Achieving Healthy Lives in the MENA Region: Towards Strong and Equitable Health Systems

Randa Alami
Economics Department
School of Oriental and African Studies (SOAS)
University of London

Achieving healthy lives is a challenge at the best of times, but doing so during three ongoing unprecedented global shocks (the Covid-19 pandemic, Ukraine war and global climate crisis) is a formidable challenge indeed. Before Covid-19 rattled the world, the developmental agenda was, to a great extent, built around the Sustainable Development Goals, or SDGs. SDGs focus on equitable human development that attenuates inequities, and address climate change concerns through links to environmental sustainability. They are concerned with health by monitoring: the availability and coverage of health services (SDG 3.8.1, 3.8.2); and the financial burden created by ill health, particularly for the poor (SDG 1.1.1).[1] These goals underline the importance of health for achieving healthy lives and ending poverty. They are also embedded in the global policy direction of Universal Health Coverage (UHC). UHC is an aspirational definition that seeks to: deliver Available, Affordable, Accessible, Quality (AAAQ) healthcare for all, cater for those who are excluded and mitigate financial burdens due to health needs. In 2010, it was endorsed almost universally, including by countries around the Mediterranean.

Thus, achieving healthy lives before Covid-19 was largely framed and benchmarked against UHC. Its underlying concepts and implied policy directions were being absorbed by the policy discourses of the region, not least because of the events of the Arab Spring. The Arab Spring exposed major developmental problems and widespread resentment, including about the status of health services, health coverage and the financial burdens they placed on citizens. Notwithstanding wars and political instability, MENA renewed its commitment to UHC in the 2018 "Health for All" Salalah Declaration, with an explicit mandate to tackle existing health inequities.

Covid-19 hit the world, rattling strong and weaker systems in both similar and different ways, but the unfolding experiences are also converging towards common lessons. Foremost amongst these is the importance of public health capacity and strong, comprehensive structures, both for recovery and as bulwarks for future crises. Furthermore, this "systemic pandemic" has quickly become a "great unequalizer," at a time when the world was frowning upon all aspects of inequalities. Indeed, Covid-19 has been a blunt reminder of the centrality of human beings for the functioning of societies, and of the futility of looking at health in isolation of its socio-economic determinants. Indeed, the barrage of public responses around the world highlighted the direct links between these determinants and the preservation of life.

This background is in line with Shami and Jardali's contributions to the 2021 yearbook. This article complements their findings, but argues that inequalities and the neglect of health sectors are both generated by a political economy process which tolerated social injustices. It proceeds as follows. Firstly, it takes a step back to revisit the links between health and equity, and the ways in which inequities shaped health sectors and social policies. It then shows that

[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.

this context shaped and worsened Covid-19's impact, as evidenced by the convergence between its impact and socioeconomic inequities, with labour market statuses and informality proving to be key vulnerabilities. The concluding remarks argue that equity, health and social policy are moving in the same policy direction, namely accelerating reforms but spearheading equity. Covid may be a pivotal moment to deliver on rebuilding the sectors on more equitable grounds, because it has pushed the equity and public health agenda pragmatically and politically. While the multiplicity of severe global shocks may complicate or even derail policy implementation, there is no need for reimagining the sector or redrawing the agenda.

The Vital Importance of Health Equity

As previously noted, the Covid pandemic has been a blunt reminder of the centrality of health for human activity and prosperity (or lack of). Historically, societies have dedicated great efforts to improving health outcomes, though progress has been shackled by poverty and discrimination. Likewise, gains in health statuses in developing countries largely resulted from massive public investments in public health capacity, preventative care and immunization campaigns in the 1970s and 1980s. Conversely, ill health can also push people into "medical poverty traps," undermining abilities to earn income and participate in society. Thus, health issues have an inherent call for policy actions, particularly in terms of ensuring fairness and reducing poverty.

Yet, historically, improvements in health and related sectors (sanitation, etc.) were initiated in the interest of ruling classes. Thus, ill health and suffering can be viewed as a political choice: societies choose to treat or ignore ill health. Consequently, health outcomes are shaped by health policies, which also underpin differences in morbidities amongst certain groups, classes or regions. Ultimately, as Sir Michael Marmot says, social injustice can kill. In the same vein, health is intimately related to labour market statuses, work, or indeed "worklessness." Certain occupations are associated with certain patterns of ill health, and unemployment underpins many adverse health outcomes.

