



Working Paper Series

ISSN 1753 - 5816

Please cite this paper as:

Alami, Randa (2014), "Health, Social Policy and inclusive growth in MENA", SOAS Department of Economics Working Paper Series, No. 188, The School of Oriental and African Studies.

No. 188

Health, Social Policy, and inclusive growth in MENA

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(April 2014)

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The **SOAS Department of Economics Working Paper Series** is published electronically by The School of Oriental and African Studies-University of London.

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Design and layout: O.G. Dávila

Health, social policy, and inclusive growth in MENA

Randa Alami*

Abstract

This paper takes stock of the current status of health sectors in MENA. From the narrow perspective of national aggregate indicators, as with most middle income countries, the region has seen significant achievements. Yet, health sectors face systemic challenges, and suffer from significant and persistent inequities in health outcomes, access, delivery, and distribution of health services. Out of pocket spending levels are amongst the highest in the world, and are driven by: privatisation, poor social protection and insurance coverage, and the inability to respond to the epidemiological transition. Consequently, the financial burden of healthcare forces significant swathes of the population into poverty, or to forgo healthcare altogether. Sectoral policies have been piecemeal and short-termist, with a clear neglect of public health sectors. These deficiencies are more evident if MENA is benchmarked against many of their peers, or against the international consensus of Universal Health Care (UHC).

To achieve inclusive growth, MENA must reverse the disinvestment in public health, and the central importance of health and health equity to development must be reinstated. By the same token, MENA countries must follow UHC centred strategies, which have a good track record in tackling similar challenges in other middle income countries. While part of the difficulties may lie in financing, the lack of political commitment and weak institutional capabilities have also been serious obstacles. Sectoral reforms must target these failures, and governments need to play a more central role in covering the poor and regulating the sector.

Keywords: health, health inequity, universal health care, Middle East, inclusive growth.

JEL classification: I14 I15, I18, H51, N35

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1. Introduction

An enduring mainstream view about the Middle East and North Africa (MENA)¹ is that its old social contract delivered significant historical improvements in health and education, but that the quality of public goods and services “are of concern”.² Like many middle income countries, MENA witnessed improvements in national indicators for many health outcomes, particularly life expectancy, which could suggest a positive picture of health. Yet, such macro-level analysis focused on a few “visible” outcomes overlooks major failings and masks widespread dissatisfaction with the status quo, and has now been challenged in several ways.

Firstly, sectoral studies using household data, assessments that look at elements of the health systems or at operational aspects, and World Health Organisation (WHO) country reports³, all point to widespread crises. Secondly, the upheavals that have shaken MENA since December 2011 exposed many structural problems, including pervasive inequalities and deficient social protection mechanisms. In this context, Karshenas and Alami (2012) show that: the region suffers serious deficiencies in health; public resources allocated to the sector were typically below international norm; and many people were being left behind because of waning government commitments. Earlier, Salehi-Isfahani (2010) and El-Laithy (2011) noted an increasing shift from the principle of universality to an ability to pay, while Elgazzar *et al* (2010) showed that much of MENA’s population shoulder the financial burden of healthcare, with significant proportions forgoing healthcare or fall into poverty as a result.

Arguably then, the question is not whether health outcomes improved historically, but why do improvements continue to elude so many people. In the same grain, policy measures emanating from a narrow approach based on macro indicators may suggest that “more of the same” is needed, whilst the aforementioned evidence clearly points to the contrary. If events of the Arab Spring clearly rejected the current model of non-inclusive growth and showed the need to go beyond standard measures of income, health also needs to be looked at in a more meaningful way. According to Sen (2004), health is a critical concern that is central to social justice.

As such, health in MENA needs to be analysed in an analytical framework that will: yield more consistent perspectives, link the sector to other aspects of public policy (particularly social protection), and produce more relevant policy suggestions. This paper argues that this wider context can be found in inclusive growth, which has already generated helpful insights on health elsewhere.

¹ In this paper, Arab Countries and Arab World refer to: Lebanon, Syria, Jordan, Iraq, Yemen, Egypt, Libya, Tunisia, Algeria, and Morocco. MENA in this paper refers to these countries plus Turkey and Iran. The latter two are mainly used as comparators, with Turkey having made the most progress.

² See Arezki and Nabli (2012).

³ See the bibliography for WHO reports used. As an example of the reforms frequently suggested, a 2007 WHO Libya brief suggested “redesigning the health system”.

It is particularly relevant for MENA because an inclusive growth strategy typically requires countries to:

- improve health outcomes for all,
- reduce inequities in the use of and access to health services, and
- reduce both the financial barriers to and consequences of healthcare, particularly for the poor.

All of these are key failures in healthcare that MENA needs to address.

Using this approach, the main aim of this paper is to examine the inclusiveness of health outcomes and health sectors in Arab countries, and to assess this performance in an international context, and against the benchmark of Universal Health Care (UHC). UHC aims to provide to key promotive, preventive, curative, and rehabilitative health interventions for all, at an affordable price (OECD, 2013; Stuckler *et al*, 2010). As such, it overlaps considerably with an inclusive growth (IG) strategy. The central message of this paper is that to achieve IG, Arab countries must work towards UHC, reverse the disinvestment in public health, address the structural deficiencies that underpin the observed inequities, extend social protection and health insurance to the excluded population, especially the poor.

The rest of the paper is organised as follows. Section II relates health in IG frameworks to the current general consensus on the health equity, and suggests an IG approach that encompasses equitability in outcomes, sectoral structure, public funding, and social protection. Section III applies this to MENA. Section IV classifies the health sectors and outcomes of MENA countries, placing them in an international context and benchmarking them against UHC. UHC is then used to derive ways forward in terms of policy directions. Section V concludes, stressing the need to put back development, equity, and inclusiveness into political priorities.

