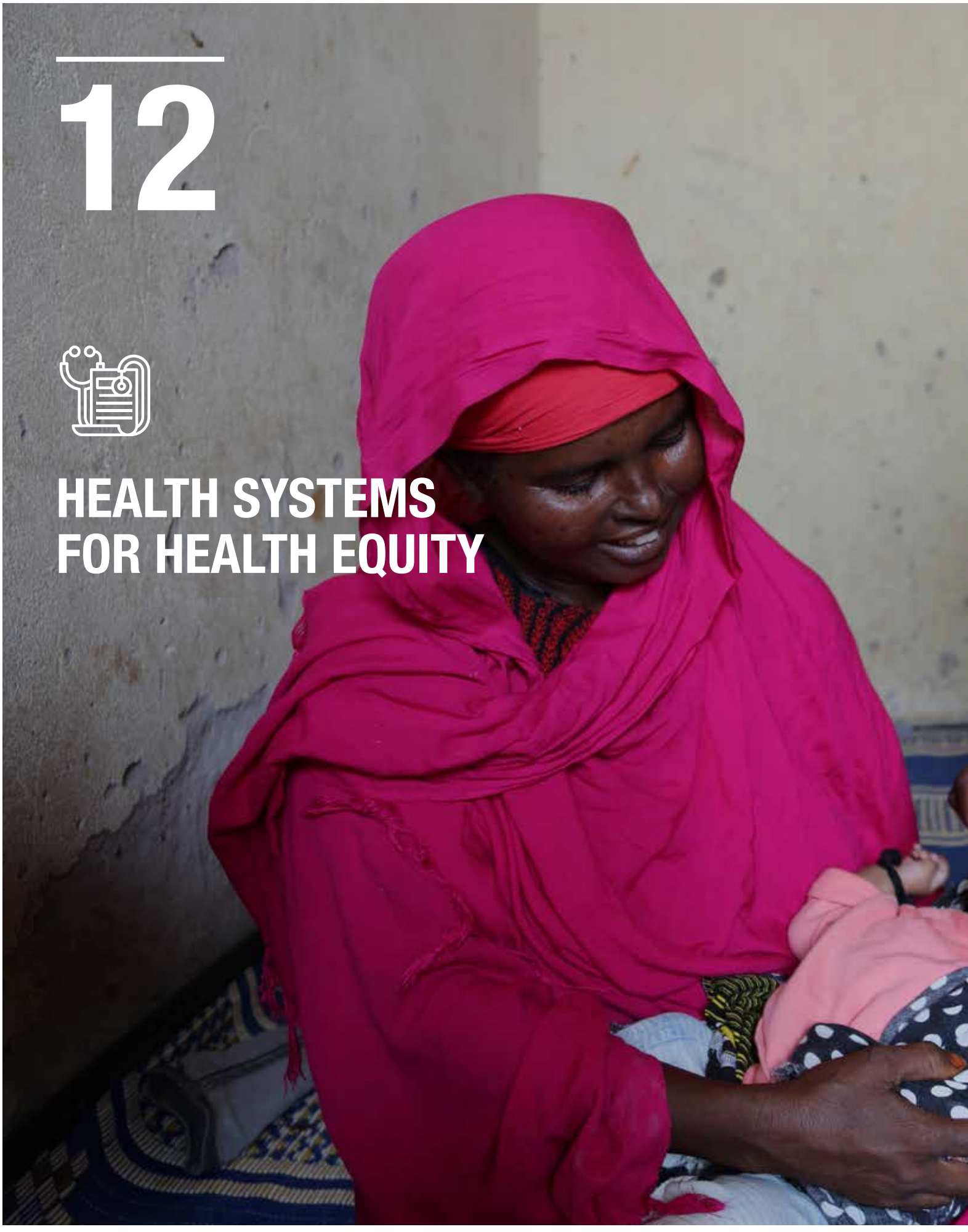

12

HEALTH SYSTEMS FOR HEALTH EQUITY

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HEALTH SYSTEMS FOR HEALTH EQUITY

INTRODUCTION

Access to health care is an essential component of the right to health and is vital for health and social equity *(1, 2)*. Delivery of health care to all, in a fair and equitable manner, relies on the presence of robust and well-functioning health systems. This Commission seeks to develop health systems across the Region that work towards tackling inequities in the social determinants of health, as opposed to just treating ill health *(3)*. Such approaches are underdeveloped in most health care systems in the Region, with reactive and curative models of health care provision predominating *(4)*. If undertaken effectively, and given sufficient resources, a social determinants of health approach could reduce demand on health care services through improving health and reducing health inequities.

This Commission's proposals for a social determinants of health approach to building robust health systems take their cue from WHO's definition of health systems *(5)*. WHO's definition of health systems goes well beyond universal access to health care, although that is a key component, and states that a well-functioning health system serves to respond to the health needs and expectations of a population in a balanced way by "improving the health status of individuals, families and communities, defending the population against what threatens its health, protecting people against the financial consequences of ill-health, providing equitable access to people-centred care and making it possible for people to participate in decisions affecting their health and health system" *(6)*.

In this chapter, we start by reviewing progress towards universal health coverage, highlighting persistent barriers to access to health care services and the generally low levels of financing, before exploring the adequacy of primary care provision in countries across the Region. The challenges posed by conflict and high numbers of migrants, refugees and other displaced persons are then illustrated by the recent experience of several of the Region's countries and territories. A brief review of the delivery of essential public health functions in the Region follows and the chapter concludes with a discussion of how the health system can play a vital role in addressing social determinants of health through building strong partnerships, engaging the workforce and the positioning of health care organizations as "anchor institutions" in the communities they serve.

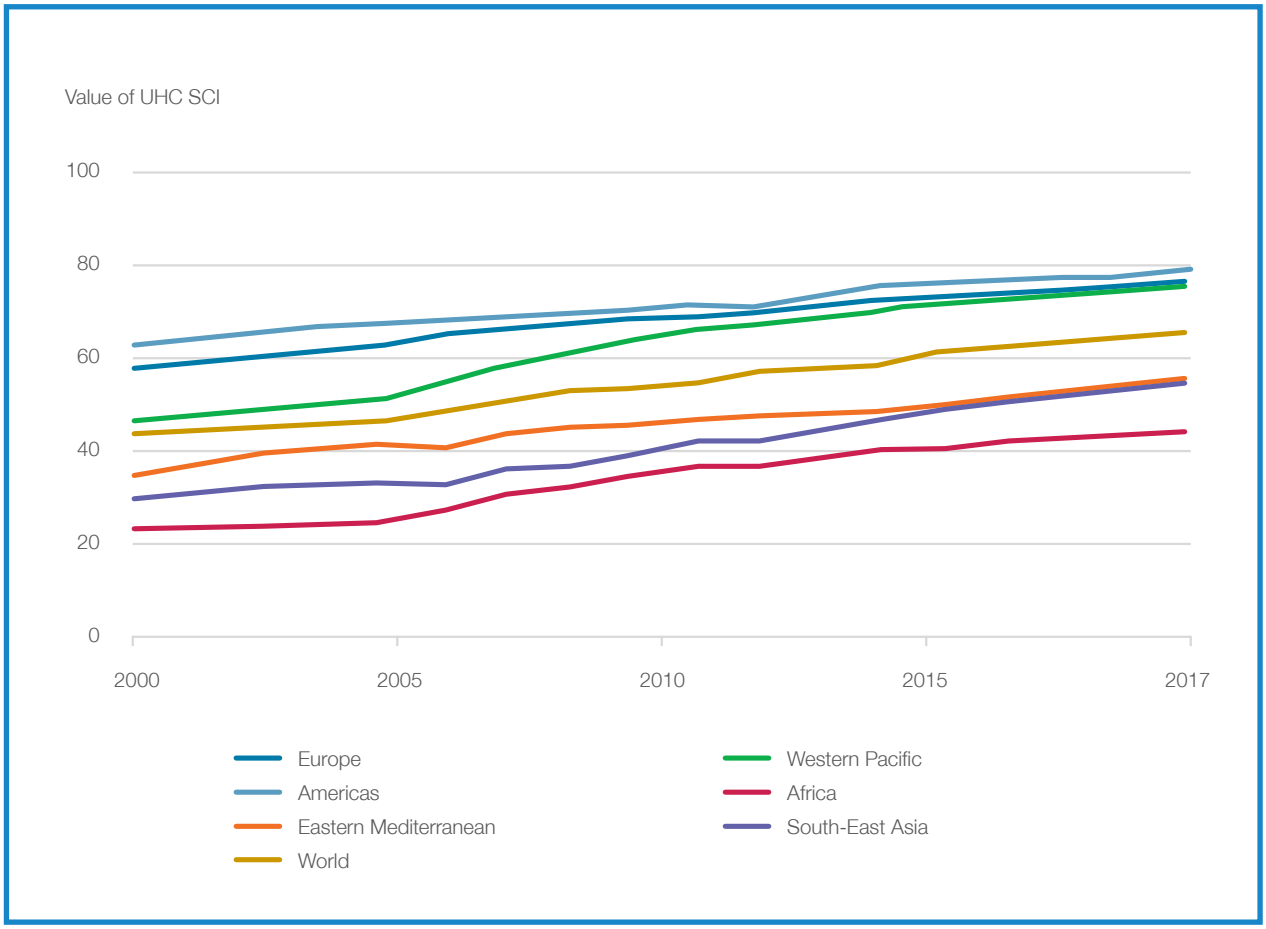
UNIVERSAL HEALTH COVERAGE

The Eastern Mediterranean Region currently faces challenges in securing the provision of equitable and accessible health care given increasing exposures to health risks, fragile and conflict-affected situations, rising health care costs, longstanding underfunding, and high rates of poverty in some countries *(7)*. Universal health coverage is central to delivering better, more equitable access to health care and is one of WHO's top priorities *(3, 7)*. Moreover, universal health coverage is the focus of SDG target 3.8, the stated aim of which is to "achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all" *(8)*.

Universal health coverage supports health equity through the provision of accessible and affordable health care services that provide effective treatment for ill health, and services that can prevent ill health, such as vaccination. In September 2018, all countries in the Eastern Mediterranean Region signed the Salalah Declaration to show their commitment to making progress to universal health coverage *(9)*.

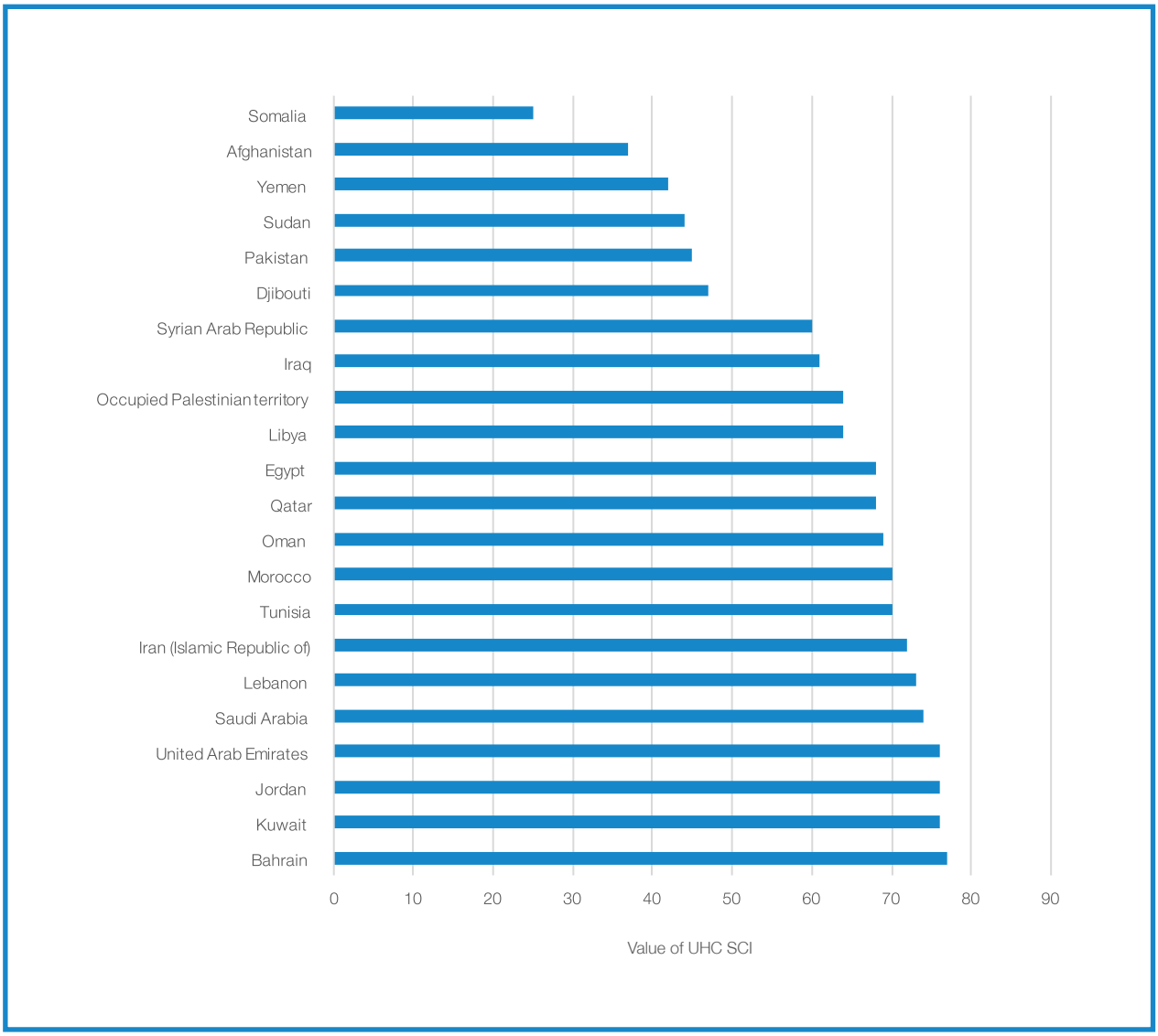
The universal health coverage service coverage index (UHC SCI) has been developed to measure progress towards SDG target 3.8 *(9)*. The UHC SCI is made up of 14 tracer indicators of essential health care grouped under four components of service coverage, as follows: reproductive health; NCDs; infectious disease control; and service capacity and access *(9)*. The index is presented as a scale from 0 to 100, with higher scores indicating better performance and with scores reaching or close to 100 being indicative of the SDG target being met *(9)*. Between 2000 and 2017, improvements in the index were seen for all WHO regions, including the Eastern Mediterranean (Fig 12.1). However, in 2017 the value of the UHC SCI for the Region was still well below the world average, and marginally above that for the South-East Asia Region. Although there is a marked variation in the value of the index between countries in the Region, overall levels are low, even for higher income countries; no country reported a UHC SCI of higher than 80 in 2017 (see Fig.12.2) *(9)*.

