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Progress report on universal health coverage and development of a package of essential health services

Introduction

1. Universal health coverage is the overarching priority for health system strengthening in countries of the Eastern Mediterranean Region, as emphasized in multiple commitments at global and regional levels. During the past five years WHO and Member States have worked intensively to assess where countries are with regard to the three dimensions of universal health coverage, and to develop regional and national frameworks, strategies and roadmaps to address remaining gaps.

2. A framework for action on advancing universal health coverage in the Eastern Mediterranean Region[1] was prepared and shared with Member States at the 61st session of the WHO Regional Committee for the Eastern Mediterranean in 2014. The framework identifies actions for Member States to develop a national vision and strategy for universal health coverage, enhance financial protection, expand coverage of needed services, and ensure expansion and monitoring of population coverage. It also specifies the support to be provided by WHO and other development partners. The framework is being used as the basis for regional and national roadmaps for moving towards universal health coverage.

3. WHO is giving special attention to identifying what should be covered under a universal health coverage agenda. A set of criteria have been identified to define a priority package of essential health services that can be adapted to countries at various levels of socioeconomic development. Defining such a package, and developing and integrating necessary delivery platforms and financing arrangements to ensure equitable access for all, are an effective way forward for achieving universal health coverage.

4. This report summarizes progress in implementing the key actions included in the universal health coverage framework since the 61st session of the Regional Committee, and provides an update on global efforts to develop a package of essential health services and on the implications for regional and national efforts towards universal health coverage.

Implementing the universal health coverage framework

Current situation

5. The Region continues to be a low investor in health, accounting for 1.6% of global health spending and 8.7% of world's population in 2013. The share of out-of pocket payments in total health spending is high, reaching 80% in some Group 3 countries[2], resulting in a significant number of people facing financial hardship (estimated at 16.5 million individuals) and impoverishment (estimated at 7.5 million individuals) every year. In terms of service coverage, the number of primary health care facilities and hospital beds, especially in Group 3 countries, continues to be limited: 0.5 primary health care facility and 4.4 hospital beds per 10 000 population in some countries. Service delivery in Group 1 countries is hospital-oriented and relies mainly on an expatriate health workforce. Group 2 countries suffer from an extensive unregulated private health sector and a maldistribution of skilled health workforce. Group 3 countries suffer from critical shortage of health workforce. Quality and safety continue to be challenges

[1] Available at http://applications.emro.who.int/docs/Technical_Notes_EN_16287.pdf?ua=1

[2] The three country groups are defined based on population health outcomes, health system performance and level of health expenditure. Group 1 countries are those in which socioeconomic development has progressed considerably over the last four decades, supported by high income. Group 2 countries are largely middle-income and have developed an extensive public health service delivery infrastructure but that face resource constraints. Group 3 countries face major constraints in improving population health outcomes as a result of lack of resources for health, political instability, conflicts and other complex development challenges.

in all three groups. In terms of population coverage, while 100% of the nationals in Group 1 countries are covered by a generous package of health services, several Group 2 and 3 countries are exploring options to expand population coverage. Large population segments, including the informal sector, expatriates, refugees and internally displaced people, continue to lack coverage in these countries.

Actions by Member States

6. Several Member States have developed a vision for universal health coverage and backed it up with necessary legislation or national health strategies. Egypt is in the process of finalizing a comprehensive social health insurance law to cover all population groups. Pakistan launched the Prime Minister's Health Insurance Scheme as a federal and provincial venture. The Islamic Republic of Iran launched a national health transformation plan to ensure fair access for all. Jordan, Sudan and Tunisia developed their national health strategies or health financing strategies on the principles of universal health coverage.

7. In order to enhance financing protection, eight countries (Egypt, Islamic Republic of Iran, Jordan, Morocco, Pakistan, Palestine, Sudan and Tunisia) assessed their health financing systems, identified the bottlenecks and are developing health financing strategies. Several countries including Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Libya, Morocco, Oman, Pakistan, Palestine, Qatar, Sudan and Yemen, are introducing, reforming or expanding social health insurance. Afghanistan discussed options for sustainable health financing involving the donor community. Bahrain, Qatar and Saudi Arabia are reforming their health financing systems to split financing from provision through social health insurance. In the process, many countries are implementing the system of health accounts 2011 to generate evidence for universal health coverage, including Bahrain, Egypt, Jordan, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Sudan, Tunisia and United Arab Emirates. A few countries have measured financial risk protection using household surveys, namely Djibouti, Egypt, Morocco and Tunisia.

8. In order to expand coverage of needed health services, the Islamic Republic of Iran, Jordan and Saudi Arabia assessed their service delivery through the family practice approach and developed related expansion plans. Sudan developed a first draft of a family health policy. Several countries worked to establish national quality or accreditation agencies, including Jordan and Sudan, and institutionalized the Patient Safety Friendly Hospital Initiative. Palestine and the Syrian Arab Republic worked to assess their public hospitals. Several countries began or continued implementing initiatives such as Urban HEART and the Healthy City programme. Afghanistan, Islamic Republic of Iran, Sudan and Yemen developed strategic plans for human resources for health.

9. In order to expand and monitor population coverage, Morocco generalized the coverage of its assistance scheme to include all poor and vulnerable populations, and the Islamic Republic of Iran expanded population coverage to an additional 7 million people, bringing population coverage to almost 100%.

WHO support

10. Several comprehensive health system reviews were conducted to identify challenges and opportunities to progress towards universal health coverage and to facilitate policy dialogue to inform national roadmaps for health system strengthening. The reviews involved the three levels of the Organization, international experts and relevant United Nations agencies. A high-level mission reviewed implementation of the Iranian health transformation plan and its impact. The challenges facing the Libyan health system were assessed and a roadmap for health system strengthening was outlined. A high-level mission assessed the impact of devolution on the health sector in Pakistan and provided guidance to institutional development at provincial level. The government health insurance scheme in Palestine was examined and its capacity to support the national universal health coverage agenda was

assessed. The primary health care system in Saudi Arabia was reviewed, focusing on its governance and organization, and progress in implementing the Somali health sector strategic plans was evaluated.

