Universal Health Coverage in Times of COVID-19 Pandemic: Actions for EMR Countries
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The COVID-19 pandemic exposed major gaps in health systems and shed the light on the degree to which countries still lag behind in achieving the Universal Health Coverage (UHC) commitments whereby, even the countries with the strongest health systems were overwhelmed by the unexpected COVID-19 shock.

Concerns related to financial hardship, equity, access, capacity, and sustainability were raised in low-to middle-income countries as well as high-income countries.

The challenges health systems faced in responding to this global health crisis should serve as an opportunity for countries to revisit their definition of resilient health systems and take immediate actions to deliver radical change.

The current pandemic proved that health security and UHC are interrelated and that strong health systems that build on the capacity of primary healthcare are needed for both.

While there is no one-size-fits-all, the recommendations suggested below can help guide Eastern Mediterranean countries in developing their roadmaps towards integrated and resilient health systems:

- Improve access to quality healthcare by expanding health service coverage
- Develop policies and regulations to ensure the delivery of high quality, safe, and patient-centered care
- Ensure timely information aggregation, analysis, and communication
- Develop financing arrangements that ensure an equitable access to care and support the financing of common goods for health
- Ensure availability of qualified and well-distributed healthcare workforce

Countries in the Eastern Mediterranean Region (EMR) should seize this opportunity to push the UHC agenda forward, advocate for health as a basic human right, adjust national priorities, and revisit current health system arrangements and strategies to ensure that no one is left behind.
الرسائل الرئيسية

- كشف وباء كوفيد-19 عن ثغرات عديدة في النظم الصحية، كما سلّط الضوء على مدى تأخر البلدان في تحقيق أهداف التغطية الصحية الشاملة (UHC) حيث حتى البلدان التي تتمتع بنظم صحية مثبتة، شكلّ لها هذا الوباء، صدمًا غير متوقعًا.

- أثار وباء كوفيد-19 الخاوف المتعلقة بالصعوبات المالية وتحقيق الإنصاف الصحي وحق الوصول إلى الخدمات الصحية والقدرة على تقديم هذه الخدمات واستدامتها، في البلدان المنخفضة والمتوسطة الدخل كما في الدول ذات الدخل المرتفع.

- يجب أن تكون تحسينات النظم الصحية المتعلقة بالاستجابة لهذا النوع من الأزمات الصحية العالمية، بمثابة فرصة للبلدان لإعادة النظر في تعريف وتحديد النظم الصحية المرنة واتخاذ إجراءات فورية لإحداث تغييرات جذرية. أثبت الوباء الحالي أن الأمن الصحي والتغطية الصحية الشاملة مترا锟طان، وأن هناك حاجة إلى أنظمة صحة عالية الجودة والقدرة على قدرة الرعاية الصحية الأولية لتحقيق الأمن الصحي والتغطية الصحية الشاملة.

- على الرغم من عدم وجود نهج موحد يناسب الجميع، إلا أن التوصيات المقترحة أدناه يمكن أن تساعد في توجيه دول منطقة شرق البحر الأبيض المتوسط في تطوير خارطة الطريق الخاصة بها، نحو أنظمة صحية متكاملة ومبنية على:

  - تحسين عملية الوصول إلى خدمات رعاية صحية جيدة من خلال توسيع نطاق تغطية الخدمات الصحية
  - وضع سياسات وضوابط لضمان تقديم رعاية صحية عالية الجودة وآمنة ومتمحورة حول المريض
  - ضمان جمع المعلومات الضرورية في الوقت المناسب وتحليلها وتحسين تواصلها
  - وضع أسس لتأمين تمويل يضمن الوصول العادل إلى الرعاية الصحية
  - ويدعم تمويل الخدمات المشتركة للصحة
  - ضمان توافر عدد كاف من العاملين المؤهلين في قطاع الصحة موزعين بشكل متساوي وعادل

