ERF Policy Brief

Health Policies in MENA After Covid: Accelerating Reforms, Spearheading Health Equity

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About the authors

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In a nutshell

- *While health has been a key global developmental target for decades, the COVID19 pandemic propelled it into the political limelight, reminding us of its essential character for the functioning of society and the economy.*
- *Universal Health Coverage (UHC) had been adopted internationally as a framework and benchmark for health policies and for ensuring Access to Affordable Available Quality healthcare for all.*
- *In 2018, MENA renewed its commitment to UHC through the "Health For All" Salalah declaration. However, public sectors remained weak, with uneven provisions that were unequally distributed. Access to healthcare was typically highly segmented and fragmented. Financial protection tended to be linked to formal labour market attachment, which is problematic in a region with low female labour market participation and low old age provisions. Special schemes were developed to cater for the uninsured and those 'left behind', but Out of Pocket Payments (OOPs) were still at between one third to two thirds of health payments, exposing citizens to poverty and catastrophic health spending.*
- *Health sector and financing mix deficiencies became fault lines during the pandemic.*
- *Worldwide and in MENA, COVID19 has been a "great unequalizer", battering the income and health of poorer and vulnerable segments of society more than others. In particular, precariousness in living, working, transport conditions, and terms of employment trapped large swathes of the population of the labour force.*
- *MENA's COVID health crisis is also a social protection crisis. Health entitlements need to be reformed so that these entitlements are portable across providers and across employment statuses. If health risks and social protection are socialised, people can move in and out of employment without fear of losing jobs or lives.*
- *Given the urgency of health issues, countries around the world are mobilising increased public funding for health and other public goods. MENA needs to take heed and mobilize largely untapped domestic resources, including the taxation of higher incomes.*

The Importance of Health

When COVID19 struck, Sir David Marmot was preparing his report on health equity (or lack of) in MENA, which highlighted the persistence of inequities in outcomes and provisions especially within countries and across income groups. His report reiterated the importance of socio-economic determinants of health for our conceptualization of health, and for policy orientation and formulation. This relationship is even more important in the context of COVID19, which is proving to be a "great unequalizer".

In that sense, health is one of the few issues on which there is a worldwide consensus, be it in terms of its practical and ethical importance, or in terms of the urgent need to tackle socio-economic determinants and ensure that no one is left behind. Health economics had already highlighted the costs of ill health, with investments in the health sector seen as a necessary bulwark against these, and as an investment in better productivity and human capital.

By the same token, the literature also established links between working and living conditions and morbidity patterns, which are in turn shaped by health policies and health provisions. Hence the need to address the socio-economic determinants of health, or conversely to tackle the drivers of affliction in society, particularly across income groups and in certain occupations. To this can be added the ethical dimension of health, whereby society can choose to ignore or address suffering, making "leaving people behind" a policy choice. UHC builds on this consensus, looking at health outcomes in terms of the social, economic, and political processes that generated them. UHC calls for a systemic approach that focus on:

- Whether everyone can Access Affordable Available Quality Care.
- Who is being excluded and why.

Thus, a key policy axis for UHC entails health risk mitigation and financial protection from the costs of healthcare and ill-health. As such, it enables individuals and societies to sustain shocks and protect health outcomes. Indeed, it is now accepted that UHC and other developmental factors (education, hygiene, sanitation, etc.) have a critical role in mitigating the impacts of disasters on health outcomes.

To achieve UHC, health systems should move on four broad fronts: addressing availability and provisions of staff and facilities with an equitable distribution of resources; working on the health financial transition that would allow health care to be funded and would pool resources; ending the ability to pay as a condition for using healthcare. A key development in this field is that country experiences have now tilted the balance against contributory paths that are linked to employment in low to lower middle-income countries. Non-contributory schemes are proving to be better and quicker at reaching more people and at lowering the financial burden of healthcare by lowering OOPS. Finally, the stewardship of strong public sectors needs to lead this transformative journey, supported by well-funded public provisions.

UHC in MENA: Too Little, Too Late?

MENA countries were supportive of the global Declaration on UHC of December 2010. Turkey led the required transformation after its earthquakes in 2003, now relying on a solid UHC system with significant improvement in access and a lowering of OOPs across the country. Elsewhere, UHC was pushed into national political dialogues in the aftermath of the Arab Spring events. Tunisia endorsed the right to health in 2014, revamping and monitoring benefit packages for lower income groups. Jordan, Morocco and Algeria were slowing expanding coverage to informal and poorer sectors through social health insurance or special schemes. Egypt finally committed itself to health financing transition in 2018, and began rolling out UHC in a few cities.

