce productivity in the labor market.

Health Service Delivery and Health Financing Challenges

The health service delivery systems in the GCC countries are facing a common set of pressures and challenges. First, the rising tide of non-communicable diseases is pressuring GCC health systems to alter their 'care model' by shifting more NCD prevention and management services down to the level of primary care practitioners. Under such a model, at-risk patients can be more efficiently screened for NCD risk factors and chronic disease patients (i.e. hypertensive, diabetic patients) can be more effectively managed. Chronic disease management requires continuous monitoring by primary care practitioners of NCD patients. In recognition of this challenge, Bahrain is currently contemplating the strengthening of its NCD services within its 27 primary health care centers.

Second, growing numbers of NCD and road traffic injury (RTI) patients are exposing weaknesses in the management and planning of health services in GCC countries. NCD patients, particularly among the elderly, and RTI patients needing long-term rehabilitative care often have extended and unwarranted lengths of stay in acute-care public hospitals. This problem stems from inadequate clinical management systems and from 'social pressures' for keeping long-term chronic patients in acute care settings. Another part of the problem is the shortage of adequate health facilities providing post-acute care services such as rehabilitative care, long-term nursing care, hospice and home-based services which exacerbates the bed management challenges of the public sector hospitals. A study in Saudi Arabia surveying physicians in Riyadh indicated that 86 percent of respondents from public hospitals believed that inappropriate hospitalization including extended lengths of stay occurred either 'sometimes' (69.6 percent) or 'always' (16.4 percent).[16]

Third, GCC health service delivery systems operating under centralized civil service and public financial management rules often lack adequate incentive structures to drive better health system performance. Managers in public sector facilities have neither full management information (due to weak e-health systems) nor do they have sufficient authority to manage their staff effectively (i.e. recruit, dismiss or promote). Centralized line-item budgeting procedures restrict management innovation and the pursuit of efficiency gains. These 'governance' problems are prompting the public sector to think about ways to provide greater autonomy to public sector health facilities. In recent years, both Saudi Arabia and Bahrain have considered delinking their public sector hospitals from the Ministry of Health system and creating autonomous entities.

[16] Al-Omar, BA, 2006, Eastern Mediterranean Health Journal, 'Factors Affecting Inappropriate Hospitalization in Riyadh, Saudi Arabia: Physicians' Perspectives', Volume 12.

Fourth, quality and appropriateness of care represents an important challenge to GCC health officials. The fragmented health service delivery networks in the public and private sector and the absence of effective national quality of care programs in the GCC countries do not create an appropriate eco-system for continuous quality improvement in health care services. The GCC countries need to harmonize quality of care standards across their numerous health service networks and develop national systems for monitoring and reporting quality of care outcomes. In Saudi Arabia, the Saudi Health Council is working to harmonize clinical coding standards across all of the six large healthcare subsystems in the country (Ministry of Health, Ministry of Defense, National Guard, Ministry of Interior, university sector, private sector). In Bahrain, the Government recently established the National Health Regulatory Authority (NHRA) to independently monitor the quality of clinical practice in the health sector.

On the health financing side, similarly, there are several important challenges confronting the GCC health systems. First and foremost, there is the question of long-term fiscal sustainability. Although macro-level spending on health is relatively low compared to countries of similar income levels (total health spending is below 5 percent of GDP in all GCC countries), there are three important factors prompting concern: (i) a fiscal base largely reliant on hydrocarbon revenues as opposed to tax revenues; (ii) increasing cost escalation arising from greater demand because of population dynamics, changing patterns of disease and the continuous introduction of high-cost medicines and health technologies; and (iii) a social contract, as reflected in different constitutional provisions, between state and society stipulating the obligations of the state to ensure access to healthcare services.

Second, there is ample room for improvements in the efficiency of spending by GCC health systems. In most GCC health systems, an excessively large portion of health spending covers higher-cost secondary and tertiary care services rather than targeting lower-cost prevention, promotion and primary care services. In Kuwait, according to National Health Accounts data, the Ministry of Health spent more on expensive overseas treatment (14 percent of the MOH budget) in 2010-2011 than it did on primary health care services (8 percent).[17] In 2012, around 21,658 UAE nationals visited 5 private hospitals in Thailand with an average spend of around (Thai Bhat) 24,000 per outpatient service and (Thai Bhat) 350,000 per inpatient admission.[18]

Third, there has been insufficient innovation in developing new provider payment systems in the GCC countries. In recent decades, many health systems around the world have migrated from traditional line-item budgeting, salaried-based payments, and fee-for-service schemes to new forms of payment systems. This transition occurred during 1970-2000 because of growing empirical evidence in the health economics literature that different types of payment systems have differentiated effects on the practice of medicine – and therefore on the fulfillment of different health system performance goals (i.e. efficiency, equity, and quality). Some of the newer provider payment systems include global budgets for public hospitals, capitated payments for primary care services, prospective payments systems based on diagnosis-related groupings (DRG) for hospitals service and pay-for-performance schemes. Each payment system has its advantages and disadvantages in terms of its health system consequences. With the introduction of new mandatory health insurance initiatives, some GCC health systems have begun to experiment with the development of new payment systems including global budgeting and capitation for primary care services.

