A critical review of options

for effective health policy formulation in Jordan

A thesis submitted for the degree of Doctor of Philosophy

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Abstract

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Jordan has in general a good healthcare system; yet it has been always exposed to both internal and external challenges which compromise the gains it has achieved over the years. This thesis examines one of the internal challenges, as something that concerns many Jordanians, is arguably holding back and disadvantaging the health sector, yet is something within Jordan's power to address it.

This internal challenge concerns the main constraints to the health sector improvement is the absence of an overall national health policy despite the existence of a constitutional mechanism. This is particularly acute in Jordan as the publicly funded health sector has three largely autonomous and parallel clusters of provision. Thus, this study intends to critically review the options for effective health policy formulation in Jordan based on investigating the current and previous status of the national health policy formulation and its main challenges. This has been done in the context of study of the literature about health policy formulation, and of the potential for and limitations to transfer of policy and mechanisms from one country to another; and with a focus on low and middle income countries.

The empirical study uses 'qualitatively-driven' mixed methods, the data was primarily obtained by conducting semi-structured interviews with High Health Council members and key Stakeholders in health sector and health related entities.

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The main results reveal that the national health policy formulation in Jordan faces numerous challenges; these challenges are not limited only to internal issues, as Jordan is vulnerable to the regional incidents. The results also reveal that the respondents recommended more than one option for formulating the national health policy effectively.

However, based on the evidences and respondents' views; and the experience reflected in the literature, the most effective option for the national health policy formulation has been identified from the options put forward. This option is argued to give the best possibilities, and harnesses indigenous skills and resources to potentially best effect.

Key word: Jordan, health policy, health policy formulation, national health strategy, Ministry of Health, High Health Council, challenges, effective policy options

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Abbreviations

CCS	Country Cooperation Strategy (WHO)
CSB	Civil Service Bureau
DOC	Department of Statistics
EMRO	Eastern Mediterranean Regional Office
GBD	General Budget Department
GDP	Gross Domestic Product
GNP	Gross National Product
GMA	Greater Amman Municipality
GOJ	Government of Jordan
HHC	High Health Council
HICs	High Income Countries
JD	Jordanian Dinar
JDA	Jordan Dental Association
JFDA	Jordan Food and Drug Administration
JMA	Jordan Medical Association
JNMA	Jordan Nurses and Midwives Association
JNRC	Jordan National Red Crescent Society
JPA	Jordan Pharmaceutical Association
JPD	Joint Procurement Department
JU	University of Jordan
JUH	Jordan University Hospital

JUST	Jordan University of science and technology
KAUH	King Abdullah University Hospital
LMICs	Low and Middle Income Countries
LOB	Legislation and Opinion Bureau
MDGs	Millennium Development Goals
MENA	Middle East and North Africa
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MOHE	Ministry of Higher Education
MOL	Ministry of Labour
MoMRA	Ministry of Municipal and Rural Affairs
MoPSD	Ministry of Public Sector Development
MoPIC	Ministry of Planning and International Corporation
MoSD	Ministry of Social Development
NGOs	Nongovernmental Organizations
NCDs	Non communicable diseases
NCP	National Council for Planning
NCDEG	The National Centre for Diabetes, Endocrinology and Genetics
NHA	National Health Accounts
PHA	Private Hospital Association
RMS	Royal Medical Services
SSC	The Social Security Corporation
UNRWA	United Nations Relief Works Agency

USAID	United States Agency for International Development
UHs	University Hospitals
WHO	World Health Organization
WB	World Bank

Chapter 1

Introduction

1.1 Introduction

This chapter presents a general overview of the thesis, which aims to investigate the main challenges that face the national health policy formulation and seeks to review the options for effective health policy formulation in the Hashemite Kingdom of Jordan. This chapter will introduce a general background of the study rationale, aim, research questions, methodology, in addition to the research motivation, and finally the thesis structure.

1.2 General overview

Jordan has worked hard to build its healthcare system, which resulted in the creation of an established network of primary healthcare centres, supported by secondary and tertiary care facilities, providing accessible healthcare services to all citizens and residents, and with a continuous motivation to move forward. It provides setting for medical and nurse education, the facilities and services are respected sufficiently to result in a significant medical tourism for secondary care.

While Jordan is a stable and well governed country and has tended to received positive assessment from WHO for its healthcare system and governance, there are, nevertheless, a number of particular features, which though not unique, particularly important factors affecting the health system and its policies, such as the existence of multiple public health providers in addition to a private sector. Furthermore, Jordan is a stable and peaceful country in a region of considerable conflict and has accepted constantly large numbers of refugees whose healthcare

needs are actually provided from the country's own health sector; this humanitarian approach is important but clearly it is not immutable and presents an unusual challenge for normal healthcare planning and resource allocation processes.

1.3 Background and Rationale of the study

The Jordanian Health System is quite complex; healthcare services are provided by public, private and NGO providers. The public health sector includes mainly the Ministry of Health (MoH), the Royal Medical Services (RMS) and Universities Hospitals (UH's), however, the MoH is the main healthcare provider in the Kingdom, thus it is granted wide authorities in accordance to the public health law to; regulate, organize and supervise the health services offered by public and private health sectors, in addition to public health related issues.

Jordan has early recognized the importance of initiating an institution that combines health sector providers, supporting institutions and related entities under one umbrella to synthesis their efforts toward the achievement of the national goals. However, one issue which has continually been a professional and public concern is the lack of stability and lack of effectiveness of the mechanism to coordinate the different policy and organizational sectors within the health system. The mechanism which has been constitutionally in place since 1966 has been the High Health Council (HHC), which initially was seen to be important because it is chaired by the Prime Minister, and while this established a feasible importance for health sector coordination, at the same time this high level of governance was seen as producing its own problems because of its distance from operational matters, and because of the extensive span of responsibilities of the PM and other senior members, along with the role conflict between MoH and the HHC.

Although, the council was established in 1966, it was unstable and its 'by-laws' and 'law' have changed several times[1], its chairman was fluctuating between the PM and the MoH minister over the years, the first general secretariat was created in 2002, and the council only produced two national strategies; the first one was not implemented and the other one was recently produced (2015-2019).

1.4 Statement of the research problem

Given the importance of health sector coordination and the shared set of values and priorities, coupled with the ever present need to optimize use of skills and resources, this thesis seeks to focus on the particular structure of health sector coordination and leadership through the HHC and to consider whether this high profile mechanism is the most effective one to provide health sector leadership and direction in a way which stimulates the trust of all sector contributors, politicians and public. Empirical work will seek to establish the strengths and weaknesses of the current HHC mechanism in Jordan, establish the causes of these strengths and weaknesses, in addition to critically review other potential options and evaluate them, and in the light of the evidence from the literature to consider the best way forward for Jordan for health policy coordination in the health sector and related entities.

1.5 The study aim, objectives and questions

This section will present the study main aims and objectives, and accordingly will present its main questions.

[1] The HHC by-law was changed in 1977-1980-1986-1988, the HHC law was changed in 1999-2014

1.6 Aims and Objectives of the Study

1.6.1 Aim of the study

In general this study intends to analyse the relevant literature on health policy making in countries similar to Jordan and to learn from experience and opinions of senior post holders and stakeholders in order to review critically the options for effective health policy formulation in Jordan based on investigating the current and previous status of the national health policy formulation and its main challenges.

The overall aim of the study is to identify the possible options, and respective strengths and weakness in order to help identify the best way for the national health policy formulation in Jordan. By its nature, this work will include and reflect the perspectives of the healthcare experts, stakeholders, and the High Health Council (HHC) members.

1.6.2 Specific objectives

The specific objectives are defined as follows:

- To identify the main challenges facing the health formulation in Jordan in general from the perspective of:
    - Stakeholders: healthcare providers, public institutions, National NGOs, International agencies, profession associations, and healthcare experts
    - HHC members (as identified by HHC law No. 9 for 1999)
- To evaluate and review the effective options for health policy formulation in Jordan from:
    - The perspective of Stakeholders: healthcare providers, public institutions, national NGOs, international agencies, profession associations, and healthcare experts.

- The perspective of HHC members (as identified by HHC law No. 9 for 1999)
- Empirically review literature, and national and international reports and documents.

1.7 Research Questions

Based on the explained importance of the study, its aims and objectives; the overarching research question is:

1.7.1 Overarching research question

What are the main challenges for the national health policy formulation in Jordan from the health sector stakeholder's and the HHC member's perspective? And what are the potential options for policy formulation in Jordan?

1.7.2 Specific Research Questions

The main question will be divided into the following sub-questions:

- What are the main *obstacles/challenges* for the national health policy formulation in Jordan?
- High health council (HHC) role in health policy formulation:
    - Does the (HHC) have effective role in policy formulation?
    - Will the recent change of HHC chairman (from the Prime Minister to Minister of health) facilitate the national health policy formulation?
    - Does the HHC membership represents the health sector properly?
- The respondent's suggestion(s) for the national health policy formulation options
    - How should the national health policy be formulated from your own perspective?

- The role of International organizations and Aid agencies in health sector and how it is related to health policy issues
    - The role of International organizations in the health sector i.e. (WHO, UN…)
    - The role of AID agencies in the health sector i.e. (USAID, JICA…)
- The absence of the national health policy

    What are Consequences of not having a national health policy?

1.8 Research methodology

The study will use a mixed methods approach, the main stands of the study being:

- Conduct a literature review to establish the current understanding of health policy formulation in low and middle income countries (LMIC), and in countries experiencing rapidly changing external challenges
- To obtain *primary data* by conducting semi-structured interviews with High Health Council members and key Stakeholders in health sector to ascertain their views regarding the main challenges that faces the formulation of the national health policy, how to overcome these challenges, and what are the possible options forward. The interview questions were designed particularly for this study.
- To obtain *secondary data*: through obtaining and analysing international organization reports about Jordan in general and health sector status such as WHO, UNDP… and other reports from Donor agencies such as USAID, in addition to the official documents and reports issued by the Jordanian government such as the annual statistics book, … and reports and documents related to the health sector in particular such as the National Health Accounts (NHA) issued by the HHC, and the annual reports issued by the Ministry of Health (MoH). The secondary data was

essential as it is generate an overall understanding of the study, further, it was used in several instance to triangulate the main results emerged from the primary data.

1.9 Study outputs, desires, and contribution

The main output from this study is to generate a PhD thesis and gather information not previously amassed, which will be of value to the Jordanian health sector and government.

This study is expected to contribute to the academic and theoretical background since the area of health policy making and planning is under-researched in Jordan. Most of the current academic contributions in the health sector in Jordan tackle issues on the micro level, mainly topics related to the reproductive health services. This study will be one of the unique studies investigating health policy making and planning on the macro level.

Additionally, the study is expected to contribute to the practical level as it investigates the key challenges that face health policy development, and how to overcome these challenges based on the interviewees' perspective (HHC members and the key stakeholders) in order to be addressed – hopefully - in the future national health policy and strategies. Consequently, the researcher intends to submit this study and its final results to HHC and MOH.

Furthermore, the study aims to contribute in filling the gap that was highlighted by some authors in LMICs studies related to health policy (ex. Gilson and Raphaely, 2008; Walt et al. 2008; Berlan et al., 2014).

1.10 Personal and professional motivation for the topic

In addition to the importance of the research on the national and academic levels; the researcher has other motivations on the personal and professional level.

Before starting my PhD journey I was a lecturer at Yarmouk University at Public Administration department; Public Administration (PA) was considered a multi-disciplinary field as reflected on the curriculum; one of the topics is 'Healthcare management', which is an elective module for both undergraduates and postgraduate students. This module is not frequently available due to the lack of the qualified staff, so I was motivated to have my degree in Health policy making related issues to be able to teach this module along with other modules I used to teach during my work as university lecturer for three years. A greater opportunity for me is the partnership which started in 2003 between Yarmouk University and Royal College of Surgeons in Ireland 'RCSI – Institute of Leadership' to deliver an MSc in 'Health Services Management', and according to the curriculum I can teach two main modules. However, the partnership ended in 2015 during this study, but because the program was successful and was attractive to professionals in Jordan and Saudi Arabia[2], the faculty board decided to accommodate the program under the public administration department (where I belong) and this should be a good opportunity for me, especially because there are few staff specialized in health policy and management issues[3].

Furthermore, I am planning to utilize my previous experience in public, national and international organizations and my academic background along with the new knowledge and ideas that I have learned during my PhD to produce articles and studies on topics rarely tackled or investigated, and I plan to focus on: public policy-making, aid effectiveness, funded project evaluation, in addition to issues related to health policy and management.

[2] the program was designed to delivered during the weekend and as Jordan is very close to Saudi Arabia border, the program attracted a number of Saudi professionals

[3] Previously it was a joint program between YU and RCSI and some modules were delivered by RCSI lecturers.

1.11 Thesis structure

This thesis is organized into eight chapters, and each chapter is divided into sections and subsections. The following is a brief description of each chapter:

- **Chapter 1**: identifies the foundation and the research direction, including the research questions, objectives, importance and its methodology.
- **Chapter 2**: presents an overview of the study contexts (Jordan) including information about: Geography and Climate, Historical and Political Background, Social and Cultural Background, Education, Economic and Social development and Refugees in Jordan. The second section presents information about the health sector in Jordan in terms of health system, main providers and main challenges
- **Chapter 3**: provides information about health policy and management in Jordan, also providing a background about the High Health Council and the Council's role in health policymaking.
- **Chapter 4**: presents the theoretical framework and literature review of the study, it contains main issues related to the health policy in general, its process and actors, in addition to present the main challenges for the national health policy formulation.
- **Chapter 5**: Presents the study design and methodology. The chapter explains the research methods used in this study and the data collection process.
- **Chapter 6**: presents the data analysis and the main results and findings; it presents the respondents' profiles, and the main challenges they reported, classified into main themes and sub-themes.
- **Chapter 7**: presents the discussion of the main the study results, and present the main options for effective health policy formulation.
- **Chapter 8**: presents the main conclusion and the possible way forwards

- **Appendices:** the study has a number of appendices, mainly related to the chapter two (the study context) and some other detailed information to support the study results and discussion.

1.12 Summary

The introductory chapter aimed to shed light on the overall framework of the study. The study context was illustrated and the main aim and objectives were clarified. The research design and methodology was briefly presented. In addition, this chapter presents the thesis structure, limitation of the study and the target audience.

Chapter 2

Jordan's Profile (context of the study)

2.1 Introduction

This chapter has two main sections; the first one will provide general information about the study context (Jordan), the second section will provide information about the health sector in Jordan in term of health system, main providers and main challenges.

2.2 The study context: JORDAN

In this section, general information will be provided about Jordan, including geography, climate, historical background, social and cultural background, education, economic and social development.

2.2.1 Geography and Climate

The Hashemite Kingdom of Jordan is located in western Asia, eastern Mediterranean region. It is located to the east of the Jordan River, northwest of Saudi Arabia, south of Syria, southwest of Iraq and east of Israel and the Palestinian National Authority (Appendix 2.1, map of Jordan). Within the total area of the kingdom (89,318 km), the arable land forms only 6.2% of the total area of the kingdom (DOC, 2014), further details (Appendix 2.2).

Jordan's primary sources of water are aquifers and basins that are fed and recharged through annual rainfall. Water deficit is one of the serious problems that face Jordan. Jordan is ranked among the top poorest countries in water resources (Hadadin et al, 2010), water deficit is not only affecting people share of drinking water, but also affecting negatively the agriculture and manufacturing sectors. There is a serious concern that in future Jordan will face severe water crises due to the population growth (mainly due to the immigration waves) which will affect both the quality and quantity of the water. Another factor associated with water scarcity is having an arid and semi-arid climate. Jordan has a large area of desert land in the southern and the eastern border with Iraq and Saudi Arabia (Hadadin et al, 2010). Despite the water deficit in Jordan; the sustainable solutions, such as water harvesting and wastewater treatment remains substandard.

2.2.2 Historical and Political Background

Historically, Jordan is part of the Middle East region, which was under the rule of the Othman Turk Empire since the 15th century until the empire collapsed after the First World War. The region was divided by the European imperial powers (Sykes-Picot) agreement in 1916. In 1921 the League of Nations officially granted the British government the guardianship over Palestine, Iraq and Transjordan. Amir (Prince) Abdullah become the ruler of Transjordan from 1921-1948, then become King Abdullah I after the Kingdom independence, he ruled until 1951 (Rayan, 2002).

The late King Hussein ruled around five decades (1952-1999). His late Majesty is considered the father of modern Jordan. Throughout his 47-year reign; King Hussein strove to achieve prosperity and advancement in different aspects of the Jordanian life, and his majesty's main concern was improving the quality of life for Jordanians. His majesty has remarkable

achievements locally, regionally and on the international community level (The Royal Hashemite Court, 2016). Since established; Jordan has witnessed several immigration waves, mainly the Palestinian refugees in 1948 and 1967, and then in recent years; Jordan hosts Iraqi and Syrian refugees.

King Abdullah II Bin Al Hussein assumed his constitutional powers as Monarch on February 7th, 1999 the day when the late King Hussein passed away. Since then, his Majesty has undertaken a significant social and economic reform programmes.

The Hashemite Kingdom of Jordan is a constitutional monarchy. Politically, the king is the head of the state. The Jordanian political system is based on the separation of the three powers (Legislative, Executive, and Judiciary). The relationship between these three authorities is a balanced, complementary, and participatory one. According to the Jordanian Constitution; 'The Executive Power shall be vested in the King, who shall exercise his powers through his Ministers in accordance with the provisions of the present Constitution' (Jordanian Constitution, article 26),the Prime-Minister head the executive branch, the cabinet is nominated by the Prime-Minister and approved by the king. 'The Legislative Power shall be vested in the National Assembly and the King. The National Assembly shall consist of a Senate and a Chamber of Deputies' (Jordanian Constitution, article 25), the Chamber of Deputies (also known as house of representative) is elected directly by the citizens for four year period, and the Senate are appointed by the King, and their number shouldn't exceed 50% of the Chamber of Deputies. 'The Judicial Power shall be exercised by the courts of law in their varying types and degrees. All judgements shall be given in accordance with the law and pronounced in the name of the King' (Jordanian Constitution, article 27).

2.2.3 Social and Cultural Background

Jordan is a young nation founded on ancient land. Several civilisations came across Jordan's land such as Nabataeans, Greeks, Romans, Persians and Islamic caliphs; all preceded the Turks and European powers in building strongholds here. Before the state was established; the region including trans-Jordan lands received some ethnic minorities who escaped their lives in the late 19th century such as the Circassians, Chechens, Armenians and Kurds, who embellished the Jordanian patchwork, alongside the local Arab people. The majority of Jordan's initial population is of Bedouin origin (The Royal Hashemite Court, 2016).

The majority of Jordanian are Sunni Muslims (92%), only about 1% are Shia or Sufi. Christians, living mostly in Amman, make up 6% of the total, with 1% representing other religions. Most of the Christians are either Orthodox or Catholic. Jordan is a tolerant nation and welcomes all religions. Arabic is the official language; however, English is widely understood and used among citizens.

According to Department of Statistics (DOC); Jordan has around 9,531,712 million people (48.5% females, 51.5 % males), largely urban population (82.6% of the population is urban and 17.4% rural). The population of Jordan doubled more than ten times within the last 55 years; the highest increase was during last decade, this was due to refugees, and forced migration waves occurred since 1948 till now, in addition to the repatriation of Jordanians and Palestinians after the Gulf war (1990). The Jordanian population (6,613,587) formulates (69.4%) of the total populations; the non-Jordanian is (30.6%), (1.26 million are Syrians, 636,270 Egyptians, 634,182 Palestinians, 130,911 Iraqis, 1,163 Yemenis, 22,700 Libyans and 197,385 from other nationalities). Annual population growth rate among non-Jordanians is (18 %), while for Jordanians it stood at (3.1 %).Jordan is relatively young; 82% of the population are below the age of 40, and 48.3% of the population are under the age of 20. Around 42.04% of the population

(Jordanian and non-Jordanian)are concentrated in Amman (capital), Irbid 18.57 %, and Zarqa14.32 %, the rest of population 25.07 % are distributed among 9 governorates ranged between 5.77%-1.01%, (Appendix 2.3 the Governorate maps of Jordan), (DOC, 2015; DOC, 2014; DOC, 2013).

2.2.4 Education

The educational system in Jordan witnessed remarkable improvements compared with other countries in the region. The illiteracy rate for Jordanians in 2015 is 6.7% (9.8% female, male 3.7%) and (14.5%) for non-Jordanian. Jordan has (10) public universities, (17) private universities, and 40 community colleges (16 public, 6 for the military, 16 private, 2 for UNRWA). Undergraduate students at Jordanian universities are (51.7% female, 48.3% male), (DOC, 2015; DOC, 2013).

Jordan Human Development index (HDI) value for 2014 is (0.748), ranked (80 out of 188 countries and territories), which placed the country above the average of the high human development category (0.744), and above the average of (0.686) for countries in the Arab States (UNDP, 2015).With notice that Jordan rank has dropped in the last few years due unfortunate events in the region, accordingly, Jordan drops three places in Human Development Index (HDI) from rank 77 to rank 80 among 188 countries (Bani Mustafa, 2016).

Jordan recognized earlier that strengthening the educational system and improving the human resources capabilities and competence could partially compensate the lack of natural resources. Accordingly, the qualified human resources become an assist as Jordan exports the educated labour force, mainly to the Gulf countries; eventually, the remittances from expatriates

is considered as one of the economic resources in Jordan. However, Jordan has a large number of expatriate workers that fill the low-paid jobs.

2.2.5 Economic and Social development

Jordan is a small, upper middle-income country with a GDP at market prices ($ 35,83 m) in 2014, GDP annual growth rate is (2.6%).Unemployment rate was 12.6% for 2013 (22.2 % females, 10.6 % males), and 13.8% for 2015 (23% females, 11.7% males). The official poverty rate is (14.4%) for 2010, the rural areas experienced higher poverty rates than urban areas. The dependency ratio in 2014 is (68.2%).The inflation rate in 2014 is (2.8%), (DOC, 2014; DOC, 2013; DOC, 2015).

Jordan has limited natural resources and is suffering from shortage of freshwater supplies in addition to wide arid land that limits the agricultural sector, along with the high cost of importing energy. Further, the Jordanian economy is very fragile to regional events, such as the negative implication of immigration waves and gulf war I and II.

The economic growth in Jordan depends on several vital bases: the export of the phosphates and potash,-as Jordan is considered the third largest producer-, the foreign aids and the remittances from expatriates. Jordan also took the advantage of its strategic geographic location, well-educated and qualified workforce (it exports labour force, mainly to the Gulf countries). Further, Jordan has signed several agreements which led Jordan to be a transit point for exports and imports between Western Europe and the Middle East. These features have a positive influence in attracting the direct foreign investments (Dandan, 2011). Tourism also is an important source of income; the tourism contributed (14%) to Jordan's GDP in 2014 and

considered the second source of GDP in Jordan, however, it decreased to (12%) in 2015, (Ministry of Tourism and Antiques, 2015).

As for the Jordanian labour market; the refined economic participation rate in 2015 is (36.7%), (60% males, 13.3% females). According to the Ministry of Labour (MoL), the expatriate workers formulated around (20%) of the total workforce in 2015. The percentage of work permits holders are (68.2%) Arabs, and (31.8%) non-Arabs, around two-thirds of the total expatriate workers are from Egypt (65%), (15 %) from Bangladesh, (5.4%) from Philippine, (4.7%) from Sri-Lanka, and the rest of the workers belong to Asians and others counties (MoL, 2015; DOC, 2014). However, it isit is expected that the illegal expatriate workers in Jordan are three folds of the registered workforce labour numbers (mainly Egyptian workers). The remittance transfer from Jordan to the worker countries estimated to be ($1.7 billion), which formulates around (5%) of the GDP.

Expatriate workers problems are escalating, practically after the Syrian crisis and the entrance of thousands of people to the labour workforce competing with the non-skilled and even skilled Jordanian works on the limited available job opportunities. The highest category affected by the expatriate workers is unemployed Jordanians with an educational level less than a secondary certificate, who formulate (41.3%) of the total unemployed Jordanian. Another issue associated with expatriate workers is the illegal workers who even reached three folds of the registered ones, who have an un-even competition with the local workers. In addition, those workers pay no taxes and consume the subsidies goods and services provided by the government, along with security issues.

Yet, Jordan is still facing several challenges; mainly the budget deficit, high external debts, high unemployment rate and high dependence on food and oil imports. Foreign aid is considered a key source to fulfil Jordan needs, however the foreign aid fluctuates greatly,

particularly after the Arabic spring spillovers, which affects Jordan's ability to satisfy its people and the increasing refugees needs, this critical situation places Jordan at risk, and the government continually express their fears to the international community to urge them to undertake their responsibility toward Jordan.

2.2.6 Refugees in Jordan

According to UNHCR; Jordan has the 2nd highest per capita refugee rate in the world (UNHCR, 2015). Since the outset of Transjordan, the country received several waves of refugees from neighbour countries and the region. Jordan's hospitality policy and tolerance in addition to its geographic location make it the first destination for asylum seekers and refugees. However, the immigration waves have several negative consequences on Jordanians, because Jordan's f natural resources including severe water scarcity are very limited. Further, economy, and infrastructure have been affected too.

Although Jordan is not a part of the 1951 Convention on the Status of Refugees nd the 1967 Protocol on refugees; it cooperates with the UNHCR. Jordan has signed a memorandum of understanding with UNHCR in 1998; this MoU is similar to the 1998 convention in many aspects (Olwan, 2009), the MoU was partially amended in 2014 (UNHCR, 2016).

Brief about Jordan history in hosting refugees:

- *Palestinian refugees*

Palestinians have been forced to leave their homeland and escape to Jordan during the 1948 and 1967 wars with Israel. The Palestinians case is quite complex as Jordan was the only country to grant the Palestinians the right to hold Jordanian citizenship, and they become a vital composition of the community. There is no official statistics of the

numbers of Jordanians from Palestinian origins as they enjoy their full citizenship rights since they have been obtained.

The total registered Palestinian refugees with UNRWA is (5,589,488), around (2,212,917) in Jordan and formulates (39.6%) of the total refugees (Lebanon 8.8%, Syria 10.6%, West Bank 16.9%, Gaza Strip 24.1%). Only (17.4%) live in (10) official camps in Jordan (Appendix 2.4: Palestinian refugee's camps map in Jordan). Further, around (18,000) Palestinian refugees who were registered in Syria escaped to Jordan after the violent events there, and it is expected that the number will increase in 2016, (UNRWA, 2015, 2016 a; UNRWA2016 b).

- *Iraq's refugees*

Iraqis have swept into Jordan as refugees in two waves; after the Gulf war in 1990-1991, and after the invasion of Iraq in 2003. Between 1990 -2002 thousands of Iraqi's came to Jordan but not registered as refugees as they were classified as being upper-middle-class people, some of them started their own business, and a number of them were qualified professionals who joined the Jordanian market and labour (Olwan, 2009; UNHCR, 2015).

Out of around (130,911) Iraqi people in Jordan, only (50,856) are registered with UNHCR in Jordan, while only (22,920) are assisted by UNHCR (DOS, 2015; UNHCR, 2015).

- *Syrian refugees*

Syria is witnessing violence, unfortunate incidents, and insecure condition in wide part of it from 2009, since then; Syrians have crossed the borders to escape their lives to the neighbour countries: Jordan, Lebanon and Turkey. Around 1.26 million Syrian people live in Jordan; only (629,034) are registered with UNHCR in Jordan as refugees. As violence

actions continue in Syria; more refugees are expected to flee to Jordan (DOC, 2015; UNHCR, 2015).

The Syrian crisis has a huge burden on Jordan; its negative consequences overrun all the refugees' waves before. Some of the reasons are the massive numbers of refugees; they formulate around 20% of the population in Jordan, and less than half of them are assisted by UNHCR, they have high fertility rate, and their number are potential to be increased continually. Only 15 % lives on camps and 85% live in the cities (Appendix 2.5: UNHCR registered Syrians map in Jordan).

In 2014, it was estimated that of every 10 refugees living in Jordan, 7 are poor, and around 55% of refugees are vulnerable to monetary poverty and 50% are vulnerable to food shocks, further around 88% are either poor today or expected to be poor in the future, more distressful fear is that the UNHCR assistance may not be sustainable in the future (Verme et al, 2016).

A huge burden is placed on the infrastructure and services including healthcare and education, and other natural resources most importantly the water supply. The Jordanian citizens sympathized with the Syrian crisis in the beginning and until now, but have more serious concerns about the long-term effects of the situation and even they feel that their share of public services has been affected negatively and they raised their claims and demands to the government to balance between its humanity duties and its duties toward their citizens. The Jordanian citizens and leadership felt they were abandoned by the international community and were left to face all those consequences alone. King Abdullah II tried to convey all these fears to the international community, one of these occasions was 'Syria donor conference' hosted by London in February/2016, the king say it clearly that Jordan is at "boiling point" because of an influx of hundreds of thousands of Syrian refugees, the King said "It hurt us when it comes to the educational system, our

healthcare," he added. "Sooner or later, I think the dam is going to burst ..." (King Abdullah II interview with Doucet from BBC, 2/2/2016).

- *Others*

According to UNHCR, there are (3,480) persons from Sudan and (3,989) from different nationalities are registered as refugees in Jordan (UNHCR, 2015).

2.2.7 Summary

Jordan is facing several challenges, most prominently the demographic challenges; the population increased by more than tenfold in the past 55 years, the majority of the population growth came from non-Jordanians, and they are formulating now around 30% of the total population, and it is expected to increase even more due to regional events, mainly the Syrian crisis and the continual influx of refugees. The demographic challenges have essential implications on different aspects such as the huge burden on the infra-structure and services including healthcare services and education. Demographics have implications on the economy such as labour and increasing unemployment rate, along with the impeded problems related to the economic sector itself which led it to be vulnerable to the external shocks and regional instability. Jordan also is faced with serious problems related to the scarcity of resources, most importantly the water scarcity and the demolishing of the groundwater to maintain the unexpected population increase. Security is a vigorous concern both internally and externally.

2.3 Health sector in Jordan

2.3.1 Introduction

Jordan worked hard to build its healthcare system, which resulted in having a network of primary healthcare centres, supported by secondary and tertiary care facilities, providing accessible healthcare services to all citizens and residents. The Jordanian Health System is quite complex; healthcare services are provided by public, private and NGO's. Yet, the public sector is the main healthcare provider. Detailed description to the health sector component and providers will be provided in section (2.3.4). Further, the indicators on the national level show a significant development. Key indicators will be presented in section (2.3.3). However, the healthcare sector in Jordan faces several challenges which will briefly be presented in section (2.3.6).

2.3.2 Historical Background

Healthcare sector development could be tracked from the early establishment of the state. Healthcare started in the Trans-Jordan era (1921-1946); a major feature was in 1926, when the first regulatory health law was decreed, it was implemented until 1971, then it was amended. The health sector was managed by a health directorate first initiated in 1925. After the independence in 1946, Jordan faced hard circumstances due to Palestinian catastrophes and its consequences on the kingdom (1948-1967) along with other challenges. Nevertheless, Jordan was able to accomplish recognized achievements, most prominently; the first Ministry of Health (MOH) which was established in 1950 along with the establishment of medical faculties, nursing colleges, and several hospitals across Jordan. The first health insurance system was implemented among armed force members in 1963, and the first civil health insurance system was established in 1965.From the 1980's until now, Ministry of Health achievements continue and expand, along

with other private hospitals, NGO's and health care institutions. Considerable advancement has been achieved in Jordan, according to universal standards in the health sector (MoH, 2016). Appendix 2.6 illustrates the detailed background of healthcare sector in Jordan.

2.3.3 Key health indicators

The health sector witnessed significant improvements which affected the citizen's health positively, and the health indicators reflect the quality of the health services in Jordan. Table (2.1) illustrates some essential demographic/health indicators.

Jordan health status has been reported in a number of international reports; according to the global competitiveness report Health and primary education index was (47 out of 144, with score 6.1 out of 7), (Schwab, and Sala-i-Martín, 2015).

Table 2-1: Demographic and Health Data in Jordan

Indicator		***2015***	***2014***	***2013***	***2012***	***2011***
Crude Birth rate (per 1000.pop.)		28.6	28.6	28.1	28.1	30.1
Population Growth Rate (%)		5.3	-	2.2	2.2	2.2
Average Persons Per Family		4.8	-	5.4	5.4	5.4
Total Fertility Rate		3.5	3.5	3.5	3.5	3.8
Life Expectancy at Birth	Male	72.7	72.7	72.4	71.6	71.6
	Female	76.7	76.7	76.7	74.4	74.4
	Average	74.4	74.4	74.4	73	73
Crude Death rate (per 1000.pop.)		6.1	6.1	7	7	7
Infant Mortality Rate (per 1000.live births)		17	17	17	17	-
Physician/10000pop		22.2	29.4	28.6	27.1	25.5
Dentist/10000 pop		7.1	10.3	10.4	10.0	10.0
Nurse (All Categories)/10000 pop		24.8	45.3	44.8	46.6	44.7
Pharmacist/10000pop		12.7	18.3	17.8	16.3	12.6

Prepared by researcher, Source (MoH, 2015, 2014, 2013, and 2012)

2.3.3.1 Healthcare expenditure

The Health sector in Jordan could be described as 'costly' system. The level of expenditures on the healthcare sector in Jordan is considered high as an upper middle-income country (7.58% of GDP in 2012). According to the WHO; the average of total expenditure on health of GDP for the upper-middle income country for 2012 is (6%), and Jordan already exceeds that average, and even it is more approximate to the global ratio (8.6%). Further, Jordan exceeds its regional average as the Eastern Meditation Region ratio is (4.6%), (WHO, 2015; MoH, 2015). Table (2.2) presents key national health account indicators for 2013-2011.

Table 2-2: Jordan National Health Accounts Main Indicators

Indicator		***2013***	***2012***	***2011***
Total Health Care Expenditures (JD)		1,880,953,104	1,665,014,650	1,580,677,286
Per Capita Health Care Expenditures (JD)		231.8	260.6	252.9
Gross Domestic Product (GDP) (JD)		23,851,600,000	21,965,500,000	20,476,600,000
Gross National Product (GNP) (JD)		23,611,200,000	21,749,300,000	20,349,000,000
Per Capita GDP (JD)		2939.6	3438.6	3275.8
Health Care Expenditures as % of GDP		7.89%	7.58%	7.72%
Health Care Expenditures as % of GNP		7.97%	7.66%	7.77%
% of Gov.Budget allocated to health		11%	9.14%	10.5%
Sources of HealthCare Financing (%)	Public	61.47%	61.93%	61.95%
	Private	34.78%	35.13%	34.42%
	Donors	3.75%	2.94%	3.63%
Distribution of Health Expenditure	Public	65.75%	66.17%	66.85%
	Private	31.57%	31.88%	31.43%
	UNRWA	0.74%	0.75%	0.67%
	NGO's	1.93%	1.20%	1.14%
Public Health Expenditure as % of GDP		5.18%	5.02%	5.16%
Private Health Expenditure as % of GDP		2.70%	2.56%	2.56%

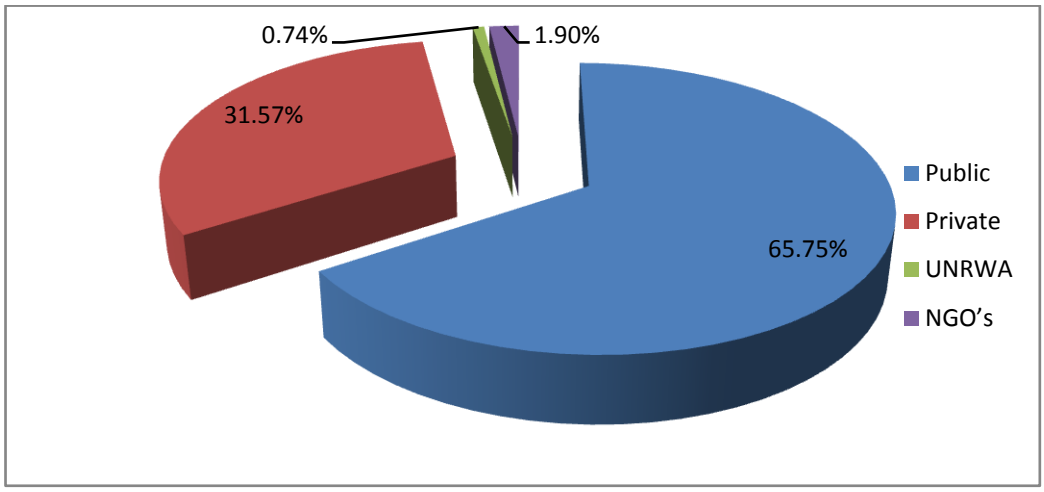
Table 2-2 (continue): Jordan National Health Accounts Main Indicators

Indicator		*2013*	*2012*	*2011*
Total Expenditure on Pharmaceuticals (JD)		500,330,700	445,408,952	427,835,670
Per Capita Pharmaceutical Expenditure (JD)		61.66%	69.73%	68.46%
Pharmaceutical as % of GDP		2.10%	2.03%	2.09%
Pharmaceuticals as % of Total Health Expenditure	Total	26.60%	26.75%	27.07%
	Public	12.17%	12.17%	12.22%
	Private	14.43%	14.58%	14.85%
Distribution of Pharmaceutical Expenditure of % of Total Pharmaceutical Expenditure	Public	45.77%	45.49%	45.12%
	Private	54.23%	54.51%	54.88%
Ministry of Health budget as % of the public budget		6.7%	6.3%	6.3%

Prepared by researcher, Source (MoH, 2015; HHC, 2016)

The major source for financing health sector in Jordan is provided by the public sector. In 2013, the public sources contribution was (61.47%), then came the private sector with (34.78%) mainly came from insurance companies, companies that are self-insured, (in addition to out of pocket expenditure) and donors (3.75%). As for health expenditure distribution; around two-thirds of the expenditure was for the public sector (65.75%), the private sector around (31.57%), NGO's (1.93%) and UNRWA percentage is less than 1%, (0.74%). The budget of the Ministry of Health has (8%) of the government budget is in 2014. Along with the high level of expenditure on health; the public sector has the problem of resource wastage, mainly on drugs. Jordan's expenditure on drugs is higher than most countries in its income group (2.03% of GDP in 2012). The MoH budget is (8%) in 2014, and because Jordan has a severe budget deficit; there is doubt that this level of spending may remain within current ratio, therefore, healthcare sector needs effective policies to be developed and implemented in the medium and long run.

Figure 2-1: Distribution of Health Expenditure (2013)

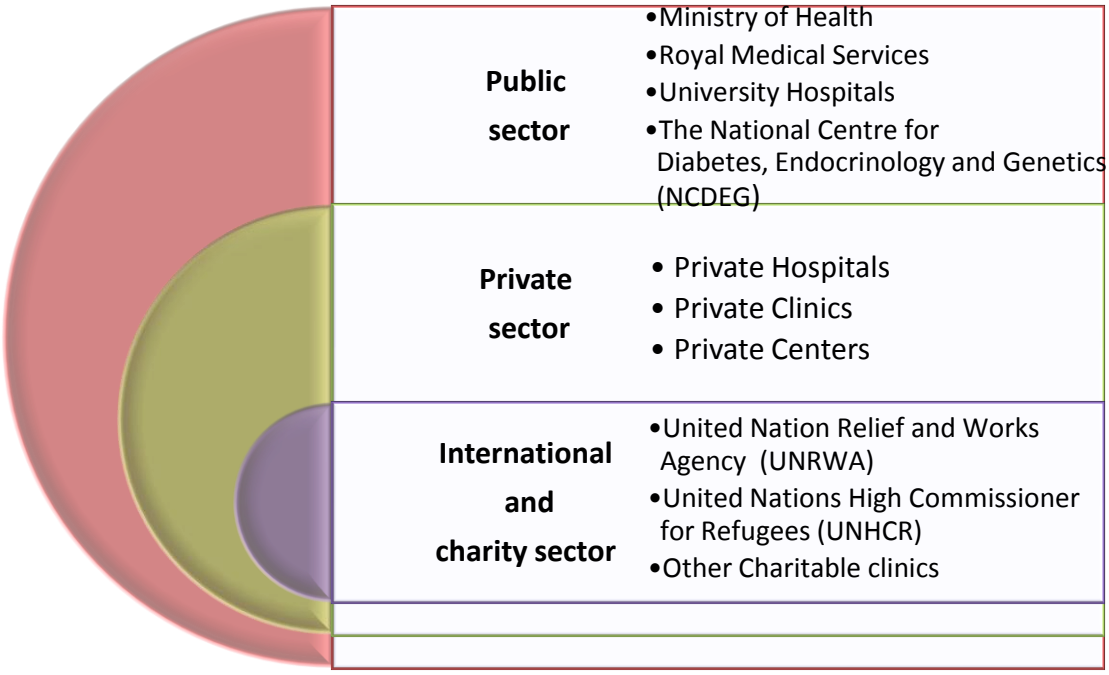


Prepared by researcher, Source (MoH, 2015, HHC, 2016)

2.3.4 Key health providers

Healthcare services are provided by the public and private sectors. The following section summarizes the main health sector service providers, in addition to shed light on some institutions related to the healthcare sector.

Figure 2-2: The Major of Healthcare service providers



Prepared by researcher

2.3.4.1 Ministry of Health (MoH)

The public sector remains the main healthcare service provider through the MoH. The MoH provides primary, secondary, and tertiary services. Accordingly, public health law, since its outset, grants the MOH a wide administrative authority over other health providers (the first public health law was in 1971, then amended in 2002 and the last amendment was in 2008). The Ministry of Health (MoH) provides health insurance for civil servants through the Civil Insurance Programs. In addition to the expansion of civil health insurance to include the vulnerable groups; the beneficiaries of the social safety net program, the children under six years old, the elderly, the resident of promote areas and the disabled persons; they are provided with free health insurance at MoH hospitals and health care centres. MoH provides both preventive and curative healthcare service, (MoH, 2016; HHC, 2015).

According to public health law in 2008, the Ministry of Health undertakes all the health affairs in the Kingdom, and its task and duties include the following (Public Health Law, 2008, article 3):

a- Maintaining public health by offering preventive, treatment and health control services.

b- Organizing and supervising health services offered by the public and private sectors.

c- Providing health insurance for the public within available means.

d- Establishing and controlling the management of health educational and training institutes and centers according to relevant provisions of the legislations enacted.

Article 4 of the same law entitles the ministry to achieve several tasks in coordination with concerned parties, such as to encourage positive health patterns, raise public health standards, encourage natural child nursing, mother and child care, mandatory pre-marital medical testing, provide preventive health services to children in public schools, private schools, kindergartens and nurseries in addition to provide health services to them, provide, supervise and control elderly services by the ministry and other institutions, in addition to implement health programs and activities to fight non-contagious spreading diseases. Other tasks include control health and safety procedures at factories and industrial institutions (Public Health Law, 2008, article 4).

Accordingly, MoH licenses, controls, and regulates professions and health institutions in Jordan. Some institutions are assigned the monitoring function in coordination with MoH, mainly the National councils (ex. Jordanian Medical Council) and medical bodies (ex. physician association).

2.3.4.2 Royal Medical Services (RMS)

The RMS was established in 1948. It mainly provides secondary and tertiary care services. It is the second largest public entity in providing health services. Beneficiaries of the healthcare services through the (Military Health Insurance System) include active and retired staff and their dependents, the staff of the Royal Court, Royal Jordanian Airlines, and Aviation Academy. King Hussein Medical Centre is the main military medical centre located in the capital; the KHMC has advanced technology and pioneer experts. The RSM also accepts referral cases from public and private sector due to the advanced level they have, also the RMS receives a number of non-Jordanian cases, of whom to be high-rank officials in their countries. The RSM has a vital role in providing services in disasters and conflict areas (i.e. Sierra Leone, Congo, Haiti …), (HHC, 2015; HHC, 2016; Al-Hadidi and Al-Kurdi, 2016).

2.3.4.3 University Hospitals

Jordan has two university hospitals (UHs); the Jordan University hospital (JUH) in Amman, and King Abdullah Hospital (KAH) in Irbid/north Jordan. They provide health insurance and services for university employees and their dependents, as well as serving as referral centres for other health sectors, and as teaching centres for medical students. Both hospitals are considered most specialized and high-tech medical centres in the public sector, (HHC, 2015; Al-Hadidi and Al-Kurdi, 2016).

2.3.4.4 Private sector

The advanced healthcare standards in the private sector and high technical diagnostic capacity led Jordan to be one for the favoured destination for medical tourism in the region. The private sector provides primary, secondary, and tertiary services through a network of private clinics (PCs), private centres (PCs) and private hospitals (PHs). More details are found in Section 2.3.5. The majority of the private hospitals and clinics are located in the capital of Jordan,(Private Hospital Association, 2016; Al-Hadidi and Al-Kurdi, 2016).

2.3.4.5 UNRWA

The United Nation Relief and Works Agency (UNRWA) is responsible for providing healthcare services to the Palestinian refugees. UNRWA delivers the primary healthcare services only, however, it subsidizes secondary and tertiary healthcare services for refugees (with certain limits) through contracting with public and private sector when it refers cases, (WHO, 2010 a; Al-Hadidi and Al-Kurdi, 2016).

2.3.4.6 NGO's and charitable organization

Although King Hussein Cancer Foundation and the National Centre for Diabetes, Endocrinology and Genetics, are funded by the government (other sources of fund allowed); they are classified as NGO's, and they have independent bodies to manage them and they are not linked to MoH.

2.3.4.6.1 King Hussein Cancer Centre

King Hussein Cancer Foundation (KHCF) is an independent, non-governmental, not-for-profit institution founded in 1997 by a Royal Decree to combat cancer in Jordan and the Middle East region. A Board of Trustees runs the Foundation. The KHCC is the only specialized centre for cancer care in Jordan and was one of the first centres in the region; it has 167 beds and forms 1% of the total beds. KHCC became the first centre outside the United States to have Disease Specific Accreditation. KHCC works to improve access to education, training, public awareness and research in order to decrease mortality and alleviate suffering from cancer following the highest standards and quality of care, (KHCF, 2016; Al-Hadidi and Al-Kurdi, 2016).

2.3.4.6.2 The National Centre for Diabetes, Endocrinology and Genetics

The National Centre for Diabetes, Endocrinology and Genetics (NCDEG) is an independent non-for-profit Organization that was established in 1996 as one of the centres affiliated with the Higher Council for Science and Technology. The main goal of NCDEG is to provide high quality care, education and training in the fields of diabetes, endocrinology and genetics, (NCDEG, 2016).

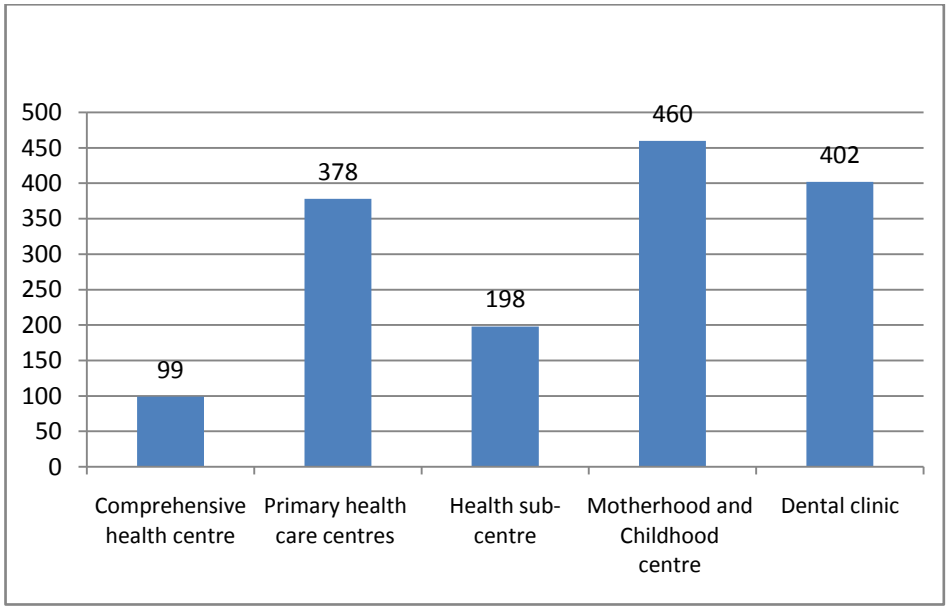
2.3.4.6.3 Other charitable clinics

Around (44) charitable non-for-profit organizations clinics exists in Jordan. Those clinics are run by national or international NGO's, and they must be authorized by the government.

2.3.5 Health Services Delivery

- *Primary health services*: Primary health services are managed by the MoH through a widespread network of primary health care centres. Figure (2.3), illustrates the numbers and types of primary healthcare centres. The Royal Medical Services provides primary healthcare services through field clinics and (8) comprehensive medical centres. UNRWA provides primary health care services through (24) medical clinics inside and outside the camps. Primary care also provided by the private sector through hundreds of clinics all over the kingdom. Health services are considered to be easily accessed and equitably distributed based on the geographical distance and the actual needs of the population to cover the needs of remote areas. The MoH is responsible for conducting a number of preventing health services, such as the school health services by conducting comprehensive periodical medical examination, (MoH, 2015).

Figure 2-3: Primary Health centres (MoH), 2015



Prepared by the researcher, Source: (MoH, 2015)

- *Secondary and Tertiary health services*: both public and private sectors participate in the provision of these services with a variation in the type and amount of service provided. Table (2.3) illustrates the number of hospitals according to the health sector for 2014. The table shows that the MoH has the highest numbers of beds, then followed by the private sector, which is considered a major provider of health services for Jordanians and non-Jordanians. The majority of private sector hospitals are located in the capital Amman (MoH, 2015).

Table 2-3: Number of Hospitals according to Health sectors in Jordan, 2015

Hospitals	Number of hospitals	Hospital Beds	Hospital Beds %
Ministry of Health	31	5077	38.7%
Royal Medical Services	12	2551	19.5%
Jordan University Hospital	1	599	4.6%
King Abdullah University Hospital	1	538	4.1%
Private Sector	59	4350	33.2%
Total	**104**	**13115**	**100%**

Prepared by the researcher, Source: (MoH, 2015)

2.3.5.1 Other institutions

There are a number of institutions which are related to one or more issues of the healthcare sector. Some of these institutions do not provide healthcare service, rather they are considered as regulatory, supporting or preventive institutions. (Appendix 2.7) provides a brief about those institutions (HHC, 2015; MoH, 2015).

Public institutions linked with Minister of Health

- High Health Council
- The Jordanian Medical Council
- The Food and Drug Administration
- The Joint Procurement Department

Public Institutions and National Institutions linked with other Ministries or special entities

- The Higher Population Council
- The Jordanian Nursing Council
- The National Council for Family Affairs

Departments/Directorates within other public Ministries or special entities

- Greater Amman Municipality and the municipalities in the provinces of the Kingdom (health sections/departments)
- Department of School Health in the Ministry of Education
- Department of Health and Safety, Ministry of Labour

2.3.6 Healthcare challenges in Jordan

The health sector is faced with various challenges and key issues. Jordan has some common challenges related to the healthcare sector with other countries and developing countries in particular such as the financial resources, the demographic challenges, health workforce, diseases prevalence, and health sector administration. All of these issues have to be addressed within the national planning and strategies; furthermore, most of these issues and

challenges affect the healthcare sector policymaking and outcomes. Therefore, it should be discussed among the concerned parties and stakeholders at the national level to achieve the health sector advancement in a comprehensive manner. The following is a brief about a number of these challenges in Jordan:

- *High level of expenditure on health:* The expenditures level on healthcare sector in Jordan is considered high as an upper middle-income country (7.58% of GDP in 2012). MoH consumes around (66%) of the expenditure. Spending on medicines is high as well, it is around (27%) of the total health budget, and around 2.10% of GDP in 2013. A strategy to rationalize spending on medicine was set in 2014; however, MoH and HHC should review and revise that policy to stop the waste. An essential step which was taken recently is the creation of the 'Joint Procurement Department' which aimed to organize a unified process for the purchase of medicines and medical supplies in the public sector. Yet, further actions should be taken to manage the increasing level of expenditures (MoH, 2015; HHC, 2016).

- *The demographic challenges and the escalating number of population and residency*; Jordan's population has increased more than ten times within the last 55 years, figure (2.4), and it is expected to keep rising. The reasons for Jordanian population increase is due to the fertility rate (3.5%) which considered high, however, it is now lower compared with the previous years, also the population number increased due to the low crude mortality rate. The reasons for the kingdom population increase is not related to the Jordanian citizens mainly; as explained earlier Jordan is the second highest per capita refugee rate in the world, and it is expected that Syrian refugees will continue fleeing to Jordan, which will lead to further population increase. The number of residencies also

increased as Jordan is considered attractive for expatriate's workers, particularly in low-skilled jobs. The Jordanian annual increase is (3.1%) and (18%) for non-Jordanians. Another challenge, which will impose a burden on the health budget, is the age structure and the increasing number of elderly in the future, along with the changing pattern of life and the non-communicable diseases (DOC, 2015; DOC, 2016).

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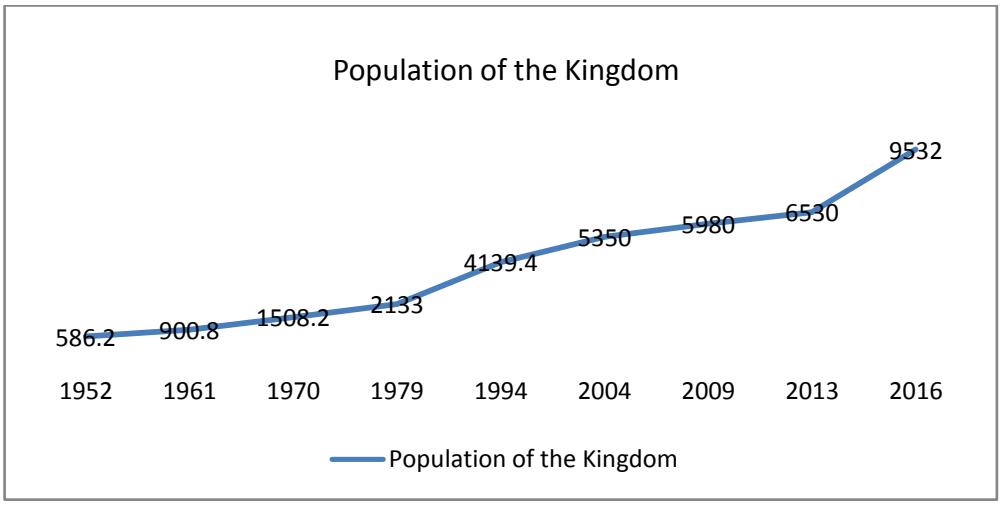
Figure 2-4: population of the kingdom (1952-2016)



Number in thousands

Prepared by the researcher, Source: (DOC, 2015; DOC, 2016)

- *Health insurance coverage:* the estimated number of insured people is varied somehow. It was estimated previously to be (86%) according to (HHC), however, according to the recent population and housing statistics in 2015, the total insured Jordanians is (68%), and the total insured people including non-Jordanians is (55%). This percentage is expected to be more than (68%), as the government grants some categories free health insurance, however, the estimation of having double health insurance is 5-6% of insured people. According to the recent population and housing statistics in 2015, Ministry of Health and

Royal Medical services are the largest insurer (41.7% MoH, 38% JMRS, 2.5% university hospitals, 2.5% UNRWA, 12.4% private insurance, 2.5% others, 0.4% outside Jordan). Jordan has a national objective, which is to cover 100% of citizens under the health insurance umbrella; this objective was declared in the National Agenda (2006-2015), it was proposed to reach it by 2015, then it was altered to be in 2017, however, several factors affect the achievement of that objective, mainly the budget constraints, the lack of accurate statistics regarding the number of insured people, the lack of clear mechanism to achieve this goal and the regional occurrence and its consequences on Jordan. According to Jordan vision 2025 the insurance coverage to all citizens is planned to reach 95% in 2025. It is worth mentioning that the MoH is providing health insurance (free of charge) to less privileged categories, i.e. Poor people, citizens residents in areas classified by the government as poor and remote areas, in addition to the people who are suffering from certain medical conditions, such as contagious diseases, cancer, kidney disease, tuberculosis and pneumonia "TB", AIDS and addiction of alcohol and drugs regardless of their ability to pay (DOC, 2015; Prime Ministry office, 2006; HHC, 2015;MoPIC, 2015).

- *Communicable disease and non-communicable disease:* Jordan has made considerable progress in the fight against communicable diseases. This contributed to the control of measles, Polio was enucleated since 1992, Diphtheria and neonatal tetanus cases was controlled, consequently, Jordan became free of diseases that are not vaccinated against such as cholera, malaria and schistosomiasis. However, due to the refugees influx, around 34314 cases of communicable diseases have been reported between the beginning of 2013 and the end of 2014 among Syrian refugees, those cases have been dealt with, but the ministry had to initiate vaccination campaigns not only for Syrian refugees, but also nationwide which incurred huge cost on the government and MoH. In contrast, non-

communicable diseases have risen in recent years, NCD are the leading cause of illness and death in Jordan. Heart diseases and circulatory system, diabetes and cancer were the most important of these diseases. Smoking is the major risk factor of contracting these diseases, unfortunately, smoking level in Jordan is very high; its (63.6% males, 10% females for over 15 years, and for the age group less than 15 years old is 34.1% males, 19.4% females), all of these rates are above the average of the income and the region category, and even above the global average according to WHO statistics. Additionally, NCD's cases are more prevalent among Syrian refugees, in addition to other issues such as maternity and child care, along with mental health problems (HHC, 2015; WHO, 2015; MoH, MoH, 2014; MoH,; Al- Nsour, et al., 2012; Hunter, 2016; Doocy et al., 2015).

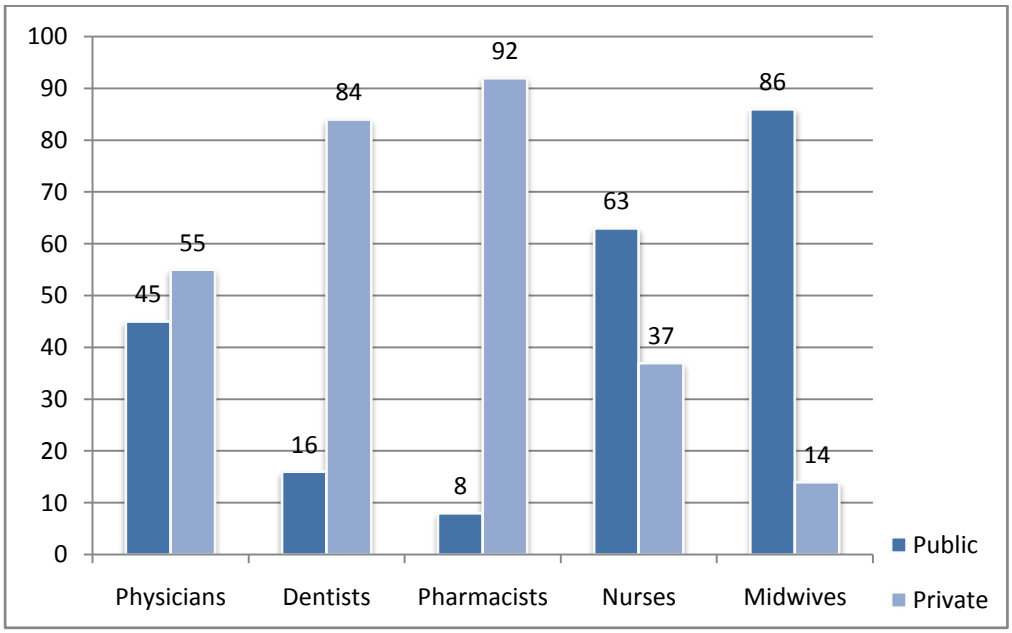
- *Primary, Secondary and Tertiary health services*:
- Jordan like many Arab countries; is focusing more on curative and episode-based care, with little attention and practices to preventive care (Rahim, et al., 2014). Jordan has a wide spread of centres and hospitals all over the country. The total expenditure on curative healthcare services in the public sector (MoH, the RMS and University Hospitals) formed around 75.45% of the total health expenditure on all functions. There is a weak investment in primary healthcare services compared to secondary and tertiary care services, primary healthcare expense was 15.7% in 2013, while it was 17.7% in 2012. Another issue is related to workforce distribution as 51.4% work in hospitals, 40.8% work in healthcare centres, 7.9% work in central directorates (HHC, 2016; MoH, 2015).

- *Human resources in the healthcare sector:*
- In many countries, the health sector is considered the main employer, particularly the public health sector (Walt, 1994; Barker, 1996). Jordan is not an exception, according to

Civil Service Bureau statistics (CSB); the workforce in public health sector is (14.7%), which consider the second highest percentage after the education sector (51.9%), while (33.4%) of the public employees are working in all other ministries and public institutions (CSB, 2015).

- Education and training for health-related professionals in Jordan are quite good, and it used to be the source of a workforce to other countries. Health personnel ratio was considered higher than the average of the region and its income classification (Physicians-Dentist-Pharmacist-Nurses), figure (2.5). Though there is a shortage of some medical specialties, such as psychological, neurosurgery and cardiovascular specialty in the public sector. In certain cases, MoH has to contract with the private sector to cover the lack of specialists. Further, Jordan has the issue of a brain drain, and according to the WHO; Jordan has a deficiency in terms of human resources plans and strategies for national and regional needs. In a recent report issued by the HHC 'National Human Resources for Health Observatory' stated that there are a number of challenges for the HRH due to the absence of the National HRH strategy, some of these challenges are: lack of national training plan, poor investment in HR development, and inability to retain the qualified staff. Also in term of workforce distribution on the national health system; most of the medical categories are higher in the private sector compared to public sector except midwives for year 2015, figure (2.5), (HHC, 2015; Al-Hadidi and Al-Kurdi, 2016; WHO, 2010).

Figure 2-5: workforce distribution in healthcare sector, 2015



Prepared by the researcher, Source :(Al. Hadid and AL-Kurdi, 2016, HHC, 2016)

- *Health information systems and health research:* MoH is the main source of information related to healthcare sector statistics on the national level. MoH cooperates with HHC to produce the national health accounts since 2007. Department of Statistic is the only institution authorized to collect and disseminate statistical data at the national level; it produces annual report and periodic census. Although the academic institutions conduct several studies to address various issues in the health sector, there is a weak link between research and health sector decision making. The HIS is faced with a number of challenges: weakness in embracing evidence base policies and decision, lack of allocating and spending on conducting research and studies, dispersed in health research, lack in the ability to translate the research into practical policies or recommendation to be adopted, other challenges related to the lack of the national records similar to the national records of cancer, (HHC, 2015; Prime Ministry office, 2011).

As for computerizing the health sector; the government launched a national initiative called 'Hakeem' in 2009, the program consists of several subsystems, and the most important of them is computerized patient record system, patients booking, laboratory, and pharmacy system. The ultimate goal is to provide an up-to-date database to be used for several purposes such as have accurate numbers of the prevalence disease among Jordanian and residents. The program was implemented in some hospitals and clinics. However, this system does not cover the private sector, and therefore, there will be a lack of information from it (Hakeem, 2016).

- *Medical Tourism contribution to GDP:* Jordan is considered a leader in the region regarding healthcare services, and among the top ten world medical destinations. In 2015, the total income from medical tourism in Jordan was (1.2) billion US$, and formed 3.5% of the total GDP. A variety of reasons lead Jordan to be a preferred medical destination including the expertise in a variety of medical specialties, competitive prices, qualified specialists certified in United States, the United Kingdom and Germany, as well as, the high level service delivery, local and international accreditation to a number of hospitals, and the therapeutic natural resources available. Medical tourism is an important source of revenue for the Jordanian economy; not only due to its direct contribution, but also to its indirect effects on other sectors. The vast majority of cases are treated in the private hospitals and the King Hussein Cancer hospital, however, few numbers of them treated in the RMS. However, there are several challenges facing the medical tourism, mainly the instability in the region in addition to the competition, mostly from Turkey, in addition to the increased healthcare standards in some gulf countries who used to come to Jordan, and the lack of proper marketing to the medical tourism. Accordingly, further support should be provided to the medical tourism to be able to capture the benefits of the

healthcare sectors and even maximize it. (Private Hospital Association, 2016; HHC, 2015; Khammash, 2012).