Thus, health can no longer be framed in terms of biological outcomes or as a list of diseases. Rather, it is largely driven by socioeconomic determinants, which in turn are shaped by policies. Successful health policies recognize health as being a pillar of socioeconomic equality, and a vital investment in human capital and well-being. In that sense, the launching of UHC in 2010 indicated a definitive and irreversible shift to adopting these determinants as a prime concern for health policies. Rather than focus on national averages for health indicators, societies are invited to place themselves in the famous UHC cube[2] and ask: who is excluded, from what, how and why? In turn, that informs the journey towards AAAQ for all, with a simultaneous emphasis on: the need for strong health systems and structures and tackling affordability and exclusion.

Covid may be a pivotal moment to deliver on rebuilding the sectors on more equitable grounds, because it has pushed the equity and public health agenda pragmatically and politically

The UHC commitment reinforced the *Alma Ata* case for strong stewardship by public health sectors, for ethical, practical and cost effectiveness considerations. It also entailed a number of institutional prerequisites, such as: ending fragmentation, the pooling of resources and the completion of the health financing transition.[3] Ultimately, health financing structures should allow for the socialization of health costs, be it via risk pooling or tax-based public provisioning. The political feasibility of UHC and its benefits in terms of social cohesion are also demonstrat-

[2] See www.who.int/medicines/areas/policy/5-DavidEvansmedicines.pdf

[3] The health-financing transition refers to the transformation of health financing mixes and includes both a rise in total health spending and a change in its composition towards a greater share for public health spending and other risk-pooling mechanisms. A key objective is to reduce out-of-pocket expenditure (OOP) (Fan and Savedoff, 2014).

ed by the fact that most countries adopting it were going through major shocks, such as wars and earthquakes. UHC was also recently shown to be an important pillar of resilience and disaster mitigation.

Covid's Impact

The devastations caused by Covid-19 have been a brutal reminder of this importance. The spread of the pandemic quickly came to take the shape of socio-economic determinants across the globe. Infections and deaths were clearly higher among people at the bottom of the income and racial ladders. They were also more severe in labour markets, particularly amongst marginal and informal workers. Migrant living spaces became hotbeds of transmission and deaths, except in countries like Taiwan, which provides health protection to all its workers.

As such, the pandemic has reinforced the case for health equity and public health. Countries that managed well benefited from strong public health systems, complete health coverage, unified information nets, all supported by strong political leadership and public health measures. Conversely, the fragmentation and privatization of services and under-investments in public health structures, compromised many systems, with some countries having to nationalize the sector in order to cope. In the later waves, some mature systems redeployed and reorganized services, reversing cuts in resources and increasing recruitment quickly. On the other hand, current Chinese zero-tolerance policies reflect weaknesses in health system capacity, particularly rural areas and ICU beds, indicating a poor ability to deal with new waves.

Many countries around the world are expanding public healthcare in response to this Covid experience and in anticipation of future challenges. Covid continues to place additional burdens, be it due to mutations or to its long-Covid forms. Moreover, the world is acknowledging that it is a new zoonotic disease that is likely to be followed by others. The pandemic has also shown that everybody's health has to be protected for all to be protected, integrating national and global health systems like never before, with UHC becoming an important ingredient of national and global health security. The link between those levels is particularly relevant for refugees and migrants. Yet, instead of international solidarity and cooperation, inequity now characterizes testing, vaccines and anti-viral drugs.

This is also true of MENA countries, which are at a disadvantage in this evolving global system. Most countries (except in the GCC) lag behind in terms of vaccination rates, most of which are below the 54% average for lower income countries. As argued in the next sections, MENA entered the pandemic war with weak and inequitable health systems, hobbling its responses.

A Defective "Old Normal" in Health Policies

As argued by sectoral analysts, Covid did not happen in a vacuum. Most MENA countries incorporated the right to health in their social contracts of constitutions, and had official commitments to health equity as of the 2018 Salalah Summit. However, large gaps existed between *de facto* and *de jure* entitlements, and between the burgeoning reforms and the UHC destination. Moreover, pervasive disparities in health outcomes at subnational levels and across income groups persisted (The Marmot Report 2021). In a nutshell, what was done before the pandemic was a case of "too little too late," with fault lines in health systems translating into accelerators of Covid, this being the case for public health capacities, as well as financing structures and social protection systems.

Existing MENA health systems could thus be easily labelled as deficient, lopsided and unfair. Deficient because of the number of areas of unmet needs, particularly in terms of NCDs, diagnostics and services (e.g mental health). Rural and poorer areas were underserved particularly in terms of the healthcare workforce, reflecting systemic shortages, maldistribution and/or concentration in richer urban areas, but also the exodus of staff to private or foreign facilities. They were lopsided because their curative-based systems focused on large urban hospitals at the expense of regional needs and preventative care. They were unfair because for poorer and marginal populations, healthcare was typically unavailable or unaffordable. Explicit and implicit privatization made things worse.

