

# Towards A “New Normal” in Health Policies in The Arab Countries

Randa Alami



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## Abstract

This paper reviews the impacts of COVID19 on health policies in the Arab region, benchmarking them against progress towards Universal Health Coverage (UHC). UHC aims to provide Access to Acceptable Affordable Quality Care for all, which is now endorsed as a key pillar of Sustainable Development Goals regionally and globally. Before COVID19, despite some progress, most countries displayed deficient and maldistributed health structures and provisions, and pernicious inequities in health outcomes and access to healthcare, reflecting systemic gaps in health coverage and financial risk protection. The transition towards fairer health financing mixes is lagging, with protection tilted towards richer quintiles and the formal sector. Large swathes of its population still shoulder one to two thirds of health spending from their own pockets. These swathes are concentrated among the poor and informal sectors, highlighting the link between health equity, social protection, and labour market vulnerabilities. These fault lines amplified the impacts of the ongoing complex global emergency, with large proportion of the populations battered by increased poverty, trapped in systemic precariousness and informality, and unable to access or afford decent health care. Thus the “new normal” may well be about recognizing that the “old normal” has reached its limits. “New normal” in policies need to include: speeding up the institutional prerequisites for UHC, particularly in financing mixes and supportive digitised information systems; addressing health equity more bluntly; tapping existing national wealth explicitly; and embracing more redistributive and progressive policies. Without these steps, both recovery and reintegration in the world economy will be compromised.

**Keywords:** Universal Health Coverage, Health Financing, Health Equity, Public Health; COVID-19.  
**JEL Classifications:** I14, I15, I 18, J 81.

## ملخص

تستعرض هذه الدراسة آثار فيروس كورونا (كوفيد-19) على السياسات الصحية في المنطقة العربية، وتقارن بينها وبين التقدم المحرز نحو التغطية الصحية الشاملة (UHC). تهدف التغطية الصحية الشاملة إلى توفير الحصول على رعاية ذات جودة وأسعار معقولة للجميع، والتي تم اعتمادها الآن باعتبارها ركيزة أساسية لأهداف التنمية المستدامة إقليميًا وعالميًا. قبل نشي جائحة فيروس كورونا (كوفيد-19)، وعلى الرغم من التقدم المحرز، أظهرت معظم البلدان هياكل وأحكام صحية غير كافية وسيئة التوزيع، وأوجه عدم مساواة شديدة في النتائج الصحية وفي الحصول على الرعاية الصحية، مما يعكس فجوات قائمة في التغطية الصحية والحماية من المخاطر المالية. لا يزال الانتقال متعثرًا نحو مزيج أكثر عدلاً من تمويل الرعاية الصحية، حيث تميل الحماية نحو الشرائح الأكثر ثراءً والقطاع الرسمي. لا تزال أعداد كبيرة من السكان تتحمل من ثلث إلى ثلثي الإنفاق على الصحة من جيوبهم الخاصة. وتتركز تلك المجموعات بين القطاعات الفقيرة وغير الرسمية، مما يسلب الضوء على الصلة بين العدالة الصحية، والحماية الاجتماعية وأوجه الضعف في سوق العمل. أدت هذه الانقسامات إلى تفاقم آثار حالة الطوارئ العالمية الجارية المعقدة، حيث عانت نسبة كبيرة من السكان من زيادة الفقر، ووقعوا أسرى لعدم الاستقرار المنهجي والطابع غير الرسمي، وأصبحوا غير قادرين على الوصول إلى الرعاية الصحية اللائقة أو تحمل تكاليفها. وبالتالي، فإن "النمط الجديد" قد يكون متعلقًا بإدراك أن "النمط القديم" قد بلغ أقصى حد له. وعليه، يجب أن يشمل "النمط الجديد" في السياسات ما يلي: تسريع المتطلبات المؤسسية للتغطية الصحية الشاملة، لا سيما في مزيج أنظمة التمويل والمعلومات الرقمية الداعمة؛ وأخذ الإنصاف في الاعتبار في مجال الصحة بمزيد من الشفافية؛ واستغلال الثروة الوطنية القائمة استغلالاً فعالاً؛ وتبني سياسات أكثر تقدمًا وتوجهًا نحو إعادة التوزيع. دون هذه الخطوات، سيتعرض التعافي وإعادة الاندماج في الاقتصاد العالمي للخطر.

## Introduction

The ongoing global COVID19 pandemic has catapulted health and health policies into center stage, albeit not exclusively. It brought new challenges for national and international health systems; compounded existing deficiencies and inequities, with typically catastrophic consequences for lives and livelihoods; and highlighted the key roles of government action and leadership in managing the pandemic and forging paths to recovery. The main aim of this paper is to assess the current impact of COVID on health policies and health equity in middle income Arab countries, using Universal Health Coverage (UHC) benchmarks to take stock of emerging lessons.

The UHC framework has now established itself as a internationally accepted key framework for analyzing health challenges, because of its firm basis in the socio-economic determinants of health, its concern for equity, and its ability to integrate a multitude of policy areas, including health system design, capacity, and financing. This makes it a useful unifying framework for the current emergency, because it allows us to examine: if inherited structures have helped or hindered COVID shocks, and if health coverage and financial protection are mitigating the unfolding falls income and increases in poverty. Since health coverage also reflects social protection policies, it allows the consideration of COVID's impact on those who 'are left behind', this being associated with vulnerabilities in labour markets.

Therefore, this paper assesses the pre-COVID regional experience against UHC benchmarks, and contextualises emerging COVID fault lines in existing health structures, arguing that many of these are compounding the effects of COVID. It finds that here as in many regions, COVID is not only a health crisis, but also a social protection crisis, in that the typical lack of coverage for the poor and for the informal sector means that the working poor are disproportionately impacted. The analysis focuses on middle income Arab countries.<sup>2</sup>

The paper starts with a brief review of the importance of health and health equity, including key implications for the COVID experience. The second section considers the "old normal" in health policies in terms of outcomes, provisions, and health financing mixes. The third section reviews these policies under COVID, noting regional specificities. The last section concludes, arguing that inadequacies in provisions and coverage, poor access to affordable quality care, and worsening poverty, compounded the impact of COVID, implying that policy responses must take into account existing inequities and inequalities to recover from the pandemic. In turn this requires regional economies to rethink health as an investment and entitlement, and to deal with informality, precariousness, and poverty. Likewise, vaccination-led strategies need to start from this reality, and build towards more equitable and resilient recovery.

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<sup>2</sup> Wars and conflicts have devastated Syria, Yemen, Libya, Palestine and to some extent Lebanon. GCC countries are high income countries. While many of the latter provide free health care to citizens, their migrants population are rarely covered, making a key challenge for UHC and a health challenge under COVID.

## Health Equity, UHC, and COVID

Health has been considered a pillar of human development for some time. First, by improving and supporting human capital, it supports productivity and economic growth. Second, by ensuring everyone is healthy and everyone's health outcomes are improved, human capabilities are protected and the inclusivity of economic growth is supported (Sen 2004, World Bank 2006). Reflecting this importance for achieving developmental outcomes, the 1970s and 1980s saw significant worldwide public investments in public health, immunisation, better nutrition for children<sup>3</sup>. Likewise, the Sachs Commission on Macroeconomics and Health (2001) stressed health's contribution to the growth of developing countries, emphasising the need to go beyond national health indicators (e.g. life expectancy) especially in middle income countries. In the same grain, Suhrcke *et al* (2006) argue that health economics needs to shift away from a perception of health as "a cost to be contained" to acknowledging it as a driver of development and well-being, highlighting the role of health as an investment that supported Europe's prosperity.

Conversely, ill health carries direct healthcare costs (termed as Cost of Illness COI approach), over and above any indirect costs of undermined human potential. Reducing these costs provide a case for public action in providing health care, that is for all those who need it. Moreover, given that poverty and social conditions are associated with higher morbidities, and that health outcomes are differentiated between and within countries, public health policy has to be conceptualised as needing to address the socio-economic determinants of poverty. That is because these determinants are significant in shaping morbidities and ill health, implying that policies need to tackle them explicitly, especially in terms of the ability to access and pay for health care.

Thus, there are two overlapping issues: the need to reduce COI through healthcare provisions and investments, and the need to recognise that there is usually a social gradient to ill health. Some recent examples<sup>4</sup> from this vast literature include a Canadian population wide study which establishes that individuals with less education, lower income, and low employment status tend to be less healthy than those who enjoy socio-economic advantages. Similarly, a Dutch investigation using large data sets establishes that lower quintiles have higher standardized health care costs. In Turkey, Özdemir *et al* (2020) find that healthier and wealthier groups are less infected with Hepatitis C and HIV. In Egypt, a study of obesity (Mowafi *et al* 2013) highlights the gendered pattern of the disease, but also finds that women with higher school education were three times more likely to be normal weight than their less educated counterparts, and women of the lowest quartile had a 24 % higher probability of being overweight than those in the highest assets quartile.

A key component of the social gradient to health is employment status and labour market conditions. Bambra (2011) emphasises their role in producing these differentiated outcomes, in that occupations lead to unequal exposure to physical hazard and psychological problems, with unemployment or worklessness producing their own pressures. While the previous studies call for reducing health differences by reducing social inequality and poverty, Bambra proposes a model of the political

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<sup>3</sup> Anand and Ravallion (1993)

<sup>4</sup> Both the Canadian and Dutch studies are reviewed by Özdemir and Özdemir (2019).

economy of health inequalities, arguing that different public policy interventions mitigate or worsen the relationship. In the same grain, a strong alliance of leading public health economists and specialists in Arab countries presented the case for the reconstruction and reorientation of public health systems to tackle their structural weaknesses, realign them with their *Alma Ata* foundations, enabling them to serve more inclusive developmental paths (Jabbour *et al* 2012).