2. Inclusive growth, equity, and health

It is fair to suggest that until recently, mainstream economics tended to view health and health improvements as a by-product or natural consequence of income growth. This approach to health was strengthened by the dominance in the 1980s and 1990s of the Washington Consensus (WC), which tended to belittle the importance of public health interventions and of the public sector in healthcare. In that framework, health was at best an item of public expenditure that merits ring-fencing. Improving the financing of healthcare systems and catering for unmet needs were to be done by championing the private sector, and by improving efficiency and cost recovery.

This narrow treatment of health was not uncontested. Amartya Sen 's work, rooted in his capabilities approach, had a seminal influence in restoring the importance of health in development, and in highlighting its direct relation to poverty.⁴ Similarly, Anand and Ravallion (1993) show that far from being a by-product of growth, two thirds of the achievements in well-being (life expectancy) could be distinctly attributed to public spending on health, whereas the rest came from poverty-reducing income growth. Sen (2004) went on to add that health achievements need to be related not just to

⁴ See Sen's interview with the WHO, http://www.who.int/infwha52/to_our_health/amartya.html

resource allocation, but also to fairness in process and access, and to the way social arrangements undermine or support health equity and the health of the deprived.

At the same time, a large body of literature was arguing that the importance of health and health investments for growth were grossly underestimated, this being captured by the 2001 Sachs report on health and the macroeconomy. For middle income countries, where life expectancies were reaching 70 years or more, the report emphasised the need to go beyond aggregate outcomes, and to build well-structured systems that reached the poor (2001, pp.16-17). It also highlighted UHC as a main strategy to do so. At the same time, compelling evidence was emerging about the presence of “medical poverty traps”,⁵ reminding us that health spending, particularly in emergencies, is often the way people fall into or stay in poverty. This helped to raise the alarm about the burden of healthcare costs, and spearheaded a large body of WHO-led investigations into Out of Pocket spending by households (OOP).⁶ All these developments certainly helped to build the case for UHC. At the same time, the WC itself was beginning to acknowledge the importance of equity in economic growth⁷. As indicated by Elgazzar *et al* (2010), both streams contributed to the proliferation of research into health inequity around the world. As will become clear in the next section, MENA has been a marginal player and late comer in this field.

These aforementioned changes also resulted in a parallel pendulum in terms of public health and equity-oriented health sector reforms. The WC-inspired budgetary cuts and retreat of public health sectors began to be reversed with the launch of the Millennium Development Goals (MDGs) in 2000. With four main goals dedicated to health,⁸ the MDG process did much to commit national and international resources for health. Together with the Sachs report, it pushed for the establishment of an international consensus on UHC, leading to the adoption of a UN resolution in December 2012.⁹ At its heart, UHC is centred three propositions:¹⁰

- Improving primary healthcare for all is key to catering unmet health care needs.
- Good quality primary healthcare provision is a cost effective way of dealing with most disease burdens.
- Pre-pooled schemes are helpful in achieving the above.

The World Bank has now rallied around this consensus stating that it:

“...supports countries’ efforts to achieve universal health coverage, with the aim of providing quality, affordable health care to everyone—ultimately improving health outcomes, reducing financial risks associated with ill health, and increasing equity”.¹¹

So how does IG fit in in this context? While IG shares similar intellectual drivers of the debate on equity and health, IG does not have a single definition. Instead, it covers a multitude of conceptual

⁵ See Whitehead *et al* (2001).

⁶ See van Doorslaer *et al* (2006), Xu *et al* (2007), Leive and Xu (2008).

⁷ See for example *The World Bank Development Report 2006*.

⁸ These are MDG 3, 4, 5 and 8E (reducing child mortality, improving maternal health, combating HIV/AIDs and other diseases, providing affordable drugs on a sustainable basis).

⁹ Jordan and Egypt were one of the sponsors of the resolution.

¹⁰ See Stuckler 2010, WHO (2010) and OECD 2013.

¹¹ See <http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series>, 28 October 2013

approaches where, depending on the school of thought or institution involved, there is different emphasis on: achieving income growth while reducing inequality, improving social opportunities, ensuring equality of access (to services and markets), and protecting the vulnerable. By the same token, IG has not eliminated ideological differences, so it is possible for the WC to support IG, while continuing to emphasise growth as a primordial tool for fighting poverty (Saad-Filho, 2010). Nonetheless, a fairly representative definition of IG is that it is about inclusive development: it is growth that grants equal access to income growth, reduces disparities, and involves “disadvantaged-reducing improvements in non-income dimensions of well-being” (Klasen 2010, p.3). IG frameworks also typically require the poor to be the main, but not only, beneficiaries of growth, and that growth improves income poverty.¹²

Another key feature of the IG literature is a clear role for public policy, the most commonly emphasised being: the need for investments in public services to support human capabilities, and the mitigation of risks via social protection. Conversely, an IG approach may focus on inequalities and their underlying causes, and may consider the political economy that made growth exclusive. However, here too, the literature can display substantive differences in the role assigned to actors (state vs market forces), and in policy recommendations. Thus, protecting the vulnerable means targeting and social safety *nets* in Post Washington Consensus (PWC) analysis, but means universalism and social protection *floor* for UN agencies.

Because health is crucial aspect of equity, development, and growth, health enters IG frameworks in three major ways: in its own right; as a pillar of equitable growth (both at the micro and macro levels); and as key of the ability to participate in the economy. Health also matters for IG because it matters for poverty reduction, since poor health can compromise the acquisition of both human capital and income, and can perpetuate poverty. In that sense, IG echoes Sen’s work on health equity, and is re-emphasising the need to improve income and well-being simultaneously. Therefore, rather than something new, IG is converging towards the aforementioned consensus on an equity-oriented view of health.