Fig. 12.1. Value of the UHC SCI by WHO region, 2000–2017



Notes: the UHC SCI refers to the coverage of essential health services which is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, NCDs and service capacity access, among the general and the most disadvantaged populations. The index is reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage (10).
Source: WHO (2019) (9).

Fig. 12.2. Value of the UHC SCI in countries and territories in the Region, 2017



Notes: the UHC SCI refers to the coverage of essential health services and is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, NCDs and service capacity access, among the general and the most disadvantaged populations. The index is reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage (10).
Source: WHO (2020) (11).

Without universal free access, health care becomes highly inequitable and access depends largely on wealth and income levels; this leads to clear socioeconomic inequities in health. Health care is free to all residents in only a handful of countries in the Region, including Oman, Sudan, the Syrian Arab Republic and Yemen *(12)*. In Tunisia, social health insurance is financed by tax revenues and health insurance premiums and only those who are insured are entitled to free health treatment *(12)*. In Iraq and Jordan, only military personnel and civil servants have access to free social health insurance and in Bahrain, Kuwait, Qatar, Saudi Arabia and the United Arab Emirates, only citizens are eligible for health care services financed by state revenues, while migrants must pay an annual fee to access such services *(12)*.

In the absence of universal free access, utilization of health services is an ongoing challenge to health systems in a number of countries in the Region. While there have been some improvements over recent decades, these improvements have been uneven, with particular populations continuing to face difficulties in accessing and utilizing various health services *(13)*. In Chapter 5 we demonstrated that inequities in access to maternity services, as well as to routine vaccination and other child health services, are evident across the Region. These inequities are associated with income level, maternal education, place of residence (i.e. rural versus urban), conflict and status (i.e. refugee versus resident) *(1)*. Evidence of inequities in access to, and utilization of, a broader spectrum of health services is briefly summarized below.

PLACE OF RESIDENCE

There is inequitable access to health care between rural and urban areas in many countries in the Region *(13, 14)*. This is primarily due to a lack of health care resources and health care professionals in rural areas *(15)*. The use of antenatal health care services in Sudan, for example, is highly unequal between urban and rural areas, and is five times higher among women living in urban areas than in those in rural areas *(16)*. Similarly, women in urban areas were 3.7 times more likely to receive a tetanus toxoid vaccination than women from rural areas. Greater distance to primary health care services in Saudi Arabia was cited as one of the main factors which influenced the reduced rates of access to and utilization of primary health care services in rural relative to urban areas. Urban–rural differences were also reported in the quality of services, including in the levels of cleanliness within health care settings, and in the access to health prevention and promotion interventions, with rural areas again performing less well *(17)*.

GENDER

Differences in access to health services between men and women tend to arise because of gender norms which result in unequal decision-making power, restrictions on physical mobility, inequities in health literacy and social constructions of gender roles, all of which can influence health-seeking behaviours *(18)*. Gender disparities in health care access and utilization in countries in the Region are particularly prevalent when women reach reproductive age and where institutional, socioeconomic and cultural factors can restrict their access to health services *(19)*.

Lack of access can be particularly acute for women with low levels of literacy living in rural areas, who often are unable to recognize a health problem and/or are unaware they have a treatable condition *(19)*. A 10-year study conducted in rural Egypt, published in 1999, found that the perceptions of women of their own health was the most significant factor impacting on their use of health services, more so than access to services *(20, 21)*. In this study, over half of the survey respondents were found to have a reproductive tract infection and over 60% were anaemic. However, most did not seek health care, as they viewed these conditions as being "normal" *(19, 20)*. A 2003 survey of Syrian men and women also found evidence of gendered barriers to health care, in this case, access to tuberculosis services. Women reported more barriers to accessing tuberculosis health services than their male counterparts; in addition women were more likely to report longer waiting times than men *(22)*.

Overall, there is a lack of data about gender-specific issues in health care access in the Region, making it difficult to establish the key factors that are driving gender inequities in access to and utilization of health care services *(19)*. Improved research and data collection are needed to better understand these gender inequities and to help to inform strategies for improving the provision of health care to both men and women.

EDUCATION

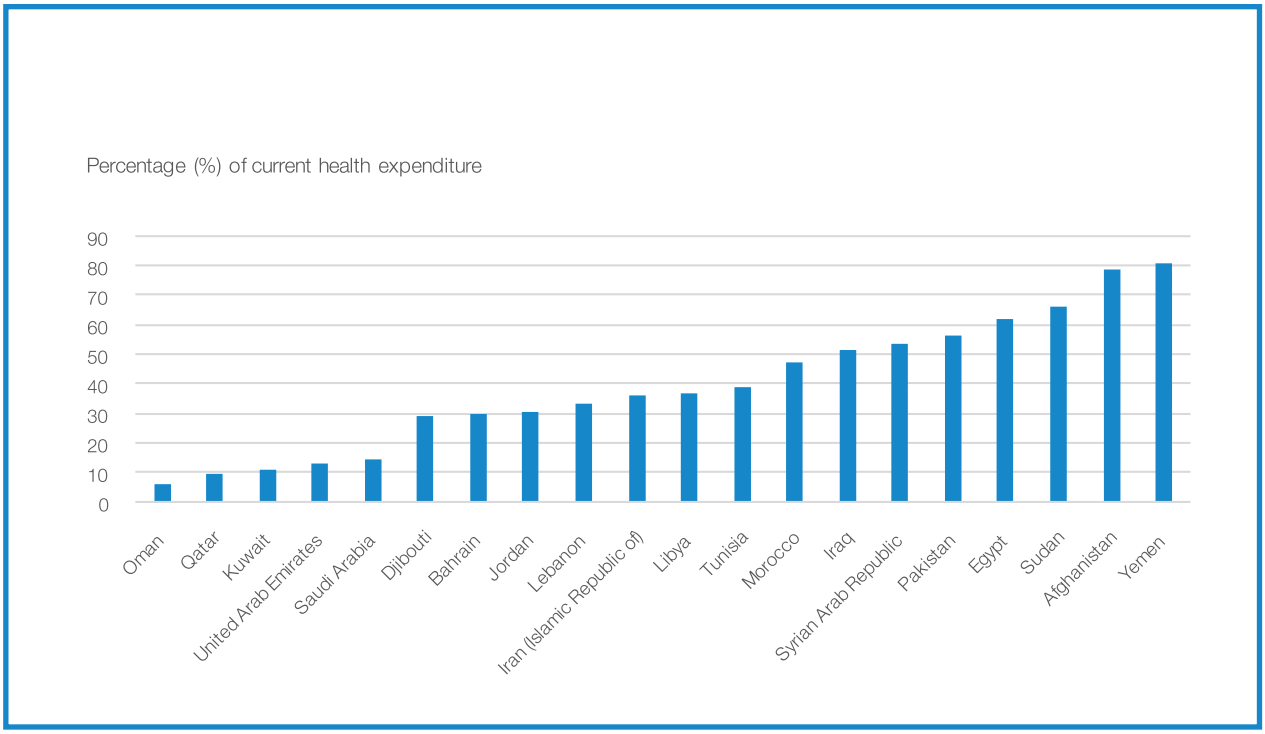
Those with higher levels of education tend to have greater access to health care services. This is partly because those with a higher level of education tend to also have greater wealth and higher incomes and are therefore better able to pay for health care. Health literacy, which in turn is closely related to the level of maternal education, has been reported to be a predisposing factor for the utilization of health care *(13, 23)*. WHO defines health literacy as "the cognitive and social skills, which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" *(24)*. Those with higher levels of education are better able to access, understand and act on information about health and health care, while those with low health literacy are more likely to forgo or delay necessary health care or experience difficulties in finding a health care provider *(25, 26)*.

INCOME

The affordability of health services can be a significant barrier to accessing health services, especially for those on very low incomes. Countries in the Region have some of the lowest public spending on health care (see Financing health services, below), which translates into high out-of-pocket expenses for those individuals and families who need health care. This forces many on lower incomes to either forgo health care or become "impoverished" *(27)*, both of which damage health and increase health inequities *(28)*. Out-of-pocket payments are defined by WHO as direct payments made by individuals to health care providers at the time of service use. This excludes any prepayment for health services, for example, in the form of taxes or specific insurance premiums or contributions *(29)*.

Fig. 12.3 shows the range in levels of out-of-pocket expenditure (expressed as a percentage of total expenditure on health) among countries in the Region. Out-of-pocket expenditure on health care accounts for over 70% of total health expenditure in Afghanistan and Yemen, and more than half in Egypt, Iraq, Pakistan, Sudan and the Syrian Arab Republic *(30)*. The actual level of out of pocket-expenses in many countries may be higher due to payments for informal care and services for older people *(12)*.

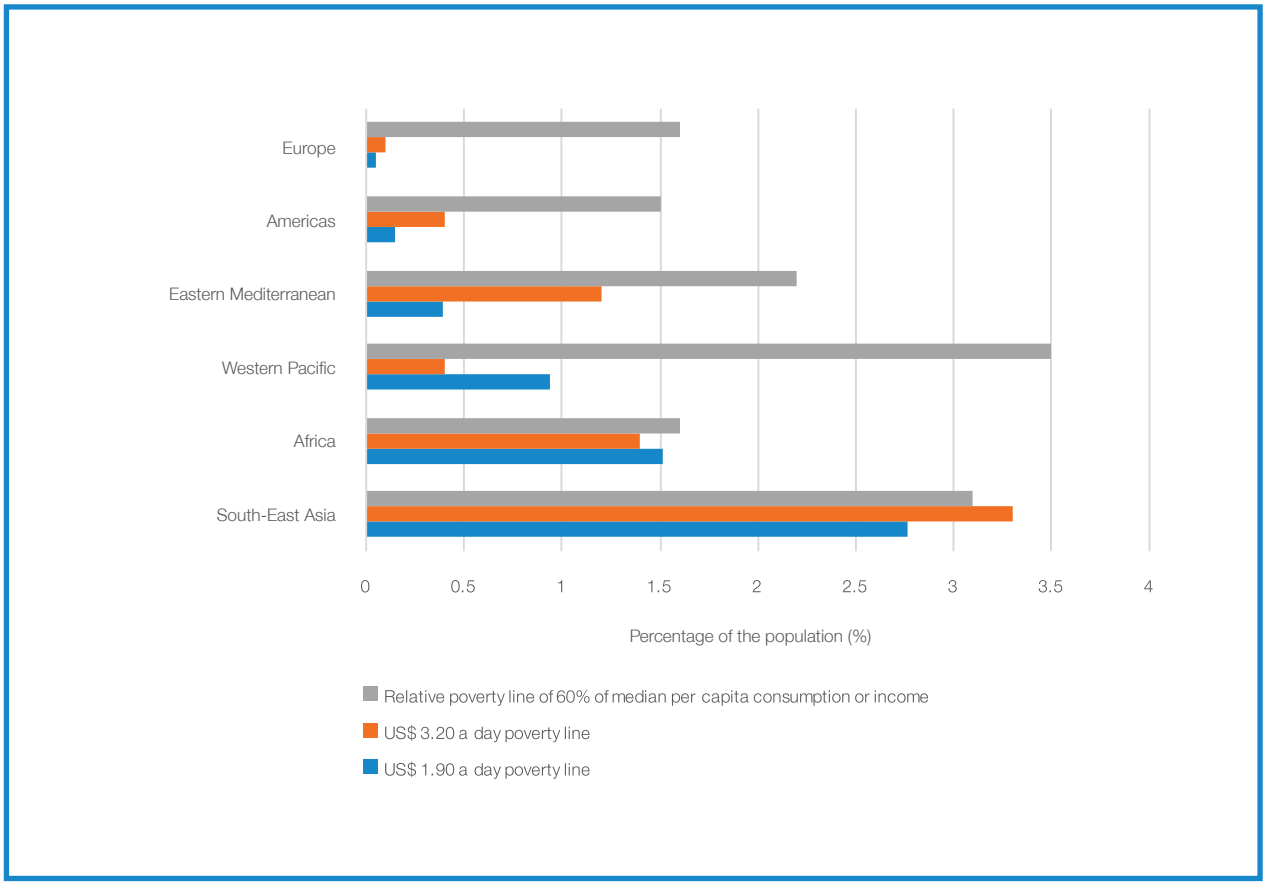
Fig. 12.3. Out-of-pocket expenditure as a percentage of current health care expenditure in countries in the Region, 2018



Notes: Data for all countries are from 2018, with the exception of data for Yemen which are from 2015. No data are available for Somalia or the occupied Palestinian territory.
Source: The World Bank (30).

Fig. 12.4 shows that impoverishment due to out-of-pocket expenses is prevalent in all world regions. The percentage of the population impoverished due to out-of-pocket expenses is lower in the Eastern Mediterranean Region than the global average for all three reported benchmarks of relative poverty (Fig.12.4), but the Region lags behind both the Americas and the European Region.