Beyond that, while poverty or poor living and working conditions often lead to ill health, adverse health events can also undermine people's ability to earn income, leading to "medical poverty traps", initially identified by Whitehead *et al* (2001). This relationship calls for a third area of public policy, namely providing financial protection when using health care. Of course, societies can ignore this, and can choose to tolerate suffering. As argued by Sen (2004), the persistence of inequities in morbidities reflect social and political choices societies make. Conversely, to ensure health equity, societies must commit to fairness in resource allocation, access and process, and policies should address underlying inequities in economic resources and opportunities.

The dual causality between poverty and ill-health, and the interlinkages between poverty, deprivation and ill health constitute the basis of literature on socio-economic determinants of health, which is now the main international framework for understanding and designing healthcare policies. In turn, this approach to health underpins the conceptualization of UHC as an overarching analytical framework to assess and formulate health policies. Indeed, UHC has been the main benchmark for policy assessment and formulation since its global endorsement in the global Declaration of December 2010.

The starting point for the UHC framework is that health inequities and health outcomes need to be analysed in terms of the social, economic, and political processes that generated them (Stuckler *et al* 2010). This has two implications which emphasize the links between health, equity and inclusivity:

1. The need to go beyond biological indicators to indicators of accessibility, affordability, availability and quality of health services.
2. The need to consider who is being excluded and why.

A third implication is that health systems and their financing need to be reformed in a way that supports labour markets, reduce poverty, and advance human development. In other words, accessibility and affordability of health services should not depend on the ability to pay, and citizens should be covered by equitable health financing systems. Thus, mitigating financial risk has to be at the heart of sectoral reforms, creating a direct link between health and social protection at the individual and national levels.

UHC goals are now incorporated in the Sustainable Development Goals, particularly through SDG 3.8.1, 3.8.2, and 1.1.1. The former is a composite index that captures population coverage of essential health services. The latter two measure the impact of health spending on income and on the proportion of people pushed below the poverty line. More importantly, UHC has many specific organizational and institutional implications for the journeys towards UHC. First, there is a stress on the stewardship

of public health and public health sectors, for a number of practical empirically based considerations, including efficiency in resource mobilisation and allocation. Second, governments need to commit to a minimum of spending, although many countries are close to UHC without being top spenders.

Finally, health financing mixes need to move towards full coverage and away from Out Of Pockets (OOPs), which are a direct measure of the financial burden of seeking healthcare (Savodoff 2012). Early discussions of health financing mixes were tolerant of any social health insurance mix that reduced OOPs. However, current evidence now supports taxation, not contributions, as a cost-effective way of achieving health equity. Leading authorities on this issue united to state that: labor-tax social health insurance programs is “ineffective or counterproductive”; and countries should focus on “using general revenues to finance universal health coverage...because general revenues are more likely than labor taxes to provide financially sustainable, efficient, and equitable health system” (Yazbek *et al* 2020, p.896). Similarly, a recent investigation shows that non-contributory schemes for the poor and near poor in Vietnam provided good financial protection by reducing OOPs significantly, while Thailand continued to focus on a tax financed universal scheme providing free care at points of service.<sup>5</sup>

### **Key health policy implications under COVID**

The UHC framework is also a useful for understanding key aspects of the ongoing global COVID pandemic. Its multi-dimensional lens allows the simultaneous consideration of key challenges: health system capacity, health financing, vulnerability, and role of politics and public action.

To begin with, COVID brought renewed attention to health system capacities, emergency preparedness, and the required investments to meet such shocks. Countries which have done that have found that learning from previous health emergencies helped them to respond more quickly and efficiently to the pandemic (Lal *et al* 2020). Significantly, Mohiedin *et al* (2021) confirmed in their cross-sectional study that emergency preparedness is helpful but not sufficient to protect developmental outcomes, while, UHC and other developmental factors (education, sanitation, etc.) are important in mitigating impacts on health outcomes

A consensus is also emerging about the primordial importance of the capacity of health systems and public health infrastructure for fighting the disease. Vadlamannati *et al* (2021) show that lower COVID deaths are found where there is strong health care equity, captured, for example by good and equitable covid tests availability. Analyses also confirmed the centrality of public health sectors in leading and managing the crisis, both in developed and developing countries, with world experts stressing the need for and the cost-effectiveness of investments in primary healthcare rather than ‘high-tech’ fix for the disease (Samman, 2020). That is because key characteristics of the sector, its ethos, outreach, are critical for responding and controlling the pandemic, with countries like Ireland and Spain essentially nationalising their private healthcare systems to respond to the crisis.

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<sup>5</sup> Tirfil *et al* (2019), Duc Thanh *et al* (2021), and *World Social Protection Report 2017-2019*, p.116.



As with other illnesses, pathways that shape poverty, health inequalities, regional disparities have been exacerbated by the pandemic. A most useful characterization of the situation is that advanced by Bambra (2020), who labelled COVID as the “Syndemic Pandemic”. She demonstrates that the DNA of the pathogen’s transmission corresponds with socio-economic determinants of health: Healthcare, Housing, Education, Unemployment/work, Access to services, etc. Consequently, inequities that were generated by existing systems are heightened, reminding us of the usefulness of viewing health through the lens of socio-economic determinants.

Within that context, the pandemic has devastated labour markets worldwide, with impacts clearly more pronounced on marginal workers and informal sectors, be it in terms of exposure, ability to work, and affordability of testing and treatment. On the international level, it has challenged both globally contracted workers linked to global value chains, as well as migration flows. A prominent example is the treatment of migrants in Taiwan and Singapore, with the former’s inclusive treatment taming the transmission of the virus, compared to more devastating numbers in Singapore. Thus, the pandemic has now linked health security at the personal, local, national and global levels like never before, cementing connections between national and global public health policies.

Finally, today’s ongoing complex emergency has left little room for inaction in terms of health policies. Indeed, government actions and trust in government are crucial for fighting the ongoing shocks. The visibility of death, suffering, and government actions are unprecedented. This is an important transformation that will continue to shape public policies for some time. The “new normal” is that health issues and policies are no longer relegated to specialist conferences. Rather, they are at the centre of public attention that is calling for immediacy in response: health and public health have to be prioritized for political, popular, and practical reasons.

### **Health policies in Arab countries: the “old normal”**

#### **Outcomes and provisions: ‘too little, too late’?**

Arab countries are no strangers to the global endorsement of UHC. and almost all countries signed the 2010 Declaration of UHC. Turkey made significant progress in ensuring the progressivity of financing and achieving large and significant falls in OOPs, particularly in urban contexts (Yardim *et al* 2014; Yilmaz 2013; Tirgil *et al* 2019). Despite reaching 76% of its population by 2006, Iran was struggling with OOPs, mainly because of weaknesses and inequities in public provisions across regions and social classes, which it tried to address through its Health Transformation Plan (Behzadifar *et al* 2020, Sajadi *et al* 2019). In contrast, many Arab countries are laggards in terms of actual policies, with notable difference between *de jure* and *de facto* health entitlements and health commitments. Health systems display a number of systemic problems, and clear, persistent health inequities in resources and outcomes. These inequities are related in no small way to the injustices and frustrations that led to the Arab Spring uprisings, whose key slogans have been freedom, dignity and social justice. Indeed, the right to health is now embedded in most regional social contracts or constitutions. Morocco introduced the right to health in Article 31 of its 2011 constitution. After extensive nationwide consultations with all stakeholders, Tunisia included the right to health in its

new constitution in 2014, while Egypt passed on its UHC law in 2018.<sup>6</sup> This section recaps on some problem areas presented *inter-alia* in Alami (2017).<sup>7</sup>

Firstly, national health achievements mask pernicious health inequities in outcomes, with clear disparities between regions and income groups at the subnational level. Recently, the Marmot report (2020) confirmed the persistence of the “gradient” in health outcomes amongst wealth quintiles: the infant mortality rate is three times higher in the lower income quintile, though differences have narrowed in Tunisia or Jordan (p.9). A recent World Bank report on Algeria shows the persistence of disparities in infant and child health across the county and income quintiles in 2019, with child mortality in the poorest quintile and region nearly double those in the top quintile (World Bank 2021, p. 34). WHO equity profiles monitor maternal and child health outcomes by quintiles, but do not cover other issues (access, NCDs, etc), and data is rather old. Egypt, and Jordan display the narrowest equity gaps with the composite index for Quintile 5 at around 80% vs 70-72% for Quintile 1 respectively, while for Iraq these stood at 69.5% and 58%.<sup>8</sup> Radwan and Adawy (2019) show that Egypt made progress in maternal care indicators, but stalled on other fronts like child mortality or the availability of emergency obstetrics. They also warn that health outcomes and service availability indicators are still shaped by strong geographical disparities, with the overall picture being “a picture of inequality in health service availability which impacts health outcomes in the same inequitable pattern (p.358)”

Secondly, health system provisions remain biased towards large urban centres and tertiary care, typically at the expense of remote areas and primary health care centres. This is also true of health workforce.<sup>9</sup> EMRO (2019) finds that in the region, 50%-80% of government health expenditure and two thirds of public workforce is spent on hospitals. Furthermore, even when clinics are available, they may not be opened or staffed regularly, with low staff remuneration not helping. Morocco and Egypt are below had par in terms of bed capacity and staffing. According to EMRO, half of the Region’s population does not have access to 16 essential health services, although averages may be skewed by the inclusion of Yemen. Afghanistan and Sudan. (EMRO 2019, P.13.).