These considerations suggest that an IG strategy has at least three policy components: improving health outcomes for all, reducing inequities in the use of and access to health services, and reducing the financial barriers to and financial consequences of healthcare. As previously argued, public spending on health is now established as a key policy instrument in achieving these aims. By the same token, in terms of achieving IG, success in, and attention to these policy areas are important barometers of economic performance, resource utilisation, and budgetary decisions.

Perhaps the clearest definition of the health dimension of IG is that by the OECD (2013): growth is inclusive to the extent that it leads to better health statuses and declining inequities in access to health services. Hence, a direct way to gauge the inclusiveness of growth as far as health is concerned is to ask the following three questions:

- a) Has growth led to better health outcomes for all?
- b) Have the provision, delivery, and access to healthcare improved?
- c) What has been the impact on the poor and on poverty reduction?

¹² OECD (2013).

In terms of outcomes, progress has traditionally been gauged by looking key health indicators across time, regions etc. These indicators easily lend themselves to being incorporated in index-based calculations of progress in IG, which allows the monitoring and ranking of country performance. This was indeed done for the Asian Development Bank (ADB) by McKinley (2010). Building on the methodology of the Human Development Index and on the literature monitoring progress on the MDG, McKinley grouped key indicators into four major components of a Growth Composite Index. Three health indicators (under-5 mortality, mortality under age of 40, children underweight) are included in the component measuring human capabilities. A similar approach is used by FEMISE (2013), where IG indexes are calculated for MENA and other regions. Here, the IG index is the geometric mean of standardised values of different indicators, grouped into seven pillars, one of them being health. The health index used indicators of: life expectancy, child mortality, tuberculosis (TB) rates (though TB is rare in MENA), public health expenditure in GDP. This analysis did pick up serious under-provision of public funding in health in Morocco and Egypt: IG scores for both countries improved as a result of improved shares of public spending.

The main advantages of these indicators are data availability, and ease of interpretation and comparison. They are also useful in highlighting differences across country groups, or within a region (OECD vs MENA, Yemen vs. Turkey). However, they are less useful in comparing countries which have achieved similar levels of life expectancy, or which have overcome major communicable diseases, which is the case for most middle income countries and MENA. Similarly, both the ADB and FEMISE indexes include indicators for water and sanitation which have severe limitations, though both issues are important for health.¹³ In other words, many aggregate indicators used in IG have a problem of relevance.

The IG literature has also discussed health outcomes using disaggregated and survey data. These tend to be better at capturing inequities and exclusions, and may offer more relevant policy directions. For example, a stylized fact in developing countries is that maternal and infant mortality rates can be 3-10 times higher for poorer women, especially in remote areas. Policies to reduce these rates are different from policies based on an average figure improved by the status of a rich minority, particularly if this minority is using private and expensive services. An example is the study by Tandon and Zhuang (2006). It uses spatial data from both Chinese micro surveys and data from WHO surveys to highlight inequalities in health outcomes across China, arguing that while large income gains have resulted in significant improvements in health outcomes, inequalities undermine the inclusiveness of China's growth, and therefore need to be addressed directly.

Moving on to issues of the provision and access to healthcare, IG has incorporated these aspects in two major ways. Firstly, using national indicators or aggregate data. However, these indicators suffer from the same problems that are currently plaguing MDGs, namely their inability to pick up problems of *quality* (i.e. it is not just the number of staff...), *access*, or *relevance*, which are particularly relevant for middle income countries. However, where available, indicators of spatial distribution of health services, or of access or use of services by income quintiles, do shed light on

¹³ Dagdeviren and Robertson (2011) show that indicators of access to water fail to capture whether: the access is delivered through a fully functioning network; the supply of water is available continuously (not rationed); and it is connected to a functioning sewage system. Similarly, despite high water access indicators, Lebanese people rely on bottled drinking water, while Gaza's fresh water is now unfit for human consumption.

inequities and disparities, and can be useful for gauging the inclusiveness of an IG process. In terms of relevance, many countries have responded to changing health needs by changing the indicators monitored,¹⁴ suggesting that monitoring health aspects of IG need to go beyond communicable diseases or immunisation rates. The second way of looking at health provision has been to look at social opportunity functions, or to construct curves and indexes for access to services by income deciles at different points of time (Ali and Son (2007), Ali and Zhuang (2007), Zhuang and Ali (2009)). These examinations are not easily integrated with other aspects of IG.

Finally, while many IG frameworks consider social protection (e.g. by discussing the coverage of social protection systems), they rarely address health insurance. Likewise, the literature has typically overlooked the financial burden of healthcare and its impact on poverty. However, this dimension can be easily incorporated by looking at OOPs, and the proportion of households who fall into poverty, or for whom health outlays have “catastrophic” consequences. Healthcare payments are considered “catastrophic” for households if they take up on average 10% or more of their total expenditure (the international range being between 5-25%) (Elgazzar *et al* 2010).

Simplistic as it is, this analysis suggests that existing assessments of health in MENA need to be altered in a number of ways. Whilst an IG approach is already more comprehensive, this approach in itself needs to: use a disaggregated level of analysis and more relevant set of diagnostics; go beyond average outcomes to look at health systems and at health insurance; firmly adopt a thematic emphasis on equity in health.