Fig. 12.4. Percentage of the population impoverished by out-of-pocket expenditure on health, by WHO region, 2015

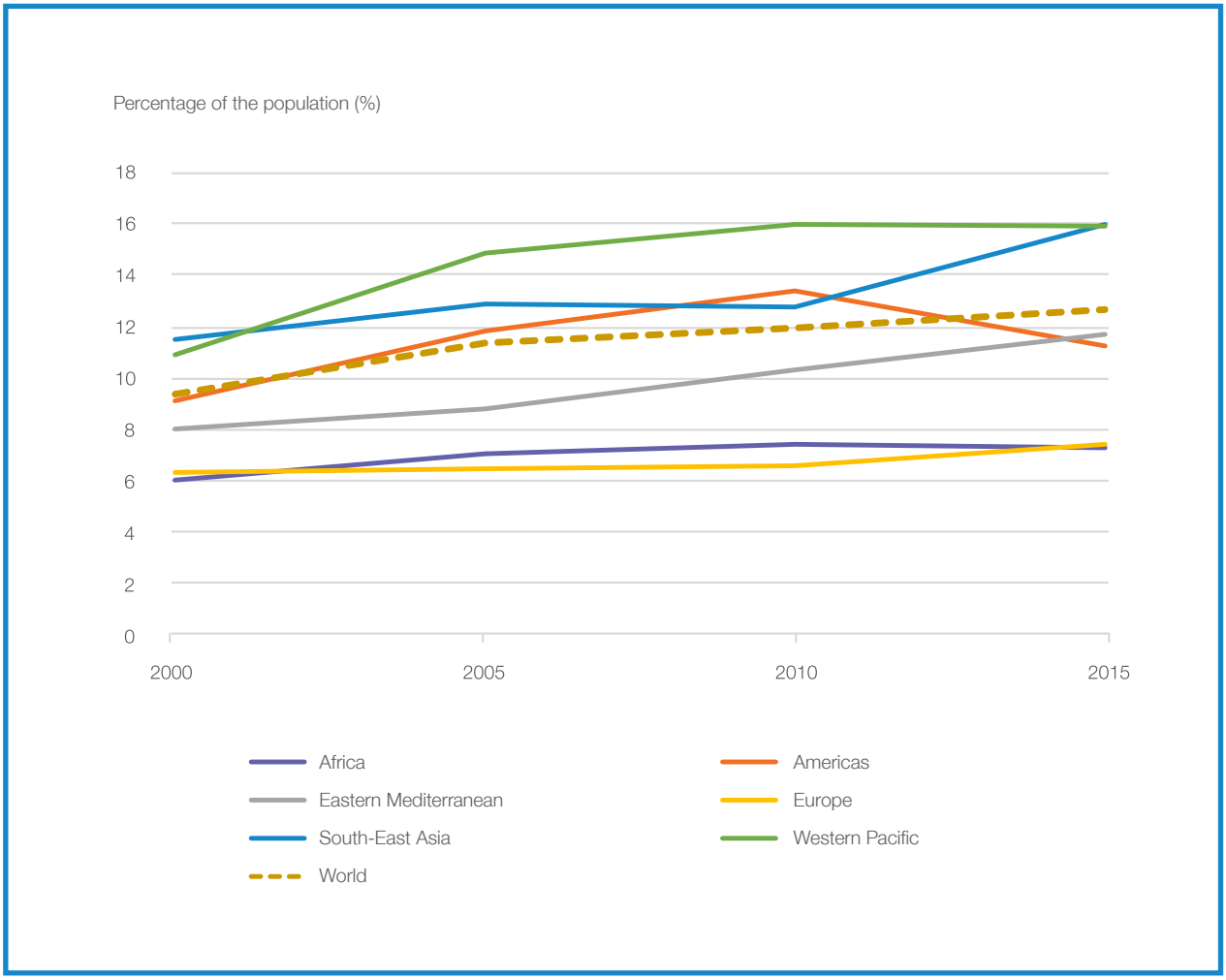


Note: The US$ 3.20 a day and the US$ 1.90 a day thresholds are internationally defined poverty lines.
Source: WHO (2019) (9) based on data from the Global Monitoring Report on financial protection in health.

SDG indicator 3.8.2 (catastrophic spending on health) is designed to "capture the impact of health spending paid "out-of-pocket" on the household budget, which could imply for some families choosing between paying for health care or other essentials like food and education. It is defined as the "proportion of the population with large household expenditure on health as a share of total household expenditure or income" *(31)*. There are two thresholds, 10% and 25%, which are widely used to define a "large" household expenditure on health *(31–33)*. Catastrophic health expenditure is usually higher in countries with high levels of out-of-pocket expenditure and lower levels of prepayment for health.

Mirroring trends observed in most other world regions, catastrophic health spending when measured against the 10% threshold increased in the Eastern Mediterranean Region between 2000 and 2015, from around 8% to nearly 12%, but remained below the global average (Fig. 12.5). On average, the proportion of the population experiencing catastrophic health spending was higher than in the African and European regions, but lower than in the Western Pacific, South-East Asia and the Region of the Americas (except in 2015).

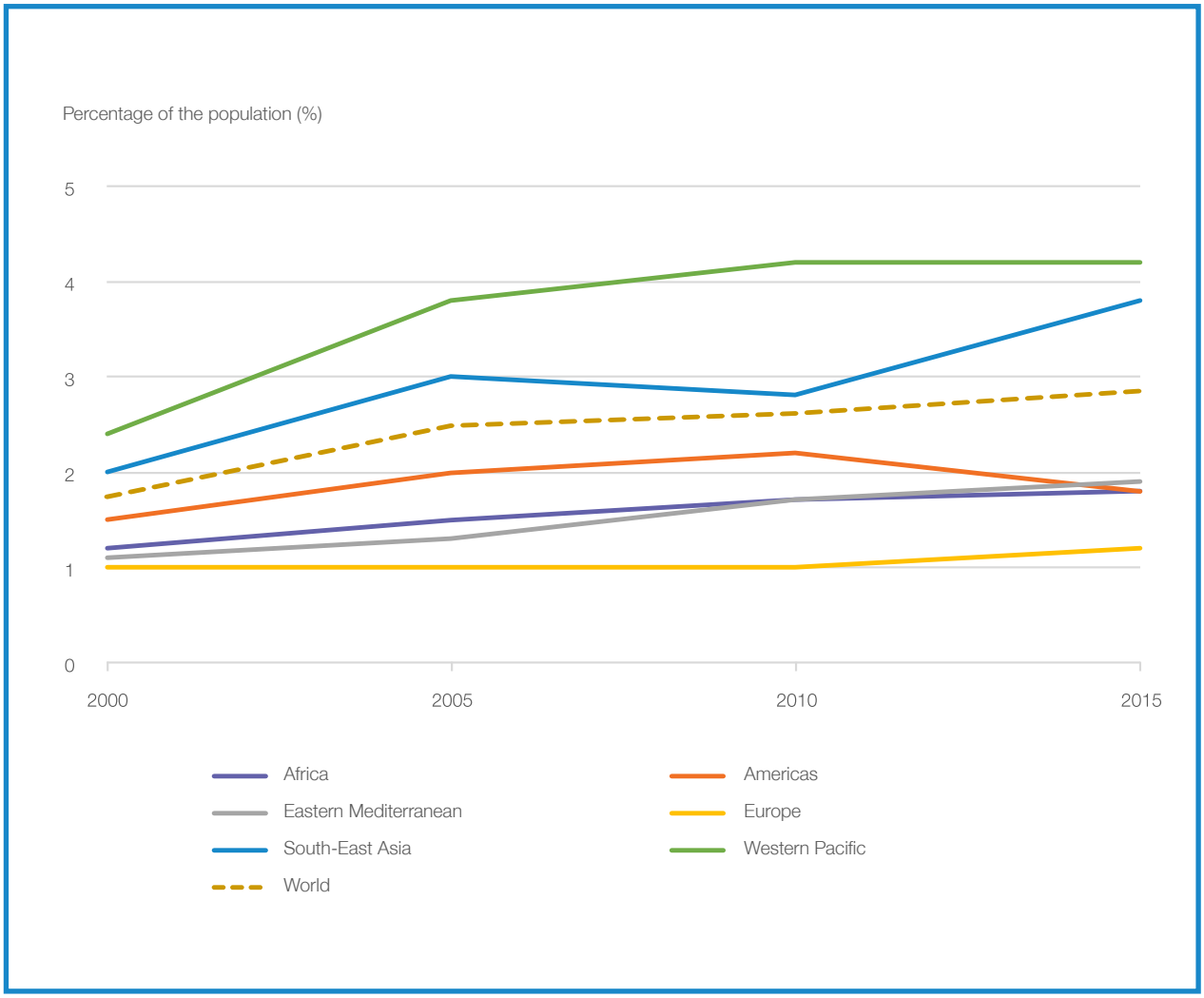
Fig. 12.5. Catastrophic health spending (10% threshold) by WHO region, 2000–2015



Source: WHO (2019) (34).

Broadly similar trends are evident when the 25% threshold is used to measure catastrophic spending on health (Fig. 12.6). In 2015, the proportion of the population in the Eastern Mediterranean Region at risk of spending 25% or more of their total household expenditure on out-of-pocket health care reached nearly 2%, up from just over 1% in 2000. However, catastrophic health spending at the 25% level in the Region remained lower or on a par with other WHO regions over this period.

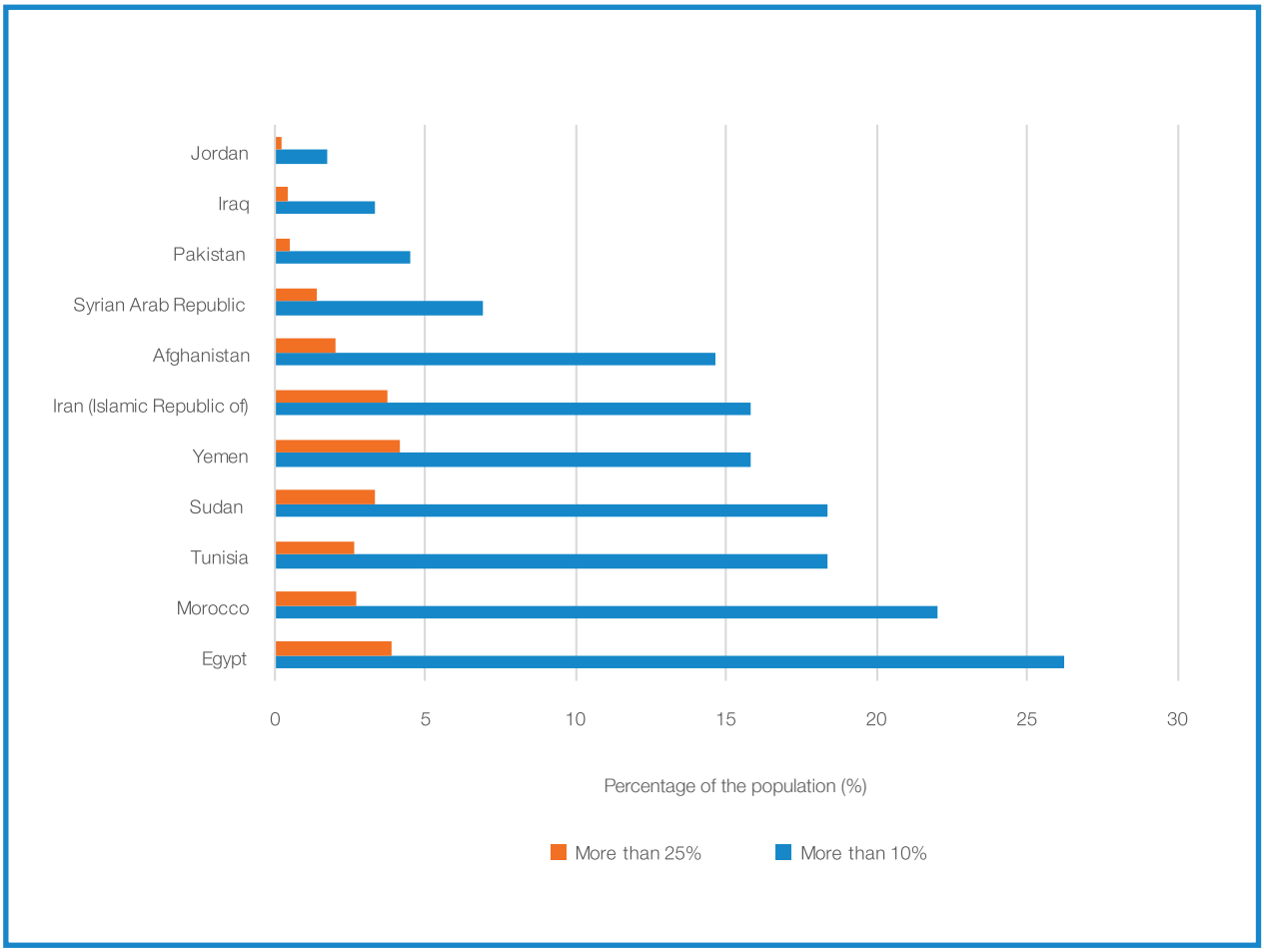
Fig. 12.6. Catastrophic health spending (25% threshold) by WHO region, 2000–2015



Source: WHO (2019) (34).

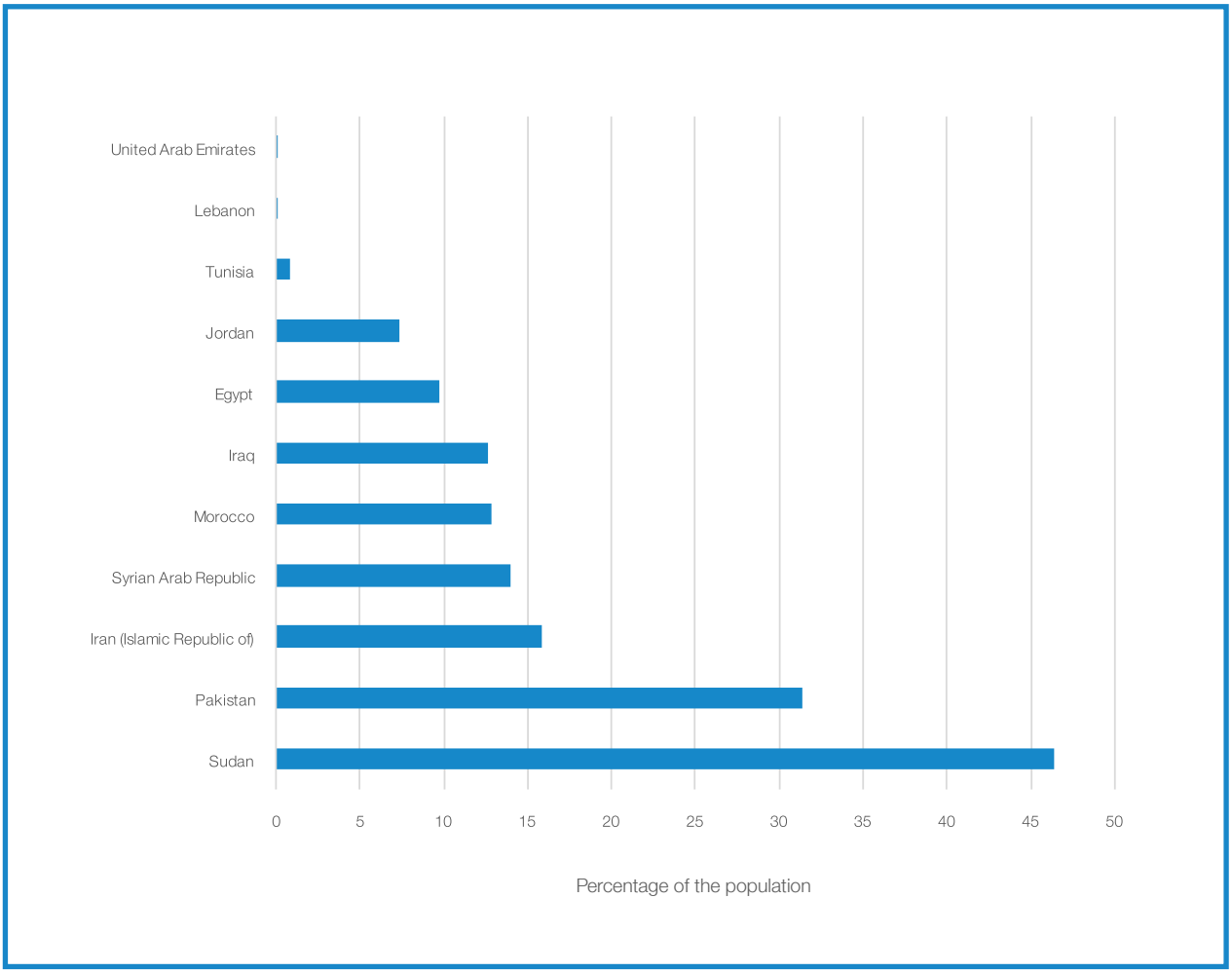
The regional averages of data on the levels of catastrophic health expenditure provide a somewhat distorted picture, and mask the fact that in several of the Region's countries, a much higher proportion of the population faces catastrophic health expenditure. Furthermore, while impoverishment is usually more prevalent in the low- and middle-income countries, catastrophic payments do also exist among the poorer population subgroups in the high-income countries. When looking at the data for individual countries in the Region shown in Fig 12.7, it is evident that at least 10 countries had levels of catastrophic spending on health well in excess of the regional average. At around one quarter, Egypt had the highest proportion of the population spending over 10% of their income on out-of-pocket health care expenditure. When more specialist health care needs are considered, the disparities between countries in terms of affordability of health care are even more stark: as shown in Fig 12.8, the proportion of the population at risk of impoverishing expenditure when surgical care is required ranged from less than 1% in Lebanon, Tunisia and the United Arab Emirates, up to 46% in Egypt.