Health systems capacity tends to be fragmented along four segments: public, military/special hospitals, private, and voluntary sectors. Due to the demise of the public sector, the private sector has expanded significantly throughout the region, and is an important provider of bed capacity, including ICUs. Private sector provisions typically replicate rather than remedy the skewed patterns of public health services, with a bias towards richer quintiles in urban centres. The sector has become dominant in some specialisms (dentistry, pharmacy) and care levels (secondary level, diagnostics, scanning), this being captured by the dominance of private provisions and facilities in those areas. This *de facto* privatisation reinforces the ability to pay as a basis of accessing healthcare, and is an important factor behind the continued dominance of upfront fees and OOPs.

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<sup>6</sup> See Mandour (2020) and Mathauer *et al* (2018)

<sup>7</sup> These challenges are also found in individual country health system profiles monitored by the WHO. Many of these are dated, and/or refer to the mid-2010s.

<sup>8</sup> See respective Health Equity Country Profiles, <https://www.who.int/data/gho/health-equity/country-profiles>

<sup>9</sup> This is also confirmed in the individual country profiles by the WHO.

The typically modest public health budgets are displayed in Figure 1, which sketches per capita Government Health Expenditure in constant dollars for 2010 and 2018. Tunisia, Lebanon, and Algeria have increased provisions, though they remain slightly below the Upper Middle Income average. Morocco and Egypt are getting closer to \$180 per capita, but the increase is lower than that of the lower middle income group. Figure 2 captures the share of Government Health Expenditure in GDP and Government Spending, with similar patterns: four countries allocate a tenth or more of their budgets to health, with Egypt at the lowest end of the scale with under 5% of the budget. By the same token the low spenders display the highest levels of OOPs.

These figures indicate under-provision and under-investment in public health. These characteristics reflect the structural adjustment years which required belt tightening and the impositions of user fees; and the deficient and fragmented provisions of health financing. EMRO (2019) estimates that the region accounted for under 2% of global health expenditure for about 9% of the world's population in 2015, while the 2017 average government expenditure on health (8.7%) was lower than the global average (10.6%). Spending did not recover when fiscal spaces opened up. The neglect of a key public service reflects the low priority of health on national government agendas, and a disregard for developmental goals and redistributive policies (UNDP 2012, Karshenas *et al* 2014, EMRO 2019).

### **Health financing mixes: transitions in waiting**

Figure 3 below shows that financing mixes in MENA continued to be dominated by two components: Public health Insurance PHI and OOPs. The latter showed that citizens still face significant financial barriers and shouldering significant proportions of the costs of ill health. Regional OOP levels in MENA are still amongst the highest in developing regions, except in Turkey whose levels declined dramatically in response to its UHC transformation. Figure 4 details OOPs by country and shows a striking trend of continued dominance of OOPs, with the average still at 41%, compared to 36% in East Asia and 31% in Latin America. Lower OOPs are where government spending on health is more generous, with Egypt Morocco and Iraq showing the highest financial burdens. Lebanon progressed in both reducing OOPs and GDP shares (before the current economic collapse). High or rising OOPs reflect a multitude of factors: the exclusion of social groups or regions coverage; the exclusion of some health needs from current benefit packages (cancer or medication); the poor availability of acceptable public health. Tunisia's Health Examination Survey<sup>10</sup> sheds some light on missing needs: there was still low take up of cancer screening; and 17% of respondents (especially in poorer income groups) could not afford medical visits. On the whole, regional evidence stresses the need to improve coverage and to give bottom income quintiles more generous packages or more affordable universal access, backed by available workforce, facilities and provisions.

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<sup>10</sup> See the 2017 *Global Monitoring Report*, p.19.

Earlier studies confirmed a significant impact of OOPs on poverty in Arab countries: *health spending deepened and broadened poverty*. 7%-20% of households incurring Catastrophic Health Spending<sup>11</sup> CHE (El Ghazzar et al (2010 Rashad, 2014; Zouari and Ayadi, 2014). These levels were significantly higher than reforming Asian countries (Abu Zaineh et al. (2013). In Tunisia and Lebanon, large proportions of the non-poor bought health care, but at the expense of other items in their budgets (Abu Zaineh et al 2013, Salti et al.2010). These studies also found that healthcare spending increases and deepens poverty by 13%-25% in Palestine Morocco and Tunisia. These number reflect the nature of poverty in the region, with many people clustered around poverty lines

The monitoring of OOPs has expanded phenomenally in the last decade. Wagstaff et al (2020) carry out a global stocktake, find that CHE and impoverishment tend to be lower in countries with better social health coverage. Surprisingly, no recent data for Arab countries is available in their survey.<sup>12</sup> Only two more recent studies were found. Oudmane *et al* (2021) find that 12.8% of households are affected by CHE at the 10% threshold in Morocco. OOPs increase poverty by 1.1% nationally but 4% amongst the poorest quintile. Poverty, hospitalisation and old persons in the household increased the risks. A study of OOP in Upper Egypt by Farahat *et al* (2021) found that OOPs were associated with poor income groups, chronic diseases and women of childbearing age, who typically have no insurance. 16.9% of the population (especially the poor) said they could not afford the cost of health visits.<sup>13</sup> More significantly, progressivity analysis conducted by Ahmed *et al* (2019) leave little doubt that poorer segments of Egyptian society shoulder most the cost of health needs, and that the Egyptian system is financed by a regressive financing mix because of its reliance on contributory elements.

Thus, the importance of OOPs reflects three sets of causation. The two were outlined in the previous section, namely the weakness and demise of public health systems, and the rise to prominence of the private sector. The third set of causation relates to the low or incomplete coverage of the population, the segmented and fragmented nature of available coverage, and the nascent nature of schemes designed to capture those who are excluded or are left behind.

Indeed, aside from Turkey and Iran. population coverage of health insurance in the region is rather low, at about half to two thirds of the population.<sup>14</sup> Algeria and Jordan are among the better performers, but 20-30% of the population, mostly the poor, are still not covered. The *de jure* access of ordinary citizens in Lebanon or Egypt is curtailed by the lack of access to care to those who cannot pay upfront, with many public services unavailable or being of substandard quality. In Egypt, only 58% of the population is covered by the main public health insurance scheme of the Health Insurance Organization (HIO). Moreover, coverage remains highly fragmented and segmented among schemes

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<sup>11</sup> A health payment is considered is “catastrophic” when it exceeds a certain threshold of household resources, forcing it to forgo other needs, incur debt, sell assets and fall into poverty, CHE are typically calculated as shares of health payments in total budgets established through surveys, for a range of thresholds.

<sup>12</sup> The two studies confirmed that at the 25% of the budget share threshold, 3.9% and 2.66% of households suffer CHE, which is higher than the 2.48% average in Latin America

<sup>13</sup> This gels with earlier data suggesting that 16-18% of the poorest quintile forgo health care due to its unaffordability (Labib et al 2021).

<sup>14</sup> *The World Social Protection* report for 2017-2019 shows the same data used in the 2014 reports. The reported deficit in coverage in countries studies are unchanged from nearer 20% in Algeria to 50% or so in Egypt and Lebanon. According to Chen (2018) 45% of the Moroccan population were still uninsured in 2014-16.

and providers, and restricted to formal and public sectors. The complexity of the Egyptian system, illustrated in Appendix A, was meant to be addressed through the Health Financing Reform decreed in 2018. Appendix B documents a less severe but nonetheless significant fragmentation of the Jordanian health system. The Moroccan system consists of seven main schemes (one military, the others civilians), with public spending spread across four categories, further subdivided into seven providers.<sup>15</sup>

These siloed provisions undermine efficiency, prevent pooling, and aggravate inequities. Furthermore, they also imply that health budgets and health entitlements are highly differentiated, and access to health is rigidly segmented. Budgets and provisions reach ordinary citizens through a cascade of filters. Richer quintiles and elites can typically afford the best private care and best public hospital. Then an array of packages is available to army and military forces, and further schemes for upper echelons of government and public employees. Government health budgets cover the top echelons and facilities FIRST, then provide cover for the general public and the lower income classes. Thus, the actual spending per uninsured (be it through special schemes or at public facilities) is a small residual of total public spending available to the insured in formal employment.<sup>16</sup>

Policies to improve coverage have involved making insurance mandatory for the formal sector in Morocco, Tunisia, and Jordan, setting schemes to serve informal sectors and special packages for the poor. These attempts have been plagued by problems of low uptake due to contributory charges, lack of provisions in public facilities. In principle, Morocco now covers 34% and 28% of its population through AMO and RAMED, but the latter faces many hiccups and challenges in practice, with marginal reductions in financial burdens (Cimini and Mansouri 2021, Chen, 2018). There is little information suggesting improvement in the Algerian and Jordanian schemes for the informal sectors, which were characterised by low uptake in the 2010s. On the other hand, in 2020, Egypt rolled out its UHC in two pilot schemes which are now serving 1 million people, this being in a population of 100 million in the middle of a pandemic.