The official political commitment of the region to health for all was reiterated at the Salalah Summit in 2018, but regional and country documents attest to the persistence of: deficiencies in provisions, uneven distribution of resources within countries, and disparities in health outcomes. Except for Turkey, health financing mixes continued to favour the insured, with coverage for the informal and poorer sectors lagging behind. OOPs were the lowest in Turkey, but were still at 60% in Egypt, with the regional average at 42%.

Existing Structures, Covid Fault Lines

Unsurprisingly, existing policies and weak public health structures shaped COVID's impact on the region, which was amplified by the considerable displacement of essential health services. This is confirmed by regional and national assessments, including by Mataria et al (2020), who: call for a holistic, determined response that ends under-investments, that tackles the long list of neglected or weak areas (telemedicine, mental health, better information systems, etc), and works towards more resilient and equitable systems. Indeed, these

weaknesses in both provisions and health coverage became fault lines that sustained or accelerated the transmission of the pathogen, with the shortages in doctors, nurses, capacity, and funding, haunting many countries.

Importantly, regional evidence shows that in MENA as elsewhere, COVID19 has impacted the poor and vulnerable more than others. In Turkey, a sample survey by Ozedemir et al (2021) found that income, employment, and education disparities were the most significant determinants of COVID prevalence, meaning that the poorer and less educated groups were more impacted. In Morocco, geographical patterns show clear links between COVID prevalence and the concentration of Morocco's informal urban and peri-urban workforce. This is also clear in Tunisia, where the growth poles of the economy suffered more than the deprived regions, at least in the first waves. Thus, patterns of morbidities and afflictions are linked to socio-economic determinants, here these being working, living, and transport conditions. In Egypt too, COVID was NOT limited to areas with poor health facilities, nor to the regions displaying acute poverty and depravation. Covid did not stop when borders closed, and was at least in part generated by people attempting to work under precarious terms of employment. The lack of financial protection and incomplete health coverage must have amplified the shocks delivered by the pervasive job and income losses due to the pandemic, which are documented inter alia by Kraft et al (2021). Once again, the links between health equity, social protection, and vulnerabilities are highlighted, be it for informal workers, women or older persons.

Policy Lessons

Thus, the "new normal" in health policies in MENA are not new as such. Rather they are about frontloading efforts to confront both the deficiencies in health and health financing systems, and addressing the socio-economic vulnerabilities that have amplified the impact of "syndemic pandemic". In MENA as elsewhere, strong public health leadership, public health measures, and health system capacity have proved to be perhaps the single most important bulwark against the ongoing shock, more than shortages of medical oxygen or ICU beds. Countries must leverage all weak areas they have identified, upscaling and accelerating sectoral reforms, including in the crucial areas of data management, information systems, and the typically missing national accounts. Without such actions, recovery will not work.
Likewise, except perhaps in Turkey and Tunisia, countries must complete their journey of transforming their health financing mixes, thereby pooling resources, ending fragmentation and segmentation, and ending affordability as a condition for accessing healthcare. In that sense, MENA must address the health protection crisis underpinning the current situation, which meant that informality had trapped great proportions of the population in their attempt to work. In other words, it is urgent that health is prioritised and thought of as a portable entitlement, with the costs of ill health socialised. That would enable everyone to sustain shocks, and to move in and out of employment statuses without fear for their lives or livelihood.

A third "new normal" is that increased public funding for the above purposes is needed, given the significant under-provisions, the gaps in coverage, and the continued health challenges presented by the evolving pathogen. This is not to mention the issues of vaccines, vaccine equity, and vaccination campaigns. The current trend in other regions is to recognize the public good nature of such spending, and to drop cost recoveries and fees as a way of meeting financing needs. For MENA, it is relevant to mobilize previously untapped resources, namely the incomes and resources of the top income echelons of society.

Past health outcome improvements have been facilitated by visible public investments in health, be it in prevention, vaccination, or in building strong, modern, health systems. However, we learned from Yemen, Iraq, and other conflicts that health outcomes and human progress can go into reverse. International data is starting to show similar reversals in life expectancy across the globe due to the pandemic. More determined and accelerated health policies are urgently needed for recovery, in the same way that vaccination has become a passport to mobility. The visibility of deaths and suffering means that revamping health policies must be done and seen to be done, with equity as the horse driving the cart.

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