Fig. 12.7. Proportion of population (%) spending more than 10% and 25% of their household consumption or income on out-of-pocket health care expenditure in selected countries in the Region, 2015 or latest available year



Source: World Bank (35, 36).

Fig. 12.8. Proportion of population (%) at risk of impoverishing expenditure when surgical care is required, by country with available data, 2020 or latest available year

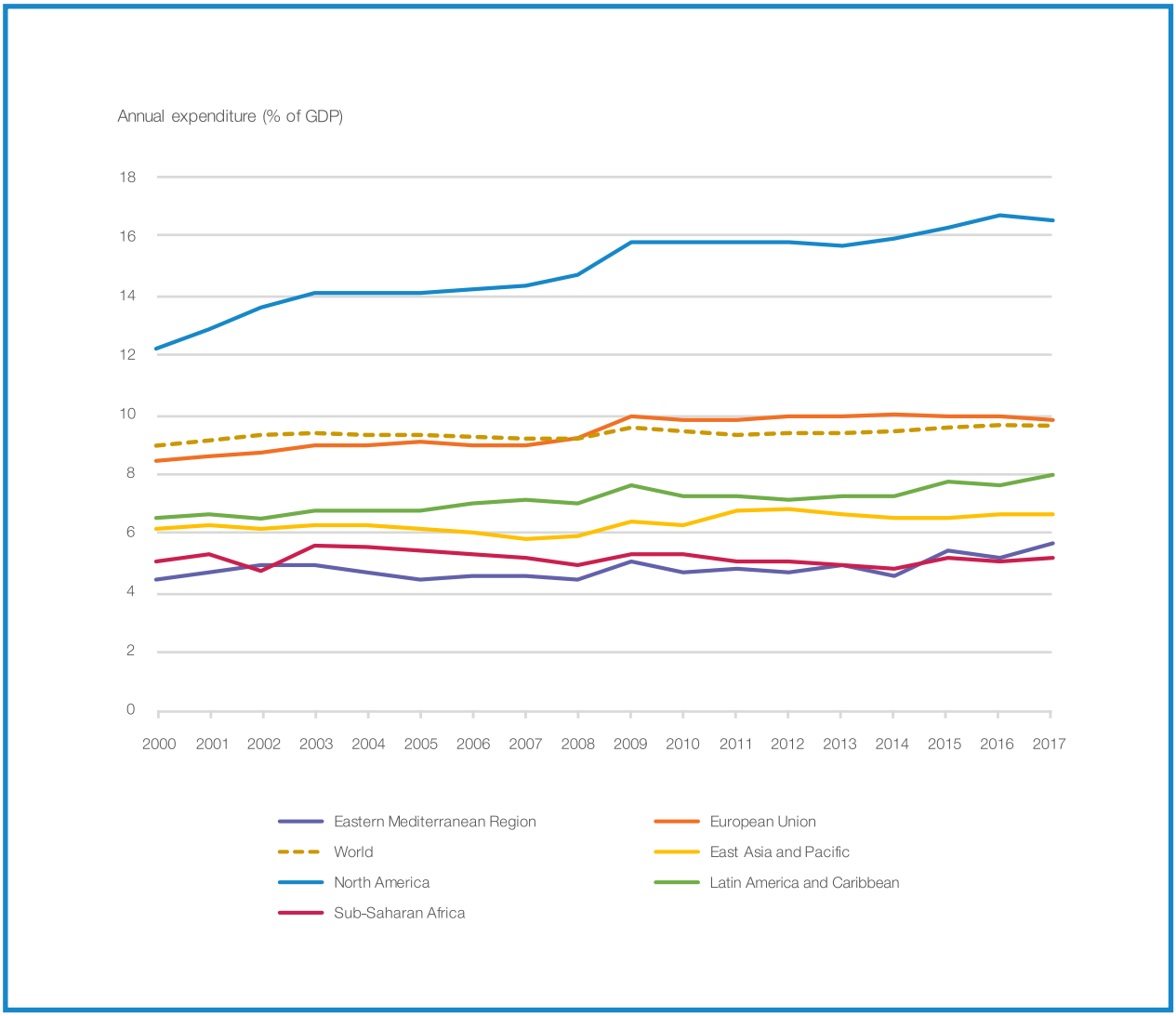


Notes: Impoverishing expenditure is defined as direct out-of-pocket payments for surgical and anaesthesia care which drive people below a poverty threshold (using a threshold of US$ 1.90 PPP per day). Data for Iraq are from 2018.
Source: World Bank (37), based on data from the Program in Global Surgery and Social Change, Harvard Medical School, United States of America.

FINANCING HEALTH SERVICES

Health financing systems are essential in ensuring progress towards universal health coverage *(7)*. However, overall, the Eastern Mediterranean Region is a low investor in health care *(7)*. Fig. 12.9 shows that the Region has a history of having one of the lowest expenditures on health care in the world (as a percentage of GDP).

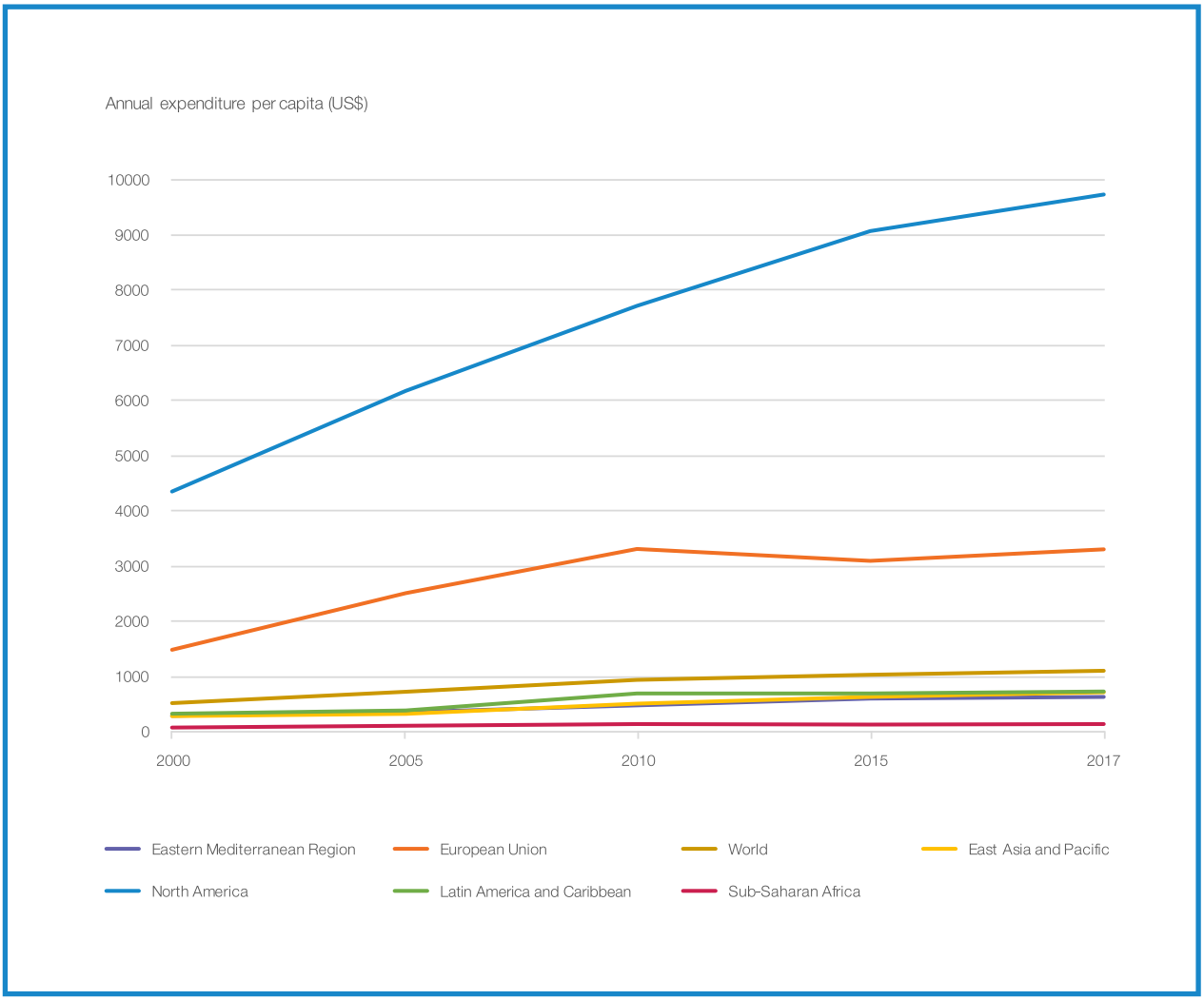
Fig. 12.9. Expenditure on health care (as a percentage of GDP) by region, 2000–2017



Notes: Estimates of current health expenditures as a percentage of GDP include all public expenditures related to the provision of health care goods and services consumed during each year. This indicator does not include capital health expenditures such as buildings, machinery, information technology and stocks of vaccines for emergencies or outbreaks (38).
Source: World Bank (39), based on data from WHO's Health Expenditure database.

Looking at differences in expenditure on health care per capita by WHO region, it is clear that the Eastern Mediterranean Region currently has one of the lowest expenditures on health per capita in the world (Fig. 12.10). This has been the position since 2000, and there has been very little growth in expenditure per capita over the period 2000–2017.

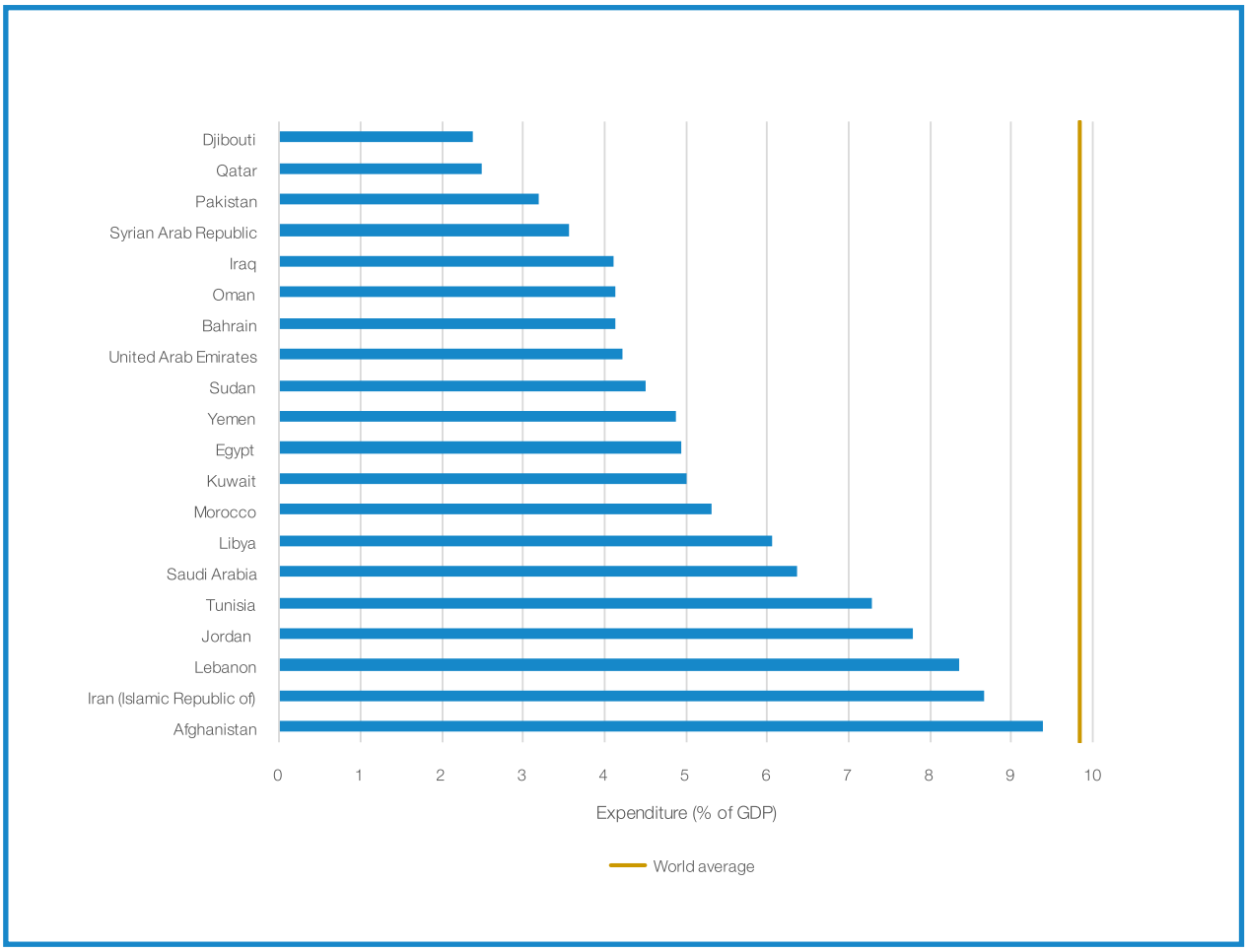
Fig. 12.10. Expenditure on health care per capita (US$) by region, 2000–2017



Note: Estimates of current health expenditure include health care goods and services consumed during each year.
Source: World Bank (40), based on data from WHO's Health Expenditure database.