3. MENA health sectors: main features and challenges

This section reviews MENA health sectors from an IG perspective. It uses the taxonomy of health systems used by the WHO (Stuckler *et al* 2010), whereby *outcomes* (health statuses, equity, public satisfaction) are the results of systems of *delivery* (proxied by access and quality indicators), these themselves reflecting the underlying *structural aspects* (financing and infrastructure). It then extends the sectoral assessment to consider the financial burden of healthcare and the availability of social protection.

a. Health outcomes

From the standpoint of the 1960s or even 1980s, improvements in national health outcomes in MENA indicate that health has progressed at great strides. The region has eliminated many of the major communicable “Type I” diseases and epidemics, except perhaps in Yemen, Iraq and now Syria, where some major diseases have reappeared.¹⁵ Except in Yemen and Iraq, life expectancy for men and women has been well over 70 years since mid-2000s. Similarly, national maternal and child mortality ratios tend to be at least twice lower than levels in Sub-Saharan Africa. These indicators

¹⁴ The OECD (2011) monitors inequality in cancer screening, waiting time for elective operations, etc.

¹⁵ Polio has re-appeared with epidemics being reported in Syria and amongst Syrian refugees (*Lancet* November 2013).

place most of these countries in the UNDP's category of medium human development. However, several problems can be noted.

Firstly, progress has tended to stall or slowdown in recent years. The region's average maternal mortality rate may be at par with Latin America or East Asia, yet all countries are behind Turkey, China, Chile or Sri Lanka (see Table 1). Secondly, however sketchy, data point out to a continued differentiation of outcomes by income levels: all indicators are twice to four times worse for the poorer income quintiles than for the richer ones (see Table 2). This trend is also confirmed by surveys and occasional studies,¹⁶ which also document the widespread persistence of regional disparities. Hence, closer scrutiny reveals serious and persistent problems, despite satisfactory achievements at the national level. In most countries, poorer and rural women and children have yet to achieve the outcomes achieved by richer counterparts a decade ago, clearly not an inclusive process.

Table 1: Arab countries: basic health indicators, 1990-2010

	Life expectancy (years)			Maternal Mortality Ratio			Mortality rate, under-5 (per 1,000 live births)		
	1990	2000	2010	1990	2000	2010	1990	2000	2010
Algeria	59.6	70.0	72.9	220	140	97	67.6	45.7	31.3
Egypt	56.2	69.1	73.0	230	100	66	93.5	44.4	22.5
Iraq	57.3	70.7	68.5	89	78	63	46.1	42.8	38.6
Jordan	67.0	72.1	73.3	110	79	63	38.3	28	21.1
Lebanon	66.6	70.6	72.4	52	38	25	38.3	19	9.9
Libya	60.0	72.5	74.8	99	67	58	44.5	27.1	17
Morocco	57.6	68.7	71.9	300	170	100	85.9	52.7	34.3
Syria	66.2	74.0	75.7	240	120	70	38.2	22.8	15.9
Tunisia	62.1	72.6	74.6	130	84	56	49.3	28.4	16.1
West Bank & Gaza		70.9	72.6				44.7	30.1	22.6
Yemen	48.8	59.7	65.0	610	380	200	128	99.1	78.5
Average	60.1	70.1	72.2	208.0	125.6	79.8	61.3	40.0	28.0
Iran	52.3	69.7	72.8	120	48	21	64.8	44	26.2
Turkey	56.6	69.4	73.7	67	39	20	79.8	48	16.3
Upper Middle Income	65.8	70.4	72.6	120.0	91.0	62.0	48.9	36.8	21.0
Middle Income	61.5	67.7	70.4	280.0	230.0	190.0	84.7	66.7	48.0

Source: World Bank Development Indicators (April 2012, May 2013)

In particular, Algeria proudly claims that its maternal mortality ratio of 97-100 per 10,000 in 2010 is above African averages.¹⁷ Yet, this rate has been stagnant for most of the 2000s; it is only at par with Morocco, and clearly worse than Syria's, despite both countries having half its per capita income. This ratio is also high given that most births in Algeria are said to be attended by skilled staff, raising serious questions. As is clear from any field visits, the under-provision and poor quality of maternal

¹⁶ See Assad *et al* (2012), Salti *et al* (2010), Boutayeb and Helmert (2011).

¹⁷ Algeria is classified in the Africa region of the WHO. The aforementioned claim was made by the Algerian health minister for the Oxford Business Group (2012). Actually, in *Health Statistics Profile 2010*, women receiving 4 or more antenatal visits stood at 41% in Algeria and 44% in Africa.

health care is a major deficiency of the Algerian health sector. According to IPEMED (2012) and the latest WHO report, this situation has been going on despite a major inquiry into the problem in 1999.

Table 2: Health indicators by income groups in Arab countries

		Births attended by skilled health personnel (%)		Urban Under-five mortality rate (%)			Underweight prevalence in children under 5 (%)	
		Poorest 20%	Richest 20%	Poorest 20%	Richest 20%	National	Poorest 20%	Richest 20%
Algeria	2006	88	98				5	2
Egypt	2005	73.6	99.2	54.3	26	31.9	8	5
	1995	39.1	93.8					
Jordan	2007	98	99.9	28	22	25.2	3	0
	1990	80.7	95.3					
Morocco	2003	73.2	95.7	50.5	17.6	44.2	15	3
	1992	44.1	82.2					
Syria	2006						10	7
Yemen	1997	7	50	58	35			
	2007/8	17	74	163	73			
Developing countries							40	15

Sources: WHO, MDG database, UNICEF *State of the World Children 2012*, Yemen: *Arab Human Development Report 2009* and *World Development Indicators 2011*

Similarly, improvements in Tunisia's maternal health outcomes are unevenly distributed. In 2002-2006, the rates for unassisted deliveries stood at 5.4 nationally, 11 in rural areas, and a high of 22-29 in the least developed regions. The corresponding levels in 1994 were respectively at 15.8, 30.6, and 34.¹⁸ According to Arfa and Elgazzar (2013, p.5), three quarters of maternal mortality is due to avoidable causes. Morocco suffers from even sharper disparities, but improved its rate of medically assisted deliveries from 18.75 to 45 per cent in five years simply by providing lodging and infrastructure for the personnel of disadvantaged regions (Elgazzar *et al*, 2010).