These difficulties echo the earlier UHC experiences of developing countries, many of which abandoned the contributory and special scheme route in favor of universal access and non-contributory schemes. Arab countries need to take heed of these lessons, but also to address the institutional barriers to achieving the health financing transition. These are not necessarily about spending more, but about institutional changes and modernizations that will allow the sectors to operate more efficiently. Most Arab countries are yet to establish single providers, key purchasing agencies, and abolish payment at points of services, or separating institutional functions of provision and financing. Another key area is the need for more integrated, digitised Information Management Systems. EMRO (2019, p.9) reiterates these challenges: poorly designed and defined public health functions; the lack of coordination, integration and transparency in sharing health information. It labels many institutional set ups as “*not fit for purpose*” for reaching UHC. Gatti *et al* (2021)

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<sup>15</sup> These are: the Ministry of Health, Public Health Institutions (ANAM and University Hospitals, Segma (for provincial and regional hospital), and three Special Accounts which focus on social cohesion and human development, including the RAMED scheme. See Chen (2018) and OECD (2020) respectively

<sup>16</sup> This is confirmed for Morocco and Lebanon in their National Accounts for 2012 (Alami 2017).

document the extensive data problems in much of MENA, which have shackled the responsiveness of health systems, prevented a better allocation of resources, and undermined their ability to monitor and response to the new pandemic.

### **Health policies in the Arab region and COVID**

Hence, Arab countries met the pandemic with a mixed bag of uneven progress, uneven political commitment, and continued inequities, with Gatti *et al* (2021) describing its health systems as underfunded, imbalanced, and ill-prepared. On the one hand, all countries reiterated their official commitment to UHC at the 2018 Muscat summit, where regional governments adopted the motto of “Health for all” and a regional roadmap to UHC. Yet this slogan requires increasing common goods and public services to tackle health inequities and work towards more resilient and equitable systems. This was clearly still work in progress, or even a case of “too little, too late”. Unsurprisingly, as illustrated in Figure 6 below. the 2017 UHC indexes<sup>17</sup> in the region were either acceptable or modest, with lower indexes levels being associated with government health spending of 2% of GDP or less. Likewise, the UHC 2017 Global Monitoring Report showed most countries lagged behind in achieving the UHC targets. Data on Financial Protection are missing or dated, and the region is facing a major, unusual, pandemic with outdated National Health Accounts, little information on the components of OOPs, and poor data sharing across levels of the system.

The fault lines outlined in previous sections particularly in terms of health equity and health system capacity became accelerators of the pandemic. Indeed, recommended policy actions listed in the World Bank’s review of the situation (Duran et al 2020) reiterate existing policy diagnoses. Whilst the region did not do too badly in terms of preparedness, Mataria *et al* (2020) exposed the lack of investment and the piecemeal approach of existing policies, calling for more holistic actions. The authors also found considerable displacements of Essential Health Services (routine immunizations, dental services, etc), with possibly 26% disruption to communicable and NCD services (Gatti *et al* 2021). The WHO also called for leveraging weak areas such as emergency care service (The Lancet, November 2020; Mowafi et al 2021). Another weakness has been the poor availability of mental health services, who are now more in demand globally because of the distress caused by COVID (Eaton *et al* 2020). Although country specific battles varied, some common challenges can be noted.

First, while many governments escalated their surveillance and emergency responses, most are far from having effective and comprehensive information systems. Governments did deploy public awareness campaigns through the media and smart phones etc., but collecting data at all levels of health systems and diffusing information have been problematic. The region lags in its use of national digital health records that can be used across levels of services, with medical and digital literacy still weak. Gatti *et al* (2021) show that in most countries, data availability and access was lacking for nine key indicators of the impact of COVID19 on health systems, health workforce, and the allocation of public resources to deal with the pandemic. The authors also suggest that infections and death rates

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<sup>17</sup> The UHC service coverage index combines 16 tracer indicators of service coverage. These relate to four categories: service capacity, NCDs, Reproductive Health and Infectious diseases

due to COVID19 may have been underestimated in many countries due to problems and anomalies deployment and recording of testing and morbidities.

Here as elsewhere, there have been reports of burn out amongst health workers, overwhelmed facilities etc. Reports of shortages of oxygen, availability of PPE kits and testing are also widely discussed in the press and social media, with some of the incidents happening at good public hospitals (Egypt, Morocco). Additionally, pre-pandemic calls for investing in health workforce and facilities haunts many countries. In Egypt, Sisi's order to raise pay for health staff is an acknowledgment of existing disincentives. Additionally, Egypt saw a 30% fall in the number of doctors in the public sector from 113,000 in 2014 to 76,000 in 2018, with graduate doctors leaving to emigrate or join private practice (Moheildeen (2020). The Moroccan health minister now acknowledges the need for an extra 95000 health workers, including 32,522 doctors (The North Africa Post (April 2021).

The pandemic has also rattled the financial stability of providers, with most countries experiencing crises in the relations between private and public providers, because of payment schemes restrictions. Owain *et al* (2021) lists many countries with problems between the private sector and health authorities, with governments having to cap spending per capita in private facilities in Jordan Lebanon and Egypt. Likewise, incidents about people dying due to lack of oxygen or unaffordability of treatment are common in the region as elsewhere.

Thus, health systems fault lines in the region undermined its ability to cope with the pandemic. Deficient access to health and the prominence of OOPs acted as an amplifier, increasing the cost of ill health, be it due to COVID or otherwise. The inadequacy of protection from financial risks is thus a second whammy. A third whammy is that COVID is proving to be “the great unequalizer”. Studies of Barcelona, Brazil, Columbia, the UK and USA document a greater impact amongst the poorer and more marginalised segments of society.<sup>18</sup> As Sir Michael Marmot (2021) states, the relationship between socio economic determinants and health applies in the context of the COVID 19 pandemic, and the region is no exception. In Turkey Ari *et al* (2021) conduct a survey to capture the role of socio-economic factors in increasing exposure to and infection with COVID. They find having higher income, being employed, and having higher education tend to attenuate the risks, while poverty, low socio-economic status (precarious work and low education) amplified he risks.

Likewise, two studies of Morocco and Tunisia highlight the larger impact of COVID on informal and vulnerable workers. This impact implies that dependency on daily livelihood, the low ability to work from home, and the digital divide are structural factors that have increased vulnerability to both COVID and its economic impact. Marouani (2021) uses the 2017 Tunisian labour market survey, and finds that the more prosperous northern regions of Tunisia were hit hardest particularly initially. Data show three sources of vulnerability: the inability to work from home, being part of a non-essential industry, and working for the private sector. However, Bounouh (2021) also shows that the highest death rates were observed in both the richest and poorest regions (Tunis and Tataouine respectively),

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<sup>18</sup> See Berkowitz *et al* (2021), Crossby *et al* (2021), Henao-Cepedes *et al* (2021) Pires *et al* (2021), Vize (2020)

the latter facing the pandemic with 5 ICUs for the entire region, not to mention longstanding deficiencies in staff and material. Mahjoub (2020) highlights crowded housing conditions and the small number of room per dwelling as an aggravating factor in the spread of the pandemic.<sup>19</sup>

In Morocco, Boumahdi et al (2021) investigate the role of working conditions, manufacturing activities, development deficits and COVID prevalence. It found a visible correspondence between industrial clusters and COVID infection rates: 10 out of the 75 Moroccan provinces most affected by the pandemic had a higher proportion of labour in industry. Yet, the most affected provinces had relatively acceptable development indicators including in health system capacity. The authors attribute the transmission and spread of the virus to working and transport conditions, and to the labour-intensive modes of production, involving chain work.

In Egypt, CAPMAS's study of the first and second waves (CAPMAS February 2021) point to two overlapping stories. The first one highlights the neglect of rural and poorer areas. The highest infection rates in the first and second waves were indeed in Assiut and Matrouh respectively, which are among the poorest regions, and had low health system and health outcome indicators. Yet, many deprived poor areas were NOT severely impacted by COVID. Figure 8 plots regional values for infection rates against two health indicators: it shows that high COVID rates do NOT always correspond to deprived areas. Hence the second story is about the precariousness of the labour force: the largest impacted group are the *working poor*, not the acutely poor. As in Morocco and Tunisia, a significant accelerator is the dominance of informal daily work as a key source of income. The impact of COVID can be related to the nature of their work, the typical absence of social protection, and working conditions. ILO data showed that in 2017, about two thirds of the labour force worked in precarious conditions, with 56% having no health insurance or pension, and 49% no social protection (Fedi et al 2019).

COVID's impact on the poor and vulnerable, income and job losses are being monitored among others by ESCWA (2020, 2021) and the ERF. Kraft et al (June 2021) confirm that over half of households, particularly the poorer ones, saw dramatic falls in income. While there was some recovery in employment in Morocco and Tunisia in 2021, unemployment reached 29% and 42% in Egypt and Jordan. Layoffs tended to affect the vulnerable and informal wage workers, who are bearing the brunt of the economic impact. The largest income losses were incurred in the lowest income quintiles of Morocco and Egypt (69% and 49% respectively). Unfortunately, the surveys used do not ask about health expenditures, be it for PPE or masks, etc. Nonetheless, such catastrophic income losses must have increased poverty, which in turn could have led to further hardships and ill health.