While Figs 12.9 and 12.10 suggest that overall spending on health care across the Region is relatively low, there are large differences between individual countries in terms of health care expenditure as a proportion of GDP. Fig 12.11 shows that expenditures as a percentage of GDP in 2018 ranged from just over 2% (in Djibouti and Qatar) to over 8% (in Afghanistan and Islamic Republic of Iran). However, most countries spent less than 5% of their GDP on health, and all countries were below the world average of 10% of GDP.

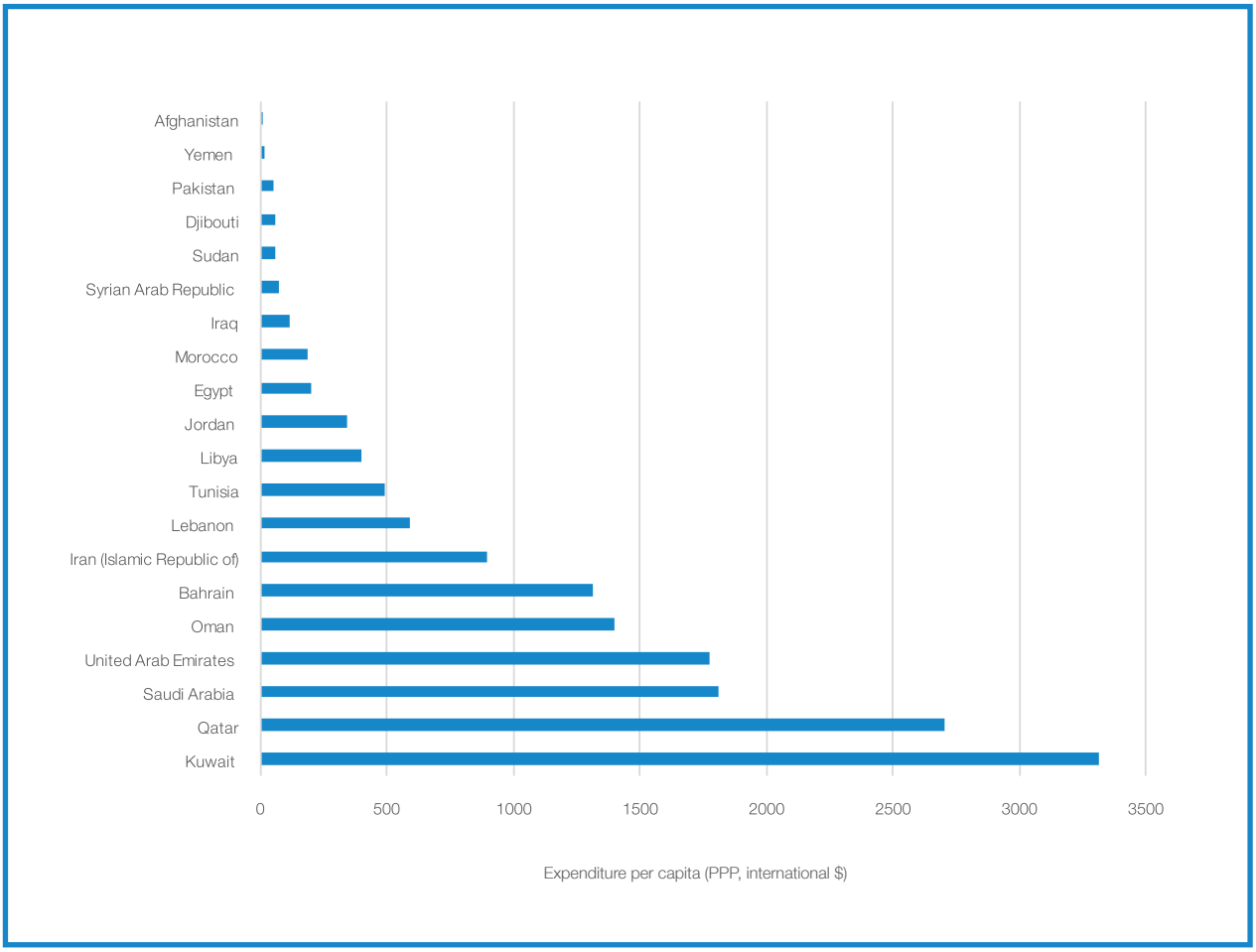
Fig. 12.11. Expenditure on health (as a percentage of GDP) in countries in the Region, 2018



Notes: Estimates of current health expenditures as a percentage of GDP include all public expenditures related to the provision of health care goods and services consumed during each year. This indicator does not include capital health expenditures such as buildings, machinery, information technology and stocks of vaccines for emergencies or outbreaks (38). Data for all countries refer to 2018, with the exception of Libya, the Syrian Arab Republic and Yemen, where the data were from 2011, 2012 and 2015, respectively. No data were available for occupied Palestinian territory or Somalia.
Source: World Bank (39), based on data from WHO's Health Expenditure database.

While the proportion of GDP directed towards health gives some idea of the priority accorded to health care, it does not necessarily follow that countries which allocate a high proportion of their GDP to health also have high levels of per person spending on health – this depends on the relative magnitudes of GDP earnings and population size. Afghanistan, for instance, has relatively high level of spending on health as a percentage of its overall GDP, but very low per capita spending. Per capita spending on health is thus a more useful measure in terms of international comparisons, as it takes account of these factors. The variation in public expenditure on health per capita (excluding international support) between countries of the Region is illustrated in Fig. 12.12, for those countries with available data. Qatar and Kuwait have the highest levels of per person spending on health in the Region *(41)*.

Fig. 12.12. Public expenditure on health from domestic sources per capita (PPP, international $) in countries the Region, 2017 or latest available year



Notes: The PPP time series is based on the International Comparison Program 2011. Data refer to 2017 for all countries with the exception of Pakistan (2016), Iraq (2015), Libya (2011), the Syrian Arab Republic (2012) and Yemen (2015). No data were available for occupied Palestinian territory or Somalia.
Source: World Bank (41), based on data from WHO's Health Expenditure database.

PRIMARY HEALTH CARE SYSTEMS

WHO has long recognized the importance of organizing primary health care around the broad needs of people, rather than just focusing solely on specific diseases. WHO's 2016 Framework on integrated, people-centred health services sets out how people-centred health services can prevent disease and support early diagnosis and treatment by coordinating with other sectors and promoting high levels of community engagement *(42)*. However, as Table 12.1 shows, there are very few countries in the Eastern Mediterranean Region that have primary health care systems which support and facilitate multisectoral coordination or community engagement. Only Tunisia demonstrates effective community participation in primary health care; most other countries lack any form of community engagement. Furthermore, as is also evident from Table 12.1, there are high levels of private sector involvement in primary health care provision in many countries. Private sector provision dominates in many countries, and in some, the regulation of this sector is weak. The widespread lack of community participation and engagement, coupled with an expanding but weakly regulated private sector, is particularly concerning for ensuring equity of access, quality and coverage in primary health care across the Region.

Table 12.1. Overview of primary health care in selected countries and territories in the Region, 2018

Country/ territory	PHC service delivery	Family practice-based PHC	Public–private partnership	PHC financing	Community engagement	Multisectoral coordination	Emergencies and PHC
Afghanistan	Quality of services has improved but access still limited in conflict and dispersed population areas	PHC programme "Sehatmandi" recently introduced	Contracting out of public health facilities through public–private partnerships is a primary source of health care	Adequate financing is a challenge; heavy reliance on donors continues	Work needed on engaging communities	Strong coordination between health ministry, donors and other nongovernmental bodies to improve health care	Safety is an issue in public health facilities and health care in emergencies needs prioritizing
Bahrain	Wide range of preventive, curative and promotion services available	Well developed family practice residency programme	Strong reliance on public health care delivery system	PHC services are free for citizens A social health insurance scheme to be introduced	Community mobilization to be added	Coordination between public and private sector partners is inadequate	Working towards institutionalizing emergency risk management in the health sector
Egypt	An essential package of health services available	Family health model	N/A	Health insurance since 2014 but there is insufficient depth Financial framework requires updating	Community engagement is a significant challenge Progress in community participation in facility management	N/A	Core capacities for preparedness, detection, surveillance and response to public health emergencies are present
Kuwait	Comprehensive package of services available; 90% of PHC facilities provide dental and diabetes care and 25% provide obstetrics and gynaecological care	Family practice implemented as the major strategy Work underway for evidence-based health financing strategy for UHC	Government control over health care but private sector participation is increasing	Coverage free for citizens Expatriates have a user fee for PHC services	Lack of focus on community engagement	Inadequate multisectoral linkages	There is a disaster response plan which is implemented through the Central Agency for Information Technology
Iran (Islamic Republic of)	Rural PHC well established since 1980s; urban PHC recently established	Family physician programme in rural areas	Established public–private partnerships for primary care through outsourcing and contracting out in some provinces	Free-of-charge services Majority of population insured	Community health workers provide links with communities in rural areas	High-level multisectoral advisory council for health is available but coordination requires strengthening	Substantial capacity of emergency preparedness
Jordan	Comprehensive preventive and curative services available; includes social determinants of health	Family practice programme implemented in several governorates but programme requires scaling up	Limited involvement of private sector in primary care services	All uninsured citizens entitled to utilize ministry of health subsidized services; vaccines and reproductive services are free for all	Lack of effort to involve communities	Decentralization law allows engaging local government in planning and mobilizing resources for health programmes	Provision of PHC to refugees from neighbouring countries

Country/ territory	PHC service delivery	Family practice-based PHC	Public–private partnership	PHC financing	Community engagement	Multisectoral coordination	Emergencies and PHC
Oman	Comprehensive PHC services Home-based and elderly care to be integrated	Family health programme in place and there is a strong communicable disease surveillance system	Private sector participation is encouraged through investment and public– private partnerships	Public financing of health care for all citizens as well as expatriates	Enhancing community participation is future priority	Decentralization of health-related responsibilities delegated to *wilayat* health governments	Emergency and disaster management procedure in place
Libya	Basic package of services available; priority programmes still need to be integrated	Large number of family physicians to serve in PHC facilities	Public–private partnerships developed for emergency situations and improving health care access	Free health services covering 81% of population	PHC is service-focused but needs integration of community engagement	Decentralized PHC system; health ministry has a restricted role	Water, sanitation and hygiene emergency preparedness and response plan in place
Lebanon	National PHC network covering five basic services available	N/A	Dominance of private sector	Financing dependent on partners, donors, and agencies such as the World Bank	Lack of focus on community participation	Unified contractual agreements for PHC network have been signed between relevant actors including health ministry and nongovernmental organizations	Early warning and response system in place Humanitarian support provided to Syrian refugees
Morocco	Health service package includes coverage for chronic diseases	Family practice programme	Cooperation partners with the Global Fund Project to reinforce PHC is under way	Payroll-based mandatory health insurance plan for employees	Community participation is a future priority	Weak coordination and collaboration between public and private sector	There is national strategy for medical emergencies and health disaster risk management
Pakistan	Limited services at basic health units, rural health centres, and district-level hospitals	Lady Health Workers programme available Family practice approach being implemented	Increasing involvement of private sector	Minimal user fee at public facilities National health insurance scheme available, otherwise out-of-pocket charges for private services	Facility and village health committees formed through private sector Lack of public sector measures	Lack of coordination between sectors	Weak emergency preparedness and response
Occupied Palestinian territory	Services are primarily provided by health ministry, nongovernmental organizations, UNRWA, military medical services, and private sector	Integration of mental health services in PHC; NCD programmes in all districts and PHC centres Family practice approach to be rolled out in the future	High participation of private sector	Government insurance for curative services but preventive services are free to all Financing heavily reliant on external sources	Primarily curative care-oriented; a community component needs to be added	Coordination gaps between health care providers Inadequate links between PHC and secondary care hospitals	General situation weak, with the exception of mass casualty management in hospitals and surveillance systems effective in detecting epidemic influenza

Country/ territory	PHC service delivery	Family practice-based PHC	Public–private partnership	PHC financing	Community engagement	Multisectoral coordination	Emergencies and PHC
Qatar	Comprehensive package of services available	Health care is a constitutional right	Increasing number of private sector health care services	Primarily tax-based financing by the public sector; also private insurance	Community-based mental health programme exists, although community participation limited	National Health Authority the main coordinating body Secondary level services are decentralized and lack of clarity between stakeholders	National Command Centre manages emergency response at local and national levels
Saudi Arabia	Essential package of services available; expanded package is being gradually rolled out	Family practice is being expanded Establishment of a national health workforce unit and development of the Health System Transformation Plan	Much attention to public–private partnerships since start of National Health System Transformation Plan	Citizens can freely access PHC services; expatriates access services through compulsory employment health insurance	Limited community-based and outreach activities	Multisectoral collaboration and work on Health in All Policies to reduce exposure to NCD risk factors is in progress	Lack of effective health disaster management
Somalia	Core package of services available and expansion of services is taking place	Family practice does not exist, although a number of public health-related laws, policies and strategies are being developed	Increasing role of private sector and public–private and partnerships are being strengthened	Almost completely dependent on external sources of health care financing	Community-based health care strategy to improve equitable access to health care services under development Lack of focus on involving communities	Coordination between different sectors has improved	National emergency preparedness and response plan includes PHC
Syrian Arab Republic	Basic PHC services provided	Family practice not well established	Outsourcing of public health facilities increasing	Out-of-pocket and donors are major source of funding, along with some government funding	Community-based mental health programme available but role of communities is generally overlooked	Health ministry is the main coordinating body	National emergency plan exists but with high reliance on external support
Tunisia	Apart from essential services, extra provisions for poor patients	Established national health programmes for maternal mortality, immunization and other services	Weak regulation and control; limited engagement with large and growing private sector	Most of population covered by mandatory individual contributions or by a non-contributory programme for poorer households	High social participation of communities and civil society	Largely centralized management of public health facilities hinders responsiveness	Disaster preparedness is part of national health policy High capacity to deal with emergencies

Country/ territory	PHC service delivery	Family practice-based PHC	Public–private partnership	PHC financing	Community engagement	Multisectoral coordination	Emergencies and PHC
United Arab Emirates	Integrated, comprehensive, patient-centred, coordinated care accessible for all	Well established and elaborated family practice programme	Mix of public and private care available	Completely domestically funded, with the main sources being Ministry of Health, Ministry of Public Works, Emirates of Dubai and Abu Dhabi, and private funding	Community mobile clinics but community participation is lacking	Health care is well coordinated and regulated across public and private sector	Policy exists on disaster and crisis resilience High standards and infrastructure for prevention and protection
Yemen	Basic PHC services provided	Family practice not established	Both for-profit and not-for-profit models are prevalent	Health care financing from six sources including the health ministry, foreign funding, governorate health budgets and the Social Fund for Development	Increased community involvement in PHC services in remote areas	Structure of coordination well laid out, but health sector is highly centralized and poorly coordinated	Rapid response team for disease surveillance and outbreak response established and there is an electronic diseases early warning system

PHC:, primary health care; UHC: universal health coverage.
Source: Department of Health Systems Development, WHO Regional Office for the Eastern Mediterranean (2018) (43).