Likewise, hardly any country had shifted to a national patient-based system or digitized national records,

with information management systems typically weak and disjointed. This implied operational and financial inefficiencies and a poor ability to coordinate services between various levels and functions of the systems. Many institutional setups were deemed by EMRO (2019) as "*not fit for purpose.*" Covid also occurred in a context of weak medical and digital literacy, outdated national health accounts and other similar deficiencies. These problems shackled the responsiveness of MENA health systems, prevented a better allocation of resources and undermined their ability to monitor and respond to the new pandemic. The region still lacks reliable data on key indicators of Covid's impact on the workforce and on the allocation of public resources to deal with the pandemic (Jardali 2021, Gatti *et al* 2021).

Health coverage in MENA is highly fragmented and segmented among schemes and providers, with siloed provisions undermining efficiency, preventing pooling and aggravating inequities. It largely excludes informal sectors and those without formal labour market attachment. This is highly problematic in a region where informality averages 68%, and where female labour force participation is amongst the lowest in the world. Many countries were expanding social health insurance and special schemes for the poorer segments of society. However, progress has been slow, with exclusion still affecting 20%-50% of the population (Algeria vs Egypt and Lebanon). Egypt rolled out two pilot universal schemes in 2020, but these only served one out of 100 million, in the middle of a pandemic.

Existing MENA health systems could thus be easily labelled as deficient, lopsided and unfair

Similarly, countries were yet to complete their health financing transition and yet to establish single providers, key purchasing agencies, or separating provision and financing. Consequently, out-of-pocket payments (OOPs) continue to dominate in their financing mixes. The average regional OOP was still at 41%, higher than in other developing regions. It was even higher in some countries, and among poorer income groups at sub-national levels. Clearly, it is urgent to improve coverage particularly among the bottom income quintiles, be it through more generous packages or more affordable universal access.

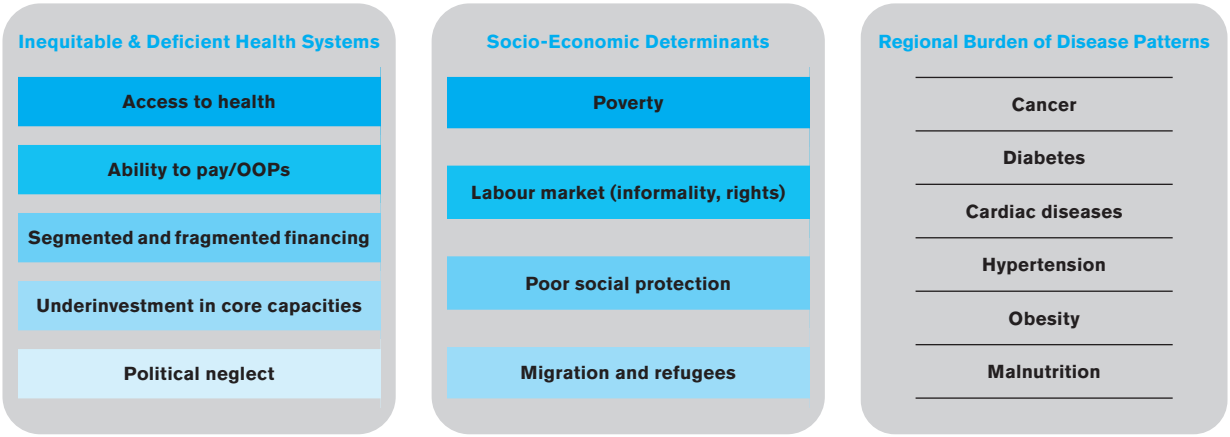
Health System Fault Lines: Amplifiers of Covid

As Chart 9 below shows, MENA did have vulnerabilities in its burden of disease that contributed to Covid. However, the structural weaknesses in its health systems and their inequitable treatment of large parts of MENA populations have been major fault lines that amplified its impact. The problems were pervasive, from poor preparedness at hospital level, to systemic shortages of staff and provisions, and weaknesses in communication and management at sectoral levels. The sectors' deficient nature, especially in the eyes of the victims, underpinned horror scenes in the best urban centres as well as neglected rural facilities. Inevitably too, there were significant displacements and postponements of essential health services (renal treatments, dental services, etc.) due to lack of resources, overwhelmed curative facilities, and weaknesses in health systems outside major hospitals (Mattaria, 2021, Gatti 2021). Consequently, MENA health systems buckled under the strains of the pandemic, especially in the second and third waves, notwithstanding heroic sectoral responses or instances of remarkable solidarity and social cohesion.