Arab governments did join the rest of the world in displaying a barrage of economic measures to beef up the economy, including the extension and deepening of existing schemes, and the launching of new ones. However, Kraft et al (2021) find that these social protection schemes in fact had a low

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<sup>19</sup> Mahjoub (2020) quotes a 2014 survey which finds that 27.6% of dwellings have 2 rooms, and another 41.5% have 3 rooms.



level of coverage: only 20% and 8% of the lowest and second lowest income quintiles received such assistance respectively. ESWA (2021) reviews the expansion of existing social protection schemes and the additions of new ones, but also note that the modesty of disbursements and outreach, with persistent problems in delivery mechanisms and e-services hampering efforts. Likewise, Makram-Ebeid *et al* (2021) detail problems with the irregular labourers' grants, which covered 5% of potential beneficiaries because of: the low level of grants (LE 500 a month) compared to a poverty line of LE 735; confusion about registration and eligibility, and a lack of a unified registry system.

To sum up, there is little doubt that in most Arab countries, ill health and exposure to financial risks amplified poverty and inequities in "normal" times. There is also little doubt that COVID has inflicted a further double whammy in terms of income losses and morbidities. However, the pandemic's impact has also been amplified by deficient health financing systems and inadequate social protection, both of which favour formal labour attachments at the expense of poorer and vulnerable segments of society.

### **Concluding remarks**

In explaining the importance of the socio-economic determinants of health, Sir Michael Marmot (2021) remarked that social injustice kills, which is why health policies must address health inequities. This approach underpins UHC, and relates to global concerns about the pernicious effects of inequality. Although UHC is an aspirational concept, it is monitored through evidence-based indicators of key aspects of health system capacity and financing mixes. A central requirement is the stewardship of a strong public sector for a number of ethical and practical reasons, including gate keeping and cost efficiencies. Equity and public health have been two crucial stabilizing dams in the protracted global battles with the new evolving pathogen.

Before COVID, Arab countries had uneven records in terms of health outcomes and health coverage. Large swathes of their population were left without appropriate cover, shouldering significant OOPs, particularly among those with no formal labour market attachment. The region followed the world *de jure* by the regional call for "Health for All" in 2018, but *de facto* it lagged in terms of the strength of public sectors and the benchmark of AAAQ. There were efforts to beef up under-provisions for poor populations and remote areas, but problems remained and public spending was often below par. Likewise health protection, progress in population coverage and financial burden cover, be it through special schemes or UHC, was slow, if not "too little too late".

A systemic pandemic, COVID has brutalised the world economy and health systems in a multitude of ways. It also put health policies in the limelight, with government measures and recovery plans tracked publicly. However, COVID also tells us many old stories about health policies. Although there are issues about medical oxygen supply or the availability of ICUs, public health sector strength, capacity, and leadership, are perhaps a most important defence against it. COVID also tells us that the socio-economic determinants of health are important amplifiers, notwithstanding the role of social behaviour or country specific burden of diseases.

In confronting COVID, Arab countries displayed many effective public health measures, and benefitted from experiences in managing pandemics. Yet, countries clearly suffered because of the gap they display towards reaching UHC. Public sectors were still being strengthened, and the under-provisions in care, workforce, and facilities became clear fault lines. Inefficiencies in operations, poor support from data systems, the nascent nature of e-health and telemedicine show years of under investment that undermined key functions in facing the pandemic. Thus, the first ‘new normal’ in health policies in the region must be about upgrading and upscaling efforts to strengthen AND transform health systems.

The second ‘new normal’ is about addressing the health inequities that made their populations more vulnerable to COVID, and about reducing morbidities among the poor. This means these can use decent public facilities and access testing and treatment. However, regional studies show that COVID is not necessarily where abject poverty is: a good proportion of its victims are informal workers and their families. Their precariousness meant that they were exposed to COVID because of living, transport, working conditions and terms of employment. Thus arguably, COVID is also a social protection crisis, which shows that well-functioning labour markets are those which provide either decent jobs and/or social protection, regardless of employment status. The costs of decent jobs and a healthy society must be socialised in order to be feasible, because this allows people to move in and out of employment and between jobs without fearing for their lives or livelihoods. This reinforces the need to think about health as a necessary investment for an inclusive and sustainable economy. In practice, Arab countries need to accelerate their health finance transition in order to facilitate resource pooling and a more equitable and universal access to health care.

A third ‘new normal’ is about the urgent need for public funding. As income are slashed and poverty is rising, governments need to, reduce the need for upfront payments at point of service. This requires public resources, which in turn requires taxation. Taxation of the top 1 or 5 percent of the richest people in the Arab region was shown by ESCWA (2020) to be an important untapped source of revenues, especially that most sources of finance have dried up, adding urgency to redistributive policies. Their proposed solidarity tax of 2.6% or about \$45 billion could cover the region’s poverty gap, thereby saving millions from poverty and precariousness, a call also echoed by Marmot (2021).<sup>20</sup> Furthermore, countries around the world are already working on expanding and increasing public health provisions.<sup>21</sup>

Savedoff (2019) noted that societies produce public health goods for historical and political, not technical reasons, adding that the “collective investments that we enjoy today were also started in troubled times”. COVID in the region has squarely underlined the costs of inaction. Most countries had already accepted UHC as part of their national dialogue. Since the visibility of suffering is now aligning advocacy, politics, and action, COVID may be an opportunity of mobilize national resources for recovery and equitable development. Without addressing this hole, the functioning of the economy

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<sup>20</sup> Marmot (2021, p.28) calculates that even excluding GGC countries, MENA countries have higher income inequities than the USA and Europe.

<sup>21</sup> Neville, S., “Covid spurs expansion of public healthcare”, *Financial Times*, 27/9/2021.

and society will continue to be impaired. Without reorienting provisions and financing to tackle health inequities, the problems will continue to be amplified by COVID.

Looking forward, the pursuit of equity has to be embedded in all policy actions. Any vaccine-led recovery strategy needs to acknowledge the current vaccine inequality. Recovery must not deepen COVID-led poverty traps. Otherwise, the region risks establishing islands of health and safety amidst oceans of suffering and deprivation, and hobbled public health sectors and policies will compromise its reintegration into the world economy.