- *The Impact of Syrian crisis on Health Sector:* The massive influx of refugees has placed a huge burden on the healthcare sector in Jordan, most notably the Syrian refugees. More than half of the Syrian refugees are in the age group (0-17) formulating (52.2%), then the age group (18-59) formulating (44.4%), above 60 is (3.4%). Only a fifth of the refugees live in the camps, the major lives in cities, particularly grouping in the northern governorates. The majority of healthcare services is provided by MoH (primary and secondary). Main effects of Syrian refugees are: the overburden on healthcare sector affects the accessibility of the Jordanian citizens to the healthcare services, mainly in the areas were refugees are concentrated (e.g. physicians / 10000 was 28.6, and when adding the Syrian refugees it decreased to be 23.4).MoH reports showed that the spread of communicable diseases among the Syrian is much larger than among Jordanians. This could lead to further spread and more risks to the Jordanians. Jordan is suffering from the re-emergence of a number of communicable diseases which were eradicated from Jordan such as tuberculosis, polio, and measles. Vaccination provision considered expensive, vaccinations are not only provided to the Syrians, but also to Jordanians. The pressure on the health sector added extra pressure on the workforce which requires the need to increase the employment, and also its pressure the medical devices which reduced its operational age, and medical supplement, which all leads to increasing the public health sector expenditures. Ministry of Planning and International Cooperation declared that there is (24%) shortfall in the availability of hospital beds, with more than 1,000 physicians needed to meet the national standard. Recently, MoPIC expected that health sector will need (US$ 532.28M) over the coming three years to face the refugee's health

requirements. In short, the burden is increasing, and the financial aids are not sufficient to face these consequences (MoPIC, 2016; HHC, 2015; Francis, 2015; Al Emam, 2016).

2.3.7 Aid in health sector

Jordan is similar to other developing countries who receive aid from international organizations and agencies in various fields including health sector. According to the Jordanian law; Ministry of Planning and International Cooperation is the only government entity that authorized to communicate with donors and international agencies, MoPIC is the 'focal point' between the donors and the line ministers, public and private institutions. MoPIC is responsible for conducting agreements and/or prepare the bilateral agreements between the Jordanian government and international agencies and donors.

United States of America is the main donor to Jordan, mainly through the USAID; also they are the main donor for the healthcare sector. However, a number of international agencies and Arabic development funds contributed in supporting some of health sector projects (Islamic Development Bank - Kuwait Fund for Economic and Social Development- Arab Fund for Economic and Social Development - Abu Dhabi Fund for Development- Saudi Fund for Development- OPEC Fund for International Development), in addition to a number of European countries, the United Kingdom, Austria, Italy, Switzerland, China and Korea, along with World Bank and UN Agencies, (MoPIC, 2014 a; MoPIC, 2014 b).

In 2014, the health sector was the fourth largest recipient of donors' funds; the largest amount of fund aimed to support the budget and then came the Water and Sanitation, and then Education and Higher Education. Hence that the health sector used to be in the third rank of receiving foreign aids, but in 2014 there was a demand to support the education sector due to the

need to build and enhance the capacity of the public school to host Syrian students. USAID is the primary donor for the health sector; they support mainly the population policies and strategies, and reproductive health, in addition to the management of information systems, quality assurance, and strengthening of epidemiological surveillance system for diseases (MoPIC, 2014 b).

Starting in 1952; the UN agencies provide constant technical support to Jordan, including the agencies related to health issues such programmes provided by UNICEF and UNDP. WHO existence in Jordan dates back to 1985, it coordinates with some of UN agencies in common areas or initiatives may arise. it provides technical and financial support to Jordan in cooperation with MoH mainly, through a number of programme: Community-based initiatives – healthy village programme - Environmental health- Good Governance in Medicines programme - Health care financing- Health technology- Human resources for health Information systems- Mental health- Occupational health- Pharmaceuticals- Service delivery initiatives- Social determinants of health. In addition to support Jordan due to the implications of refugees in coordination with related UN agencies (WHO-EMRO, 2015; WHO, 2010 a).

2.3.8 Summary

This chapter presented an overview of Jordan's contexts and an overview of the main features of the health sector and its main challenges, such as healthcare expenditure, demographic issues including the increasing number of population and the changing structure of age and the increasing number of elderly in the future …. All of these challenges are expected to impose huge pressure on healthcare services and inflate the amount of healthcare spending. Consequently, it is quite important that all of the health determinates and challenges to be addressed when formulating the health sectors policies and strategies.

The next chapter will present an overview of the health policy and management in Jordan, including the main challenges that are facing the management of the health sector.

Chapter 3

Health Policy and Management in Jordan

3.1 Introduction

This section will present a brief background about the High Health Council (HHC), t the role of the HHC in policy formulation on the national level, and the current process of policy formulation and the main participants.

3.2 General background

The Ministry of Health is the main public health provider and has wide authorities according to the public health law; to undertake all health affairs in the Kingdome[4] (chapter 2). However, as the health system is quite complex and has multi providers, the government decided to establish the HHC to be as an umbrella for the health sector to enable it to formulate the national health policy for the health sector.

3.3 HHC historical background

The Health service is delivered by multiple providers; therefore, it was important to find an umbrella that combines these bodies to maintain coordination's and networking. The first council was established in 1965 (bylaw No. 21), it was called the High Health Advisory Council,

[4]for example: according to the public health law, MoH should: Organizing and supervising health services offered by the public and private sectors (public health law, article 3, b)

then it was amended in 1986 to become the High Health Council (bylaw No. 29). The High Health Council (HHC), with its current law No. 9 in 1999, is the latest stage of previous efforts to create an institution to provide advice and support to the health sector and policymaking. The General Secretariat was established in 2002, and technical and administrative staffs were hired in addition to HHC Secretary General, (HHC, 2013).

The law of 1999 stated clearly that the role of the HHC is to "formulate the general policy of the health sector and to put forward the strategy to achieve it in order to organize and develop health work as a whole, so as to extend health services to all citizens according to the most advanced methods and sciences" (HHCLaw, no. 9, article (4)).

3.4 HHC Chairman and membership

3.4.1 HHC Chairman

The HHC chairmanship was not static over the years, it was chaired by the Prime Minister three times, and was chaired by the MoH minster three times; each time the council was restructured according to a new bylaw, the president was changed according to the PM perspective at that time, now the HHC is chaired by MoH minster. Table (3-1) illustrates the council chairman and membership since 1965 until now.

3.4.2 HHC Membership

The membership of the previous councils was identified based on its bylaw(s) and the latest law. Table (3-1) illustrates a comparison of the council members over the years. The council membership currently is identified by law no 9 for 1999, article (5-a). The council was chaired by

the Prime Minister, and the Minster of Health was the vice president along with (11) members. However, in May 2014, article (5-a) was amended and the Minister of Health became the head of HHC. The main reasons for this change were to reduce the burden borne by the Prime Minster, additionally, the government aimed to implement austerity measures to eliminate duplicity and enhance government performance. The reconstruction plan was administered by the Ministry of Public Sector Development (MoPSD), which was authorized under 'restructuring public institutions and departments law for 2014'.

The Members could be classified as permanent and periodic members; permanent members are (8) including the chairman; their membership is stated by law in specific. The periodic members are (4); their categories are stated by law, but the members are selected and appointed by the HHC chairman, their membership is for two years alternately, those members are : (1) the Dean of one of the medical faculties (Jordan have (4) Medical faculties: University of Jordan, Jordan University of Science and Technology, Mu'ta University, Hashemite University), (2) the head of a health-related association (the related associations are: Jordanian Dental Association, Jordan Pharmaceutical Association, Jordan Nurses and Midwives Council), (3) two experts from the health sector.

The council is formulated officially now, and the periodic members are the Dean of the faculty of Medicine Jordan University, the president of the nurses and midwives association, however, the experts are not appointed yet.

According to HHC law, the members should meet every two months at least or when needed. The meetings are considered legal if attended by the majority of council members and if headed by the chairman or the vice-president (HHC law, no. 9, article (5-b)).

Table 3-1 : The HHC Chairman and Membership since 1966- present

The Council Duration / The council Law/By Law / The council Chairman and Membership		Proposed law	May 2014-present	1999-2014	1986 -1999	1980 - 1986	1977 - 1980	1966 - 1977
			Law No (9), 1999 (amended-2014)	Law No (9), 1999	By Law (29), 1986	By Law (90), 1980	By Law (60), 1977	By Law (21), 1966
	Chairman	**The Prime Minister**	**The Minister of Health**	**The Prime Minister**	**The Minister of Health**	**The Prime Minister**	**The Prime Minister**	**The Minister of Health**
	Vice President	MoH Minister	Director of RMS	MoH Minister		MoH Minister	MoH Minister	
	Members							
Permanent Member	Director of Royal Medical Services	✓	✓	✓	✓	✓	✓	✓
	Minister of Finance	✓	✓	✓	×	×	×	×
	Minister of Planning & International Cooperation[5]	✓	✓	✓	×	✓	✓	×
	Minister of Social Development	✓	✓	✓	×	×	×	×
	Minister of Labour	✓	✓	✓	×	×	✓	×
	President of the Jordan Medical Association	✓	✓	✓	✓	✓	✓	✓
	Head of Private Hospitals Association	✓	✓	✓	×	×	×	×
	The Minister of Higher Education	✓	×	×	✓	×	×	×
	The Minister of Education	×	×	×	×	✓	✓	×
	The Secretary General of the HHC	✓	×	×	×	×	×	×
	The Secretary General of MoH	×	×	×	✓	✓	✓	✓

[5] In 1980 and 1977, it was the National Council for Planning, become later as Ministry of Planning and International Cooperation

	Members	Proposed law	May 2014-present	1999-2014	1986 -1999	1980 - 1986	1977 - 1980	1966 - 1977
Permanent Member	President of Jordan Pharmaceutical Association	×	×	×	×	✓	✓	✓
	President of Jordan Dental Association	×	×	×	×	×	✓	✓
	President of Nurses and Midwives Association	×	×	×	×	×	✓	✓
	The head of Jordan National Red Crescent Society	×	×	×	×	×	×	✓
	One expert appointed by MoH minister	×	×	×	×	×	×	✓
	One expert appointed by PM	×	×	×	×	×	×	✓
	Three experts appointed by PM	×	×	×	×	×	✓	×
	The Dean(s) of medical faculties	×	×	×	×	✓	✓	×
	The Director of Environment in Ministry of Municipal and Rural Affairs	×	×	×	×	✓	×	×
	The Secretary General of the Ministry of Municipal and Rural Affairs	×	×	×	×	×	✓	×
	The Director of General Budget Department	×	×	×	×	×	✓	×
	The Greater Amman Municipality Mayor	×	×	×	×	×	✓	×
	The General director of the Social Security Corporation	×	×	×	×	✓	×	×
	The President of University of Jordan	×	×	×	✓	×	×	×
	The President of Jordan university of science and technology	×	×	×	✓	×	×	×
Periodic member	the Dean of one of the medical faculties	✓	✓	✓	×	×	×	×
	the head of a health related association	✓	✓	✓	×	×	×	×
	One expert	✓	×	×	×	×	×	×
	Two experts	×	✓	✓	×	×	×	×
	One director of the University Hospitals	✓	×	×	×	×	×	×

Prepared by the researcher, Source: Legislation and Opinion Bureau database (www.lob.gov.jo); HHC by-law 1966, 1977, 1980, and 1986. HHC law 1999, 2014

3.5 HHC role in policymaking

3.5.1 HHC role as stated by Law no. 9, 1999

According to the High Health Council law; ''the objective of the council is to formulate the general policy of the health sector and to put forward the strategy to achieve it in order to organize and develop the health work as a whole, so as to extend health services to all citizens according to the most advanced methods and scientific technology through the following roles and responsibilities'' (HHC law, no. 9, article 4):

- Periodic evaluation of health policies introducing needed amendments after implementation.
- Identifying the needs of the health sector and taking decisions regarding distribution of health services in different regions of the kingdom to achieve equity and qualitative improvement of the services.
- Contribution in planning the educational policy for different medical sciences within the kingdom, and organizing the process of studying these sciences abroad.
- Encouraging and supporting scientific research, programs, activities and services in order to achieve the goals of the general health policy.
- Coordinating work of health institutions in both public and private sectors to guarantee integration of their work.
- Enhancing cooperation between local, Arabic, regional, and international health organizations and agencies.
- Continuous extension the of health insurance umbrella.
- Studying problems and obstacles facing the health sector.

- Studying the proposed laws, bylaws, and regulations, of the HHC and the health sector and submitting the required recommendations.
- Promotion of the medical sector, raising the efficiency of the personnel in the public sector, and providing them with appropriate incentives.
- Determining the annual budget of the council and raise it for the prime ministry for approval.
- Any other health issues the president consider as important to present for the council.

3.5.2 Actual status of the HHC role in health policymaking

Despite the fact that HHC is entitled to formulate the general policy of the health sector by law; the council's actual role in policymaking was not as proposed. In practice, the HHC was ineffective during the previous years, although they performed a number of tasks and met occasionally, but in some years it was totally marginalized. Further, there is no proper documentation of the HHC historical background for several reasons, such as being ineffective basically, and moving between PM and MoH minister authority, and because of the absence of the Secretary General for several periods, thus it was difficult to collect the relevant information about the HHC as it has weak archive, even the previous HHC bylaw(s) were obtained from Legislation and Opinion Bureau database[6].

[6] an ex-Health Minister (Dr. Zaid Hamzah) has wrote about this issue in particular (as part of an article in a daily newspaper), he mentioned that he was trying to help a researcher who was writing about hospitals history in Jordan, and the researcher asked the ex-minister help as an expert, so the minister tried to refer to the archive of the HHC in order to give an accurate information on a particular issue, but he was surprised that the documents either missing, or were poorly kept. (Hamzah, 2015)

3.5.2.1 The council re-structuring

The council was restructured and a new law was endorsed in 1999, the HHC general secretariat started to undertake their duties in 2002, the council then conducted a number of meetings. Since 2002, the council started to participate in a number of studies and reports about Jordan.

3.5.2.2 The first National strategy

The first National strategy was formulated in 2007 for the years (2008-2012); however, no meetings took place after 2008 until the Prime-Minister called to activate HHC role in 2013. Appendix (2.8) highlights the major stages of HHC (1965-2015).

The National strategy for (2008-2012) was not implemented as planned nor monitored and evaluated. However, the council General Secretariat has several participations since 2005 concerning the development of health-related national strategies (e.g. national strategy for senior citizens), plans and reports (e.g. the national health accounts reports) which was done in cooperation with concerned parties and institutions.

3.5.2.3 The council re-activation in 2013

In September 2013; the HHC convened for the first time since 2008, the Prime Minister HE Abdullah Ensour chaired a meeting of HHC and emphasised its role as a representative of all healthcare providers in the Kingdom (Appendix 2.9). At the meeting, the PM urged the council to undertake their role as policymaker of Jordan's health sector in cooperation with partners from public and private sectors. In the same meeting, the PM pointed that computerization of the health sector to avoid technical and economic loss, the squandering of medicine, and provide

medication for patients from Arab countries who seek treatment in the Kingdom's hospitals are key priorities, (Jordan News Agency, 2013).

As stated earlier, the council structure had changed in May 2014 and now it is chaired by the Minster of Health instead of the Prime Minister. The change aimed to reduce the burden borne by the PM, on the other hand, it aimed to increase the opportunity of conducting the regular meetings and coordination meetings on the council member's level, so the HHC chairman supported by the HHC Secretary General will be able to devote more time to follow up and coordinate with all partners within the health sector or other institutions related to health sector.

Since 2014, the HHC started to conduct meetings and workshops to network with partners in the health sector, in addition, to communicate with the public institutions and NGO's related to one or more issues of the healthcare sector. Following, brief summary about the current national strategy for health.

3.5.2.4 The first strategy draft (2014-2016)

The national strategy for the health sector should be issued initially for the period (2014-2016), and the draft was already including this duration. The council conducted a workshop in November 2014, it was funded by WHO to present the main themes of the strategy and to gain feedback from the participants who were the HHC members and a number of invited stakeholders. The researcher attended the whole workshop as it was concurrent with the data collection stage and the 'research and study section' in the HHC permit me to attend the workshop. One of the questionable notes was why to set a strategy for 2014 while the year is almost finished, the justification was that it took them a while to set the strategy draft and they needed the permission from the Prime-Ministry and from the WHO (who fund the strategy

formulation activity) to change the dates, but they said they wanted to discuss the main ideas and themes basically.

3.5.2.5 The final strategy draft (2015-2019)

After the workshop in late 2014; the council conducted consultation meetings in 2015, and then the strategy was amended and become officially the 'National Strategy for the Health Sector in Jordan (2015-2019)'.

The council formed three committees: Steering Committee, Technical Committee, and Monitoring and Evaluation Committee. They were chaired by the Secretary General of the HHC. The strategy development methodology contained key stages: (setting the stage – situation analysis - strategic analysis – vision and mission development – strategy conceptual framework – strategy monitoring and evaluation plan – consensus and participation of stakeholders – production of the final document), (HHC, 2015).

The strategy became available to the concerned parties in late 2015, and it was published later through the HHC official website.

3.6 Health policy formulation challenges

By law; HHC is the official institution which is entitled to formulate the national health policy/strategy, while on the other hand; MoH has a wide authority in managing the health sector and its issues for both public and private sector.

HHC recently formulated the 'National Strategy for Health Sector in Jordan 2015-2019'; it is considered an attempt to take their role as policymaker after several years of being in the

shadows. It could be said that all of the Healthcare challenges presented and discussed in section (2.3.6) are considered very influential on the health policy formulation, which needs to be addressed on a national policy level. In addition to what was presented earlier; the issues of governance, health sector fragmentation, and networking between health sector institutions and other related public and private entities are being viewed as major challenges to health policy formulation, and will briefly present in this section.

The Health sector in Jordan is described as a complex mixture of fragmented private and public sector. Health services are delivered by multiple providers (public, private and NGOs), along with a number of independent institutions that provide technical, educational, administrative and professional services. Each entity has its own strategy or plan, they have some objectives in common, but the coordination among them is insufficient. Moreover, there are number of strategic objectives stated on the national level documents such as the National Agenda, Jordan national vision and strategy 2025, and the King initiatives related to health sector 'comprehensive health insurance' to all citizens, however, the main challenge remains the lack of networking and coordination between different entities and agencies.

The issue of networking and communicating among these entities was always a concern. Several reports both locally and internationally raised the issue of the lack of coordination within the health sector, most of those reports addressed their concerns of not having sufficient level of coordination without getting into details to the reasons behind that. However, this study will contribute to the literature – among other things- by providing potential justification to the lack of networking and coordination, which will be presented later.

The WHO was one of the organizations that addressed the lack of coordination and networking at the policy level. WHO reported that one of the issues that need to be considered is enhancing the capacity for health policy and strategic planning, it was addressed in the Country

Cooperation Strategy for WHO and Jordan 2003-2007 and the Country cooperation strategy for WHO and Jordan 2008–2013. Also it was addressed in the country health system profile, for example, it was stated that the inadequate coordination between the public sector and the increasingly significant private sector considered as one of health system challenges, (WHO, 2006).

The World Bank has conducted an assessment report of Jordan's health sector in cooperation with the government in 1997. The report identified a number of issues related to the health system such as; increasing costs of service delivery. Further, the study stated that 'there is virtually no overall policy coordination for the entire sector' (World Bank, 1997, p35), the study pointed out some potential reasons for that, of which some are still valid nowadays, such as the turnover of key ministers, lack of specificity in its mandate, no formal meeting schedule, and lack of a dedicated budget and permanent staff (World Bank, 1997, p35). In that report, the WB recommended establishing a body to coordinate the health sector activities; they suggest the government to reconstruct the HHC (World Bank, 1997). Thus the government restructured the council in 1999, but the general secretariat was assigned in 2002. Years later, in one of the WB reports for an implemented project in the health sector; among other issues they pointed to HHC ineffective role: 'The reform related to the establishment of the HHC secretariat that is supposed to oversee the whole health sector in Jordan does not seem to be sustainable',(The World Bank, 2005, p 22).

Other potential reasons are: the overlapping between roles, such as the functions of MoH and the wide authorities granted to MoH by the public health law and the HHC in policy formulation; before 1999, the HHC role was consultative in nature only, and the HHC is still facing a number of legislative and organizational challenges. Also, a number of public and semi-public institutions have some duplication in their roles which affecting the coordination between

different institutions such as the role of the Nursing Council and the nursing and midwives professional associations.

On the national level; lack of coordination and communication was raised by HHC and reported in the strategy as one of health sector weakness under the strategic analysis, (HHC, 2008).Likewise, the importance of activating HHC role in policy formulation was raised in the national health account report (HHC, 2014).

In response to this issue; the HHC in their latest strategy 2015-2019, stated that good governance should be one of the strategy outcomes (Good governance and policy environment that enhances the performance of the health system) in order to enhance policy setting and implementation,(Appendix 2.10) presents this objective and its outputs in details. Further, the latest national strategic document in Jordan; (Jordan 2025, a National Vision and Strategy) has addressed the need to activate the HHC role in health policymaking, along with setting a number of targeted indicators related to health sector such as increase health insurance coverage, reduce the percentage of expenditure on health while increasing the quality, (MoPIC, 2015; HHC, 2015).

Nevertheless; the challenges that are facing the health system and its policies and strategies is immense. Moreover, it is mingled with internal and external factors; (Appendix 2.11) includes the situation analysis (strengths, weakness, opportunities, and threats) for the current national health strategy, the national health strategy for 2008-2012, and the MoH strategic plan for 2013-2017, in addition to the main challenges identified by the WHO in the CCS for 2008-2013.

3.7 Summary

This chapter presents a brief about the study context (Jordan) in addition to provide brief information about health sector in Jordan. Jordan has considerable achievements in the health sector compared to all difficulties, limitations and challenges confront it. Health sector entities, principally the public sector (MoH and RMS) have contributed significantly to tangible achievements in the health sector, resulting in having positive health indicators. This chapter shed light on the main challenges that are still facing the health sector in general and the health policy formulation in particular. The main aim of pointing these challenges is to maintain and even improve the health sector status and the positive indicators and results which were achieved during the previous years.

The health sector is considered a combination of fragmented entities (public, private, NGOs), therefore, it is important to find a way to insure the desired level of coordination and networking among them. HHC was seen as an umbrella to combine these different entities to ensure a better level of coordination to achieve the national objectives of Jordan in related to the health sector, however, this role has faced with several obstacles and this study aims to identify those obstacles and challenges, then proposed to most effective health policy formulation option. However, before investigating these challenges empirically; a general overview of health policymaking and planning will be presented in the next chapter.

Chapter 4

Health Policy making and planning

4.1 Introduction

Health policy is not a discipline that could be classified under one field only, although it's classified under public policy umbrella; public policy itself crosses boundaries with other fields' mainly public administration and politics, and therefore it's reflected on health policy.

As the research scope is very wide and falls within major areas in public policy, public administration, management, health policy and politics, the literature review was selective and focused on the key issues of the study. This chapter provides information about the main concepts of the study. It aims to define policy, public policy, and health policy.

4.2 Public policy

4.2.1 Introduction

In this section, the concept of policy and public policy will be briefly presented.

4.2.2 The concept of policy

Several scholars tried to define policy, some of them have offered a general definition; Policy, is a term used to describe the process of setting goals and identifying means to achieve them, mainly included in written or unwritten documents (Buse et al., 2012). Others describe

policy as a course of action based on stated and esteemed principles (Hill, 2013; Anderson, 2006). Policy is not only limited to the public sector, as private sector and NGO's set their policies as well.

4.2.3 The concept of Public Policy

Public policy has been defined by different scholars in different ways (Cahn, 1995). Public policy usually refers to government policy or policies by governmental organizations (Buse et al., 2012; Anderson, 2006), on the other hand, some authors like Day, 2001, claim that public policy does not necessarily embrace actions as no actions could be a policy as well, according to Day "Public policy is whatever government chooses to do or not to do" (Dye, 2001, p2). Day's concept is considered very broad, as it includes a government choice of taking no actions at all. In its simplest meaning, public policy could be viewed as public solutions that are decided to be implemented to solve public problems (Cahn, 1995).

4.3 Health Policy

4.3.1 Introduction

In this section, the concept of health policy will be discussed in addition to its importance. This section will include the use of evidence in health policymaking, the policy process, its actors, and then the main challenges to health policy formulation. The last section will be for the national health policy formulation.

4.3.2 Health policy definition

Before defining health policy, a brief definition of health and public health will be presented. Some of those concepts may be used interchangeably.

According to WHO, **Health** is defined as “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1984, p100). Baggott comments that the WHO definition implies the positive sense of health, while the negative sense merely focuses on the absence of disease or illness, therefore, health policy is affecting which meaning(s) is being adopted or to be adopted (Baggott, 2015).

Public Health has different meanings based on different perspectives. According to Beaglehole and Bonita; despite having different definitions to public health, they share a common thing, which is to define public health in terms of its aims rather than by a theoretical framework or a particular body of knowledge (Beaglehole and Bonita, 2004). One of the preferred definitions in the UK and other countries for public health is ‘The art and science of preventing disease, promoting health, and prolonging life through organized efforts of society’ (Acheson report 1987 cited in Beaglehole and Bonita, 2004, p 174). This definition is very similar to WHO definition to public health.

Health Policy "means different things to different people" (Walt, 1994, p 1). Even ‘policy’ and ‘health’ concepts have different interpretations, which makes it a challenge to provide a definition (Baggott, 2015). However, in this section, a brief discussion based on the scholars’ definition will be viewed with a focus on the ones who are relevant to this study. For Walt, ‘health policy is about process and power, it’s concerned with who influences whom in the making of policy and how that happens’ (Walt, 1994, p 1). Health policy refers to all actions taken by the government to influence the provision of healthcare services, in addition to different government actions or attempts to influence public health and well-being (Kraft and Furlong, 2010, 218).

Health policy can be viewed narrowly by limiting the government action to healthcare service provision, in broad terms it can be viewed as government involvement in different activities which affect both public and private healthcare decision-making (Kraft and Furlong, 2010). Niessen et al. even provide a wider definition of health policy by pointing other actors roles, 'Health policy in the broadest sense can be defined as those actions of governments and other actors in society that are aimed at improving the health of populations' (Niessen et al., 2000, p 860). This definition is consistent with Buse et al. 2012, as they viewed health policy 'to embrace courses of action and inaction that affect the set of institutions, organization, services and funding arrangements of the health system', and it may cover public and private sector policies (Buse et al. 2012, p.6). Most of these definitions imply that health policy consists of a sequence of government decisions.

It could be said that different authors have different views on the scope of health policy; however, the majority of them are limited to the government actions, and some of them include other actors as well. Nevertheless, the government is considered the main player and has the main influence. WHO in its definition of health policy stressed the role of the government and the need to have a formal statement regarding health issues. They define health policy as 'a formal statement or procedure within institutions (notably governments) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures' (WHO, 1998, p 10).

Healthcare and Health Policy: Health policy is not limited to healthcare provision; health policy consists of a chain of governmental decisions related to the type of care to be provided and how it will be done, in order to improve the health of the population, (Paton, 1996)**.** Although the concept of 'health policy' is wider in scope compared with 'public health policy', it could be said that health policy and public health policy are integral to each other, and they are used sometimes synonymously, including in this study.

4.3.3 The importance of health policy

The Health sector is one of the most vital sectors in any state and one of its key pillars due to its nature. Health sector has a unique nature as it's highly influenced by a number of policies and actions in any given country, such as policies related to water, sanitation, taxation on sales of tobacco, agriculture, food safety and environmental policies (Blakemore and Warwick-Booth, 2013; Walt, 1994). Also, health policies cross-over all sectors (Walt, 1994; Buse et al., 2012). Health is a central input into the economic development and poverty reduction (WHO, 2001). From economic and financial perspective, healthcare sector is one of the main sectors, which consumes a considerable share of the public budget and expenditure (Marmor et al., 2005; Barker, 1996; Baggott, 2015; Walt, 1994). In several countries, health sector is the main employer, which has important implications for the individuals and society (Walt, 1994; Barker, 1996).

Health policy has a wide range of policy actors who influence – or work toward influencing – the health policymaking; It's not limited to the government, public agencies and senior actors, but also to private sector (private hospitals, pharmaceutical industry …), pressure groups and NGO's (local and global), (Walt, et al., 2008; Baggott, 2015). A number of those actors have a competing interest.

4.3.4 Health and Politics

4.3.4.1 State role in the health sector

Providing healthcare services is a key component of the 'social policy', as the state generally aims to improve people's welfare and satisfy their needs in health, education, housing and social security (Blakemore and Warwick-Booth, 2013). In many countries, government is the major provider of health services. Government intervenes in the healthcare sector due to several

reasons, merely due to the 'market failure' principle, as the private sector will not perform efficiently (Lee and Mills, 1982). Also, healthcare and health issues can only be achieved through 'collective actions', which are undertaken by government (Oliver, 2006). Health issues have 'externalities effect', as described by economists, which require government interference to control, compensate and restrict some actions (Oliver, 2006). Health issues are linked with different sectors; for example, healthy population affects the economic growth positively (Oliver, 2006).

However, government intervention takes different forms, and it varies between countries. Government role could be: sector planner, service provider, regulator, stimulator of research, protector of less privileged groups, financer of health programs, purchaser of health services and medical supplies, hence that any country could combine one role or more at the same time (Walt, et al., 2008; Hill, 2006; Lee and Mills, 1982, p26). Additionally, the government controls other providers such as private, charitable and other organizations by setting the regulations and standards (Green, 2007). It's claimed that the state role in healthcare financing and provision is even growing compared with previous years (Paton, 2006).

Providing health services is one of the political tools, as the right to health is an essential social citizenship right (Bambra et al., 2005). The right to health was stressed in the United Nations Universal Declaration of Human Rights 1948, article (25): ''Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, ….'', (United Nations, 1948, article 25, pp 5-6). However, countries vary in achieving these social services for different reasons, such as country regimes, their economic status and whether they're considered as capitalist, socialist or communist. Further, the health policy definition offered by WHO stated clearly that healthcare service is provided based on the available resources and 'other political

pressures' (WHO, 1998, p 10). Thus, the government is the main health provider, and also accountable for the national health services.

4.3.4.2 The influence of political aspects on health policy formulation

Debates of linking or separating policy and politics still exist. There has been some literature written about both sides' opinions. However, it could be argued that policy and politics each provides a critical perspective on the other, and they are closely tied (Mead, 2013)

Several studies and authors have indicated the **political** influence over policy making in general and health policymaking in particular (Oliver, 2006; Liverani et al., 2013; Humphreys and Piot, 2012; Marmor and Wendt, 2012). Several approaches could be followed to formulate the health policies, however, it could be claimed that health policy cannot be politically neutral in effect in any approach followed.

It could be concluded that health and its promotion are profoundly political, yet the discipline of 'health politics', the 'political science of health' has not been adequately articulated, and has been underdeveloped. Thus, researchers need to pay more attention to the policymaking process (Bambra et al., 2005; Bernier and Clavier, 2011).

4.3.5 Evidence based policy and decision making

In the previous section, the influence of political considerations on health policy was highlighted. Several studies pointed that political aspects overruled the decision-making, particularly in developing countries (Ensor et al. 2009; Bambra et al., 2005). Despite that,

evidence-informed decision can support the health systems, and according to Banks, good evidence can 'neutralise' the political hitches (Banks, 2009).

Evidence-based policy is not a new concept, but it gained considerable attention in the few decades. For example, in Canada it emerged in the 1990s (Mitton et al., 2007), in the UK it started to gain attention since 1997 under the Blair administration's (Sutcliffe and Court, 2005). Evidence-based policy is defined as 'an approach that helps people make well-informed decisions about policies, programs, and projects by putting the best available evidence from research at the heart of policy development and implementation' (Davies, 2004, p 4). It's consistent with Oxman and his colleagues' definition, as they defined evidence-informed policymaking as an approach that aims to ensure that decision-making is informed by the best available research evidence in a systematic and transparent way (Oxman et al., 2009 a, p 4). These definitions have been challenged, as various factors affect the decision-making and policy process. Although research is a vital source of evidence, policies should be informed through a broad knowledge base (Langlois et al., 2016).

4.3.5.1 Evidence in the health care sector

The concept of having better informed practices based on research findings has extended from medical to management and policy decisions (Lomas, 2000; Kemm, 2006; Behague et al., 2009); evidence-based medicine is one aspect of evidence-based policy in the health sector. Evidence-based policy in health sector requires that 'the right people have the right information at the right time and in the right formats' (Kiefer et al., 2005, p 2). A number of authors pointed that clinical and medical research is well articulated compared with non-research evidence in health policymaking (Tso et al. 2011). Health policy context is complex and uncertain compared to

clinical contexts, which imply using different approaches to identify, interpret and apply different types of evidence to support health decisions (Tso et al. 2011). **Non-research evidence in health policymaking or 'colloquial evidence'** can be understood as 'evidence about resources, expert and professional opinion, political judgment, values, habits and traditions, lobbyists and pressure groups, and the particular pragmatics and contingencies of the situation' (Lomas, et al., 2005, p1). Some techniques could be used in non-research evidence, such as conducting focus groups and using the Delphi technique, which will help in developing and refining the decision aid, to assess policy appropriateness and implement-ability (Tso et al. 2011).

Evidence in the health sector could be quantitative data (e.g., epidemiological) and qualitative information (e.g., narrative accounts), which both are important (Brownson et al., 2009). Brownson and his colleagues suggested three domains of evidence-based policy: process, content, and outcome (Brownson et al., 2009). Table (4-1) illustrates the research domains:

Table 4-1: Domains of Evidence-Based Public Health Policy

Domain	Objective	Data Sources
Process	To understand approaches to enhance the likelihood of policy adoption	Key informant interviews Case studies Surveys of setting-specific political contexts
Content	To identify specific policy elements that are likely to be effective	Systematic reviews Content analyses
Outcome	To document the potential impact of policy	Surveillance systems Natural experiments tracking policy-related endpoints

Source: Brownson et al., 2009, p 1578

The Importance of Evidence Based Policy

Evidence-based policies and decisions gain distinct attention in the health sector due to several reasons, mainly because the complexity of the health sector and the various factors that influence the policies (Remme et al., 2010; Hunter, 2009; Brownson et al., 2009). However, it's claimed that health policies are not well informed by research evidence in reality (Oxman et al., 2009 a).

Basically Evidence-based policies are a supporting tool for politicians; they show that the policymaker is keen to use good information to base their decisions on. It reduces the uncertainty in their decisions and choices, and then helps them to avoid the consequences of uninformed decisions, (Oxman et al., 2009 a).

4.3.5.2 Health Research and Policymaking

Health researches and studies are a vital tool in informed health policymaking. Several attempts have been made to define health research that aims to improve health systems and the fact that these produced different definitions were due to the different views, perspective and domain of each author. Remme and his colleagues have produced an interesting work, and they define research by its primary characteristics; the focus of the research, the users of the research outputs, and the utility of the research outputs (Remme et al., 2010, p2-3). Table (4-2) illustrates the research domain and the primary characteristics of research.

Table 4-2: Defining research to improve health systems

Research Domain	Primary Characteristic		
	Focus of the Research	**Users of the Research Outputs Utility of the**	**Research Output**
Operational	Operational issues of specific health programs	Health care providers program managers	Local
Implementation	Implementation strategies for specific products or services	Program managers, R&D manager	Local/broad
Health System	Issues affecting some or all of the building blocks of a health system	Health system managers, policy maker	Broad

Source: Remme et al., 2010, p3

All of the research domains are important. They are not 'mutually exclusive', and there is some interlock among those three domains (Remme et al., 2010). Nevertheless, this study is concerned with health research that addresses the health system issues on a broad level, such as health governance, health financing, policy planning and management issues in the health system.

Research in the health sector is not limited to the individual countries, as the World Health Organization (WHO) considered health as an essential issue, it was identified in the WHO constitution; 'to promote and conduct research in the field of health – article 2' (WHO, 2012 b, p 1). The WHO has significant contributions regarding health research.

Despite the importance of health research in improving health systems and the call of policymakers to adopt evidence-based policy by addressing research results, there is still a gap

between research evidence and their use by the policymakers (El-Jardali et al., 2012 a; Oxman et al., 2009 a). In the next sections, the main challenges facing the use of research in policymaking, generally, and how to overcome them will be briefly presented.

4.3.5.2.1 Main challenges and limitations for evidence utilization in health research

As pointed earlier, research findings and studies could be used as a tool that provides information and evidence to the policymakers. However, in reality, there is a number of **challenges** facing the use of research and studies to support decisions and policymaking process. Some authors have discussed a number of those barriers and/or challenges. The most prominent challenge is the inability to address the non-research evidence in the health policymaking process (Lomas, et al., 2005; Tso et al. 2011). There is a lack of research (evidence) that addresses the health policy issues (Zardo et al., 2014; Lavis et al., 2006; Oliver et al., 2014), and the lack of relevant research (Oliver et al., 2014). The nature of the health system of being multidisciplinary, mainly associated with social science, economics, and the anthropological investigation is another challenge (Remme et al., 2010). Other challenges could be attributed to the lack of effective methods for dissemination of research findings to the policymakers and stakeholders (Lavis et al., 2006; Mitton et al., 2007; Mills, 2012; Oliver et al., 2014). The research evidence may not be significant to the policymakers' concerns (Lavis et al., 2006; Kammen et al., 2006; Mills, 2012; Hunter, 2003), and sometimes evidence could be outdated and invalid (Hunter, 2003). Further, the weak translation of research into health policy and practice, it's expected to be effective by 8-15% only (Best and Holmes, 2010 cited in Zardo et al., 2014). Also, there is a lack of studies related to the effectiveness of the use of research in public health policy and decision making (Grimshaw et al., 2012; Lavis et al., 2006).

The policymaker's perspective toward the value and importance of research is a determinant factor towards adopting research results in policymaking (El-Jardali et al., 2012 b; Oliver et al., 2014; Oxman et al., 2009 b). Sometimes, the policymakers lack the experience and capacity to evaluate the evidence and how to apply the research findings into policies and practice (Oliver et al., 2014; Mitton et al., 2007; Kiefer et al., 2005; Brownson et al., 2009; Oxman et al., 2009 b). Other factors related to the organizational level, such as unsupportive culture to research (Mitton et al., 2007; Hunter, 2003), competing interests (Mitton et al., 2007), lack of budget support and funding to researchers and research institutions (El-Jardali et al., 2012 b).

On the other hand, the researchers themselves shoulder part of the responsibility for the limited use of research and study results in public policies. Sometimes, the policymaker cannot find adequately good evidence to be used in the policy process, particularly in situations which require quick decision making (Banks, 2009; Ensor et al. 2009; Mitton et al., 2007; Brownson et al., 2009; Hunter, 2003). Bernier and Clavier, 2011, claimed that most of researchers are focusing on measuring and evaluating the impacts and the outcomes of a given policy, while they have paid less considerable attention to the policy-making process (Bernier and Clavier, 2011). Health researchers are focusing more on micro and meso-level of health issues 'individual and organizational level', rather than macro-level issues that have influence on health policymaking (Bernier and Clavier, 2011; Navarro and Shi, 2001; Grimshaw et al., 2012). According to Bernier and Clavier, public health researchers view policymaking as a linear model, they think that public policies are the final product of a chain of research. Additionally, they try to influence the public policies over the formulation of recommendations regarding the course of action that public authorities should adopt, as they think that good data leads to good policy decisions. However, health policymaking in reality is a complicated process with various internal and external factors affecting the policy process (Bernier and Clavier, 2011).

4.3.5.2.2 Suggestions to overcome the limitations that face the use of research in policymaking

It is vital to understand the reasons behind the limitations of utilizing research and study findings into policymaking,. Thus, those reasons could be addressed with a view to trying to eliminate them. It could be said, that if all the challenges highlighted above were handled, eliminated and treated properly, it will foster the use of research in health policymaking. However, some issues need to be echoed. Several ways could be applied in order to utilize the research findings into policymaking. Most importantly, is to involve the decision makers with research priority settings and initiate strategic alliances between researchers and policymakers (Oliver et al., 2014; El-Jardali et al., 2010; Ensor et al. 2009; Hunter, 2009; Philpott et al. 2002; Lavis et al., 2006; Lomas, 2000; Panisset et al., 2012; Mills, 2012; Oxman et al., 2009 b). The research should be reliable and with high quality (Oliver et al., 2014), with good timing (Oxman et al., 2009 b; Oliver et al., 2014). The researchers should possess clear understanding of the health policy, objectives, operation and measurement (Niessen et al., 2000; Brownson et al., 2009).Furthermore, they should master the essential skills needed for such complex research, including technical skills (Langlois et al., 2016; Mills, 2012, Zardo et al., 2014), and being knowledgeable in public policy process and politics (Kemm, 2006; Oliver et al., 2014). The researchers should be able to communicate their results effectively, produce substantial briefing, present the results in an easily comprehended format and provide it through different channels, including direct contact with key decision makers, and the potential beneficiaries of the research results 'stakeholders' (Ensor et al. 2009; Hunter, 2009; Philpott et al. 2002; Grimshaw et al., 2012; Lomas, 2000; Mitton et al., 2007; Oliver et al., 2014; El-Jardali et al., 2012b; Brownson et al, 2009). There is a need to increase the funds to support researchers and research institutions to improve

evidence informed policymaking (El-Jardali et al., 2012 b), and work on capacity building for the research institutions (Mills, 2012). Hunter pointed out that as the health system is complex, evidence should not be limited to clinical and medical evidence base only, otherwise, it won't be informative to the policymaking process (Hunter, 2009).

Based on what has discussed above, it could be claimed that policymakers have the responsibility as well to enhance the use of research in policymaking. Some points have been raised, such as the policymakers' participation in priority settings of research, and the importance of two-way communications and interactions. Policymakers should be encouraged to use the evidences and even demand it (Langlois et al., 2016). Other responsibilities could be: ensuring that research institutions have the necessary funds (mainly from the government) to conduct the research (Lomas, 2000). It is equally important to work on enhancing and building policymakers' technical capacity to evaluate and use evidence (Langlois et al., 2016; Mitton et al., 2007; El-Jardali et al., 2012 b). Vitally, there is a need for an organizational culture that adopts the concept of evidence-informed policy (Langlois et al., 2016).

4.3.5.2.3 Knowledge Transfer and Exchange (KTE)

In order to enhance the use of research results by policymakers, we should ensure a proper level of interactions between researchers and policymakers. A number of authors offer some initiatives or frameworks to achieve this goal. The main idea is to focus on knowledge transfer and exchange (KTE) between research producer and research user(s) (Mitton et al., 2007; Kiefer et al., 2005). There are a number of acronyms and terminology used to describe the approach aimed to enhance the interaction between researchers and policymakers, such as 'knowledge transfer, knowledge translation, knowledge management, and knowledge brokering'.

Some authors point out some differences between them, and all of these terms fall under the umbrella of the 'knowledge utilization' concept (Rutter et al., 2013). One initiative, which was offered by Jonathan Lomas and the Canadian Health Services Research Foundation to promote evidence-informed decision-making 'Knowledge brokering approach' (Lomas, 2000; Kammen et al., 2006). The focus of this approach is 'organizing the interactive process between the producers (researchers) and users (policy-makers) of knowledge' to create feasible and research informed choice. It is a two-way process, which aims to motivate the policymakers to have greater response to the research findings, and encourage researchers to conduct research and translate their findings to the policy-makers in a significant way (Lomas, 2000; Kammen et al., 2006, p 608).

The KTE, in principle, seems to be a good initiative, but still have some questionable issues, such as who should organize the knowledge brokering process, how will it institutionalized, and who should take the lead to initiate the interactions?, (Kammen et al., 2006). Mitton and his colleagues in 2007 conducted extensive literature review and stated that there is inadequate evidence for conducting 'evidence-based' KTE for health policy decision-making 'yet' (Mitton et al., 2007, p756). In 2013, Rutter and her colleagues conducted a literature review on KTE and the use of research evidence in policy and practice. They have concluded that the way in which KTE functions in reality is not deeply evaluated (Rutter et al., 2013). KTE is being criticized for not addressing sufficiently the health policymaking process complexity and the policy power and dynamics (Greenhalgh and Wieringa, 2011; Langlois et al., 2016). However, this approach still growing, and further studies are needed to show the link and impact of using research in health policymaking, and also further studies on how KTE should operate and how, in addition, the effort of KTE should be evaluated.

4.3.5.3 How evidence should be produced and applied

An important issue which cannot be overlooked when discussing evidence-based policy is the possibility of manipulating the evidence. In some cases, evidence is selected to favor a policy already chosen by politicians (Kemm, 2006). A number of actions could be taken to eliminate the evidence manipulation, which basically related to how evidence is being produced. There are some contributions in this regards, and there follows a brief presentation of 'Banks essential ingredients in forming evidence-based policy'.

How evidence is produced, is a vital issue to be considered (Banks 2009; Hunter, 2009). Banks set a number of essential ingredients to produce good evidence in general, starting with comprehending the issue adequately, using sound and proper methodology, the researchers should obtain the needed skills to conduct the analysis and the subsequent tasks, such as technical skills. Also, the evidence should be available to inform decisions with consideration of the time constraints to the policymakers. Good data is a prerequisite to the analysis and producing good evidence. Equally, the credibility of evidence should be ensured, through transparency (how evidence was produced, availability of data to the relevant parts, being open to public, and accepting debates and discussions) and independence (public interest is the main concerns of the research and creating evidence, and independence is related to vital steps starting from choosing the methodology, how data is being collected and presented). The most important ingredient according to Banks, is that the evidence should be considered by the policymakers, (if they prepared professionally). He describes it as 'receptive environment' to evidence (Banks, 2009). It could be assumed that adopting evidence-based policy is not faced by technical issues, knowledge translation and exchange primarily, rather it's political challenges (Humphreys and Piot, 2012; Liverani et al., 2013). However, Liverani and his colleagues thought that the political influence on the use of evidence in policymaking process is relatively unexplored by the scholars, and there is a lack of understanding of the influence of the state structures or

institutional bureaucratic systems that may hinder or facilitate the use of evidence for health decision-making (Liverani et al., 2013).

4.3.5.4 Conclusion: Evidence based policy and decision making

Research could be a supportive tool for evidence-based informed health policymaking. However, evidence-based policy is faced with a number of challenges, which limited its ability to support the policymaking. These challenges could be classified as causes related to the researchers themselves, (i.e. analytical skills, lack of knowledge in policy and politics…), the research contexts (i.e. focus on micro level rather than macro level, sound methodology, reliability...) the policymaker's perspective (i.e. mainly considered colloquial evidence, decisions are mainly politically driven, ….), and causes related to the organizations (such as the culture of adopting EBP). Accordingly, to have an evidence-based policy, we need to enhance the collaboration level between policymakers, researchers and the research institutions, in order to produce profound and reliable evidences. The researchers should pay more attention to the determinants of health policymaking and examine them, particularly on the macro level. It is important for the researchers to combine different types of evidence, so the policymakers could adopt these evidences and then could reach an evidence-base judgment and acceptable decisions.

4.3.6 Health Policy Process

Health policy process is not isolated or different from the public policy process and conceptualizations in general. Largely, public choices, policies, and decisions are not linear directions; policymaking is faced with uncertainty and complexity in most cases.

To understand the policy process; it is essential to be aware of the intergovernmental policy community or subsystem composed of bureaucrats, legislative personnel, interest group leaders, researchers, and specialist reporters within a practical policy area-as the basic unit of study (Sabatier, 1991, p 48).

The process of health policy making is complex. However, if the process itself was studied, it will produce better policies (Barker, 1996). The complexity could be attributed to the determinants of developing and implementing the policies, mainly social, economic, political and cultural determinates (Bambra et al., 2005; Brownson et al., 2009; Barker, 1996; Collins, et al., 1999). Complexity in the health sector is also attributed to the interaction between local, regional, national and global factors influencing health system decision-making processes (WHO, 2012 a). Therefore, it is significant to recognize the factors that have an influence on health and health policy process (Khan and Heuvel, 2007; Lavis et al., 2012; Walt, 1994; Walt and Gilson, 1994; Collins and Green, 2014).

Evidence-based or informed policy is supposed to enhance the health policymaking process. However, it is important not to overestimate the role of evidence in policymaking. In the real world, although some evidence is generated, several changes could happen during the policy process and may lead to overshadowing the evidences by other factors, which are considered more important (Hunter, 2003). Nevertheless, if evidences were created in a good manner and most of the limitations were eliminated, it will enhance the possibility of evidence to being more likely to be used. Equally, it is important to keep in mind that evidence could be only one

component of the policy process. In the health sector, many aspects are considered in policymaking process: experience: judgment, resources and values, professional opinion, political judgment in addition to evidence (Lomas, et al., 2005; Hunter, 2003). According to Hunter, a successful policymaking and management practice could be achieved by creating a balance between those variables (Hunter, 2003).

Public Policy process encompasses essential stages: problem identification (sometimes referred as agenda settings), formulation, implementation, and evaluation (Buse et.al, 2012). Despite these stages being common in the policy cycle, the actors or the influential individuals/agencies in each stage may differ mainly due to power distribution. Hill pointed out that we must understand the nature of power in any given country and who dominates the power (Hill, 2013). As well, Walt said that power is at the heart of every health policy process (Walt, 1994). Generally, the policy process/stages apply to a wide range of issues, but a number of tiny differences may exist due to the nature of each sector. Herewith follows an overview of the policy process with a focus on agenda setting stage, as it is the core of this research:

4.3.6.1 Agenda Setting

Agenda setting is a pivotal stage. Some problems and issues may exist, but they won't be addressed by any form of public policy process except being recognized by the agenda (Lieberman, 2002). Health policymakers worldwide are facing crucial situations in identifying and setting the priorities (Youngkong, et, al., 2009). In general, health issues are eminent on the political agenda (Baggott, 2015; Smith et al., 2012), for both developing and developed countries (Smith et al., 2012). Nevertheless, some issues may gain greater attentions than other health issues (Baggott, 2015).

Recently, there are more calls towards using evidence in formulating policies. Thus, agenda setting is an essential stage to address and consider the available data and evidence. The Kingdon Model is considered one of the prominent models in agenda setting.

4.3.6.1.1 The Kingdon Model

According to Kingdon, an agenda is 'the list of subjects or problems to which government officials, and people outside of government closely associated with those officials, are paying serious attention at some given time' (Kingdon, 2011, p3). The Kindgon model focuses primarily on agenda-setting, the thought of the policy agenda as a series of streams, circumstances or activities within public policy institutions and process (Kingdon, 2011). The *problem stream* (agenda setting) is the belief or perception that an issue has become a potential policy problem requiring government action. Kingdon pointed that a problem could be recognized by monitoring indicators, or by experiencing an event, on the other hand, some problems are not easily objective conditions, thus framing the problem is a crucial issue. The *policy stream* includes the examination of potential solutions to those problems. Kingdon said that during this process, thoughts and ideas evolved then some of them develop and refine and other ideas fall away. The *politics stream* is influenced by the policymaker status and thinking, and other policy actors who shape the policy agenda (in this stage, politicians set the agenda and specialists may contribute in defining the appropriate alternative(s) to adopt). The policymaking process is also influenced by factors inside and outside the government. Each of these streams has a life of its own: they can operate independently. Once the problems are identified and their solutions are available and the political conditions are right, then the three streams get joined together, eventually, a policy window has opened. The 'policy entrepreneur' facilitates the joint of these streams. The policy window stays opened for an only short period, and if a disjoint between streams occurs, the

window will be closed (Kingdon, 2001; Kingdon, 2011). Policy decision-making is viewed to arise in a 'garbage can' in which the streams of problems, policy and politics co-exist.

According to Lieberman, Kingdon's contribution is vital as he raised an essential question in the model, as we might know about how issues are decided, but we have limited information how they become issues in the first place (Lieberman, 2002).

4.3.6.2 Policy Formulation and Development

Policy formulation and implementation cannot be detached from the context in which they take place. The political, social and economic context influences the policy formulation and how these policies are going to be implemented.

The formulation stage is crucial, and it includes vital questions and encompasses actors and processes that may vary considerably from other stages in the policy cycle (Berlan et al., 2014; Sidney, 2007). Critically, the formulation stage is an intermediate stage between agenda setting and implementation (Berlan et al., 2014). Jann and Wegrich have provided a clear definition to policy formulation: 'During this stage of the policy cycle, expressed problems, proposals and demands are transformed into government programmes. Policy formulation and adoption includes the definition of objectives—what should be achieved with the policy—and the considerations of different action alternatives' (Jann and Wegrich 2007, p. 48).The formulation stage has two essential steps; the first one is to decide what is to be done about the problem, and the second step is to draft a policy that has specific objectives (Theodoulou, 1995), sometimes it's referred to as 'adoption', where formulation includes alternatives for actions, and the final adoption is considered the formal decision to take on the policy (Jann and Wegrich 2007; Anderson, 2006).

Unlike agenda setting, the policy formulation process is practiced out of the public eye, and it includes fewer participants compared TO agenda-setting phase (Sidney, 2007). Usually, policy formulation is the task of government bureaucracies, in addition to interest group offices, legislative committee rooms, meetings of special commissions, and think tanks. It includes details that are prepared by technical staff in bureaucracy departments/agencies (Dye, 2002, p 41; Kraft and Furlong, 2010).

It is claimed that in the literature, there is inadequate knowledge regarding the area between agenda-setting and policy implementation (Berlan et al., 2014). Further, the policy formulation stage may interrelate with the agenda-setting stage (Berlan et al., 2014; Sidney, 2007). The Kingdon model for agenda-setting, for example, includes some aspects of the policy formulation stage (Sidney, 2007), for that reason that the formulation stage is described as 'the bit in the middle' (Berlan et al., 2014).

4.3.6.3 Policy Implementation

Once the policy has been formulated and approved to proceed with, then comes the implementation phase. Usually, it is considered a top-down approach; from the top down to the front-line staff.

The implementation phase may be faced with a number of **difficulties** that should be addressed, mainly the failure to translate the policy into practical actions. The main causes of this gap are an unclear 'road map' of answering the specific questions related to what, where, when, how and by whom activities are to be implemented (Jansen, et al., 2010, p4). In addition, due to the lack of clear SMART-formulated policy goals (Specific, Measurable, Acceptable, Realistic and with Time specification), which lead to insufficient monitoring (Jansen, et al., 2010; Stone, 2002).

Further, there is a possibility of 'policy distortion', which may occur when bureaucratic authority deviates from the main objectives of the policy, and as bureaucrats implement the policy they may replace the original policy objectives by their own (Theodoulou, 1995; Dye, 2001).

In policymaking, it is important to balance between the decision maker perspective 'top-down' with the action-oriented perspective 'bottom-up' (Ham, 2009; Hill and Hupe, 2014). Also, deciding the right approach to use (top down or bottom up) might depend upon the issue itself (Hill and Hupe, 2014). However, according to Dye, 'top-down' is the most dominate approach even in democratic societies. Thus, public policy will reflect its values, preferences, and interests of the governing elites (Dye, 2001).

4.3.6.4 Policy Evaluation

Initially, evaluation should be continuous and occur through the policy phases and not limited only to the final stage (Jann and Wegrich 2007; Theodoulou, 1995). This process aims to assess the policy performance and outcomes (Sallis et al. 2006; Jann and Wegrich 2007).

Sometimes policies may **fail** to achieve the intended aims and objectives for various reasons, such as the lack of clear aims and objectives, the failure to convert the clear aims and objectives into achievable actions, resistance conditions within the system, the ambiguity or absence of evaluation criteria for success (Theodoulou, 1995; Jansen, et al., 2010).

The evaluation process has some **debates**, for example: success and failure could have various dimensions. If something judged to be a relative failure from a financial perspective, it could be successful from a political perspective (Baggott, 2015). Moreover, there are many cases where the evaluations results didn't reveal– if conducted – as it may encompasses risk to the political elite (Stone, 2002), and sometimes, It's difficult to be objective regarding the success or

failure of policies (Jann and Wegrich 2007). Nevertheless, conducting the evaluation will lead to policy learning, and it is expected to have its implication on the policy process (Jann and Wegrich 2007).

4.3.6.5 Summary

Although public policy has a profound ground in literature, yet health policymaking needs more deep investigation. There is a lack of studies related to health policymaking and process. It is important to study the various aspects or functions of the policy process to recognize the potential challenges and strategies related to each of them (Sallis et al. 2006). Brownson and his colleagues call for the need to study the policy process and document the factors that influence the process including the political factors (Brownson et al., 2009; Sallis et al. 2006).

A policy process 'phases' approach was criticized to be too rational, linear and top-down (ex. Sabatier, 1991). Despite that, policy process phases or stages are still widely used, being seen a useful way to illustrate the process, and it is useful for policy analysis (Hill, 2013; Berlan et al., 2014; Jann and Wegrich 2007; Walt and Gilson, 2014). Hence, those stages are not isolated from each other, and policy process does not often have a clear-cut beginning and ending (Jann and Wegrich 2007).

4.3.7 Health Policy Analysis

Policy analysis, in general, is the study of what government should do regarding public problems (Mead, 2013). **Health policy analysis** is 'a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests, and ideas in the policy process' (Walt et al. 2008, p 308). The policy analysis could be done retrospectively and/or prospectively. It is used to evaluate policy failures or successes, and then use this evaluation as a lesson learnt in the future (Walt et al. 2008). Public policy analysis is considered as an integral part of public policymaking process. Although it is considered complex and requires inter-disciplinary knowledge and approach, it has a vital role to assure that the decisions related to a particular policy are consistent with decisions made in other policy areas (Simon, 2007, p 78).

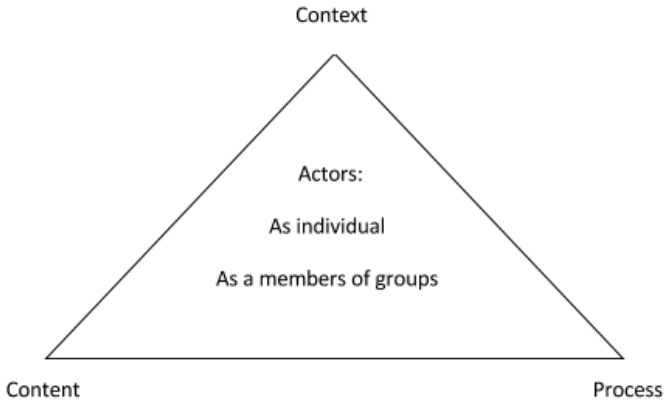
4.3.7.1 The Policy Triangle

Health policy analysis could be viewed from different frameworks. The most renowned being the Walt and Gilson model which is also called the policy triangle. The model viewed policy making from macro level and in accordance with socio-political view. The framework contains four determinates of health policymaking; Processes, Actors, Context and the Content (Walt and Gilson, 1994)

- Policy Context: It concern where the policy is being formulated and implemented, several factors affect the policy within the context such as politics, economic and culture …
- Policy Actors: Actors could be individuals or groups; they could be involved in producing the policy and/or its implementation

- Policy Processes: It concern of how the issues get on the policy agenda, and how other factors and actors power affect the process
- Policy Content: It includes the policy components such as the objective, policy design, mechanism, and implementation plan …

Figure 4-1: a model for health policy analysis



Source: (Walt and Gilson, 1994, p 354)

4.3.7.1.1 General comments on the model

This model was initially created for developing countries and health sector reforms, but it could be useful for low, middle and high-income countries. The model was created to, as Walt and Gilson noted that, most of the researcher focused on the policy content and there is little attention to the policy context, actors, and process. This model could be used to help both policymakers and researchers to gain a better understanding to health policy process and reforms. A significant contribution of this model is that it can be used both retrospectively and prospectively (Walt and Gilson, 1994; Walt, et al., 2008).

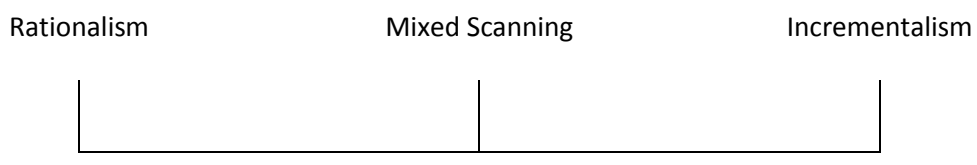
4.3.7.2 Summary

Health policy analysis in LMICs still has a gap in the field. Gilson and Raphaely conducted analysis to the publications in the field and found that there is lack of explicit conceptual frameworks, little detail on research design and methodology, and the majority of case studies focused on specific issues (Gilson and Raphaely, 2008).

4.3.8 Models of Policy Making

Over the years, a number of public policy models have emerged from political sciences and other discipline, mainly the Institutional Model – Process Model - Rational Model- Incrementalism Model - Game Theory Model - Elite Model - Group Model – Public Choice Model(Dye, 2002; Anderson, 2006). Each model has its major concepts. Although they were not derived to study public policy in particular, each model has contributed to study public policy from different angles (Dye, 2002; Kraft and Furlong, 2010). Moreover, it's difficult to judge on a policy as belonging to one of these models exclusively, rather most policies are considered as a mixture of more than one model (Dye, 2002, p11-12). As for health policy making, some authors (ex. Walt, 1994) pointed that there are three approaches or models that could be relevant to health policy and planning: rational, incremental and mixed scanning model (figure4-2).

Figure 4-2: models of policy making



Drawn by the researcher

4.3.8.1 The Rational Model

The rational model is widely portrayed. Under the rational model, the goals and objectives should be identified (sometimes referred to as setting the agenda), then evaluate the available options and alternatives by the policymakers' in order to select the suitable course of actions (Lee and Mills, 1982). According to Lindblom, this model is the ‘root approach to decision making’ (Lindblom, 1959).

Some authors raised a number of drawbacks of the rational model. It is assuming that policymakers could identify the problems and the solutions in a consensus manner, while in reality there are several actors who have different perspectives (Simon, 2007; Walt, 1994). This model is considered costly as identifying problems and all potential solutions require in-depth analysis, and consume time and money. Also, policymakers won’t probably be able to spend the time to study and evaluate all the alternatives. Measuring the impact of the policy is another issue, as policies require time to show their impacts, additionally, some consequences cannot be anticipated (Simon, 2007; Walt, 1994).

This model is described as being a 'distant ideal', as it assumes that policymakers approach the issues in a linear manner, while in real practice, it is much more complicated. Nevertheless, some authors defend the model of being ‘'distant ideal’, as it does describe how policy should be made in a rational manner. Simon proposed the idea of ‘bounded rationality’, which simply means that policymakers seek to achieve satisfactory level rather than to reach the maximum level (Simon, 1957 cited in Walt, 1994, p48). Simon claims that decision makers are intentionally rational, but due to the constraints in reality are limited in their ability to make perfect rational choices (Simon, 2000). Further, decision-making could be improved by using new management techniques and by technology. Despite those drawbacks, the approach is still favored, thus the government is looking to improve this approach. Mainly by improving the policy

analysis and by adopting evidence-based policy concept (Sanderson, 2002). According to Baggott, the challenge now to this improvement attempt is to enhance evidence policy concept by ensuring reliable and credible evidences (Baggott, 2015).

4.3.8.2 The Incrementalism Model

Lindblom is one of the main contributors to this model, mainly through his article "the science of muddling through" (Walt, 1994). Lindblom was skeptical about human rationality, particularly in the complex policy environment. For that reason, he believed in incrementalism. The main features of this model are: The selection of goals and objectives are entangled with the means of its implementation. Policymakers consider only a few alternatives to address the problem. Most of them probably tend to choose alternatives that differ slightly from the existing policies. Only the significant implications of the alternatives will be addressed. There is no optimal solution as it depends on agreement among the policymakers, which implies that the chosen decision may not be the best one. In this model, policymakers thought that policies were already being identified, and if needed, the problems/current policies would be revisited and consequently minor changes could occur (Lindblom, 1959; Walt, 1994). This model is referred to as the bureaucratic model, and it is considered practical as it saves time and effort to reach a satisfying level of decisions.

This model also has some drawbacks. Some of them related to the features of the model itself. Mainly, when policymakers look for agreement on the decisions, which could not be the optimal or even the satisfied level of decisions. Additionally, it is based on making few changes to the existing policies, which could limit the ability of creativity and come up with new strategies and ideas and may lead to change resistance (Buse, et al. 2012). Another critique is that this

model works best when conditions are stable and few changes are expected, but it is limited in its usefulness when significant changes occur and decisions should be made accordingly (Walt, 1994). Simon adds this model is invalid in a situation where policy is being dominated by special interests and few powerful actors (Simon, 2000).