Survey data confirm a similar pattern of uneven and unequal with respect to child health. At first glance, the region is doing well in terms of nutrition, but children stunting remains a significant problem in Egypt, Morocco, Syria, and Yemen (see Table A1), with the proportion of underweight children amongst poor quintiles significantly higher. Children in poorest quintiles in North Africa belonging are 3 to 5 times more likely to die (Boutayeb and Helmert, 2011, pp.7-9). Similarly, Assaad *et al* (2012) highlight inequalities in outcomes and opportunities in child health in Egypt, Jordan, Tunisian and Turkey. They find that children from poorer locations and poorer households are over-represented amongst poorer health children. Total inequality and inequality in opportunities only clearly improved in Turkey, which also had the lowest health differentials amongst its children.

¹⁸ Data from a 2006 cluster survey in Boutayeb and Helmert (2011).

Therefore, in terms of basic health interventions, there is room for improvements. By the same token, more efforts and additional health interventions are needed for Arab health systems to start responding to the widely documented epidemiological transition to non-communicable diseases or NCDs (diabetes, cardio-vascular and mental diseases, etc).

b. Provision and structures

As a general feature, most MENA health infrastructures remain centred around tertiary care and big hospitals (Femise 2009, El-Laithy 2011, Kronfol 2012 a and b). Services and workforces are also concentrated in urban areas and geared towards richer income quintiles. As shown in Table 3, in terms of hospital beds, except for Yemen and Iraq, the number of beds in most countries is in the range of 1.4-2.4 beds per 1,000 displayed by middle income countries, but below the rates for China, Sri Lanka, or Brazil. The national bed/population of 3.6 in Lebanon has a highly skewed distribution: bed capacity is concentrated around Beirut, where the ratio is 7 (Salti *et al* (2010). Moreover, most of these beds are available only to private or insured users. Similarly in Morocco in 2005, the ratios of private practice per population were 1 per 3,057, and 1 per 59,561 in urban and rural areas respectively (IPEMED 2012).

Table 3: Key health infrastructure indicators per population

	Beds per 1000 people (1) (2005-2010)	Physicians (2) 2010	Primary Health Care units or centres (3) 2010
Algeria	2.1	12.1	..
Egypt	2.2	28.3	2.2
Jordan	1.8	26.5	2.4
Iraq	1.3	6.1	0.7
Libya	3.7	19.0	2.6
Lebanon	3.6	30.7	2.3
Morocco	1.1	6.2	2.9
Syria	1.5	15.1	0.7
Tunisia	2.1	12.3	2.0
Yemen	0.7	3.0	2.0
Average	2.0	15.9	2.0
Middle income	2.4		..
Upper middle income	3.2		..
Iran	1.7	8.9	3.2
Turkey	2.3	15.4	

Notes:

(1) World Development Indicators 2013; Algeria: 1994 data; Libya WHO report (2011)

(2) Per 10,000 people. Source: WHO, except for Algeria and Turkey (WDI 2013)

Rates for Sri Lanka, Brazil and China: 4.92, 14.6, 17.6

Countries with least improvement since 2000: Yemen and Syria

(3) Per 10,000 people. Source: WHO, except for Algeria and Turkey (WDI 2013). Egypt (2005); Libya (2011)

Another worrying feature of health infrastructures is the rising importance of private health facilities, even in public-led systems like Jordan or Tunisia. In Tunisia, in 20 years only 3,000 public

beds were added, with private sector expanding its share to 12.5% in 2008. Likewise, modern and heavy equipment (scanners etc) are concentrated or only available in private facilities (IPEMED 2012, pp.106-108). In Jordan, private hospitals account for about a third of bed capacity, but the occupancy rate is low, often below 50%. Significantly, *19 percent of bed capacity is reserved for the military and their families.* (Ajlouni 2011).¹⁹

In terms of health workforce, Table 3 shows that only Libya, Lebanon, and Egypt have more than 20 physicians per 10,000. Yemen only had 2 physicians and 7 nurses per 10,000. Yemen, Morocco and Iraq are among 57 countries indicated by the WHO as facing a critical shortage of workforce.²⁰ Algerian levels looked better at 12 doctors and under 20 nurses per 10,000, but the ratio of the health workforce *has fallen* from 3.4 to 2.4 per 1000 between 1999 and 2008 (IPEMED 2012), with shortages noted in specialists, surgeons, and pharmacists. According to Ajlouni (2011), Jordan had a low ratio of nurses in the private sector, mainly due to the poor salaries. In terms of distribution of the workforce, except perhaps in Tunisia, country studies show qualified health staff are concentrated around urban centres and richer regions, in line with the concentration in the infrastructure. For example, most Jordanian Ministry of Health personnel were in hospitals (only 6% in primary health centres), and physicians were mostly urban based (90%) and in the private sector (28%) (Ajlouni 2011).

Most countries have a basic, though typically thin, network of primary health care centres, with the ratio typically ranging between 1 and 2 per 10,000 people (Table 3). Turkey, Jordan and Egypt did better than the rest, but substantive physical barriers in terms of adequacy and distance remain in most countries. This is particularly true of Yemen, Morocco, and Syria, where most people have to travel more than 5 km to reach basic health care (El-Laithy 2011). These centres also suffer from a number of problems affecting their role in health provision, such as insufficient resources, dilapidated facilities, or short opening hours. In Tunisia, 45% of primary care centres opened 1 day a week (WHO Country Brief 2006). In Lebanon, only 120 of the 800 primary health care centres are public, the rest being run by NGOs or the private sectors (WHO Country Brief 2010). An important consequence of the weakness of primary care is that patients are forced onto the more expensive secondary and tertiary sectors.