In terms of morbidities, the pandemic continued to ravage the region after borders closed and despite strict lockdowns. Covid did not only strike poor and neglected areas. It also had an urban aspect due to its relation to crowded living and transport conditions, and due to its links to informal labour markets. With little scope for tele-workability, millions were forced to work in precarious conditions to protect their livelihoods (Marouani, 2021). Whilst before the pandemic, they shouldered large financial burdens, during the pandemic, they had little compensation for protection, testing or treatment. Thus, large swathes of the population have been trapped by income collapses as well as Covid-related, medical poverty traps.

There is a remarkable convergence amongst economists and sectoral specialists about sectoral lessons and policy interventions needed in the current after-

CHART 9 **Health Systems and Covid Fault Lines in MENA**



Source: World Bank, ASPIRE Atlas (2022).

math. The consensus view is that these fault lines should be dealt with by activating current advocacy to achieve health for all. The key policy reforms commonly proposed include:

- Strengthening public health sectors and reversing years of underinvestment.
- Improving provisions and workforce in poor and neglected areas.
- Integrating all providers so as to pool capacities and reduce fragmentation.
- Leveraging existing needs, such as emergency care and mental health services.
- Addressing the huge shortfall and/or maldistribution in workforce or workers' remuneration (particularly in Morocco and Egypt).
- Accelerating the development of reliable information systems, national digital health records and the use of telemedicine.

Lastly, the region needs to rethink provisions and financing for migrants' health, with Mashreq countries also needing to address the health needs of refugees. Both groups cross boundaries and use national health systems. Yet there is little agreement about responsibilities and financing of their health needs.

During the pandemic, MENA countries did deploy policy actions, showing that existing challenges can be addressed quickly if there is the political will. Morocco may not be able to quickly recruit the tens of thousands of doctors it said it needs, but it did establish a solidarity fund quite earlier on. Egypt decreed a pay rise for doctors, especially in remote regions, and mobilized millions of volunteers. Lebanon's Health Ministry organized successful vaccine marathons, which included migrant workers too. But perhaps Lebanon is also an acute example of the costs of the historical neglect of the public health sector, which left the population totally exposed to the Beirut port blast, Covid and other shocks. Thus, the key issue at stake is not about tackling a list of shortages (e.g. ICU beds or medical oxygen). What is required is nothing less than rethinking the role of health and realigning existing systems to serve all the population equitably. Only stronger and fairer systems can tackle the current state of affairs, meet future challenges and provide long-term resilience.

Towards More Inclusive Social Protection

Like whit its health policies, MENA's social policies showed a weak commitment to mitigating vulnerabilities and reducing poverty. Social protection schemes, typically cash transfer programmes, were scaled up and expanded, and some emergency measures were introduced. Yet, they had very low coverage levels particularly for the lower income quintiles, and were typically hampered by organizational issues, the low level of grants, confusion about eligibility etc. Moreover, they did not provide

effective relief from the dramatic income shocks delivered by Covid, nor did they compensate for the financial burden due to ill health, which remained unchanged during Covid. Since access to testing and treatment were neither universal nor free, Covid can only have aggravated the financial impact of ill health, leading to a rise in OOPs.

Therefore, MENA is arguably suffering from both a social protection and health crisis, which have amplified each other. They are rooted in a political economy that has yet to put social justice at its heart. As argued by Messkoub (2021), the region needs to reverse that, and move firmly towards more inclusive, entitlement-based social systems. Covid clearly showed that the poor, the working poor and informal workers were trapped by their living, transport and working conditions. The social gradient of ill health, which worsened during Covid, requires more equitable and inclusive health systems. Such systems would allow people to move in and out of employment statuses and between jobs without fears for their health or livelihoods. In terms of health sectors, this requires a two-pronged approach. Firstly, revamping and strengthening systems through public investments that tackle issues of availability and quality. Secondly, improving equitable access and affordability by reducing financial burdens, through the immediate expansion of health insurance, especially through the faster route of tax-financed provision.

The key issue at stake is not about tackling a list of shortages. What is required is nothing less than rethinking the role of health and realigning existing systems to serve all the population equitably

In other words, cash transfers and emergency handouts are not a substitute for good health services. Though current crises may require a continuation of income support schemes, higher public investments and better health sector policies remain urgent and necessary. They are a cost-effective way of providing a vital service and tackling a major source of poverty and social injustice. This is why so many countries have already committed to upscaling their health budgets and provisions.