4.3.8.3 Mixed Scanning Model

As both models have several positive features and some drawbacks, some authors call for looking for a middle position between rational and incremental model. According to Walt, the incremental model describes what is happening, while the rational approach describes what should happen (Walt, 1994). Etzioni, was one of the early authors to call for a mixed scanning model. His idea was to combine both models elements to avoid the ideal assumption of the rational model and the conservative assumption in the incremental model (Etzioni, 1967). In mixed scanning models, a decision is classified into a macro and a micro level, and according to Etzioni, mixed scanning models could use two cameras: abroad angle lens, which covers all parts of the issue without details and using other or more concentrated lens to focus on details (Etzioni, 1967; Walt, 1994).

4.3.9 Health Policy Actors

This section illustrates the main health policy actors within the government and outside the government. Decision-makers in the health system are diverse, in theory they include policymakers, implementers and frontline workers, in addition to researchers, media, professional

associations, civil societies … etc. The extent and level of those actors involvement in policymaking and agenda settings vary from one country/system to another.

In an attempt to define health policy, some authors limited health policy to the government actions and actors, while others pointed to other actors. A number of authors supported the idea of considering non-governmental actors when planning and setting policies for the health sector (Paton, 1998; Pavignani and Sandro, 2009). Some authors pointed out that policy actor's influence on policymaking is not only different from one country to another, but differ from one sector to another within the same country (John, 2012). Additionally, actors' influence on health policymaking is seen as exerting their invested power (Barker, 1996). The power is not political only, as other sources form individuals or group power such as wealth, hereditary status, professional status, ideas or knowledge power, physical and military power …(Barker, 1996). Generally, actors are individuals and groups, both formal and informal, who attempt to influence the creation and implementation of public policies and decisions (Cahn, 1995; Gilson, 2012).

This section will describe the actors in the health sector and how they will be viewed in general.

4.3.9.1 The President, King and Head of State as Agenda Setter

The head of any state is expected to have a considerable role in public policymaking due to the importance of health sectors and its issues that are relevant to every citizen. However, it is difficult in this study to cover all the potential forms of presidents or head of states role in policymaking. Generally speaking, the head of the state's role in policymaking is extremely varied based on the political system adopted in that state and the distribution of power.

4.3.9.2 Government as Agenda Setter

In general, it could be said that each country has distinct features, which make their case different from another country even if they adopt the same system. Governments could be classified into appointed government or parliamentary government.

The UK has a profound parliamentary government, which has been emulated in several countries worldwide. In the UK, the leader of the largest single party in the House of Commons will be asked to form the government by the monarch. The leader of the party becomes the Prime Minister and then he chooses 100 people approximately to take up ministerial appointments. Then, the most senior of them (20 person) comprises the Cabinet (ministers could be from House of Commons and House of Lords). So, the government is made up of cabinet and non-cabinet ministers (Ham, 2009; Hill and Irving, 2009). Hill and Irving indicate that even though different counties has borrowed the UK system, it still holds unique features that are embedded in the UK solely, (Hill and Irving, 2009) which proves the claim that each country has a distinct feature and policymaking will vary accordingly.

It is claimed that, even though there are a number of actors who may influence the policy process phases, the government remains the key player with crucial role in policymaking. (Buse et al. 2012; Jann and Wegrich 2007; Walt, 1994) Even more, the government in many cases plays a vital role in influencing the actor's constellation within the 'policy networks-actors' (Jann and Wegrich 2007).

Generally, government role in health policymaking could be done through key players:

4.3.9.2.1 Bureaucrats

Senior civil servants usually influence the health policymaking by providing their advice to the minister of health and other ministers in relation to health issues (Baggott, 2015; Buse et al.

2012). Middle-rank civil servants could participate in policy formulation by providing relevant information to the higher-ranks officials. Also, they have a role in policy implementation by setting the needed plans and actions to implement the policy (Baggott, 2015; Dye, 2002; Simon, 2007).However, the traditional view of the politicians and bureaucrats relationship (politicians or ministers make policy and civil servants only implement it) has been challenged (Green and Bennett, 2007). Nevertheless, the politicians and bureaucrats' relationships are varied considerably in terms of their role in policymaking according to the regime of a given country. In general, it could be claimed that executive bureaucracy has substantial role in the policy process in most developing countries (Grindle and Thomas, 1991).

4.3.9.2.2 The Ministry of Health

The ministry of health (MoH) has an essential role in managing the health system and overall health issues (Cassels, 1997; WHO, 2000; WHO, 1998; Siddiqi et al., 2009; Buse et al. 2012). The MoH is the main health provider in developing countries in particular (Siddiqi et al., 2009; Green and Matthias, 1996). Further, the MoH is seen to be the main producer of the national health policy document (Cassels, 1997; WHO, 1998; Green and Matthias, 1996). Having an overall role to manage the system is sometimes called the stewardship function which is assigned to MoH in general on behalf of the government. It requires vision, intelligence, and influence. However, some functions related to health are taken by the government as a whole as some activities maybe beyond MoH authority and influence (WHO, 2000).

4.3.9.2.3 Other Ministries and Governmental Agencies

Although the ministry or department of health is the main agency concerned with health issues and health policy, other ministries and departments within the government are concerned with health policies. One of the main agencies to involve in health policy is the ministry of finance or treasury (WHO, 2006), as the health sector usually consumes quite a large amount of the state budget. Budgeting for health is not like any other sectors or activities (Cashin, 2016), it requires a mutual understanding between the MoH and MoF. Sometimes, it is refereed to 'Health financing policy dialogue', which according to Cashin is not easily achieved as MoF tend to be inflexible. But on the other hand, if MoH has clear strategic plans, with reasonable and reliable cost estimate, and has reasonable performance indicators, it will facilitate both MoH and MoF dialog.

Other miniseries or departments who may have related to health issues are the providers of clean water, environmental sensation, food and nutrition (Siddiqi, et al., 2009). However, in practice, the relationship between MoH and other ministries and government agencies is not easily portrayed and varied considerably between countries.

The educational and research institutions also influenced the health sector and its policies. It has various forms of influence, such as provide trained and qualified staff. In addition, they conduct research and studies that contribute to the health sector (Shi, 2014). In several countries, educational institution is owned, operated and legislated by the state.

4.3.9.3 Politicians

Politicians may encompass different descriptions. However, in democratic societies they relate to the electoral process, where citizens select the policymakers/representatives who represent them (Kraft and Furlong, 2010). In some societies, the elected members belong to

parties with identified ideology and perspectives. Those representatives have a number of defined duties, mainly to pass legislation, and examine the public expenditure and control the government (Ham, 2009). The relationship between politics and policymaking is not linear or clearly defined. The politician's role in decision making and influencing the policies is tied in with various factors and varies considerably based on the political system adopted in any given country.

4.3.9.4 International Organizations and Agencies

Health is a global issue. For that reason, various international bodies are involved in health issues and health policy, prominently the World Health Organization (WHO). It was founded in 1948 to be a specialized agency with a broad mandate for health. The WHO main objective is 'the attainment by all peoples of the highest possible level of health'. WHO membership is open to all UN member states (WHO, 1948). WHO is now governed by 194 member states, and it has a unique feature among UN agencies by the establishment of regional organizations. However, WHO is faced with financial limitations, which affect its ability to perform those core functions and protect health for all (Sridhar, et al., 2014). WHO undertakes reforms started in 1989, and the last reform was in 2010 (Clift, 2013). The aim of these reforms should focus on maintaining WHO's uniqueness and irreplaceable role in global health (Frenk and Moon, 2013).

WHO is not the only organization working on health issues globally, other international agencies are working on health issues and some of them even challenge WHO role as being the only leading and coordinating authority (Clift, 2013; Frenk and Moon, 2013). The World Bank, for example, is involved in the health sector through loans on a large scale and agreements with

countries (Clift, 2013). Also, other UN agencies that work on health related issues as part of their scope, such as UNICEF - UNAIDS - UNODC - UNHCR- UNRWA - UNEP (Frenk and Moon, 2013). For example, UNICEF (United Nations Children's Emergency Fund) performs different tasks to improve the health of children, as it is one of its major tasks. Nevertheless, it is important for those different actors to clarify their roles and avoid functions overlapping between them, and to reach a consensus on each actor role and domain, so it will strengthen the global health system (Frenk and Moon, 2013).

The WHO is faced with a number of challenges. Mainly is identifying the WHO role in comparison to other UN agencies and other organizations. Such as, UNAIDS, the Global Alliance for Vaccines and Immunization(GAVI Alliance), the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) and UNITAID (Clift, 2013) in addition to the Organization for Economic Co-operation and Development (OECD) and the World Trade Organization (WTO) and the European Union (EU), that have health-related activities as part of their scope. Having various organizations, raises some questions that should be addressed by WHO, as different players globally are interfering in health issues, including NGOs, charitable foundations and the private sector-private philanthropists, and the need to revise WHO role (Clift, 2013; Szlezak et al., 2010). Further, WHO faced criticism on some aspects mainly for its funding resources, its independence and neutrality, being tied to specific programs, extreme bureaucracy, lack of leadership and being heavily politicized (Sridhar, et al., 2014; Baggott, 2015).

WHO's role in health issues is essential and irreplaceable in certain aspects. Meanwhile, these challenges facing WHO has its reflection on the local governments they are working with and implementing their programs. So, WHO's role in policymaking may be affected in some countries. Generally speaking, it could be assumed that WHO has the more influencing role in developing countries compared to developed countries.

4.3.9.5 Non-Governmental Organizations (NGO's)

There is a wide range of NGO's classification in the health sector. It could be: the Health consumer and patients organizations, Single issue group, who usually defend a certain case, such as anti-smoking NGOs, other voluntary organizations, such as research and service provider charities. Those organizations' influence on policymaking and even their relationship with policymakers and healthcare professionals varies considerably. It depends on several factors, such as the organization's activities, power, lobbying skills, resources, expertise and knowledge (Baggott, 2015; Green, 2007).

4.3.9.6 The Interest/Pressure Groups

Interest groups and pressure groups have several definitions, which sometimes lead to widen the scope. It is not the purpose of this study to discuss the distinction between terms, but it could be said that most of the pressure groups have some interests to protect (Cahn, 1995). They seek to influence on specific policy issues (Anderson, 2006).

Pressure groups' influence on policymaking varies as well, even among countries with similar systems. For example, both USA and UK are considered as democratic countries. It is claimed that pressure groups are more influential on policymaking in the USA compared to the UK. Several causes could lead to the variation of pressure groups roles, most importantly the political system characteristics within each country (Hill and Irving, 2009).

Interest and pressure groups may have either positive or negative role in influencing health policymaking. They play a positive role by supporting the government with facts and

provide the needed consultation to them (WHO, 2006). While on the other hand, their role can be perceived as negative when they exert their power to divert policymakers from the aims of the policy towards that group's own narrow interest (WHO, 2006). However, it is advisable to communicate with interest and pressure groups and listen to them, and even this could be legitimized by creating a mechanism to obtain their opinions and views (WHO, 2006).

4.3.9.7 Medical Profession, Health Professionals and Associations

Health professionals include medical doctors, nursing professionals, midwifery professionals, dentists, pharmacists, and therapists. Healthcare is considered a highly technical sector, accordingly, the expected relationship between health professionals and policymakers is different from other sectors. Also, most of policymakers and politicians may lack the necessary expertise (John, 2012). Thus, the healthcare professionals and their associations have a strong standing. The professional associations could exert their influence on policymaking through their associations and representative bodies (Baggott, 2015; Marmor and Wendt, 2012). Their role can range from being directly involved in policymaking, to be consulted on certain issues or being neglected.

Healthcare professionals' influence on policymaking varies considerably among countries and governing systems. There are even differences in power and influence between healthcare professionals themselves within the same country. Medical doctors used to be the most influential among other healthcare profession (Barker, 1996; Lewis, 2006; Baggott, 2015; Marmor and Wendt, 2012). However, the status of power may change over time. For example, in UK recently, there is a change in the medical professional status and they are not seen by the NHS to have the greatest impact on health policymaking, as other professions' -mainly nursing- status has

been recognized as well (Blakemore and Warwick-Booth, 2013). However, Baggott pointed that several observers believe that medical profession still has a powerful influence on policymaking compared to other professions and organizations (Baggott, 2015).

4.3.9.8 The Private Sector

Even in democratic states, where there is a well-developed public healthcare system, private health care services could exist (Hill, 2006). The private sector role in health policymaking is varied. Main player in health sectors are the private hospitals and pharmaceutical industry. Other private entities have less impact on policymaking, such as medical suppliers.

4.3.9.8.1 Private Hospitals

Private hospitals are existed in both developed and developing countries. Its spread and scope of services is varied greatly between countries (Mackintosh, et al., 2016). It is difficult to evaluate the role of private sector in policymaking, unless it is examined within its contexts (Mackintosh, et al., 2016).

4.3.9.8.2 Pharmaceutical Industry

The pharmaceutical industry is highly affected by government policymaking and decisions. For that reason, the pharmaceutical industry is seeking to take part in the policymaking process to maintain their rights and positions (Shi, 2014). Although it is privately owned, the government exerts its control by regulating different aspects of the industry either directly such as pricing, or indirectly such as the employment policies (Baggott, 2015). The pharmaceutical industry could be powerful. However, pharmaceutical industry involvement in policymaking should be considered

with caution, mainly because their primary aim is to maximize their profit, and because public is viewing them in unfavorable perspective.

In some countries, the pharmaceutical industry maybe more influencing than others on policymaking based on their economic and political power.

4.3.9.8.3 Medical Suppliers

The health sector is depending on private medical suppliers (i.e. medical equipment's, instruments and devices). The health sector suppliers' role in policymaking is not strong compared to others as those suppliers could be local or international companies and they refer to different categories.

4.3.9.8.4 Others

This may include private outsourced services companies or other industries such as food industry and tobacco industry which have a direct and indirect impact on health status and health policymaking, and their impact is quite complex (Baggott, 2015).

4.3.9.9 The Mass Media

The media has a key role in public policymaking. In general, politicians, policy participants, and interest groups are seeking to control public opinion to gain support to a certain issue. Media is one of the main tools for this purpose (Simon, 2007; Callaghan and Schnell, 2001). According to Callaghan and Schnell, media has the power to influence public opinion and related political

perceptions by determining the issues to be covered, focusing the attention on certain issues over other existing ones, and by framing of issues (Callaghan and Schnell, 2001, p 188).

The mass media has a key role in health policymaking as well. It could be in different ways, as raised by Callaghan and Schnell. Also media could adopt a particular case, such as mental health issues or elderly care services and initiate campaigns to drag people, professionals and government attention to these issues (Ham, 2009). Media could also work on conveying the citizen voice to the policymakers and their opinion regarding several issues in the health sector, such as the level and quality of services. Sometime the media role could be indirect and include other policy actors, such as government agencies, pressure groups and parliament (Callaghan and Schnell, 2001; Baggott, 2015).

When raising media role in policymaking there are some crucial questions -which will not themselves be analytically discussed in this study- that one needs to be aware of when evaluating the media role in policymaking such as: who controls the media? Do policymakers consider the issues raised by media? Is the media biased or partial in tackling the issues? What is the reliability and credibility of reports and media coverage?

4.3.9.10 NGOs

Historically, the majority of religious-based organizations that provide health services are related to Christian church and missions. However, other faith philosophies, such Islamic and Hindus organization, provided health services (Green and Matthias, 1996). Nevertheless, the funding for faith-based health organization is not stable (Green and Matthias, 1996).

NGOs influence on policymaking process is varied considerably between countries and due to NGOs and international NGOs potentials (Green and Matthias, 1996). Further, as Green

and Matthias stated that INGOs involvement in health sector activities may advocate influencing the policy of bilateral or multilateral donors, which eventually may influence some countries (Green and Matthias, 1996). In the third world countries, there is a number of issues related to the national NGOs, such as their relationship with the government, in addition to their relationship with INGOs and donors, which eventually determine their ability to influence health sector policymaking process (Green and Matthias, 1996).

4.3.9.11 Others

In addition to the previously mentioned potential actors who may influence policymaking, there are some groups and actors who may have an influence on the health sector policymaking, mainly:

- **Religious groups**

In some countries, faith-based-health-care is considered one of the healthcare providers. However, most likely they will not have an influential part in policymaking (Green, 2007). Faith-based organizations exist more feasibly in low and middle-income countries (Green, 2007). Further, religious elites, notably in developing countries, have influential power on policy choices (Grindle and Thomas, 1991). For example, they may challenge or support decisions of birth control and abortion.

- **Parties**

Parties' role in policymaking is varied considerably, and it is related to the state regime. In some countries, parties may not be interested in influence the policymakers as much as in gaining policymaking positions for their members (Cahn, 1995). Further, some parties might gain the

opportunity to officially participate in the decision-making process, if they were elected and joined the parliament.

- **Experts and Consultants**

Experts and consultants role is not limited to the government only. They may not have a direct impact on policymaking, but they provide advice and assistant to politician and policy makers, and sometimes to other parts like international agencies.

Consultants could be technical and/or political or both. It is claimed that political consultants are costly, and, thus affordable only by those who own greater resources (Cahn, 1995). It is claimed that both the government and the private sector are more aware of the consultant's power in the policy process, and there is a growing trend to include advisors on policy from industry or the private sector (Green and Bennett, 2007).

Consultations could come from the think-tanks; which could be local or international like the international organizations (Jann and Wegrich 2007). The main role for the think-tanks is to promote the exchange of policy ideas, solutions, and problems among governments and beyond (Stone, 2002). The major role of think-tanks is during the formulation process (Dye, 2001).

- **The community**

In general, there are different ways of community engagement in policymaking and it varies among countries. In some communities, they may be grouped under organized and formal forms. In other countries, the government may use straw polls, questionnaire, public workshops and seminars, focus groups or meetings (WHO, 2006). However, it is claimed that community participation in policymaking is facing several difficulties on the local and national level (Mansuri and Rao, 2012; Rifkin, 2014), including the lack of frameworks to understand the relationship between community participation and improving health outcomes (Rifkin, 2014).

4.3.9.12 Summary

As indicated earlier, health policymaking includes different actors and their role varies considerably. Health sector actors and stakeholders have different interests. In practice, it is difficult to please them all (Peters and Chao, 1998). Actors aim to influence the policymaking in early stages, namely the 'agenda setting' stage (Kingdon, 2011; Lewis, 2006). Moreover, each stage of the policy process may have different actors (Green and Bennett, 2007). Additionally, even if some actors may exercise their power to influence the policymaking in transparent manner, it is difficult to a straightforward examination (Lewis, 2006). Actor's role in health policymaking varied between high-income country (HIC), and low and middle-income countries (LMICs). To understand the actor's role, we need first to understand the context of each country and even the timing of the policy (Walt, et al., 2008). However, actor's role is not constant over time; a number of scholars indicated that there is a movement toward including other actors in health policymaking and not limited it to the traditional state actors, particularly in LMICs (Buse, et al., 2012; Walt, et al., 2008).

4.4 Main Challenges facing Health Policymaking

Health policymaking is faced by enormous challenges. Some of these challenges may have different effects on developing and developed countries. A number of the policy challenges are based on challenges within the healthcare sector itself. This section will present the main challenges, and then present the main health sector challenges in developing countries.

The main challenges are:

- **Defining the essential terms**
- The different views to the 'policy' and 'health policy' definitions is the main challenge, as later implications could result from the definition(s) that will be adopted and used as a base for policymaking and analysis (Walt et al. 2008).

- **The Interconnection of Healthcare sector with other sectors**
- One of the key challenges facing the health policy maker is that some issues fall outside the traditional healthcare sector, such as economic instability, population and demographic changes, pollution and environmental challenges. Even more, some of these challenges are on global scale (WHO, 2006; Blakemore and Warwick-Booth, 2013; Murray and Frenk, 2000; Green, et. al., 2002). Other global challenges are the movement of disease, the migration of health professional ... All of these challenges place their pressures on the national health planning, and sometimes policymakers have limited abilities on controlling these issues.
- The health sector is not only influenced by other sectors inside the state. It is influenced also by factors that lie outside the state boundaries, and these are influenced by other sectors and actors (Buse, et al., 2012; Murray and Frenk, 2000), such as being influenced by global actors and institutions. Further, the health sector is influenced by decisions that are made in other global policymaking arenas, such as environment, trade and immigration. One of the global health system aspects shows that national health policies in several countries cannot be separated from its global context (Walt et al. 2008; Szlezak et al., 2010; Frenk, 2010; Frenk and Moon, 2013).

- **Resource Availability**
- In practice, governments in all countries have a considerable involvement in the health sector. Health policies and expenditure levels on healthcare services and its scope in developing and developed countries are highly affected by the economy and resource management of any country (Lee and Mills, 1982).
- Resource availability is another challenge to policymaking. As it is affecting developing countries relatively more than developed countries (Green, 2007). Resources, is not limited to financial resources, but also to qualified human resources and other resources and facilities, such as technology.
- Prioritizing healthcare needs is another important issue, which is highly linked with resource availability (Green, 2007).
- Providing healthcare services considered relatively expensive and place constraints on the public budget, and therefore affect the sector agenda setting and planning (Marmor et al., 2005).
- It is claimed that the state role in healthcare financing and provision is even growing compared to previous years (Paton, 2006).

- **Organization and Planning**
- Although the state is seen to have a major impact on public health, it is faced with several challenges to undertake its responsibility which is considered poorly planned and coordinated (Beaglehole and Bonita, 2004).
- The failure of implement the plans, which lead to having plans on paper and not reflected on the actual ground (Green, 2007), the gap is attributed mainly to the unrealistic planning, such as the imbalance between needs and the available

resources, the lack of plans and process to utilize the available resources, improper evaluation of the alternatives…

4.4.1 Health Policymaking in Developing Countries

In this section a brief view of the policymaking in developing countries will be offered, and then it will highlight the major challenges to health policymaking in developing countries.

The international agencies such as World Bank and WHO, have provided terms to show the classifications between countries based on a number of criteria, such as economic status, and sometimes the classification based on region. Common classifications: developing and developed countries, north and south, first world and third world and rich and poor … (Beaglehole and Bonita, 2004).

Hence, in this section, the term "Developing and Developed Countries", will be used as its most commonly used in literature generally and by WHO publications. In addition to use sometimes low and middle income countries (LMIC's), and high-income countries (HIC's) as they existed in quite a number of studies, and to keep the authors credit for using these terms when they were referred to.

Public Policy theories and literature are focused mainly on developed countries, while there is a lack of studies on policymaking in developing countries. It is difficult in most cases to reflect developed countries theories on developing countries; this is mainly due to the contextual differences between them, which heavily influence the logic and process of policymaking (Osman, 2002). Nevertheless, the existing policy theories could be used as guidance –to some extent-to analyze the developing countries' policies (Osman, 2002).

Generally, public policies in developing countries have shared features that affect the policymaking, mainly the instability in the socio-political environment, in addition to a number of difficult issues facing those countries, such as high unemployment rate, poverty, illness and illiteracy (Osman, 2002). Hence, those challenges vary from one country to another.

Health Policy is not an exception to the above. Health Policy process is originated mainly in high-income countries (HICs) (Exworthy, 2008; Walt and Gilson, 2014). A number of authors pointed out that there is a lack of the theoretical and conceptual approaches related to health policy analysis in LMICs, and they still have little guidance on how to do health policy analysis (Walt and Gilson, 2014; Walt, et al. 2008; Exworthy, 2008; Erasmus and Gilson, 2008). Public policy theories in HICs could be helpful to LMICs in general; likewise, health policy theories in HICs) could be helpful to LMICs and could be used to provide a certain level of understanding. Hence, the use of that concept and theories should be used and transferred carefully (Walt et al. 2008)

Although there is a lack of studies related to health policy in LMICs, the available literature revealed that politics, process, and power should be included when studying health policies and the practice of health system development. Yet further studies and efforts are still needed to understand the health policy, its process and other related factors within LMICs context (Gilson and Raphaely, 2008).

It is worth stressing that the developing countries are not homogenous, there are a wide variety of factors and indicators throughout any region, and there is an enormous difference between countries (Beaglehole and Bonita, 2004). Some of the issues will be discussed in this section may exist in whole or part of a given developing country. According to Frenk, even if some countries may fall under the same level of income categories, there will be a divergence in health system performance between those countries (Frenk, 2010).

4.4.2 Main Challenges Facing Health Policymaking in Developing Countries

Healthcare policymaking in developing countries is faced enormous challenges. Some of these challenges are similar to developed countries; however, the health sector in low and middle-income countries (LMICs) faces extra or different challenges compared to HICs. The main challenges are:

- **Pluralism in Developing Countries**

  Generally, pluralism means the power is distributed among different groups (Lewis, 2006). Pluralism in developing countries is seen to be weak compared to developed countries (Osman, 2002). Societies are not organized in an adequate manner so they could raise their demands. One of the reasons is that the government is considered the main provider of health services and even the main employer to the healthcare staff (Green, 2007; Barker, 1996). However, it is claimed that health politics is 'elitist' as the power is concentrated, centralized and exercised continuously (Lewis, 2006, p 2126).

- **Decision Making in Developing Countries Is Highly Centralized**

  In developing countries, the state undertakes the main role of policymaking (Osman, 2002; Grindle and Thomas, 1991). State actors strongly influence the agenda setting and influence the selection of the potential alternatives (Grindle and Thomas, 1991). Accordingly, other actors and even factors have limited influences. Walt pointed out that professional associations in developing countries have limited influence on health policy (Walt, 1994).

Bossert and his colleagues described the ministries of health in low and middle income countries to be highly centralized with fragmented vertical programs and depend on indeterminate donor funding (Bossert, et al.,1998). However, LMICs are varied in the level and degree of having all or problems as described by Bossert and his colleagues: *"Ministries of health in low and middle income countries have a reputation for being among the most bureaucratic and least effectively managed institutions in the public sector. Designed and initiated in the early 20th century and given wide responsibility for financing and operating extensive public hospital and primary care systems in the post-war period, they became large centralized and hierarchical public bureaucracies, with cumbersome and detailed administrative rules and a permanent staff with secure civil service protections. The ministries were fragmented by many vertical programs which were often run as virtual fiefdoms, dependent on uncertain international donor funding"* (Bossert, et al.,1998, p59)

- **The Lack of Considerable Attention o Health Research and Evidence-based Policy**

Evidence- based policy and the use of health research evidence in policymaking are an underserved area in low and middle-income countries (LMICs) and is mainly disease-specific (Hawkes et al., 2016). Further, most of the studies are led by the researchers, not the policymakers (El-Jardali et al., 2010; El-Jardali et al., 2012 a).

The Health system research field has not gained a considerable attention in low- to middle-income countries (LMICs) compared to developed countries (Mills, 2012). Cheung and his colleagues analyzed the printed media in 44 low- to middle-income countries (LMICs). The result revealed that those countries had the lowest number of articles central to the evidence-informed health system (Cheung et al., 2011).

Panisset and his colleagues reported that one of the obstacles that faced the progress of Millennium Development Goals, (MDGs) was the deficit of health systems in several (LMICs) to implement effectively the evidence-informed interventions (Panisset et al., 2012). El-Jardali and his colleagues conducted a study and found that there is no practice for priority settings in health policy and systems research in nine countries in MENA region (El-Jardali et al., 2010).

In general, information needed for decision making is considered inadequate in developing countries compared to developed countries. Thus, some developing countries depend on foreign consultants and resemble their experiences and solutions (Walt, 1994).

- **Health Finance**:

Budgeting for health is not like any other sectors or activities (Cashin, 2016). However, LMICs face additional challenges related to its revenue and expenditure. The LMICs may have macroeconomic and fiscal constraints resulted from government poor resources, ineffective tax systems. Also, priorities most likely are not reflected in budget allocations due to some causes mainly depending on donors on some projects and the inflexibility between related authorities during budgeting process (Cashin, 2016). As for health spending, it is inefficient and at the same time there is a constant need for increase spending. Also, budgeting decisions are not vested in MoH only, as it connected with MoF, and with other players that varied from one system to another (Cashin, 2016).The financial resources devoted to health in many countries are a matter of political decision in most cases (Lee and Mills, 1982).

The lack of financial resources has placed the health sector and its policies – to some extent- under the control of donors and international agencies (Lee and Mills, 1982; Osman, 2002; Green and Bennett, 2007). In general, the level of health spending in LMICs is inadequate to address the health challenges they face (WHO, 2001;Peters and Chao, 1998; Youngkong, et, al., 2009)

- **International Organizations and Aid Agencies**

  International organizations and aid agencies provide assistance to the developing countries in various fields and health is one of the main targeted sectors for assistance. International organizations and aid agencies become an influential actor on the national policies of the developing countries (Gilson and Raphaely, 2008; Osman, 2002; Liverani et al., 2013; Walt et al. 2008; Ensor et al. 2009). They are seen to influence the priority settings and the resource allocations on the developing countries (Behague et al., 2009; Ensor et al. 2009; Osman, 2002). Walt pointed that 'Health policy environment is increasingly populated by complex cross-border, inter-organizational and network relationships, with policies influenced by global decisions as well as by domestic action' (Walt et al. 2008, p 309).

  In general, countries in conflict or suffering from the lack of financial resources will be more exposed to the external influences (Green and Bennett, 2007).

- **Social Determinants of Health**

  Social Determinants of Health (SDH) impose major challenges on health policymakers, in both developing and developed countries (Exworthy, 2008).

According to Exworthy, SDH was neglected in the policy analysis and other imperatives were considered (Exworthy, 2008).

- **Policy Actors**

  Both developing and developed countries have many **'actors'** who influence the policy process. It was explained earlier that an actor's role in health policy varied between (HIC) and (LMICs), and it is even varied within each classification due to the contextual factors and policy environment. In LMICs, other factors influence the policy such as the prevalence of political power, and the influence of external factors, such as the donor's agencies and international organizations (Walt, et al., 2008; Green and Bennett, 2007).

4.5 National Health Policy Formulation

In this section, an overview of the national health system will be provided, including the main considerations, limitations and challenges.

4.5.1 General Overview of the Health System

Before discussing the national health policy and strategies, it's desirable to give a general overview of the health system, which is defined according to WHO as 'all the activities whose primary purpose is to promote, restore or maintain health' (WHO, 2000, p5). Better health is the most central objective of the health system, this main objective encompasses: improving population health, responding to expectations and providing financial protection against the costs

of ill-health. However, these objectives are not always attained, in particular in poor countries and for poor populations (WHO, 2000).

A health system has four essential functions:

(a) Stewardship (oversight): the government should undertake the responsibility to oversee the health system and clearly define the health policy vision and direction. The government usually practices their influence through rules and regulations. Also, the government is responsible for collecting and using key data in their policies and strategies.

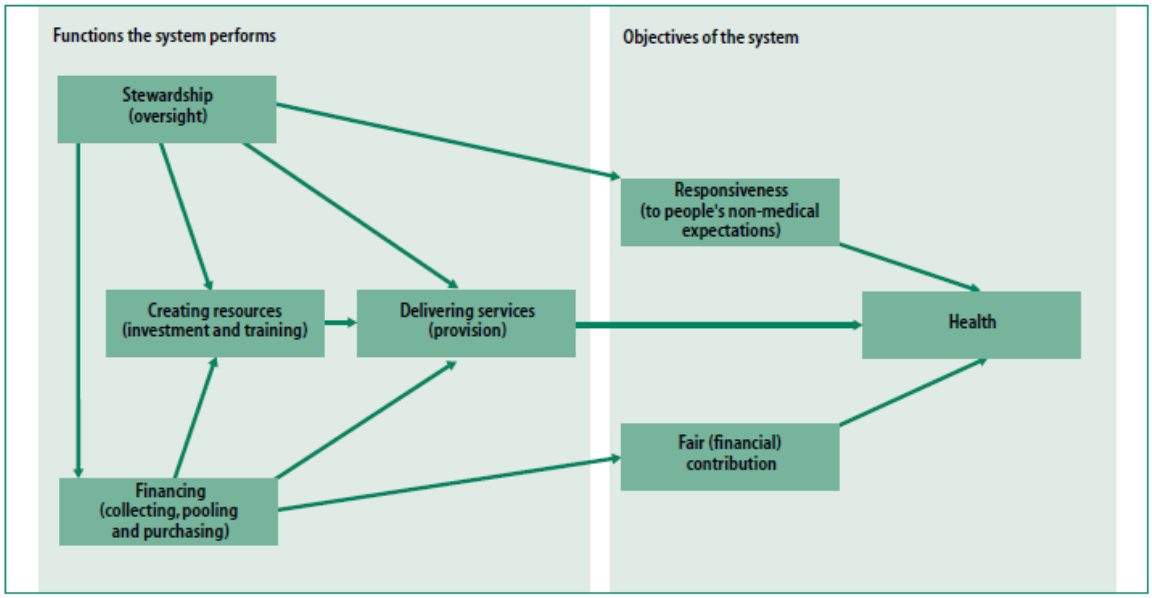
(b) Delivering service (provision): healthcare services could be provided by public, private and non-for-profit organizations.

(c) Creating resource (investment and training): it includes generating resources for key activities and inputs related to health sector, such as human resource including training and capacity building and drugs and medical supplies, and physical capital.

(d) Financing (allocating, pooling and purchasing): it is concerned with securing the needed financial resources of the health system from various sources, and then transferring resources to service providers.

Figure (4-3) illustrates the relationship between functions and objectives of a health system (WHO, 2000).

Figure 4-3: Relations between functions and objectives of a health system



Sources: WHO, The World *health report 2000. Health systems: Improving performance. P25*

It is claimed that Stewardship is the most essential function of the health system. The main reason for that is the government has the ultimate responsibility for the general performance of a country's health system. Further, stewardship influences the other functions, also I is essential for the achievement of the system objectives (WHO, 2000). Stewardship includes six main sub-functions: overall system design (policy formulation), performance assessment, priority setting, inter-sectoral advocacy, regulation, and consumer protection (Londono and Frenk, 1997; Murray and Frenk, 2000)

Although WHO domain of stewardship is one of recognized governance frameworks, yet the framework has not explicitly indicated some governance principles, such as the rule of law, effectiveness, efficiency, and equity. In addition, measuring the domains of stewardship in countries and its instruments are not clear in some aspects (Siddiqi et al., 2009; Arah, et al., 2003).

4.5.1.1 General Overview of the National Health Policy Formulation

Understanding the process of policymaking is an essential step to be aware of how health policy is being formulated. In general, the policy is the instrument of governance, aimed to direct public resources toward one direction. It could be viewed as 'the outcome of the competition between ideas, interest, and ideologies that impels the political system' (Bridgman and Davis, 2004, p3). With no doubts that health sector is one of the vital sectors in any state, and having a national health policy is essential. The ultimate objective of the national health policy is to construct the conditions that guarantee good health for the whole population (Navarro, 2007). National health policies, strategies, and plans are used to give direction and consistency to the country's efforts to improve health sector (WHO, 2010 b; WHO, 2000). Formulating a national health policy is seen to achieve several aspects: The existence of a clear vision will lead to alignment of short and medium-term plans with the vision. The policy outlines the priorities in addition to the responsibilities of each part. Policy also is one of governance role as its builds consensus and informs people (WHO, 2000).

Countries experience varies in terms of having a formal national health **policy document** (WHO, 2000). Some countries may have a formal document titled as 'national health policy', and most probably it is considered a part of wide development planning scope. Other countries may have a collection of projects and programs, which constitute the national trends (WHO, 2000,). However, the trend since the late 1990's is toward having a 'national health policy' document that serves as an inclusive policy framework, which maps the policy direction and general trends (WHO, 2000).

As indicated earlier, health is a global issue. Thus, the World Health Organization (WHO) - as part of its tasks, works in assisting countries to develop their national polices through its technical cooperation and facilitates the national policy dialogue and inter-country interchange. In

addition to assist them through normative work and international policy frameworks on a high level (WHO, 2010 b).

National health policy development considered a complex process (Buse, 2008; Gilson and Raphaely, 2008). Health policy has several approaches, each of them has distinguishing features, and it is not easy to compare and choose which is more appropriate. According to Exworthy, 'No single policy model offers a fully comprehensive description or understanding of the policy process as each answer somewhat different questions' (Exworthy, 2008, p324). It is stated earlier that different countries have different health systems, mainly due to the contexts they existed in and to the key policy determinates. Even if some countries may fall under the same level of income categories, there will be a divergence in health system performance between those countries (Frenk, 2010). Therefore, implanting other countries systems and even policies should be done with extensive investigations, the literature of comparative policies and policy transfer could be helpful in this regards (Bridgman and Davis, 2004). However, there is a number of factors and considerations that could be common among countries in terms of a national health policy formulation main objectives, process and general issues.

4.5.1.2 Main Considerations to Formulate a National Health Policy

Basically, national health policy formulation should consider and aligned with the wider context and the national policies (Collins and Green, 2014). In general, good policymaking implies that previous policies should be reviewed to draw lessons from them, in order to be utilized in the next policy cycle (Bridgman and Davis, 2004). Lessons learnt need to have a structured policy process initially and to be documented. Nevertheless, when policymaking have many actors it makes the learning process difficult (Bridgman and Davis, 2004).

In order to develop an effective health policy, initially, policymakers need a comprehensive understanding to the context and to the local conditions that affect health to address it in the health strategies and decisions including ecological, social, demographic, economic, and political conditions (WHO, 2001; Lavis et al.,2012; Green and Bennett, 2007; Green, 2007). Further, policymaking requires 'good policy environment', which exists in democratic societies, where there is an opportunity for policy debate and consultations. Also, it requires strong governance systems, including mandatory rules and inspection bodies (Green and Bennett, 2007, p 23).

Good policymaking should have strategic focus, which requires long-term vision, comprehensive perspective and assess the internal and external factors that may affect the strategy in the long run (WHO, 2006). Likewise, Casseles and colleagues suggested key components for the national health policy framework: (a) Identify clearly the respective roles of the public and private sectors and NGO's in financing and provision of healthcare, (b) Identify the policy instruments and the institutional arrangements required in both the public and private sectors to attain health system objectives. Consequently and by doing this, it will set the agenda for capacity building and organizational development, (c) The framework should identify how priorities are being set for both government and donor expenditures to link the issues analysis to decisions regarding how resources will be allocated (Cassels, 1997, p36).

4.5.1.3 Who Formulate the Policy?

The Ministry of Health in many countries is seen to handle the task of policy formulation and communicating with related parties, and communicating and coordinating with donor and international aid agencies (Cassels, 1997; WHO, 1998; Omaswa and Boufford, 2010). National

policies are often influenced by international policy concerns and funding, particularly in LMIC's (Ensor et al. 2009; Walt et al. 2008).

Health policy actors may participate and even they can influence the policy priority settings and the policymaking process, the potential policy actors were presented in section (4.2.9). In general, the national strategy/policy should be consulted with the relevant stakeholders (Green, et. al., 2002). Also, it is important to determine the proper point of time that the relevant stakeholders' consultation is needed and the expected stages to be involved in (Green, et. al., 2002). Further, the means of consultations should be identified in order to select the most convenient alternative, which could be varied from one country to another. Consultation could be for instance through focus groups, surveys, publish the document to gain feedback, or any other convenient means (Green, et. al., 2002).

4.5.1.4 What Factors/Elements Are Important in Developing Sound Health Policies?

Some scholars tried to describe the main characteristics of a **sound health policy development**. Gostin identified five elements of policymaking: (1) impartial decision making; policymakers should be objective and unbiased; decisions should be based on valid data, Gostin thought that it is not essential for policymakers to be technical experts as long as they can have expert advice. (2) Accountability; policymaking bodies and authorities should be accountable for their decisions. (3)Collecting full and objective information; policymakers should insure that they rely on reliable and objective information. However, some may attempt to mislead the decision makers with biased information, so policymakers should look for information from neutral sources, not only the government entity or interest groups. (4) Applying well-considered criteria for making decisions; criteria support the decisions maker to formulate the goals, chose the

means and set the scientific, social, and ethical parameters for decision-making, in addition to reduce bias and arbitrariness that my associated with the decision-making process. (5) Following a rigorous and fair process to arrive at the decision; all relevant facts and arguments should be examined; also, relevant persons and organizations should have the means to participate in the policy argument (Gostin, 1995, p337- 339).

In addition, as health sector strategic plan(s) is influenced by other sectors plans and in turn will affect other sectors. It is vital to conduct a comprehensive mapping of that plans and identify their potential relationship with the strategic plan (Green, et al., 2002).

WHO also recommends some **elements of good practice** that will enhance the policy dialogue and produce strong policies, strategies, and plans:

(1) *Sound process*: Effective implementation of the National Health Policies, Strategies could be enhanced by stakeholders (social, technical, political) involvement during the development process of polices and strategies (WHO, 2010 b).

(2) *Realism*: there are some elements that may enhance National Health Policies, Strategies and plans implementation, mainly: being made by people who will implement them, convenient to the available resources and constraints, to secure political and legal commitment to the policy direction, plans linked to the health policy and strategy should be flexible to cope with any unexpected changes, to be aware of the implementing and middle levels of the health sector, and ensure political and government commitment of health sector management, in addition try to satisfy stakeholders competing interest (WHO, 2010 b).

(3) *A comprehensive, balanced and coherent content:* A country context and constraints must be addressed in a holistic, balanced and cohesive manner when formulating National Health Policies, Strategies and plans (WHO, 2010 b):

- Work on align inter-sectoral policy vision, values, goals and targets
- Conduct strong and comprehensive situation analysis that includes: an assessment of social determinants of health, health needs, expectations, health system performance, health sector capacity, health system resources, and stakeholder positions.
- Create possible scenarios and policy directions for key health issues.
- Create an inclusive strategy to respond to the challenges and implement the policy directions with addressing its potential implications.
- The leadership and governance should ensure needed arrangement to implement the strategy, such as identifying the role of different institutions and stakeholders, monitoring and evaluation activities, ensure sustainability through regulation, coordinate with other sectors, coordinate with donor agencies if they theirs any.

(4) *Linking with medium-term and sub-national plans*: some countries may have centralized or decentralized approach, and each has its pros and cons. But it's important to link the National Health Policies, Strategies and plans with the sub-national partition plan (WHO, 2010 b).

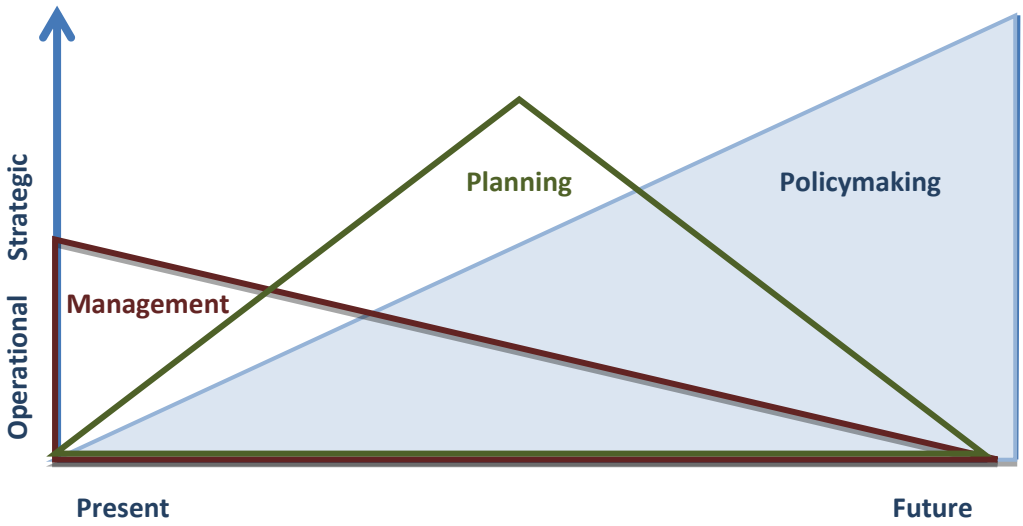
(5) *Linkage with programs*: Some countries may have lack of linkages between National Health Policies, Strategies and plans and between specific programs, merely disease-specific programs, which leads to disparity between planning and later problems in implantations (WHO, 2010 b).

4.5.2 Health Sector Planning and Management

Policy and planning may be used inter-changeably, and in some literature, it is common to find the term 'policy and planning'. Some authors thought that there is no difference between policy and planning, while others provide a ground for the differences between them. Walt was one of those authors; according to Walt 'planning follows policy: planners help to put policies into practice, although the planning process itself may help to develop and refine health policies' (Walt, 1994, p7).

The relationship between policymaking, planning, and management could be summarized in figure (4-4), where it shows that policymaking is on a strategic level and for long-term duration, Planning is the stage where the broad policy statements become more specific and identified, while management is the detailed operational level on short and midterm that aim to implement the plans. However, in the real world, the relationship is not linear and there is a gap between policymaking, plans and operational managerial actions, in addition to the lack of technical ability to translate the policies into practical and implemented plans (Collins and Green, 2014). Although the figure is representing the relationship between (policymaking, planning and management) terms, but I think that they shouldn't be drawn to the extreme edge of the figure.

Figure 4-4: Relations between policymaking, planning and management



Re-drawn by the researcher, source: (Collins and Green, 2014, p 208)

4.5.3 Challenges to Formulate a National Health Policy

Despite having some elements of sound policies and suggestions to formulate the national policies; the formulation of a national health policy is faced with a number of **challenges**. According to WHO, these challenges are not technical only, and require strong policy responses. Some of these challenges are:

- Health authorities and politicians are facing pressure because of incongruity between the actual performance of fragmented health systems on one side and with the increasing expectations of society on the other hand. This lead to increasing call toward strengthen and renewal of Primary Health Care Based Health System (WHO, 2010 b).The Government realizes that they hold the responsibility for converting these calls into national health policies, strategies, and plans. Under pluralist and

diverse health system, national health policies, strategies and plans should handle the issues for the whole health sector not only in public sector (WHO, 2010 b).

- The trend now is not only to address healthcare delivery issues, but to move to broader public health issues towards addressing the social determinates of health, and interact with other sectors. However, several countries having difficulties in creating the tool to implement this broad scope and interaction (WHO, 2010 b). Earlier, Cassels in 1997 concluded that the national health policy development challenge exists as a number of policy instruments and institutional arrangements needed to improve health sector performance are beyond the scope of the ministry of health's authority, thus it's essential to assess other ministries and institutions that support or oppose health policy formulation (Cassels, 1997).
- Consider policy development as one-off task to be prepared prior to any activity rather being continuous process (Cassels, 1997)
- The lack of connection between policy frameworks and strategic analysis with decisions related to resource allocations (Cassels, 1997)
- Health considered a complex sector and as indicated earlier it is affected by other sectors and policies. Thus to formulate a sound policy with taken into account all the relative considerations will be time-consuming (Cassels, 1997).
- The pressure, unpredictability and resource constraints placed on the policymakers due to the increasing globalization of many health issues (Green, 2007).
- The difficulties in balancing between political and technical roles. The planners in the health sector are faced by several determinates, mainly the increasing public demands, the professionalism and the politicians (Green, 2007).

4.6 Summary

This chapter has presented the summarized overview of the health policy; the main topics are the importance of health policy, the evidence-based policy in the health sector, the health policy process, the main policy actors, the main health policy challenges for health policymaking in general and in developing countries in particular. The last section was devoted to overview the national health policy formulation and its main challenges.

Consequently, based on this review, it's clear that the issues needing consideration in the field work should focus on the driving forces influencing stakeholders, the expectations and limitations imposed by the constituency from each one comes, the skills and competences they could bring to the process and the interplay between these aspects. Further, this review contributed in

Chapter 5

Research Design and Methodology

5.1 Introduction

Building on the issues identified in chapters two and three which explain the Jordanian situation and chapter four the key issues in policymaking, this chapter presents the rationale and design for data collection, methodology, and data analysis. This chapter consists of five main sections: the theoretical framework and context of the study (section 5.1); the justification of using 'qualitatively-driven' mixed approach (section 5.2); the research design including data collection, instrument, participant's recruitment and ethical considerations (section 5.3); the data collection process and analysis explained (section 5.4); the validity, reliability and researcher reflexivity as well as the limitations of the study (section 5.5); and a summary and concluding remarks.

5.1 Theoretical Framework and Context

The theoretical framework of this study leads to the selection of the qualitative research and case study approach as primary source of data. Limited knowledge and resources are available about health policy formulation in Jordan. Thus, this study aims at investigating the main challenges facing health policy formulation in Jordan and reviewing the effective options for health policy formulation. This study is an exploratory study guided by constructivist paradigm. In this section, the logic behind choosing the paradigm and research methods will be explained.

5.1.1 Theoretical Paradigm

A **paradigm** could be viewed as a 'set of basic beliefs (or metaphysics) that deal with ultimate or first principles 'based on ontological, epistemological and methodological assumptions (Guba and Lincoln, 1994, p. 107). Any Paradigm has three main interrelated questions starting with what the reality is like (ontology), what the relationship is between the researcher and that reality (epistemology) and what methods can be used for studying the reality (methodology) (Punch, 2014, p.15). These interrelated questions clarify the connections between methods and the implicit philosophical issues, contrariwise, methods affected by the paradigms (Punch, 2014).

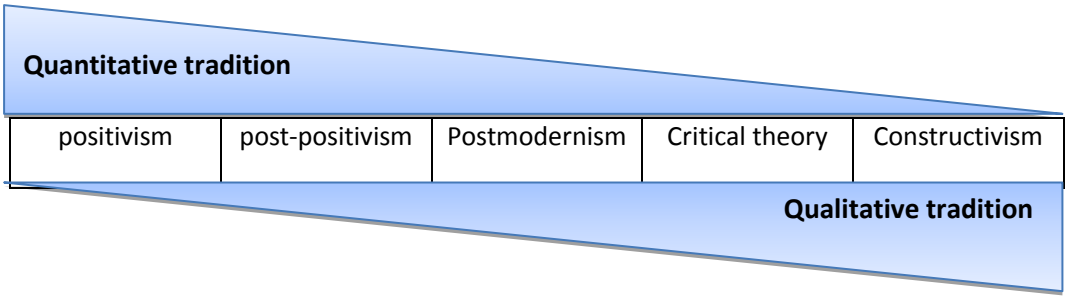
Research Paradigms

As for research approaches referred to as paradigms, they could be described as positivism, post-positivism, constructivism and critical theory (Guba and Lincoln, 1994; Denzin and Lincoln, 2008; Mills and Birks, 2014).

This research is guided by a 'constructivist paradigm'. Constructivism's main idea is that reality is constructed by people who experience it and the researcher role is to interpret and reconstruct that reality (Mills and Birks, 2014; Creswell, 2014; Ritchie, et al., 2013).

Several scholars claimed that interpretivism/constructivism is mainly associated with qualitative methods, while positivism mainly linked with quantitative methods (Punch, 2014; Mills and Birks, 2014). This leads to having different features for qualitative and quantitative research, and the selection of any approach must match with paradigm and the philosophical implications. Research paradigm and philosophy could be visualized by the following figure:

Figure 5-1: Philosophical moment and research Paradigms



Re-drawn by the researcher, Source: Mills and Birks, 2014, p 21

According to Denzin and Lincoln: '**Constructivism** assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent co-create understandings), and naturalistic (in the natural world) set of methodological procedures (P 32)'. 'Findings are usually presented in terms of the criteria of grounded theory or patterns of theories. Terms such as credibility, transferability, dependability, and confirmability replace the usual positivist criteria of internal and external validity, reliability and objectivity (p. 33)', (Denzin and Lincoln, 2008).

Type of research

In general; research is about answering questions, solving problems and developing knowledge (Punch, 2014, p 4). Social science research is vital in a 'reality based community'; People are the main source of these studies as it aims to find more about the social reality (Neuman, 2011; Punch, 2014). Rosenberg argues that the role of social science is to discover the rules that govern people's actions as these actions used to represent the reflections of people's deep beliefs and interests laid in them (Rosenberg, 2012). Rosenberg points out that social science is not only focused on individual actions rather it focuses on the collective actions of the

society members, and scientist should pay attention to the rules that organize individual actions within particular society (Rosenberg, 2012). Thus, the research should have identified purposes, and it could be classified as exploratory, descriptive research and explanatory research.

In ***Exploratory*** research; the main purpose is to examine an issue or phenomena that may have slight understanding to develop initial ideas about it and then move toward refined research questions (Neuman, 2011). In ***Descriptive*** research; the main purpose is to create a general configuration about a certain issue by using words or numbers, usually it seeks to answer questions of: who, when, where and how (Neuman, 2011). Finally, in ***Explanatory*** research; main purpose is to expound and clarify why a certain events happened and build, elaborate, expand or test theory (Neuman, 2011).

5.1.2 Research Orientation

As described earlier; **exploratory** research is mainly used when there is a lack of knowledge about a certain issue, it usually addresses 'what' question; 'what is this social activity really about?' (Neuman, 2011). Consequently, as the issue of health policy formulation and its main challenges has limited scientific knowledge and resources in Jordanian contexts; this study is designed to be as an exploratory study. This research is guided by 'constructivist paradigm'; this approach often combined with interpretivism, and this approach relies on the participants' views of the situations being studied, also it is based on broad questions so the participants can construct the meaning of that given situation (Creswell, 2014; Ritchie, et al., 2013; Creswell, 2007).

Further, the results of the study will be enlightened by the Grounded Theory (GT). Although the exact process of GT was not adopted, it drew inspiration and gave some ideas to this

study. The Grounded Theory is commonly used within qualitative approach, and it's rooted in interpretivism and constructivist tradition (Broom and Willis, 2007; Neuman, 2011). The Grounded Theory is convenient when the research concept is under-examined, such as the health policy formulation in Jordan. Further, this study focused on the respondents' perspective of the main challenges that face the national health policy formulation; thus, the key analytical tasks were concerned with generating an understanding of the respondents' perspective. This study also used the thematic approach, which considered essential in GT as well as its wide use in the qualitative data analysis (Bryman, 2016). However, some essential concepts of the GT was not adopted in this study, for example, the original version of GT, require that data should be collected on more than one stage until reaching saturation and use the theoretical sampling, while in this study, it was very difficult to conduct the data collection on different stages due to the unique features of the interviewee, such as being purposively selected due to certain criteria. Further, the multi stages within the GT is based on the assumptions that the researcher has limited knowledge about the phenomena/issue that being examined (Ritchie, et al., 2013; Broom and Willis, 2007), while this is partially applicable to the challenges of the policy formulation in Jordan; through the literature review and various document review, it was generated general understanding to the topic, which leads to articulate the study questions.

Thus, this research is based primarily on data collected from interviewees representing the HHC members and key stakeholders in the health sector and health related issues in Jordan. However, although the study primarily based on the interviews, other methods will be used including the document review and analysis, and the utilization of the secondary data, therefore, the study will use mixed method approach. The main themes of this study come from an under-researched area whereby no previous studies were found in Jordanian academic contexts. Therefore, most of the literature review was done based on the general concept and other countries' experiences from both developed and developing counties.

Before introducing the study design and method in details, an overview on the research methods generally will be provided with focus on the qualitative methods.

5.2 The Research Methods

Methodology refers to the wider scope of how research should proceed, and it provides explanation for the selected research method(s) and explains how the researcher make decisions about the study (Carter and Little, 2007; Mills and Birks, 2014), while methods usually refer to more detailed decisions, such as participants' recruitment and sampling, data collection and analysis (Mills and Birks, 2014), a method is viewed as 'research action' (Carter and Little, 2007).

Identifying methodology is initial; consequently, the researcher will be able to select the appropriate methods for data collection and analysis of data (Silvermman, 2011; Carter and Little, 2007; Petty et al., 2012b; Mills and Birks, 2014). The selection of methods mainly depends on the research questions and aims (Punch, 2014; Silverman, 2013; Petty et al., 2012a; Mills and Birks, 2014).

5.2.1 Case Study Approach

Case study is one of the most commonly used methodologies in research (Yin, 2014; Petty et al., 2012b). It is mainly associated with qualitative research. However, some scholars claim that case study concept could be used in some types of quantitative research (Yin, 2014; Robson and McCartan, 2016; Ritchie, et al., 2013).

Case study has several various definitions; some scholars focus on the scope of a case study inquiry and other on its features (Yin, 2014). However, without getting into the definition

debates, simply it could be defined as ‘a case that investigates a contemporary phenomenon in depth and in its real-world context’ (Yin, 2014, p 237). The cases may be varied; they may include individuals, groups, organizations, events, or geographic events (Neuman, 2010; Robson and McCartan, 2016).

Case study has no specific methods of data analysis to be used with, as the research aims will lead to which method to be adopted (Petty et al., 2012b). However, some claim that case studies tend to use qualitative methods (Bryman, 2015). Hence, case study is not a method, rather its strategy of how to undertake the research (Punch, 2014); its aim to investigate intensively a certain case or cases in depth and its surrounding circumstances (Neuman, 2010; Punch, 2014).

5.2.2 Quantitative and Qualitative research approaches

In social science researches, both Quantitative and Qualitative approaches could be used, and each approach has several methods and tools within it. Choosing which approach to use depends on key variables such as the research objectives and the research questions. In this section both quantitative and qualitative methods will be elaborated on with special focus on qualitative methods, types, potentials and limitations, as well as explaining the rational of choosing the mixed method approach and the semi-structured interviews in this study.

5.2.2.1 Main Similarities between Qualitative and Quantitative approaches

Qualitative and quantitative approaches have several ***similarities***; these similarities authorise different tools and methods to achieve them. Basically, both qualitative and quantitative research is concerned with answering research questions about the nature of social

reality. Both approaches aim to link the data analysis to the available and related research literature to their topic. Both have a huge volume of data, and then they do data reduction in to examine and come up with findings. Both are concerned with finding the variations, and explaining and exploring the ins and outs behind the variations. Both are focus on reducing bias, maximising objectivity and preventing any deliberate distortion from happening. Both approaches are keen to show they conduct the research in transparent ways and explain the producers for that. Both may have a possibility of errors occurring, but by identifying their possibilities in the ontial stages it could be reduced and avoided. Overall, both approaches should use the appropriate methods to the research questions (Bryman, 2015, pp402-403).

5.2.2.2 Main Differences between Qualitative and Quantitative approaches

Qualitative and quantitative approaches have several ***differences***; Firstly, the one evolved from the nature of the data itself whereby 'soft data' such as pictures, symbols and words associated with qualitative research, require different methods and tools from those used for 'hard data' generated in numerical forms and associated with quantitative research. Secondly, in qualitative research there is more emphasis on interpretation and look beyond the exact words (meaning) in an attempt to link it to the social context, while in quantitative research concentrates merely on measuring the variables and testing the hypotheses. Thirdly, a lot of qualitative research comes up with new hypotheses and presents the cause and effect relationship to detailed issues, while the quantitative research focuses on proving or disproving the pre-identified hypotheses. Fourthly, unlike quantitative research that follows orderly logic; quantitative research follows non-orderly logic as it is related to the continual practice (Neuman, 2010, p 165-167).

5.2.2.3 Mixed Method Approach

Despite the differences between qualitative and quantitative approaches, some researchers combine the two approaches within the same study, usually referred to as mixed method approach (Yin, 2014; Sale, et al., 2002), and it is used in health care research as well (Sale, et al., 2002). Using mixed methods in the same study entitles that these methods should address the same research question(s), usually it is used to collect complementary data, to conduct parallel analyses, to collect more evidences and to conduct deep analysis (Yin, 2014, p65-66).

According to Morse and Cheek, most of the mixed methods are 'quantitatively-driven', while the 'qualitatively-driven' studies could generate deeper and richer understanding to the issue under investigation (Morse and Cheek, 2014). This study is 'qualitatively-driven' mixed methods, as the primarily method is (semi-structured interviews), as well as using document review and analysis, and the utilization of the secondary data.

5.2.3 Qualitative research approach

Whether using qualitative, quantitative or mixed method approach, each of which has its strengths and limitations. This section shed lights on qualitative approach mainly in term of its strength and limitations.

Qualitative research has different meanings (Denzin and Lincoln, 2008) and it is difficult to define (Ritchie, et al., 2013). However, in most definitions there are similar grounds. According to Denzin and Lincoln 'Qualitative research is a situated activity that locates the observer in the world. Qualitative research consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field-notes, interviews, conversations, photographs, recordings, and

memos to the self' (Denzin and Lincoln, 2008, p 4). Bryman defines qualitative research as 'the understanding of the social world through an examination of the interpretation of that world by its participants' (Bryman, 2015, p375). The definitions imply that qualitative researchers study issues or phenomena in their natural settings, and researchers conduct the interpretation of the 'meaning' developed by the studied people (Denzin and Lincoln, 2008).

Qualitative research has a wide range of empirical materials; it could be personal experience, introspection, life story, interview, observation, audio-visual, text or images, (Denzin and Lincoln, 2008; Creswell, 2014). Qualitative research methods are commonly used for exploratory studies (Creswell, 2014; Neuman, 2011), and it's based on interpretivism and constructivist paradigm (Punch, 2014; Sale, et al., 2002). There is an increasing tendency toward using qualitative research methods in social policy research. Additionally, it is widely used in health and health services research (Bowling, 2014; Sale, et al., 2002).

Qualitative research has several **strengths**; most of these strengths lie in its strategies and designs; mainly its study of people, things and events in their natural settings (Punch, 2014). It gives the researcher the flexibility of conducting the research, and does changes and adjustments when needed (Bryman, 2015).

Despite having several strengths, some **limitations** may exist when conducting qualitative research which may mainly related to the subjectivity, flexibility and the interpretive nature of qualitative research as this flexibility could affect the reliability (Bryman, 2015). Qualitative design could probably delay conceptualizing and structuring of data until later stage in the research (Punch, 2014). Another limitation relates to the lack of transparency to some qualitative research, where some researchers didn't offer enough explanation how they reach the reported results (Bryman, 2015).

Qualitative research has the problem of generalization as the results of qualitative research are seen to be restricted to that case being studied (Bryman, 2015; Flick, 2014). However, some authors defend the generalization issue by describing as its main aim to investigate a certain issue in depth. Nevertheless, some of the limitations associated with conducting qualitative research, in general, and interviews in particular, have some precautions that could be done to overcome and eliminate these limitations. Qualitative research could be summarized by using Creswell's description:

> 'Qualitative research begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis is inductive and establishes patterns or themes. The final written report or presentation includes the voices of participants, the reflexivity of the researcher, and a complex description and interpretation of the problem and it extends the literature or signals a call for action' (Creswell, 2007, p 37).

5.2.3.1 Qualitative Interviews

Interviews can be divided into structured (closed-ended questions), semi-structured and unstructured (open-ended questions) interview types. Each type has its strengths, and weaknesses, and is used for different purposes. The key features of semi-structured interviews will be presented briefly, and then will present the justification for using it in my study.

Interviews are the most commonly data collection tool used in qualitative research (Punch, 2014; Bryman, 2015). Also, Interviews are the most commonly used qualitative method in health services research (Bowling, 2014). Semi-structured interview is widely used, and it includes spectrum styles and depths (Bryman, 2015; Yin, 2014). It is one of the primary sources of case study information (Yin, 2014).

Conducting interviews has several **advantages**. It is considered flexible and it allows adjustment to occur on the spot according to the conversation direction (Bryman, 2015; Robson and McCartan, 2016). It generates rich and detailed answers (Bryman, 2015). It encourages cooperation and rapport (Robson and McCartan, 2016). It leads to having a proper assessment of respondent's beliefs (Robson and McCartan, 2016). Further, it could come up with unexpected or unanticipated answers (Robson and McCartan, 2016).

Conducting qualitative interviews has some **difficulties**: its time consuming when preparing and conducting interviews, in addition to transcribing and coding (Aberbach and Bert, 2002; Robson and McCartan, 2016; Bowling, 2014). It considers costly (Aberbach and Bert, 2002; Bowling, 2014). Also, as it is based on open-ended questions it makes the analysis more difficult (Aberbach and Bert, 2002; Bowling, 2014). Another challenge is the difficulty in some fields to gain cooperation/acceptance from potential interviewees (Robson and McCartan, 2016).

These limitations and challenges could be eliminated and reduced by identifying them and be aware of them basically and by following certain strategy to reduce its effects (section 5.5.1: validity and reliably).