But low per capita ratios are far from being the only problems affecting access or equity. Regional and country studies point to a host of systemic challenges. The first category of issues are: the *quality* and *safety* of the facilities, medication and treatment; ways of monitoring them; ensuring continuous improvements, etc.²¹ Furthermore, there is a lack of effective regulation and/or of regulatory authorities, to impose or control quality and safety standards in either sectors.²² Clearly, quality problems in the public sector are directly related to under-resourcing, so that the public sector is now synonymous with bad quality and long queues (Salehi-Isfahani 2010). Benefit incidence curves in Egypt confirm that only the poorest use the system (El Laithy, 2011).

¹⁹ No comparable data exist for countries with substantive military establishments (Algeria, Egypt, Syria).

²⁰ See WHO (2006), "List of 57 Countries facing Human Resources for Health Crisis", <http://www.who.int/workforcealliance/countries/57crisiscountries.pdf>

²¹ See El-Laithy (2011); Kronfol (2012 b and c); Jabbour (2013).

²² Ibid; also Ajlouni (2011) and IPEMED (2012).

The regional literature also point to a second category of problems, namely inefficiencies in the use of available resources. This can be in unused bed capacity in the private sector in Jordan, high nursing staff levels in Libya, idle high-tech equipment in Lebanon, or in procurement systems. The third and related problem is that of the lack of coordination between providers and between various levels of health care, *and between financing schemes*.²³ This means health systems are unable to mobilise effectively to meet overall healthcare needs. Poor governance and poor administrative capacities also hamper the interface between private and public sectors. In the Syrian case, the poor administrative capacity made the shift to private provision more ineffective and inequitable (Sen and al Faisal 2011).

Similarly, a fourth ubiquitous problem is poor data collection and information systems, and poor management of these, meaning that systems fail to respond to or track: patients, patient needs, or the usage of services etc. Examples range from: the lack of systematic or coherent recording or deaths in Jordan and Algeria; the reliance of Tunisia's FMAP system on manual recording and varied data systems that do not monitor quality or cost; the need for digitization and training staff in using information systems in Libya. Hence a common recommendation has been that all countries desperately need more: evidence based research; systematic and comprehensive data collection; actuarial and feasibility studies; and performance assessments and utilisation analyses.²⁴ Evidence based research is also crucial for improving sectoral performance, guiding policy, or moving towards UHC. Indeed, successful processes of adopting UHC were supported by accurate statistical and actuarial information, and by developing appropriate administrative capacity.²⁵

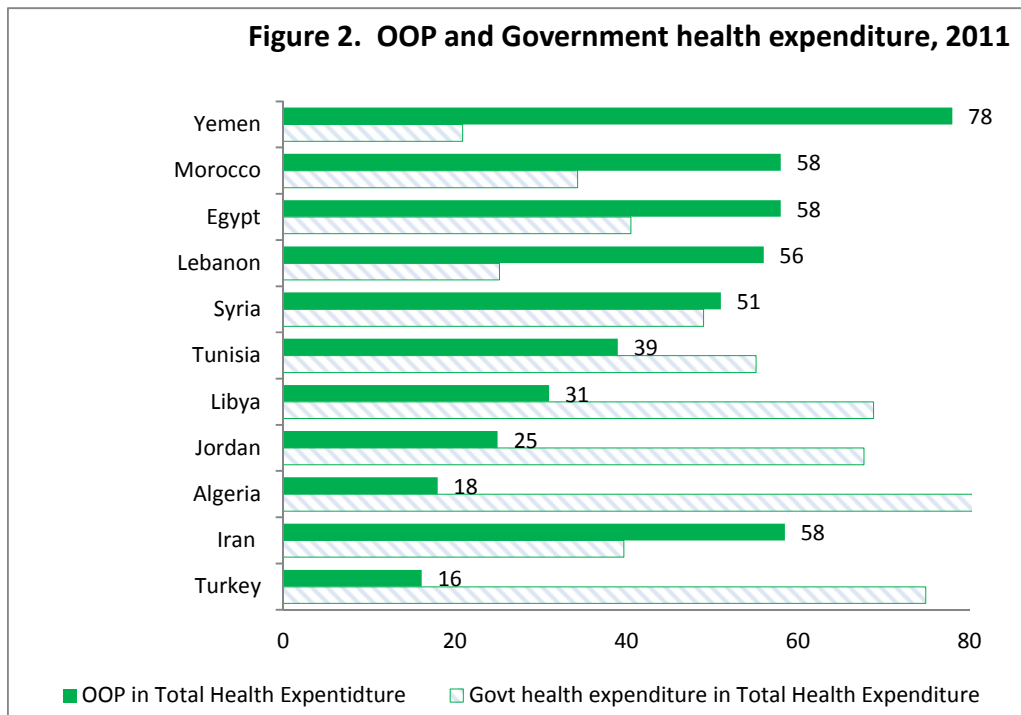
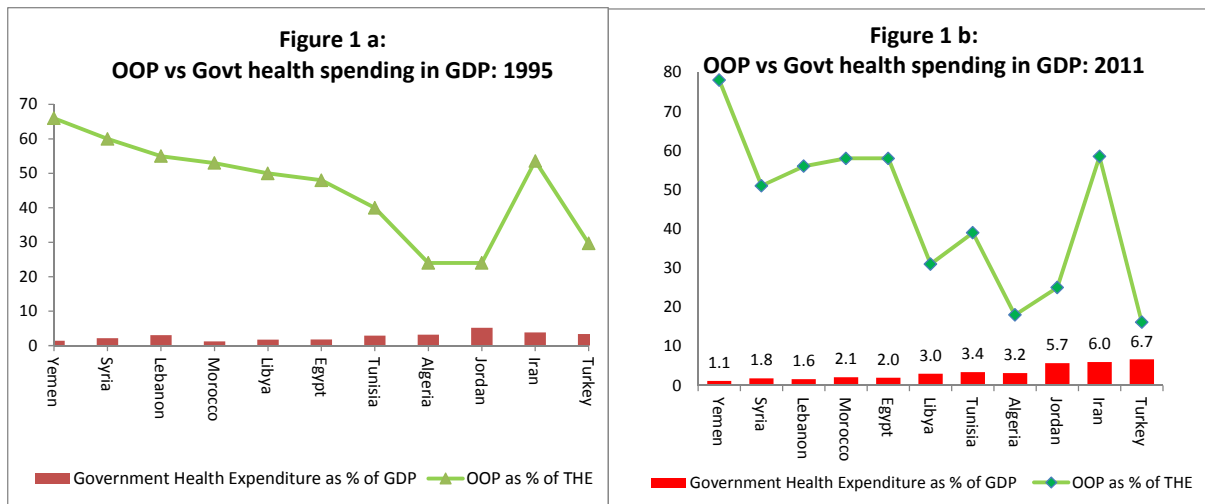
c. Financial burden of healthcare and OOP