- على دول منطقة شرق البحر الأبيض المتوسط أن تعتني بفترة كوفيد-19 لتفعيل العمل على دول أعمال التخطيط الصحية الشاملة، والدعوة إلى اعتبار الصحة حق أساسي من حقوق الإنسان، وإعادة النظر في الأولويات الوطنية، وترتيبات واستراتيجيات النظام الصحي الحالية لضمان حق الجميع بالرعاية الصحية.
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In 2005, the World Health Organization (WHO) member states called for governments to develop financing arrangements that can ensure UHC i.e. ensuring that all people obtain the health services they need without suffering financial hardship (WHO, 2005). Subsequently, in 2012, the global community unanimously adopted the United Nation’s resolution and committed to working towards UHC by pooling risks, decreasing household payments at the point of service, and preventing catastrophic expenditures on healthcare (UN, 2012). UHC received further momentum in 2015 as governments around the globe endorsed the sustainable developmental goals (SDGs) including SDG 3.8 for UHC (WHO, 2015). While all of the aforementioned initiatives exhibited a high level of political commitment, the current pandemic exposed major gaps in health systems and shed the light on the degree to which countries still lag behind in achieving the UHC commitments whereby, even the countries with the strongest health systems were overwhelmed by the unexpected COVID-19 shock. (Lafortune, 2020).

Concerns related to financial hardship, equity, access, capacity, and sustainability were raised in low-to middle-income countries (LMICs) as well as high-income countries:

**Issues related to financial hardship and catastrophic expenditure on health surfaced as out-of-pocket expenditures discouraged people from accessing care, and mass lay-offs resulted in the loss of healthcare coverage.** Out-of-pocket (OOP) expenditure influenced people’s decision to seek care therefore directly affecting containment efforts. For instance, in a recent poll in the United States, 68% of the respondents stated that co-payment shares might have a direct influence on their decision to access care when suspecting COVID-19 infection (King, 2020). This was also the case in many LMICs where it was often unclear who will cover the COVID-19 testing and treatment bill (Armitage & Nellums, 2020). Additionally, the impact of the pandemic on the economy resulted in mass lay-offs in the United States resulting in millions of people losing their employment-linked health insurance and risking catastrophic consequences on healthcare provision amidst a worldwide pandemic (King, 2020).

Inequities in access to care were exposed as the refugees, poor, and disabled were unable to access COVID-19 services and routine care. The exclusion of refugees and migrants from mainstream national health systems and public health measures risked jeopardizing disease containment efforts. This is because their exclusion risked inhibiting disease detection, contact-tracing and prompt treatment resulting in serious public health risks as outbreaks among their communities may go unchecked (Hargreaves et al., 2020; WHO, 2020a). The current pandemic has also exacerbated the existing inequities in the access to health in LMICs by challenging the access of the poor and disabled to COVID-19 services and routine care (Armitage & Nellums, 2020; Kelley et al., 2020).
Limited access to COVID-19 and essential services, risking immediate and long-term consequences on the population’s health. The surge in the demand for healthcare due to the rapid spread of the disease resulted in a shortage of key medical resources limiting access to care. More precisely, the shortage of Intensive Care Unit (ICU) beds and ventilators was a major concern even in high-income countries such as Italy, South Korea, and the United States (Emanuel et al., 2020; Ranney et al., 2020). This resulted in ethically problematic decisions to ration the use of ICU beds and ventilators that inhibited those with lower survival chances from accessing critical care (White & Lo, 2020). Additionally, shortage in Personal Protective Equipment (PPE) is putting the healthcare workforce at an increased risk of contracting the infection resulting in a high number of quarantined frontline workers. Subsequently, uninfected workers are faced with increased workload and stress which is significantly impacting the quality of care they are providing and resulting in relatively high mortality rates (Bedoya & Dolinger, 2020; Sim, 2020). This problem will likely worsen as the number of COVID-19 cases increases in LMIC where infection prevention and control systems are not in place and the rate of healthcare workers was insufficient even before the pandemic (Bedoya & Dolinger, 2020). Access to essential services not related to COVID-19 was also challenged in LMIC as the majority of the resources and efforts were shifted to the emergency response. This resulted in an increased risk of mortality and morbidity from diseases not related to COVID-19 (Nelson, 2020). For instance, models estimating the impact of discontinuing maternal and child services, such as safe hygienic deliveries or antibiotic treatments for neonatal sepsis and pneumonia cases, are expecting an increase in the monthly under-5 child deaths and maternal deaths in LMICs by 9.8–44.7% and 8.3–38.6% respectively (Roberthon et al., 2020).

Neglect for public health functions resulted in a late anticipation of the size of the pandemic and its risk. To attain UHC, countries have been focusing on population coverage and health outcomes while often neglecting the common goods for health such as surveillance systems, governance structures, and health information systems (UHC2030, 2020). As a result, public health authorities reacted late to the pandemic and experienced a steep increase in the number of cases resulting in the shortage of key healthcare functions and increased death rates (Khanna, 2020).
While this pandemic exposed numerous health systems gaps it also reinforce the role of primary healthcare (PHC) in expanding health service coverage. Countries with established PHC networks were able to divert mild cases to primary care and home care. The pressure on hospital care was therefore decreased and scarce hospital beds were reserved for moderate to severe cases (Armocida et al., 2020). This further validated previous evidence that directly linked the establishment of strong PHC networks to the realization of UHC (van Weel & Kidd 2018).