5.2.3.2 Interviewing Elites

There is a debate regarding the definition of elites (Harvey, 2010). Some of this debate based on the criteria of whom should be considered as elite; some thought it should be based on the current position title in the organization, or based on his strategic positions within a social network, which may linked to the social structure (Harvey, 2010). Some define elites in relevance to power they have or the resources they have control on (Goldman and Swayze, 2012), others even make distinguish between elites and experts, and indicate that elite is more generalists and experts described as narrow specialists (Undheim, 2003). The challenges facing elites definition is that these criteria are not applied everywhere and may be varied in different geographic locations and cultures, and elite status is not static as it may change overtime (Harvey, 2010).

Semi-structured interviews are considered an effective tool to obtain data from elites compared with other tools (Harvey, 2010; Berry, 2002; Aberbach and Bert, 2002). According to Harvey and Berry, there are still a 'methodological challenges' in interviewing elites and more effort is needed to conceptualize elite research from across the social sciences (Harvey, 2010; Berry, 2002). However, some scholars contribute to this issue by offering some recommendations when interviewing elites. Interviewing elites is not an easy task; and several aspects should be considered during preparation stage, conducting the interviews, and later stages.

The main stages are to identify the potential participants, then the researcher needs to find ways to gain access, then schedule an interviews with them. There are a number of points that may help the researcher to get access to interview elite:

- The researcher should identify clearly the targeted participants to be invited to participate in the study. The target population must be determined by the research question (Beamer, 2002; Goldman and Swayze, 2012).

- Send an official letter in advance that clarifies the aims and the research basic outline. In addition to clarify the ground rule of the interview (Goldstein, 2002; Aberbach and Bert, 2002).
- Realize the importance of elites' gatekeepers (secretary, personal assistant, office manager). Elites' gatekeepers could be an obstacle or an opportunity due to their control of elites in most cases, and it depends to some extent on how the researcher approaches to them (Harvey, 2010; Goldman and Swayze, 2012). Harvey advises researchers to deal with gatekeepers professionally to gain their support (Harvey, 2010).
- The researcher may use his connections (ex. Colleagues, friends, relatives, friends of friends, etc) to support him to schedule an in interview with elite (Harvey, 2010; Goldstein, 2002; Undheim, 2003). However, this should be done carefully as it may have its advantages and disadvantages (Goldstein, 2002).

After getting the access and approval to conduct the interviews, there are several aspects that the research should be aware of. Interviewing elite figures needs good preparation. During the preparation stage, the researchers should be flexible when scheduling interviews with elites, times and venues should be determined based on the participants ease and comfort (Harvey, 2010; Goldman and Swayze, 2012). Interviewing elite figures needs also good level of interpersonal communication skills. Several authors presented their experience and advice on how to conduct an interview with elite people. Most of the tips and advice related to the researcher behaviour and knowledge. Generally, they recommend the researcher should present himself properly, the researcher should be well prepared and acknowledge himself about the research topic, be transparent and should inform the interviewee about sensitive information such as the purpose of the study, how the data will be used, construct sound questions with paying attention to its format and wordings, and to have the skill of quick and accurate note

taking (Harvey, 2011; Goldstein, 2002; Aberbach and Bert, 2002; Beamer, 2002; Berry, 2002; Goldman and Swayze, 2012). Harvey claims that elite figures may vary from one interview to another and the researcher should be able to adjust quickly to that (Harvey, 2011). Communication skills are one of the vital skills that the researcher should acquire. It will assist the researcher in several aspects such as the ability to manage the conversation and to be centred on the main themes of the research topic (Mason, 2002; Harvey, 2011). Mason indicates that the researcher should be a good decision maker so he/she could deal with instant situations during the interview properly (Mason, 2002).

Other tips when interviewing elites could include the following: in most cases it is preferable to move from general to specific questions, and the researcher should avoid asking the elites about objective information which already available and published (e.g. demographics, statistics, etc.), this is important for utilizing the time and for not to give a negative image about the researcher and show him as being not prepared for the interview and topic in general (Beamer, 2002).

5.2.3.2.1 The Elites participants of this study

The participant's recruitment of this study is clarified in details in section (5.3.2). Although most of the respondents were purposively selected; the majority are considered as 'elite' figures. As indicated in the section above; elites may have different criteria (Harvey, 2010). In this study, the participants considered elite due to the current and previous positions they had occupied; (table 6-1, chapter 6) presented in details the position titles of the study respondents, for example, some participants were ex-minters, presidents of medical related associations, hospital general directors ...

Further, some authors considered experts as elites (Undheim, 2003), in this study, a number of participants could be considered as both elites due to their official positions, and as elite-experts due to their profound experience in the health sector, hence quite number of them holds high specialized degrees (figure 6-2 and 6-3) shows the participants academic level. Also, some participants are consultants with international agencies such as the WHO, UNDP, and UNICEF.

Nevertheless, very few participants were interviewed in this study that does not consider as 'elite' due to their positions, but they have fair experience, this happened in few occasions where some participants delegated other next-in-line staff to be interviewed instead of him/here; this issue was listed among the study limitations.

5.2.3.3 The rational of adopting (semi-structured interviews) method in this research

Despite having several of limitations associated with using the quantitative approach such as bias and validity; the benefits of using this method exceed the potential limitations. The theoretical framework of this study led to selecting the qualitative research (Semi-structured interviews) as the primarily method.

Structured and Semi-structured interviews are one of the main and preferred tools to collect data from politician and policymaker's elites (Berry, 2002; Aberbach and Bert, 2002; Harvey, 2010). Semi-structured with its open-ended questions allow the respondents to articulate their responses without restrictions (Aberbach and Bert, 2002). There are a number of considerations that determine the use semi-structured interviews with elites, mainly when there is a lack of knowledge about the research topic, to maximize response validity; by providing the opportunity for the respondents to answer within their own framework, and due to the nature of the respondents; elites and well educated people prefer open-ended questions rather than close-

ended questions, so they could articulate their views and clarify their thoughts (Aberbach and Bert, 2002; Harvey,2010).

Consequently, the rational of adopting semi-structured interview method in my research can be attributed to the lack of knowledge, in the field, about health policy formulation in Jordan, as well as capturing all the benefits semi-structured interview method illustrated above.

Hence, the majority of the study respondents could be identified as elite, and all the considerations explained earlier about interviewing elite people were taken into consideration when preparing and conducting the interviews.

5.2.4 Summary

This study is 'qualitatively-driven' mixed method. Semi-structured interviews are the most appropriate approach to this study, as most of the interviewees are senior professionals with extensive experience, and it will be an opportunity to express their experience and provide useful information, not only by answering the questions, but also by contributing relevant information to the study, which may not be included in the main questions. In addition, it will be helpful as there is a scarcity in health policy literature in Jordan; by meeting policymakers and stakeholder elite, it is expected to generate valuable information. Furthermore, overview officials and different stakeholders opinions will help in compare their perspectives and find out the most agreed on or divergence issues.

5.3 Research Design

A research design generally means all issues related to planning and executing the research project (Punch, 2014). The research design is serving as guiding plan for conducting the research.

The research design connects the research questions to data by addressing key questions regarding collecting data and analysis: what strategy will be followed? Within what framework? From whom? And how? (Punch, 2014, p115).This section will address those questions and will illustrate the research design for the study.

5.3.1 Data collection instrument

The study aims and objectives lend themselves easily to the use of semi-structured interviews as a primarily research method (section: 5.2.3.3).

5.3.1.1 Designing the interview questions

Questions asked during the qualitative interviews are greatly varied depending on the topic and research focus. Though, there are several aspects which should be considered when designing the interview questions, such as:

- The questions should be researchable in the first place (Ritchie, et al., 2013)
- Questions should be clear, comprehensible (Ritchie, et al., 2013)
- Questions should be focused but at the same time not narrow (Ritchie, et al., 2013)
- It is advised to have one or two central research questions, and each central question may have no more than seven sub-questions if needed (Creswell, 2014); and

- It is advised to start the research questions with ‘what’ or ‘how’, which implies that the researcher is asking an open-end questions (Creswell, 2014).

Obviously, the interview questions are derived from the research primary question. It is claimed that well-articulated and constructed research question(s) will have an impact on selecting the methodology and research design (Mills and Birks, 2014) which will lead eventually to answering the research question(s).

Most of the above aspects were considered when the interview questions were designed. Further, as the interviews were conducted with seniors and high official ranks; the questions were designed to be straight-forward and short.

5.3.1.2 The study questions

As stated in chapter one, the aim of this research is to investigate the main challenges facing health policy formulation in Jordan. A ‘qualitatively-driven’ mixed method approach (primarily the semi-structured interviews) is used as it best serves the study aims and objectives. There is a lack of academic knowledge on the subject matter in Jordan. Consequently, the questions were drawn based on conducting literature review related to the research issues in general, along with reviewing the Jordanian contexts from both local and international documents and reports. The interview questions were designed to extract information related to the study main aim and objectives and from the identified gap on the lack of knowledge of health policy formulation in Jordan. The same questions were asked to the HHC members and the stakeholder’s to figure-out their perspectives regarding the research issue by conducting face-to-face interviews. The main questions are presented in table (5-1) below.

An interview guide was constructed with five broad topics based on the study questions. Table (5-1) illustrates the key issues covered during the interviews. All the participants were asked the same questions to maintain the consistency and to be able to analyse and discuss the results. The interview guide was the same for all of the interviewed participants; however, in some cases, the 'senior representatives' were having limited time so, the focus was on the major questions of the study.

Hence, the questions were formulated in English language and then were translated into Arabic language. The English version was translated into Arabic by the researcher and then the Arabic was back translated by accredited Arabic-English translator. Minor differences were found and it was considered to have the final version of questions.

Table 5-1: Key issues covered during the interviews

Key Questions	Key issues covered
The main **challenges** for the national health policy formulation	- What are the main ***obstacles/challenges*** for the national health policy formulation in Jordan?
The (HHC) **role** in health policy formulation	- Does the (HHC) have **effective** role in policy formulation? - Does the HHC **membership** representing the health sector properly? - Will the recent change of HHC chairman (from the PM to the MoH Minister) facilitate policy formulation?
The respondent's suggestion(s) for the national health policy formulation options	- How the national health policy should be formulated from your own perspective?
The **role** of International organizations and Aid agencies in health sector and how is it related to health policy issues	- The role of International organizations in the health sector i.e (WHO, UN…) - The role of AID agencies in the health sector i.e (USAID, JICA…)
The **absence** of a national health policy	- What are the Consequences of not having a national health policy?

5.3.1.3 Pilot study

The purpose of conducting a pilot study was to test the relevance, validity and reliability of the data collection instrument. The pilot study was conducted in the early stage of the data collection. As explained; the participants were chosen purposively, thus the pilot interviews were selected from the study participants. The first three interviews were considered as pilot interviews (two interviews represented stakeholder's institutions and one represent HHC side); the interviews were reviewed, transcribed and analysed by the researcher. The pilot interviews were included in the analysis as no change has to be made on the interview guide or the questions. The pilot interviews were helpful not only in testing the instrument, but also for the researcher interviewing skills and time management.[7]

5.3.2 Participants Recruitment

This study is based on interviewing 'senior officials' from different entities, quite a number of participants considered as elite. As explained earlier, the concept 'elite' is not static and may have different meanings. In this study 'elite' will be used to describe the people who – at time of the study and data collection - occupied senior positions at their institutions/entities, and they have an influence on decision making process (adapted partially from Harvey, 2010). However, I decided to select 'senior representatives' as the term to be unified for all interviewed participants since I have met a number of elites (the highest rank official in the participants entity) in some cases, and in other cases the interviews were delegated to the second person in-charge,

[7] The researcher's skills and preparations for the interviews is explained in section (5.4.1), further, the researcher participated in a funded research project in 2009 in Jordan, which part of it was based on conducting interviews with managerial level staff.
As for time management skill, the pilot interviews were helpful as they gave indications of seniors style of responding to the various questions, and as a researcher be aware of that and learn how to prioritise questions when the time is limited.

so if detailed information about the participants described it may affect their anonymity (will explain further) in ethical considerations. Also, elite in some cultures – like Jordan - is associated with the head of the institution/entity to be interviewed; accordingly it was avoided and replaced by 'senior representatives'.

The study participants were chosen purposively. Purposive sampling is non-probability form of sampling; the researcher should identify the exclusion and inclusion criteria for sampling or choosing the participants (Bryman, 2015; Ritchie, et al., 2013). It is common for purposive sampling to be used in qualitative research as the aim is to investigate a certain issue in depth from the perspective of person(s) existed in a certain social realty who shared certain features (Bryman, 2015; Ritchie, et al., 2013).

Thus, as this study investigates 'health policy formulation in Jordan', and the health sector has an identified actors and a number of stakeholders; they couldn't be avoided and must be included in the study. The purposive participant of this study was chosen based on certain criteria; as being members in the High Health Council as identified by law or classified as being stakeholders in the health sector in Jordan, as detailed below.

5.3.2.1 The High Health Council members

The HHC is formed by (12) members; the membership is specified according to the HHC Law No. 9, 1999, article (5).

Permanent members

- Minister of Health – chairman of the High Health Council
- Director General of the Royal Medical Services - Vice President of the High Health Council
- Minister of Finance

- Minister of Planning and International Cooperation
- Minister of Social Development
- Minister of Labour
- The President of the Jordan Medical Association
- Head of Private Hospitals Association

Periodic members

- The Dean of one of the medical faculties. Currently the (Dean of the Faculty of Medicine Jordan University)
- The head of a health related association. Currently the (The President of the nurses and and midwives Association)
- Two experts from the health sector (has not been not assigned yet)

In September 2013, the HHC convened for first time since 2008. In May, 2014 a major change happened, and the Minister of Health became the chairman of HHC instead of the Prime Minster. The council was formed in end of May, 2014.The council membership should consist of 12 members; the current council is only (10) members as the health experts have not been assigned yet.

Interviews were conducted with 'senior representatives' of the council's members, including the current and previous permanent and periodic members and health experts. In some cases, the head of the organization/institution/entity was interviewed. In some other cases, the interviews were delegated to other senior staff, noticing that those delegated staff were – in most cases - either the person in charge to follow up the health file in that entity, and/or they have attended parts of HHC sessions conducted in 2014 to reactivate the HHC roles, and/or few of

them were members in the technical committee which was formed to prepare for the national health strategy for (2015-2019). The list of participants' of the organization/institution/ministry is listed in (Appendix 5.1).

The researcher has met 'senior representatives' that cover all members of the HHC; however, (one) interview was eliminated as it was delegated to another 'senior representatives' in the next hierarchal level at that Ministry/entity. The main reason for the interview to be eliminated as it is found out that the senior is not aware of the HHC role in policymaking, although he has a fair knowledge about health sector issues. Hence, the interview at that time was taken to the end as a matter of courtesy.

5.3.2.2 Rational for choosing the key stakeholders

The stakeholders broadly mean in this study; 'the actors who have an interest in the policy but may or may not be involved in health policymaking process' (Collins and Green, 2014, p 161). The researcher has identified the stakeholder for this study from the following sources:

(a) HHC has identified a number of public, national and international organizations as a partner in health related issues. The researcher was given the permission to obtain a copy of this list from the (Research and Studies department in HHC). The researcher then contacted the organizations and institutions in the list.

(b) The researcher has prepared a list that includes:

    1- The local partners in Jordan who involved in the health aid projects (funded by international organizations)

    2- A number of private, public institutions and NGO's related to one or more issues in the health sector (i.e. women and family organizations)

3- Medical academic institutions

4- Experts in health sector/health policy issues

The researcher has conducted interviews with 'senior representatives' from the public, private entities and NGOs who are classified as key stakeholders. Observing that in very few cases the head of the member organization/institution/entity delegates the task of being interviewed to another senior staff who is responsible for following up the HHC file within that entity, hence most of the delegated seniors were members either in the steering committee or the technical committee which was formed to prepare for the national health strategy for (2015-2019), or had attended one of HHC workshops after mid of 2014. The list of participant's organization/institution/entity is listed in (Appendix 5.1).

The majority of targeted participants who have classified as stakeholders have agreed to take part in the study, around (2) targeted participants didn't accept to be interviewed without further explanation, and their desire was respected, (2) targeted participants apologized for either being travelling abroad and having tight schedule afterwards, (1) targeted International agency was having changes in their staff allocation, so the national senior advisor who supposed to be interviewed has placed to a different regional location at the time of data collection, and the position was still vacant. As well, (2) interviews were eliminated as the interviewees mention that they were not aware of HHC role in policymaking, although they have a fair knowledge about health sector issues, and their organization/entity deals mainly with Ministry of Health. Hence, the interview at that time was taken to the end as a matter of courtesy.

5.3.2.3 Participants Confidentiality and Anonymity

In this study, it is inevitable to declare the public institutions and ministries, NGOs and other entities who took part in the study, particularly, some of the participants are identified by article (5) of Law (No. 9) of the year 1999, and also it is important to be declared for credibility considerations. Significantly, the participants are not identified by their names, their institutions or their official titles. Consequently, and in order to maintain the participant's confidentiality and anonymity the following precautions were taken:

- In (Appendix 5.1), a list of the Ministries, public, private institutions, entities and NGO's attached without indicating the name or the position title of the participants, the phrase which used is (a senior representative from …)
- The participants are not identified by their names or institutions they belong to, either in presenting the data results or when they will are quoted.
- Similarly participants are not identified by their position because this will reveal their identity.
- The participants were numbered on random order (1, 2, 3 … 47) and when quoted in thesis, they are numbered (P 1, P 2 … P 47), where P means 'participants'.

5.3.3 Ethical considerations for the study

Ethical issues should be considered among all research disciplines; however, ethical considerations are varied from one discipline to another, and sometime in the same discipline, as topics may vary. Some authors point out a number of general principles among various disciplines that should be considered, mainly: the voluntary participants, protection of research participants, assessment of potential benefits and risks to participants and obtaining informed consent

(Silverman, 2013, p 184; Punch, 2014; Flick, 2014). In this research all of these considerations were addressed and documented (i.e. participant's information sheet) as explained below.

The researcher is the key to addressing the ethical issues, not only by adopting ethical guidelines (i.e. consent forms, participant's information sheet), but also by implementing the ethical research practice in all states. According to Silverman, the researcher's ethical responsibility is not limited to framing research topic and analysing data, but also when completing the study (Silverman, 2011).

It is important for ethical issues and considerations to be 'institutionalized' and create a set of requirements, procedures and regulations (Punch, 2014; Flick, 2014), therefore, respectful research institutes and academic universities (i.e. UK universities) are keen to maintain ethical considerations. Keele University has a set of regulations and requirements to maintain high standards in research undertaken by staff and students. This study received an ethical approval from 'Keele University Ethics Committee' before the interviews were conducted. The forms associated with the ethical approval were produced and then approved by the committee.

The ethical considerations were adopted in all stages of the research. In preparation stage; when sending the invitation letters, the participants were told that their participation is completely voluntary and even if they accept to be interviewed, they have the right to withdraw at any time (as clarified in participant's information sheet). Before starting the interview, the researcher presented a brief summary about the research aims and objectives to the participants, in case they didn't read the information sheet in details. Then the consent forms were signed before conducting the interviews. The participants have been told that the interview will be recorded and they have the right to accept or refuse this. Further, they have been told that during analysing and presenting results, their personal details will be omitted to maintain their anonymity and ensure confidentiality.

Three documents were sent to the participants: the invitation letter, the information sheet and the consent forms. All of these forms were translated into Arabic, and both Arabic and English versions were used based on the participant's request or their office managers/secretary request. All of the participants signed the consent form - before conducting the interview- which includes (5) statements, and most of them accepted the statements in the form; only 6 participants didn't agree on one statement related to record the interview. All of the participants signed the consent form for the use of quotes, and accepted to use their quotes.

The ethical considerations were strongly existed during analysis stage, the respondent's views were presented in transparent and honest manner, the only interference I did as a researcher was to omit some words that may reveal the identity or the entity the respondents belong to in order to maintain their anonymity.

Ethical considerations will be maintained even after the research will pass the degree requirements, as the original audiotapes with names and documents may reveal the personal identity, they will be destroyed according to Keele University's regulations. Hence, the participants were informed in the 'participant's information sheet' that their contributions/views maybe used in other academic forms such as journal articles and presentation (with maintaining their confidentiality and anonymity).

- **Confidentiality and Data Protection**

As explained earlier, several precautions have been made to maintain the participant's anonymity and confidentiality. Likewise, data protection was considered. The original copy of the audio recordings which contain the names was kept secured on external hard disk with a password access, and then the analysis was made based on the interviews' numbers which does not indicate the participant's identity. The anonymous audiotapes were kept in a secured file with

a password on a laptop while transcribing the interviews. Then, the transcribed data were stored securely and it was accessible only by the researcher and the lead supervisor.

5.4 Data Collection and Analysis

The following section illustrates the data collection process and data analysis.

5.4.1 Data Collection Process

One-to-one Semi-structured interviews were conducted with 47 respondents from October 2014 to end of December 2014 in Jordan, all interviews were face-to-face base. Ethical approval was obtained prior conducting the interviews and ethical considerations were maintained during each stage of the research.

Although the researcher's identification as a PhD student at Keele University was accepted by most of the participants and their institutions when arranging for the interviews; the researcher was asked by a number of them – particularly public ministries and institutions - to provide a cover letter from a national institution in Jordan. This request was easily attained as the researcher is a member staff at Yarmouk University, which is the second biggest and oldest university in Jordan, and I was granted a scholarship from Yarmouk University to obtain my PhD and then I proposed to resume my job as a lecturer again. Two types of supporting letters were offered by Yarmouk University; general cover letter indicates that I am a member staff at Yarmouk University and the study aim is to fulfil my PhD degree requirement in Keele University and an individual invitation letter to a number of HHC members was signed by the university president.

As a researcher, I was aware of the importance of the self-reflection during the fieldwork stage, therefore, I was keen to reflect myself as a professional person to gain the interviewee's trust to take part in the study and during conducting the interviews. Some of the techniques that I have used: sending the required documents in advance, searching for the interviewee's curriculum vitae and profile before the interview and reading about their history and related information about the institutions they currently represent, using the accurate 'official title' when talking to them[8], and wearing formal suits during the interviews. My previous experience was an asset for me, I have worked for the government, national and international organizations before joining the university as a lecturer, and it helped me to be aware of how to conduct conversations with officials and seniors, and how to approach them. Mostly, I was able to approach the interviewees through the formal channels, however, in few cases I have to ask my previous colleagues to help me to gain access to some senior officials.

Moreover, during the field-work stage, the HHC conducted a meeting with a number of health related institutions and stakeholders to discuss the main themes of the national health strategy for the coming years. This meeting came after one year of the Prime-Minster's call to reactivate the HHC after a five year hiatus. This meeting was sponsored by WHO-Jordan. I was informed about the event by the head of research and studies at the HHC and I expressed my interest to attend the meeting and then my request was approved. It was a great opportunity for me to attend the meeting and listen to discussions and debates took place at that meeting. Also I was able during the breaks and lunch time to present myself and the research I am doing, and I was able to talk directly to a number of senior officials who were identified earlier as a key participants to my study, and most of them showed their initial approval to participate in the

[8] In Arabic culture including Jordan, it's important to use the 'official titles' when talking to seniors, such as Your Excellency, Professor, Doctor…

study. After the workshop/meeting, I contacted their office managers/secretaries to arrange for the interviews.

The interviews arrangement started in the UK before travelling to Jordan in order to utilize the time efficiently, and to give flexibility to the interviewees as it was expected that they may have to reschedule the meetings due to other commitments, and that actually happened for a number of them. The Interviews were conducted in the participant's workplace; the interviews were scheduled according to the participant's availability and commitments. In some cases the initial arrangement was done through the senior's secretaries and office managers.

Around (41 out of 47) participants accepted to be audio taped, the (6) participant's desire for not being audio taped was respected and those participant's responses were recorded by hand written notes. Apparently, even most of the interviews were recorded, the researcher was taking notes during every interview. All of the interviews were conducted in Arabic. English words, statements were mentioned in a number of interviews as most the participants have an advanced educational level. A verbatim transcription was undertaken for each interview.

Prior to each interview, brief information about the study (Participant Information Sheet) and a consent form were sent by email, fax or by hand whenever is appropriate and requested by the participants. During the interviews, the participants were asked kindly to sign the consent form; their signed copy by the researcher was handed to them before conducting the interview. The interviewees were told that they have the right to postpone or end the interview at any time; fortunately, this situation was not faced at all. Nevertheless, three high ranked officials informed the researcher that the interview time will be shortened to (15 minutes) due to other emerging commitments prior conducting the interviews, the researcher complied with this request and focused on the main questions, and completed the interview within the desired time.

The interview questions were developed from the research questions and an interview guide was developed to be followed while conducting the interviews with each participant; however, some questions were asked to clarify things being told by the participants when it is related to the research scope. The interview guide was the same for all interviewed participants; however, for those seniors who asked to shorten the interview duration, they were asked only the main questions. The interview average was 31 minutes (the shortest interview was 13 minutes – the longest was 90 minutes). The total interview minutes was (1410), which equivalent to (23.45 hours).

The interviewees generally were kind, and they showed a very good level of cooperation, I think it could be attributed to key considerations; they were motivated by the study aims and objectives and would like to share their knowledge, opinions, and experiences with relevance to the study scope, particularly as the issue was at glance during the data collection (HHC was activated in end of 2013, and first meeting was in May 2014 after a five year hiatus). Another reason is that the majority of the public officials and the senior stakeholders participants have an advanced educational background (chapter 6, section 6.2), and some of them were at the time of study or in previous stage academic professors, so they were more cooperative, devoted generous time for the interview, and they showed their understanding and support to the research considerations.

5.4.2 Document review and analysis

Official documents deriving from the state could be an important source of information in qualitative research and could be helpful in the analysis process (Bryman, 2015). However, the documents should have some criteria, such as being creditable, unbiased, trusted. There are other

types of documents such as official documents deriving from private sources, mass media output, virtual documents and the real documents, each type of them has several criteria to be considered, some of these documents are faced some criticisms as their drawback exceeds its expected benefit (Bryman, 2015).

Nevertheless, in this research, the researcher relied more on official documents deriving from the state and from creditable international organizations and agencies. Thus, in order to understand the context of the study; the researcher conducted an extensive review to primary and secondary resources including published and unpublished documents and resources related to public policy, health policy, health planning and management. Additionally, the researcher has reviewed a number of local published and unpublished documents related to the Jordanian contexts. In addition, the researcher reviewed a number of international reports and publication related to Jordan in general and health issues in particular.

Some of the documents that have been reviewed:

- International reports about Jordan issued by international organizations, including WHO, UNDP and UN agencies.
- International reports about Jordan issued by international and donors agencies, including USAID and EU.
- National documents issued about Jordan such as the national agenda, Jordan First and the vision of 2025.
- National documents for the health sector, including the ministry of health reports, High Health Council reports and the National Health Accounts reports. In addition to MoH's strategic plans, and the national health strategies
- National documents for sectors and institutions related to one or more of health issues, such as the higher population council reports.

Most of these documents were publicly available on the official website of the international organizations and agencies, in addition to the Jordanian ministries and institutions. Most of the available public resources were read before conducting the interviews, which enhanced the researcher's knowledge about the topic and facilitated the conversation with the interviewees. Further, some documents were obtained – voluntarily - from the national institutions during the field work stage; hence, most of these documents are public ones but are not uploaded on those institutions websites. Some of the above mentioned documents were reviewed again during writing the discussion chapter.

Moreover, the document's review and analysis encompasses a number of memorandum and working documents. Insights into thought process and other factors, which interact during the policy formation process, can frequently be gleaned from working communication and interim documents. The researcher was given opportunity to peruse some of these documents as shown by individual respondents; these were very valuable in helping clarify and reinforce key points being put forward, for example, the researcher was permitted by one of the HHC members to read the meeting agenda and the minutes of meetings for the HHC meetings after it was activated[9]. However, as they were confidential and privileged; these cannot be quoted, but the reading of them has helped to confirm the accuracy of the points recorded from the interviews.

On the other hand, due to the time and effort constraints; it was difficult to conduct an extensive policy analysis to some strategic plans; mainly to the MoH strategic plan (2008-2012) due to the lack of accessibility to the evaluation information, and the current strategic plan then

[9] one note for example; there is a noticeable absent rate when discussing the national strategy directions for (2015-2019), the absence of the high-rank officials for attending the meeting that it's not attended by the MoH minister, in addition, sometimes the HHC member delegates other staff to attend the meeting, I noticed that in 2 meetings, the member had delegated two different employees!, which was an indication for more than one aspect ...

(2013-2017), the policy analysis could gave more insight into the MoH role in managing the health sector and enrich this study and its results even more, however, these strategic plans were generally read and reviewed by the researcher to gain a general understanding, also, it was compensated by reading summary reports and discuss it with some participants who were informed in this regards. Also, due to the time and effort constraints, it was difficult to conduct extensive analysis to the National strategy for (2008-2012), particularly it was not implemented at all, however, it was generally reviewed the researcher and commented on it, when discussing the HHC role in policy formulation.

5.4.3 Transcribing the interviews

The interviews were transcribed by the researcher, as the field notes were taken for each interview, it facilitated the transcription process. The majority of the interviews were audio taped based on the participant's approval, while (6) participants did not favoured to be audio taped, therefore, the researcher wrote their responses and comments. In order to ensure the non-recorded participants' responses were fully captured; the researcher used the technique of short hand writing during the interviews and then wrote it in full words after the interviews had been conducted immediately to avoid any equivocal may occurs[10]. All the interviews were verbatim transcribed in Arabic, as a first step of analysis.

After transcribing the interviews, it was coded randomly by numbers starting with number 1, 2, 3….47 to maintain anonymity and confidentiality requirements. The transcripts were the raw materials for analysis.

[10] When I scheduled the interviews, I tried to have enough time span for moving from one interview to another (if more than one interview were in the same day), and this helped me to transcribe the 'non-recorded' interviews immediately, to make sure that the main ideas is written and might not be mixed with the next interview. In non-recorded cases I used to stay in a café or restaurant near the next interview and write it down in full.

5.4.3.1 Interview Translation

All the interviews were verbatim transcribed in Arabic, however, English terms and short sentences in English language were widely used by the respondents, eventually; some transcripts have both Arabic and English words and sentences. English language was used by quite number of participants due to their educational background as explained in (chapter 6, section6.2).

Before conducting the analysis, the interviews were translated into English language by following these steps. First, all the interviews were verbatim transcribed in Arabic by the researcher (each interview was transcribed, then printed in the word document and then the interview was heard again to make sure everything was fully transcribed) . Second, the researcher created a form which has the main questions and sub-questions. Third, the participant's answers to the research questions were organized under each question (as some participants' added information in different positions for the same question). Fourth, the participants' answers were reviewed and then the irrelevant information (such as unrelated examples, personal information, issues not related to the main topic …) was coloured. Fifth, using the same form, relevant participants' contributions were translated from Arabic into English for each interview by the researcher (I am a native Arabic speaker). Six, the transcripts were reviewed and 'Classical/standard Arabic language' words were listed in (brackets) when too odd 'spoken language' was used by the respondents, the main reason for this is to help in the translation process and to facilitate the translator's task who will review the transcripts. Seven, the researcher sent the English and Arabic transcripts to an 'accredited Arabic-English translator'[11] to ensure the content validity for the translated English transcripts. Eight, the interviews were reviewed after the translation, and checked if there are any comments. Nine, the analysis was conducted based on the translated English versions of the interviews.

[11] The translator's native language is Arabic and she used to be a teacher for non-Arabic speakers in UK for more than 20 years, and she is a translator (on casual bases) with UK immigration office

Hence, several factors facilitated the translations process in order to increase the accuracy and validity. First, the researcher transcribed and translated all the interviews; this insured the consistency of the translation process and the terms used while translating. Second, conducting literature review before data collecting stage creates a richness of knowledge in the research topic and related issues, and eventually increased the ability to use the precise terms. Third, as explained above, both Arabic and English transcripts were sent to 'accredited Arabic-English translator' to review them. Fourth, English terms and short sentences in English language were widely used by the respondents, and some transcripts have a mix of Arabic and English words and sentences. English language was used by quite number of participants as English is the main language of their obtained academic degree and in some cases English is the official language of their workplace (i.e hospitals, medical and nursing faculties).

5.4.4 Analysis of interview data

To analyse data means 'systematically to organize, integrate, and examine', to analyse 'we connect particular data to concepts, advance generalizations and identify broad trends or themes '(Neuman, 2010, p 506). Analysing semi-structured interviews is not an easy task, because respondents are allowed to express their opinion freely and within their own frameworks which made the coding and then the analysis harder (Aberbach and Bert, 2002). The data analysis in qualitative research is considered time consuming (Petty et al., 2012 b).

Data for this study was primarily obtained through conducting semi-structured interviews along with reviewing relevant documents and academic resources. The data were analysed manually despite the availability of qualitative analysis software such as Nvivo which could be helpful in qualitative research. It was decided to do the analysis manually for several reasons; one

of them is the pitfalls associated with using software products in qualitative analysis. Also, even when the software was used, it is mainly a data management tool, and still the data analysis should be undertaken by the researcher (Petty et al., 2012 b), for this research, the researcher did the data management by using a form (described in previous section).

Essentially, the main reason to favour the manual analysis is that the researcher conducted all the interviews and did all the transcriptions and translations and still memorizing parts of the participant's conversations. Therefore, it was more convenient to analyse the data manually. Furthermore, I organised the respondent's contribution under each question which made the analysis more systematic; the researcher did the analysis for each question to the whole interviews and wrote the main results, and then continued with other questions. Also, the interviews' scripts were printed and personally the researcher was more comfortable with using a paper version and writing comments then typing it into the results chapter.

Coding is an essential stage as later analysis is based on how coding was made (Punch, 2014). Identifying themes and codes for this study was challenging, however, some factors facilitated the process to an extent. Most of the respondents were highly educated; most of them have conducted several conversations with media and other public talks and conferences. Thus, in most cases their answers to the interview questions were direct and precise. Also as described earlier, most of the participants were seniors and they had limited time devoted for the interview, so they answered some questions without wasting time for unnecessary talk. However, some interviews were long and include many details, but they were fully examined. In this study ***thematic coding*** was used. Thematic analysis is widely used in qualitative research.

In **summary**, the analysis was conducted on sequent steps. First, the researcher read each interview as a whole text to familiarize myself with respondent's answers. Second, the researcher read the first question with respondent's answers for all interviews and wrote initial comments,

and then did the same for other questions. Third, three interviews were selected (1 from HHC respondents, 2 from stakeholders respondents) in order to be able to identify the main themes for the interview questions. Fourth, the researcher created a list with each question themes and codes. Fifth, after identifying a number of themes and codes for each question, the researcher read the first question again and marked the themes and codes identified earlier, in some cases other themes and codes were emerged and then were added to that list. Sixth, after creating the themes and codes; the researcher wrote the analysis for each question, and then reviewed it again. Seventh, during the sixth step, a number of quotes were chosen to support the results for each question and quotes were coded. Eighth, field-notes were reviewed more than once during the coding and analysis processes to review my notes and comments taken on-spot during the interviews and sometimes some notes were written after one or several interviews. This was very helpful to support the analysis to some issues. Third-Fourth-Fifth-Sixth-Seventh-Eighth steps were repeated for each question. Then, the interviews' transcript were read again and then read the analysis to make sure that the main ideas were considered, and did any changes when needed.

5.5 Validity, reliability, researcher reflexivity and limitations of the study

5.5.1 Validity and reliability issues

Validity and reliability in qualitative research have distinct meaning in quantitative research. Validity and reliability measures are significant as they ensure research quality, rigour and integrity (Bryman, 2015; Silverman, 2011).

Qualitative data by its nature is subjective. However, there are some strategies that could be helpful in reducing the bias and subjectivity, which were adopted in this research. Triangulation is considered one of the effective tools to overcome the limitation of qualitative

data and subjectivity, and enhancing research **validity** and research findings (Punch, 2014; Thurmond, 2001). Triangulation simply means looking for something from various points of view in order to improve the accuracy (Neuman, 2010). Triangulation means also the use of different sources of data when studying any social phenomena (Bryman, 2015; Flick, 2014). This concept was used in the current research as the respondents' views were reinforced by empirical data, and with reviewing the relevant documents, reports both locally and internationally in addition to reviewing the related literature.

Reliability could be handled by using some suggestions such as documenting the research and case procedures in detail (Yin, 2014), and reviewing the transcripts to assure that no mistakes occur during the interview's transcription (Creswell, 2014). In this study, all the procedures to undertake the research including data collection and analysis were explained.

It could be argued that validity and reliability measures in qualitative research are facing controversial opinions between scholars; some aspects of this argument is the call by some scholars for using alternative terminologies to evaluate qualitative research instead of adapting validity and reliability criteria to fit the qualitative research. The main criteria for evaluating qualitative research are research ***trustworthiness***, which includes credibility, transferability, confirmability and dependability (Bryman, 2015), where credibility parallels internal validity, transferability parallels external validity, confirmability parallels objectivity and dependability parallels reliability, another criteria is authenticity (Bryman, 2015, p 384; Guba and Lincoln, 1994, p114).

a. ***Credibility.*** Parallels internal validity. It concerns with ensuring that the research was conducted by following research good practice and principles, and informing the related member of the social world with findings in order to have credible findings (Bryman, 2015). Two major techniques are followed in credibility; the respondent's validity and

triangulation. Respondent's validity has several types; provides the respondents with an account of their contributions (i.e interview scripts), or provides feedback by the researcher to a group of people or organizations on some or most of the findings related to them (Bryman, 2015). In this research it was difficult to ask the respondents to review the interview's transcripts due to main issues: most of the participants are seniors and they do not have enough time to respond to later stages in the research process. Also, most of them have been contacted by their office managers, secretary and their official emails usually checked by them, so there will be a great threat to conditionality. Further, as described earlier, the process of data collection followed strictly the ethical consideration and the researcher gained the interviewee's trust and all the interviews were conducted fully to the end. As for sharing the findings, this thesis (after gaining the degree) will be available to public (in UK; Keele Library and ETHOS: e-theses online services) and in Jordan, this thesis will be available at my sponsored university library as mandated by our internal regulation, and accessible to other Jordanian universities. Further, the researcher was asked by the HHC to submit a copy of my thesis and conducted a session with them about the main results when I come back and gain my degree. Also, a number of participants asked to be informed about the findings of the study, and they will be contacted in the future and they will be handed the study summary as requested.

b. ***Transferability***, parallels external validity. Qualitative research examines a certain issue or peoples in-depth and with details, accordingly findings will be oriented in relevance to that particular context (Bryman, 2015). However, results may be difficult to generalize to other studies, but it provides ‘thick description’ to that certain issue which contribute in creating deeper understanding to that issue (Bryman, 2015). In this research, maybe it is

difficult to generalize Jordan's case to other accounts, but at least part of it may be relevant to other policy sectors in Jordan, and even some other developing countries.

c. ***Dependability,*** parallels reliability. According to Guba and Lincoln, researchers should adopt an 'auditing approach', which includes complete records of all research phases and process such as field work procedures, in addition to other research members, observers or peers review the process and product of research (Guba and Lincoln, 1994; Bryman, 2015). In this research, it was explained earlier about how reliability was maintained, while the other point recommended by Guba and Lincoln is difficult to apply in this thesis due to several considerations, mainly ethical issues and maintaining the data privacy and protection. I think in qualitative research, the academic supervisor is actually acting the role of credible observer.

d. ***Confirmability,*** parallels objectivity. The researcher should ensure that his own beliefs will not override the main research concepts and findings, and as a researcher he should follow the needed requirement to reduce subjectivity and enhance research objectivity (Guba and Lincoln, 1994; Bryman, 2015). In this research, several strategies have been taken to enhance the research subjectivity (see triangulation and researcher position and reflexivity).

e. ***Authenticity*** is another criterion suggested by Guba and Lincoln, which mainly related to the broader political impact of research; the criteria include fairness, ontological authenticity, educative authenticity, catalytic authenticity, tactical authenticity (Guba and Lincoln, 1994; Bryman, 2015). According to Bryman, the authenticity criteria are seen as not being influential, but some of the criteria are seen to be more related to action research, however, these criteria are not popular by researchers (Bryman, 2015).

5.5.2 The researcher's position and reflexivity

Qualitative research is being criticized for being subjective as it is reliant heavily on the researcher in several aspects mainly as being the data instrument of data collection and the researcher did the data interpretation and concluded the findings. In addition to select the topic in the first place (Bryman). Researcher's reflexivity is still debatable between scholars, mainly counts as reflexivity, and, the effect of reflexivity on research quality (Mills and Birks, 2014). It was explained earlier that several strategies and steps were taken to reduce some drawbacks associated with using qualitative research. The findings of this study were based on the participant's perspectives, and then were triangulated with other supporting documents and references; yet, it is claimed that in general the researcher's reflexivity still exists, mainly as the interpretations of data are undertaken by the researcher.

The researcher does not have a medical background or worked previously in any of health sector institutions and entities, so I could describe myself as an outsider. However, I could describe myself as fairly acknowledged with the health sector issues for different reasons; my academic background is 'Public Administration' and through this discipline I have studied different topics including one module about 'healthcare management'. Additionally, Public Administration is about how to manage state sectors effectively and efficiently, and the general principles are applied to various sectors with addressing the differences that may be needed due to the specific characteristics of each sector. Further, I have worked with an international donor agency in Jordan for two years (2007-2009); 'health sector' and its related funded projects was one of the issues I was assigned to follow-up. Also, health sector issues are interested to all citizens and as a citizen with academic background and professional experience, I used to view the sector issues generally with more analytical point of view. My general knowledge of the health issues and being an outsider helped me in asking the proper questions without getting into unnecessary details (i.e

medical issues) and keeping the focus on the sector's policy settings and management. Also, it helped me to be neutral and reduce the bias which may occur toward particular individual(s) or entities' perspective, and depend more on evidences.

Finally, as described earlier, the study's results were triangulated with other resources to increase the study's reliability and validity and to minimize the personal perspective of the researcher. The participants in the first place were chosen purposively, so they could have relevant knowledge of the research topic. Hence, as a researcher, I expressed my views and justifications to some issues based on my practical experience and my academic qualifications, and in most cases I supported my views with some evidences.

5.5.3 Limitation and boundaries of the study and methods

The main limitation in this study was the inability to reach the higher rank officials/decision-makers in some public ministries, organizations and institutions, which will be highlighted further in the discussion chapter in addition to other limitations that related to the lack of resources relevant to the study's context.

Other limitations related to the use of qualitative approach itself such as the internal validity, as the data relied on the participant's comments and responses. Nevertheless, the limitation of using the qualitative approach was addressed and handled by several steps; starting from participant recruitment stage as mentioned previously, ensuring the accuracy of audio and handwritten transcribing, and using the triangulation which was explained earlier.

5.6 Summary

In this chapter, the methodology and research design were discussed in details. The objectives of the study and the opportunity to focus on the qualitative work at the highest level of the health sector were key determinants and aspects of the methodology as well as on the subsequent analysis.

The qualitative semi-structured interviews were described and the rational for using it in this study was highlighted. Table (5-3) presents a summary of the study framework.

As with any research; the underlying objectives sought to produce robust material to form the basis for meaningful and justifiable analysis and conclusions. Thus, the subsequent chapter will present the detailed results of this study that were generated by utilizing the research methods that were presented in the research design and methodology chapter.

Table 5-2: Summary of the study framework

Research contexts	***Paradigm***	Constructivism - Exploratory	
	Research orientation	Epistemological orientation:	Interpretivism
		Ontological orientation:	Constructivism
	Ethical considerations	Obtained by Keele University ethical committee	
	Methodological limitations	- Difficulties in interviewing a number of higher rank officials in some 'entities' identified either as HHC members or stakeholders - Limitations usually associated with using qualitative – semi structured interview in general	
Research Design and Strategies	***The research problem***	Jordan is faced with a number of challenges that hindering the formulation of a national health policy although there is a national institution assigned to undertake this task	
	The research purpose	To critically review the options for effective health policy formulation in Jordan based on investigating the current and previous status of the national health policy formulation and its main challenges	
	The research strategy	Case study 'qualitatively-driven' mixed method Primary method: Semi-structure interviews	
	Data Collection	Tools:	Face-to-face, open-ended, semi-structured interviews
		Participants:	Selected purposively: - The HHC members - The Stakeholders in Health sector
	Data Analysis	Thematic analysis	
Research Outcome and Final Product	- Generating in-depth understanding to the main challenges facing health policy formulation in Jordan - Recommending the most effective options for policy formulation in Jordan - Contributing to the academic and practical field in Jordan and developing countries contexts with relevance to the study focus		

Source: the researcher

Chapter 6

Results and Findings

6.1 Introduction

Given the focus on the research questions to consider how to better support the health policymaking process in Jordan; this chapter reports the outcomes of the empirical investigations to identify not only the main challenges, but also both concepts and opinions on how progress could be made.

The main aim of this study is to investigate the main challenges that face the health policy formulation on the national level in Jordan. As explained in the methodology chapter; this study is an exploratory study guided by the constructivist paradigm. Data were collected through conducting semi-structured interviews with senior representatives from various Ministries, public and private institutions and entities and NGO's. Parts of the analysis and the discussion chapter will be triangulated with documents review and relevant studies and reports. This chapter will provide an overview of the study results. The next chapter will discuss the core issues deeply.

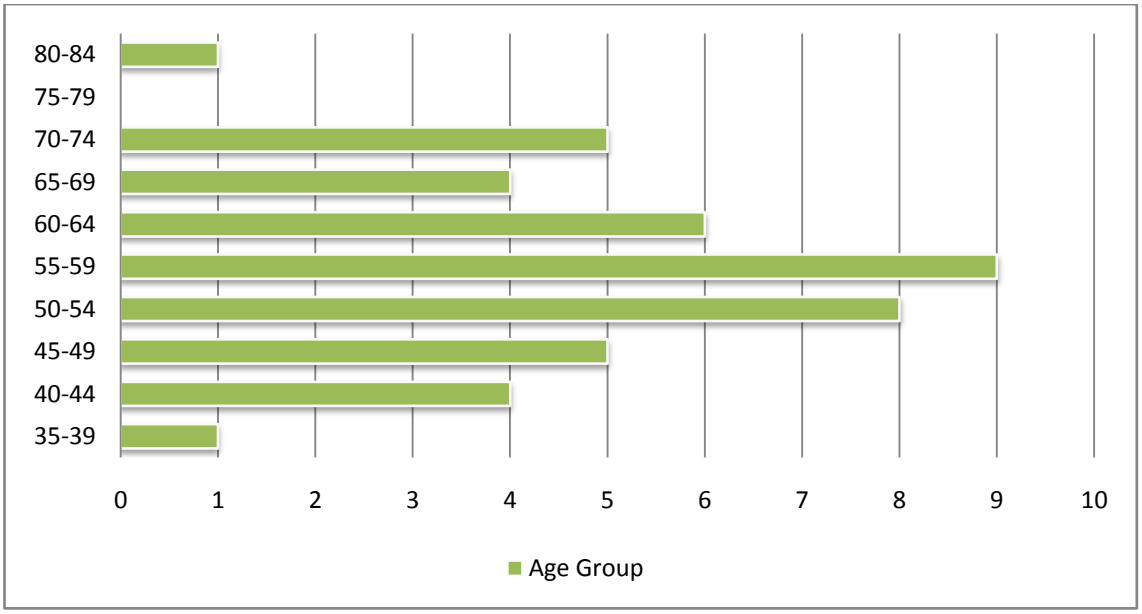
6.2 Participants' Profile

The study participants were 'Senior Representatives' from various Ministries, public and private institutions and entities and NGOs. The core information about the participants was decided to be presented as general summary not a detailed table to maintain the respondents' confidentiality and anonymity. As explained in section (5.3.2), the participants were chosen purposively; thus there might a risk when presenting their information in details and might

increase the possibility of being identified, accordingly the participant's core information are presented in categories and summarized as follows:

Demographic information: Age and Gender. The participants' age ranged from 37 to 84 years. Figure (5-2) shows that the highest frequent participant age is for the ones in their 50s (n=17), then came the 60s (n=10) and then the ones in their 40s (=9). As for Gender; the majority of the participants were males 72% (N=31) while females were 28% (N=12).

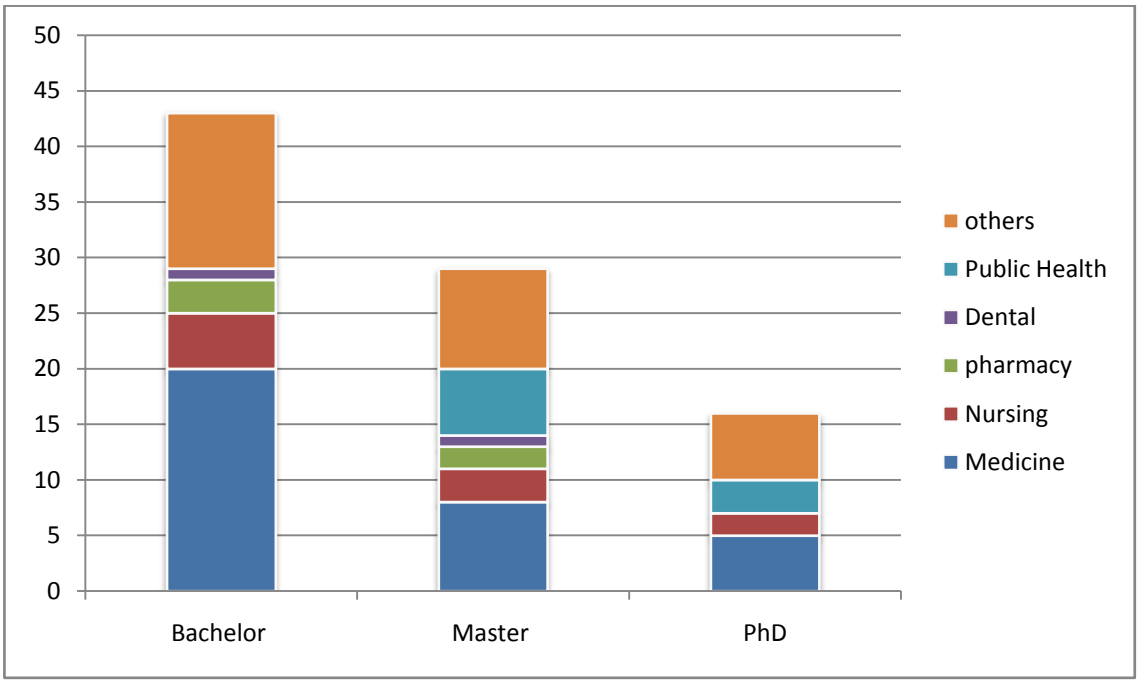
Figure 6-1: Participants' age group



Educational and Professional background: The study participants have a quite advanced educational background; all of the participants have bachelor degrees. Master's degree holders are (27), they represent (63%) of the total participants. PhD degree holders are (16), they represent (37%) of the total participants.

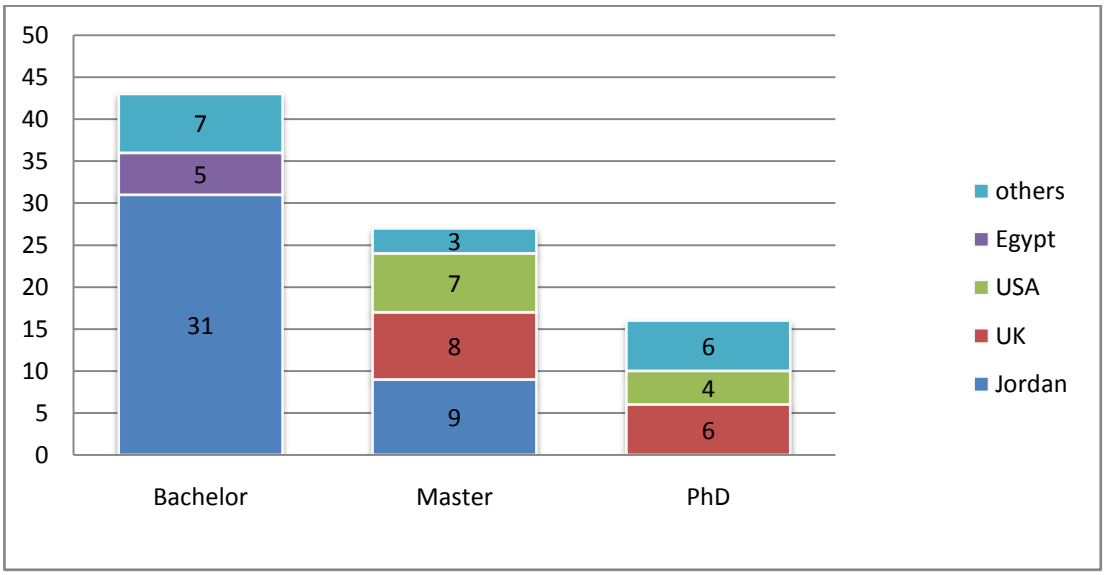
The majority of the participants have academic degrees related to health sector technical specialities (Medicine, Nursing, and Pharmacy) (Bachelor level: n= 20 medicine, n=5 nursing, n=3 pharmacy; Master level: n=8 medicine, n=3 nursing, n=6 public health; PhD: n= 5 medicine, n=2 nursing, n=3 public health); with notice that a number of the participants have both advanced clinical level (consultants) and academic level. Further, (7) participants have (Professor) title (3 in Medicine&2 in Nursing) in addition to non-medical related discipline (1 in economic and 1 in marketing). Also, (7) patricians have teaching roles (part-time) along with their current duties (full time), they hold (associate professor and lecturer) titles, and all of them are working in medical related fields. Non-medical and health subjects were (economic, management, marketing, biostatistics, hospital management, environmental health, education, social work, nutritionist and engineering), (Bachelor level: n= 14; Master level: n=9; PhD: n= 6), Figure (6-2) illustrates the participants' academic level and degrees.

Figure 6-2 : Participants' classification according to academic level and degree



Most of the participants' first degrees were obtained in Jordan, while their Masters and PhD degrees were obtained from the United Kingdom, United States and Jordan in addition to a number of European and other countries (Ukraine, Spain, Italy, Greece, Turkey, Romania, Ireland, Lebanon and Egypt); figure (6-3) illustrates the countries from which the participants' obtained their degrees. Also, a number of medical practitioners obtained their fellowships from a number of European countries and USA, and Ireland.

Figure 6-3 : Countries where Participants' obtained degree



Experiences: The study participants have a rich and extensive professional experience. It is worth mentioning that there are a number of participants who hold more than one position title at the same time, or who has held more than one position title during their career. Most interestingly, a number of participants' previous experience has placed them to be classified as one of HHC members (as stated by law) and being classified as stakeholders; for example, one of the participant is the head of one of the biggest private hospitals in Jordan currently and he was previously the head of the physician association (permanent HHC member). Table (6-1) summarizes the interviewees' current and previous position titles and occupations. Appendix 5.1 presents a list of the Ministries, public and private institutions, entities and NGOs that the study participants work for currently.

The fact that many participants have rich experience in different positions was one of the main reasons for not conducting a comparison between HHC members and stakeholders perspectives when presenting the results as a big a number of the interviewed seniors have played previously and currently different roles and their contributions and opinions were based on their accumulated experience. In addition to maintain the respondents' confidentiality and

anonymity of the participants as they were assured that their identity will not be revealed during the analysis and presentation of the results.

Table 6-1 : Current and previous position titles hold by the study participants

Position Title	Description
Ex- Ministers	- Health Minister - Non-Health related issues Minister
Ex-Secretary General	- Ministry of Health
Secretary General	- Public Institution(s)
Secretary General	- National Institution(s)
University Professors	- Medical Specialities: Ophthalmology , Medicine and Surgery, Nursing - Non-medical specialities : Management and Economics - Academic rank : Professors – Associate Professors
Faculty Deans	- Medicine school - Nursing school
Medical Specialist and Senior Consultants	- Private Hospital(s) - Public Hospital(s) – Ministry of Health - Public Hospital(s) – Royal Medical Services - Public Universities Hospitals - Private owned clinics
Colonel	- Retired Colonel in medical specialties, with previous service in Royal medical services (RMS)
Executive Manager	- National Development institution
Association Head	- Physician Association - Nursing Association

	- Pharmacists Association
Association deputy – Association member	- Physician Association - Nursing Association - Pharmacists Association
Parliamentarian	- Member(s) of The House of Representatives (The Lower House) - Member(s) of The Senate House
Director	- Public Ministries/ entities
Senior Advisor	- Public Ministries/ entities
Advisor	- Advisor at Ministry of Health - Local and regional Advisor: WHO, UNDP….
Freelancer Consultants	- Contracted consultants for specific missions in public Ministries/ entities - Contracted consultants for specific missions with WHO/UN agencies
Chairman Board of Directors	- Private Hospital(s)
General Director	- Private Hospital(s) - Public Hospital(s) - MoH Directorates - RMS
General Director	- Association Director (NGOs)
Project manger	- Funded projects by Donors and International agencies
Head- Member	- NGO's (women, youth, consumer protection,…)
Head- Member	- Technical societies (i.e. Surgical Society …)
Journalist	- Senior Journalist specialised in covering MoH news and other health issues and activities in one of biggest daily newspaper in Jordan

6.2.1 Summary: Participants Profile

The vast majority of respondents were relevant to the context of the study; they have one or more of the following:

- Relevant academic background to medical education and other relevant fields.
- The majority of the participants holds graduate degrees (Master level (63%) of the total and PhD level (37%) of the total participants)
- Relevant practical experience with senior level in the health sector (public and private) and relevant national and international institutions.
- Some participants were (periodic/permanent) members in HHC previous rounds.
- Some participants were members in the working committees formed by the HHC to prepare the 'national strategy for health sector in Jordan (2015-2019)':
    - Steering Committee: I have met (6) out of (12)members
    - Technical Committee: I have met (5) out of (8) members
    - Follow-up and Evaluation Committee : I have met (5) out of (11) members

Thus; having a combination of all the above has contributed greatly to generate valid and reliable results and build the discussion accordingly.

6.3 Analysis overview

The study questions and sub-questions are listed in table (6-2). Hence due to some senior officials' time limitation; some sub-questions were not asked. Nevertheless, every participant – with no exceptions – was kindly asked to present his/her views regarding the key study questions (What are the main obstacles/challenges for national health policy formulation in Jordan? Do the (HHC) have effective role in policy formulation? How the national health policy should be formulated?).

Although the study has key questions; nonetheless, the analysis is presented based on the core categories and the related themes that arose during the analysis. It is found out that there was an intersect and interrelation between some themes in some questions, so in order to avoid duplication and to maintain the logic of the grounded theory 'method', the results are presented based on the core categories and their themes. Moreover, during presenting the data and its analysis; a number of quotations that are important to capture the dimensions of a category or a theme was selected, yet, those quotations were coded to ensure the participants anonymity.

Table 6-2: The study main questions and issues

Key Questions	**Key issues covered**
The main **challenges** for the national health policy formulation	- What are the main ***obstacles/challenges*** for the national health policy formulation in Jordan?
The (HHC) **role** in health policy formulation	- Does the (HHC) have **effective** role in policy formulation? - Does the HHC **membership** representing the health sector properly? - Will the recent change of HHC chairman (from the PM to the MoH Minister) facilitate policy formulation?
The respondents' suggestion(s) for the national health policy formulation options	- How the national health policy should be formulated from your own perspective?
The **role** of International organizations and Aid agencies in health sector and how is it related to health policy issues	- The role of International organizations in the health sector i.e (WHO, UN…) - The role of AID agencies in the health sector i.e (USAID, JICA…)
The **absence** of a national health policy	- What are the Consequences of not having a national health policy?

Hence that the questions and the sub-questions used the term “policy” as its most frequently used in the developed countries literature. However, in the respondents' contributions they have used the term ‘’strategy’’ as it is the official word used to describe the highest national effort for the health sector, and it is used in the official HHC documents such as the latest national strategy (2015 – 2019). Further, the term ‘’strategy’’ is most commonly used for written plans on the national and sectoral level in the Arabic culture. Thus, although the questions included the term “policy”, it is equivalent to ‘’strategy’’ in this context. Hence sometimes the term “policy” is used in several quotations as it is verbally used by the respondents when they give general views about health policy related issues.

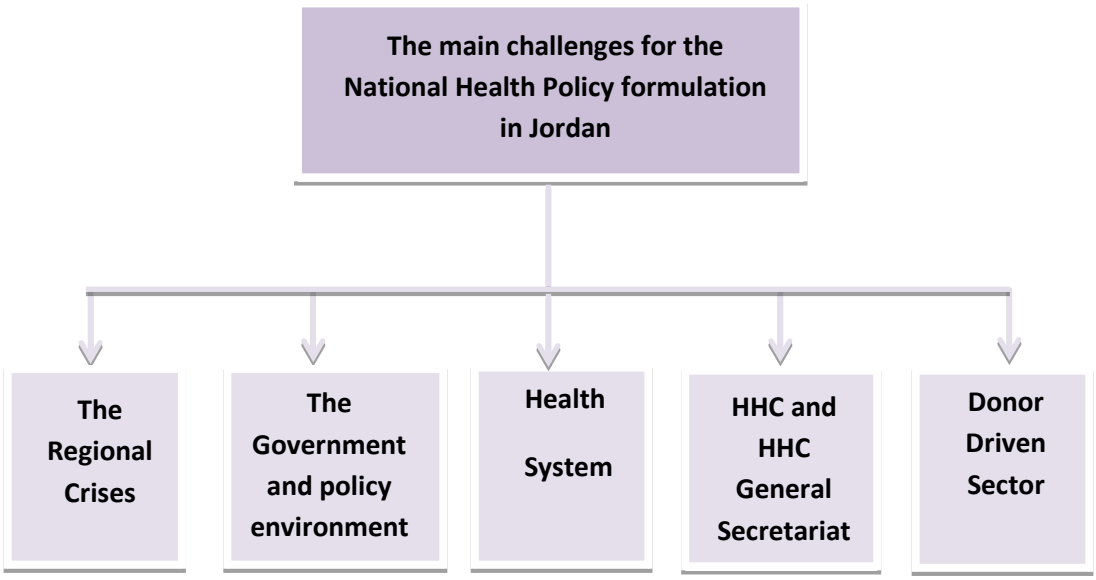
6.4 The main challenges for the national health policy formulation in Jordan

This is the core question of this study; thus, it was asked to all participants. The participants contributed thoroughly to this question and they mentioned various obstacles and challenges that hindered the efforts to formulate a national health policy that combines health providers and main entities in Jordan. Hence during the interviews, a number of participants talked about obstacles and challenges on policy level (macro level), while other participants talked about obstacles and challenges that related to macro, meso and micro. Accordingly, to keep the study focused on the main aim; the issues related to macro level will be highlighted, other levels will be presented occasionally when needed as examples, and/or when it is mentioned in the respondents' quotes.

The most frequent causes, obstacles, and challenges raised by the interviewees were coded and grouped into core categories. However, it is more convenient to start with a logical order by presenting the external factors (regional crises), then the challenges related to the public

policy environment in general, followed by the health system, then the challenges related to HHC (and its secretariat general). Figure (6-4) illustrates the core categories of the main challenges for the national health policy formulation in Jordan.

Figure 6-4: The study categories (Theoretical Categories)



6.4.1 Regional Crises

Jordan has been always under the pressure of the regional crises since their outset. These crises have affected Jordan negatively in various aspects such as the national economy and the limited resources, in addition to increase the population massively. Table (6-3) summarizes the main crises in the region which have a direct and a major impact on Jordan on various aspects, with notice that the table only shows the demographic increase aspect.