Taking action to improve living and working conditions is essential to improving the health of the population, a theme that is reiterated throughout this report. Primary health care provision has a significant role to play as part of the social determinants of health agenda and can be oriented towards these goals. Several countries in the Region have made efforts to focus their primary care provision on improving health as well as treating disease. Kuwait and Morocco are cases in point and their efforts in this area are described in more detail in Box 12.1.

Box 12.1. Health promotion through primary health care

Kuwait

Kuwait has a strong primary health care system, and in 2019 most of the SDG 3 targets had been fully met *(44)*. Kuwait's health care system is a mix of public and private. The public sector is the largest primary care provider and provides services free of charge for Kuwaiti nationals. Non-Kuwaitis access services at reduced cost through a public insurance scheme. There are more than 90 health care centres across the country which offer primary care services; these are run as polyclinics, allowing patients to access a range of services in one building, including general practitioners, dentistry, maternity care, nursing care, preventive care, family medicine and a pharmacy *(45)*. Other services are offered in the community. Local needs are determined by district community councils, and services provided as deemed necessary *(46)*. Health systems in Kuwait have traditionally adopted primarily curative care or disease management and lacked provision of preventive measures. In more recent years, however, public health improvements through primary care have been implemented, such as reducing salt in bread products by the Kuwait Flour Mills and Bakeries *(47)*.

Morocco

In 2011, reforms to Morocco's constitution included Article 31 which states Moroccans have the right to health care. In Morocco, primary health care is provided free and delivered by public providers through health centres staffed by general practitioners and nurses who provide traditional public health and health promotion services. The private sector also provides primary health care services. Morocco has made efforts to reduce inequities in service provision, but despite improvements in universal health coverage and access to primary care, there remain substantial shortages in primary care provision and family medicine staff, particularly in rural areas *(46)*.

In seeking to reduce inequities in access to primary care, in 2018, Morocco's Council of Ministers launched its Plan Santé 2025; this ambitious plan is focused on strengthening primary health systems in rural areas, strengthening disease control programmes and improving governance and resource allocation *(48)*. Plan Santé 2025 also aims to offer mobile health care services in rural areas and will consolidate existing mother-baby-oriented care programmes. The investment required for Plan Santé 2025 is at least 24 billion Moroccan dirhams (US$ 2.7 billion) *(49)*.

CONFLICT AND ACCESS TO HEALTH CARE

Conflict can be severely disruptive and destructive to the functioning of health systems. Conflict heightens health care needs due to the effects of violence and the increased risk of the spread of infectious disease and increased rates of unmet needs for the management of NCDs *(50)*. It causes both direct and indirect damage to health facilities and supplies, restricts health care funding, leads to deterioration in health care governance, and limits access to all forms of health care *(1, 51)*. This lack of access to health care, as well as to other determinants of health such as education and employment, has huge adverse impacts on population health, worsens health inequities and poses significant challenges to achieving universal health coverage and other SDGs *(1)*. Box 12.2 outlines the impacts of conflict on the health system in Yemen.

Box 12.2. Impact of conflict on the health system in Yemen *(51)*

Significant deterioration in the health care system in Yemen was seen following the internationalization of conflict in March 2015. However, even prior to this conflict, the health system in Yemen was fragile and heavily dependent on out-of-pocket financing. Nevertheless, progress in a number of the key health indicators had been made, for example, in terms of life expectancy and infant and maternal mortality.

The conflict has threatened to reverse much of the progress made prior to 2015. Since March 2015, public funding for health care has significantly declined as a result of the contraction of the economy. GDP in Yemen declined by 32.9% in 2015 and a proportion of the available public funding was reprioritized away from health care. International aid funding also decreased. Direct attacks and damaged infrastructure have also impacted on the delivery of health services. These factors combined have substantially reduced access to basic health services. In August 2015, it was estimated that 58% of the population did not have access to basic health care. In 2016, a survey conducted by WHO found that 8% of 3507 facilities were either partially or completely destroyed by conflict; 17% were considered to be “non-functional”, either because of critical damage to infrastructure, lack of equipment or staff, or because they were physically inaccessible. The 2016 survey also revealed large shortfalls in particular health service domains; for example, maternal and newborn health services were available at only 35% of surveyed health facilities.

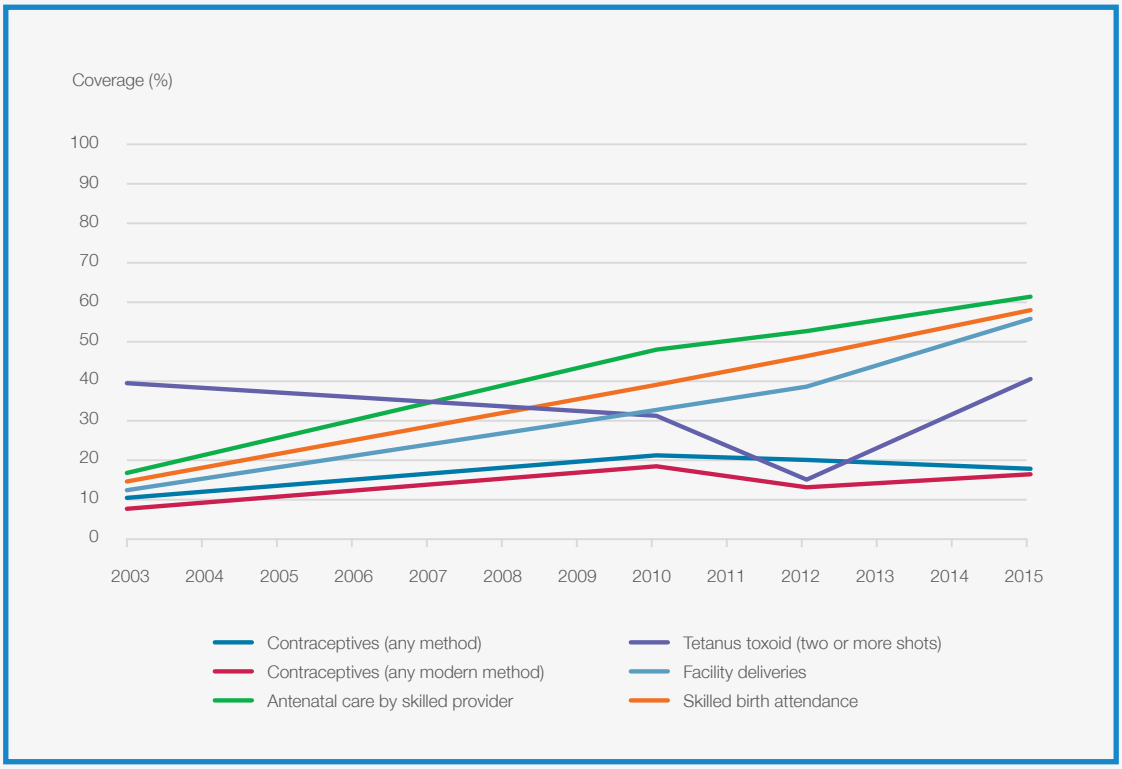
Public health preventive services have also been adversely impacted by the ongoing conflict, with some data suggesting that there have been rapid declines in vaccination coverage. In 2015 there was a large dengue fever outbreak across a number of governorates, and the control of infectious disease outbreaks has become increasingly difficult across the country.

Women and children have specific health care needs and are thus often especially vulnerable to disruption of services during conflicts *(52)*. Box 12.3 details the impact that conflict has had on the delivery of maternal and child health services in Afghanistan. The impacts of the occupation on the health system in the occupied Palestinian territory, including east Jerusalem, are described in Box 12.4.

Box 12.3. Impact of conflict on the delivery of maternal and child health services in Afghanistan

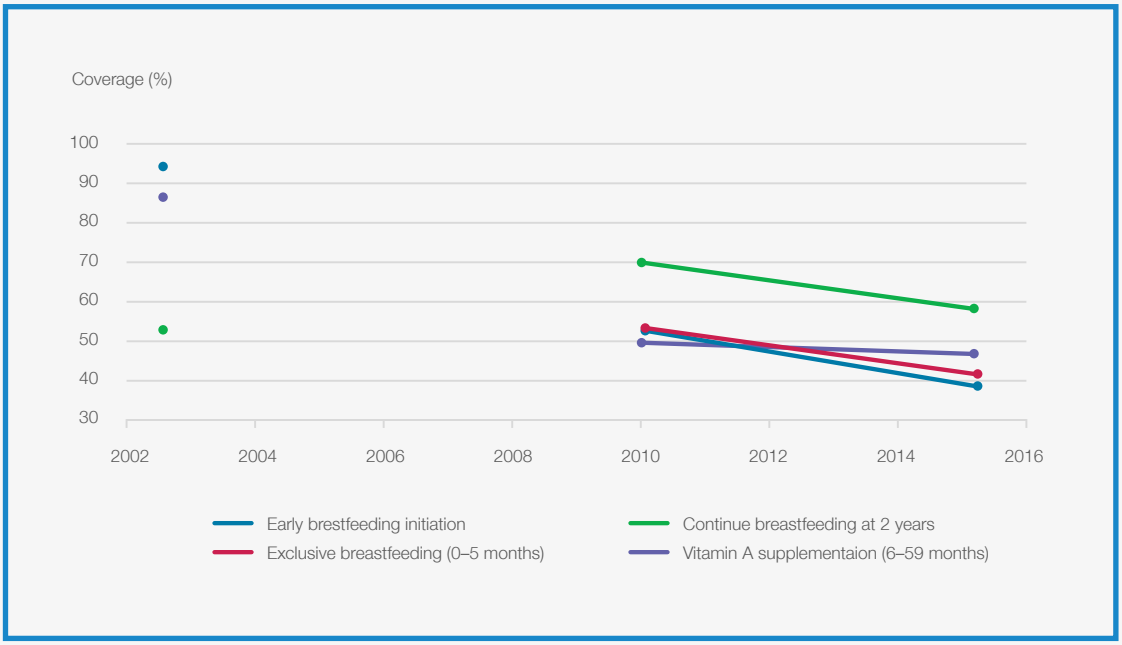
Conflict has been ongoing in Afghanistan for over four decades *(53)*. This has had significant impacts on delivery of all public services including health. The health system in Afghanistan was left in disarray as a result of ongoing conflict and poor governance in the decade prior to the overthrow of the Taliban. Rates of maternal and child mortality were some of the highest in the world and coverage rates for reproductive, maternal, newborn, child and adolescent health and nutrition services were low *(53)*. Despite ongoing conflict, some gains have been made in relation to coverage of most reproductive, maternal and child services, including antenatal care, facility delivery, skilled birth attendance and vaccinations (see Fig. 12.13). In contrast, key nutrition indicators including those related to breastfeeding and vitamin A supplementation have decreased since 2010, a negative trend that has been largely attributed to increasing levels of conflict (Fig. 12.14) *(53)*. Analysis has revealed regional differences in some indicators such as coverage of antenatal care, facility delivery and skilled birth attendance that appear to be related to levels of conflict; coverage for these services were significantly lower in provinces more severely affected by conflict compared with those where levels of conflict were lower *(53)*.

Fig. 12.13. Coverage of reproductive and maternal interventions in Afghanistan, 2003–2015



Source: Mirzazada et al. (2020), based on data from household surveys including the Multiple Indicator Cluster Survey (2003 and 2010) and the Demographic and Health Survey (2015) (53).

Fig. 12.14. Coverage of nutritional interventions in Afghanistan, 2002–2016



Source: Mirzazada et al. (2020), based on data from household surveys including the Multiple Indicator Cluster Survey (2003 and 2010) and the Demographic and Health Survey (2015) (53).

Factors that were found to affect the delivery of care in Afghanistan, based on a qualitative analysis, included those related to security, the health care workforce, financing, supply chains, governance, the information system and monitoring *(53)*.

In summary, the conflict in Afghanistan over the past several years has hindered the delivery of reproductive, maternal, newborn, child and adolescent health and nutrition services; however, the impact of conflict has been exacerbated by poor collaboration at all levels, inadequate infrastructure and weak stewardship *(53)*. While there has been some progress in improving health, for gains to be fully realized other related sectors need to be involved in the health system, and parallel improvements are needed in economic development, education, infrastructure and food security, as well as in poverty alleviation *(53)*.

Box 12.4. Impacts of occupation on health systems in the occupied Palestinian territory

Lack of integration and shortages of supplies have affected the provision of health care services in the occupied Palestinian territory, and access to basic services has suffered as a result. Additionally, the accessibility and affordability of health supplies and equipment has been impacted by restrictions on movements of commodities, leading to shortages of vaccines, beds, electricity, fuel and specialized equipment *(54)*. In the Gaza Strip, during 2018, 46% of items on WHO's Essential Medicines List had, on average, less than a month's supply remaining *(54)*.

The violence associated with occupation has had a direct impact on health care facilities. In 2018 alone, there were 363 recorded attacks on health care facilities in the Gaza Strip *(54)*. Additionally, resources have been diverted to treat trauma and provide physical and mental rehabilitation services *(54)*. The financial sustainability of the health system is further compromised by the limited control that the Palestinian Authority has over natural resources, referral spending and tax revenue, as well as by high levels of donor dependency *(54)*. Unsustainable financing tends to result in high out-of-pocket costs for individuals; according to the latest estimates, 45.5% of financing for health care in the occupied Palestinian territory comes from out-of-pocket expenses and 1.8% of the population is experiencing catastrophic health spending or is impoverished by the cost of their health care needs *(54)*.

Movement restriction policies have limited access to existing health care services. It is estimated that 114 000 individuals have had limited access to primary health care as a result of occupation in the West Bank *(54)*. The need for access permits has also led to delays in accessing health care. In 2018, 77% of referrals required individuals to obtain an Israeli permit in order to attend secondary health care services; in the previous year, 54 patients from the Gaza Strip died while waiting for security approval for a referral *(54)*. The Israeli permit system has also limited the movement of health care professionals; health workers in east Jerusalem, for example, are required to apply regularly for permits which are only valid for up to 6 months *(55)*. Ambulances are also often delayed at check points.

Despite the hugely damaging direct and indirect impacts of conflict on health and health systems, there are always opportunities to improve health, even in the most difficult contexts. Positive results have been achieved in Yemen, even during times of conflict, following the successful implementation of a child nutrition behaviour change programme, which included cash transfers (see Box 12.5). Cash transfer schemes have provided important social determinants of health and health benefits in other parts of the world *(3)*.