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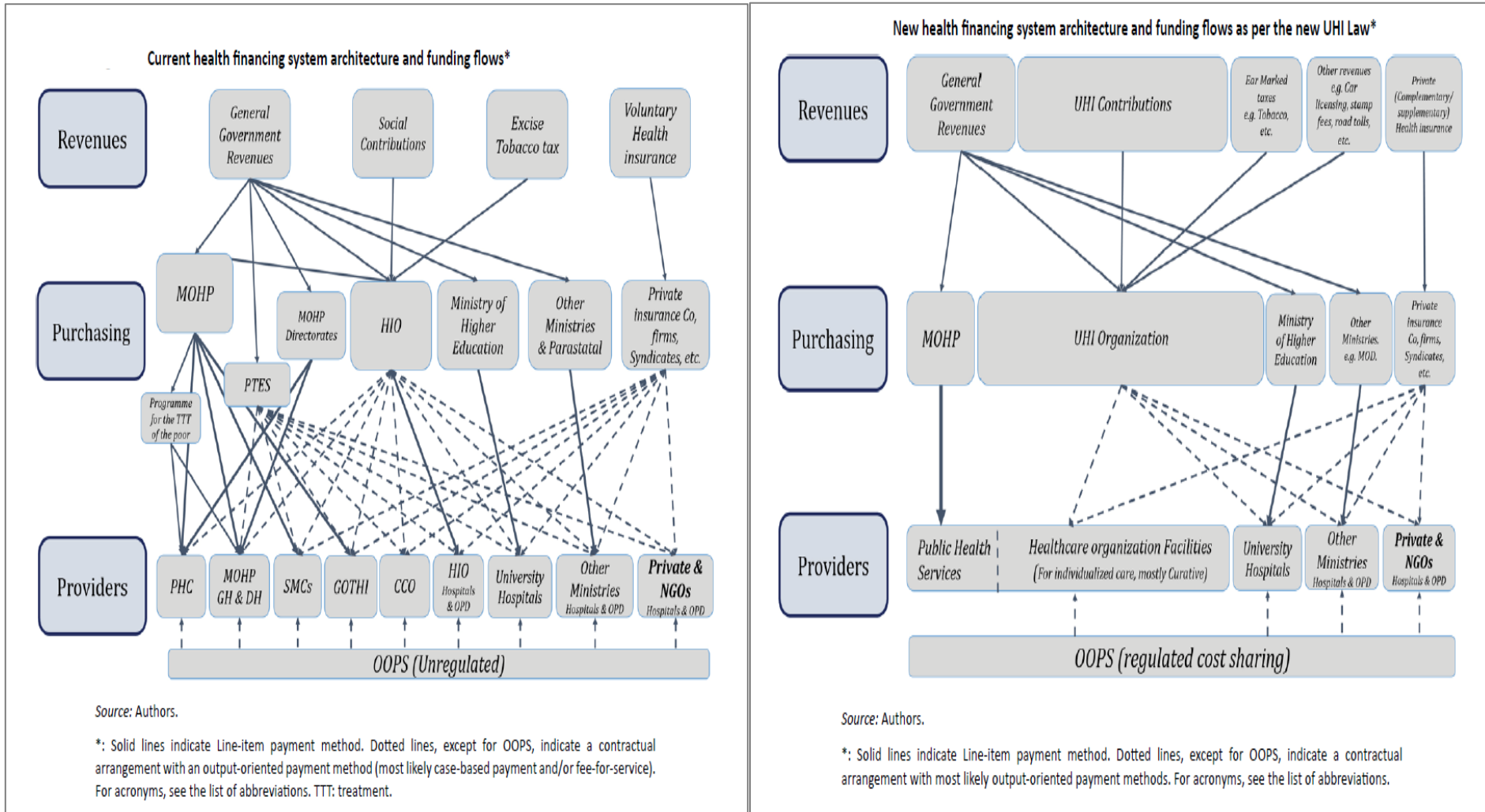
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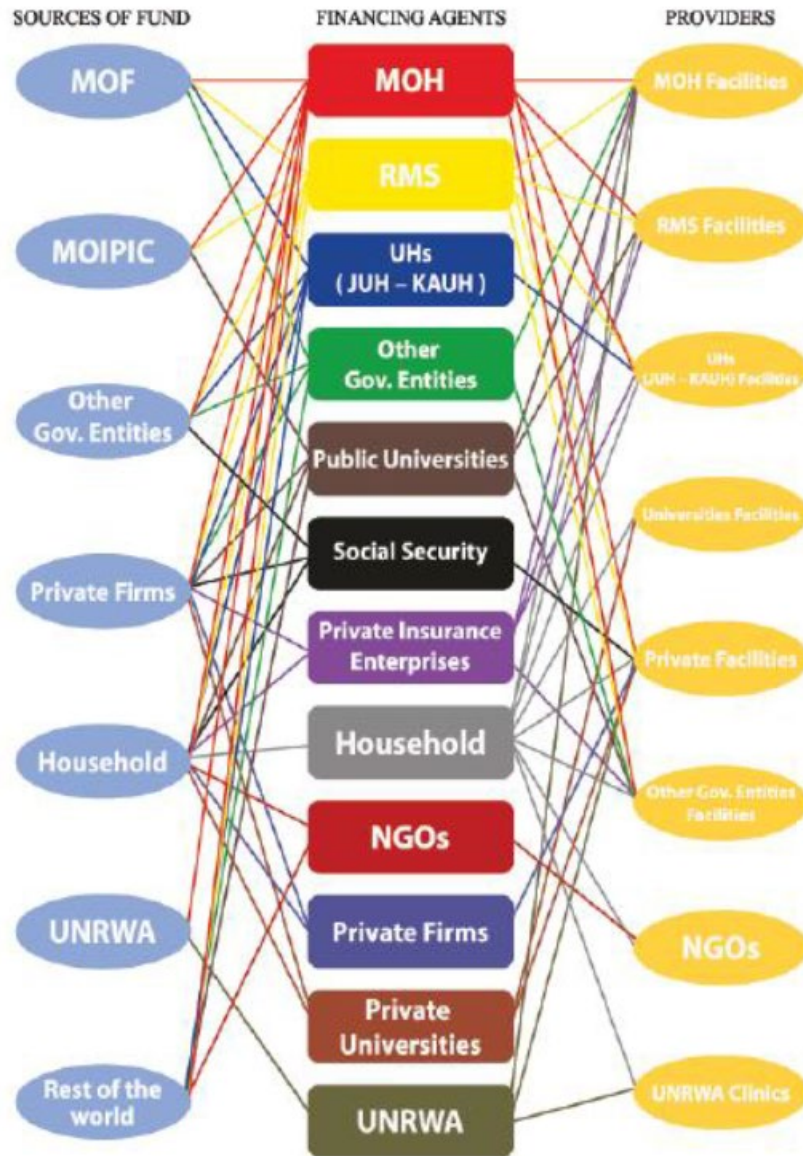
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## Appendix A: Current & New financing Systems in Egypt

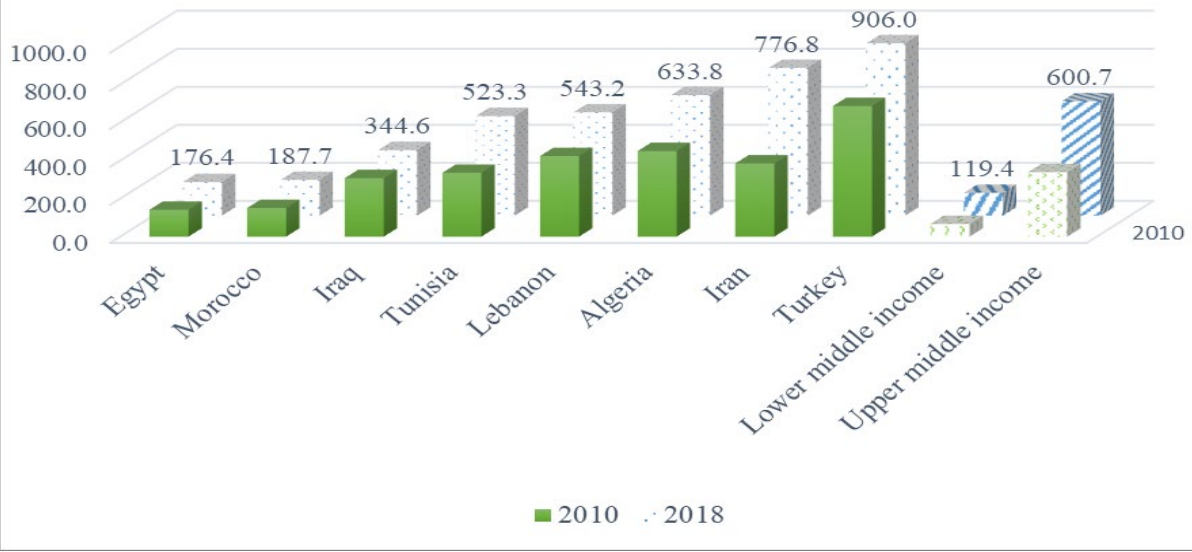


Source: Mathauer et al (2019).