11. In the area of essential medicines and health technology, focus was kept on strengthening national regulatory systems for medical products and on institutionalizing health technology assessment. Six countries, namely the Islamic Republic of Iran, Iraq, Jordan, Lebanon, Sudan and Syrian Arab Republic, were assisted to assess their national regulatory authorities and subsequently to develop institutional development plans. The Eastern Mediterranean Drug Regulatory Authorities Conference was held in Tunisia in May 2016. Attention was given to harmonizing and strengthening post-market and vigilance regulatory functions for medicines, vaccines and medical devices, and a regional meeting on pharmacovigilance was organized in Morocco in 2015. Afghanistan, Iraq, Morocco and Pakistan were supported to develop national action plans under the Good Governance for Medicines initiative, with six countries of the Region belonging to phase 1, seven to phase 2 and three to phase 3 of the initiative. A step-by-step guide for regulating medical devices was produced. Regional engagement in the Member State mechanism to address substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products was scaled up, with the Islamic Republic of Iran and Pakistan assuming the chair and vice-chair positions.

12. In the area of health workforce development, frameworks for action on reforming medical education and on strengthening nursing and midwifery were finalized. A regional strategic framework for health workforce development (2016–2030) was developed and will be presented at a technical meeting in 2016. Technical cooperation was provided to review and finalize the health workforce plan of the Islamic Republic of Iran. Accreditation standards for medical education in Iraq were finalized. Mapping and assessments of nursing, medical laboratory professionals, medical imaging professionals and health rehabilitation professionals were also carried out.

13. For integrated service delivery, support was provided to scale up family practice as a strategy for people-centred integrated health care in the Region. A framework for quality improvement in primary care was developed and tested in 40 primary health care facilities in Jordan, Islamic Republic of Iran, Oman and Tunisia. Several countries including Kuwait, Morocco, Oman, Qatar and Sudan were assisted to review their national policies and strategies for quality and safety and the prevention and control of health care associated infections. Five countries were supported to develop, validate and implement national reporting systems for medical errors. Health care accreditation was promoted in a regional meeting held in December 2015. A number of joint activities took place including implementation of a study to assess the magnitude and scope of adverse events, with the Saudi Central Board of Accreditation of Healthcare Institutions; development of a short course to improve the knowledge of general practitioners, with the American University of Beirut; and development of a ten-day course on hospital administration that was offered to hospital directors from 13 countries, with the International Hospital Federation. The second edition of the patient safety assessment manual was published, in addition to a patient safety toolkit and curriculum.

14. In the area of health governance and financing, the second round of the Leadership for Health programme was held between 15 November 2015 and 30 January 2016, in collaboration with the Harvard School of Public Health and Ministry of Health of Oman. The programme was reviewed based on the lessons from the first round and involved 35 public health leaders from the Region to build their capacities and skills in addressing local, regional and global public health challenges. A regional meeting on expanding universal health coverage to the informal sector and vulnerable groups took place in September 2015. Work in public health laws and equity analysis continued. Capacity-building in the implementation of social health insurance was provided to Egypt in June 2015. Support was also provided to Morocco and Qatar to assess their essential public health functions.

15. Work on evidence generation on effective practices continued, including finalizing policy briefs or regional discussion papers on service delivery through the family practice approach, improving quality and safety of care, strategic purchasing, demand-side financing and an essential health service package.

Developing a package of health services for universal health coverage

16. There is longstanding collaboration between the Regional Office and the Disease Control Priorities Network as part of the third edition of the Disease Control Priorities project (DCP3). DCP3 aims at generating global and regional evidence on the effectiveness, costs and cost-effectiveness of approaches to the prevention and control of diseases relevant in low-income and middle-income countries. The term "approaches" is deliberately used to describe a range of interventions, programmes and policies extending from narrowly defined medical and surgical interventions to broader public health and intersectoral programmes and policies. In the Region, the collaboration contributed to building regional and national capacities in health economic evaluation and to generating selected similar evidence from countries.

17. Following the identification of multiple sets of "essential" interventions, programmes and policies related to the specific disease groups examined by DCP3, efforts are being made to combine the findings into a high priority universal health coverage package and an essential fiscal and intersectoral package, to cover interventions, programmes and policies within the health sector and beyond. The proposed packages would then constitute a reference point for decision-making at country level.

18. Three main criteria are used to define the two packages: a) evidence of high value-for-money in terms of cost-effectiveness and affordability; b) evidence on feasibility to scale to full population coverage by 2030; and c) evidence on preferential impact for the worst-off either in health gains or in financial risk protection (or both).

Way forward

19. Attention will be given to advocating universal health coverage as part of the SDG agenda, giving focus to building national health systems and identifying means for mobilizing domestic resources to fulfil commitments. Country cooperation will be pursued to adapt the framework for action on advancing universal health coverage in the Region to local contexts, considering the particular circumstances of acute and chronic emergencies prevailing in the majority of countries. Efforts will be intensified to build regional and national capacities in family practice, prepayment arrangements, national regulatory authorities and health workforce management and in reporting on core indicators. More engagement will be sought with priority programmes, e.g. noncommunicable diseases, mental health, maternal and child health, communicable diseases and others in the universal health coverage agenda. Analytical work in health system strengthening for universal health coverage will continue to be pursued and universal health coverage will continue to be monitored in its three dimensions. Attention will be paid to further strengthen the capacity of WHO in all these areas.