Box 12.5. Behaviour change communication programme in Yemen *(56)*

A child nutrition behaviour change communication intervention was carried out during 2015–2017 in Yemen. This intervention was conducted as part of the Yemen Cash for Nutrition, which is a Yemen Social Fund for Development pilot programme directed at reducing the rates of child malnutrition in Al-Hudaydah, a city in Yemen. As part of this programme, cash transfers were provided to mothers on the condition that they attended monthly nutrition training sessions. These training sessions were conducted by female community health volunteers, who were locally recruited.

An evaluation of the programme concluded that there was significant improvement in breastfeeding and water treatment practices as a result of the programme. Specifically, participants who received the intervention were 16% more likely to report breastfeeding within the first hour of delivery and 14% more likely to exclusively breastfeed their children up until the age of 6 months. In addition, there was a 16.7 percentage point increase in the probability of adults consuming treated drinking water and a 10.3 percentage point increase in the probability of children aged under 2 years consuming treated drinking water. Evidence to suggest that there was transfer of knowledge from programme participants to non-participants was also reported, in terms of both breastfeeding and water treatment practices. This suggests that such programmes can have wider positive impacts in improving health promoting behaviours and therefore could be instrumental in improving community health.

Post-conflict, the recovery of health services is often driven by international agencies *(50)*. However, while essential services may be provided, post-conflict settings often experience high levels of fragmentation of health systems, given that the standards and facilities put into place by external agencies are often unsustainable once they exit these countries *(50)*. Box 12.6 outlines a recent WHO-led initiative to support sustainable health systems in emergency and post-conflict settings. A collaborative effort to support sustainable and more equitable health care access and improve public health in Yemen has had some positive impacts, particularly in relation to the provision of vaccinations for children. Further details of this initiative are provided in Box 12.7.

Box 12.6. The Health Systems in Emergency Lab in the Eastern Mediterranean Region

In July 2018, the WHO Regional Office for the Eastern Mediterranean established the Health Systems in Emergency Lab *(57)*. The main aim of this initiative is to improve the resilience of health systems in the Region through the integration of “health system strengthening, emergency preparedness, response and recovery” *(57)*. The initial work was funded by the Government of Japan and has involved providing support to Afghanistan, Somalia and Sudan and for aligning interventions for health systems strengthening with joint external evaluations and national action plans for health security *(57)*. Additionally, a regional framework for post-emergency health system recovery is in development.

Box 12.7. The Deliver Accelerated Results Effectively and Sustainably (DARES) collaboration

In 2017, a WHO team in collaboration with other health partners, developed an intersectoral strategic approach for addressing the emergency health care needs of the population in Yemen *(58)*. WHO, UNICEF and the World Bank worked together to develop a framework for the Emergency Health and Nutrition project, which was approved in January 2017. The primary aim of the project was to address the urgent health care priorities of the Yemini population by providing support for health care systems *(59)*. Among the most notable achievements of the collaboration was the mobilization of a large network of health care workers in the most vulnerable districts in the country which meant that in 2017, 5% of health facilities across the country were reopened and close to 5 million children received vaccinations for vaccine-preventable diseases *(58)*.

Building on these positive results in Yemen, the DARES collaboration was established following a meeting between the World Bank, UNICEF, WFP and WHO in July 2017 *(58, 60)*. The aims of DARES are to maintain and improve health care systems in conflict-affected countries *(61)* and to "deliver accelerated results, effectively and sustainably … through a stronger emphasis on prevention, by increasing national capacity to deliver essential services, to mount effective outbreak response, and leave no one behind" *(60)*. The underlying principles of this collaboration include: supporting national systems; implementing multi-year, flexible programming; ensuring evidence-based programming; and maximizing partnerships *(60, 61)*. DARES pilot countries in the Region include Djibouti, Libya, Somalia, Syrian Arab Republic and Yemen *(61, 62)*.

MIGRANTS, REFUGEES AND DISPLACED POPULATIONS

Migrants, refugees and IDPs can face significant challenges in accessing health services, in particular preventive services, treatment services for chronic conditions, and long-term care *(63)*. They also face barriers related to affordability of health services, as they often lack financial support and protection for health care *(63)*. Influxes of refugees place strain on local health service infrastructure and resources *(64)* which can also limit health care access, not only for refugees but also for the host country population. Providing health service coverage for refugees is a significant challenge for many countries, especially those with large refugee populations *(4, 65)*. Countries such as Egypt and Iraq that have smaller refugee populations have faced fewer challenges; in both of these countries, refugees living outside of camps are often covered by the same basic public health schemes as citizens *(4)*.

A number of countries in the Region have launched initiatives to improve access to health care for refugees; some of these are described in more detail in Box 12.8.

Box 12.8. Access to health care for refugees and IDPs

Afghanistan

In Afghanistan, 36% of IDPs and returnees have been diagnosed with NCDs which are considered life threatening. Addressing this has often been overshadowed by more acute health care needs among this population, including infectious disease outbreaks and trauma *(66)*. However, in 2017, essential medicines and supplies for the management of NCDs were provided by WHO as part of the emergency response for IDPs and returnees in Afghanistan, in collaboration with the Afghan Red Crescent Society *(66)*. Additionally, training on how to identify and manage NCDs was provided for frontline workers to strengthen their capacity to respond to the NCD challenges in this population *(66)*.

Djibouti

Access to health care for refugees in Djibouti is mainly provided by international nongovernmental organizations *(67)*. In January 2017, a national refugee law which was adopted by parliament in 2016 was put into place by Djibouti's head of state *(67)*. This law ensures the fundamental rights of refugees – including the right to access health services as well as other important socioeconomic determinants of health such as education and employment *(67)*.

Iraq

In 2018, WHO implemented a large-scale health support programme aimed at providing health facilities in refugee camps in Iraq *(68)*. As a direct result of this programme, which received funding from the United States Bureau of Population, Refugees, and Migration, nine primary health care centres in refugee camps were equipped with various medical devices and laboratory supplies *(68)*. This has resulted in increased access to health services in these camps; a clinic in the Darashakran refugee camp, for example, is now able to treat 150–160 patients a day *(68)*. The programme has also supported the training in July 2019 of over 250 health care providers from different governorates in the management of cases of sexual violence in refugee camps and host communities. In addition, over 50 health practitioners have received training in how to use the Mental Health Gap Action Programme Intervention Guide to help to strengthen the delivery of mental health services in target areas which accommodate refugees *(68)*.

Lebanon

Every individual residing in Lebanon is able to access primary health care services, provided by the Ministry of Public Health, at a minimal cost. Free vaccinations for IDPs are also provided by the Ministry at all of their centres, as well as at border and registration sites (67). Furthermore, the Ministry provides support and access to medications to those with chronic conditions through the Young Men's Christian Association. Tertiary care for displaced individuals from the Syrian Arab Republic is provided in public and private hospitals with financial support from UNHCR and other nongovernmental organizations *(67)*.

Occupied Palestinian territory

There are ongoing efforts by UNRWA and WHO to support and strengthen the health services available for Palestinian refugees. These efforts are focused on advocating for the right to health for Palestinians under occupation and on integrating mental health services into public health care using a family practice approach. Service delivery through this family practice approach, which is implemented in three of the districts of the West Bank and which emphasizes the integration of services at both primary and secondary care levels, has been promoted by WHO *(69)*.

PUBLIC HEALTH SYSTEMS

In this report, our focus is on reducing inequities in health through action on the social determinants of health. However, it is also necessary to focus on changing harmful behaviours such as smoking, alcohol and drug abuse, and obesity. Evidence from around the world, including from the Eastern Mediterranean Region, shows that harmful behaviours and risks of NCDs, such as smoking and obesity, are associated with socioeconomic factors. We therefore suggest that action to change behaviours needs to happen in the socioeconomic drivers of these behaviours – and interventions to support behaviour change need to be geared and proportionate to inequities in those behaviours.

Although some public health strategies in the Region have recognized the need for such an approach, many health systems in countries are not designed to tackle the social determinants of health or the prevention, early detection and management of NCDs *(42)*; the majority are even further from being able to target activities where disease rates are highest and the risks are greatest. Instead, for many countries in the Region, the focus remains on infectious diseases. These types of diseases are also much more prevalent among poorer and excluded populations. The higher COVID-19 transmission and mortality rates among those in crowded living and working conditions is recent evidence of this, and highlights the need for efforts to reduce infection and mortality from infectious diseases to also be geared around equity.

One of the key responsibilities of WHO is to help countries to improve their ability to prevent and respond to public health challenges *(70)*, which range from dealing with health emergencies through to implementing preventive care services. There are various examples of actions carried out by WHO in the Region to support countries develop their capacity to address their public health challenges. The case of Afghanistan is detailed in Box 12.9.

Box 12.9. WHO and country support in Afghanistan *(71)*

WHO has provided support to Afghanistan in a number of ways. In terms of emergency health care support, some of the actions carried out by WHO's Health Emergencies programme have included scaling up trauma services in high-risk areas and the training of 2547 medical staff and community health workers in advanced and basic life support. WHO has also assisted Afghanistan in delivering its response to the increase in the burden of NCDs by helping to strengthen the implementation of tobacco laws in restaurants in Kabul and training two individuals in the Ministry of Finance on implementing tobacco taxation policies. WHO also trained 75 schoolteachers and principals on preventing the use of tobacco among children.

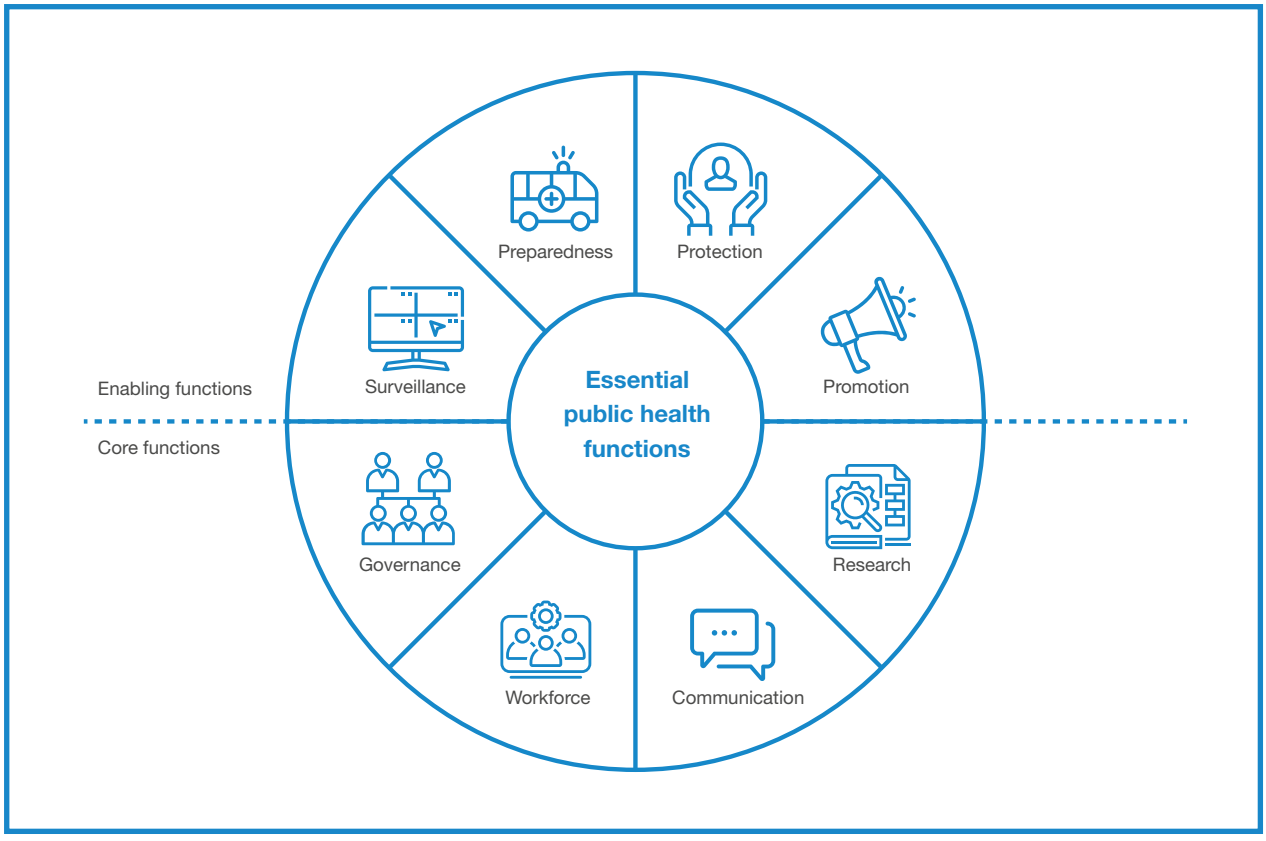
There are very different levels of guarantees for public health across the Region. Guarantees such as "defence of public health", "access to preventive services", "illness prevention", and "creation of favourable conditions for good health" are enshrined in the constitutions of Afghanistan, Bahrain, Iraq, Qatar, Syrian Arab Republic, Tunisia and the United Arab Emirates. Other countries either have no specific provision or are aspirational or subject to realization, meaning that the constitution "protects the right to public health but does not guarantee it" *(72)*.

ESSENTIAL PUBLIC HEALTH FUNCTIONS

Essential public health functions refer to "the indispensable set of actions, under the primary responsibility of the state, that are fundamental for achieving the goal of public health which is to improve, promote and protect, and restore the health of the population through collective action" *(73)*. Assessments of essential public health functions help ministries of health to identify the strengths and limitations of the public health system in their countries. This is important in developing interventions for improving health system performance and for reducing health inequities, although the latter element is still underdeveloped *(73)*. In 2013, WHO's Regional Office for the Eastern Mediterranean launched an initiative to support Member States in assessing their essential public health functions, with the aim of providing evidence-based recommendations for improving public health capacity and performance *(73)*.

A conceptual framework for essential public health functions was developed by the Regional Office based on a review of experiences from other WHO regions *(74)*. This framework is shown in Fig. 12.15 and includes eight interrelated functions, four of which are classified as core functions and the other four as enabling functions *(74)*. Subheadings and subfunctions have also been outlined under these, which serve to provide "a comprehensive package of public health services that all Member States in the Eastern Mediterranean Region should aim to provide to their populations" *(74)*.

Fig. 12.15. Essential public health functions framework



Source: WHO Regional Office for the Eastern Mediterranean (2017) (75).

WHO has supported two countries in the Region (Morocco and Qatar) in conducting pilot assessments of their essential public health functions using the regional framework *(74)*. These pilot assessments have helped to identify development needs in each of the countries and have provided lessons on how the assessment process could be streamlined and simplified *(70)*. A number of other Member States in the Region have expressed interest in conducting this assessment *(74)*.