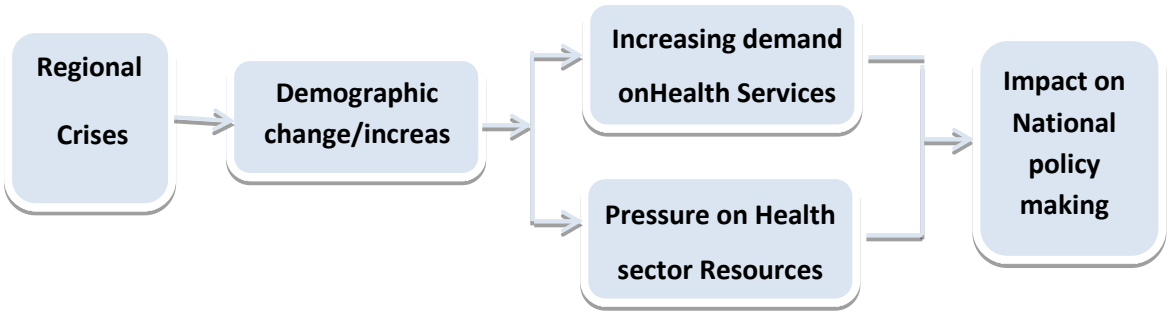
Table 6-3 : The main regional crises that affect Jordan

Regional crises		Implications on Jordan in term of demographic changes
Year	**Crises/Event**	
1948	Arab-Israeli War	As a result of this tragedy; tens of thousands from Palestine flee to Jordan
1967	Six-Day War	As a result of this disaster; tens of thousands from Palestine flee to Jordan
		The vast majority of Palestinian refugees became Jordanian citizens
1990	Gulf War	Tens of thousands return to Jordan from Gulf countries, mainly from Kuwait. The main reason is the political stand of Jordan against the war at that time and the call for peaceful options. And due to the Palestine Liberation Organization's (PLO) support to Iraq against Kuwait, which led to force around (400,000) Palestinians (with Jordanian citizenship) to leave Kuwait, the majority of them came to Jordan.
1990	Gulf War	Thousands of Iraqi families escaped to Jordan In addition to Jordanian and Palestinian who were resident in Iraq
2003	Invasion of Iraq	Tens of thousands of Iraqi families escaped to Jordan
2006	Lebanon War	Thousands of Lebanese families escaped to Jordan, in addition to Jordanian and Palestinian who were resident in Lebanon
2011	Syrian crisis	Since the crisis started, around one million and a half escaped to Jordan, considered to be the highest influx witnessed in Jordan, unfortunately the crisis still evolving

Source: Prepared by the researcher

A diagrammatical representation of the Category and related themes that arose during analysis is presented in Figure (6-5).

Figure 6-5 : Category: Regional Crises



6.4.1.1 Demographic change and increase

Although the regional crises affected Jordan in several aspects; the demographic challenge is the main one due to its direct and indirect effect on all sectors, including the health sector. The table (6-4) showed that all of the regional crises had increased the population in Jordan; in the past 55 years, the population increased more than tenfold, now (31%) of the population are non-Jordanian, around (45%) of them are Syrians (DoC, 2015). Jordan now is named top Refugee-hosting country.

The recent influx of Syrian refugees was mentioned by a number of respondents. One participant said:

> 'In the last few years and due to the Syrian crisis; Jordan' population increased with more than one million and a half; according to the Higher Population Council in Jordan, it was expected to reach that increase (the

> Demographic Opportunity) within 16 years, but we reach it within 16 months !…, it has severe consequences on Jordan' (P, 45)

The massive increase of population has a number of consequences on Jordan in general. However, the respondents have associated the population increase –within the health sector- with two main issues, which could be classified into two main sub-categories: pressure on health sector due to the increasing demands for health services, and pressure on resources allocated to health sector.

6.4.1.1.1 Increasing Demands on Health Services

The unexpected population increase was always a challenge to the government, however, the previous exodus and migration waves were less harmful compared to the Syrian crisis consequences on Jordan. Healthcare is one of the main sectors that has been affected by the influx of refugees.

> 'The external factors increased the demand on our services in general and place its burden on the health sector in particular, you know now Jordan population has increased by 20% due to the Syrian crisis….' (P, 26)

> '… worse than this is the fact that, refugees may need more health services, as around half of Syrian refugees are under the age of 19, and they might be suffering from health difficulties before they came to Jordan , so they need more services now…' (P, 10)

> '… The northern governorates, in particular, are witnessing huge pressure on health services due to the Syrian crisis'[12] (P, 3)

The essence of increasing demands on health services that it is not equivalent to the supply side; the health service provision is not growing or increasing in the same level of the increasing demands on health services due to some limitations. However, an important aspect related to the pressure on health services is the drawbacks on Jordanian citizens, because it is affecting their accessibility to health services in public sector centres and in hospitals in particular.

A respondent described it:

> '… the poor and mid-level citizens started to suffer from the burden placed on the health services, for example, they have to wait more hours in the health centres, and there is a long waiting list now to see the specialists … some citizens could afford the cost of the private health care services, but most cannot … as a result the Jordanian citizens spending on healthcare services (out of pocket money) has increased, even if some of them are insured with MoH …' (P, 45)

6.4.1.1.2 Pressure on Health sector Resources

A huge pressure was placed on our resources in general (details in chapter 1), including health sector resources, which include financial resource, human resources, and other tools, equipment's and facilities. Some respondents raised the issue of the huge cost incurred by MoH and the Jordanian government to cover the Syrian refugees treatment cost.

[12] Two Northern Governorates have borders with south of Syria

> ‘With no doubts; the cost of providing health services has increased, for example the drug cost and the equipment cost, and even the medical staff, the MoH has not only employed more medical staff, but also sometimes contracted with specialists from the private sector (purchase their services) to work in MoH hospitals, especially in the capital and northern governorates’ (P, 3)

Some respondents pointed out that; to some extent, the donors and international agencies have supported Jordan, but due to the prolongation of the crisis, their contribution decreased considerably.

> ‘The international community is not supporting Jordan in a way that will help us to handle this situation, since late 2014 the donors are not supporting the treatment cost of refugees, accordingly, Syrians have to pay the cost of their treatment, the problem is not only here, but, because of Jordan commitment to the humanitarian situation of the refugees; the Syrians are treated as the uninsured Jordanian citizens, which means that they get the health services in MoH centres and hospitals with (80%) subsidized by Jordanian government, as the uninsured citizen pay only (20%) of the treatment cost. Moreover, mothers and children healthcare is free to everyone in Jordan …. MoH has worked as a shock absorbent, but the question is, until when!’ (P, 47)

Another participant said that:

> ‘… the international community promised to help Jordan, but actually they didn’t, it is estimated that the health services for refugees cost us around 1 billon, but we received only 200 million…’ (P, 10)

This pressure on Jordan's limited resources was emphasized also by a number of participants, for example, they talk about the cost of vaccination against diseases declared free from Jordan since 1990s.

> '… the recent influx of refugees has increased the health expenditure in various ways, for example, Jordan was declared to be free from polio, but many cases detected within the refugees, which need vaccination campaigns to all, not only to a certain group. The WHO supported us in that, but MoH also contributed to the cost, and, this unplanned expense will be deducted from other programs due to our financial limitations' (P, 1)

Another participant pointed to the concerns of a possible decline of Jordan's international rank due to the emergence of some diseases and the possibility of affecting the medical tourism sector.

> '… the recent influx of Syrian refugees and the Iraqi refugees in the last few years have affected Jordan's rank negatively in some international indicators, for example, we successfully eradicated (polio) and Jordan is free from other disease such as diphtheria since 1992 … but now it has re-emerged, although there were not many cases and they were mostly controlled, but it affected negatively Jordan's rank according to WHO and maybe other agencies … and I'm afraid it will accordingly affect Jordan's rank as one of the best medical tourism destinations in the region…' (P, 14)

This indicates that the pressure on resources is not direct only, as there are indirect consequences that need more effort and resources, such as spending on the health sector to maintain our positive indicators and ranking. And even more, there are fears of the 'lost opportunity' of revenue generated from the medical tourism if things did not get improved.

6.4.1.2 The Impact of the regional crises on the national policymaking

The respondents indicated that the regional crises affected the policy settings in Jordan in two major aspects; the first one is limiting our ability to set long term-plans, and postponing any possible plans, due to the need for responding to the urgent events.

> 'With no doubts, the Syrian crisis is one of the major challenges that face the policymakers in general, including health policies' (P, 1)

> '…the crises in the region, most notably the Syrian and the influx of refugees have limited our ability to set long-term plans and even if we have ones, quite part of it will stop in response to the urgent occurrence..' (P, 28)

Another participant explained how it is difficult to plan for issues related to Syrian refugees in Jordan:

> '… I think we face a problem in predicting the refugee's status, what is happening now is indicating that the refugee's number will increase due to the early marriage tendency and the high fertility rate among refugees in Jordan, and due to unfortunate situation in Syria and the possibility of more refugees to come …, so the logic indicates that we need to improve our health services, but some still hoping the crisis will end in the near future and Syrians will return home, personally I do not think this may happen, even if some of them return home, many will stay for several years until everything settled down there, which is again unpredictable… what makes things worse is the lack of our financial resources and the lack of donors assistance to Jordan'(P, 1)

Further, another participant said that:

> '… In the recent years, the government is working mostly on 'responsive principle'; we cannot set plans and strategies for the long run, not only for health sector, but for other sectors such as education …' (P, 34)

> 'The policies in health sector are changing in response to the occurrence of migration, refuge and political events around us …' (P, 6)

It is noticed from the participants' views that the health sector was affected by the huge influx of Syrian refugees, another important aspect is the role of donors and international agencies in supporting the health sector in response to the current crisis, which was seen by most of the respondents as not adequate. However, the donors' role in the health sector in general and its influence on the sector policymaking will be highlighted under the category (donor-driven sector).

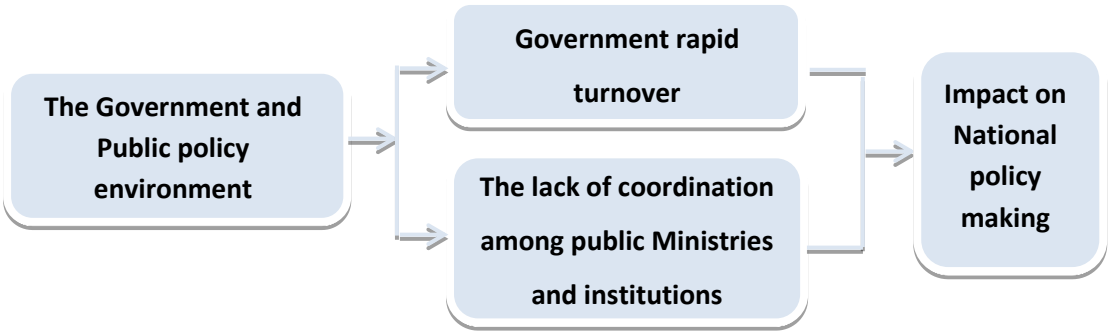
6.4.2 The Government and public policy environment

The respondents pointed that we cannot isolate policymaking in health sector from the general environment policymaking in Jordan. The respondents highlighted mainly the issue of government quick turnover and the lack of coordination among sectors.

> ' … I think the challenges that are facing the health sector regarding policy and strategy settings is similar to those facing other sectors to some extent…. we have policies and strategies in some sectors, but some of them are still only on papers and cannot find its way to implementation …' (P, 37)

Although the public policy environment has several issues; the respondents highlighted two main issues only from their views, to be the most influential on policymaking in all sectors in Jordan. However, with relevance to health policymaking, they mentioned a number of issues, which will be presented in the next section. A diagrammatical representation of the Category and related themes that arose during analysis is presented in Figure (6-6).

Figure 6-6: The government and public policy environment



6.4.2.1 Government Rapid Turnover

The rapid government turnover was a major challenge for policymaking in Jordan, one of its consequences is the lack of full implementation of the policies and strategies, and the weak monitoring and evaluation system for the results and outcomes.

It was described by some respondents as follows:

> '… when the government change, some policies will change, there is no accumulative work in some cases …' (P, 20)

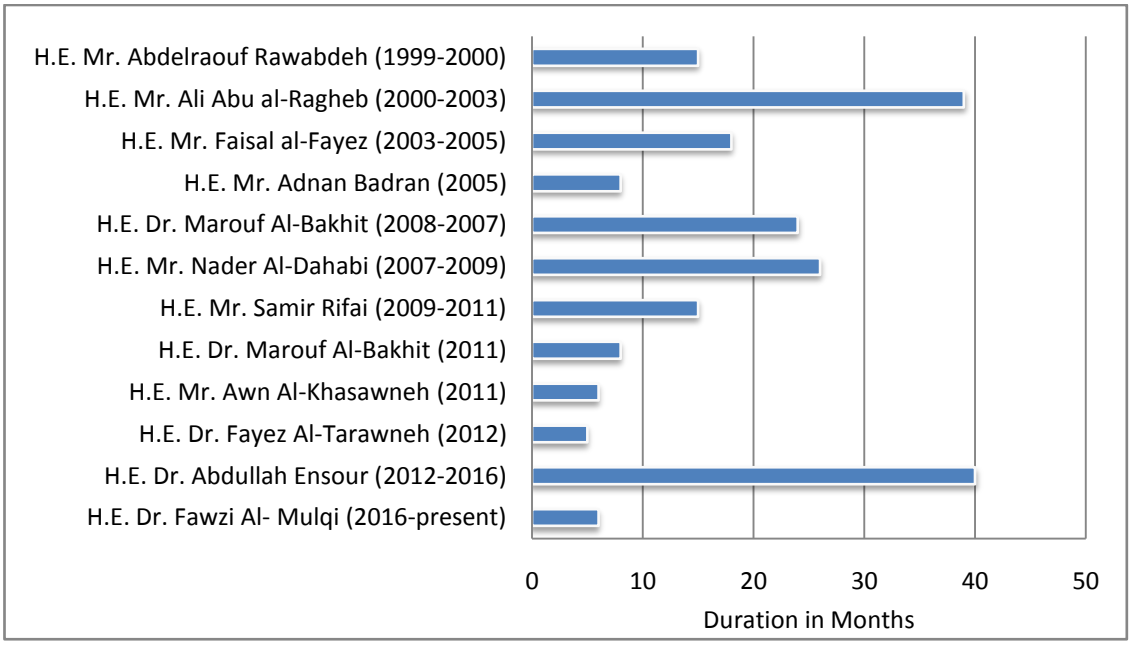
> 'The short life of government will not enable the government and its ministers to set policies and strategies and then implement them …' (P, 15)

'The challenge is not setting a strategy; the real challenge is to implement it, and to develop a mechanism to ensure the actual implementation and then monitor the progress …' (P, 20)

'… I think due to the continuous change on government officials and minister's, it is affecting their ability to set policies, implement them and follow them up…' (P, 5)

Since 1999, the government of Jordan (Cabinet) was formed and partially reformed sixteen times and headed by twelve different Prime-Ministers. During the last 16 years, the government duration for more than three years was only twice and even then it last less than four years. Figure (6-7) summarizes the Prime Minsters duration since 1999 until now.

Figure 6-7: The Prime Ministers duration in Jordan since 1999- present



Prepared by the researcher, source: Prime Ministry of Jordan database (www.pm.gov.jo)

Because that the respondents highlighted some consequences of the government turnover without talking about its causes; due to their assumption toward me as a Jordanian researcher, but due to their importance, the government turnover causes will be briefly displayed in the discussion chapter.

6.4.2.2 Coordination among sectors

The coordination among sectors and related institutions is vital, but according to the participants, there is a lack of coordination among sectors, particularly with the shared and interrelated tasks.

The respondents describe it as:

> '… personally, I think the lack of coordination among sectors is one of the key challenges to any policy, including health policy …' (P, 33)

> '… I think there is a lack of the teamwork spirit concept, which make the collective work in the governmental institutions and ministries toward achieving the mutual aims and strategies a hard task' (P, 20)

> 'The lack of coordination is hindering development in Jordan and is distracting our efforts, for example, there is no coordination or networking between the higher education and universities on one side and the labour market needs in term of disciplines that classified as stagnant or oversupplied on the other side' (P, 23)

6.4.3 Health System

The majority of respondents raised several issues within this theoretical theme. However, there are a number of core themes that were mostly discussed by the respondents.

An important point that should be clear when presenting the results related to the health system and its influence on the national policymaking, is the fact that the High Health Council (HHC) was inactive for several years and even when it was reactivated in 1999 its role in policymaking was meagre, consequently, most of the respondents kept MoH and its role in their mind when talking about health sector policymaking for some aspects like evidence-based policy, monitoring and evaluation. MoH is entitled according to the Public Health Law (last amended in 2008) to undertake all health affairs in the kingdom including controlling and regulating other institutions, in addition to that, MoH is the main healthcare provider within the public sector. Accordingly, MoH was and still having the leading and influential role in the health sector. Thus, in the discussion chapter, one of the key issues which is highlighted is who shall be responsible for formulating the health policy in Jordan. A diagrammatical representation of the Category and related themes that arose during analysis is presented in Figure (6-8). Figure (6-9) shows the rank of each theme according to participants' perspectives.

Figure 6-8 : The main challenges to policy formulation in the health system

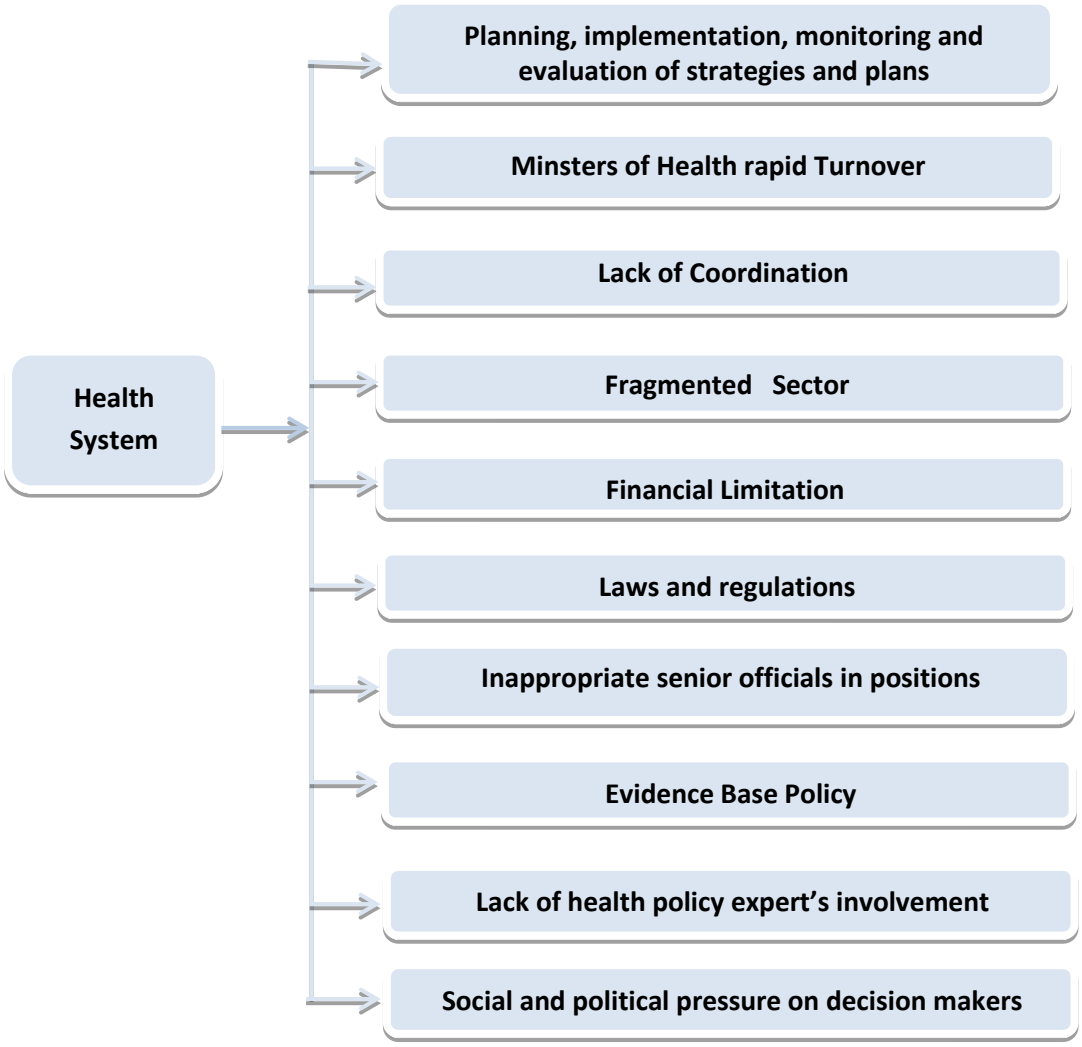
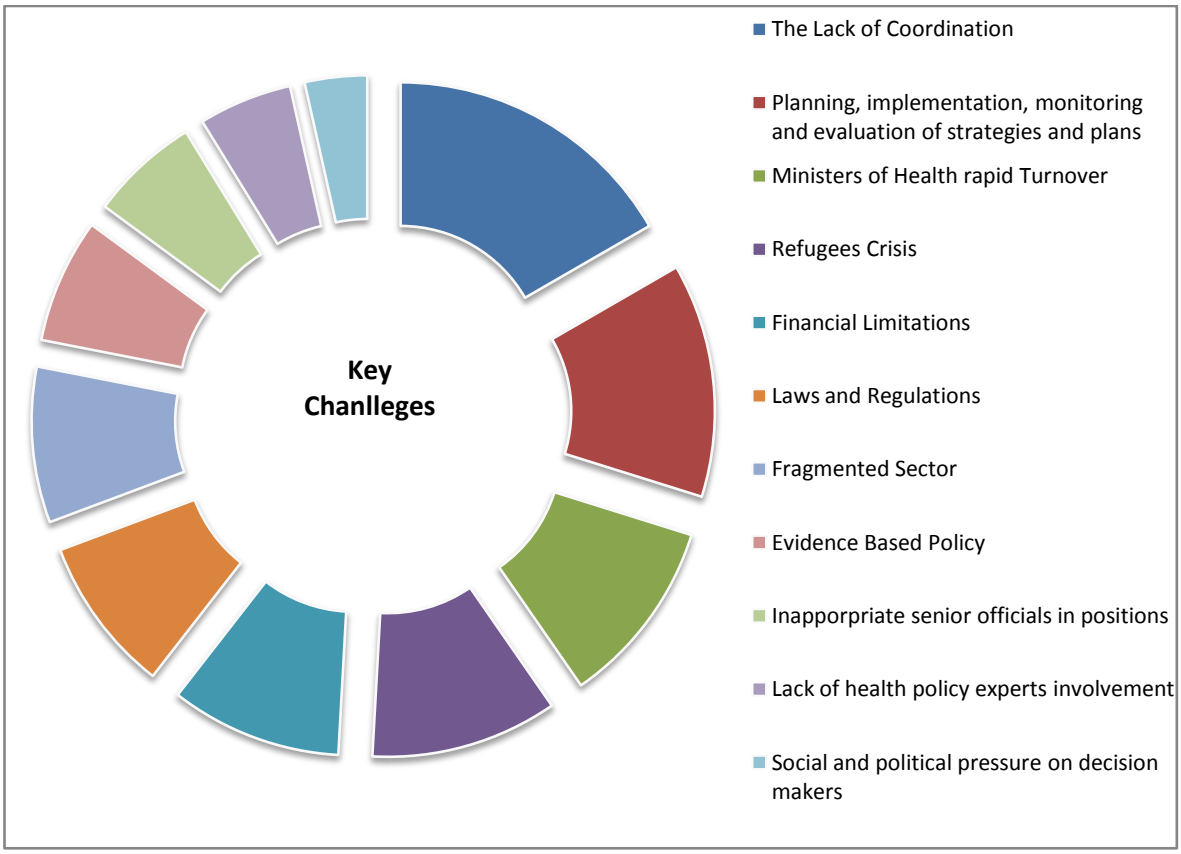


Figure 6-9 : The key Challenges to Health Policy Formulation in Jordan



Prepared by the researcher, source: the participants of the current study perspectives

6.4.3.1 Planning, implementation, monitoring and evaluation of policies, strategies and plans

Quite a number of participants pointed to issues related to the policy process; planning, implementation, monitoring and evaluation of policies, strategies, and plans either on national, sectoral or institutional levels within the health sector. Although most respondents quote's mentioned planning, implementation, M&E in the same sentence; they are placed under themes they stressed more on.

6.4.3.1.1 Improper planning

Some respondents pointed to the issues related to planning and early stages for formulating the policies and national strategies. The main issues related to planning are: some strategies have no clear implementation plans, some strategies are not based on evidence, and some the strategies are not even implemented sometimes.

The respondents describe it:

> ''sometimes we have a problem in the early stages of developing the policy, as it is not based on solid evidence … so in later stages it will be affected by that …', (P, 45)

> 'Some of MoH policies are just (ink on papers), sometimes they set the policy or strategic decisions without thinking how to implement them …', (P, 1)

> 'It is important that our policies and strategies do not remain (ink on papers), they should be translated to operational and action plans', (P, 26)

6.4.3.1.2 Lack of implementation mechanism

Under this theme, the respondents pointed that the main challenge is not developing the policy or the strategy, but to implement it properly and then set monitoring and evaluation system for it.

> 'Developing policies is not difficult in Jordan, we are professional in that…, the most difficult part is the effective implementation of those policies and following them up and then evaluating them, (P, 23)

> 'I think the latest draft of the national health strategy is descriptive; I mean it describes what we want, but without indicating the tools or the methods to do it. Also the strategy has some indicators, but it is not clear how these indicators will be measured, monitored and evaluated' (P, 18)

6.4.3.1.3 Lack of Monitoring and Evaluation systems

Some respondents criticized the monitoring and evaluations system, either for the previous national strategy (2008-2012)[13] or for the new national strategy (2015-2019), in addition to this, they criticized the MoH monitoring and evaluations system for some tasks entitled to it by the public health law. The respondents thought that M&E are associated with the absence of proper mechanism of implementing the national strategies and policies.

> 'We have proper strategies and plans, some of them are developed by experts and specialized people, but the problem is the weak monitoring and

[13] The strategy was not implemented

evaluation system – if any – and this affects the implementation and leads to having a gap between planned and actual status', (P, 25)

'I think we can work together and formulate a national health strategy; but the key issue is a mechanism of implementing the strategy …I think the current strategy is good and comprehensive … now the questions are: what is my role, who is going to monitor what Iam doing ... usually there are systems and procedures following the formulation of the strategy or the policy … but we have problems in performing that'', (P, 12)

Another respondent emphasized the issue of weak mechanism and the lack of M&E system:

'Sometimes we do not set proper plans and strategies, and if we set proper ones we do not oblige them, or we implement them partially, this is due to decision-makers dereliction to the monitoring and evaluations system … There is something missing when we set some policies and strategies … when we formulate a policy or a strategy, we should think how it should be implemented and monitored…', (P, 20)

The critique was not only for the national strategy, but also for MoH major issues related to the health sector in general and affecting the whole kingdom. Most of the respondents who raised the issue of the lack of implementation mechanism mentioned the "anti-smoking law"; they said that the law is modernized, it includes penalty when breaking the law (fine and/or

prison sentence), but the major issue is with the absence of effective tools to implement the law provisions and defeat actions that violating the law.

> '… we have some good stuff (such as anti-smoking law), but there is no proper mechanism for its implementation …', (P, 7)

> 'We need collaboration from different entities to decrease the high smoking rates in Jordan, we have a law but it is still on paper since 2008 and there are poor enforcement and meagre fines … I think there is a chaos related to this issue, intervention from some influential stakeholders and citizen resistance to the law … the main reasons for that is the lack of implementation mechanism and the lack of proper monitoring and evaluation system', (P, 1)

6.4.3.2 Ministers of Health rapid Turnover

The ministers of health turnover was a major issue that perceived by the respondents to have a direct influence on health sector policymaking. The majority of respondents indicated that rapid turnover has negative consequences on policymaking for the health sector in general and on monitoring and evaluation of the previous strategies and plans for MoH in particular.

The respondents expressed their opinions below:

> 'The continuous change of the high-rank officials in the government and the health sector has negatively impacted the effort of implementing the plans on various levels' (P, 25)

> ‘I think the Ministers turnovers since the 1990s is dramatic, we almost have around 17 different ministers of health so far…, how we expect them to have plans and policies … I think if the minister will work properly he needs to spend time to be aware of the ministry major issues and conduct a number of field visits to some hospitals, then he will be able to work, but, (ironically) after he reaches this stage, he will leave and a new minister will come …’ (P, 15),

> ‘The lack of high-rank official’s consistency is one of the challenges for the health sector…’ (P, 33)
>
> ‘ … I didn’t hear about any communication between a new minister and the preceding one when handing tasks …’ (P, 33)

> ‘Unfortunately, there is a quick change in MoH ministers, and even in HHC secretary generals positions, based on that we have weak implementation of some strategies, what is happening now is that we depend on the plans and policies that were set 20 years ago, and occasionally updated’ (P, 1)

Rapid turnover also has a number of consequences, such as the loss of accumulative work and the personalist (individualism) of some decisions:

> ‘When a new minister come, he tried to take over from square one, and he doesn’t like to build on the preceding minister work … we don’t have accumulative building of efforts…’ (P, 42)

> ‘Some ministers refused to build up on the previous minister work, they simply give the preference to their own perspective over the strategy or the plan that previously prepared, I think those minsters prefer the Individualism over the accumulative and institutional work’ (P, 10)

> ‘The MoH approach or strategy is may be influenced by the minister’s background and specialty, for example, if the minister background is based on primary healthcare (or his preference); he will geared the Ministry’s programs toward that, and probably will neglect other projects’ (P, 33)

Despite the negative influences of rapid turnover on strategy and policy level, it is quite fair to mention that some respondents explained why MoH was able to manage its duties and responsibilities despite the rapid change. They indicated that usually MoH has a five years strategic plan, and a good percentage of its components are being followed.

> ‘Yes we have problems on policy level, but MoH is able to perform their duties as some strategies and sub-strategies are linked with directorates and departments in MoH, and there is more consistency in the Directorial level’ (P, 41)

> ‘But on the same time, I think having many sub-strategies may affect the overall indicators, it is satisfactory, but not ideal; we could do much better than that if we have a clear and comprehensive policies and strategies’ (P, 41)

Another respondent commented on the importance of formulating proper strategies:

> 'I think if we have a strong and well prepared strategic plan, the change on Ministers level will not be catastrophic; yes the turnover will have some drawback on the strategy, but if we have a strong internal system it should be fair enough' (P, 37)

However, it is important to mention that the MoH five years strategic plan is for MoH hospitals and centres only and rarely include tasks shared with others, apart from tasks assigned by law, like the vaccination campaigns all over Jordan which required coordination with others, or other issues that is legally mandated to work with others such as Physician associations, or for some funded initiatives.

Some respondents indicated the need for more consistency in MoH Minister duration, and even one participant pointed to UK experience in the 70s 'stop-go' policy, and it is positive results if imitated in Jordan.

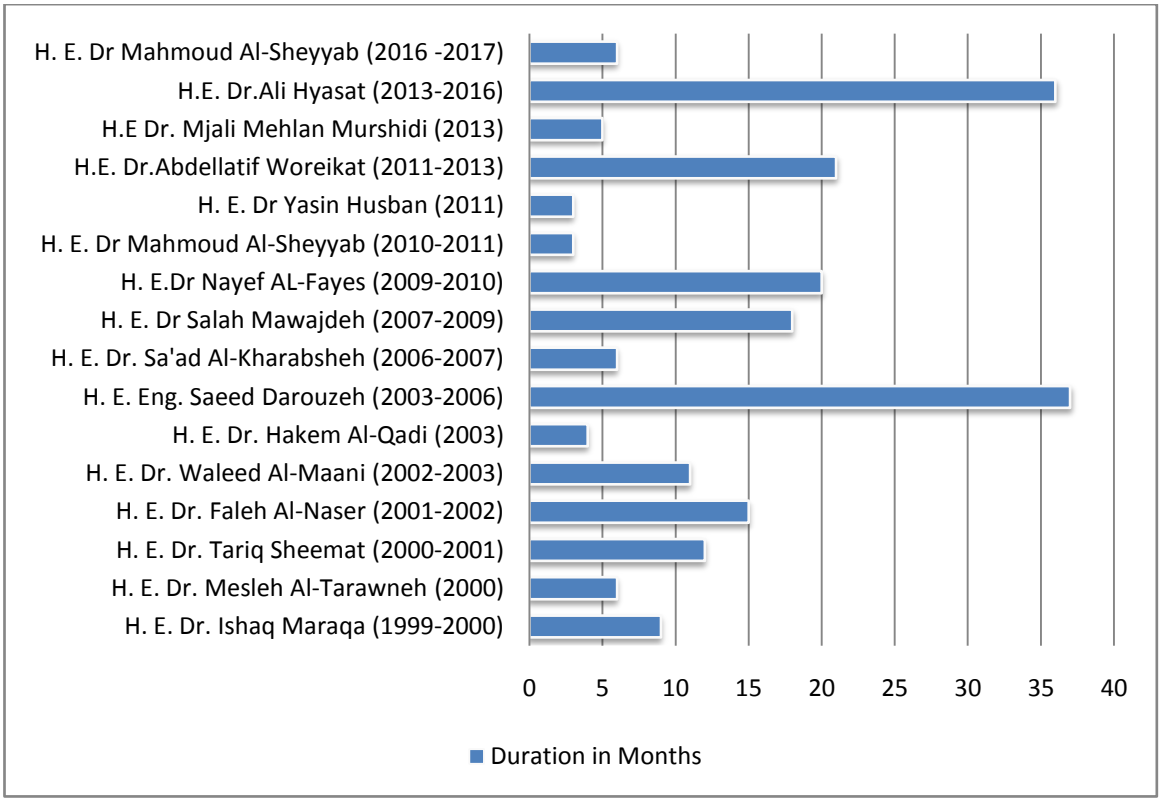
> 'Consistency led to more positive results and enhances performance. I think recently there is a tendency to prolong the government duration to be concurrent with Parliament duration in Jordan' (P, 34)

> 'Further, I suggest to adopt what UK did in the 1970s, when they adopt 'stop-go' policy; the results were very impressive, I remember that while I was in UK for my study … consistency leads to positive results and enables us to build on the accumulative efforts instead of current distracted efforts' (P, 34)

A general overview to MoH ministers turnover

Minister's turnover is associated with the government turnover in general. Since 1999 till present, the ministers of health were changed sixteen times, the highest duration for the Minister of health to keep his position was 36 and 37 months respectively, which happened only twice during the last 17 years, figure (6-10) show the minister of health duration since 1999.

Figure 6-10 : The Ministers of Health duration since 1999- present



Prepared by the researcher, source: Prime Ministry of Jordan database (www.pm.gov.jo), and Ministry of Health official website (www.moh.gov.jo)

6.4.3.3 Fragmented sector (Multi Healthcare Providers)

The healthcare services are provided by the public sector, private sector, NGO's and UNRWA. However, Ministry of Health is the major healthcare provider in the kingdom (more details in chapter 2).

Providing healthcare services by different providers is seen to be one of the main challenges by the respondents. More specifically, the respondents criticized having multi-providers within the public sector, as it is inconvenient that healthcare services are provided by various public entities without having one umbrella to synthesise their efforts.

The respondents described this issue as follows:

> 'I think having multi healthcare providers for the health sector is impeding the efforts to have a clear strategy on the national level '(P, 21)

> 'Public health sector is fragmented institutions, Ministry of Health, royal medical services, university hospitals and others … I think the problem is that each entity seeks to gain the privilege for them, probably they give the preference to their entity's interest rather than the national interest' (P, 37)

> 'So far, the HHC didn't succeed to achieve its assigned tasks and duties, and didn't succeed to be the umbrella for the health sector, the health sector is still fragmented and has different references, each organization see itself to have full authority and independence from others …..', (P, 31)

> ‘Having multi providers is a key issue, each provider has its own hospitals and centres, and they deal with different beneficiaries and different insurance schemes, I think this could be acceptable for private sector, but not for public sector entities’, (P, 38)

> ‘I think providing health services by the private sector is not a problem; the real problem is the fact that we have multi providers within the public sector itself. In some countries like the European countries they used to have services provided by the military, but gradually all health services become under the civil insurance scheme. The RMS has a recognized role inside and outside Jordan, however we should reach to a point where public health sector have homogeneous insurance scheme …’, (p, 25)

As a result of having multi healthcare providers within the public sector; each entity has its budget, law and regulations, different benefits for the staff, and even having different insurance schemes for the beneficiaries. Although these issues were mentioned by the respondents along with their importance, it will be difficult to present the results related to them in details to keep focusing on general policy level issues and the core of the study. However, section (6.6) will present the main results/consequences for the absence of a national health strategy, which is partially cause by having a fragmented sector.

Having multi healthcare providers is seen to be associated with another highlighted challenge (the lack of coordination) with the health policy by the respondents. Figure (6-11) illustrates the relationship.

Figure 6-11 : Scattered sector relation to the lack of coordination

6.4.3.4 The Lack of Coordination

The lack of coordination was highly stressed by the respondents; the weak level of coordination between public sector providers and between public healthcare providers and institutions related to the health sector was criticized. The lack of coordination among health sector entities was seen to be associated with multi healthcare providers.

6.4.3.4.1 The lack of coordination among healthcare providers and health related entities

Although the respondents were focusing on the lack of coordination among public sector entities, they indicated the need for coordination among all health providers between private sector, NGO's and UNRWA.

As a result of having Multi healthcare providers within the public sector; each entity has its laws, regulations, strategies, and plans. Consequently; it makes the coordination among these different entities difficult, which will eventually affect the effort to formulate a national health policy.

The lack of coordination was described by the respondents as follows:

> 'I think there is a lack of networking between public health providers; they work vertical rather than horizontal', (P, 17)

> 'There is a lack of coordination between healthcare providers and NGO's, each entity doesn't accept others to interfere in its work, they are like isolated bubbles… they prefer individual decisions rather than collective decisions' (P, 3)
>
> 'Sometimes they (other providers) perceive the NGO's as competitors, but we should be completing not competing each other's' (P, 3)

> 'Policy coordination among sectors is not well established in Jordan. Moreover, there is a lack of coordination between health sectors and other sectors', (P, 41)

The respondents mentioned some examples to support their views. One example was mentioned by more than once by different participants to indicate the weak level of cooperation related to the decision to initiate a new hospital:

> 'If the RMS, for example, decided to build a hospital, or even expand the services in one of its current hospitals; there will be no criteria for that and there will be no coordination with others. In the United States, they have something called "certificate of needs", but we don't …' (P, 22)

However, the respondents indicated that there are exceptions for the lack of coordination, mainly things related to the vaccination campaigns:

> 'Despite the weak coordination among healthcare providers, it is fair to say that there is a proper coordination on the national level during the vaccines campaigns, and I think also there is a sort of national cooperation in reproductive health projects … perhaps because they are usually funded projects' (P, 3)

Although coordination on the policy and the strategic levels is perceived to be weak, there is a coordination and cooperation on the micro level, for example, it occurs for patient referrals for critical cases, as mentioned by one respondent:

> 'there is a certain level of cooperation in term of mutual agreement for treatment and other services, but do you know that MoH agreement with RMS is different from MoH agreement with university hospitals' (P, 38)

6.4.3.4.2 The lack of coordination between the health sector and other sectors and its institutions

The lack of coordination was not only criticized among healthcare providers, but it was also criticized among health sector and other ministries and institutions related to health issues, in particular with the higher-education sector; mainly the issue of weak linkages between related medical faculties and the actual need of human resources in Jordan's health sector:

> 'There is a weak planning for health sector human resources due to the lack of coordination and the absence of a focal point, for example, now we

have around 9000 students studying in the pharmacy colleges in public and private Jordanian universities, however, in best cases around 30% of them will get a job. Notice that Jordan is one of the highest countries in term of pharmacies percentage to population…. Unfortunately, no one is taking the lead to manage the human resources requirements for the health sector' (P, 12)

'We have a problem that will emerge in the next few years, and there is no action yet from the HHC or MoH; we are expecting more than 7-8 thousands physician to graduate from medical schools either in Jordan and outside Jordan, which means that we will have high unemployment rate among physicians … its really dangerous to have unemployed qualified personnel' (P, 4)

6.4.3.5 Laws and regulations

The respondents raised the issue of old laws and regulations and sometimes contradiction and overlapping between laws and regulations in various entities.

6.4.3.5.1 Not up-to-date laws and regulations

Some respondents pointed that some laws and regulations are not up-to-date, they need to be re-examined and modernized. It was described as follow:

'The laws and regulations that organize the health sector are not up-to-date they should be modernized, including medical related associations laws and regulations', (P, 8)

'I think we need modernize legislations and we need the will to implement them', (P, 22)

'One of the health sector problems is not having up-to-date legislations; it is important to know when to know how to balance between flexible, responsive, effective and at the same time consistent legislations, (P, 7)

6.4.3.5.2 Overlapping between laws and regulations

The respondents pointed that one of the key issues is the duplication of roles and authorities resulted from different laws and regulations.

'We have diverse laws and regulations for MoH, medical associations, the medical council, and other councils and institutions … we should work on reviewing the various laws and regulations that govern the health sector; each institution has its own regulations and sometimes they contradict with other regulations of other councils or entities', (P, 5)

'We need to review the legislations to eliminate the overlapping among them, which leads sometimes to duplicate authorities between different entities', (P, 22)

The influence of laws and regulations on the national health strategy

Having various laws and regulations, which are not be up-to-date and overlapped sometimes, hinder the efforts of formulating a national health policy, because entities' policies and strategies are based to some extents on those laws.

One respondent described it:

> 'It goes without saying that if you have different laws and regulations, you will end up having different policies', (P, 45)

> 'The law of any organization, including the health sector govern its policies and strategies, you can say that the law is a policy by itself, but since the various organizations have different policies this means that they have different strategies …', (P, 45)

Moreover, there is an overlap between MoH and HHC role in policymaking; MoH operates based on the Public Health law that entitles them with all health affairs in the Kingdom, and the HHC law entitles the council to set the policy for the health sector. This issue was raised by some respondents, for example:

> 'I'm not quite sure who is responsible for policymaking within the health sector, we have MoH and HHC. MoH has its strategy, while the HHC are working currently on the national health strategy. Their relationship is not clear for me, who has the authority over the other, who is really taking the lead of the policymaking?' (P, 18)

6.4.3.6 Financial limitations

The respondents pointed to the financial limitations that face the health sector in general and its influence accordingly on the national policy and strategies. The lack of financial resources and the inefficiency are seen to be the most challenges.

6.4.3.6.1 Lack of financial resources

The respondents pointed to the lack of needed financial resources for the healthcare services, and also to the imbalance between what we have and what the public sector offers:

> 'I think we have a problem in health sector financing; the government sometimes are not able to provide the needed resources to implement the strategy and its objectives', (P, 18)

> 'The multi healthcare providers have different budgets, and each item of spending is different, which makes it difficult sometimes to agree on shared objectives for the health sector', (P, 33)

> 'the difficult equation in the health sector is that the demands are much more than the actual needs, and the result is that we spend resources more than what we have … we should maximize the benefits from the limited resources that we have, and we should keep in mind that we should offer the basic needs, not responding to the various demands only, in health insurance scheme we should give the patient what he needs, not what he asked for' (P, 24)

6.4.3.6.2 Inefficiency

Some respondents raised some issues related to the inefficiency of managing the limited resources that Jordan has. Some respondents indicated that:

> 'Inefficiency is one of the policy challenges, our health system cost a lot; we could have better outcomes with the same amounts if we have efficient and effective use of the resources …we have inefficiency in services delivery and in managing our resources …', (P, 34)

> 'In the health sector, the budget excessively focuses on curative, rather than preventive aspects, if you look to MoH strategy you will notice that it focuses mainly on curative dimension such as communicable disease, but the curative dimension is weak, and the attention to mental health is weak as well, which does not reflect 'Health' concepts according to WHO … I think being curative oriented will always increase the cost of healthcare services', (P, 32)

Another feature of inefficiency is providing subsidize services without considering its cost and its implications, or even without thinking of efficient alternatives; an example is mentioned by more than one respondent:

> 'the government has to think about the implications of its decisions, for example, the government decided that 'dialysis' is free of charge for any Jordanian citizen regardless of his status, but it has a huge cost on the budget, as most of the treatment occurs in private hospitals. Certainly, I'm not saying the government shouldn't do that, but they should think of a

better way of doing it so it will be with less cost and more efficiency … the same applies for Thalassemia and cancer', (P, 7)

6.4.3.6.3 Inability to estimate the exact cost of core services

Another issue related to the financial theme is the inability to estimate the exact cost of services, which was seen to affect the planning on the micro and macro levels. One respondent describes it as follow:

'Health sector financing is one of the challenges to formulate the national strategy; we don't know the exact cost of health services, we know the actual incurred cost and the general figures such as the cost of salaries ..., but we don't know the estimated budget for core services, for example, we don't have an estimated budget for a given hospital, also we don't know the cost of operations … it is difficult to estimate the cost of core services in the hospital … I think weak automation of health services is part of the problem…. so how can we plan properly if we don't know the exact cost …', (P, 47)

6.4.3.7 Evidence Based Policy

A number of issues have been revealed by the respondents concerning the use of evidence in policymaking; they indicated mainly the lack of use of evidence in policymaking and the dependency on international studies rather than local ones.

6.4.3.7.1 Lack of Evidence Based Policy

The lack of the use of evidence is seen as a challenge to policymaking and planning by the respondents, it is mainly caused by to not up to date and scattered data, and by not relying on data and information as a ground for decisions.

It was described by the respondents as follow:

> '… but the formulation of the policy is not based on evidences … I think one of the national policy success factors is to be based on evidences …', (P, 41)

> 'during one of HHC meetings, I've asked them to provide us with valid and accurate information about medical tourism in Jordan… in general I think when the information is absent or not updated we cannot have proper planning, our planning should be based on valid and accurate indicators ... you know that some health indicators and some information are varied between MoH and department of statistics…', (P, 31)
>
> 'There is no institution that has all the needed information and data that will enable us to formulate the national policy in proper manner, but it is quite fair to say that we have information in MoH, RMS and private sector, but this information is (scattered) not unified. for example, do you know that we don't have accurate numbers about any critical issue, like the number of insured citizens and/or the number of people who have duplication of health insurance … I think the lack of accurate data and information hinder reform and development efforts …', (P, 35)

> ‘In short we don’t have evidence based policy; we should have an independent institution apart from the influence of public and private sector that has all the relevant information about the health sector and its key indicators’, (P, 12)

> ‘Although we have some studies, our decisions are not based on quantitative evidence such as hospital standards …’, (P, 36)

6.4.3.7.2 Lack of specialised local research and studies

Some respondents pointed to the need of conducting local studies that reflect Jordan’s actual status instead of depending merely on international studies and reports to be used in planning and policymaking.

It was described by the respondents as follow:

> ‘during one of HHC meetings, they presented some suggestions, most of which were based on international studies and reports such as International Monetary Fund study about Jordan years ago, the problem is that most of these studies are not updated, and I think these studies are not considering the health sector status in a holistic view, in addition some of these studies contain some sophisticated terminologies and are not well explained … I think we don’t have real and valid studies that reflect Jordan’s status …’, (P, 31)

> ‘There is a lack of local research and studies about Jordan. Most of the studies came from international organizations, such as smoking rates which come from WHO not from local institutions, the problem with that is the international organization reports and studies reflect their interest in the first place, which means that some areas are not well investigated, so I think we should devote our efforts to investigate our reality and conduct local studies in order to be used as an input for planning …’, (P, 15)

6.4.3.8 Lack of health policy experts involvement

The respondents criticized the lack of health policy experts' involvement in the preparation of the national strategy; some of them indicated that Jordan has high-profile experts, but they are not involved in the process and in the preparation of the current national strategy and other sub-sector strategies, either as full-time or part-time contractors. Also some participants indicated that some qualified staff already work in the MoH but they are misplaced and they didn’t have the opportunity yet, further, even if they participate sometimes; their contributions might not be considered. On the other hand, it was claimed that the HHC is facing financial limitations in attracting qualified experts. The respondents’ critique was directed to MoH and HHC. The respondents describe it:

> ‘One of the policy challenges is the lack of experts and experienced people involvement; I think both MoH and HHC, are not keen to ask for experts assistance, the consultants or even the think tanks … not every senior in the government has the ability and the knowledge to set the national strategies, for that reason there are experts in the field who are specialized in setting policies or strategies drafts based on analyzing various data, so

the draft submitted to the decision makers is supported by analysis and evidence…', (P, 1)

'In Jordan, we have highly competent and qualified people, who are willing to work sincerely for the benefit of the country, but the problem is they are not being assigned to participate in the policymaking process. Further, even if they participate; their contributions might be overlooked', (P, 11)

'I was a member in a number of committees; one of them is a committee formed on the national level 10 years ago to discuss the medical tourism strategy for Jordan. The main partners were MoH, MoPIC, private hospital association and the physician association, I was representing (--). We had a lot of discussions and we set a number of recommendations in order to set the general outline of the strategy… I remembered in that meeting I told them I have a dream (I excerpt Luther King famous quote) and said *''I have a dream that our recommendations will be in the right place that should be … and to reach to the top decision makers and become actual decisions*"…', (P, 11)

6.4.3.9 Inappropriate senior officials in positions

The respondents indicated that some senior positions in the government including the Minister of MoH position and HHC Secretary General are not always selected according to technical abilities and qualifications merely due to other considerations that are counted, such as selecting the ministers based on geographic or tribal quotas, which consequently led to have

inappropriate candidate for the positions and also prevent more qualified persons from undertaking these positions. Also favouritism (Wasta)[14] was criticized for other senior positions (lower positions under the minister and the head of other national institutions). Some respondents describe it as follows:

> 'Some senior positions are occupied by improper persons. Jordan has quite qualified and skilful persons compared with other countries, but unfortunately, they are not in the right positions as these positions are taken by others … which led to brain-drain for most of those qualified persons …', (P, 15)

> 'The ministers sometimes are being selected based on quota, which affect the selection criteria, accordingly we may have unqualified seniors in critical positions that need advanced skills in decision making', (P, 15)

> 'Having the improper persons in the right position is one of the challenges to policymaking and to the coordination among various entities. Leaders and seniors should be selected on certain criteria so they will be able to handle their responsibilities in professional manner's, (P, 43)

> 'I think there is a degree of inequity in selecting some directors in MoH; I think some of it based on favouritism (wasta), which is reflected on their performance', (P, 40)

[14] Wasta is an Arabic word that has more than one synonym word such as: favouritism, nepotism, mediation

6.4.3.10 Political and social pressure

Healthcare services are seen by some participants as being under social and political pressure. Usually, the tribal figures or the members of House of Representatives exercise their pressure and influence over MoH to demand some services, which may not be reasonable from the ministry view, such as build a new hospital or ask for comprehensive healthcare centre instead of a primary one. These demands, affects the planning for the health sector and increase the cost considerably.

It was described by some respondents as follows:

> 'The government and MoH are facing political and social pressure, for example, some members of House of Representatives request to establish health centres or hospitals, unfortunately, the government sometimes respond to their demands although there are no actual studies to support these demands', (P, 1)

> 'One of the policy challenges is that the distribution of health services is not even based on the international and logical criteria, this happen for some reasons, more critically the social and political pressure to claim more health services, for example residents in a certain area demand comprehensive healthcare centre, while if we implement the standards they should have only primary healthcare centre, but sometimes the government approves their demands, which incur more cost on the government', (P, 7)

> ‘We have a waste of resources in the health sector due to establishing more hospitals and transform the primary healthcare centres to comprehensive ones; this happened due to the political pressure practiced on MoH and the government by tribal leaders, members of House of Representatives and members of House of Senates …’, (P, 10)

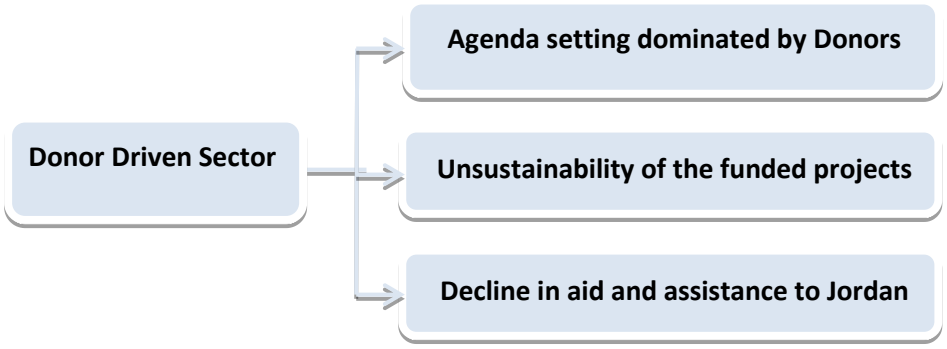
6.4.4 Donor Driven sector

Jordan become an independent state officially in 1946, after a short period it faced the 1948 tragedy, since then the international agencies and donors started their aid programs to Jordan to assist the refugees. Further, the UN agencies started to help Jordan as a developed country in different fields including the health sector.

The respondents were asked about their perspectives regarding the donors and international agencies role in the health sector and its potential impact on the policies and strategies.

The respondents were asked in two separate questions about their perspectives regarding the role of International organizations in the health sector i.e (WHO, UN…), and the role of aid agencies in the health sector i.e (USAID, JICA…). The respondents were aware of the differences between aid and international agencies; nevertheless, most of them thought that their concerns such as agenda settings are applied to both in general, thus I will use ‘donors’ to represent both of them. A diagrammatical representation of the Category and related themes that arose during analysis is presented in Figure (6-12).

Figure 6-12: Category: Donor Driven Sector



Most of the respondents expressed their gratitude to the aid and international agencies for their contributions in supporting the health sector and enhancing its services, and they believe that these contributions assisted Jordan to have a good health system. Some of the respondents' remarks:

> 'We don't deny that the aid and international organizations provide assistant to us in some fields including health sector…', (P, 6)

> 'Personally, I do value the international agencies contributions such as WHO, when I was (--) I knew about their assistance to communicable diseases and vaccinations campaigns. Also USAID contributed to the renovation of some health centres …', (P, 30)

However, the respondents raised some issues and concerns regarding being dependent on the foreign aids and its potential influence on national strategies and priority settings. Further, they exposed a number of issues related to dealing with donors in some detailed aspects. This section will present the most frequent issues raised by the respondents that are relevant to the study scope. The following issues were highlighted by the participants.

6.4.4.1 Agenda setting is dominated by Donors

The most concerning issue related to the donors is agenda setting and prioritizing needs. The majority of respondents thought that the donors are imposing their agenda on Jordan.

> 'Donors have their own agenda. They are supposed to fit our needs and priorities, but what actually happens is that; they come with their own agenda and they implement it …There is a gap between their expected role and their actual one …', (P, 29)
>
> 'Most donors have their own agendas; I don't mean by that the negative sense, I mean they have pre-identified specific programs regardless of our needs …', (P, 1)

> 'Donors decided what they want to implement, not what we actually need. Personally, I faced a problem when one (organization) asked me to sign the project without even reading the protocol of the project … unfortunately, this happens sometimes and it is both sides responsibility …', (P, 33)

> 'Sometimes we depend on donor's agencies funding, and they came with their own mandate. Now the question is, to what extent that mandate really contributes to what we need according to our national agenda. Here is the question: what we need? Do this contributes in solving the gap?. And we become independent and if we don't have funds, we don't initiate activities …thus, we are responding to the needs of others and not to what we see fit to be done, when, how, and where ….', (P, 41)

6.4.4.1.1 Donors dominated agenda settings due to our deficiency

Although donors exert their influence on the agenda; the respondents blamed the Jordanian side for not well defending our priorities and for having a passive role when dealing with donors.

6.4.4.1.1.1 Lack of clear priorities identification on the national level

Some respondents indicated that there is a lack of clear priorities identification, mainly due to health sector fragmentation and for not having a well set national strategy for the health sector that could be used as a reference.

> 'The donors can impose their programs and priorities, simply because of our weakness and the lack of clear prioritizing we have … also because of the lack of data and evidence sometimes and unfortunately the weakness of our will … even worse, some people from our side are seeking for narrow institutional or even personal gains by complying with the donors … some donors have realized this and they took advantage of it, and some of them deal with us arrogantly because of this…', (P, 7)

> 'generally speaking, If we are fully aware of our needs we will force them to fulfil our needs, I mean we shouldn't wait for them to choose to give us or even to impose on us, we should take the lead to present our needs … otherwise, if we accept things not within our top priorities it will consume our time and effort and will distract us from our main focus… also we shouldn't be attracted by incentives that some donor may provide to accept that programs …', (P, 17)

Further, some respondents pointed that quite often when the donors come with their funded projects and initiatives; the projects become a priority for us:

> 'The main problem is that we work on the priorities to see whether they will be funded, and in case of no funding, they will be freeze. Even sometimes considering an issue to be priority is associated with having fund for it …', (P, 1)

> 'As for WHO; for example, they have an international and regional mandate, but at this stage do we have to go through this (what they offer to us), for example the maternal mortality, while it has good indicators in Jordan. But it is one of the regional initiatives. Sometimes we apply for that fund although we don't need it. So WHO said … this is our programs, if you have these programs we will fund you, so we create the programs because we don't want the money to be lost. Se we are drifting off from what we need to work on as priority …', (P, 41)

Even when we are able to set our priorities; it is not well considered by donors in most times.

> 'We want this assistance to be channelled to our priorities … we inform them about what we need, but at the end they did what they planned for …', (P, 38)

> ‘one of our weakness is that we don’t update our priorities and even when we know our priorities, we cannot defend them properly when dealing with donors … for that reason we are part of the problem …’, (P, 43)

Moreover, some respondents linked the lack of clear priority settings with the absence of a clear national strategy for the health sector.

> ‘The national strategy is important as a reference document, so the donors can be aware of our strategic priorities, which will facilitate directing the funds toward the needed areas, instead of being be directed by them, which happened quite often to us in Jordan …’, (P, 44)

> ‘I think there is a chaos when dealing with donors because there is no clear national strategy and donors deal with different entities … from my observation I think we are not utilizing the fund properly, sometimes it may be wasted for no real impact and maybe spent unjustly …’, (P, 23)
>
> ‘I think the mechanism of donors’ projects in Jordan has to be audited and to be subject to supervisory authority check …’, (P, 23)

> ‘We should work collaboratively, all national agencies and entities have to organize with MoH to strengthen our relations with donors …’, (P, 28)
>
> ‘If we have a clear strategy, we will be able to maximize the benefits from the foreign aids …’, (P, 30)

6.4.4.1.1.2 Having passive role when dealing with donors

Although donors exert their influence on the agenda; the respondents criticized the national entities including MoH for not having a lead in directing the projects and initiatives to our real needs. They describe it as follows:

> 'I think the role of donors is largely determined by the national entity they are coordinating with …', (P, 6)

> 'one of our defects when we deal with WHO, USAID and other donors is the fact that we have a passive role … the donors come with their agenda, and the public entities agreed without proper discussion … the donors set the country plan for a year or two or even more and we simply agree … while those projects and initiatives are supposed to be based on our actual national needs …', (P, 7)

> 'We need to know our needs, and we need to direct the fund to match our needs and their needs ... as much as possible. it has to be a win-win situation, we should not continue to be passive receiver to the foreign aids, we have to try our best to direct the fund to meet the needs of both sides …', (P, 7)

6.4.4.1.2 Donors focused on specific programs and initiatives

Some respondents pointed that some donor agencies are focusing on specific programs and initiatives, the most repetitive example was USAID emphasis on reproductive health programs for long years. The respondents believe that reproductive health is important, but it

consumes an extensive amount of funding compared with other issues, some respondents stated that USAID recently added other components to their assistant scheme in Jordan, but it is all related to RPH.

> 'Most of the international agencies are focusing on family planning issues. USAID is heavily focusing on family planning, however, they added other issues such as health system development, but it is all geared towards family planning …', (P, 7)

> '… I think some donors assign big portion of their funds to reproductive health programs and focus heavily on it …', (P, 10)

> '… also those donors concentrate most of their programs on reproductive health, although it is important, but it is not the most important issue that we are facing, we have other important issues such as drug use, shortage in some medical staff, training programs and communicable disease … we should ask the donors to consider our needs more than other issues … However, those agencies has their own agendas, thus, some people from our side though are taking the benefit of things that we don't highly need, it is better than nothing …', (P, 20)

> '… Some donors largely focus on family planning and reproductive health and they spend generously on these programs which may raise the citizen suspicious …', (P, 33)

6.4.4.2 Unsustainability of the funded projects and initiatives

Some respondents also pointed to the unsustainability issue as most of the funded projects and initiatives are designed for specific duration, and after that either the program will end, or will continue but without being funded anymore, and it becomes one of MoH (or receiving entity) functions and managed by them, which add more burden on health sector entities as seen by some respondents as some of them are not among our top priorities.

> 'Sustainability is an important issue; especially for these projects and programs that are not requested by us in most times …', (P, 41)

> 'USAID is different … they qualify Jordanian staff and train them with best practices approach, with international experiences. Nevertheless, we have some problems, the first one is: There is no sustainability; we (---) is the only exemption and we are the only institution that left behind USAID project, So aid projects should consider of sustainability. Another problem: these donors come with their agenda; well, its fine, but at least let's have 60% for the aid agenda and 40% for Jordan needs … but as I said it is a coin of two faces', (P, 12)

> 'We need to think about the substantiality of the projects and initiatives. For example, there was MeTA[15] project which was one of the few initiatives that involved the stakeholders in addition to the public sector entitles, private sector and international agencies… when the project ends we (---)

[15]Medicines Transparency Alliance (MeTA) is an initiative by the UK Department for International Development (DFID), in partnership with World Health Organization (WHO), the World Bank and the Health Action International (HAI). (2008-2010)

thought to continue working on some themes of the initiative, but we don't have the needed fund for that, otherwise, the project or the initiative good impact will diminish…', (P, 46)

6.4.4.3 Decline in aid and assistance to Jordan

Some respondents raised the concern of aid and assistance decline nowadays although Jordan is still under huge pressure due to the Syrian crisis.

'Although Jordan now is suffering due to the implications of Syrian refugees including the health sector, there is a decline in international agencies funding …', (P, 44)

'We are exposed to unexpected emergencies, and it affects our potential projects with donors, most of the programs that were directed to Jordan has stopped, and for the few approved ones; we are obliged to include some Syrian refugees …', (P, 28)

'The problem is if anything happens in Iraq or any neighbour country in the region, the programs stops in Jordan and this affect our needs accordingly...', (P, 12)

Nevertheless, some respondents indicated that we shouldn't rely on the donors and funding agencies, and we should consider their role as complementary not essential.

> ‘We appreciate what the donors and international agencies did in the past, but we should deal with them as having complementary role, not essential one …’, (P, 45)

> ‘We should consider the donor’s role in our health system as assistant not essential … and we should place that funded programs in our plan not vice-versa …’, (P, 26)

The decline in aid assistance is not limited to providing funds only, but also to provide technical assistance. Some participants indicated the decline of WHO support in funded projects and more importantly a decline in their role as senior policy advisor to the country, one respondent described it as follows:

> ‘WHO supposed to act as policy advising for the government, but this role is not active anymore due to a number of reasons, related to both WHO and Jordan. WHO representative is supposed to be the advisor for MoH minster, I know it may be difficult due to the quick turnover of ministers, but WHO-Jordan office should examine our situation properly and understand our status and provide support to us, and not to relay on one ready formula for all’, (P, 29)

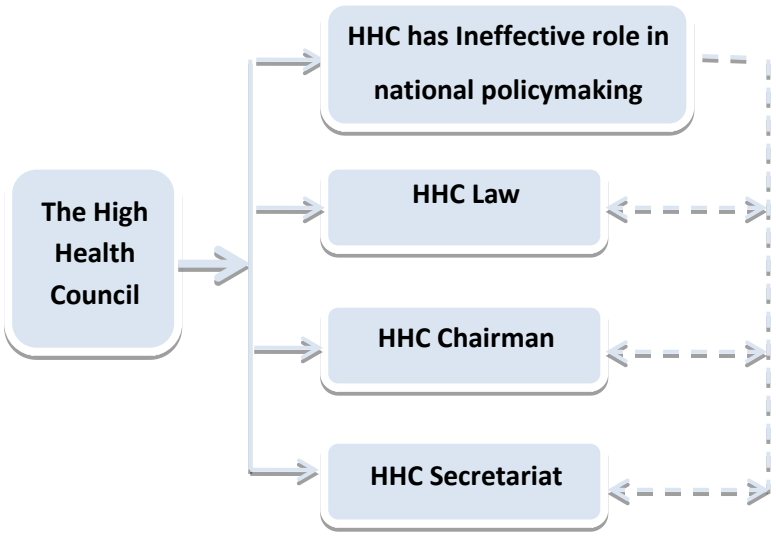
> ‘WHO should consider ministries as patients, although there is a standard procedure, but at the end each patient case is different from others … otherwise, you will not be sensitive to the specificity of the country. They have to offer their advice to the MoH seniors, it is their essential role, it is not an option …’, (P, 29)

6.4.5 The High Health Council

The main idea behind establishing the High Health council is to combine the health sector providers and the different entities related to it under one umbrella in order to formulate the national policy for the health sector and to put forward the strategy to achieve it. The council in its early stages was seen to have mainly an advisory role and it was called "High Health Advisory Council" from 1965-1986. But Since 1986 it was called the "High Health Council", and it was reformed by Law No. 9 for 1999, and then the General Secretariat was established in 2002.