OOP spending is now considered a good indicator of financial burden and accessibility of healthcare. High OOP can, but not always, lead to increased poverty, and can be progressive or regressive depending on the structure of financing and health coverage available to households. But in general, countries with 2 percent or less poverty tend to have OOP levels of less than 15 percent (*World Social Security Report 2010/11*). In this sense, it may be suggested that healthcare payments are key reason for under-estimation of poverty. By the same token, OOP tends to be lower (under 20%) where there is UHC.

²³ See Arfa and Elgazzar (2013)

²⁴ See Kronfol (2012 b), IPAMED (2012,) WHO (2010), Ajlouni (2011).

²⁵ van Ginneken (2003) ; Stuckler *et al* (2010).



By definition, OOP levels tend to be inversely related to levels of government spending on health. Figures 1 and 2 show that this is also true in MENA (except for Iran). In MENA, OOP tends to be below 20 percent when government health spending is above 3% of GDP and over 60% of total health spending. This is in line with findings elsewhere, including in recent data for the OECD (2011). The figures also show the relative lack of progress between 1995 and 2011, a trend also confirmed by data in Table 4 below.

Crucially, Table 4 captures a fact previously noted by Karshenas and Alami (2012) and ESCWA (2012), namely that *MENA countries display some of the highest OOP levels in the world*. The regional average of 42.4% in 2010 was higher than the 31.8% displayed by Sub-Saharan Africa. Though comparable to the 48% displayed by low income countries, the MENA average was clearly above the

2010 rates of 33.3% and 36.4% in upper middle and middle income countries respectively. Additionally, MENA OOP levels have been the worst for at least a decade. While in other income groups, levels clearly fell from the 2000-2002 levels of 41-45%, MENA did NOT make any progress. Clearly, MENA households shouldered most of the burden of healthcare in most MENA countries, with Egypt, Morocco, Syria, Yemen and Iran displaying ratios of 50% or more for over a decade.

Table 4: Out-of-pocket health expenditure (% of total expenditure on health)

	1995	2000	2005	2010
Algeria	23.9	25.8	22.9	20.9
Jordan	24.4	38.7	39.8	25.1
Egypt	48.0	58.0	58.4	61.2
Iraq	..	69.9	26.6	18.8
Lebanon	55.3	55.7	41.9	44.7
Libya	50.4	42.8	38.2	31.2
Morocco	52.7	54.1	59.5	53.6
Syria	60.3	59.6	49.5	54.0
Tunisia	37.9	36.2	40.9	39.8
Yemen	65.5	43.7	64.8	74.8
AVERGAGE	46.5	48.4	44.2	42.4
Median	50.4	48.9	41.4	42.2
Iran	53.6	56.2	53.2	57.8
Turkey	30.0	28.0	23.0	16.0
Sub-Saharan Africa	29.6	31.5	34.5	31.8
Middle income	39.4	43.8	42.4	36.4
Low income	53.1	51.9	51.6	48.1
Upper middle income	35.7	40.9	39.2	33.3

Source: World Development Indicators (May 2013)

Despite the importance of the phenomenon, there is only one study of OOP in MENA (Elgazzar *et al*, 2010), which was limited to a handful of countries and to the mid-2000s, due to the paucity of data. According to this study, catastrophic health payments in MENA affect between 7-13 percent of households. Furthermore, 10-35 percent of households *forgo* healthcare because of these costs. OOP spending also have clear effects on poverty, *with 23% more people pushed below the poverty line when health care is taken into account. Thus, in MENA poverty may be underestimated: headcount poverty post-healthcare payments tended to increase by 5-14 percent.* In Yemen, the poorest households display lower OOP because they forgo healthcare altogether. Compared to the situation in Asia (van Doorslater *et al* 2006), these percentages are slightly above the rises in poverty headcounts in Asia when the US\$2 poverty line is used, but in line with the 14% increase when the \$1.08 is used.²⁶ Note that Salti *et al* (2010) warns us that paying for healthcare also has significant impoverishing effects for the non-poor.²⁷

²⁶ In West Bank and Gaza, OOP imply a rise in the proportion of poor households from 14% to 25%..