HEALTH PROMOTION

In terms of health promotion and education activities, there are very few countries in the Region that have a national strategy on health promotion and education. According to the Regional Office for the Eastern Mediterranean, most available health promotion strategies are related to specific diseases and promotion of healthy lifestyles and none include a focus on improving social and economic conditions (76). Much more emphasis on the social determinants of health in these strategies is needed in all countries in order to facilitate progress towards achieving health equity.

The varying strengths of health systems across the Region means that some countries have limited capacity to achieve immunization targets for vaccine-preventable diseases and/or limited capacity to detect and diagnose NCDs at an early stage to allow appropriate disease management *(77)*. Additionally, emergencies and political instability which disrupt the functioning of health systems have exacerbated the challenges faced by a number of countries, both in terms of the treatment and the prevention of diseases *(77)*.

IMMUNIZATION PROGRAMMES

Immunization programmes are an important component of preventive health services and are one of the most successful and cost-effective public health interventions for preventing illness, disability and death from vaccine-preventable diseases *(78)*. There has been significant increase in the number of people receiving vaccinations in the Region in recent years *(79)*. However, immunization coverage still varies within the Region, with a number of countries experiencing challenges in terms of maintaining optimal vaccine coverage due to political unrest, socioeconomic hardship and humanitarian crises *(80)*. Political crises and conflict in the Region led to a drop in the coverage of the diphtheria–tetanus–pertussis vaccine. Coverage of the third dose of the oral polio vaccine has also fallen, from 86% in 2010 to 80% in 2015 *(80)*. Vaccination rates for seasonal influenza are very low in the Eastern Mediterranean Region relative to other world regions, with less than 20 doses being distributed per 1000 population, compared with 45 in the Western Pacific, 112 in Europe and 275 in the Americas *(81, 82)*. There are also disparities in the rates of immunization between particular vaccine-preventable diseases and certain population subgroups in the Region. Box 12.11 outlines public health achievements of the Sehatmandi Project in Afghanistan, which includes increasing vaccination among children.

Box 12.10. The Sehatmandi Project in Afghanistan

The System Enhancement for Health Action in Transition Project for Afghanistan is a three-year programme (2018–2021) implemented by the Afghan health ministry and administered by the World Bank through the Afghanistan Reconstruction Trust Fund *(83)*. The main objective of the programme is to increase the quality and use of health, nutrition and family planning services *(83)*. An important achievement of the programme was a 28% increase in the number of people receiving essential health, nutrition and population health services between 2017–2019 *(84)*. Between 2018–2020, over 4 million children were vaccinated, and in 2019 there were 60 million individual visits to health, nutrition and population health services (which equates to 2.1 health facility visits per capita). Furthermore, the volume of services delivered under the Project increased for all but one of 11 key health-related services (which includes services such as immunization, family planning visits and skilled birth attendance). For example, there was a 49% increase the provision of contraception at facilities between 2018–2019 *(84)*.

In terms of the COVID-19 pandemic, there are stark inequities in vaccine distribution and access between countries. In February 2021, the International Federation of Red Cross and Red Crescent Societies reported that the majority of vaccines given so far had been administered in high-income countries *(85)*. Specifically, close to 70% of all administered vaccine doses had been given to people living in the 50 wealthiest countries globally, while only 0.1% of administered doses had been given to people in the 50 poorest countries. Access to the COVID-19 vaccine in the Region is discussed further in Chapter 3 *(85)*.

POPULATION HEALTH SYSTEMS

This chapter has examined inequities in access to health care and the limitations of health care systems in providing universal health coverage and essential public health functions in the Eastern Mediterranean Region. These limitations largely relate to inequities in health and in diagnosis and treatment of disease. In this report we have seen that understanding and acting on the social, economic, cultural, commercial and political determinants will do a great deal to support better health and health equity in the Region. In relation to the role of health systems, this requires shifting health care systems from being solely focused on treatment towards becoming population-based preventive health systems, which work to improve equity in the social determinants of health as well as to treat ill health. Health care organizations and the health care workforce must be involved in the broad societal endeavour to improve health equity through action on the social determinants of health *(86)*.

In this last section, we outline ways in which health systems can be developed and showcase what roles the health workforce and health care organizations can play within a broad population-based preventive health system. As a precursor to this, it is instructive to consider the key components of a health system that is built on a social determinants of health approach; these are summarized below *(87)*.

- **A focus on preventing ill health and supporting good health** as well as treating ill health: this involves moving from reactive services that focus solely on treatment for people who are already ill towards services that work to improve the conditions in which people live, which in turn will improve their health.

- **A focus on place**: this supports a focus on smaller areas and seeks to influence the environment and social and economic conditions of the place in order to improve the health of residents, especially for the most disadvantaged areas.

- **Cross-sectoral collaboration**: reducing health inequities requires close collaborations between multiple organizations and sectors reaching beyond health care, public health and social care. These may include, for instance, housing, early years services, and training and education, all of which profoundly influence health.

- **A focus on population health**: in order to improve health and reduce inequities it is important to understand local population health and health risks for specific groups and areas. This requires health assessments that include the broader social and economic drivers of health as well as a focus on and inclusion of particular communities who are at risk of poor health.

- **Action on the social determinants of health** as well as medical treatment: there is much that health professionals and health care organizations can do to take action on social, economic and environmental factors that would significantly drive improvements to health outcomes and health inequities.

- **Development of "proportionate universalism" approaches**: designing interventions and strategies that respond to local health risks and needs will require additional resources and actions for more deprived communities and areas. Approaches that focus on improving health equity may look quite different to those that focus only on improving average population health, as they are responsive to those with the greatest levels of need and the highest risks of poor health.

The importance of collaboration across sectors to the development of health systems based on disease prevention and health equity is well recognized. A health care system which is focused on the social determinants as well as the prevention of disease, and forges strong partnerships with other sectors, will also contribute to other advantageous social and economic outcomes, for example, fairer employment practices and better housing *(3)*. The strategic planning process behind a national initiative to address the social determinants of obesity in Jordan (described in Box 12.11) involved collaboration between a wide range of stakeholders from different sectors, including representatives from government health departments, local municipalities, academia and the private sector, as well as representatives of other associations such as the Jordan Food and Drug Administration and the Jordan Standards and Metrology Organization *(88)*.

Box 12.11. Addressing obesity in Jordan using a social determinants of health approach

In response to its obesity epidemic, Jordan launched a national health initiative directed at addressing the broad factors associated with obesity *(89)*. The main goals of this programme were to reduce the incidence of obesity in the community, to build the capacity of health care professionals involved in the prevention of obesity and to encourage the use of evidence to inform the development of policies for supporting actions to reduce obesity, as well as actions on other social determinants of health *(88)*. A strategic planning process involving a number of stakeholders, including 18 representatives from different sectors, was coordinated by the Ministry of Health *(88)*. As a result of this process, a collaborative work plan for each of the stakeholder groups was established and various policy options were identified for addressing obesity in the country *(88)*.

Specific actions of this programme included the simplification of food labelling to ensure that nutritional information such as sugar, fat and salt content and serving sizes could be more easily understood by consumers so that they might be encouraged to choose healthier options *(88)*. In order to improve access to areas for walking and exercise among women (as the main target of the programme), four public gardens were opened in the Greater Amman Municipality; each of these gardens had set opening times specifically for women *(88)*. Furthermore, a Jordan Social Determinants of Health website was established to ensure the accessibility of information relating to the social determinants of health *(88)*. The intention is to expand aspects of the programme to cover other governorates, and to focus interventions on women, children and students by working with schools, universities and civil society across the country.

Several countries in the Region, including for example Pakistan, do have broadly conceived health system strategies which include cross-sectoral collaborations and incorporation of the social determinants of health (see Box 12.12). However, it is uncertain how far these national strategies will translate into transformations of the health care system, specifically into population health systems focused on equity.

Box 12.12. Pakistan's National Health Vision 2016–2025

Pakistan's National Health Vision 2016–2025 aims "to improve the health of all Pakistanis, particularly women and children, through universal access to affordable quality essential health services, and delivered through resilient and responsive health system, ready to attain Sustainable Development Goals and fulfil its other global health responsibilities" *(90)*. Strengthening the health system and improving universal health care are central to the Vision; intersectoral collaboration is also a strong element *(91)*. Equity is one of its principle values, alongside good governance, transparency, accountability and cross-sectoral synergies.

The Vision refers to the impact of political, social, economic and developmental factors on health, and lists illiteracy, unemployment, gender inequality, food insecurity, rapid urbanization, environmental degradation, natural disasters, and the lack of access to safe water and sanitation as the drivers of poor health among individuals and communities. The Vision states partnerships outside of the health sector are needed to improve health and reduce deaths and disabilities. As a way of taking cross-sectoral actions, the Vision supports a Health in All Policies approach and the Government states it will "develop a common vision, framework and a platform with multiple stakeholders from across the sectors to work for health, for instance education, food security, agriculture and livestock, housing, sanitation, water, environment, IT, local government, social protection". The Vision also regards involving communities and improving women's empowerment and local/rural development as the "key channels for cross-sectoral action" *(90)*. The Vision commits the Government of Pakistan to increasing its spending on public health *(91)*.

THE HEALTH WORKFORCE

The Region's health workforce, alongside national and international health care organizations, can potentially play a major role in facilitating the development of population health systems with a strong focus on equity. However, as elsewhere in the world, this potential has yet to be fully harnessed. There are multiple ways in which the health care workforce can take action on the social determinants of health *(86)*. For example, health care staff can provide advice during clinical appointments and refer patients to housing, financial and social protection support services *(3)*. Health care professionals can also be advocates for action at a community level, advocating for improved access to education and employment opportunities *(3, 92)*. Such advocacy at a community level could help to mitigate the negative health impacts which have been associated with unemployment and a lack of quality education. Additionally, health professionals can assist in developing or improving policies on the social determinants of health at local, national and international levels and can promote and input into the Health in All Policies approach (see also Chapter 13). The health workforce, and the organizations they lead, can form collaborative partnerships with other sectors outside of health care which can also have an influence *(92)*.

The World Medical Association has outlined six areas in which the health care workforce could be supported to take greater action on the social determinants of health.

1. **Understanding the issue and what to do about it: education and training**

- Improve access to medical training
- Teach the practical skills and competencies to address health inequity
- Make use of different channels, such as e-learning and community involvement, to teach health professionals
- Develop the social agency of doctors.

2. **Building the evidence: monitoring and evaluation of health inequities**

- Use international, national and local level data to help to design services to meet the needs of patients and communities
- Make use of technology to capture data.

3. **The clinical setting: work with individuals and communities**

- Rethink consultation times and format
- Take social histories and develop care plans and social prescribing
- Create networks in neighbourhoods.

4. **Health care organizations as employers, managers and commissioners**

- Ensure equitable recruitment
- Provide and advocate for good quality employment
- Ensure good practice throughout the procurement chain.

5. **Work in partnership with the health care sector and beyond**

- Form partnerships both inside and outside the health service
- Work with a range of local organizations and services
- Work across government sectors to ensure the health implications of decisions are considered.

6. **Health professionals as advocates**

- For individuals and communities
- For working conditions for staff
- Act as international advocates for health
- Support students as advocates *(92).*

While incorporating the social determinants of health approach into the education and training of health professionals has been acknowledged as an essential part of the overall strategy to tackle inequities through action on these determinants *(86)*, there is very little evidence that this is happening within countries in the Region. While the WHO Regional Office for the Eastern Mediterranean offers an online course aimed at family doctors which provides general information about the social determinants of health and their role in health equity, it is not yet embedded in core medical training curricula in countries *(93)*.

HEALTH CARE ORGANIZATIONS AS ANCHOR INSTITUTIONS

The "anchor institution" approach, which has been developed in other regions in the world, offers a useful model for countries in the Eastern Mediterranean Region seeking to reorientate their health care organizations and systems to deliver health improvement as well as health care. It sees large hospitals and other public institutions as having great potential to improve the health of their workforce and the local population by improving employment conditions, focusing procurement on sustainable and local supply chains, and working with local communities to support better health. A recent analysis conducted in England which has explored the potential of its National Health Service (NHS) to be an anchor institution concluded that, through its size and scale, the NHS could make a positive contribution to local areas beyond the provision of health care through:

- purchasing locally and for social benefit
- using buildings and spaces to support communities
- working more closely with local partners
- reducing its environmental impact
- widening access to quality work *(94)*.

While the NHS is of a greater scale and size than most other health systems, the general approach is transferrable and could be adapted to ensure a greater focus on the health needs of the most deprived and excluded communities in a bid to improve health equity across the Eastern Mediterranean Region.

SUMMARY AND RECOMMENDATIONS

Access to quality health care is an essential component of the social determinants of health approach. This chapter outlines the significant gaps and inequities in access to health care across the Region and the high risk of impoverishment that can result for those on lower incomes who require medical care. There has been a strong focus on achieving universal health coverage in the Region, and while that has not been fully achieved, there are signs of progress. However, the impact of the COVID-19 pandemic threatens access to health care, and both the disease itself and its impacts on health care workers and health care systems threaten to undermine recent progress.

The amount of public funding dedicated to health care in the Region must increase; it is currently highly inadequate. There is also scope to invest further in health care systems in fragile and conflict-affected settings and ensure that coverage includes migrants and those on the lowest incomes, who are currently excluded deliberately or as a result of poverty. The focus on health during the COVID-19 pandemic may help to garner the political and public will needed for further spending on achieving universal health coverage.

Health systems are well positioned to initiate and support health improvements and greater actions on social determinants. We have set out several ways this can be achieved – from every country meeting essential public functions, to reorienting health care systems towards prevention of ill health and improvements in living and working conditions. The health care workforce, including public health and community workers, can work directly with stakeholders such as employers, providers of essential services and the education and transport sectors to support healthy living and working conditions. The health system has leverage within local systems and at national level to advocate for changes in the social determinants, and health care organizations can be leaders in the societal endeavour to improve health and reduce health inequities.

Recommendations	Relevant SDG targets
1. Strengthen universal health coverage across the Region and ensure equitable and affordable access to health care.	1.4
• Increase public financing to support equitable access to health care and reduce the likelihood of catastrophic expenditure on health care.	3.8, 3c
• Include migrants in universal health coverage.	10.2, 10.3, 10.7
• Implement and uphold the right to health, particularly in conflict-affected settings.	16.10, 16a, 16b
2. Implement and ensure essential public health functions for each country to achieve universal public health standards.	17.1, 17.14, 17.16
3. Develop population health systems with a strong focus on equity, prevention and action on the social determinants of health.	
• Focus health care system interventions on social and economic drivers of health-related behaviours and mental health.	
• Develop whole-system approaches to health which include action to improve living conditions and health education and training programmes.	
• Strengthen partnerships with other sectors including housing, transport, social protection and education.	