The respondents were asked about their views regarding the council role in health policymaking, they were asked about the council membership and also they were asked about the recent restructuring of HHC chairman (now linked to MoH rather than the PM). The council is facing several challenges to undertake its essential objectives and responsibilities, along with the challenges that have been addressed earlier. A diagrammatical representation of the Category and related themes that arose during analysis is presented in Figure (6-13).

Figure 6-13: The High Health Council main challenges



6.4.5.1 HHC has ineffective role in national policymaking

Most of the respondents were sceptical about the HHC role; they thought that the council has an ineffective role in the national policymaking and formulating the national health strategy. Even after the council was restructured in 2002, the council role was perceived as weak and ineffective. There are a number of challenges that face HHC and weaken its role in national policymaking that could be referred to its current law, HHC Chairman and its General Secretariat. Hence that these challenges were raised by the respondents sometimes as being both causes and consequences of council ineffective role, thus; HHC law, chairman and its General Secretariat will be presented separately. Figure (6-13) represents the relationship among the core themes.

The respondents view the council to be ineffective, and not being able to perform the duties and responsibilities it was assigned to do. They describe it as follows:

> 'The council role was not active; it should formulate the national strategies and combine the different parties: MoH, RMS, Medical council, the university hospitals … and the private sector …', (P, 4)
>
> 'the HHC should have a role coordinating with Minister of higher education for medical education issues … but this is not happening actually …', (P, 4)

> 'The HHC is supposed to undertake the responsibility of setting the national strategies, but the council was inactive in the past. Years ago I was representing (--) in the council and during that period the council has no meetings at all. However, now there is an attempt to activate the council

role and they are working on the national strategy 2014-2016[16], and I hope the strategy will have action plans ...', (P, 26)

'The structure (ups and down) between PM and MoH is a sign of its insignificance …', (P, 29)

6.4.5.1.1 MoH overshadowing the HHC role

Some respondents pointed out that the MoH role in the health sector is one of the causes for the HHC to be ineffective and inactive. Interestingly, some respondents thought that there is no need for the council to set the national strategies as long as MoH is leading the health sector and is more empowered by public health law.

'The absence of HHC role is one of health policy challenges, recently it was reactivated. Usually MoH is the one who sets the policies and strategies for the health sector, although it is part of the system … however, things have changed due to the private sector expansion, now MoH is not the only player and there is a need to give more attention to the private sector role, NGO's and charities who provide health services', (P, 7)

'The MoH and its Minister are the primer responsible for managing the healthcare and health issues all over Jordan including setting the needed policies and regulations … so by law the MoH has the power and the control, but they do not practice their full authority, particularly in

[16] when HHC reactivated in September 2013 they were asked to formulate the national policy for 2014-2016, but they spent a long time in preparation, and in Nov 2014 they met to discuss the strategy, which was shifted to be from (2015-2019)

supervising and monitoring other health entitles, but still I think that MoH is the leader for the health sector not HHC', (P, 36)

'... I think MoH – the main health provider in the kingdom – didn't have the desire to coordinate with the HHC, not only MoH, but the key health entities didn't have the desire to coordinate with council … accordingly, the HHC have ineffective role… I think most of them they don't even believe in the council role and its feasibility of existence …', (P, 44)

'So far, the HHC didn't succeed to achieve its assigned tasks and duties, and didn't succeed to be the umbrella for the health sector, the health sector is still fragmented and has different references, each organization sees itself to have the full authority and independence from others … but on the other hand MoH is taking over the public health issues and is responsible for the national programs such as national immunization programs, they are responsible for the primary healthcare and also they offer secondary healthcare services … I think MoH should be the incubator, and the main one to be in charge with heath sector overall issues including setting the national health strategies …', (P, 31)

'I think MoH should be the umbrella for policymaking; the ministry already is the main health provider, and empowered by the public health law to do this, although they don't use that power sometimes …', (P, 3)

6.4.5.2 HHC Law

The current HHC law was seen to be one of the major obstacles that hindering the council role in national policymaking. Although the law listed HHC main duties and responsibilities, at the same time the council has no authority over health sector and other entities in order to perform these duties and responsibilities, thus, this was reflected on the council role to being viewed as advisory only.

6.4.5.2.1 Lack of authority

The respondents were aware that one of the council challenges is that its law lists the responsibilities without granting the council the needed authority for applying them. The respondents describe it as follows:

> 'Until now we cannot combine the different health providers because the council has no authority to do so', (P, 17)

> 'The HHC should be the umbrella for all health providers and related entities, but actually, the council is inactive because it has no authority … the council recently tried to change its law to have more authority, but nothing changed yet', (P, 38)

> 'The law of any organization, including the health sector govern its policies and strategies, you can say that the law is a policy by itself, as the various organizations have different policies it means different strategies…. and it is a major challenge to have a unified health policy. If the HHC was empowered and mandated by law, the council will be entitled to coordinate

between health sector entities and then monitor and evaluate their commitment to the national policy, things will be much better', (P, 45)

6.4.5.2.2 HHC has advisory role only

Some respondents believed that the council has merely an advisory role; the Council's recommendations and even strategies are not binding to any of health sector entities. Perceiving the council's role as being advisory merely is associated with the council's lack of authority. The respondent describes HHC role by saying:

> 'I think the council's role is advisory only; they don't have the power or the authority to make decisions and set shared goals for the health sector', (P. 13)

> 'The council is weak, simply because it has no authority; it has been considered as an advisory body, but not binding at all … even now after the council reactivated and set the national strategy, will it be binding to health sector entities?, or at least for public sector entities? … The council is advisory more than anything; it can't hold accountable any entity including public sector entities…', (P. 45)

> 'Since it was established, the council's role was powerless and advisory only, and it will remain so … I never see it has an effective role, and probably will not have', (P. 19)

'In the current status, the council will not be able to perform its tasks, simply it has no authority and its role is advisory only…', (P. 22)

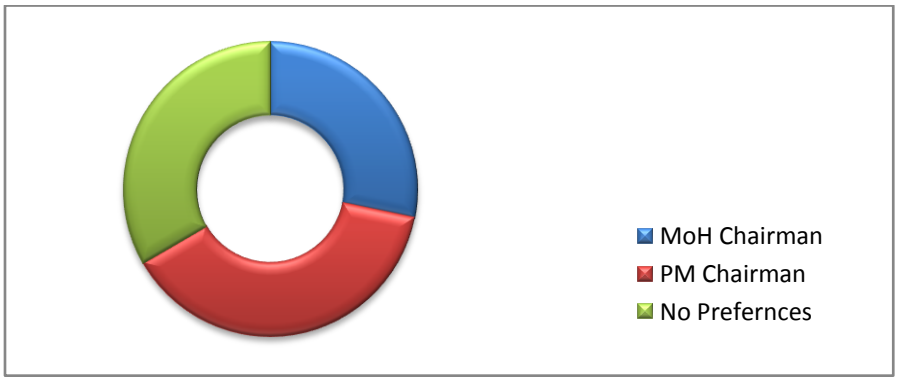
6.4.5.3 HHC Chairman and Membership

The council chairman was perceived as one of the issues that affect the council role in formulating the national policy for the health sector. However, the council's membership has less concern according to the participants' views.

6.4.5.3.1 HHC Chairman

The council was chaired by the Prime Minister from 2002 until 2014, now it is chaired by the Minister of Health. The respondents were having different opinions about the recent change to the HHC chairmanship; however their opinion could be grouped into three main themes:

Figure 6-14 : Respondents preference to the HHC Chairman



6.4.5.3.1.1 The Council should be chaired by the Prime Minister

More than half of the respondents who thought whether HHC should be chaired by the PM or MoH Minister preferred to be chaired by the PM for several reasons:

The respondents believed that if the council will be chaired by MoH Minister, it will weaken the council's role even more than before. Some respondents expressed that clearly by saying:

> 'Now the council will be only a directorate of MoH overall structure…', (P 45)
>
> '… this change (MoH become the HHC chairman) will reflect negatively on the HHC role in policymaking…', (P 38)

Most of them were conscious about the hierarchy of authority now and its effect on the enforceability of the council decisions. Some respondents pointed out that although the HHC law didn't contain articles that entitle the council to have the proper authority; the Council's authority was derived from the fact that it was chaired by the PM who has the authority among all ministries and institutions:

> 'The power of the HHC is derived from the PM as chairman of the Council; he is the highest authority in the government (after the king) and he could support the council decisions …' (P 47)

Some of the respondents were aware of the lack of meeting constrains due to the PM's huge responsibilities, but they said it could be easily solved as the Minister of Health is the vice-

chairman (before the amendment of 2014) and the PM could delegate some of his responsibilities to the MoH Minister.

> 'If the PM remains the chairman of the council, even if he was not able to attend all meetings, it's much better than being chaired by the MoH Minister … in this case the MoH Minister could chair the meetings (as vice chairman) and report to the PM, so any needed decisions will come along with the PM signature, so we will be able to have the benefits from both sides (chaired by PM and managed by MoH Minister)', (P 44)

This idea was raised by others, for example:

> 'Personally, I'm against the fact that the council will be chaired by MoH Minister; health sector is one of the vital sectors that should be directly linked with the PM; however, he could delegate some of his responsibilities related to HHC, and by doing so, the decisions will eventually be signed by the PM' (P 37)

Further, if the council meeting frequency will be solved by being chaired by MoH Minister; another major challenge will arise, namely the lack of authority:

> 'Although the council could meet more frequently if it is chaired by MoH Minister, but the authority problem is not solved yet, which's important …' (P 11)

6.4.5.3.1.2 The Council should be chaired by MoH Minister

On the other hand, some respondents thought that the council should be chaired by MoH Minister; yet, they have different reasons for that. Mainly they thought it will facilitate the communication between all service providers and stakeholders of the health sector as the Minister may have more flexible schedule compared to the PM, and the minister will have more direct relation with the PM.

> '… I was a member in the council when it was chaired by the PM years ago, and he rarely attended the meetings, and that affected the council's ability to make decisions on time, if it is chaired by MoH Minister the council might meet more', (P. 36)

> 'If the council is chaired by MoH Minister, it will facilitate the communication with health sector entities …', (P24)

> 'I think linking the HHC with MoH Minister has some advantages such as facilitating the council's meetings. Also, the MoH Minister has a direct relationship with the PM according to the government structure so that the minister will be more close to the highest authority… I think the advantages of linking the council with MoH Minister excesses its drawback', (P. 6)

Other respondents found this to be a good decision as it will resolve the prickly relationship between the HHC and MoH.

> 'I think the council was linked with MoH in reality even before it was formally changed, all of HHC Secretary Generals and staff are previous MoH

staff, even mostly they still keep the way MoH used to follow in doing things … ', (P. 29)

'you know that we have government turnover, but can you imagine that some PM's don't even know that the HHC is linked to them, … I think that some MoH Ministers purposively neglect the council and marginalize its role …', (P. 43)

6.4.5.3.1.3 No preference for PM or MoH minster to chair the council

Some participants didn't point out to their preference for who is more convenient to chair the HHC for two main reasons:

Some of them were sceptical about the council's role in policymaking; they believed that the council is ineffective and there will be no major changes, especially if the HHC law remained unchanged.

'Even when the council was under the PM Chairmanship, the council was not able to undertake its duties and responsibilities, I wonder why this happens…' (P. 18)

'The council has a passive role, I did not feel it existed at all … the council has an ineffective role in reality', (P. 21)

Other respondents were reluctant to give an answer as the council was not active for a long time because the last meeting of the Council was held in 2008. And they said that they

cannot give a proper answer because they need to wait and see the council performance afterward.

> 'Honestly, I can't evaluate the council after all these years of discontinuity …', (P. 3)

> 'I think the return of the council on the national level is not clear, nor is it efficient … I can't be quite sure if it will be better after being chaired now the MoH Minister, (P. 32)

6.4.5.3.2 HHC Membership

The council's membership was not controversial compared with council chairmanship. The current membership was seen to be convenient as it includes the main providers and other related parties, but they recommended three main changes that could enhance the council's role. Thus, it could be said that HHC was not seen as a major challenge to policy formulation.

The respondents suggested the following members to join the HHC:

1. The medical associations

According to the HHC law, only physician association has a permanent membership, while the other related medical associations are represented once (for two years round) every four years. The majority of respondents supported the suggestion to include all medical related associations as permanent members:

> 'I think all medical related associations (Medicine, Nursing, Dental and Pharmaceutical) should be permanent members of the council' (P. 4)

2. The related academic medical faculties

Some respondents thought that including related medical faculties will be helpful as it's related to key issues within the health sector such as academic degrees, educational programs, and continuous training programs.

> 'I think related medical faculties could be represented periodically so that every two years we have one of them, let's say medicine faculty becomes a member for two years, then nursing faculty… and so on. or -if possible– it is preferable to have one representative from each faculty (Medicine, Nursing Dental) but each of them should be from different university', (P. 4)

Another participant said:

> 'I think when the council include all the related medical associations, it will be stronger. Further, it's preferable to add the related medical faculties as well', (P. 6)

3. Citizen's voice and civil society representation in the council

Some participants raised the importance of including representatives from the community and civil societies in the council. But, there are a number of issues associated with this note:

- There is no representative currently from civil societies and NGOs

> 'There are some NGO's or bodies that represent the patents and defend their interest; however, the HHC law didn't grant the civil sector the right to be legally represented in the council. We should work toward advocating the inclusion of civil sector and its societies in policymaking process ', (P. 27)

- Some thought that there is no willingness by the decision-makers and the HHC to include a representative from the civil societies

  'I think if civil societies and NGOs participated in the policymaking by being represented in the council, it will help HHC and MoH in achieving their goals, particularly in terms of awareness; however, we feel that there is no serious will to do that', (P 46)

- Although some interviewees support the representation of citizens in the council, they didn't know what is the convenient way to do that. However, some suggested that it could be done through the civil societies and NGO's which work closely with patients and other targeted groups. Again it was difficult to identify the suitable representative among different NGOs and societies.

  Further, a participant indicated that:

  'I think the civil societies in health sector need capacity building because they are not qualified to participate in policymaking properly, particularly the health issues which involve scientific aspects', (P 46)

Concerns about the size of the council:

Some thought that if we have many members it will hamper the council's role, meetings frequency, and decision-making ability. So, it's preferable to maintain the current members along with adding only the other related medical associations. And when there is a need for other contributions or feedback by institutions or entities, they can be invited to join that particular meeting.

'… I think the related medical association should be permanent members, but we should be aware of the number of council members and remember it's a decision-making committee…. And if we need any technical opinion or feedback from other public ministries/institutions or other stakeholders, they will be contacted and invited to join then on temporary basis…' (P 47)

6.4.5.4 HHC General Secretariat

Under this theme, three major issues were raised by the respondents: the inconsistency in the council formation, the general secretariat SG and staff inadequacy.

6.4.5.4.1 Inconsistency in the council formation

Some respondents indicated that since the council remained ineffective and inactive for several years, this was reflected on its formation, structure and on recruiting its Secretary General.

Some respondents describe it by saying:

'The lack of HHC consistency is one of the obstacles for the national policymaking … in case of holding the meetings, I think they tend to be protocol actions rather than executive meetings', (P. 8)

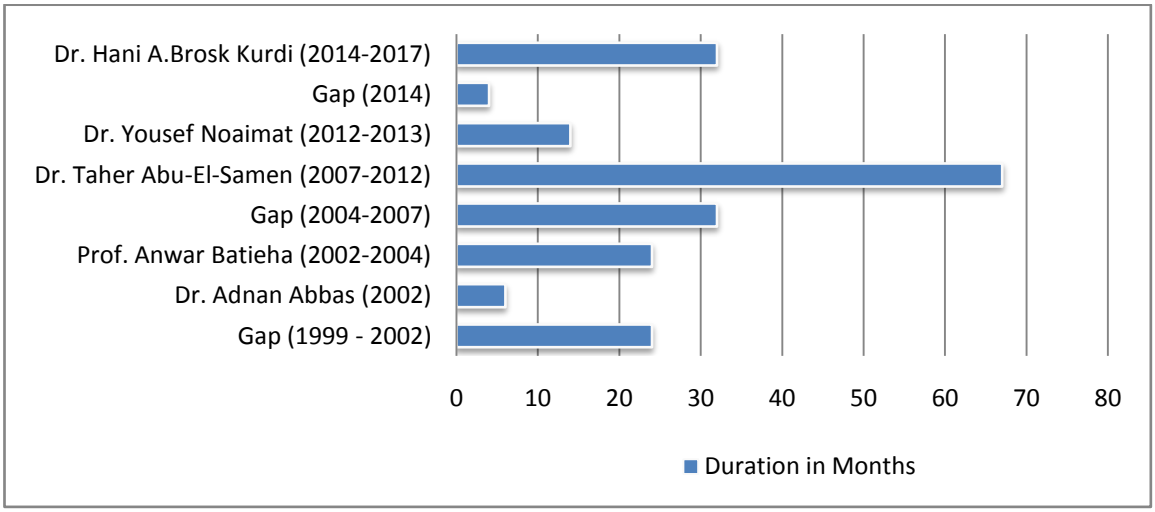
'Unfortunately, there is a quick change in MoH Ministers and even in HHC secretary general's positions …', (P. 1)

Another issue of inconsistency is related to the swap of HHC chairmanship between PM and MoH and the last change in 2014 (from PM to MoH) was not the first time since the initiation of the council. A respondent indicated that:

> 'The fluctuate structure (ups and down) between PM and MoH is a sign of its insignificance …', (P. 29)

Hence, the council was almost neglected for several years, and then in 1999 it was decided to be activated. Accordingly an amended law was issued in 1999. Nevertheless, the General Secretariat of the HHC was established in 2002.And since then, five Secretary Generals were commissioned, noting that there were periods when there's no SG was appointed, particularly between 2004 and 2007.

Figure 6-15 : The HHC Secretaries General since 2002- present



Prepared by the researcher, source: HHC report 2013, the HHC official website (www.hhc.gov.jo)

6.4.5.4.2 The Secretary General of the council's General Secretariat

Some respondent's criticized the SG's of the council general secretariat in general and some of them raised some comments regarding the current SG. Mainly, they though the SG's didn't have adequate policymaking and strategic planning skills, and most of the HHC SG's were previously one of MoH staff, thus, they think on micro and administrative level rather than national policy level.

Some respondents commented that:

> 'if we look to the policymaking kitchen, (I mean by that the HHC) I can say that the council itself is part of the problem as being inactive, and its leadership will not be able to set proper policies for the country, we will return to square zero. Under the current situation, if we manage to set a national strategy, I think it won't render results or have political impact …', (P. 7)

> 'The current SG was (12) years out of Jordan; I don't think he is aware of all health sector issues', (P. 41)

> 'Some positions in the government like the SG of the HHC turned to be a source of benefits for some seniors in the MoH to be promoted to higher rank (executive rank), and there is no actual performance such as setting the national policy or other related strategies …', (P. 10)

> 'The current SG is not well qualified to the position in my opinion; he is general practitioner not even specialist. The SG should have the proper

medical qualifications background in addition to advanced top management skills and competencies ...', (P. 10)

6.4.5.4.3 The staff of the council General Secretariat

As for the council staff, almost the same critique applies. The council staff doesn't have the needed experience, and the council is not equipped with the needed qualifications to be able to undertake the council roles and tasks. The respondents describe it by saying:

> 'I don't think that those in charge of managing the HHC are capable of doing the necessary steps to set the national strategy, I think they are not qualified enough…', (P. 19)

> 'The council general secretariat is not well-equipped, the staffs are not specialized in policymaking and strategy related issues… ', (P. 29)
>
> '… All of HHC Secretary Generals and staff are previous MoH staff, even mostly they still keep MoH way of doing things … ', (P. 29)

On the other hand, some commented that the council general secretariat is facing some limitations that affected their ability to hire specialized staff or even contract with them for short-term.

> 'There are some problems facing the general secretariat, mainly the inability to attract qualified staff due to the financial limitations. And due to the recent government restructuring plan, all independent institutions in the public sector will have a unified system of allowances, which means

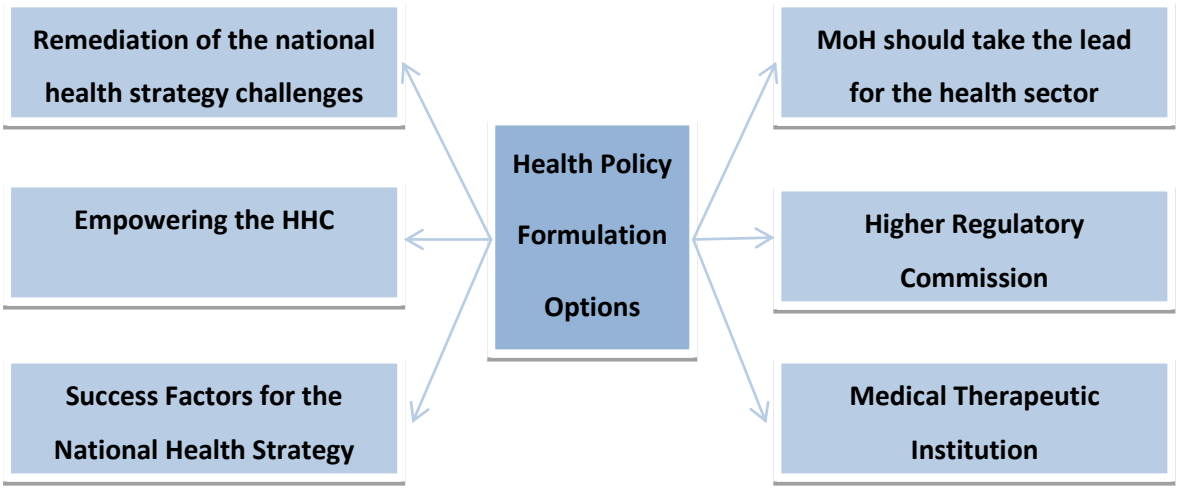
that the council will not be able to retrain the current staff and even more the council will not be able to attract qualified ones. Currently, only three technical staff in the HHC who are capable of working on the preparation of the national strategy …', (P. 44)

'Further, the HHC tasks request people to be specialized in certain aspects such as financing healthcare and HR …, but currently this is not happening. The technical staff work is based on their individual efforts …. Even more the council is facing problems in basic needs such as developing the HHC website', (P. 44)

6.5 Health policy formulation suggestions

Having expressed their views about the main challenges facing the national health policy formulation in Jordan and the HHC role in policymaking, the respondents were asked about their own views of how the national health policy should be formulated. The respondents' contributions to this question varied considerably. Although the majority realized the need for a national health strategy, there was no consensus on how we could achieve that. The respondent's contributions and suggestions could be classified into six main themes. A diagrammatical representation of the category and related themes that arose during analysis is presented in Figure (6-16).

Figure 6-16 : Health Policy formulation suggestions from the respondent's perspectives



6.5.1 Remediation of the national health strategy challenges

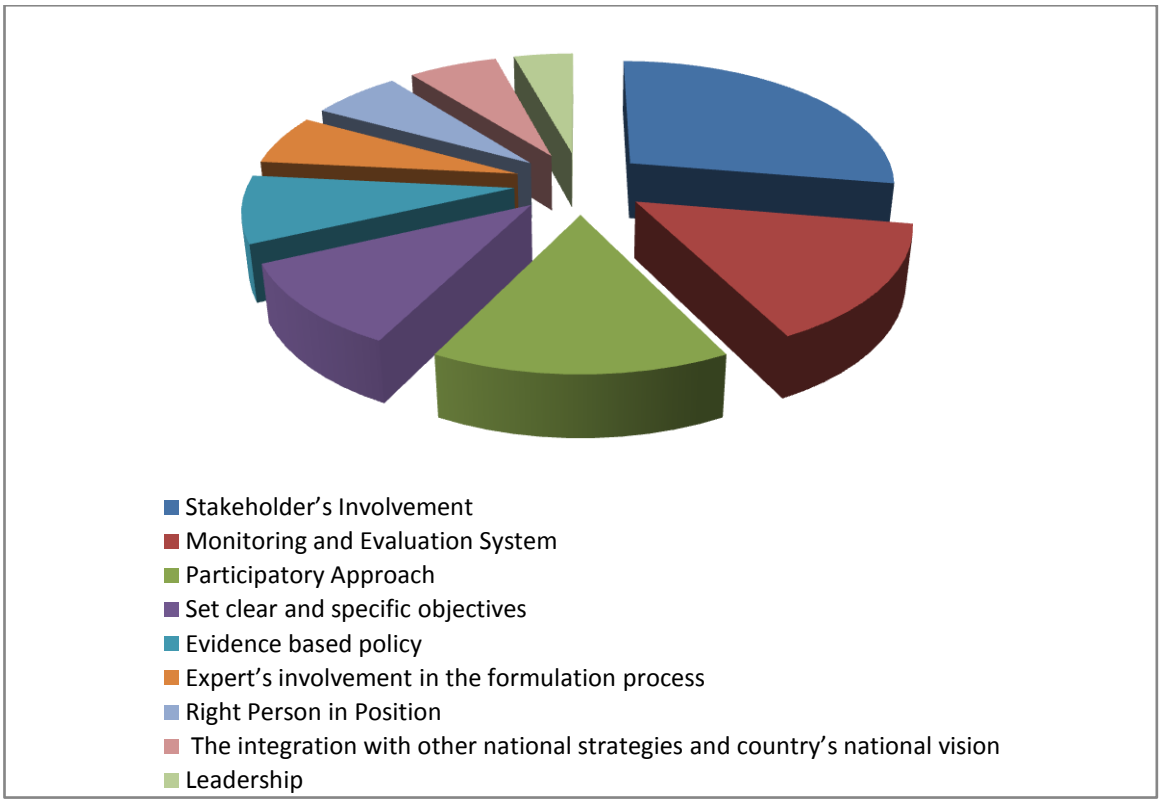
Some respondents failed to provide precise answers; however, they simply said that if the previously mentioned challenges were remediated we could have a proper national health strategy in Jordan. The main challenges are summarized in figure (6-8).

> 'The case in Jordan is already diagnosed; we don't need more diagnosing, we need solutions instead. In short, we must overcome and remediate the current health strategy challenges …', (P. 25)

6.5.2 Success Factors for the National Health Strategy

Some respondents mentioned some particularly interesting points; yet these points could be more likely considered as 'success factors' for a rational policy formulation. Most of these points were already mentioned in the main challenges. The most repetitive success factors to the national strategy according to the perspectives of the respondents are shown in figure (6-17). And since most of these factors were previously presented, they will be briefly described:

Figure 6-17 : key success factors for a national strategy formulation



6.5.2.1 Stakeholders Involvement in policymaking process

Some respondents addressed the importance of stakeholder involvement in the policymaking process. They indicated that the involvement creates the sense of ownership and facilitates the policy/strategy adoption and implementation. Stakeholder's suggestions were not limited to public sector entities, but also to the private sector and NGO's in addition to citizens.

> 'the current council representatives are mostly from the public sector, so they probably will adopt one perspective. The council should include all relevant stakeholders such as representatives of insurance companies, so the council will be represented by service providers and financiers …', (P. 35)

> 'Things has changed now, the private sector has a recognized contribution in the health sector. The private sector should be involved more in the process of policymaking. Also, the government should discuss with this sector the legislations that affect it before the final issuance and approval of such legislations…', (P. 14)

> 'I think we should seek to hear from the recipients of the services and from service providers in the field. These strategies are set in isolation from what's going on out there. In western countries there are groups of citizens/members of the community who give that perspective. So, people there feel that they are being listened to, and that they know what is going on …. We need to go down to community on the field and listen from the people …, sometimes it could be simple demands but have good impact …', (P. 7)

6.5.2.2 Participatory Approach

A Participatory approach was seen by the participants to exceed the identification and involvement of stakeholders. Some respondents urge both the HHC and MoH to have a real partnership with the relevant stakeholders and partners and engage them actively in the policymaking process.

> 'The best way to set the national strategy for health is the participatory approach involving all concerned parties. I think all healthcare service providers should participate in the policymaking …', (P. 47)

> 'I think we should adopt the participatory approach because it's a national strategy. I mean it's for the whole country and the participants should be from public and private sectors, in addition to NGO's and the associations who represent the citizen perspectives …', (P. 27)

> 'We need participatory approaches supported by consultants whether at the local level or even from WHO, but the input from all stakeholders is very essential to draw a policy in line with political will …', (P. 17)

6.5.2.3 Monitoring and Evaluation system

Adopting an effective monitoring and evaluation system was seen as one of the main challenges and at the same time one of the success factors of the national health strategy according to participants' perspectives.

> ‘It’s important to set an effective monitoring and evaluation system for the proposed national strategies…’, (P. 14)

> ‘We should develop effective monitoring and evaluation system for the national strategy and for the health entities itself and its top management …’, (P. 43)

Monitoring and evaluation was not perceived as essential elements for the future strategies only, but also for the previous strategies that were implemented, partially implemented, or even not implemented at all in order to figure out the lesson learnt.

> ‘Frankly speaking, we are working on formulating the national health strategy, but the previous strategy was not assessed. There was no proper analysis to where we are, and what worked or not worked … unfortunately, this is not limited to the national health strategy, but also to other national strategies such as the “Poverty Strategy”. They formed more than one strategy without proper evaluation to the previous strategies to find out what worked well and what didn’t in order to avoid committing the same mistakes …. I think the current health strategy was not based on proper analysis. If you look at the SWOT analysis, it’s more like a desktop review and was made in hurry …’, (P. 7)

> ‘There should be a system for monitoring and evaluation of the previous health strategies. Also failure to implement the established strategies should be held accountable …’, (P. 20)

6.5.2.4 Set clear and specific objectives

The respondents pointed out that when the national strategy is set, it should include clear and specific objectives, and these objectives should include the expected indicators.

> 'They should set a strategy for specific years, and it should include a number of clear objectives, and most importantly that strategy must be implemented…', (P. 10)

> 'We should have simple plans and goals because when focusing on specific goals it will spill over other targets and issues …', (P. 12)

> 'The national strategy should be clear; We need vision, mission, situation analysis, scenarios, alternatives, impact, planning and policies', (P. 29)

6.5.2.5 Evidence based policy

Building the national strategy based on valid and accurate evidence was considered to be one of the successful factors. It was explained earlier that the respondents perceived the lack of EBP as one of the policy challenges.

> 'The first step to formulate the national strategy is to have an up-to-date database; we already have data and information, but it's dispersed and not grouped in one place or institution; it is outspread between MoH and different councils and institutions… We need a national information system, this is the first step and it is a crucial issue', (P. 29)

> ‘I think it’s important to have a vision, and then translate it into a mission … At the same time it is important to have National health information system or statistics otherwise people may use the lack of statistics as excuses …’, (P. 29)

6.5.2.6 Expert involvement in policy formulation process

The respondents indicated that it’s important to involve policymaking and health policy experts in the formulation process to have a sound national strategy.

> ‘We need qualified and experienced people in the health sector; we need individuals who are specialized in advanced data analysis, statistics and strategy formulation. Further, there should be coordination and cooperation with the national institutions such as the Department of Statistics and the Higher Population Council as they have huge data such as the distribution of population… which could be utilized in planning …’, (P. 4)

6.5.2.7 Right Persons in Positions

Some respondents addressed the need for assigning the qualified persons in the senior positions since those individuals have recognized reflections on setting the strategies and plans.

> ‘We need simply to appoint the proper persons in the right positions’, (P. 10)

> ‘It’s important to overcome some corruption aspects when assigning the improper persons in positions because on the long run it will not only influence the policymaking and planning negatively, but also will lead to the brain drain of real qualified persons …’, (P. 18)

6.5.2.8 The integration with other national strategies and country’s national vision

Some respondents pointed out to the importance of integrating the national health strategies with other national strategies in other sectors that involve health issues, and to integrate with national documents such as the national agenda, and the recent vision for Jordan (2025). Moreover, some respondents pointed out that the current level of integration is not satisfactory.

> ‘Recently the King called for the economic vision for Jordan (2025). I have attended the meetings for the preparation for the national vision. One of its themes is the health services, such as considering the cost of health services and the comprehensive insurance scheme and focusing on the primary healthcare … I think the national health strategy should consider the 2025 Vision. Now, the plan for Jordan and all of our national strategies should considering that, but I’m not sure if the HHC will be able to do so …’, (P. 1)

> ‘The national health strategy should integrate with other sectors that have health aspects such as the strategies of the Ministry of Social Development, the Ministry of Environment, the Ministry of Education and the Ministry of Higher Education … as far as I know I don’t think this is happening unfortunately …’, (P. 18)

> 'It's important to integrate with other sectors. In my opinion, the priority now should be to integrate with the educational sector in health-related education programs. I think the health education is somehow isolated from the real needs; the human workforce will not be in line with labour market needs … the gap is not in the health education only. I think the education sector has to be in line with the market needs …', (P. 7)

6.5.2.9 Leadership

Some respondents addressed the need for a powerful leader who will be able to work with different relevant stakeholders and lead their efforts towards setting and implementing the national health strategy.

> 'We need a leader who can bring the different parties and stakeholders together, and who can create a sense of ownership among them… we need the will and the belief in partnership', (P. 43)

6.5.3 Empowering the HHC

More than half of the respondents believed that the High Health Council (HHC) will not be able to undertake its duties and responsibilities if its law remained unchanged; there is a need to grant the needed authority to the Council. The council was seen by most of the respondents as ineffective and inactive for decades. And to change this mental image, radical changes should be carried out, and the most important change is the one to be introduced to the Law. The HHC role in health policymaking was described in detail in section: 6.4.5; however, some of the respondents' views will be presented:

> ‘The problem is that the HHC has no authority …so if we want the council to set the national strategy; the council should be highly empowered’, (P. 12)

> ‘The HHC should be given the needed authority, so that it is able to control and monitor the health sector and its strategies …’, (P. 33)

When the respondents stressed on the need to empower the HHC, some of them thought it should be linked to the PM and others thought it should be linked to MoH Minister, more details are available in section: 6.4.5.3.

6.5.4 MoH should take the lead for the health sector policymaking

Some respondents pointed out that it’s the role of MoH to set the policies and national strategies for the health sector for several reasons: The Ministry is already empowered by the public health law, it is responsible for tasks on the national level such as vaccination campaigns, and it is the main health provider in the public health sector. Yet, the MoH is facing some issues such as being overburdened with tasks and the lack of coordination with other organs. The MoH – HHC relationship was presented in section: 6.4.5.1.1 and section: 6.4.5.3. However, when commenting on this question, some respondents stressed on the fact that they perceive the MoH as the leader of the health sector despite some limitations they already described.

> ‘The HHC role is just an ink-on-paper, so it should be linked with MoH. The MoH has the power to over-rule the health sector. The Council should set the policies in coordination with other then follow up the implementation

of the national policy. They should enforce the implementation of law and bye-laws …', (P. 40)

'MoH is the main entity to be responsible for the health sector and it should lead all other sectors to achieve the national strategy. I know that MoH find some difficulties in doing this role on the ground, but they have the power of law. Also, they can organize and control with others and establish committees to ensure the cooperation and coordination level…', (P. 42)

'The national health strategy is the MoH responsibility, but MoH is overburdened with daily routine work; therefore, we should do some changes that eventually will allow the Ministry to undertake its duty of managing all issues related to the health sector according to the public health law … yet I think it's not an easy thing to do …', (P. 45)

6.5.5 Higher Regulatory Commission

Few respondents suggested the idea to have a different 'body' for organizing the health policymaking process. They suggested the establishment of a body to assume the role of a Regulatory Commission, which already existed in Jordan in the Telecommunications, Energy and Transportation sector.

'We should have one body to regulate the issues related to the health sector if we want to achieve results and at the same time we need to consider the cost. Such single body shouldn't be linked with MoH Minister and linked directly to the PM and shouldn't be affected by the government

turnover. We have successful experiences (Telecommunications Regulatory Commission, Transport Regulatory Commission and Energy and Minerals Regulatory Commission), and I think if we have a higher regulatory commission for health it will be a good idea …', (P. 30)

'I think there should be an authority higher than the HHC, such as the Regulatory Commission which sets the main objectives for the sector. And then the health sector entities set their plans and action plans within the agreed general objectives …', (P. 13)

6.5.6 Medical Therapeutic Institution

Some respondents who witnessed the Medical Therapeutic Institution[17] experience 30 years ago, said that it will be a good idea if it replicated, however some of them thought that the challenges faced the Institution years ago are still there, but at the same time it's one of the key steps that will assist in facilitating the proper planning for the health sector and reducing the cost.

'I was a hospital director in (--) when the idea was implemented in 1987, I enjoyed the experience from the beginning to the end … and I can say that it was a very good idea, and if it was properly implemented. It will have positive results … the idea failed for some reasons, the most important of which is favouring the narrow interest instead of the overall interest of the health sector and the country, and due to the individual conflicts. I think

[17]This institution was established in 1987 and terminated in 1990; its main idea to have a group of hospitals under one administration (including RMS, MoH and university hospitals) and the primary healthcare services was managed and provided by MoH. thus it was aimed to have unified roles and regulations for the whole health sector

anyone who considers the interest of the country and witnessed the experience at that time will find it as a good idea …', (P. 30)

'I have worked for the MoH for 20 years before I become (--). I witnessed an attempt to unify the public health sector. The Medical Therapeutic Institution was then established; it has several benefits such as elimination of the duplication, unifying the procedures and achieving the equity of services provision for the citizens and equity among all medical and other supporting workforce, but unfortunately it was terminated …', (P. 22)

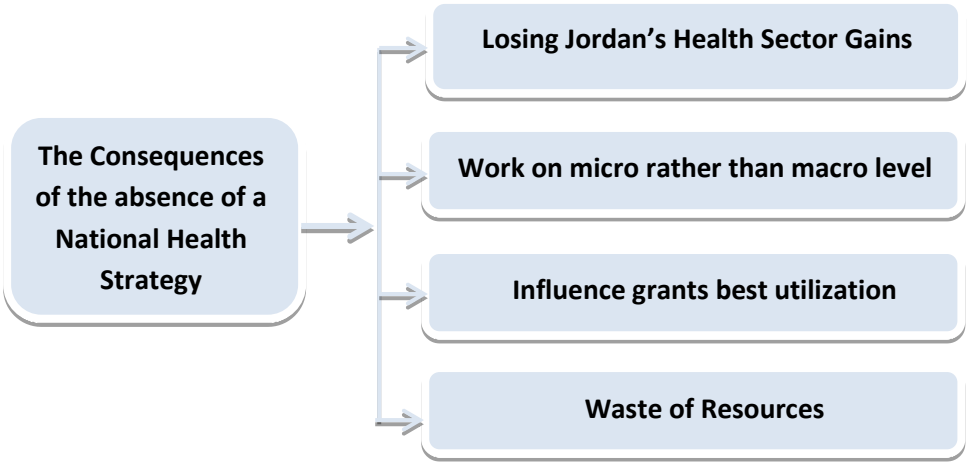
'I think all public sector hospitals (RMS, MoH and university hospitals) should be under one reference body (Medical Therapeutic Institution) and the primary healthcare should be the MoH responsibility …', (P. 22)

6.6 The consequences of the absence of a national health strategy

Respondents were asked about the potential results and consequences of not having a national health strategy from their perspectives. There is a comprehensive consensus that the waste of resources is the most obvious consequence, along with other implications such as the fear of losing our gains that were built throughout the years. Some of these consequences were even raised by the respondents when they were asked about the main challenges for policy formulation; mainly when they commented on health sector fragmentation.

Nevertheless, the results for this question will be briefly presented with more emphasis on themes that most related to the focus of this study. A diagrammatical representation of the Category and related themes that arose during the analysis is presented in Figure (6-18).

Figure 6-18 : The Consequences of the absence of a National Health Strategy



6.6.1 Losing Jordan's Health Sector Gains

A considerable number of respondents raised the concern of losing gains that were achieved throughout the previous years. They criticized the absence of a national health strategy and the fragmentation of the health sector entities, particularly within the public health sector. Although they said that in previous years there was no formal strategy for the health sector, but things were different in term of internal and external challenges and the health issues itself, thus the current challenges require us to change our way of dealing with them.

> 'Well, can you imagine that we have good rank among the countries of the region and we have these scattered efforts; however, if we coordinate our efforts together we will be ranked among the developed countries…', (P. 3)

> 'We lost 40 years of progress … we are sad because we look at our achievements and we are doing fine. Almost our level is approximate to the industrial countries when we monitor our indicators such as accessibility to

health care or TB vaccination … So, without proper system we are at that level ! If we have a proper system it will be much better …', (P. 12)

'The medical advancement in the Kingdom was built during the 70's, 80's and 90's … we are reaping its benefits in this period… but we don't build on that progress nowadays … If we don't remedy this situation, the health sector in Jordan will decline …', (P. 31)

Some respondents were emotional when they talked about losing our gains as some of them were pioneers in the health sector, and they witnessed its progress and evolvements.

'I'm afraid it's the end of the honeymoon … we sincerely built Jordan's medical reputation and laurels all those years … the problem is that we reach a very good rank which makes the current decision makers slacken … they don't realize, or maybe they do, but they did nothing because the fact that countries around us become more developed. I belong to a generation where the doors were open widely to Jordanian qualifications, but it's no longer a competitive advantage for us … you know that Jordan is not the leading country in the medical tourism anymore and Dubai book its place in medical tourism … I didn't expect that I will live and see these things happening ….', (P. 11)

'We will lose the future! We eulogize the medical and health sector in Jordan, which honestly is …. but what about the next 5,7 or 10 years, what will happen? The region and everything around us is changing and

developing. If the government failed to adopt the rational and governance principles to avoid all the pitfalls and set a national health policy; we will lose our status in the near future …', (P. 26)

6.6.2 Work on micro rather than macro level

The absence of a national health strategy was seen by some respondents to deepen the gap among the health sector entities. It also leads to focus the efforts on the micro level and give the priority to a given institution rather than the overall benefit of Jordan. Further, it leads to having strategies for certain issues without achieving proper intergradations with other strategies, plans and initiatives.

'If we don't have a national strategy, everything else will not work alright … If you have no guidance (which is the national health strategy), everything else will work by its own i.e. independently … We will have sub-sectors, sub-specialties, sub- interest, and so on…', (P. 29)

'If we don't have a national strategy; all our thinking will be on micro and institutional level not on macro and whole sector level …', (P. 1)

'We don't have a comprehensive vision for the health sector … Unfortunately, sometimes we look to things in a selfish way, which will reflect on all entities of health sector…', (P. 25)

'There is no vision for the future; although the King requested the government and MoH to set a vision for the future of the health sector, but I think the decision makers did not received the king's messages well. There

is apathy in the health sector although it's essential pillar for the social security…', (P. 20)

6.6.3 Influence grants best utilization

Some respondents linked the absence of the national strategy to its influence on our relationship with donors; they addressed the best utilization of the grants such as linking these grants with our highest needs and distribute them evenly throughout the Kingdom. It was described by some of them as follows:

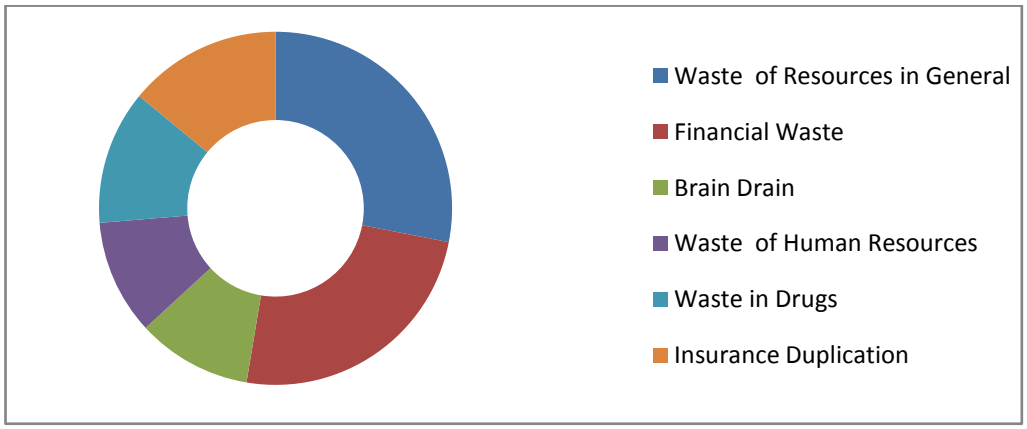
'It's hindering the utilization of grants and leads to imposing the donor's conditions on us …', (P. 8)

'Sometimes Jordan loses grants due to consuming long-time of coordination between ministries, especially the MoPIC and MoH …', (P. 40)

6.6.4 Waste of Resources

The waste of financial resources was the most repeated issue among other mentioned sources of waste such as brain drain, drug waste and tools and equipment. Noting that some participants mentioned that there is a waste of resources in general without identifying them specifically.

Figure 6-19 : Waste of resources as a consequence to the absence of national health strategy



Waste of resources was highly emphasised by the respondents, but it's difficult to present them in detail, therefore, each sub-theme will be briefly described with one selected quote.

6.6.4.1 Waste of resources in general

Some respondents mentioned that a direct result of the absence of national strategy is a waste of resources in general.

> 'There is a waste of resources due having multi providers and due to the lack of having health strategy with clear features, I think in general there is waste of resources in Jordan which is not limited to health sector … while the logic implies that we should utilize our limited resources', (P. 31)

6.6.4.2 Financial Waste

Financial waste was mentioned by a number of respondents. They linked it to various aspects such as the unplanned expansion of services. Also, it was linked to the humble investment in primary healthcare compared to secondary and tertiary healthcare. Further, financial waste was not limited to public sector entities because some respondents mentioned examples of waste in tools and equipment in private hospital and clinics which will reflect eventually on the cost of services for citizens.

> 'There is more than one reason that led to imperfect our health system which leads to having high rates of expenditure on health services and health insurance …', (P. 25)

6.6.4.3 Brain Drain of Specialists

The drain of brains was raised by some respondents. The brain drain happens internally (from the public to private sector) and externally (mainly to Gulf countries). Respondents talked about its main causes such as lack of incentives and work pressure in public sector; and they addressed its potential implications. The problem is already influencing the MoH as they have a lack of specialists and they have to contract with the private sector for some specialities.

> 'We have a problem in MoH due to the decline in the number of specialists; our qualified specialists are attracted by Gulf countries, and we are not filling the gap in a way that matches such drain. Filling the gap could be done by local training and speciality program under the supervision of the Medical council, or through overseas training. … The health sector is dependent now on the senior specialists who received their education and

> training abroad during the 70s and 80s. But I think there's no serious actions taking place to resolve this, and sooner or later we will face difficult situation which will have various implications including the loss of our competitive advantages in medical sector …', (P. 26)

6.6.4.4 Waste of Human Resources

The waste of human resources is linked to more than one aspect. For example, it was raised when commenting on initiating healthcare centres and hospitals due to the political and social pressures, not the real needs, which led to waste of HR along with other resources. in addition, it was linked to the lack of best utilization due to the lack of training and focusing on medical profession more than the allied health profession. Also, the increasing turnover rates in the medical profession especially female nurses was a major cause. Further, this kind of waste was raised when commenting on the lack of proper planning and the linkages between educational programs and actual needs.

> 'We are losing many qualified human resources because we can't retrain them. Also, we focus on medical professionals we are not focusing on the allied health professionals, and how to retain them and maintain the quality of services' the poor quality causes waste. And if people are not treated well it will cost more …', (P. 7)

6.6.4.5 Waste in Drugs

Some respondents pointed out to the waste of drugs in Jordan since it's considered as a major issue and consume a recognized portion of health sector budget.

> ‘Unfortunately, there is a waste of almost all resources, including the drugs; we are on the top of the region's countries in term of drug consumption and waste. One of the causes of such waste is the pharmacists themselves, and the puzzle of importing drugs while we are among the leading countries in pharmaceutical Industry …’, (P. 36)

6.6.4.6 Duplication of Health Insurance

Some respondents indicated that we still have the problem of duplication of health insurance. This was listed as a separate theme since it is crosscutting with all kind of resources wasting. The duplication of insurance occurs within public sector entities and between public and private sector.

> ‘There is duplication in the health services. For example the members of one family may be insured with more than one insurance agency such as public-public, or public-private…’, (P. 24)

6.7 Summary

In this chapter, the main results of the study fieldwork were presented. The results revealed that the national health policy formulation in Jordan is faced with numerous challenges and these challenges are not limited to our internal issues merely, because Jordan is vulnerable to the regional incidences. The respondents indicated that there is a need to develop a national strategy for the health sector; such strategy should combine the different entities, however, they have varied perspectives on how this should be made. Especially, the argument of who should

lead the health policy formulation efforts prevailed, is it the Ministry of Health or the High Health Council. Hence, the MoH and HHC have a prickly relationship which was highlighted by the respondents. Thus, the options for effective national health policy formulation in Jordan will be presented and discussed in the Discussion Chapter.

Chapter 7

Discussions of Findings

7.1 Introduction

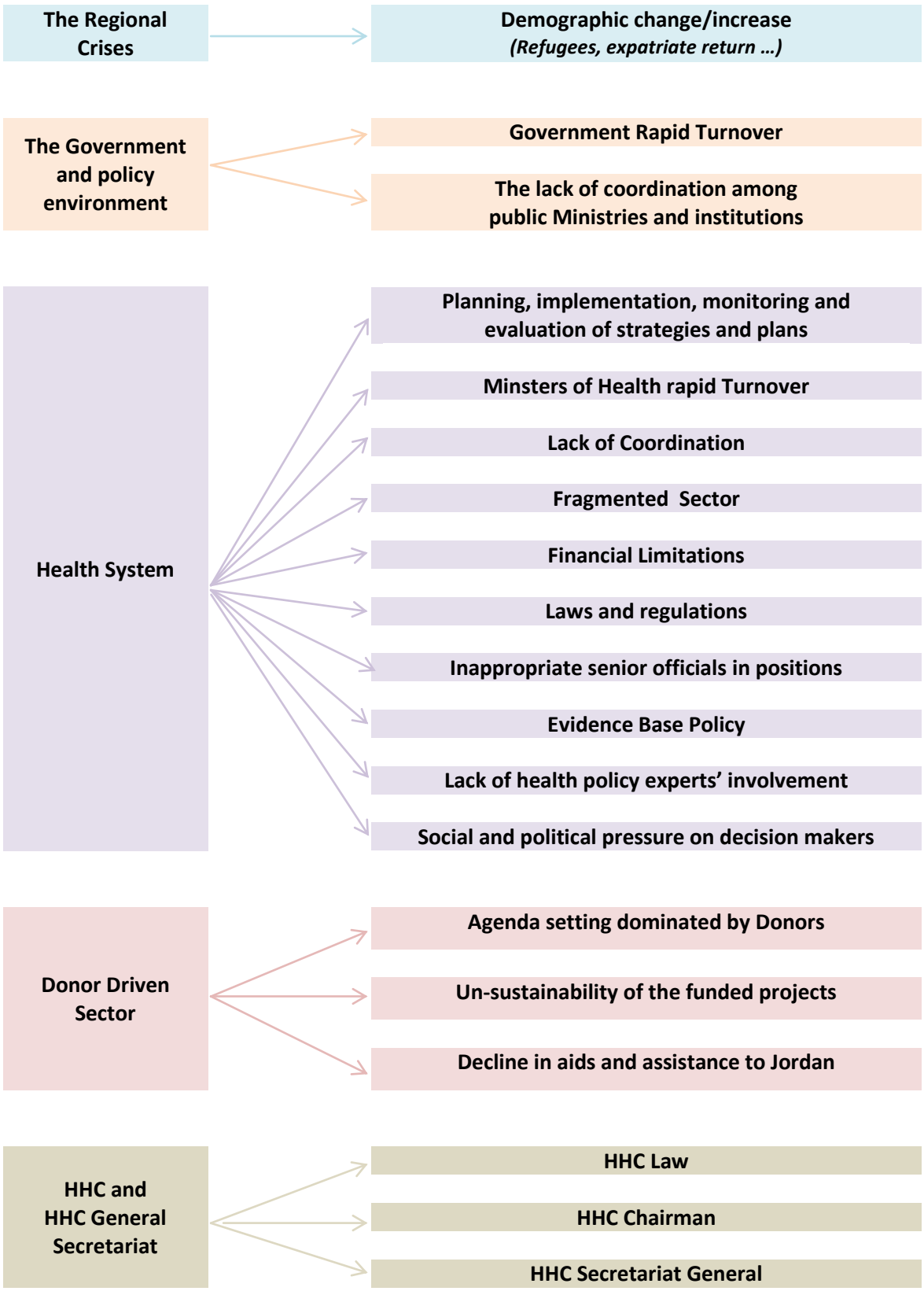
This study aimed to investigate the main challenges that face health policy formulation at the national level in Jordan. The previous chapter presented the study results in details, and in this chapter, the main challenges will be briefly discussed, along with presenting and discussing the possible effective options for the national health strategy formulation in Jordan.

7.2 Principal findings

The study revealed a number of principal findings related to the main challenges which facing the health sector in Jordan in general and the health policy formulation in particular. Figure (7-1) summarizes the key challenges as reported by the study respondents.

The results showed that Jordan encounters numerous challenges that affect the health sector and its strategies. The challenges were classified into five main theoretical themes and each of them has core themes and sub-themes. Yet, it will be difficult to discuss each and every single result due to the huge amount of information; further, each theme of the results is a wide topic on its own such as health financing. Thus, the results will be discussed briefly and will be triangulated with some national and international studies and documents. As for the main challenges that face the HHC in the national policymaking, it will be part of an essential discussion about the effective options for effective health policy formulation in Jordan.

Figure 7-1: The main challenges for the National Health Policy formulation in Jordan from the respondent's perspective



7.2.1 The Regional Crises

Jordan is considered vulnerable to the regional crises. Throughout Jordan's history, a number of major events occurred which have negative consequences in most cases. Previously, the international community and some of the Gulf countries helped Jordan to overcome the consequences of the regional crises and they offered their assistance in different fields. However, since 1990 things changed significantly due to the Gulf war and Jordan's position then had negative and severe implications for economic, social, political and military aspects, along with hundreds of thousands of Palestinians and Jordanian expatriates who returned back to Jordan, as well as thousands of Iraqi migrates to Jordan. Along with that sever economic and diplomatic strain then; Jordan signed the 'Peace treaty' with Israel in 1994, which boosted the internal and external challenges.

Years later, major crises in the region occurred and influenced Jordan, mainly the invasion of Iraq in 2003 and the Lebanon war in 2006. However, the Syrian crisis since 2011 is the most devastating for several reasons; it is the largest human influx witnessed in Jordan, the regress of international community and donor assistance, and the elongation of the crisis and its implications on various aspects and fields on Jordan including the national security aspects.

All of the regional crises were associated with a massive increase of population in Jordan; they have multifaceted consequences including on the health sector. These challenges resulted from demographic changes that affect the health system's ability to set long term plans, and result on its working functions mainly as reactive, rather than proactive. The Jordan population has increased more than 10 fold during the last 55 years, and now about 30% of Jordan's residents are non-Jordanian.

Some studies have addressed the need to link planning for future healthcare services and its financial substantiality with population demographics and the demand for expected health

services (Whittaker, et al., 2016; Birch, et al., 2015). Other studies pointed that resource scarcity is a crucial issue for many health systems, and healthcare resource allocations are affected by several issues such as demographic changes (Robinson, et al., 2012). In general, long-term crisis negatively affect the effectiveness of policymaking and planning (Pavignani and Sandro, 2009).

7.2.2 The Government and policy environment

In general policy formulation is affected by the context in which it exists. Several factors are affecting the national policymaking in Jordan (chapters 2 and 3). Nevertheless, one of the constraints which was stressed by the study respondents is the **Government rapid turnover**, which could be attributed to internal and external causes. As Jordan is vulnerable to the regional crises; this has influenced its internal affairs. Changing the government Prime-Minister sometimes was a means to cope with the regional crises and events; the PMs in some periods were selected based on their potential and acceptance by the main external powers.

The government rapid turnover is considered an irritating phenomenon since independence in 1946[18]. The government average period is around 14 months. However, since 1971 things have improved, it is quite fair to say that Jordan's prosperity and advancement were constructed between (1970s-1980s). However, since the 1990s many things have changed significantly as explained, and Jordan faced complex situations and various implications. Nevertheless, the development process was continuous but with fewer rates of achievements compared with previous years. I think that since the 1990's Jordan reaps the fruits of that essential period, as Jordan became overburden again with the regional crises and its implications, continuing until the present day.

[18] since 1948 – present , Jordan Has witnessed 63 government

The rapid turnover has affected the government's ability to set long term plans for various aspects, and if they manage to do so, most probably, they will not be able to implement it, and they mostly deal with routine aspects rather than planning for the future. King Abdullah II on various occasions declared his intention to support the prolongation of the Cabinet duration in order to be able to achieve the national goals. Further, the king called the elite and the experts to set the national agenda for Jordan, so as to serve as a master plan and guidance to the consecutive governments. The initial version was from 2006-2015, and then it was amended to be from 2007-2017. Nevertheless, the so called the 'Arab Spring' that started in 2010 has affected Jordan; one of its consequences is causing the rapid turnover of the government to occur again (4 governments within 2 years). Though, as Jordan is working hard to undertake some serious reforms on various levels and to cope with internal and external events, the king supported H.E. Dr. Ensour (PM) to lead the government for 40 months from 2012-2016, which is the longest duration since 1989. In 2014, the king requested the government to set Jordan's vision for the next decade that should consider the difficult challenges that face the Jordanian economy due to internal, regional and international conditions (MoPIC, 2015); later in 2015 saw the launch under the King's patronage of ''Jordan 2025: a national vision and strategy'', which should serve as Jordan's 10 year blueprint for economic and social development.

This national strategy not only seeks to divert the various governments' efforts towards the aspired national goals, but also to synthesise their efforts toward its achievements, and to increase the coordination level among various public entities, in addition to other relevant stakeholders.

The unsatisfactory **level of coordination** was seen by the respondents of this study as one of the challenges that face the country in general. The potential causes for that is the rapid governmental turnover and its implications, and even sometimes, some PM's have different views

regarding the merge or demerge of some ministries. The other reason may be attributed to the existence of the independent institutions which sometimes intersect with some ministries duties and responsibilities, without proper mechanism of coordination.

Thus, in an attempt to restructure the public sector, the Ministry of Public Sector Development (MoPSD) conducted between (2012-2015) a restructuring plan to reduce the number of independent institutions by proposing the merging/termination of some of them in addition to linking some institutions to the related ministries instead of the PM (such as the HHC to be chaired by MoH minister instead of the PM), as well as the goals such as restructuring the salary scale of public employees. However, the restructuring plan was disappointing and did not achieve most of its goals as the MoPSD didn't succeeded in solving the independent institutions' unnecessarily existence despite various experts and academics comments which are supported by evidences in some cases.

Moreover, the unsatisfactory **level of coordination** which affects the overall performance in addition to the weak Monitoring and evaluation system, were recently highlighted in his majesty's sixth Royal Discussion Paper as a general concept in the state – among other issues – which was mainly about the rule of law and civil state, which he said that:

> 'During recent years, however, the level of performance and achievement in administrative agencies has not met our expectations and has not been up to what the public deserves. All state institutions must, therefore, join efforts to improve administration processes and cement the rule of law. This requires adopting a process of regular evaluation and advancement of individuals and institutions to achieve the highest performance levels we aspire to'. (King Abdullah II, Jordan Times, Oct. 2016)

7.2.3 Health System Challenges

As indicated earlier the national health strategy formulation in Jordan faces numerous challenges, some of them related to the health system in Jordan in general. Some of these challenges were raised either as weakness or threats when conducting the situation analysis in the MoH strategic plan for 2008-2012 and 2013-2017, and mentioned in the recent national health strategy for 2015-2019; further, the WHO-Jordan country cooperation strategy (CCS) for 2008-2013 pointed to some of these challenges (Appendix: 2.11).

However, some of these challenges are not unique to Jordan's case as they exist in several developing countries and some developed countries, but some issues are unique to Jordan such as the massive number of refugees.

7.2.3.1 Planning, implementation, monitoring and evaluation of policies, strategies and plans

Several issues were raised under this theme such as improper planning, and when there are plans they are not well implemented, along with weak monitoring and evaluation issues. Some studies have pointed to some of these aspects. In a study conducted by Hill, he concluded that structured strategic planning is having limitations under complex situations of high uncertainty, with little reliable information and a rapidly changing environment (Hill, 2000, p. 1711) although his study was on Cambodia in 1997 where a major action occurred, the conclusion still valid – to some extent - for the countries that are faced with major events such as Jordan.

The gap between planning and implementation stages were pointed by the respondents and also have been addressed in some studies within the developing countries contexts. A study concluded that one of the HIV/AIDS national plans failures in South Africa are attributed to the

gap between policymaking and policy implementation, along with other issues related to the policy context, process and actors interactions (Wouters et al., 2010).

Despite lack of studies in the Jordanian contexts to address these issues, this was highlighted in the national strategy and MoH plan (Appendix: 2.11). The Ex-Minister of health in the ceremony of launching the MoH strategic plan 2013-2017; has criticised the missing links between plans and strategies at MoH and the implementation and follow-up, he said that 'If the planning is not followed with implementation, evaluation and auditing, it will not succeed', (Malkawi, 2013).

7.2.3.2 Ministers of Health rapid Turnover

In Jordan, when the PM resigns, the Ministers consecutively resign. However, there are some cases where the Minister of Health – or any other ministers - could be reassigned to work with the successor PM again. A detailed table shows the MoH duration in comparison to the Cabinet duration (Appendix: 7.1); the table shows that the least duration for an MoH health Minister was four months, and two Minsters were assigned for the highest duration compared with others, which were around three years.

Some developing countries may have that political instability, which may affect its policymaking. Khan and Heuvel concluded in their study that Pakistan faced political instability, unbalanced power structure and frequent changes in government; these issues have affected negatively the health policymaking, planning and implementation (Khan and Heuvel, 2007).

7.2.3.3 Fragmented sector (Multi Healthcare Providers)

Fragmentation in this study is not primarily focussing on the public-private sector; rather it criticized the fragmentation within the public health sector itself (MoH, RMS and UH's) and its various consequences - mainly resource utilization. Some countries may face the problem of a fragmented health sector but within its own contexts and different aspects of fragmentation, for example: Stange has reported that fragmentation – even if it may be well-intentioned - in the USA may lead to several consequences, including: inefficiency, ineffectiveness, inequality, commoditization of healthcare, de-professionalization, depersonalization, and despair and discord (Stange, 2009). Bazyar and colleagues pointed out that there are fragmentations in Iran's health insurance system, which has some negative implications such as lack of coordination between health insurer funds, inequity, inefficiency and duplications coverage, and then they proposed three options for health insurance funds in Iran (Bazyar, et al., 2016).

7.2.3.4 The Lack of Coordination

The participants of this study criticized both the lack of coordination among public health sector entities and also criticized the lack of coordination level between the health sector and other related sectors and institutions. The most mentioned example was the weak coordination between ministry of higher education, the Higher Education Accreditation Commission (HEAC) and Civil Service Bureau (CSB) on one side and the MoH and HHC on the other side, which affect the proper planning for the health sector workforce.

In a study conducted on policymakers from 10 countries including Jordan, the respondents were asked about the factors that influence the health policymaking; the highest rated factor was the lack of coordination in governmental/ministerial relations across different

ministries (74.9%), then the lack of coordination in government/health provider relations hindered the health policymaking process by (65.2%), (El-Jardali et al., 2012 b, p 6).

7.2.3.5 Laws and regulations

One of the main issues according to the study respondents was the lack of updating of laws and regulations, and the overlap between laws and regulations. This issue was mentioned in the HHC latest strategic national plan as one of health system weakness 'Overlap and duplication in some health laws', (HHC, 2015).