Lastly, current shocks may require a panoply of interventions, including longer term structural measures such as minimum wage legislation. Moreover, food price inflation will impact health outcomes by compromising dietary intakes, and will probably lead to worsening malnutrition and stunting. These looming challenges will require public health interventions, and may even revive the case for price controls and subsidies of staple foods. Health sectors thus need to be revamped to meet both old challenges and new pathogens, neither of which can be dealt with through quick, high-tech fixes.

Concluding Remarks

In conclusion, the global shocks that are currently pounding the world will continue to derail lives and societies for some time. However, none of these shocks nor Covid are a detour in terms of the key strategic focus the region needs to achieve healthy lives, namely to reinforce public health sectors and tackle health inequities. The advocacy in terms of specific sectoral policies is already there, with UHC continuing to provide relevant benchmarks for policy formulation and progress. The challenge is to rebuild the sectors, whilst spearheading health equity. There is a strong consensus among experts, such as Marmot, Mataria, Mewafi, Jardali and others, that these reforms are necessary, doable and cost effective. The regional Covid experience also showed the possibility of leapfrogging with social solidarity and political will.

Achieving healthy lives in MENA has never been merely a medical issue. Rather, it has been hampered by the socioeconomic determinants of health, namely poverty, inequality and precariousness, particularly outside the formal sectors and urban centres. Misery belts and overwhelmed, hobbled health systems were important transmitters of Covid, as they were with previous morbidities. Therefore, it is urgent to recognize the vital importance of health and to place socioeconomic dimensions at the heart of all sectoral plans. This requires, *inter-alia*, an expansion and improvement of coverage through more inclusive, entitlement-based social protection sys-

tems. Without addressing this hole, the functioning of MENA economies will continue to be impaired, and recovery will be compromised.

There is little doubt that the multiple crises of wars, food insecurity and climate change shocks will complicate the journey, be it in terms of implementing, operationalizing or financing the necessary actions. However, continuing with the status quo is no longer possible. Conversely, failure to act may deliver further blows to health and to social justice. Developmental gains could go into reverse, and indeed setbacks in health outcomes are all too visible in war-stricken countries such as Palestine. Achieving healthier lives cannot be taken for granted.

References

Commission on Social Determinants of Health in the Eastern Mediterranean Region (The Marmot Report) *Build back fairer: achieving health equity in the Eastern Mediterranean Region: report of the Commission on Social Determinants of Health in the Eastern Mediterranean Region – executive summary*. Cairo: WHO Regional Office for the Eastern Mediterranean; 2021, https://applications.emro.who.int/docs/9789290224976-eng.pdf?ua=1.

Gatti, R.; Lederman, D.; Fan, R. Y; Hatefi, A.; Nguyen, H. M.; Sautmann, A. & Rojas, C. J. *Overconfident: How Economic and Health Fault Lines Left the Middle East and North Africa Ill-Prepared to Face COVID*. World Bank Publications, 2021.

El-Jardali, F. "Impact of COVID-19 on Health Systems in the Mediterranean." *IEMed Mediterranean Yearbook 2021*. IEMed 2021. www.iemed.org/publication/impact-of-covid-19-on-health-systems-in-the-mediterranean/

Marouani, A. "The first victims of Covid-19 in developing countries? The most vulnerable workers to the lockdown of the Tunisian economy." *GLO Discussion Paper*, No. 581, 2021 www.econstor.eu/bitstream/10419/221745/1/GLO-DP-0581.pdf.

Mataria A.; Brennan R.; Rashidian, A.; Hutin, Y.; Hammerich, A.; El-Adawy, M. and Hajjeh, R. "Health for All by All" during a pandemic: "Protect Everyone" and "Keep the Promise" of Universal Health Coverage in the Eastern Mediterranean Region. *East Mediterranean Health Journal*. 2020 Dec 9;26(12):1436-1439. doi: 10.26719/2020.26.12.1436. PMID: 33355380.

Messkoub, M. "How exclusionary social protection systems in the MENA are making the COVID-19 pandemic effects worse." March 2021 https://issblog.nl/2021/03/03/covid-19-how-exclusionary-socialprotection-systems-in-the-mena-are-making-the-covid-19-pandemics-effects-worse.

Regional Office for the Eastern Mediterranean (EMRO) *Health and well-being profile of the Eastern Mediterranean Region: an overview of the health situation in the Region and its countries in 2019,* World Health Organization, 2019. https://applications.emro.who.int/docs/9789290223399-eng.pdf?ua=.

Al Shami, F. "The Mediterranean Region: A Hotspot of Inequalities in the Aftermath of COVID-19." *IEMed Mediterranean Yearbook 2021*. IEMed 2021. www.iemed.org/publication/the-mediterranean-region-a-hotspot-of-inequalities-in-the-aftermath-of-covid-19/.