## Appendix B: Jordan's Health Financing Mix 2016-2017

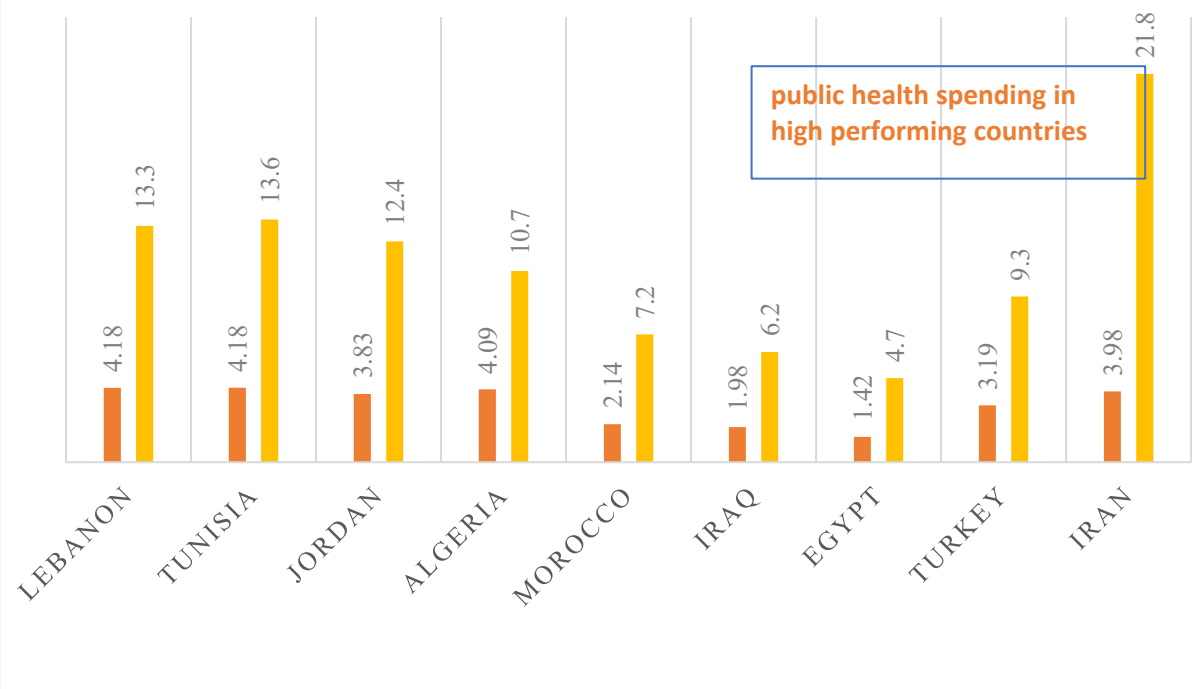


**Figure 1: Govt Health Expenditure per capita PPP 2018  
(current international \$)**



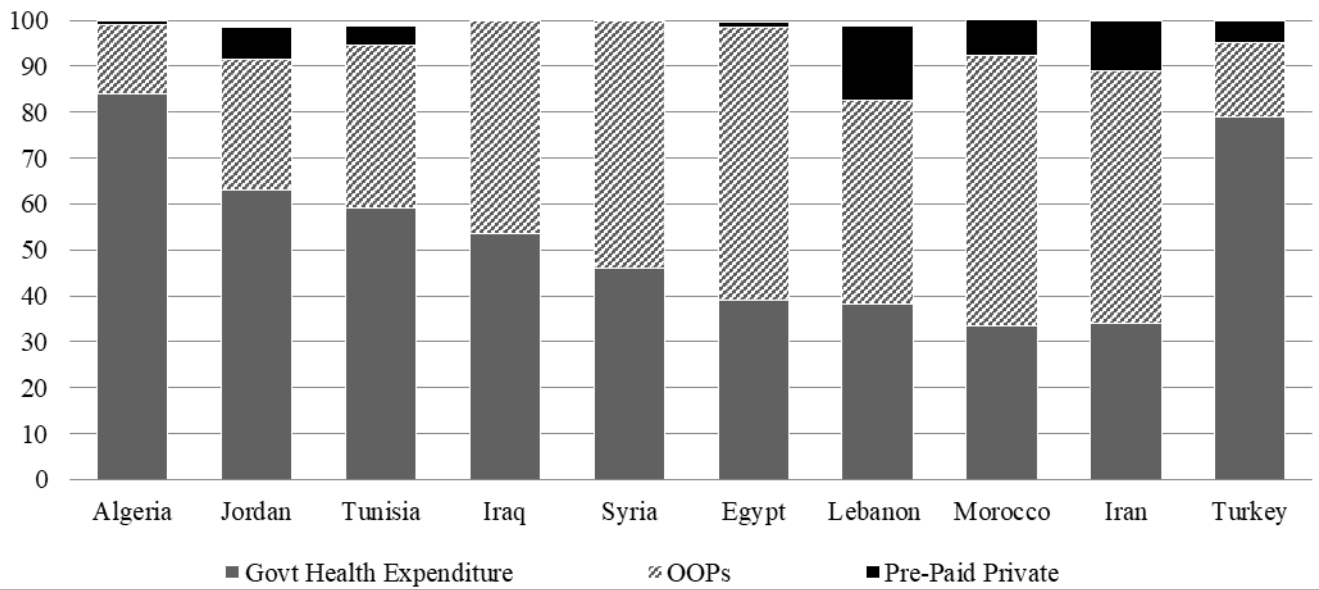
**FIGURE 2: GOVERNMENT HEALTH EXPENDITURE IN GDP AND IN GOVT SPENDING, 2018**

■ Government Health Expenditure in GDP ■ Govt Health Expenditure in Govt Spending

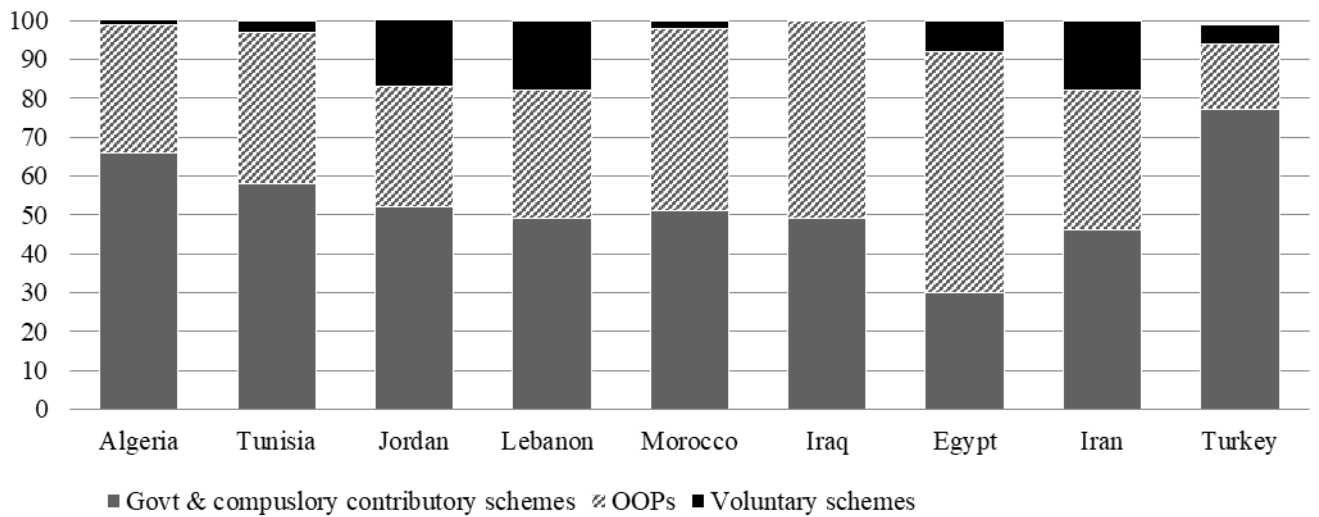


Source: World Bank Development Indicators (July 2021).

**Figure 3 a: Current Health Expenditure by Financing Agent, 2012  
(in percent)**



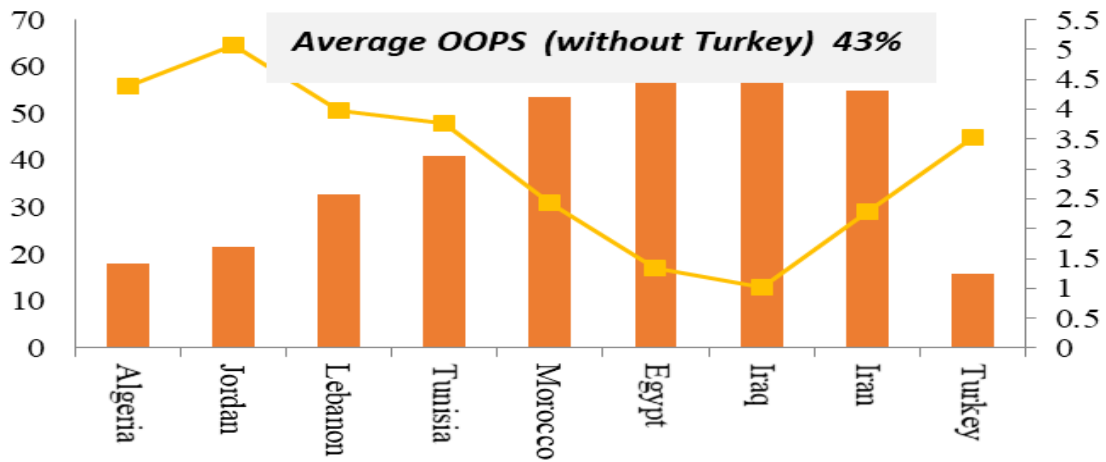
**Figure 3 b: Current Health Expenditure by Financing Agent, 2018  
(in percent)**



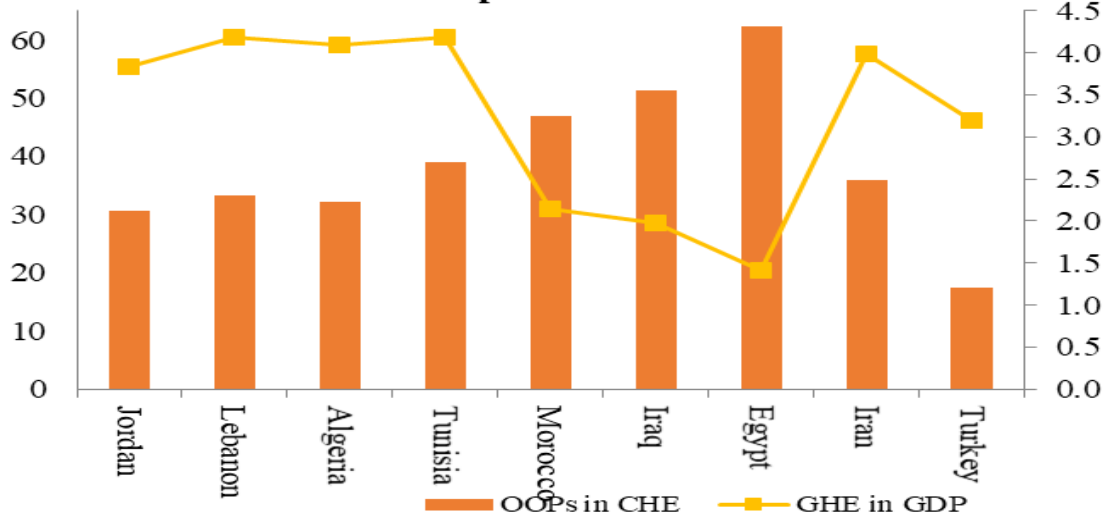
<http://apps.who.int/nha/database/Select/>

[Indicators/en](#)