The duplication and overlapping between rules, regulations and agencies' roles are not limited to developing countries as they could occur in developed countries as well, particularly within countries who adopt federal system. For example, the US Government Accountability Office (GAO) issued an annual report to identify the fragmentation, overlap, and duplication aspects in various areas including health sector in an attempt to reduce them and achieve the system efficiency and effectiveness (GAO, 2016).

7.2.3.6 Financial limitations

Despite the variance of health systems between countries, they are all facing financial challenges (Robinson, et al., 2012). Financial limitations in Jordan are associated with a number of issues, such as the lack of the health system efficiency and the universal health coverage (UHC). The UHC is a national goal, which was planned to be achieved in 2013, but due to the unexpected circumstances, along with the disagreement between MoH and relevant stakeholders on the proper mechanism to implement it, it was shifted to be achieved in 2025 by 95% (MoPIC, 2015), with notice that around (80%) are currently insured (HHC, 2015), while in practice any uninsured

Jordanian citizen has the right to receive assistance – when requested – from the Royal Court and the Prime Ministry to cover their treatment cost (Al Emam, 2015). Also in Jordan, children below six years old and above 70 are insured by government through MoH.

Financial limitations were seen as challenge to the health policymaking in several studies such as El-Jardali and his colleagues, as around (79.2%) of the their study participants thought that limited public funding for health exerted a strong influence on the health policymaking process (El-Jardali et al., 2012 b, p 6). Financial limitations were not only an internal concern, as some respondents raised the issues of constant decrease in the foreign aid, despite the increasing challenges that face Jordan and its health sector due to the massive number of refugees. Some mentioned the decreasing financial assistant of the WHO and other donors. As indicated earlier; WHO itself is facing a number of challenges related to how to secure funding for its activities and the competition of other international agencies and actors working on health sector issues, who intersect of its role and affect its share of financial resources (Clift, 2013; Szlezak et al., 2010), which consequently place more pressure on Jordan on how to secure its requirements under all these challenges.

7.2.3.7 Evidence Based Policy

The respondents highlighted two main issues; the lack of Evidence Based Policy (EBP) and the lack of specialized local studies and research. In general, there is a lack of an inclusive National Health Information System (NHIS) that combines all health sectors, which were raised for several years, such as in the MoH strategic plan and the recent national strategy but without serious actions yet.

Some studies pointed to a number of issues that were raised by the study participants. One study pointed to the influence of political considerations on the health decisions, such as Tanzania health policy in HIV prevention is not merely evidence based driven as its resulted from 'politically negotiated aggregation of competing, frequently non-optimizing rationalities' (Hunsmann, 2012, p 1477). Another issue, which is noticed in Jordan (through some academics and some national institutions), is the focus on micro level and sectoral issues within the health sector, mainly the reproductive health and maternity issues; this could be attributed to the donors and international agencies focus and interest on these issues. This is consistent with some studies which found that most of public health focuses on micro level rather than macro level issues such as the key determinants on health policy formulation (Bernier and Clavier, 2011 ; Navarro and Shi, 2001; Bryant, 2002). Also the single case studies on particular issues dominates the research style in LMIC's (Gilson and Raphaely, 2008; Walt et al., 2008).

An important issue pointed to by the respondents is depending on donor studies and reports. Blume and Tump indicate the increasing tendency to depend on international rather than national data and evidence will have major consequences for national scientific competences (Blume and Tump, 2010). Likewise, Behague and his colleagues stated that 'importing EBP's derived in settings outside their own country undermines national experts' experiential knowledge and the credibility of locally-generated solutions' (Behague et al., 2009, p1543). Also they found that the international research and evidences are more powerful than national research in developing countries contexts, and good quality national-driven research may be overlooked if it's not aligned with the global trends (Behague et al., 2009).

7.2.3.8 Inappropriate senior officials in positions

Some seniors and mid-level positions in the government and public institutions (including the health sector) are occupied by some people who are not well-qualified compared with their potential competitors on those positions. Nevertheless, they may get appointed due to their relationships, nepotism, mediation, relative support; this called in Arabic (Wasta). Wasta is deeply engrained in the Jordanian community, particularly the Bedouins tribes. While Wasta was used in the past for good causes like mediation and conflict resolutions between tribes, families and others, it has gradually become recognized as a negative behaviour when it is practiced to gain benefits and privileges that the person(s) are not entitled to have according to the state rules and regulations.

One immediate consequent of practicing Wasta – which was raised by the study respondents also - is 'not having the right person in the right place', which eventually affects the overall work performance and outcomes, along with other issues such as lack of equity. This phenomenon becomes irritating in Jordan, particularly after 2011 as citizens demand for more transparent procedures to ensure the equal opportunities principles and protect the public interest. The government promised to take some actions, such as establishing a committee in 2015 under the Prime Minster office to supervise senior officials' selection and recruitment in the key positions, but still more serious action is needed in this regards.

In his majesty King Abdullah's sixth Royal Discussion Paper, he stressed respecting the rule of law and civil state. His majesty pointed to some issues associated with that and urges the government to seriously address them; one of these issues is the Wasta and nepotism, his majesty wrote:

> 'We cannot address the issue of the rule of law without recognising that wasta and nepotism jeopardise development efforts. Wasta does not only

> impede the country's progression, it erodes achievements by undermining the values of justice, equal opportunity and good citizenship, which are the enablers of development in any society …' (King Abdullah II, Jordan Times, Oct. 2016)

Accordingly, the PM has promised to enhance the transparency, equality and fairness principles in selecting the senior officials and the civil employees.

7.2.3.9 Political and social pressure

Although Jordan has undertaken several steps toward being a civilized country and enhancing the rule of law in all aspects; decision makers are sometimes responding to the tribal leaders and some groups' demands regarding various services including health services. It's not a unique feature for Jordan as it has existed in Arab countries and other developing countries. Grindle and Thomas pointed out that it has existed in many African counties, and sometimes it's important for the major tribal groups to have a member in high rank in the government (Grindle and Thomas, 1991). Further, several studies pointed that evidences in health sector is overshadowed sometimes by the political considerations (ex: Ensor et al. 2009; Bambra et al., 2005).

Unfortunately, in Jordan; some members of the House of Representative and Senators are practicing their power on the MoH to gain more services – even if they are not really needed - to gain popularity and other political and social gains, while in principle they should be more supportive to the government policies and show their understanding to the documents, studies, evidences and other limitations.

However, in some countries the demand of healthcare services could be justified as some minorities and marginalized groups may need customized health services or conditions, such as American Indian communities (Gone, 2007; Beals, et al., 2005).

7.2.3.10 The Syrian Refugees in Jordan

Some international reports and studies have reported that Syrian refugees have good access to healthcare services in Jordan. Doocy and colleagues concluded that refugees' children have good access to healthcare, for which more than half of them went to public sector rather than the charity sector and private sector (Doocy et al., 2015).

As indicated earlier, Jordan hosted more than 1.5 million Syrian refugees, of which more than 85% are not in camps; this massive influx has affected several sectors, which were presented in chapter 2. The study respondents have stressed some negative consequences, such as the increasing expenditure of the public health sector, the increase of non-communicable diseases rates and the re-emergence of some of communicable diseases, and the severe cases of some of refugees due to the war injuries and the long term cost issues. Furthermore, the Jordanian citizens have been affected by several means such as reducing their accessibility to the public health services and increasing their out-of-pocket expense on health.

Since November 2014; things have become more complicated as it was decided that Syrians have to pay for their fees due to donors' withdrawal from funding and covering the health expenditure. Despite all of these constraints Jordan is offering the health services to Syrians at the same cost of uninsured Jordanian citizens, as the government subsidizes the treatment by 80% (JT, 2016). The estimated cost for Jordanian public healthcare services to Syrian refugees around

JD 271 million, and the overall cost since the beginning of refugee crisis until end of 2016 is JD 1.5 billion (Al Emam, 2016).

7.2.4 Donor Driven Sector

As Jordan is overburdened with unfortunate crises in the region; it makes Jordan dependent on external funding and foreign aids, including the healthcare services. The USAID is the largest donor to the health sector in Jordan (USAID, 2015). The respondents have raised several issues under this core category. It is quite fair to point out that health aid has some positive contribution on some aspects such as mother and child healthcare and other indicators, which was acknowledged by the respondents of this study. On the other hand, the respondents pointed to several issues related to the donors, such as dominating agenda setting, and the sustainability of projects and initiatives, which in some cases my become an extra burden on the government budget. However, at the same time they criticized the MoH and other entities for acting passively when dealing with donors, and for their slackness in setting our national priorities and defend it.

Some studies addressed the donors' relationship with LMICs including the health sector. Some of these studies pointed that donors and international organizations are one of the factors that influence the national health policymaking in LMICs (Liverani et al., 2013; Walt et al. 2008; Behague et al., 2009; Ensor et al. 2009; Khan and heuvel, 2007), but there are very few studies within the Arab context to evaluate the donor organizations influence on decision making generally and in health sector in particular. In a study conducted on policymakers from 10 countries including Jordan to evaluate the factors that affect health policymaking and the use of evidences in policymaking; around (72.5%) of the respondents thought that donor organizations

exerted a strong influence on the health policymaking process (El-Jardali et al., 2012 b, p 6). Despite the lack of studies in the Jordanian context regarding the donors relationship, there is an article that reviewed 'Obama Healthcare plan' written by an ex-Health minster; he mentioned an incident when he was a minister[19], that he wondered how the USAID and the World Bank were trying to impose certain directions – not mentioned in the article - on our health system. Although it was evident that USA has a number of pitfalls in their healthcare system, he explained in that article how he used an ex-USA health minister's book to argue with them about their suggestions to some issues (Hamzah, 2017).

Another study by Ensor and his colleagues stated that national policies are often influenced by international policy concerns and funding, and they presented Nepal's experience of focusing on maternity health for decade as it was one of the donor's main programs; the national agenda was altered to focus on child mortality as it was one of MDG objectives to gain the donors support (Ensor et al. 2009). Some studies pointed to the drawback of donor-driven policies; Khan and Heuve said that this dependency on donors could have a negative impact on the Ministry of Health and the government, as this dependency led to uncertainties concerning the amount and flow of financial resource and intrudes implementations (Khan and Heuvel, 2007, p283). Further, some studies such as Mussa and his colleagues found out that although donors supported the health sector, but they face difficulties in coordination between externally funded projects and MoH, along with other issues such as the brain drain from public health sector to international NGOs in the country and abroad (Mussa, et al., 2013).

Also, it's quite fair to indicate that some studies have pointed to the positive impact of donors on health status in developing countries. According to Afridi and Ventelou, health aid is broadly viewed to improve the health outcomes; their study found that health aid has reduced

[19] He was a minister between 1985-1988

adult mortality in developing countries (Afridi and Ventelou, 2013), while other studies found that donors have a positive impact toward the achievement of the MDGs (Behague et al., 2009). Also another study pointed that aid has a positive effect on the infant mortality rate, but still more support is needed to support the health indicators, such as the MDG targets (Mishra and Newhouse, 2009).

7.3 Critical Review of Options for Effective Health Policy Formulation

In this section; the options for effective health policy formulation will be presented and discussed. The respondents already participated in some ideas that were presented in the analysis chapter, yet, they just endorse the options without further supportive causes for being recommended; the only exception was when they pointed to some issues to support MoH option to lead the health sector policymaking, and when criticizing the ineffective role of the HHC in policymaking, or when they pointed to the need of empowering the HHC in order to be effective. However, the respondents' opinions were varied and it didn't show the most preferred options for them, particularly with relevance to MoH and HHC role in the national policymaking. Nevertheless, the main identified options from the participant's perspectives are:

1. The creation of Higher Regulatory Commission for health sector
2. The Medical Therapeutic Institution (MTI)
3. Empowering the HHC to lead the health sector policymaking
4. MoH should primarily take the lead for the health sector policymaking

The Creation of Higher Regulatory Commission and the replication of Medical Therapeutic Institution experience are considered the least preferred options as will explained in the next section. Further, the respondents contributed to some extent toward supporting the MoH in leading the policymaking and others were supporting the HHC role in policymaking, which were presented in details in the results chapter. However; the discussion of these options will be presented from theoretical perspective, then will present the most effective option for health policy formulation from theoretical and practical stands.

7.3.1 The least preferred options

Generally speaking, the creation of a Higher Regulatory Commission and the replication of the Medical Therapeutic Institution were the least preferred options, and they were only mentioned by few respondents, however, in this section, both of them will be presented, discussed and explained to show their inability to be adopted nowadays. The main arguments, particularly for the MTI will be descriptive as there is no adequate documentation to the MTI experience in Jordan as explained earlier. Thus, this section will contribute in filling the lack of information for MTI experience. Hence, the MTI is not considered a policymaking model/approach as it was a unique and incomplete experience in Jordan, however, it was explained as it was raised by the respondents and they link it in part with the main challenges that are facing the synthesis efforts within the health sector.

Furthermore, the Higher Regulatory Commission is not an effective option to be implemented due to several limitations, such as the difficulty of limiting the government role in the health sector to regulatory role only; particularly in the developing countries.

7.3.1.1 Regulatory Commission for the Health Sector

A few respondents suggested the 'Regulatory Commission' to administer the health sector, but only one has explained what he means by that, but the others they mentioned it as a general concept and they indicate it has been applied in Jordan in other sectors such as energy and telecommunication. Thus, this section presents the 'Regulatory Commission' experience in Jordan, and discusses how it is not applicable for the health sector in Jordan.

7.3.1.1.1 Introduction

Jordan has a market friendly strategy, and the private sector in Jordan has a major role in economy, and the private property and private enterprise is protected according to the law, which is based on both religious and secular principles (Kanaan, 2005). Jordan moves toward enhancing the private sector role in the economy by several initiatives including privatisation.

7.3.1.1.2 Privatization

The privatization fad in Jordan emerged in the beginning of 1990's, although it was justified by economists and experts, but the mechanism of privatizing most of the national institutions were ambiguous and some cases were debatable and spiky. Thus the public has negative impression toward privatization.

As a general view; the main drivers for the privatization were: the economic crisis of 1988 implications on Jordan, the rise of liberal economic and free markets, the external pressure practiced by the IMF, WB and USA, and the perceived low efficiency levels of state-owned enterprises (SOEs) in the economy, which was reported in some international organizations reports including the WB (Kanaan, 2005; Orieqat and Saymeh, 2013).

The assessment of privatization in Jordan is a multifaceted issue; particularly given the lack of information available to the public. In general, privatization has a number of pros and cons. However, as a response to the public pressure; the PM formed an independent 'Evaluation Committee' to review the privatization experience in Jordan. According to the report, some privatized entities were operating according to the best practices, while others were moderate and few are below standards. Also, less few cases were described as 'lacking transparency standards' (Al-Razzaz, et al., 2014), I think the expert team was moderate in presenting the results of the privatized cases, especially the highly criticized ones.

7.3.1.1.3 Regulatory Commissions in Jordan

Telecom and energy entities were privatized; their impact according to the evaluation report was 'positive impact' for telecom industry, while the electricity sector was described as 'below acceptable' (Al-Razzaz, et al., 2014). The government has established the 'Regulation Commissions', to organize the privatized entities; and there are a number of regulation commissions, most notably: The Telecommunications Regulatory Commission (TRC), Energy and Minerals Regulatory Commission (EMRC), and Land Transport Regulatory Commission (LTRC).

The main tasks and duties for the committees is to be responsible for all the regulations related to privatized entities scope of work, and insure the alignment of the entities work are according to the overall interest of the country. In addition to other tasks such as identify the service standards, to protect the interest of beneficiaries, to ensure fair competition, services pricing … (TRC, 2017; EMRC, 2017).

7.3.1.1.4 The possibility of adopting the Regulatory Commissions in the health sector

7.3.1.1.4.1 Public-private sector partnership

Privatization has many forms; the extreme is the total transfer of ownership to the private sector, while there are other forms such as contracting and partnership.

The effectiveness of public-private sector partnership is not widely evident in a developing countries context. A systematic review of research studies was conducted by Basu and colleagues to compare the performance of private and public healthcare system in LMIC's and they conclude that the reviewed studies didn't show evidence that the private sector is more efficient, accountable, or medically effective than the public sector, despite that the public sector has some issues such lack of hospitality toward patients and lack of timeliness (Basu, et al., 2012).

Conversely, this issue is debatable and other studies may claim the opposite and the private sector is more efficient in providing the health services. In an article a number of commentators have questioned the role of private health sector in poor countries; they were having two main opinions, the first one led by Hanson, Gilson, Goodman and Mills who pointed that there is no alternative to strengthen the public role in the health system, while the others led by Smith, Feachem, Koehlmoos and Kinlaw thought that the private sector should be engaged more to improve the healthcare in LMIC's (Hanson et al., 2008).

Further, some studies within developed countries contexts may support one of the previous opinions. For example, a study reported that although there is an increasing trend from European governments to partner with the private sector, in general the results showed that the experience with these partnerships has been mixed (Barlow, et al., 2013).

7.3.1.1.4.2 The Private sector role in health sector in Jordan

The 'Regulatory Commission' implies that the government has to withdraw or at least outsource – to a wide extent - its duties to the private sector (at least this is the concept that took place in Jordan). The private health sector in Jordan is already has around one-third of the health services share (chapter 2), and there is a good level of medical tourism in the region, which is mainly directed to the private sector.

It is noteworthy that the MoH has an agreement already with the private hospitals to provide Dialysis to the both insured and uninsured patients and the ministry handle 100% of the cost. In addition to having an agreement to provide healthcare services to the "first and special degree" which include the Ministers, House of Representatives members, Senators, high rank officials and their dependents[20].

7.3.1.1.4.3 Is it possible to implement wider partnership with private health sector in Jordan and have a (Regulatory Commission)

Private health sector is already in existence and being contracted for some services. There are no reliable studies that evaluate the performance of private healthcare sector that could be assisting toward extending the partnership and its expected cost and efficiency in Jordan. But it appears dangerous to think of widening the relationship with the private sector and think about privatizing the health sector for several reasons.

Several sources have addressed the role of the state vs market in providing health services and pointed that market failure is one of the main reasons that derives the state to be

[20] this group basically are insured in public sector hospitals, but they have the choice to use the private sector instead, and the MoH will pay them

primarily involved in providing the health services. Also the private sector is primarily profit driven, while the government may have to consider other issues such as equity even if some services are not cost effective. These considerations are applicable in Jordan along with other issues, such as the need to have a strong system of accountability and transparency for the state and when dealing with the private sector. I think if the government privatizes more services, it will incur more cost to the government budget. For example, currently, the government have to contract with a private company to work as an auditor to the received invoices from the private hospitals for the first and special degree insurance.

Further, In a paper prepared by the Jordan Insurance Federation (JIF), it is indicated that one of the challenges that faces the insurance companies for health insurance applications (in the private sector) is the potential misuse and misconduct practiced by some individuals, hospitals and medical centres, and the difficulty to monitor the service providers, which increase the insurance expenditure and marginalize their profit (JIF, 2014). This could be an indicator for the difficulty that will face the MoH if they heavily contracted the private health sector to provide the health services.

As for policymaking level, the Regulatory Committee is not the only influential player, as the policies of the sector(s) they regulated are dynamic and changing according to the market both internally and globally, which is not suitable for the healthcare services.

7.3.1.1.5 Summary

People in Jordan have an unfavourable image regarding privatization, or the excessive contracting with the private sector. Healthcare services are essential, and among people's priorities. Consequently, it is quite difficult to have the regulatory commission concept in the

health sector, more specifically for the market-failure principle and for the social security concerns, particularly as Jordan is overwhelmed by external and internal challenges, and is still suffering from the spill overs of the 'Arab Spring'. The government is trying to undertake the King's directions toward political reforms and enhancing the level of services with considering the efficiency and effectiveness, moreover, the citizens are now more aware of their rights and they will not compromise their rights in receiving good level of health services. Above all, Jordan is having difficult economic conditions. Thus, adopting such an option will be seriously dangerous on the national security level.

7.3.1.2 The Medical Therapeutic Institution

7.3.1.2.1 Introduction

The Medical Therapeutic institution (MTI) was established in Jordan in 1987, and it was cancelled in 1990. Unfortunately there are no records about (MTI) in the MoH or HHC; the only available information is its laws in the Legislation and Opinion Bureau- Prime Ministry database. However, a number of senior officials and stakeholders interviewed in this study witnessed the experience and they commented on it and they thought that if the idea were to be implemented again it will lead to synthesise the efforts of the multi health providers and enhance the policymaking of the health sector.

7.3.1.2.2 The main idea of the MTI

The main idea of the MTI is to create a central body for all public hospitals in the kingdom including MoH, RMS and Universities hospitals, and this body is responsible for the hospital policy

and participate with the overall policies of the health sector. Primary healthcare is the responsibility of the MoH. According to MTI law; citizens who are already insured have the right to visit any hospital in their areas regardless whether it was previously under MoH or RMS, while uninsured citizens will have to go through another process (but its subsidized services). The staff, both medical and administrative is subjected to the same regulations and consequently the same benefits (MIT, 1987, articles 2 -12). It was planned that the hospitals will be classified to three categories.

The MIT council consisted of: PM is the chairman and the military advisor of the king is the vice-chairman and the membership of: Minister of Health, the President of Jordan University of Science and Technology, the Chairman of the Joint Chiefs-of-Staff, the MTI general director and two experts appointed by the PM (MIT, 1987, article 6).

The MIT was perceived by most of the interviewed respondents as a good idea, it's somehow like NHS experiences, that primary healthcare is MoH responsibility and the hospitals have separate administration. Also I was told by some respondents that MoH staff was happy of the experience as they enjoy more benefits than being with MoH alone, as RMS and JU's have better-off conditions for staff compared with MoH, so it achieved equity among staff. Other benefits are having one reference point to all hospitals, the purchase of the medical supplies and other requirements are centralized which save the cost and efforts, it is supposed to lead having centres of specialties in hospitals, in addition to maintaining equity for service quality to citizens.

However, the MTI was cancelled according to law no 10 for year 1990, the law didn't indicate why the MTI was cancelled rather it's stated it was because of the procedures and the legal and financial implications. The law mainly stated that the MTI does not exist anymore and everything will return to its previous status before September 1987, and the MoH is responsible to handle any disputes or financial implications (MIT, 1990, articles 2 -8).

7.3.1.2.3 Why the MTI has failed?

Despite the perceived benefits by some respondents of the MTI during that short period or the expected benefits if it was prolonged, the institution was cancelled in 1990. There are no studies or assessment reports on the MTI experience; however the discussion of this question is based mainly on the study respondents' opinions. The main reasons are:

- The favour of narrow interest instead of the overall interest of the health sector in Jordan.
- The fear of military domination on the administration of the MTI.
- The resistance from JU's staff as they were not satisfied to be managed by an institution of whom the majority were from a military background.
- Although MoH staff was happy with the benefits they get; MoH seniors are not happy to lose their power over the health sector, as MoH used to be – and still is – the largest healthcare provider and insurer.
- The conflict of interest; the seniors in MoH, RMS and JU's has lost part of their benefits and gains when they join a unified system to all hospitals, so the resistance was not only from MoH seniors, but from RMS and JU's as well.
- The financial implications; as all staff supposed to enjoy the same benefits, which means either raise all MoH staff (mainly medical) to be on level with the benefits of RMS and JU's or reduce some of RMS and JU's benefits with little raise to MoH staff to be almost equal.
- The pressure on RMS and JU's hospitals due to their advanced level compared with MoH hospitals.
- The inability to accommodate some specialities to RMS and JU's, for example the educational programs of the JU's in the hospitals.
- The lack of coordination and commitment between relevant parties.

- The institution duration was very short, so it was not able to undertake its tasks and work to yield recognized results.

7.3.1.2.4 The replication of MTI nowadays

Some respondents recommend the need to replicate the MTI experiences nowadays, and they thought it will solve the fragmentation in the public health sector, while others although still thought it was a good idea, they were pessimistic, moreover, they said that the causes that leads to fail the MTI still to some extent existed nowadays, mainly the conflict of interest.

Although in theory the MTI looks a good idea, it would be difficult to replicate it nowadays. Most of the reasons that were raised by the respondents are still valid. Moreover, now and after 30 years, every one's power (MoH, RMS, JU's) has even duplicated and their independent entities become deeply rooted, and it's not easy to merge them again or to bring them together under one administration.

Another important constraint to the implementation of MTI or an improved version to that experience is the current status of the primary healthcare (PHC) in Jordan. Although MoH has a wide network of PHC centres all over the kingdom; the investment of the PHC is very weak compared with secondary and tertiary care as public sector expenditure on curative care are (75%) compared with (15.7%) on PHC of the total expenditure. This issue has to be addressed seriously first, even if the target was not the replication of MTI experience due to the high expenses on the curative aspects, MoH addressed the issue of PHC in its latest strategy and the one before, but the situation is not improved yet. Also the citizen's behaviour is an obstacle, as they used to visit the hospital directly without being referred, or even if they visit the PHC centres they consider it as referral point not treatment centre. Thus, to change this behaviour of patients

and even for care providers it does need several aspects to be addressed and it will be a long process.

7.3.1.2.5 Summary

In principle the idea of MTI aimed to create a unified reference point to the hospitals and its administration and set it policies. Yet the idea was challenged and then failed, also many challenges still existed. Thus, there should be another approach that will lead to synthesis of these entities' efforts, which maintain their identity and in the same time increase the level of cooperation and coordination among them.

7.3.2 Effective Health Policy Formulation Options in Jordan

As indicated earlier; there were a number of suggested options for the effective health policy formulation in Jordan; two of them were least effective, and the other two options were suggested by the respondents but with no solid consensus on one of these options. Nevertheless, most of the respondents acknowledged the strong status of MoH and they criticised the ineffective role of the HHC in policy formulation. This section will discuss the role of the MoH and the HHC in health sector policy formulation from theoretical perspective, but it is quite important to explain the main challenges for policy transfer and learning for Jordan case.

7.3.2.1 Policy transfer and learning for Jordan's case

The Healthcare system in any country is considered a unique one. In general, the healthcare system in general is faced with a number of challenges that could be found in other

countries but with various levels or effects, and some countries could have similar challenges with slight differences due to the contexts they exist in.

Some countries may conduct reforms or change their national health systems to meet the demanding needs and challenges they are facing. Learning from other countries experience and systems could assist the country to undertake change or reforms for their current systems, and this could be individually done as an initiative by any given country, or it could be done through the international organizations' assistance (i.e. WHO, EU, IMF …) when requested (Baggott, 2015; Dolowitzand Marsh, 2000). It is claimed that in small and poor countries, the learning and transfer of knowledge is important, but it should be considered with relevance to the local context (WHO, 2006). However, learning process and transferring ideas seem to be easier between similar types of health systems (Marmor et al., 2005). In general, identifying the purposes of conducting comparative studies is an essential step to facilitate learning process (Marmor et al., 2005; Dolowitzand Marsh, 2000). Usually comparative health policy analysis concern about 'learning *about* national health arrangements and *how* they operate, learning *why* they take the forms they do, and learning policy lessons *from* those analyses' (Marmor et al., 2005, 339), according to Marmor and his colleagues these classifications are not well addressed by scholars (Marmor et al., 2005).

On the other hand, although learning and policy transfer could be helpful; it has some challenges. According to Baggott, even if any country decides to conduct changes in their health system based on other countries' experiences; policy is then 'implanted differently once imported' (Baggott, 2015). It's claimed that in practice, only limited policy learning may actually exist (Ettelt et al, 2012 cited in Baggott, 2015; Marmor et al., 2005), and in most cases it faced local cultural resistance (Marmor et al., 2005). Another challenge related to learning from other countries experience is the focus of comparative research on institutional structure rather than

the outcomes such as health status or health inequalities (Marmor and Wendt, 2012). Also, learning about health policy implementations requires both defining and measuring health policy results (Marmor and Wendt, 2012). In general the development of policies could be linked to certain events, decisions, policies and ideas outside its borders (Baggott, 2015, p263). Finally, it is claimed that 'The delivery and finance of healthcare vary between nations more than any other public policy' (Poullier 1989 cited in Marmor et al., 2005, p338).Thus, the challenges associated with policy transfer and learning in health policy field lead to the lack of policy transfer and learning studies (Marmor et al., 2005).

7.3.2.1.1 Unique features for Jordanian health systems and its policies and strategies

Jordan has a number of unique features that make it difficult to copy other countries experiences. This health policy formulation needs to accommodate the unique features, which have already been explained in more details earlier, but in particular:

- **Unique development status**

There is an issue related to the classification of developed vs developing countries, or LMIC's and HIC's. Although these classification are universal, due to the contextual factors there are variations among countries within the same classification, so even there is a lack of health policy studies in LMIC's[21]; the available ones are not suitable to be compared with Jordan's situation which is classified as "upper middle-income country", with good health indictors, so it was difficult even within developing countries to find something comparable to Jordan's case.

- **Impact of location in a high conflict area**

[21] I think quite number of studies are focusing on African Countries, who are facing difficult situations, mostly the HIV and AIDS control, so most studies are focused on these issues, which do not exist in Jordan

Another feature is that Jordan is located in a high conflict area, which resulted in having several refugees' waves since 1948 to present. According to an Amnesty International (AI) report; Jordan has topped a list of 10 countries that host more than half of the world's refugees, (Amnesty International, 2016). The refugees' influence on health sector has explained earlier, which turned to be very crucial, despite that, Jordan is not receiving the needed support from the international community and donors. The conflict in the region has caused constant fluctuation in Jordan, thus, the policy formulation needs to be flexible and adaptable.

- **Strong Medical Military services**

Further, there is a strong Medical Military services, but this unlike many military health services has spilled into a civil insurance style of service in Jordan for the current and retired military members and their dependents. Several countries are providing medical services to its members in field areas during emergencies or near the boarders, however, even some of them provided medical services to its members and their dependents; they gradually integrated with the civil insurance. Jordan is one of few countries that medical healthcare services still provided by the military medical personal through the Royal Medical Services (RMS). RMS is the second largest public entity which provides primary health care services in addition to secondary and tertiary (details in chapter 2). Moreover, the RMS has regional and global contributions through sending its medical teams and field hospitals to disaster and conflict areas, and their services continually increased internally and globally.

7.3.2.1.2 The Absent of a National Health Policy in Jordan

As indicated in chapter three; there is a gap between the proposed and actual role of the HHC in formulating the national health policy. The first national strategy was for the period (2008-2012), yet it was neither implemented, nor evaluated and the HHC become overshadowed again. As a general overview; the strategy seems to be mainly descriptive, also, some indicators were not realistic and not justified, and many objectives were set without proper timelines and lack of clear mechanism, even the situation analysis was not comprehensive (Appendix 2.11). Consequently; it was difficult to conduct policy analysis and generate the learnt lessons, as policy analysis is vital for evaluating the policy failures or successes both retrospectively and prospectively (Walt et al. 2008). Further, the current national strategy for (2015-2019)[22] was still evolving when carrying out this study. Thus; conducting policy analysis was difficult, as well as, it was not the prime intention of this study.

7.3.2.2 Effective policy formulation options from theoretical perspective

It is quite challenging to suggest the proper framework to formulate the national health policy in Jordan due to various reasons including the aforementioned reasons, and due to the importance of contextualizing the health policy environment in terms of theories. Nevertheless, the public policy theories could be used to some extent as guidance to analyze the developing countries' policies (Osman, 2002; Walt, et al., 2008). Before presenting the convenient model for the national health policy formulation, the main approaches for policymaking will be viewed bellow:

- **Ministry lead approach to the national policy formulation**

[22] The strategy was later shifted to be for the period (2016-2020)

In many countries – including Jordan – the MoH is the main health service provider. Accordingly, the MoH is the key players and the main influencer on the health sector policymaking. The MoH in many countries is seen to handle the task of policy formulation and communicating with related parties, and communicating and coordinating with donor and international aid agencies (Cassels, 1997; WHO, 1998; Omaswa and Boufford, 2010) in addition to be assigned with producing the national policy document in many countries (WHO, 2000).

Some authors distinguish between 'Health Plan' and 'Healthcare plan', as the latter focuses more on healthcare provision (ex. Green, et. al., 2002). In Jordan, the legislation entitled the MoH wide authority to manage the public health issues, either directly or by coordinating with other relevant entities. Reviewing some documents and publications such as the MoH strategic plan (2013-2017), showed that the MoH plan includes objectives and activities that are beyond healthcare provision as it includes a number of objectives and activities that planned to be implemented in corporation with partners from public sector entities, such as environmental health services, school health services and occupational health services, in addition to coordinate with other national and international partners such as RMS, UNRWA, USAID and WHO.

However, there was a critique occasionally to the MoH overall role in setting its strategies and plans, such as the lack of effective coordination with other related entities and stakeholder's involvement. In addition, not to practice their full authorities sometimes even they are entitled to do that by law.

Nevertheless, a quite number of respondents believe that the MoH should lead the health sector policymaking due its potential and as being mandated by law, and some of the respondents even questioned the existence of the HHC as long as MoH existed, and they mentioned several supporting points for that (more details chapter 6). In general, the MoH policies and strategies

could be described as central, top-down, and MoH policymaking approach tends to be incremental mainly.

On the other hand, there was an early recognition in Jordan that health issues is not limited to the health service provision and Ministry of Health as health issues that intersects with other sectors, and there is a need to coordinate among these related sectors. Accordingly, the idea of the HHC establishment has emerged to advise and assist the MoH in this regards. However, the HHC role in the national health policy formulation was ineffective so far and faced with several limitations that were explained in chapter 3 and chapter 6. In practice, the MoH overshadowed the HHC role in leading the health sector and its related issues.

In the next section, two of the health policymaking options will be discussed, followed by the discussion of the models of policymaking and its implications on Jordanian context.

- **The collaboration approach**

There are some approaches which aimed to enhance the policy formulation for the health issues through collaboration, as a general note, some of them were used for specific situations and didn't gain considerable attentions due to some limitations associated to that approaches. However, the **Health in All Policies (HiAP)** framework gains considerable attention in the last decade, which becomes increasingly favored by the WHO.

> *Health in All Policies* is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an

> emphasis on the consequences of public policies on health systems, determinants of health and well-being. (WHO, 2014, p 9)

The HiAP framework has six key components that should be considered in order to put the HiAP into actions: (1) Establish the need and priorities for HiAP (2) Frame planned action (3) Identify supportive structures and processes (4) Facilitate assessment and engagement (5) Ensure monitoring, evaluation, and reporting (6) Build capacity (WHO, 2014, P7). The HiAP is seen to reflect the principles of (a) legitimacy of rights granted by national and international law (b) accountability of governments towards their people (c) transparency of policy-making and access to information (d) participation of wider society in the development and implementation of government policies and programmes (e) sustainability in order that policies aimed at meeting the needs of present generations do not compromise the needs of future generations (f) collaboration across sectors and levels of government in support of policies that promote health, equity, and sustainability (WHO, 2014, P9).

In principle; it could be said that some of the 'proposed' tasks that should be performed by the HHC are severing slightly the concept of the Health in All Policies (HiAP), for instance, the HHC membership includes the Ministry of Labour, the Dean of one of the medical faculties to represent the related medical education sector, also as indicated that the MoH strategic plans includes a number of tasks/activities that conducted with other partners such as 'school health' in coordination with Ministry of Education, and the 'occupational health' in coordination with ministry of labour. However, adopting the HiAP in Jordan is expected to be faced with several challenges, most of these challenges were similar to those that are facing the formulation of the national health policy in Jordan and the challenges that are hindering the HHC to be effective (Chapter 3 and 6).

The researcher thinks that a number of the pre-requests for adopting the HiAP approach is not quite existed in Jordan, most importantly is the lack of coordination among governmental sectors and within the health sector entities, which was highly stressed by the respondents (section 6.4.2.2 and 6.4.3.3). Furthermore, the HiAP is a very wide scope, and the researcher thinks that the HiAP is an advanced stage of sectoral coordination's that requires initially each sector is well-structured and has its policies/strategies that are well-developed, implemented and monitored. Accordingly, the coordination and networking among sectors under the HiAP framework will yield its expected results. Further, this approach requires pluralist policy decisions, while in Jordan; like many developing countries, the power is most likely central, in case of health sector its central to the MoH. Moreover, some parts of the HiAP approach concepts and principles still evolving and it needs to be articulated and well-established such as 'joined-up' initiatives (Carey and Friel, 2015).

On the other hand, the main focus of this study was on the national health sector 'itself' policy formulation that includes its main health providers and other related and supportive entities (ex medical associations). The results of this study showed that there is a need for tremendous efforts to overcome the various challenges that are facing the national health policy formulation within the health sector in particular and within the context of public polices in Jordan in general. Consequently, when being able to formulate and implement the national health policy effectively; then in future, it will facilitate adoptions the HiAP framework as an advanced cross-sectoral cooperation in relevance to health issues. However, the assessment of the HiAP framework components, pre-requests and it is potential for being adopted in Jordan required more detailed investigation, which is not essence of this study, as the main concern currently is the national health policy formulation within the health sector and other health related entities.

- **Summary**

The MoH role in leading the health sector policies is inevitable; however, the MoH should ensure that stakeholders' not only consulted but also actively involved in the National health policymaking. There are different approaches that could be utilized, which should be examined to the context of each county. The HiAP was seen as a favored approach for collaborations cross sectors, however, the limitations of its utilization in Jordan was discussed.

Further, it was explained earlier that Jordan faces various challenges that hindering the national policy formulation efforts despite the existence of the HHC and the wide authorities granted to the MoH by law. Thus, one of Jordan's main considerations is how the national health policy should be formulated. In the next section, the main models of health policy formulation will be briefly discussed in relevance to Jordan's case, and then will suggest the most convenient model that best support the efforts of formulating the national health policies.

7.3.2.2.1 Models of Policymaking in the health sector

There are a number of public policy models that have its major concepts, which contributed to study the public policy from different angles (Dye, 2002; Kraft and Furlong, 2010). Health policy is considered a multi-disciplinary field, thus, the public policy theories and models could serve the health sector and its policies. Some public policy theories and models could explain the decision making in the health sector to some extent. However, some authors (ex. Walt, 1994) indicated that there are three models that could be more relevant to health policy

and planning compared with other models, they are: rational, incremental and mixed scanning model (see section 4.3.8).

- **Rational model**

In general the rational approach was described as being a 'distance ideal', then Simon proposed the idea of ‘bounded rationality’ which implies that policymakers seek to achieve satisfactory level rather than reaching the maximum level, (Simon, 1957 cited in Walt, 1994, p48), however, this approach still receiving considerable criticism. The researcher thinks when the government based its policies and strategies on the rational model merely, it probably will not effectively achieve its objectives, and also it causes a gap between policy formulation and implementation. In this study, a number of respondents indicated that some of the MoH strategies/decisions are 'just ink on paper', which could be attributed to some causes including the desire to set rational strategies without realizing the real boundaries on the ground, thus there is a gap between polices/plans and their implementation.

- **Incremental model**

The incremental model is seen to be practical and it saves time and effort to reach to a satisfying level of decisions. The MoH policymaking approach is tend to be 'Incremental', which could be fairly said it was convenient to Jordan's case to some extent, particularly due to the challenges that are facing the health sector, including the limited resources and the rapid turnover of the government and the MoH Ministers. Some respondents implicitly pointed to the advantages of incremental model, for example, they pointed that despite facing several challenges, we still achieve a good level of service and we have a good health indicators according to WHO statistics, they attributed this partially to the existence of specialized directorates in the MoH which have sub-strategies and plans (ex. NCD's, mother and child healthcare…) which contributed to the MoH and health sector overall aims and objectives.

However, this model was criticized for being too conservative, as it depends on few incremental changes, which may hinder the creativity, and adopt new strategies and conduct major changes. The researcher thinks this critique is valid to some extent to Jordan's case as incremental model focus on policymaking within bureaucratic entities and it's difficult to introduce radical changes to MoH and health sector strategies. It was noted by the study respondents that despite we already have a good level of health indicators, working on the micro and meso level most of the times will eventually lead to lose our competitive advantages and waste our limited resources due to the lack of an overall directions on the macro level to our health sector. Incremental model is used more likely for meso and micro level of planning, while planning for macro level requires more creativity and flexibility, and the national health policy requires the integration of the three levels together, thus the mixed scanning model is more convenient for the national policy formulation

- **Mixed scanning model**

Rational or bounded rationality model is ineffective under uncertainty context along with other limitations. Although Jordan is a stable country, the regional occurrences have major impact on Jordan's policies including the health sector, which implies that it is difficult to adopt the rational model merely in Jordan. Further, some of the pre-requests of this model is not well-structured, such as adopting evidence based policy concept to a wide extent when formulating the polices and key decisions. On the other hand, in Jordan; most of the public sector policies and strategies are following the incremental approach most likely. Nevertheless; the adoption of stand-alone models (rational vs. incremental) is not favored as each of them has its limitations, thus, the mixed scanning model has emerged in order to avoid the rational and the conservative assumptions. Etzioni assumes that mixed scanning model will considered both macro and a micro

level of decisions (Etzioni, 1967). In reality, it is difficult to classify a certain country to adopt either rational or incremental model merely, as it is actually falls somehow between these models, but with various ranges.

- **Mixed scanning model and the National Health Policy formulation in Jordan**

The researcher thinks that mixed scanning model will enable the MoH to formulate the national health policy more effectively in coordination with the HHC. The national health policy should include elements that related to the rational and incremental model of policymaking; thus, it will include long-term rational goals, and short and mid-term objectives to be implemented incrementally. Further, despite the policy formulation is top-down most likely, the mixed approach will facilitate the opportunity for bottom-up contribution when considering the strategies and plans on micro level. Moreover, the health issues are complex and require coordinating actions across health and non-health sectors, it requires more flexibility and active involvements of other related sectors in setting health sector policies and strategies which could be achieved through the mixed scanning model.

As will explained in the next section, the MoH has the power and the potential to oversight the health sector issues on long, mid and short term, however, it become overburden with issues on meso and micro level, thus, the HHC could assist the MoH on setting and achieve the long-term goals of the overall health sector and coordinate actions across sectors and other key actors from other public entities, private sector and NGO's. The coordination should couple also with active involvement of the key actors in the policy formulation for the health sector. Key actors and stakeholder's engagement in policy formulation and implementation has gained attention in general and there are some recommendations for enhancing the participation with other related actor's such as stakeholder's engagement approach and actor network theory,

however, as for the health sector in particular, there is a considerable attention to the HiAP approach.

The limitations of adopting the HiAP approach currently in Jordan were pointed earlier, also the key components of the HiAP approach were identified among the challenges that are facing the national health policy formulation in Jordan; most prominently is the lack of coordination among public ministries and entities and lack of coordination within health sector entities, which's the essence of the HiAP approach, in addition; the HHC role in policy formulation is ineffective, which in theory should lead the coordination actions in the health sector and other related entities. Thus, to facilitate the adoption of the HiAP approach; the identified challenges should be remediated. Nevertheless, I think that the mixed scanning approach could create the platform for the HiAP adoption in the future, as the mixed scanning approach will consolidate the efforts for setting clear and realistic policy goals for the health sector and enhance the policymaking process, which eventually will have positive impacts later on the cross-sectoral coordination's. Thus, I think that the cross-sectoral coordination's (the essence of HiAP approach) requires the health policy formulation, implementation and evaluation within the health sector are well-established and functioned, and the coordination's among relevant health entities are grounded on solid base in the health sector initially, and then the health sector (in Jordan; MoH and the HHC) will be able to lead the adoption of the HiAP approach effectively in the future.

7.3.2.2.2 Effective policy formulation from practical perspective:

Although some respondents criticised the MoH for some aspects, such as the lack of coordination with other relevant entities, they still support its key role in leading the policy formulation in the health sector. On the other hand, It was evident in this study that the HHC

currently is ineffective and incapable to lead the health sector policy formulation. Nevertheless, from practical perspective; it could be said that the effective policy formulation in Jordan is that **MoH should take the lead for the health sector policy formulation in coordination with the HHC**. Following, a summary to the main challenges that face the HHC in leading the health sector policy formulation, and then present the potentials of the joint efforts between MoH and the HHC in term of formulating the national health policy.

7.3.2.2.2.1 The main challenges that face the HHC role in leading the policymaking in health sector

Most of the respondents thought that the council has an ineffective role, and even some of them are not optimistic of the council's role after it was recently activated. Hence, it was indicated earlier that a quite number of the respondents are seniors who witnessed several periods of the council history and they were synchronous to periods where HHC by-law(s) and law changed, particularly since 1986, and some respondents were members in the committees that were assigned to draft the latest National health strategy (2015-2019).

The reasons that led the HHC to be ineffective were presented in detail in chapter (6). In general, the council was unstable since it was established; the council chairman was changing between the PM and the MoH Minister constantly, even its members were changing each time the council by-law(s) changed (Table 3-1, chapter 3). The council law and by-law(s) indicate its duties, but without ensuring the council the needed authority to perform these duties. Further, the HHC secretariat is having limitation in resources, and it is not well-equipped with adequate and qualified staff.

One of the main challenges that face the HHC is the clashes between MoH duties and the HHC role in setting the health sector policies, strategies and plans. As indicated earlier the Public Health Law is granting the MoH wide authorities in managing all health and public health issues all over the kingdom, including setting and suggesting the needed policies and regulations. Interestingly; all of the HHC by-laws were issued based on Public Health law from (1966-1999)[23] and since 1999 it become the HHC law.

The government high turnover rates, the PM wide span of control, and the different perspectives toward the HHC role, the prickly relationship with MoH, along with the council internal weakness; has led to freeze the council's role for several years. The council in some periods was no more than 'ink-on-paper'. The first general secretariat was established in 2002, previously the general secretariat duties were swinging between the PM and the MoH ministerial offices, and even after 2002; there are periods where the HHC had no SG (figure 6-15, chapter 6).

Will the HHC will be able to lead the policymaking for the health sector?

It is clear that the HHC is seen as a necessary organization in principle, but the constant change of the structure means it has never worked properly. The HHC has witnessed more than one attempt to reactivate its role, but it was not quite successful yet. Although there is no national assessment report on the HHC role in health sector policymaking, the absence of its effective role over the years is a quite obvious sign to its status. Further, some international reports such as The World Bank 1997 and 2005 (chapter 3) has indicated the HHC ineffective role.

The issue now: will the HHC will be able to lead the policymaking of the health sector?

[23] The legal statement of the HHC issuance for 1966 - 1980 - 1986 is: By-law No () for the year () High Health Council by-law, issued Pursuant to the article () of the Public Health Law No () of year ().

The researcher thinks that the HHC will ***not*** be able to lead the policymaking of the health sector under the current status, for several reasons;

In general, most of the aforementioned challenges still exist, and some of them are inevitable.

The HHC has no authority over the health sector, it has a consultative role only[24]. In reality, MoH has the regulatory and executive power over the health sector in the kingdom. The other health sector entities have power too, mainly the RMS. The private sector is a major component, but mainly the MoH by law has the executive and regulatory power over the private health sector.

The lack of major contributions:

There are no records of the HHC contributions in the 1970s, 1980s and 1990s, but according to the participants' opinions and witness to that duration; they indicate the the council was ineffective for most of its duration. An example of that is the MTI experience (1987-1990) that was explained earlier; it is noticeable that the HHC was not part of the MTI board, and even was not mentioned in any of its articles, which could be justified as a sign for its insignificance at that time. However, things have changed, and could be traced back to the new law in 1999. Since the council was activated in 2002, the council conducted and contributed in some studies and reports in addition to producing the National Health Accounts (NHA), but it was not able to have major contributions on the national policy and strategy level.

Although the HHC conducted a number of studies, such as Human Resources for Health, there appear to be no successful examples of the HHC's actual contribution to the health sector issues, even after it was activated. For example the Human Resources for Health (HRH); now it's

[24] The HHC was called the ''High Health Advisory Council'', from 1965-1977

become a serious problem, the HHC has identified a number of challenges for the HRH due to the absence of the National HRH strategy, and some of these challenges are: lack of national training plan, poor investment in HR development, and inability to retain the qualified staff (Al-Hadidi and Al-Kurdi, 2016). However, the HHC has issued the 'National Human Resources for Health Observatory' for the years 2013, 2014 and 2015, and all of the identified challenges are still the same without being approached yet, even more, the recommendations in the end of each report are the same over years.

More importantly the national health strategy itself:

- ***The national strategy for (2008-2012)***

It was the first national strategy prepared by the HHC, yet as a general overview, it seems to be mainly descriptive, also some indicators were not realistic and not justified, and many objectives were set without proper timelines and lack of clear mechanism, even the situation analysis was not comprehensive (Appendix 2.11). Nevertheless, after the strategy was prepared in 2008, the council didn't meet until late 2013, and eventually the strategy was not implemented.

- ***Shifting the National strategy from (2015-2019) to be (2016-2020)***

The national health strategy process was mentioned in chapter 3, but surprisingly the time-span was recently shifted. The HHC official's website states that the national health strategy is for (2015-2019)[25]; nevertheless, in May 29, 2016, it was published in some local newspapers and one of the private TV channels that the HHC SG conducted a press conference with some journalist to announce the launch of the 'National Strategy for Health Sector in Jordan (2016-2020)', it was reported that the HHC SG explained the main themes of the strategy (Al-Tarawneh,

[25] Last check on the HHC official website is Feb 19, 2017.

2016). There were no justifications for this shift, even all of the official documents on the HHC website and even Jordan webpage on WHO website for example still indicating that the national strategy is for (2015-2019). There was no clarifications why this shift occurs, but anyway the researcher thinks that this is an indicator for the HHC inability to manage the strategy so far, it was partially justified in late 2014 to shift the strategy and to be from (2015-2019) instead of (2014-2016) as it took them a while to set the national strategy in cooperation with relevant parties, but now it is shifted again. Another interesting note is that the HHC didn't conduct a proper launch for the strategy after being shifted to (2016-2020); they only invite some journalist to the HHC meeting room and present the main themes of the strategy, without other activities, or the presence of the relevant partners and stakeholders.

Summary

The idea behind establishing the HHC is noble and vital to the health sector in Jordan, yet the previous attempts were not quite adequate to enhance the council's role in leading the policymaking for the health sector. It requires tremendous efforts and changes to enable the council to undertake its duties, such as change in law to grant it the necessary authority, which seems not to be within the foreseen future. In summary, the council in its current status is not capable to lead the policymaking of the health sector.

7.3.2.2.2.2 MoH should primarily take the lead for the health sector policymaking

In many countries – including Jordan – the MoH is the main health provider, accordingly, the MoH is the key players and the main influencer on the health sector policymaking. It was indicated earlier the Public Health law; MoH has a wide authority to manage all related issues to the health sector. Quite number of respondents believe that the MoH should lead the health

sector policymaking, and some of them even questioned the need for the HHC as long as MoH existed, and they mentioned several supporting points for that (more details chapter 6).

Will the MoH will be able to lead the policymaking for the health sector?

In practice, the MoH is the key player of the health sector and its policies. The MoH has a number of strengths – in addition to what presented in chapter 6 – that entitle the Ministry to lead the health sector policymaking, mainly:

- **The Power**

Power is at the essence of every health policy process (Walt 1994; Erasmus and Gilson, 2008). Power is not limited to the agenda settings and policy formulation, as some authors pointed to the importance of examining the practices of power in health policy implementation, which is still an underserved research area in LMICs (Erasmus et al., 2014; Gilson, et al., 2014; Erasmus and Gilson, 2008). Thus, MoH has the power for policy formulation as a key actor, and has the power of implementation as the main public health provider in Jordan, and is entitled by law to influence other entities and sectors in issues related to health and public health.

- **The ownership of various resources**

Setting a national strategic plan requires resources, mainly the qualified staff and the information (Green, et. al., 2002). There is no comparison even between MoH and HHC in this regards as the MoH is well-equipped with qualified staff and specialized directorates, while the HHC is not equipped with adequate qualified staff (currently only four staff members in the HHC are working on the national health strategy, along with following up other tasks). The organizational structure of MoH is shown in Appendix 7.2, the organization structure of the HHC in Appendix 7.3.

Obviously, MoH is the source of the main health indicators and other data, they have a specialized department and sections devoted to that, thus, and even when the HHC prepares the National Health Accounts (NHA), they depend on the MoH, however, it's important to indicate that the HHC has no difficulties in obtaining the available data from MoH database. On the other hand, the MoH has more potential and capacity to obtain the information needed from other entities, and even to produce it if needed.

- **Coordination with donors**

The Health sector receives external funding and foreign aid. Thus, it's important for Jordan to maximize its benefits from available funding opportunities, and for that reason Jordan assigned to the Ministry of Planning and International Cooperation (MoPIC) the task to coordinate with donors and cooperate with the relevant local stakeholders. MoPIC and MoH are having a good level of cooperation. Basically, most of the funded projects have to pass through the MoH to other entities and including NGO's.

The coordination of health sector funded projects and initiatives is gaining particular attention due to several reasons, mainly; the existence of more than one donor - despite USAID being the main donor to the health sector in Jordan, there are other donors, mainly the WHO, other UN agencies that support some health issues, such as UNICEF. Nowadays there are a number of international agencies, NGOs and charitable foundations on global level. Thus it is vital for all these donors to have a central point such as MoH to oversee the funded projects and initiatives. The other reason is the excessive burden of refugees' crisis on the health sector, consequently some donors have contributed in funding some health services.

Some respondents thought that the funded projects and long partnership with donors such as USAID, could be a reason for the continuity of some plans that depend on those projects and initiatives. On the other hand, from the researcher's own observations and from the respondents' views; the relationship with donors is not optimal due to some causes within Jordan, such as acting passively when identifying the priorities … (more details chapter 6), and due to the 'moderate-low' level of coordination among donors themselves, which I think should be done primary through MoH in coordination with MoPIC. In sum, it is the time not only to think about how to increase funding, but most importantly to think about aid effectiveness.

- **The sub-sectoral committees**

Although MoH was not able to set a formal national strategy to combine the various public health providers, they have a number of committees that organize some health issues on the national level, which includes partners from public health entities, NGO's, UNRWA and private sector, such as Non-Communicable disease committee. Actually this point has been raised also by some senior respondents from various backgrounds including working previously in MoH, national institutions, and health experts.

One of the MoH national initiatives, is the establishment of the Joint Procurement Department (JPD) in 2004, which combines all public health sector entities in its board, its main aim is to unify the purchasing system for medicines and medical supplies in public sector, which will have several benefits including cost reduction (Appendix 2.7).

- **MoH chairman and membership of key health and health related institutions**

MoH Minister is formally the Chairman of the Board of Directors (BoD) to a number of public institutions and the MoH SG is a member in the BoD, those institutions are: Jordan Food and Drug Administration (JFDA), Joint Procurement Department (JPD), Jordan Medial Council (JMC). Also, the MoH minister is currently the chairman of the HHC, (Appendix 2.7) presented brief about these institutions.

Further, MoH is a memberin the BoD in a number of National institutions and National NGO's, mainly:

- The Higher Population Council (HPC): MoH is a board member.
- The National Council for Family Affairs (NCFA): MoH is a board member.
- The Jordanian Nursing Council (JNC): MoH SG is the vice-president, MoH head of nursing department is a board member.
- Higher Council for Affairs of Persons with Disabilities (HCD): MoH SG is a board member.
- National Women Health Care Center (NWHCC): MoH SG is a board member.
- Health Care Accreditation Council (HCAC): MoH head of quality directorate is a board member.

- **The stability of the next in line officials**

MoH and other ministries witnessed the problem of high government turnover; usually the Secretary General (next high official rank position after the minister) usually has more stability in his position duration. While its varies from one ministry to another, but it could be several

years, for example the MoH SG was in his position for six years, and he recently retired[26]. Also there is more stability in the directorate directors' positions, which lead to having continuity to the work - to some extent - due to that stability. Some studies have pointed that in some countries, including developing countries, not only the 'Street-level bureaucrats' employees influence the implementation of the policy, but also contributing in its formulation. This issue is a coin of two faces, as it could be important for stability, on the other hand, it may hinder the change and advancement, and there is a fear of seniors' manipulation to their positions and power that coupled with short minister durations, thus, the SG of MoH and any other ministry should have both advanced technical and managerial experiences, in addition to policymaking skills.

Summary

In general, the MoH owns the power, the resource, the executive authority, the authority to coordinate with donors, and networking with national institutions related to health issue, but the HHC didn't enjoy any of these aspects. Although the MoH has no formal national health policy document; it follows the sub-sectoral national committees to follow up some health aspects.

However, the MoH is overburdened with the daily routine and huge responsibilities due to the fact of being the main public healthcare provider. Although MoH is entitled with all public health issues according to the public health law, but with the current structure of MoH and huge burden it is not quite able to manage the overall national health strategy issues. Thus, the Minister of Health should have a ''policy advice unit'' that contributes to synthesise the MoH efforts with other concerned parties to achieve the main goals of the national health strategy, and

[26] He retired in Jan 2017

current sub-national initiatives. Thus, as long as we have the HHC it could act like the 'policy advice unit' to the MoH.

7.3.2.2.2.3 MoH should take the lead for the health sector policymaking in coordination with HHC

Arguably from the evidence of this thesis and the literature review. The most effective option is that the MoH should lead the health sector policymaking in coordination with the HHC. The main claims for this option are:

- **It will serve in enjoying the strengths aspects and the strong position of the MoH**

  As mentioned previously MoH owns the power, various resources and networking with relevant health related entities. Thus, it is expected to facilitate the council's role when contacting and coordinating with these various entities. Hence, as mentioned earlier the MoH is chairing a number of councils of the main related health issues, and being a board member of other entities, while in the same time, the HHC is not a board member of any of them.

  As for resources for example, the HHC is suffering from the lack of qualified and adequate resources due to several reasons, mainly due to their ineffective role so far, and due to the government tendency recently to postpone employee hiring due to the state budget deficit – unless it is urgently needed for other sectors - so it's unlikely that the council will be able to hire new employees, thus, the council would be able to utilize the qualified resources when needed from MoH staff.

- **HHC will act as an ''policy advice unit'' to MoH and health sector**

As indicated earlier; MoH has wide authorities, but mostly is overburdened with executive responsibilities and service provision. Therefore, MoH needs a ''policy advice unit'' in order to synthesis the MoH efforts with others partners in relevance to the national health policies due to its huge responsibilities, thus, the HHC could act as ''policy advice unit'', and linked directly with MoH minister.

Hence, while the HHC are having shortage of HR resources, at the same time there are a number of senior staff who are professional and well-educated (five specialist)[27], but due to the lack of resources those seniors have to spend considerable time on routine tasks rather than devoted to undertake their specialized tasks, thus, by being linked with MoH, they can now have more time devoted to their specialized tasks. Also, they could work on knowledge exchange and transfer with other ministry's specialized staff.

- **Resolve the 'role conflict' between MoH and HHC**

  By linking the HHC to MoH, it will resolve the 'role conflict' between MoH and HHC in relevance to leading the health sector policymaking, which hopefully will change the relationship from competing to coordinating and complementing each other's roles. Resolving the role conflict will lead to role distribution

  Role conflict was not perceived by the MoH only toward the HHC, but also was perceived by a number of health related entities towards the HHC, which was reflected negatively on their relationship and coordination level with the HHC.

- **Enhance the various health entities acceptance to the HHC role**
- As indicated earlier; HHC is powerless and above all is being stamped by being ineffective since it was established, thus, changing this mental image is not an easy task, particularly

[27] Appendix 7.3 present the organizational structure of the HHC, they have 1 director without employees, one director with 2 sections, but there are no employees in these sections, only the sections head

under the mentioned limitations, which most of it still exist. So, it's predictable that the public and other health entities may not seriously coordinate with the council in its current status; even some respondents questioned the need for the HHC as long as we have the MoH. Thus, when the council now is chaired by MoH minister it's expected to facilitate its work[28], and participate in eliminating the negative image of the council role if they prove their ability of following up the current national strategy and afterword's.

- **HHC role depend on MoH**
- HHC is heavily depending on the MoH in performing its activities, such as producing the National Health Accounts, and all other statistics, and now by being linked to the ministry. It will not only facilitate obtaining the data, but it will also facilitate overcoming the other limitations, such as requesting the assistant of the qualified staff in MoH specialised directorates.

7.3.2.2.2.4 Summary

This is a pragmatic applied research which mediates between theory and external practice in one hand, and local values and expectations specific to Jordan population and challenges on the other hand.

The practical option that seen to be most effective is (MoH should lead the health sector policy formulation in coordination with the HHC), which will serve in eliminating the drawbacks of assigning the policymaking tasks to the HHC primarily, and the difficulties that face the MoH in undertaking its national duties toward the health sector, and in the same time, it will enjoy the

[28] The HHC SG rank is below the Minister, while the MoH Minster is in the same horizontal level of authority with RMS Director General and other HHC members

benefits of MoH strong stand and the HHC existence. Thus, it is considered as hydride between MoH-lead approach and the collaborative approach which assumed to be undertaken by the HHC.

Furthermore, the MoH and the HHC should formulate the National Health Policy based on the mixed scanning approach, as this approach reduces the unrealistic aspects of rationalism and assist in overcoming the conservative aspect of incrementalism, thus, it will combine both the policy direction on long run and the incremental and fundamental actions that serve that direction. The mixed scanning approach does not only lead to the effective formulation of the national health policy, but also contributes in flourish the ground for participatory approaches in the National health policy such as the HiAP approach, which become increasingly favoured by the WHO, this approach in particular requires high level of cross-sctoral coordination's.

The mixed scanning approach has the potential to be more adopted in Jordan, though, further efforts required to set the platform for its utilization, such as enhancing the evidence-based policy concept. In the conclusion chapter; some practical recommendations will be highlighted to support the mixed scanning approach adoption and the national health policy formulation in Jordan.

7.4 Strengths and Limitations of the research

This study has a number of strengths and limitations. The study strengths lay in its main aim and the study outcomes. The main study limitations were identified in early stages of the research in an attempt to reduce their influence to the minimum.

7.4.1 Strengths of the Research

Health policy formulation challenges have not been well-examined in the Jordanian context, thus, this study is considered a vital contribution with in depth and comprehensive analysis. The study was enriched by systematically seeking the views of highly profile experts in the health sector in Jordan, along with other drivers with field of knowledge - most of them have extensive experiences and quite number of them have both practical experiences and advanced academic degrees. Further, some of them spent part of their experience in the academic field. The study combined and synthesised literature review, desk analysis of the changing situation in Jordan over several decades up to the present time, and viewed experts' and stakeholders perspectives.

The study's nature implies multi-fields including politics, public policy, health policy and management science. Further, using mixed method approach can be considered one of the strengths of the study. Moreover, the study was following up the relevant updates to the HHC and MoH and health sector in general since the study was sponsored until February 2017.

7.4.2 Limitations to the conceptual framework

The study has a number of limitations. There is an absence of explicit conceptual frameworks in LMICs, and limited details on research design and methodology, and the single case studies on particular issues dominates the research style (Gilson and Raphaely , 2008; Walt et al., 2008). In a study conducted by Gilson and Raphaely, they reviewed hundreds of articles related to health policy issues in LMICs between 1994 -2007, then screened those articles to 164 to analyse them according to the study criteria. They came up with interesting results, mainly that health policy analysis in LMICs is not well-rooted and it is in early stages (Gilson and Raphaely, 2008, p 303). Further, Gilson and Raphaely concluded that the main question in most of these

studies is ‘what happened’, rather than raise the question of ‘what explains what happened’ (Gilson and Raphaely, 2008).

The main limitation in this study was the inability to reach some higher rank officials/decision-makers in some public ministries, organizations and institutions, and the interviews were conducted with their deputies; however, these deputies or the delegated persons who undertook the interview in most cases were in charge of the health issues/policy file in that ministry, organization and institutions, and most of them have attended the High Health Council meetings, either as a member of one of the preparatory committee meetings prior to the official HHC meeting, or for being nominated as the senior liaison officer between the HHC secretariat and their ministries, organizations and institutions. The main implication of interviewing deputies is that sometimes they express their views which related to the implementation stage and to practical issues rather than policy level issues.

The lack of resources was another of the study limitations; the research topic was not researched previously in the Jordanian context and there are no academic studies to validate the interviewee's responses. Nevertheless, the data were analysed and compared with other secondary data resources such as the international organization reports and the related Jordanian official reports and documents, in addition to some studies and journal articles within low and middle income countries (LMIC) and developing countries experiences.