The importance of investing in resilient health systems that builds on the capacity of PHC to ensure equitable access to care and respond to public health emergencies such as the COVID-19 pandemic is now more evident than ever. It is time to re-assess the capacity of health systems, re-define the priorities, and accelerate the progress towards UHC and health security.

Selection Process

UHC in the Eastern Mediterranean Region

In the EMR, government-provided health coverage has been embedded in various EMR state laws for years. More recently, all EMR countries exhibited political commitment towards achieving UHC by signing the UHC2030 Global Compact and endorsing the Salalah agreement in which EMR countries confirmed that UHC is both a desirable and attainable goal (Saleh, 2014; WHO, 2018; Mataria et al., 2020).

Yet, health systems in the region are still facing numerous challenges including wars and other emergencies, rising healthcare costs, increasing population risk exposure, and lowering access to quality healthcare (Mataria et al., 2020; WHO, 2019a). Additionally, many EMR countries have not yet prioritized healthcare and have insufficiently invested in this industry. For instance, while the EMR population represented 9% of the world’s population in 2015, the regional current health expenditure amounted to 2% of the global current health expenditure (WHO, 2019a).

By examining the three UHC dimensions (1) financial protection, (2) population coverage and (3) service coverage a wide disparity can be observed among Eastern Mediterranean countries with poor regional averages:

- Low financial protection is observed with regional OOP expenditure averaging to 40% of current health expenditure between 2000 and 2015 and ranging between 6% in Qatar and 81% in Yemen in 2015. This resulted in a high degree of financial hardship and subsequent health-related impoverishment. More than 55.5 million people in the EMR were facing financial hardships (spending more than 10% of their income on health) and 7.7 million were pushed to poverty because of OOP expenditure in 2015 (WHO, 2019a).

- A wide disparity in population coverage is observed among EMR countries with fragmented pre-payment schemes in some countries such as Lebanon, and full government coverage for locals and expatriates in other countries such as Oman. Additionally, national pre-payment arrangements frequently exclude the displaced and the refugees (WHO, 2019a). For instance, Palestinian and Syrian refugees in Lebanon are dependent on external funding from UN agencies for coverage (Blanchet et al., 2016).

- Little improvement was observed in the average regional UHC service coverage index compared to global improvement in the latest UHC Global Monitoring Report (Mataria et al., 2020). The average UHC service coverage index amounted to less than 60 (maximum is 100) in the EMR and varied greatly among nations; the index ranged between 37 in Afghanistan and 76 in Kuwait in 2017 (WHO, 2019b).

Three dimensions to be considered while moving towards UHC are achieving financial protection by reducing cost-sharing, extending population coverage and increasing service coverage (Mathur et al., 2015).

- **Financial protection** can be measured through indicators that measure the incidents of household catastrophic expenditure and impoverishment from out-of-pocket expenditure on health or the direct expenditure on health at the point of service (Abiio & De Allegri, 2015).

- **Population coverage** measures the percentage of people reached with health services (Sharma, 2014).

- **Service coverage** is measured using the UHC service index which includes 14 indicators related to maternal and child care, infectious disease control, management of non-communicable diseases and service capacity and access (WHO, 2019b).
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Accelerating progress towards UHC in the EMR

The current pandemic similar to the Ebola epidemic showed that health security and UHC are interrelated and that strong health systems that build on PHC are needed for both (UHC2030, 2020). Therefore, to attain UHC, countries need to focus not only on population coverage and health outcomes but also on other health system performance measures such as its ability to detect and mitigate public health emergencies (Tumusiime et al., 2019). As such, a whole system approach including actions related to the different areas of the health system and incorporating the provision of common goods for health should be adopted when accelerating the progress towards UHC. While there is no one-size-fits-all, the recommendations suggested below can help guide EMR countries in developing their roadmaps towards integrated and resilient health systems (Beattie et al., 2016; Dolea et al., 2010; Kutzin, 2013; Lagomarsino et al., 2012; Mbemba et al., 2013; McPake & Edoka 2014; Obermann et al., 2018; Prinja et al., 2015; Reich et al., 2016; Savedoff et al., 2012; Spaan et al., 2012; Sparkes et al., 2019; Stuckler et al., 2010; Wagner et al., 2018; WHO, 2007; WHO, 2016a; WHO, 2016b; WHO, 2018).
01. Improve access to quality healthcare by expanding health service coverage