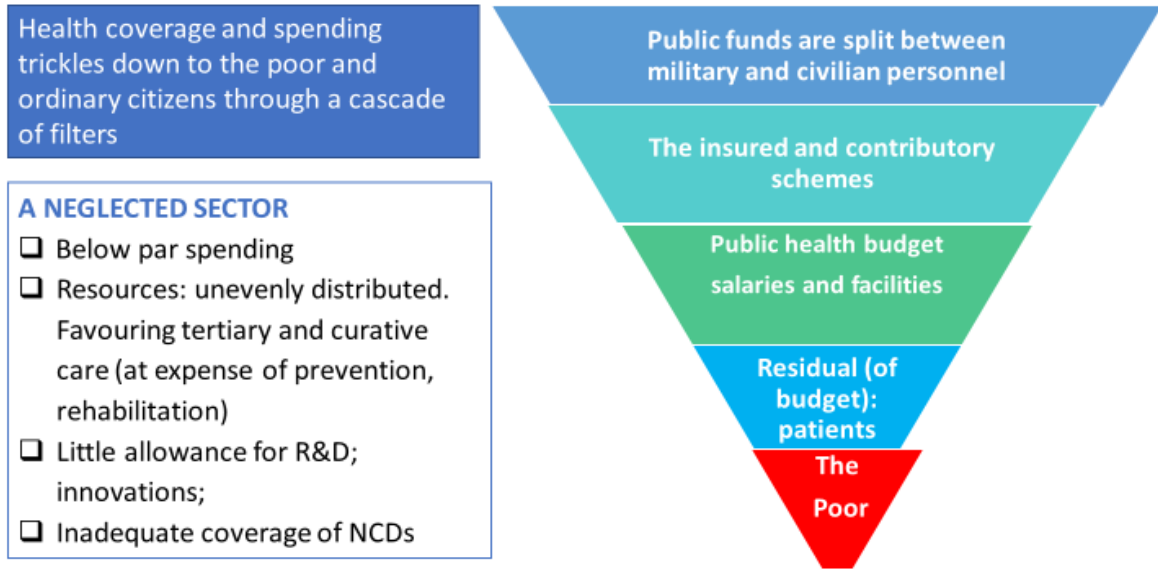
**Figure 4 a: OOPs in Current Health Expenditure vs Govt Health Expenditure in GDP, 2012**



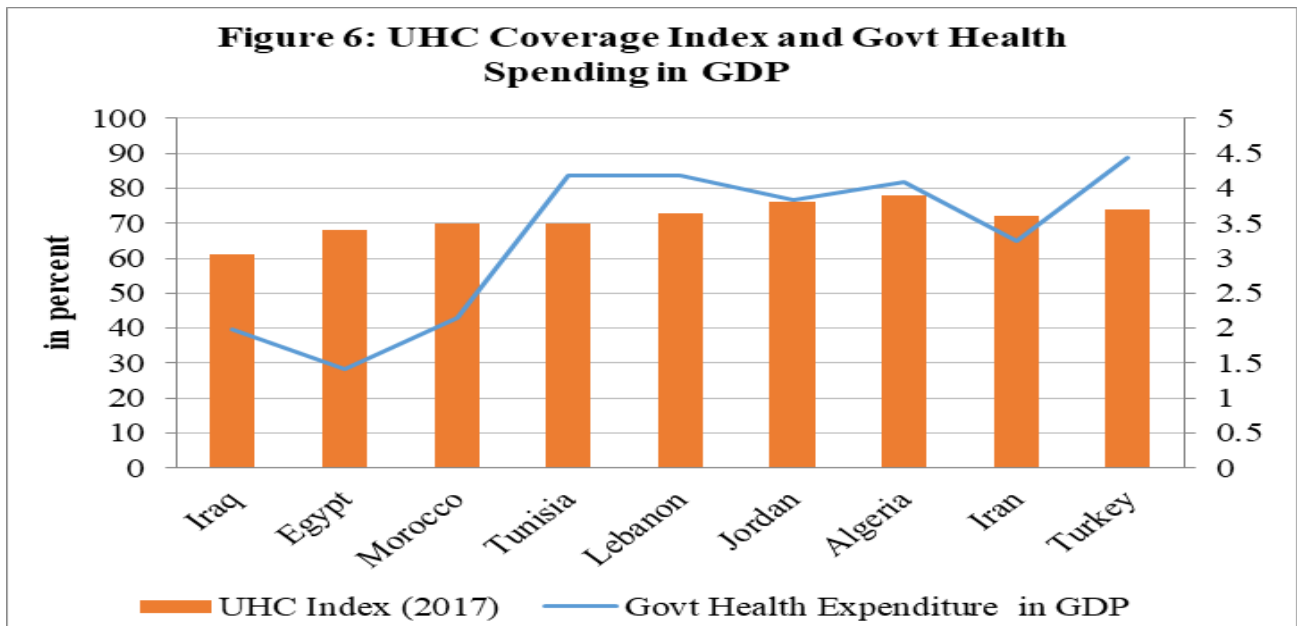
**Figure 4 b: OOPs in Current Health Expenditure vs Govt Health Expenditure in GDP 2018**



**FIGURE 5: Public Health Coverage: a cascade of filters**



**Figure 6: UHC Coverage Index and Govt Health Spending in GDP**



<https://www.uhc2030.org/what-we-do/knowledge-and-networks/uhc-data-portal/> (June 2021).

**Figure 7: Health Inequities and COVID fault lines in Arab countries**

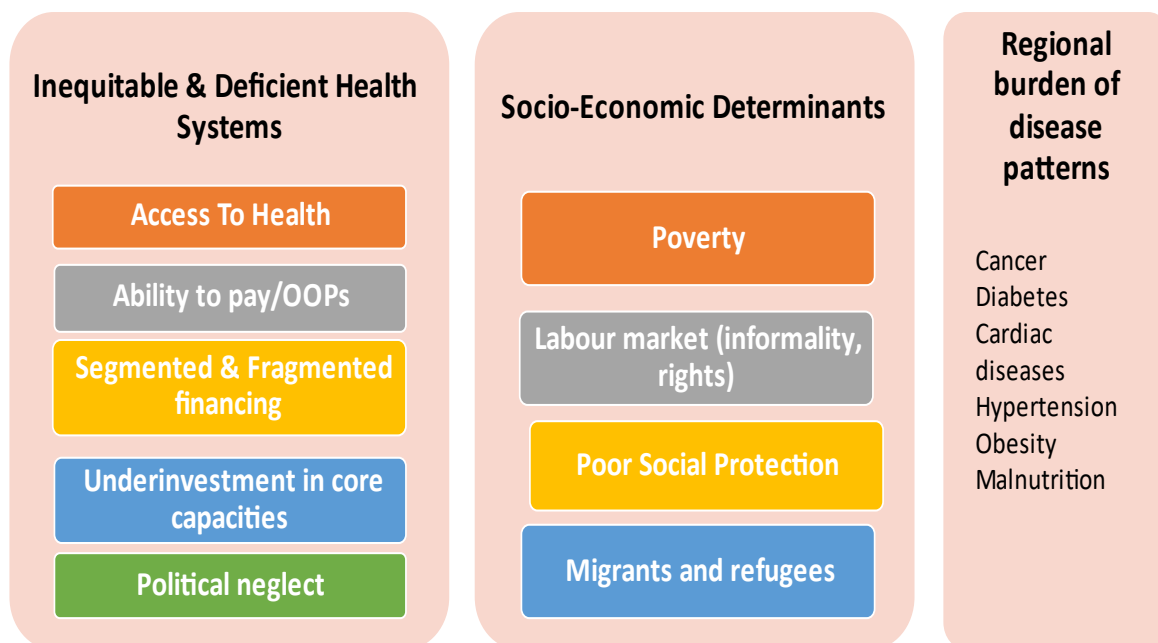




Figure 8 a: Egypt: Covid rates vs Child Mortality

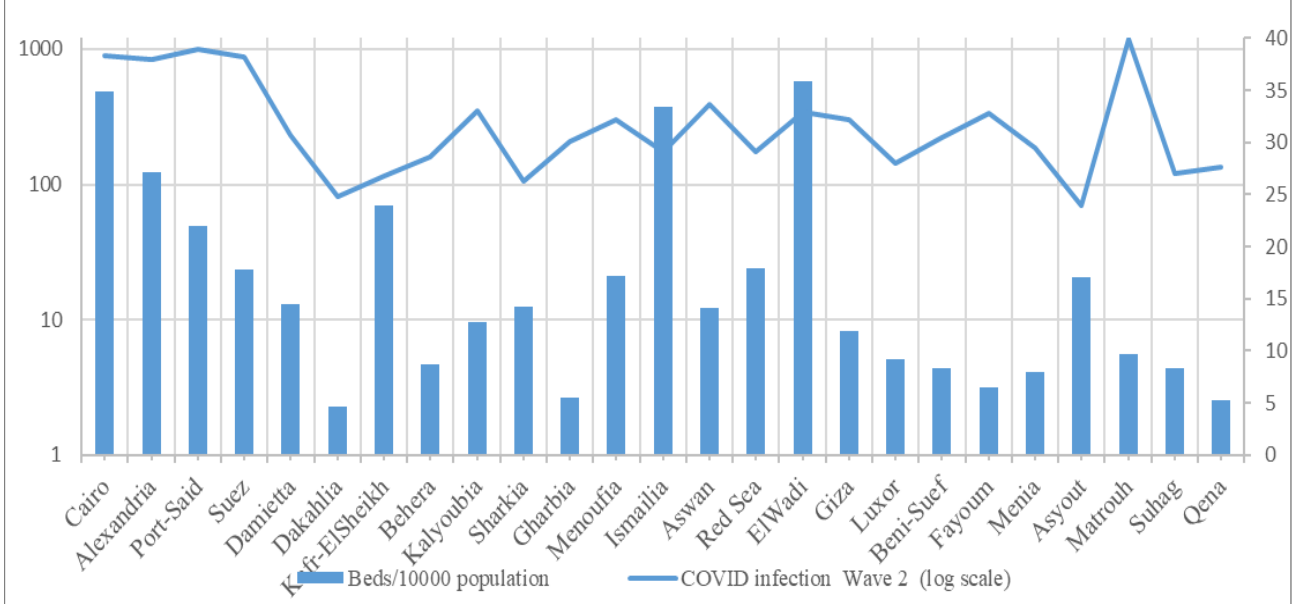


Figure 8 b: Egypt: Covid rates vs Bed Capacity