Another limitation related to translation issues; the interviews were conducted in Arabic and then translated into English language. The process of translation may include unintentional errors, a number of steps were taken to eliminate and reduce potential errors; however, such a process could involve unintentional errors, and it may have a small impact on analysis.

Other limitations related to the use of qualitative approach itself such as the internal validity, as the data relied on participant’s comments and responses. Nevertheless, the limitations

of using the qualitative approach were addressed and handled by several steps such as; purposive participant recruitment, ensuring the accuracy of audio and handwritten transcribing, and using the triangulation which was explained earlier (chapter 5, methodology).

7.5 The Study Contribution

This study contributes to fill the gap that has been noticed in the health policy studies in general, and in explanatory study in particular as health policy research in low and middle income countries (LMICs) which are underserved areas (Gilson and Raphaely, 2008; Walt et al. 2008). According to Gilson and Raphaely, most of the available studies in LMICs concerns with 'what happened' with less attention to 'what explains what happened' (Gilson and Raphaely, 2008, p 303). Further, there is little knowledge about health policy formulation and adoption phases (Berlan et al., 2014). Thus, the study wide aim was to fill the gap that has been noticed in the health policy in LMICs, while its particular attention is to investigate the challenges facing health policy formulation in Jordan. The study was an attempt to both explain what happened and explain the underlying causes for what happened. Additionally, the study aimed to provide effective options for health policy formulation in Jordan.

Further, the study results are vital in this particular point of time; when work was started on the study in early 2013, the main question was why the HHC was not able to undertake its duties and responsibilities, later in that year, the PM decided to activate the council after five years of dormancy. This changed some of the study plans; it can be considered as a positive incident even though it necessitated some changes to the study plan. Attention was then directed toward questioning the council's ability to undertake its duties when it was decided to be activated again, which led to the wider question ''what are the main challenges that face the

national policy formulation in Jordan?'', and then to think about the most effective options for formulating the national policy including the prickly relationship between the HHC and MoH. Thus there is reason to hope that the study will be taken into consideration by the decision makers.

Moreover, the study has a number of practical contributions, such as; although MoH and HHC conducted situation analysis to the main challenges, the study results could assist in focusing attention on the most perceived issues that should be tackled. Also the study will serve as evidence to support the arguments about HHC role in policymaking, and its relationship with MoH, instead of relying on subjective opinions, particularly, where there is no assessment to the HHC role before.

In summary, the study contributed in analysing the national health strategy challenges and tried to present an effective option for the national strategy. Although in EMRO and LMIC countries, the policymakers are not well considering the research studies; it is expected that this study will gain attention due to its particular features and due the HHC request to be informed about the results of the study.

7.6 Dissemination of Results

The main findings of this study are planned to be disseminated in variety of means, including:

7.6.1 Presenting the main results in conferences

The study's initial plan and later its initial results were presented in Health Policy and Politics Network (HPPN) annual conference in 2014, 2015 sequentially. Further, it is planned to

participate in a number of conferences later in 2017 and 2018 to present the study final main results.

7.6.2 Conduct a brief meeting with HHC and MoH to present the main results

The HHC has provided the researcher's some assistance during the data collection stage, most importantly; they gave the researcher permission to attend the workshop in Nov. 2014 in which they presented the first draft of the national health strategy. Subsequently, they asked for a copy of this study after satisfactory completion. Further, it is planned to arrange with HHC and MoH to present the study's results in a seminar when it’s convenient to them.

7.6.3 Provide a summary of the study to the participants

A number of the study participants requested to be informed about the study's results. Accordingly, a short brief about the study and its main results will be sent to them.

7.6.4 Peer Reviewed Publication

It is planned to publish the key themes of this study in addition to work further on some topics and themes, in addition to work on documenting the history of HHC and MTI. The initial ideas and titles under consideration so far are:

- The main challenges for the health policy formulation in Jordan.
- The history of the HHC and its role in national policymaking I (1965-1999).
- The history of the HHC and its role in national policymaking II (1999-2017).
- The Story of The Medical Therapeutic Institution in Jordan (1987-1990)
- Become a donor-driven sector is it an advantage or curse? The case of the health sector in Jordan.

- To what extent we are aware of ‘aid effectiveness’ concept in Jordan? The case of the health sector aids.
- The influence of government rapid turnover on the national policymaking, the case of the health sector in Jordan
- The main challenges for evidence base policy utilization, the case of the health sector in Jordan
- Human resource management for Health sector
- MoH strategic plan (2013- 2017) assessment according to Walt and Gilson Model
- The national health strategy (2015-2019) assessment according to Walt and Gilson Model.

7.7 Summary

The study results showed that Jordan is facing numerous challenges and in the same time the policymaking is a complex process and it is intertwined with several factors. This chapter presented the potential options for the health policy formulation, which was primary related to the Jordanian contexts as it was difficult to contrast Jordan case with other countries. The study concludes that the most effective options is that MoH should lead the health sector policymaking in coordination with the HHC. Furthermore, from theoretical and practical perspective; the National Health Policy should be formulated through the 'Mixed-Scanning Approach' as it is most convenient to Jordan's case.

Based on the study results and discussion; the final chapter will presents the conclusion and the main recommendations that are relevant to the national health policy formulation in Jordan.

Chapter 8

Conclusion and Possible Way Forwards

8.1 Introduction

The study aimed to investigate the main challenges that are facing the national health policy formulation in Jordan in an attempt to recommend the most effective and convenient option. The study was primarily based on seniors and experts opinion of the HHC members and various stakeholders in health sector and other related fields.

8.2 Academic conclusion

Jordan is a small country facing its own problems from a sound base, it can't copy a solution from the text books or from any other countries, but it can draw a lot of principles and good learning from text books. Further, Jordan has a sound base of its health systems. Jordan faces external challenges particularly in coping with refugee crises and its own version of political and stakeholders' conflict. This study has helped to shed light on the strength of what Jordan has, its weaknesses, and how to draw the best ideas from the literature and experiences elsewhere.

8.3 Theoretical contribution

Based on this study results, it was concluded that the policy and planning formulation model in the Jordanian health sector is 'Incremental model' most likely. Despite having several advantages to this model, there are a number of limitations that weaken its utilization nowadays

due to the tremendous challenges that are facing Jordan, which requires more innovation, flexibility and addressing the changes that influence the policymaking, in addition to need for more active involvement of the key actors of the health sector in setting its policies and plans. Accordingly; the 'Mixed-Scanning' is the most convenient model to formulate the National Health Policy in Jordan.

Further, it was concluded that, although the MoH has a central approach most likely when formulating the health sector policies and strategies; it could collaborate with the HHC to enhance the networking and coordination among health sector entities and other relevant stakeholders.

Yet, in practice; several issues need to be practically considered and addressed to be able to formulate the national health policy in effective manner. Thus, in the main results and possible way forward section; the main considerations were highlighted.

8.4 Main Results and possible way forwards

8.4.1 Main Results

Jordan faces numerous challenges related to its system and policymaking environment generally and health sector in particular. A number of these challenges are internal, including constant change of health policy leadership institutions and political leaders, weakness in dealing with NGOs and donors, power struggles between multiple public sector providers, and some political positioning. However, many of the more extreme challenges are beyond its control, having a major, direct and sever effect on the country, most notably the series of refugee crises.

There is recognition to the importance of having national health policy for the health sector, but the mechanism (the High Health Council) is not effective and have several limitations. Thus, it was vital to examine the potential options for effective policy formulation.

8.4.2 Possible way forwards

The empirical research has empowered senior stakeholders from both policymaking and service delivery in addition to experts, to draw upon their own experience of strengths and challenges. As a result of this, it is now possible to identify the best way forward for Jordan, based on both a situation analysis and an evidence base. The study concludes that the most effective option is that MoH take the lead for the health sector policymaking in coordination with HHC; this option was supported by a number of claims, mainly the MoH power and ownership of resources, and to avoid the role conflict between MoH and the HHC in term of leading the national policy formulation. It would harness the wider skills of the HHC membership, and enable the health stakeholders outside the MoH to feel heard and respected, and thus likely to accommodate shared health sector policy.

Thus, it is important now to undertake actual steps towards the attainment of an effective national policy formulation:

8.4.2.1 Set a Framework of the MoH and HHC relationship

Now the HHC is linked to the MoH minister, it is within the MoH authority and it is important to set the framework for their relationship that will eliminate the previous period's discords, and turn the role conflict to role distribution. At the same time the HHC should capture the advantages of being linked with MoH.

8.4.2.2 The Success factors for the National Health strategy

There are a number of factors that should exists in order to ensure an effective formulation of the national health strategy, many of which were raised by the respondents and presented in the results chapter, the main ones are:

8.4.2.2.1 Stakeholder involvement

As indicated the health sector in Jordan is complex and includes different providers, in addition to the existence of a number of health related institutions and NGO's. Stakeholder involvement is important for various aspects such as enhancing the policy/strategy adoption and implementation. Stakeholder involvement may take different forms at different stages; it could be through attending shared meetings and committees, consultation, information sharing …etc.

Thus, it is important to conduct a comprehensive stakeholder mapping and identify the best form of their involvement.

8.4.2.2.2 Participatory Approach

Participatory approach is beyond stakeholder involvement as it implies active involvement of the stakeholders in key aspects. Although MoH is the key actor in the health sector in Jordan along other public health providers. On the other hand, and within the narrow and broad concept of health, there are some actors who influence the health policy inputs, process and outputs that should not be undermined.

In order to have effective participatory approach, the policymakers should accept initially the concept of participation from others, whom should be identified based on clear inclusion and exclusion standards. The participatory approach encompasses the community contribution; while the mechanism is debatable sometimes; the existence of some societies or groups who represent particular groups of patients in Jordan could facilitate their participation.

8.4.2.2.3 Monitoring and Evaluation system

Having effective Monitoring and Evaluation process (M&E) was seen as one of the main challenges for the policy formulation by the respondents and in the same time was seen as one of

the main success factors to the health strategy and plans when it is done properly. Having a weak M&E system not only affects the current strategy in place, but also affects our accumulative learning from the previous policies and strategies and end-up doing the same mistakes.

It is important to conduct assessment of the previous policies and strategies to extract the lessons learnt, so it could be used as an input in the subsequent policies and strategies. Further, the M&E shouldn't be only in the later stages, but it should be a continuous process in order to conduct the correct action when needed.

8.4.2.2.4 Set clear and specific objectives

Although the national policies or strategies highlight the overall goals, but they shouldn't be rhetorical goals, rather, they should have the overall goals along with the specific objectives, and should include specific indicators and the desired output and outcomes should be identified.

Some national policies or strategies include rhetorical statements, which consequently affect the planning for medium and long-term, it also affects the alignment of the national strategies with other entities plans. Further, it will lead to have a weak monitoring and evaluation system.

Thus, it is important to set clear and specific objectives that are realistic in the same time, and set proper M&E system for following up the achievement.

8.4.2.2.5 Evidence based policy

Jordan has a quite good health statistics and indictors database, but there are some issues associated with Evidence Based Policy (EBP), as it is not well utilized, while it is important to set the strategies and plans on valid evidences. Also, some data is dispersed between various entities, while it should be grouped under one centre to be the reference for policymakers and scholars. In

general, we still have a deficiency in health system research, and neither MoH nor HHC has established proper links with the educational institutions although we have good health professional education, MoH and HHC should bridge the gap between them and the educational institutions by setting and updating the health priority research areas and disseminate them to the educational institutions, and create direct links with the educational institutions who could contribute actively in generating sound and reliable research without cost even as it should be considered part of their educational program requirements. Further, it will serve in overcoming the critique of depending heavily on aid agencies and international reports and studies.

8.4.2.2.6 Experts' involvement in the formulation process

The lack of experts' involvement is not related to the lack of experts rather to the lack of proper mechanism and financial limitations. Jordan has qualified experts in various fields including the health sector and its policies, although the cost could be a barrier to their involvement, other alternatives could be applied such as giving the opportunity to the qualified staff within MoH and other related entities to participate, and conduct knowledge transfer from the seniors in MoH and HHC to the others. Other options could be seeking the assistance of the think-tank and the academics, and conducting focus groups and workshops with volunteer experts.

8.4.2.2.7 Right person in position

Some high rank and middle level positions – in health sectors and other sectors – are occupied by inappropriate persons, due to the practices of Wasta (nepotism) sometimes; this is reflected negatively on the work progress generally. The Wasta does not only placed inappropriate persons in key positions, but at the same time it prevents the qualified persons from their rights, which affects negatively their perceived concept of justice and leads to internal

and external brain drain. Although the government has undertaken some actions such as established a committee for high rank official recruitment, yet it should ensure the fairness and transparency of the selection criteria not only for the high rank posts, but also for the middle level management and all other senior and supervisory positions and at the same time ensure other candidates' rights to complain against any unfair decisions. Generally, it is important to enhance the rule of law in all work practices including employee selection and promotion.

8.4.2.2.8 The integration with other national strategies and the country's national vision

The National health strategy should be aligned with the overall national strategies. In 2015; the ''Jordan 2025: a national vision and strategy'' was launched in order to set a 10 year blueprint for economic and social development which includes a number of health indicators and desired outcomes; the current national strategy (2015-2019), and MoH plan (2013-2017) were amended to consider the 'Jordan 2025', but it is important to have a clear mechanism to maintain the desired alignment.

The alignment and integration is important also with other related sector plans and strategies, such as health education in various levels. The current level of integration is not satisfactory as indicated by the respondents, thus it should be improved through adopting the participatory approach and the real partnership.

8.4.2.2.9 Policymakers skills

In addition to the aforementioned key success factors, it is important to accommodate additional factors, related to Jordan situation of being fragile to the regional crises, most notably the refugee burden. It is recommended that policymakers and their assistants should be equipped with the necessary skills of planning under difficult situations (i.e. uncertainty and crisis); being

exposed or affected by the regional and even global crises is inevitable nowadays. It is vital to be able to handle the unexpected situations and then select the least harmful decisions.

8.5 General conclusion

Jordan has a good health system base, but it faces internal and external challenges many of which are unique to its situation. It has overall stability, a sound health sector, and some skills in health policy and implementation. It needs to move forward with health policy formulation, to meet the population's needs and also to remain stable and effective in the face of regional instability and refugee influxes – which present both health delivery and resource over-stretching challenges.

This research has brought together the best relevant external evidence, an assessment of the specific needs of Jordan, and the views of key stakeholders and experienced personnel. While an external solution cannot be carbon copied and dropped into Jordan as it would not fit the specific and very unusual and challenging local issues, synthesis of these sources has enabled an evidence-based solution to be formulated.

Better alignment of the MoH and the HHC, coupled with stability of structures and key personnel, with investment in skills development; should help Jordan to achieve an effective health policy formulation system. A further advantage of this proposed solution is that it can be developed from local resources and expertise, enabling purposeful natural development rather than disruptive change.

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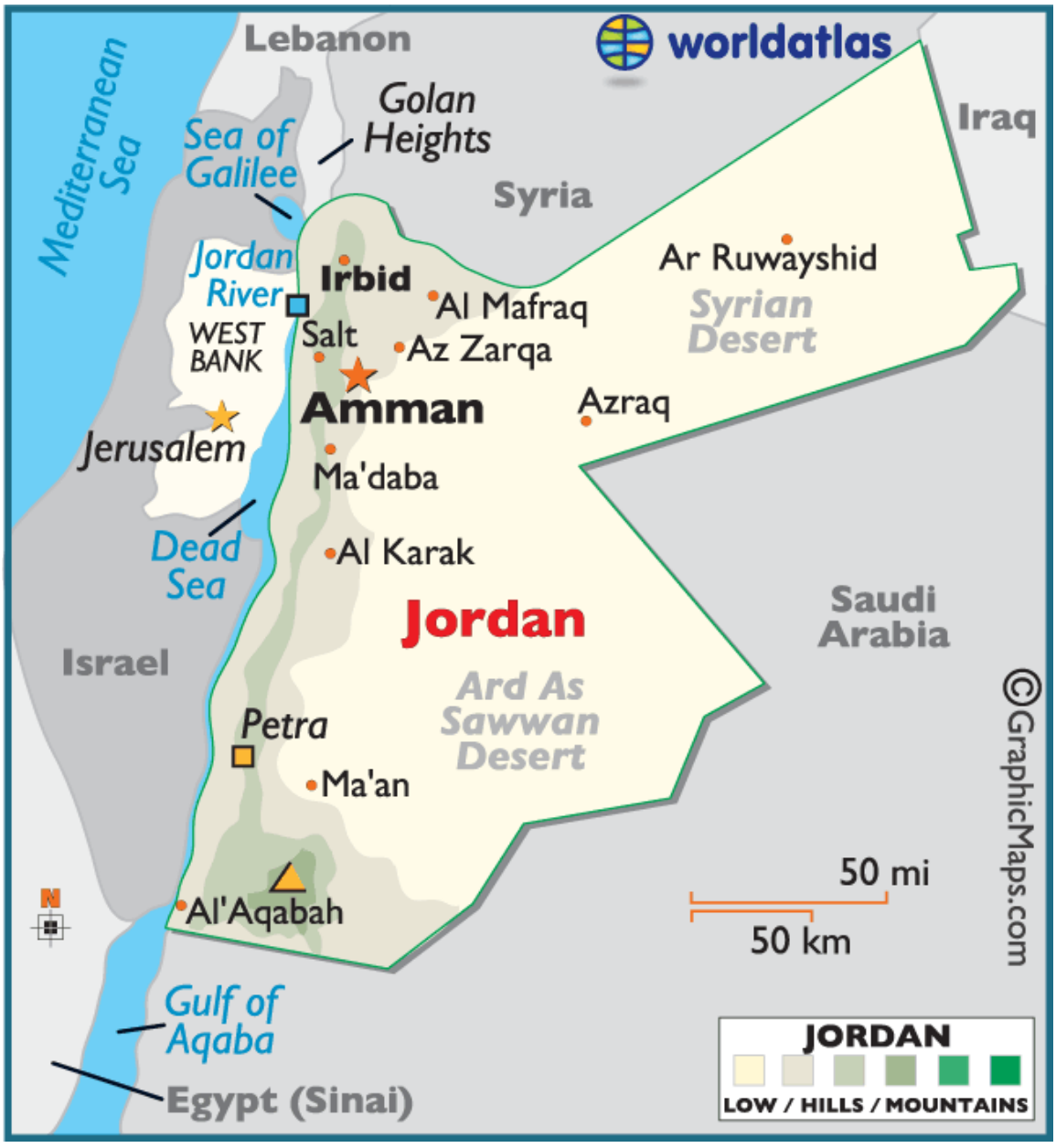
Appendix 2.1 a: Map of Jordan and its geographical location



Source: World Atlas website (http://www.worldatlas.com/webimage/countrys/asia/lgcolor/jocolor.htm) accessed 22/2/2016

Appendix 2.1 b: Map of Jordan and its regional and geographical location

Source: World Atlas website (http://www.worldatlas.com/webimage/countrys/asia/lgcolor/jocolor.htm) accessed 22/2/2016

Appendix 2.2:The Kingdom's Area By Topography

Indicator	Area (Km2)	Percentage
Total Area of the Kingdom	**89,318**	
Land Area	88,778	
Heights	550	0.60%
Plains	10,000	11.20%
Rift Valley	8,228	9.20%
Badia (Semi-Desert)	70,000	78.40%
Territorial Waters	540	0.60%
Dead Sea	446	
Aqaba Gulf	94	
		100%

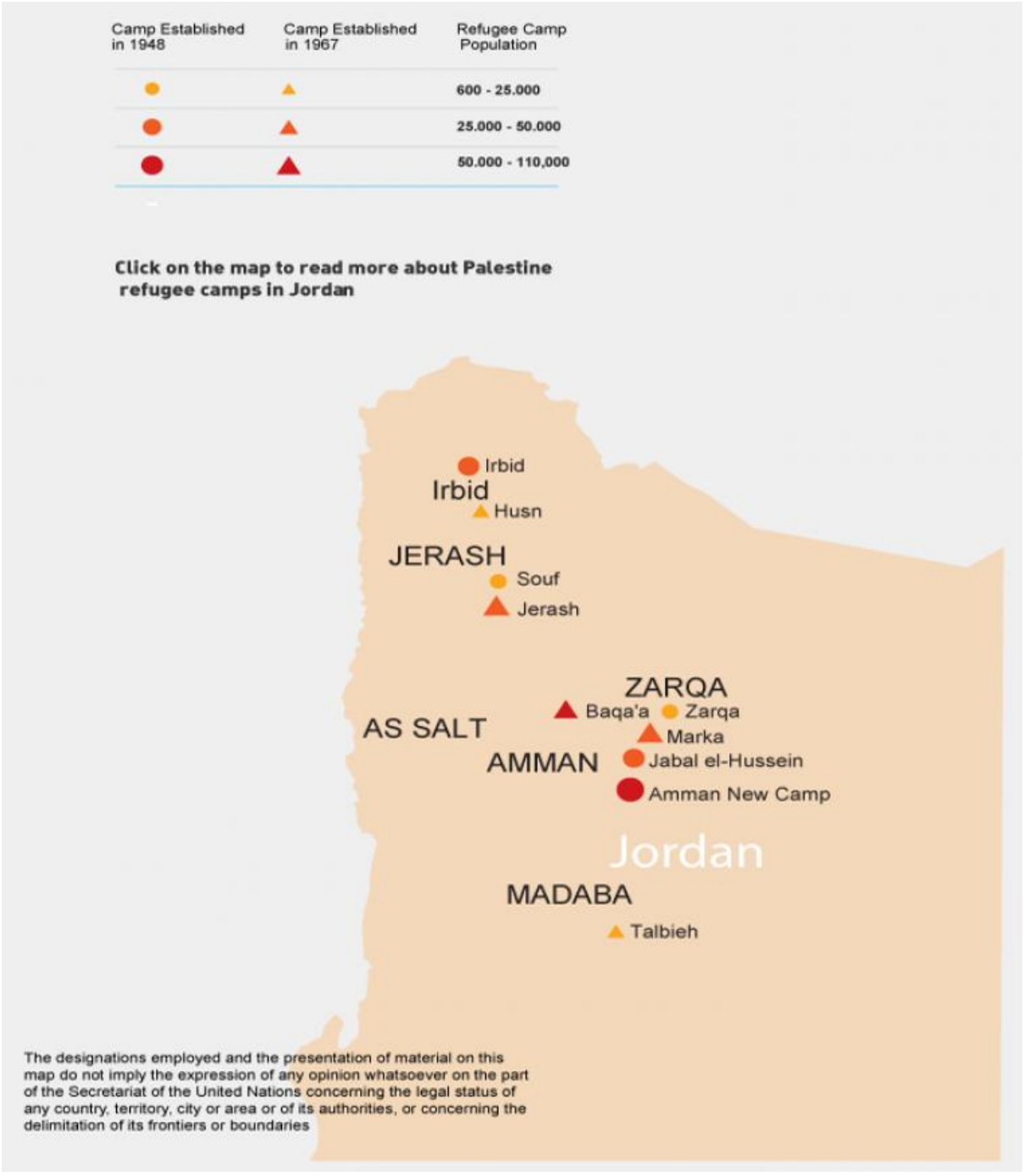
Source: Department of Statistics 2015, *Jordan in Numbers for 2014,* Department of Statistics, Amman - Jordan.

Appendix 2.3: Governorates map of Jordan

Source:

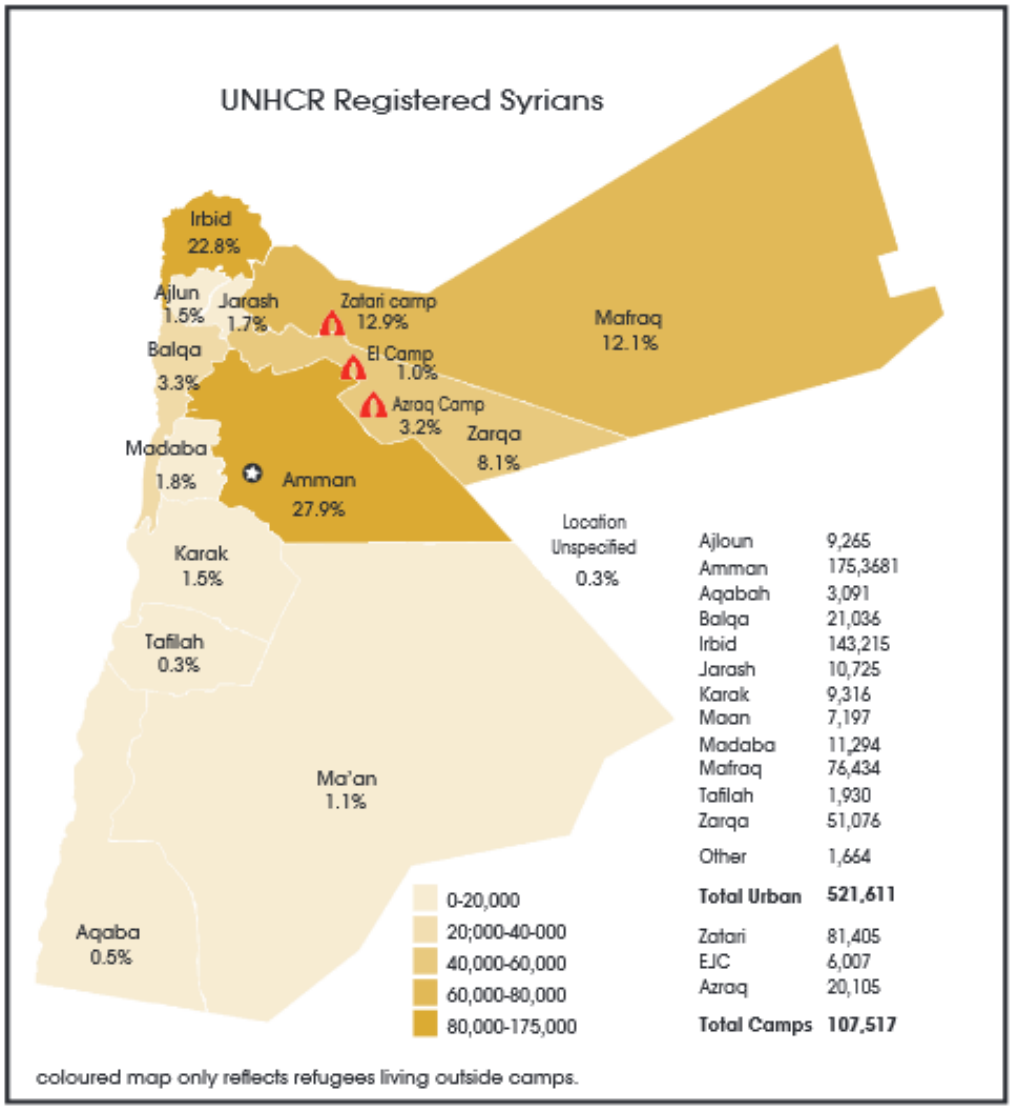
World of Maps , *Jordan Governorates map* [Homepage of World of Maps], [Online]. Available: https://www.worldofmaps.net/en/middle-east/map-jordan/map-jordan-governorates.htm [2016, March/6].

Appendix 2.4: Palestinian refugees camps in Jordan



Source: UNRWA official website (http://www.unrwa.org/where-we-work), last accessed in February 27/2016.

Appendix 2.5: Syrian refugees camps in Jordan



UNHCR, 15/10/2015

Source :Ministry of Planning and International Cooperation 2016, , *Jordan Response Plan for the Syrian Crisis Appeal 2016-2018* [Homepage of Ministry of Planning and International Cooperation], [Online]. Available:http://static1.squarespace.com/static/522c2552e4b0d3c39ccd1e00/t/56b9abe107eaa0afdcb35f02/1455008783181/JRP%2B2016-2018%2BFull%2B160209.pdf [2016, February/29].

Appendix 2.6 :About Ministry of Health – Key Milestones

The Health Sector in Jordan in the Transjordan Era

1921	Math'har Basha Arasalan was recognized as the first health consultant to work in Jordan
1921	Dr. Rida Tawfeq was appointed as head of the Jordanian healthcare sector
1921	Jordan's first public hospital was established (20 beds)
1925	Dr. Haleem Abu Rahmeh established the first regulatory department for the Jordanian Health Sector and this department remained the first of its type until 1939.
1923	Transjordan saw the issuing of its first health law. This law was the law of hospital medicine
1924	His Royal Highness Prince Abdullah accredited the terms and conditions set forth for the establishment of the Italian Hospital in the Salt area.
1924/1925	Medical expenses incurred by the healthcare departments of Transjordan amounted to 4991 sterling pounds
1924	The city of Jerusalem saw the establishment of its first medical lab
1925	Jordan's first pharmacy was launched in Amman
1926	The first regulatory health law was decreed. This law was implemented in Jordan until 1971
1926	The first set of regulations pertaining to the government run health institutions was issued. An operational system was devised for the running of health institutions, and regulations were especially devised for sectors working in fields that pose a health threat to their employees. Instructions were even posed to prevent people from working in such fields and for the payment of compensation fees in this regard.
1926	A law was issued for fighting malaria and in the same year another law was issued calling for the correct usage of dangerous medications
1926	Around (28) male and female health specialists were working in Jordan
1927	The number of doctors reached (39)
1927	The number of beds available in government run hospitals reached a total of (60) and in private hospitals they reached (99)
1927	The first Medical Laboratory was created in East Jordan, in the city of Maan
1927	The first legislative action of Pharmacy and trade of Drugs Act
1927	The number of patients, who were treated by the health department in eastern Jordan, reached more than 70 thousand patients and its budget was 11 thousand pounds a year.
1929	Instructions have been issued on medical committees for government employees
1932/1933	Department of Health's budget has become (12,230) pounds
1935	Establishment of public hospital in Irbid (12 bed) and in Al-Karak (36 bed)
1939	Ministry of Interior was established and the Department of Health was linked with MoI
1940	The establishment of the first laboratory in Amman
1948	the number of hospitals in Amman were (7)

The Health Sector in Jordan between 1948 -1980

	Despite hard conditions Jordan passed due to Palestine catastrophe and its negative health sequences in 1948 and 1967-, comprehensive health prosperity occurred during 40 years, and great achievements in medical field had been done. But we can say that the real health prosperity in Jordan, occurred after country independence, establishment of the Hashemite kingdom of Jordan, and union of the two banks of Jordan River.
1951	MOH started its responsibilities, which considered the beginning of health prosperity in Jordan
1951-1952	The establishment of six departments in the kingdom districts, related to the central management of MOH, in which the head of each department was a physician.
1953	The first nursing college was opened
1954	The physician union/association was established
1955	The central laboratory for medical tests was established
1962	Nursing College of Princess Mona was established
1963	The first health insurance system in the kingdom was implemented among force army members
1965	The first civil health insurance system was implemented in the kingdom
1970	A medicine faculty was established in Jordan University
1971	Public health law number 43 for 1966 was replaced by Public health law, number 21 for 1971
1973	The medical Hussein City was inaugurated
1973	The allied medical professions institute was inaugurated in Amman
1977	Publish of high health council system, number 60, for 1977.
1978	The allied medical professions institute was inaugurated in Irbid
1980	A pharmacy faculty was inaugurated in Jordan University

Prepared by the researcher

Sources :Ministry of Health 2013, , *About Ministry of Health* [Homepage of Ministry of Health], [Online]. Available: http://www.moh.gov.jo/EN/AbouttheMinistryofHealth/Pages/About-MinistryOf-Health.aspx [2016, Jan. 25].

Appendix 2.7: healthcare supportive institutions

- *The Jordanian Medical Council: is a Public Institution, linked with Minister of Health*

  Aims to train and rehabilitate specialist and general practitioners through the planning, implementation and supervision of the scientific programs, plans and academic curricula of various accredited medical specialties to grant the higher competence certificate (The Jordanian Board), which is considered the highest professional health certificate in Jordan.

- *The Food and Drug Administration: is a Public Institution , linked with Minister of Health*

  Is acting as a national reference body which aims to ensure food safety, quality and suitability for human consumption in all trading phases, as well as ensuring the safety of the drug and its quality, effectiveness and accessibility for all poor and marginalized people. It also regulates the circulation and use of many goods, consumables and medical devices. The administration pursues the obligations of Jordan after accession to the World Trade Organization and its signature on the free trade agreement with the United States. In order to achieve these goals, the administration has developed strategies and action plans based on measurable indicators.

- *The Joint Procurement Department: is a Public Institution , linked with Minister of Health*

  aims to organize a unified process for purchase of medicines and medical supplies in the public sector, conditions of participation and the way offers are studied, evaluated and decisions of awarding and the contracts of follow up and implementation. It also conducts the necessary studies for the development of this process provided that it maintains the approved standards for purchased materials and developing the principles and conditions of accepting the participation of companies and suppliers.

- *The Higher Population Council*

  Is the national reference entity in regard to policy formulation, planning and implementation of the programs relevant to population and development issues. The council has set up national health plans and strategies for reproductive health / family planning and the document of population opportunity policies in addition to the creation of demographic research base and the implementation of many relative studies and researches.

- *The Jordanian Nursing Council*

  is contributing to the protection of members of the community and improving their health by regulating the nursing profession and developing it scientifically and practically. The Jordanian Nursing Council has developed the National Strategy for Nursing in Jordan and created the licensing system for nursing professional levels, standards for the nursing, as well as the instructions for giving chemotherapy. The council also convenes regional and international conferences, identifies research priorities of nursing issues and implements many of them

- *The National Council for Family Affairs*

  Is acting as a supportive umbrella for coordination and facilitation of the governmental and non-governmental partner national and international institutions, and the private sector, especially in the field of family protection to achieve a better future for the Jordanian families. The council has developed the Jordanian National Strategy for the elderly 2008-2013 and is currently pursuing a participatory approach to evaluate and update it. The council also developed a national plan for children 2004- 2013 and carried out several studies and research on domestic violence, child labour and the analysis of the situation of the disadvantaged children

Source:(HHC, 2015, pp 24-26).

Appendix 2.8: High Health Council major stages (1966-2015)

Year	Description
1965	• First health council was established • High Health Advisory Council bylaw No. 21 for the year 1966
1977	• High Health Council bylaw No. 60 for the year 1977
1980	• High Health Council bylaw No. 90 for the year 1980
1986	• High Health Council bylaw No. 29 for the year 1986
1989	• High Health Council bylaw No. 59 for the year 1989
1999	• High Health Council law No. 9 for the year 1999 (in force)
1999	• HHC articles were refined and clearly stated the council role in health policy formulation
2002	• The HHC general secretariat started to undertake their duties
2007	• HHC formulated the national health strategy for 2008-2012
2008	• HHC last meeting (on members level)
2013	• Prime Minister Call to activate the HHC Role
2014	• The HHC general secretariat started to prepare for the national health strategy
2015	• HHC formulated the national health strategy for 20015-2019

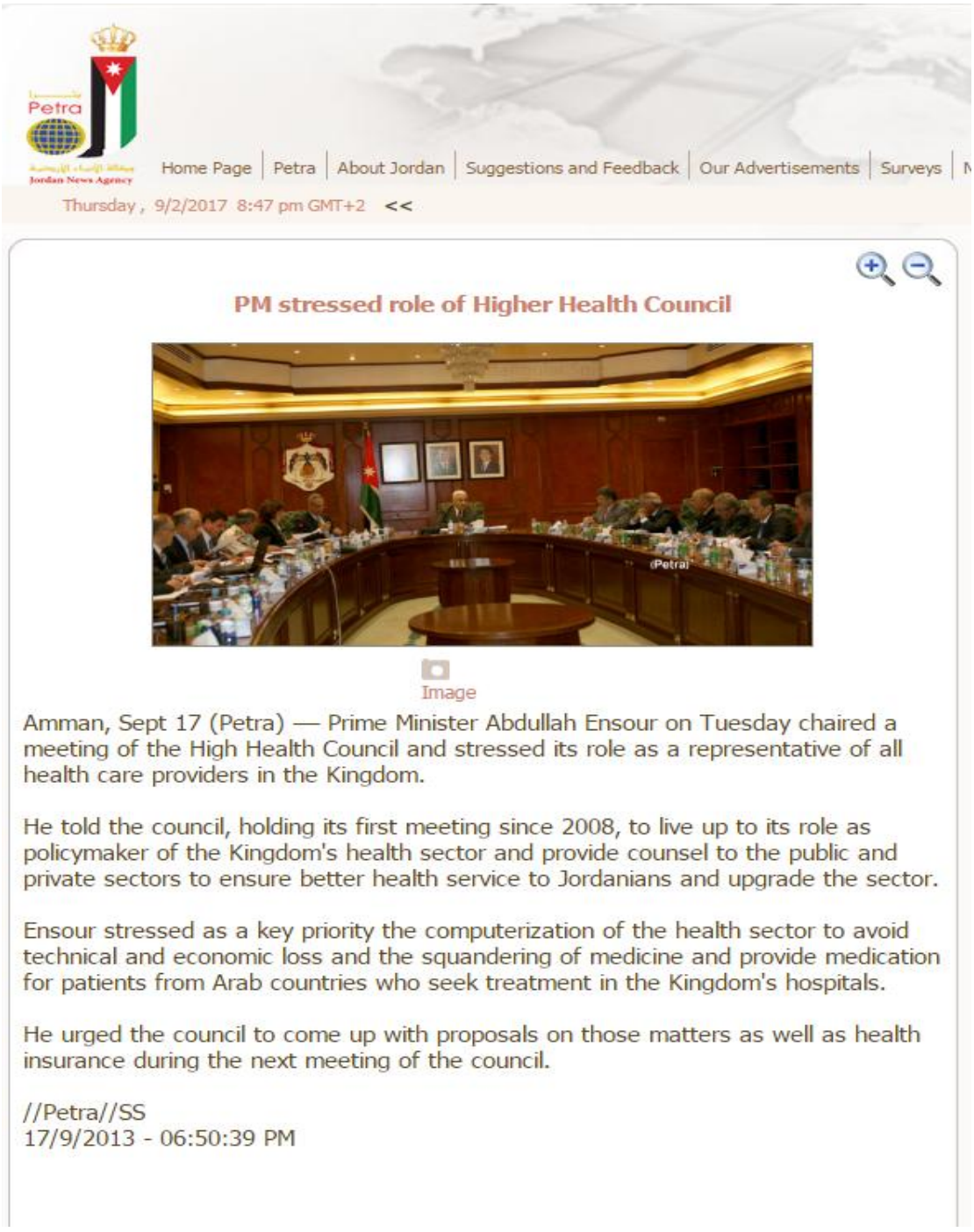
Prepared by the researcher

Source:

(High Health Council 2013, *The High Health Council Brief Handbook*, General Secretariat, High Health Council, Amman – Jordan).

Legislation and Opinion Bureau- Prime Ministry of Jordan data base

Appendix 2.9: High Health Council Re-activation in 2013



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Thursday , 9/2/2017 8:47 pm GMT+2 <<

PM stressed role of Higher Health Council

Image

Amman, Sept 17 (Petra) — Prime Minister Abdullah Ensour on Tuesday chaired a meeting of the High Health Council and stressed its role as a representative of all health care providers in the Kingdom.

He told the council, holding its first meeting since 2008, to live up to its role as policymaker of the Kingdom's health sector and provide counsel to the public and private sectors to ensure better health service to Jordanians and upgrade the sector.

Ensour stressed as a key priority the computerization of the health sector to avoid technical and economic loss and the squandering of medicine and provide medication for patients from Arab countries who seek treatment in the Kingdom's hospitals.

He urged the council to come up with proposals on those matters as well as health insurance during the next meeting of the council.

//Petra//SS
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Appendix 2.10: Good Governance objective

The 'National Strategy for Health Sector in Jordan 2015-2019'

Objective (1): Good governance and policy environment that enhances the performance of the health system.

Outputs are:

- ***A clear and enabled role for the Higher Health Council***
  - Develop a new modern law for the Higher Health Council to expand its powers and functions so that it becomes binding on all health sectors
  - Strengthening the role of the Higher Health Council as a high reference body that draws health policies and coordinates between all health sectors and other concerned parties.
  - Support the General Secretariat of the Higher Health Council and provide the Council with the necessary physical and human resources.

- ***Active partnership between all relevant sectors***
  - Strengthen the partnership between public and private institutions and CSOs (charity) and the international organizations
  - Improve coordination within the health sector to achieve integration in the delivery of health care services.

- ***Evidence based plans, policies and decisions***
  - Link the results of studies and research in the field of health with policy and decision-making based on the health sector needs
  - Strengthen the role of the National Observatory of Health Human Resources as a national reference body in decision-making and related policies
  - Promote the use of national health accounts and linking results to health policy-making.
  - Establish a national regional centre for training, studies and research in the field of health policy in collaboration with WHO and relevant International and local parties.
  - Update the health map and use it as a tool to ensure the provision of health services to all citizens
  - Include the health dimension in all strategies and policies

- ***Developed and effective information and applications system for E- Health.***
  - Develop a public health monitoring system in Jordan (on communicable and non-communicable diseases and maternal and child health care for Jordanians and non-Jordanians)
  - Develop a monitoring system for causes of morbidity and mortality and oblige all health institutions to adopt the international classification of diseases (ICD) in all hospitals.
  - Promote the concept of knowledge management (instead of the concept of information management).
  - Automate the system and develop health information systems

- ***Approved and effective legislation to improve the health system performance***
  - Enact laws to combat smoking and the use of narcotic substances.
  - Adopt and approve a modern law of medical and health accountability
  - Adopt amendments to the law of the Higher Health Council
  - Activate the Medical Council law relative to re-evaluation of competence certification and issue legislation to oblige health institutions to organize ongoing training programs for all employees in health professions
  - Activate the regulatory legislation for the process of organizing the delivery of health services in all sectors
  - Organize and institutionalize the work of CSOs concerned with the health sector

- ***Community Participation and accountability and fair practices***
  - Promote community accountability in the health sector among citizens
  - Support research and studies on integrity issues in the health sector
  - Promote information disclosure policy to achieve transparency and accountability
  - Introduce mandatory implementation of the Code of Ethics and professional conduct in all health sectors
  - Adopt monitoring and evaluation systems for professional individual and institutional performance in the health sector

Source: (HHC, 2015, pp87-88)

Appendix 2.11 a: The Situation analysis for

The National Strategy for Health Sector in Jordan 2015 - 2019

According to the recent national health strategy; a strategic analysis using SWOT model was conducted and the following has been identified as the main strengths and weaknesses in the internal environment in addition to the analysis of the opportunities and risks in the external environment.

Strengths
• Significant improvement in most health indicators • Having good infrastructure and advanced technology in the areas of medical diagnostic, curative and rehabilitative services • The existence of qualified and highly efficient medical and health cadres. • Easy access and getting health service all over the kingdom • The inclusion of the poor and disadvantaged groups under the umbrella of social health insurance • The existence of distinct and highly reputable specialized medical centres at the level of the region • The developed medical tourism industry and its acquiring of more markets and occupying advanced position at the global level. • An advanced pharmaceutical industry that enhances the value of pharmaceutical exports • A Higher Health Council with law No. 9 of 1999 with the aim of drawing the public health policies and the development of strategies for implementation and coordination between all health sectors • The existence of Health Institutions Accreditation Council • The existence of Health laws for regulating the health sector notably the Public Health Law • The existence of strategy plans for most of the components of the health sector. • Jordan effective participation at the international level in the provision of humanitarian emergency medical services in the areas of wars and disasters • The existence of a national observatory for human resources for health in the Higher Health Council • Institutionalized national health accounts as an important tool to draw a health policy in Jordan. • The existence of national registries such as the National Cancer Registry, Kidney and mortality

Weakness
• Lack of a comprehensive health insurance system and duplication of public health insurance and health service delivery. • Lack of a comprehensive national plan for the promotion and development of human resources for health, and weak ambulance and emergency services • Lack of strategies and policies to contain and recover costs • Weak investment in primary health care services compared to secondary and tertiary services • Unplanned expansion of health services based on demand and not on the actual need • Lack of a comprehensive national health information system that covers all health sectors, the weak application of electronic medical records systems, and weak cooperation and coordination between the different health sectors and the concerned health councils. • Poor governance and lack of governmental or independent technical and administrative arm to monitor the performance of health sectors • The absence of health emergency plans to cope with crises and forced migrations. • Weak synergies between the objectives and plans set by the strategic level and those set by the executive level • Lack of a national characterization system (unified guide for medical protocols and procedures) • Weak training process in the field of management and strategic planning • Inactivation of the monitoring and evaluation systems for institutional performance in the public sector • Adoption of the centralization system • Overlap and duplication in some health laws • Multiplicity of references in relation to scientific research on health issues in Jordan, weak process of publication of studies for researchers and interested organizations to benefit from them, and the lack of research in the field of health policies and systems

Opportunities
• Political support at the highest levels for health issues and giving top priority to the health of citizens • Government conviction by the entrusted role of the Higher Health Council and its intention to activate it. • Political and security stability in Jordan • The presence of a health committee represented in the parliament which consulted in the study of important laws and health issues • The existence of Higher Councils concerned with health issues such as the Jordanian Nursing Council, the Higher Population Council, the National Council for Family Affairs and the Higher

Council for Persons with Disabilities

- Creation of the Food and Drug Administration
- Creation of a Joint Procurement Department
- The existence of strategies for many health-related issues such as: the National Strategy for reproductive health/family planning, the Jordanian Strategy for the elderly, Health Communication and Media strategy, the National Strategy for Diabetes and the National Strategy for AIDS
- The existence of supporting international bodies and organizations
- The existence of tourist and natural therapeutic sites that help the health sector to compete and attract more Arab and foreign patients for treatment in Jordan
- The existence of initiatives to promote integrity, transparency, and accountability in the government agencies
- Increased citizens' awareness and interest in health issues
- The advanced ITC means and social media and broad number of users and the possibility to take advantage of these in the health sector.
- The inclusion of health care in some of the national social and economic plans
- The existence of a strategic plan to reach the population opportunity and its optimal use
- High quality health education level in Jordan The existence of the Department of Statistics as a governmental reference party for data and information
- The existence of the Department of Civil Status and the possibility of linking their databases with health institutions
- Investment in infrastructure

Threats
• Demographic challenges (the stability of the fertility rate, forced migrations, rapid population growth and the increasing proportion of elder persons) • Paradigmatic shift of disease, increased rates of chronic disease and the difficulty of controlling the causes and risk factors • Increased risk of Pandemics & Emerging diseases • Climate change and its impact on health • High debt, slow economic growth and high poverty and unemployment rates • The high cost of health services • Scarcity of financial resources allocated to health care, including the current expenditures in the public sector • Migration of health competencies • High direct-of-pocket health spending, particularly on drugs • Quick volatility in senior positions leading to a change in the order of national priorities • The absence of the role of the HHC in the formulation of health education policy

- Slow enactment of the legislation
- Corruption and slow deterrent sanctions against the corrupts
- Acceleration in technological development in general and in medical technology in particular
- Globalization and the global financial crisis
- Weak citizens empowerment to gain support for their own interests and to hold local governments accountable

Source:the High Health Council 2015, National Health Strategy 2015 – 2019, [Homepage of the High Health Council;], [Online]. Available: www.hhc.gov.jo

Appendix 2.11 b: The Situation analysis for

The National Strategy for Health Sector in Jordan 2008-2012[29]

According to the national health strategy (2008-2012); a strategic analysis using SWOT model was conducted and the following has been identified as the main strengths and weaknesses in the internal environment in addition to the analysis of the opportunities and risks in the external environment.

Strengths	Weakness
- Developed infrastructure of construction and equipment. - Desire for excellence and development. - Accreditation programs for medical institutions. - Distinguished medical staff at the regional level. - Medical teaching centres in the Kingdom	- Weakness in communication and coordination. - Limited health plans and programs - Scarcity of motivation programs and developed human resources - Weakness in security and safety substructure. - Ambiguous roles of service providers - Weakness of health information systems - Duplication of service provision
Opportunities	**Threats**
- Governmental support - Political climate - Award of King Abdullah the Second for excellence - Raising the level of health knowledge. - Strong infrastructure and updated communication systems - Good lifestyle - Specialized medical centres	- Population growth and disease transition - Increased cost of medical services - Accelerated growth of technology - Loss of technically qualified staff - Poor confidence of citizens - Weakness of the financial policy in paying back the cost - Absence of universal health insurance.

Sourcethe High Health Council 2008, National Health Strategy 2008 – 2012, [Homepage of the High Health Council;], [Online]. Available: www.hhc.gov.jo

[29] The strategy was not implemented

Appendix 2.11 c:The Situation analysis for theMoH Strategic Plan for 2013-2017

Strengths
• Supportive leadership to achieve vision and mission of the ministry. • Existence of a public health law. • Existence of laws and regulations. • Adoption of initiatives that support the future (expanding the umbrella of health insurance, institutional performance appraisal, accreditation, etc.). • Outstanding achievements in primary health care at the national and regional levels. • Cooperation agreements between concerned authorities and organizations. • Wide coverage of ministry health centres and hospitals for all populated areas. • Subsidized health services for citizens within their financial capabilities • Availability of modern medical equipment. • Availability of specialized training opportunities. • Availability of good infrastructure • Availability of comprehensive Health services including tertiary services

Weakness
• Incomplete and inactive job descriptions. • Inappropriate organizational chart • Centralization. • Weaknesses in communication skills among service providers. • Weaknesses in human resources management. • Weakness in knowledge management. • Financial resources allocated for tertiary care much more than primary health care. • Lack of data for decision making. • Weak national information systems • The brain drain of qualified staff • lack of monitoring and evaluation system • Mal-distribution of services based on specific criteria • Lack of marketing of the ministry activities and achievements

Opportunities
• High leadership support for health services • King Abdullah II Award for Excellence. • Wide coverage of health services by partners • Supportive international programs and projects. • Opportunities for many institutions that can support the programs and the goals of the ministry. • Presence of supportive national strategies such as emergency response strategy, population national strategy, Aids national strategy, Diabetes national strategy and etc… Advanced information technology and communications tools. • The existence of a Higher Health Council, Jordan Medical Council, HCAC and Nursing Council. • Improved level of education rate in Jordan. • Demographic opportunity

Opportunities
• An Increase in number of aging population. • Forced migration from abroad. • Paradigm shift of disease towards NCDs. • Low per capita income and high rates of poverty and unemployment. • Globalization and its implications on health services and health situation in Jordan. • Rapid turnover in senior positions. • Social and political pressures. • Rapid evolution in medical technology. • The existence of inflexible legislations that impede the work of the ministry. • Absence of medical accountability law. • Weaknesses in educational output and lack of its adaptation to the needs of the Ministry. • Attractive job opportunities for qualified medical staff outside of the MOH, locally and abroad. • Weak coordination between various stakeholders (public, private and university hospitals). • Weakness in the emergency services • Absence of comprehensive health insurance for specific social categories. • Plateaued fertility rate. • Limited financial resources. • Climate changes and its negative impact on health • Absence of an updated and effective health map

Source: Ministry of Health, Ministry of Health Strategic Plan 2013-2017 [Homepage of Ministry of Health], [Online]. Available: http://moh.gov.jo/

Appendix 2.11 d: The Major Challenges for Health sector according to the CCS for WHO and Jordan

The main challenges

The main challenges of health sector in Jordan fall within the following two clusters: health system (governance, financing, human resources, evidence and research); and epidemiological transition (chronic and non-communicable diseases, lifestyle and behavioural risk factors).

Specific challenges include the following:

- Lack of systematic burden of disease assessment
- High expenditure on health as a percentage of GDP (9.4%, with 41% out of pocket)
- Relatively high percentage of total health expenditure on pharmaceuticals (30%)
- Lack of universal health insurance coverage
- Lack of evidence-based health system performance
- Weak health system research
- Variable quality of health services
- Concerns on equity of the health system Incomplete role and regulation of the private sector (domestic, medical tourism, pharmaceutical sector)
- Need for more attention to environmental health and food safety

Source: World Health Organization 2010, "Country cooperation strategy for WHO and Jordan 2008–2013", P25-26

Appendix 5.1: The study participants list

This researcher has interviewed a number of *'Senior Representatives'*[30] from the following Ministries, institutions and entities[31]:

- Ministry of Health
- High Health council
- Ministry of Labour
- Ministry of Finance
- Ministry of Social Development
- Ministry of Planning and International Cooperation
- Ministry of Trade - Supervision and Control of Insurance Supporting Services
- Jordan Food and Drug Administration
- Royal Medical Services
- Jordan Medical Council
- Jordanian Nursing Council
- Higher Population Council
- Health Care Accreditation Council
- The Economic and Social Council
- Jordan Nurses and Midwives Association
- Jordan Pharmacists Association
- Jordan Medical Association
- The House of Representatives (The Lower House)
- The House of Senate

[30]In order to maintain the participant's anonymity; the term 'senior representative' will be used
[31] The order in the list is not associated with the interview numbers in the analysis chapter, or elsewhere

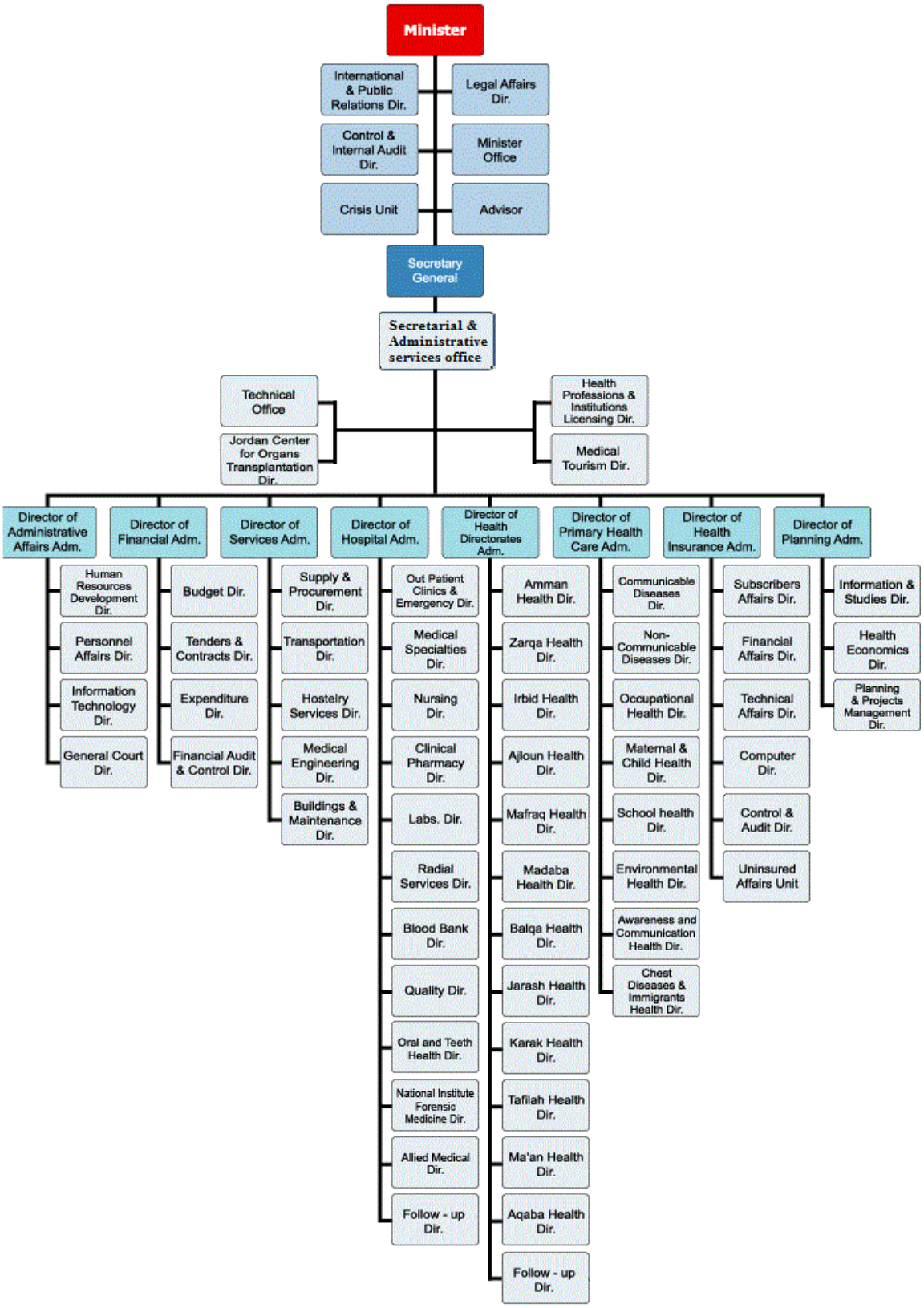
- Jordan University - The medical faculty
- Jordan University - The University Hospital
- Jordan University of Science and technology- The medical faculty
- Jordan University of Science and technology- The University Hospital
- National e-health program:HAKEEM
- Private Hospitals Association
- Jordanian Hospitals association
- United Nations Relief and Works Agency for Palestine Refugees (UNRWA)
- United Nations High Commissioner for Refugees (UNHCR)
- United Nations Children's Fund (UNICEF)
- National Association for Customer Protection
- National Women's Health care centre
- Jordan National forum for Women
- The Jordan Association for Medical Insurance
- The Jordanian CSO (Civil Society organizations) Health Alliance
- The Royal Health Awareness Society
- Petra news Agency
- Private hospitals general directors
- Health Policy Experts

Appendix 7.1: The Minister of Health Duration in Compared to Cabinet

No.	Year	Minsters of Health	Ministers Duration			Prime Minster (Cabinet)	
			Duration	*From*	*To*	Prime Minsters	Duration
1	2017	H. E. Dr Mahmoud Al-Sheyyab	0 Y, 9 m	01/06/2016	present	H.E. Dr. Mulqi	0 Y, 9 m
2	2016	H.E. Dr.Ali Hyasat	3 Y, 0 m	21/08/2013	29/05/2016	H.E. Dr. Nsour	3 Y, 7 m
	2015						
	2014						
3	2013	H.E Dr. Mjali Mehlan Murshidi	0 Y, 5 m	30/03/2013	21/08/2013		
4	2013	H.E. Dr.Abdellatif Woreikat	1 Y, 9 m	11/10/2012	30/03/2013		
	2012			02/05/2012	10/10/2012	H.E. Dr. Tarawneh	0 Y, 5 m
				24/10/2011	26/04/2012	H.E. Dr. Khasawneh	0 Y, 6 m
	2011			02/07/2011	17/10/2011	H.E. Dr. Al-Bakheet	0 Y, 8 m
5		H. E. Dr Yasin Husban	0 Y, 4 m	09/02/2011	26/05/2011		
6	2011	H. E. Dr Mahmoud Al-Sheyyab	0 Y, 3 m	24/11/2010	09/02/2011	H.E. Mr. Sameer Rifai	0 Y, 3 m
	2010						
7	2010	H. E.Dr Nayef AL-Fayes	1 Y, 8 m	14/12/2009	22/11/2010	H.E. Mr. Sameer Rifai	1 Y, 0m
	2009			23/02/2009	09/12/2009	H.E. Mr. Nader al Dahabi	2 Y, 0 m
	2009						
8	2007	H. E. Dr Salah Mawajdeh	1 Y, 6 m	25/11/2007	23/02/2009		
	2008						
	2009						
	2007			02/09/2007	22/11/2007	H.E. Dr. Al-Bakheet	2 Y, 0 m
9	2007	H. E. Dr. Sa'ad Al-Kharabsheh	0 Y, 8 m	22/11/2006	29/07/2007		
	2006						
10	2006	H. E. Eng. Saeed Darouzeh	3 Y, 1 m	27/11/2005	22/11/2006		
	2005						
	2005			07/04/2005	24/11/2005	H.E. Dr. Adnan Badran	0 Y, 8 m
	2005			25/10/2003	05/04/2005	H.E. Mr. Faisal Al-Fayz	1 Y, 6 m
	2004						
	2003						
11		H. E. Dr. Hakem Al-Qadi	0 Y, 4 m	21/07/2003	22/10/2003	H.E. Dr. Abu Al-Raghib	3 Y, 3 m
12	2003	H. E. Dr. Waleed Al-Maani	0 Y, 11 m	26/09/2002	20/07/2003		
	2002						
13	2002	H. E. Dr. Faleh Al-Naser	1 Y, 3 m	14/01/2002	26/09/2002		
14	2001			16/06/2001	14/01/2002		
15	2001	H. E. Dr. Tariq Sheemat	1 Y, 0 m	19/06/2000	16/06/2001		
	2000						
16		H. E. Dr. Mesleh Al-Tarawneh	0 Y, 6 m	15/01/2000	18/06/2000	H.E. Mr. Al-Rawabdeh	1 Y, 3 m
17	2000	H. E. Dr. Ishaq Maraqa	0 Y, 9 m	04/03/1999	15/01/2000		
	1999						

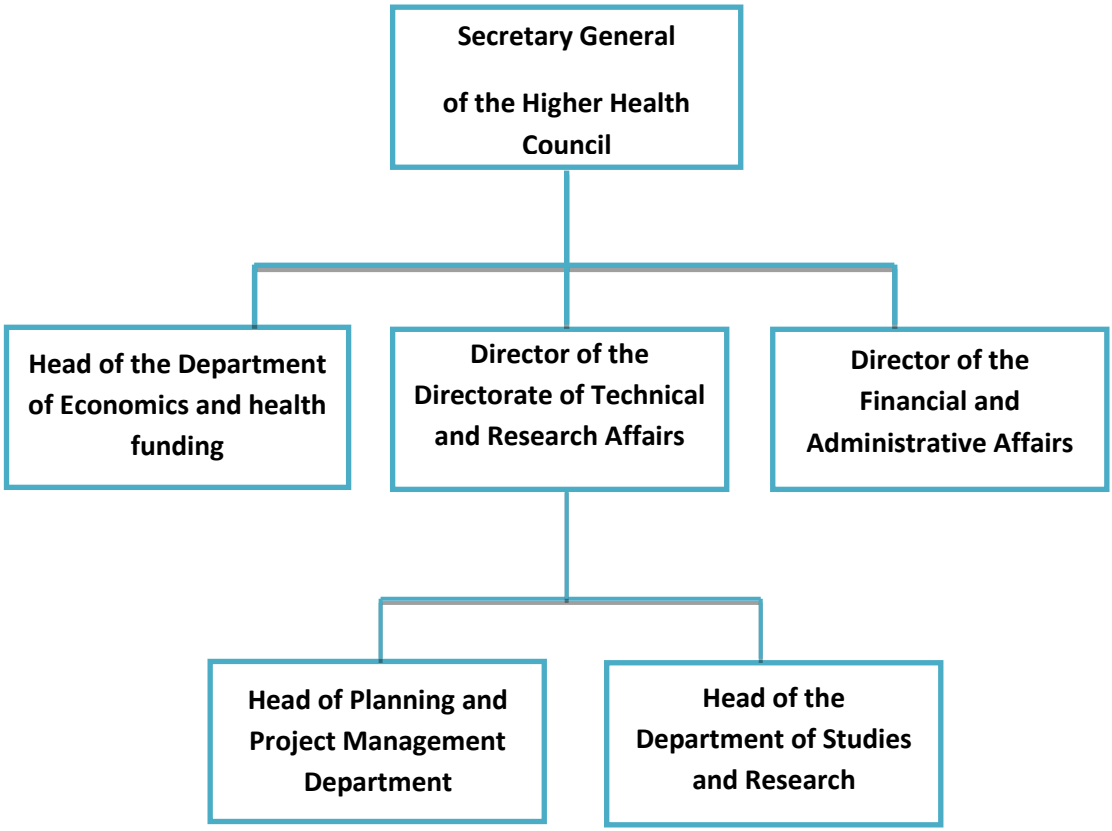
Prepared by the researcher. Source: the Prime-Ministry Database (www.pm.gov.jo)

Appendix 7.2: The Ministry of Health Organizational Structure



Source: Ministry of Health official website (www.moh.gov.jo)

Appendix 7.3: The High Health Council Organizational Structure



Soruce: Prepared by the resacher

The HHC didn't publish their organizational structure on the website, or in the latest national health strategy, thus the structure was drwan based on the researcher information during the data collection, however, the names and the postion titles of the HHC staff was listed in the latest strategy

- Head of the Department of Economics and health funding: only the director, no employees.
- Director of the Directorate of Technical and Research Affairs: has two sections, each section has section head, without employees (total number of employees are three)