- Build an integrated health system with PHC as the primary gate keeper
- Expand the primary care network and ensure that PHCs receive continuous and sufficient financial resources
- Define country-specific essential health service packages, and ensure their quality and effective delivery. Preferably, an essential health packages should include a comprehensive list of services such as preventive care, primary, secondary and tertiary care, emergency care, and maternal and neonatal care.
- Leverage on private health providers through strategic purchasing to expand essential health services
- Leverage on technology to expand capacity to meet individuals’ need in emergency and non-emergency settings
02. Develop policies and regulations to ensure the delivery of high quality, safe, and patient-centered care

- Set standards to regulate the delivery of health, related to medications, health technologies, health facilities, and patients’ rights.
- Ensure the delivery of patient-centered care by developing evidence-based policies and protocols catered to patient and public health needs.
- Enable service user engagement by enhancing individual and communities health literacy, monitoring user satisfaction and empowering users by engaging them in decision making and providing them with peer support.

03. Ensure timely information aggregation, analysis, and communication

- Strengthen health information systems and ensure that it includes population and facility information. This can support adequate monitoring of country-specific health system outcomes, and detecting, investigating and containing public health threats.
- Build capacity on information synthesis and communication, and foster an evidence-driven culture for policy generation.
Develop financing arrangements that ensure an equitable access to care and support the financing of common goods for health

Implement a system to track and analyze information on health expenditure
- Collect detailed information on equity in health financing and coverage disaggregated by gender, socioeconomic status, and other demographic factors
- Collect and analyze information on health expenditure patterns to track inefficiencies

Increase public funding, expand and optimize pre-payment arrangements, and reduce medication cost to reduce OOP
- Develop country-specific tax-based systems or compulsory health insurance contributions to increase funding from pre-payment arrangements and reduce expenditure at point of service
- Increase public health financing through earmarked taxes for health (such as taxes on tobacco)
- Decrease fragmentations in pooling of finances
- Ensure the availability of high quality and affordable medication for all

Develop innovative and efficient strategies to optimize health services procurement
- Establish a system of pooled procurement for health supplies and medications
- Adopt an active outcome-based strategy for the procurement of resources and services

Decrease reliance on donor’s aid and establish a flexible financing mechanism that is adaptable to changing needs

Establish efficient financing mechanisms to ensure continuous financial resources for Common Goods for health
- Map available funding for common goods for health to identify duplication and overlap
- Identify functions and programs that can be unified, and consolidate their financing and management to decrease resource needs (i.e. human and physical). For instance, a unified surveillance system can be developed for all communicable diseases.
- Establish outcome based program budgeting mechanisms to allow flexible financing of functions that require efforts across multiple governmental entities
- Coordinate the financing and governance of common goods for health across all levels of the government to prioritize investment based on country level needs

Common Goods for health include public health functions related to 5 categories: “policy and coordination; taxes and subsidies; regulations and legislation; information collection, analysis, and communication; and population-wide services.” Common Goods for Health provide population wide benefits excluding personal services and are not financed through market forces therefore require collective financing from government and donor sources (Yazbeck & Soucat, 2019).
05. Ensure availability of qualified and well-distributed healthcare workforce

→ Enforce healthcare workforce licensing, mandate continuing professional education, develop clear registration standards for foreign healthcare workers, and develop an accreditation mechanism for healthcare workforce educational institutions

→ Develop flexible career paths and non-traditional career entry to address workforce shortage

→ Develop incentives to motivate the assignment or re-assignment of health workforce to shortage regions such as scholarships and other financial incentives
Moving Forward

The challenges health systems faced in responding to this global health crisis should serve as an opportunity for countries to revisit their definition of resilient health systems and take immediate actions to deliver radical change. While this pandemic is a global health crisis, it is also an unprecedented opportunity for policymakers and stakeholders in EMR countries to learn from existing challenges and advocate for change. The immense pressure that this pandemic imposed on health systems presented a clear understanding of health system gaps and identified priority areas for change. Additionally, the repercussions of weak health systems on populations’ health and subsequently countries’ economies are more evident now than ever before. EMR countries should seize this opportunity to push the UHC agenda forward, advocate for health as a basic human right, adjust national priorities, and revisit current health system arrangements and strategies to ensure that no one is left behind.
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