[17] Source: Kuwaiti Ministry of Health, National Health Accounts Report, 2014.
[18] Source: Noree, T. 2012, 'Medical Tourism in Thailand', presentation. Note: The 2012 mid-year THB per 1 USD currency exchange rate was 36.1.

World Bank Health Engagement in GCC Countries

The World Bank uses its global experience, sectoral expertise and country context knowledge to provide GCC countries with a 'one-stop' window for advisory services covering policy development and implementation support. It also organizes knowledge-sharing events for the GCC countries focusing on global best practices across a wide array of sectors. The World Bank health engagement in GCC countries currently focuses on three clusters of research and technical assistance activities as shown below.

1. Developing Multi-Layered Solutions for Improving NCD and Road Safety Outcomes

Within this cluster, the World Bank draws on the work of its Health Global Practice in Latin America, the Caribbean, Eastern and Central Europe and East Asia and the Pacific[19] to focus on the following activities:

- Analyzing the economic burden of NCDs and road traffic injuries (RTIs)
- Examining the cost-effectiveness of multi-sectoral solutions to address the growing epidemic of NCDs and RTIs
- Assessing the supply-side readiness of GCC health systems to respond to future demand for health services stemming from NCDs and RTIs
- Providing global best practice evidence for ways to address major NCD risk factors
- Designing pay-for-performance schemes for enhanced NCD screening programs
- Assessing the quality of NCD health care services

2. Health System Strengthening

Under this cluster, World Bank activities focus on the following work:

- Developing and independently assessing health strategies and benchmarking health system performance
- Analyzing health financing systems, expenditure trends, reform options and providing implementation support (activities include public expenditure reviews, institutionalizing health accounts, analyzing health insurance options, designing new payment systems, supporting the development of 'health technology assessment' capacity)
- Strengthening the rationalization of health service delivery (activities include health sector 'masterplanning', developing options for addressing dual practice by physicians)
- Analyzing opportunities to increase private sector participation in health service delivery
- Examining options to improve health care quality and accreditation systems

[19] Note: Examples of recent World Bank NCD publications include: (i) 'Toward a Healthy and Harmonious Life in China: Stemming the Rising Tide of Non-Communicable Diseases'; (ii) The Economic Implications of Non-Communicable Disease for India; (iii) Addressing the Challenge of Non-Communicable Diseases in Brazil; (iv) Promoting Health Living in Latin America and the Caribbean: Governance of Multi-sectoral Activities to Prevent Risk Factors for Non Communicable Diseases; and (v) Supply-side Readiness for Universal Health Coverage: Addressing the Depth of Coverage for Non-Communicable Diseases in Indonesia

3. Integrating Health Policy Solutions within Wider Institutional and Policy Frameworks

The work under this component would focus on the following activities:

- Analyzing how improved governance arrangements can enhance health system performance (e.g. how civil service and public financial management rules affect reforms in health service delivery such as provider payment or hospital autonomy reforms)
- Leveraging sectoral linkages to improve health status outcomes (e.g. developing integrated strategies between the health, transport, education, agriculture and urban sectors to address NCDs and RTIs)
- Supporting the development of regulatory frameworks in important areas of the health sector (food, drugs and medical devices) within and across the GCC countries
- Analyzing options and developing solutions for greater GCC regional health collaboration (e.g. streamlining the portability of health insurance coverage, harmonizing regulations governing physician licensing, accreditation standards, and pharmaceutical policies)

Summary Observations and Outlook

The World Bank Group is well-positioned to support GCC countries with comprehensive health policy advisory services. Its international mandate, broad policy experience, in-depth technical expertise, local country presence and multi-service platform enable it to provide these services covering the areas of policy analysis and implementation support. Two of its own institutions - the International Bank for Reconstruction and Development (IBRD) and the International Finance Corporation (IFC)) - work together to catalyze private sector participation and investments in the health sector. With its strong connections to Ministries of Finance and development organizations around the world, it also has the institutional networks to leverage the totality of global experience in support of priority health policy reforms in the GCC countries.