²⁷ The study shows that "health obscured" households (i.e. whose non-health expenditure makes them poor) face a very high risk of catastrophic payments.

Both Salti *et al* (2010) and Elgazzar *et al* (2010) find that households affected by high OOP tend to be the uninsured, though the impact of the lack of coverage varies. In many countries, the insured may see their spending rise even if much of their spending is covered by social insurance, because of: cost sharing; and of the exclusion of items or levels of care from available schemes (e.g. cover for hospitalisation but not medication, or for cancer diagnostics but not treatment). In MENA, Elgazzar identify the most important components of OOP to be out-patient care in Iran and pharmaceuticals in Tunisia. In rural Iran, higher OOP also reflects from the extension of healthcare and insurance to rural areas and the reduction of forgone healthcare.

Hence, MENA citizens, not just the poor, are forced to bear most of the burden of healthcare, and the access and use of healthcare is increasingly dependent on ability to pay. As with other regions, the poor continue rely on their own resources in the absence of or problems in financial protection, a point addressed in the next section. But beyond the lack of social insurance, in light of analysis in the previous section, it can be argued OOP is particularly high in MENA because of four additional factors:

- 1) The deterioration in the quality and availability of public health, forcing patients to use the less affordable private sector, which is now effectively the dominant supplier in most countries.
- 2) The neglect of primary health care, forcing people to use specialists, secondary or tertiary care.
- 3) The shift to *cost-sharing* and fee recovery, resulting in forgone healthcare for the poor, and high OOP for those who can buy it.
- 4) The inability of MENA health systems to respond to the epidemiological transition to NCDs,²⁸ resulting in big gaps in both services and social protection available.

d. Health insurance and protection

As reflected by high OOP levels, a common feature of MENA is the low level of both private and social health insurance, so that most countries face the challenge of extending and revamping existing financial protection or risk-pooling mechanisms. In fact, only Algeria, Libya and the UAE have UHC, while private health insurance is only significant in Lebanon. According to WHO data, the Arab world is distinctly behind other regions in terms of the availability of social and private insurance.²⁹ Except for Lebanon and the West Bank and Gaza, the coverage of private insurance in MENA is so minimal that there is hardly any data on it.

In principle, in many MENA countries, public healthcare and/or insurance are available to all citizens. In practice, public health insurance is *only* available on a *contributory basis*, and tends to be restricted to civil servants and the military. Therefore, public health insurance only really covers 30%-40% of the population, and the rates are much lower in Egypt, Morocco and Yemen (see Table 7). In Syria, only 20.5% of the population have social protection; the social health insurance pilot

²⁸ This lack of responds is documented by most WHO reports used, IPEMED (2012) and others.

²⁹ In 2011, social health insurance and private plans accounted respectively for 5% and 4% of health finance in the Arab world, and 37% and 17% in the Non-Arab world. OOP for the two regions stood at 31% and 18% respectively.

scheme introduced in 2008 was contributory, and suffered from poor administration and poor data (Sen and El-Faisal, 2011).

Furthermore, the systems are fragmented, because financing and risk management are split between the public funds and public agencies involved, leading to considerable inefficiencies and distortions.³⁰ Consequently, there are often parallel forms of covers, with bureaucratic and budgetary limitations complicate the access to or use of refunds. The use of the private sector therefore tends to be restricted to the rich, insured, urban based population. Indeed in Lebanon, health insurance coverage rises monotonically from 18 to 70 percent between the bottom and top income quintiles (Salti *et al* 2010).

Recently, there have been some attempts to start addressing these gaps, particularly for the uninsured. In Lebanon, apparently hospitalisation has now been allowed for the poor uninsured, but this is hardly known or used in practice (Kronfol 2012 a). Similarly, Morocco has also began work towards UHC, making health insurance mandatory as of 2005 and introducing in 2013/14 RAMED, a health card system for the needy. Similarly, UHC was decreed in Libya in 2009, though the practical implications are not clear (WHO Country Cooperation Strategy 2011, p.27).

On a *de jure* basis, Tunisia has made progress in overcoming the fragmentation between various contributory schemes. In 2007-2008, it merged its two formal medical insurance systems, unified its mandatory schemes, and started defining the basket of services covered (ISSA, 17/12/2008). Yet, the availability of protection is still driven by a contribution rate: population coverage remains at 31% (Elgazzar *et al* 2010). Arfa and Elgazzar (2013) show the persistence of substantive problems. Only 40% of the poor (now believed to be 15 percent of the population) are enrolled in the FMAP program targeted at them. An additional 20% of the population have health cards, but there are severe limitations in practice. Because of the prevalence of co-payments and the reluctance of providers to provide free care, OOP for the poorest is at 68%, and there is widespread dissatisfaction at “worsening” delivery. In other words, even in the best case, substantive financial barriers remain, and schemes aimed at the poor are left wanting.

To sum up, using the WHO’s three dimensions of UHC looking at who, what and how much is covered in terms of healthcare (Stuckler *et al* 2010), it seems that MENA insures or covers less than half of its population, only for basic health issues or with important exclusions, and this public cover typically amounts to half of household health spending.

e. Trends in public health spending

The previous sections clearly showed persisting inequalities in health care outcomes and access in most of the region, forcing people to bear to most of the burden of healthcare. As argued by Salehi-Isfahani (2010), El-Laithy (2011), Karshenas and Alami (2012), this reality is that public health

³⁰ See Femise (2009), El-Laithy (2011). The latter mention that 29 agencies are involved in Egypt. In Tunisia, 10 public agencies collect data but there is no centralised system to deal with poor beneficiaries (Arfa and Elgazzar, 2013).

systems have been struggling to serve larger populations, improve performance, and meet additional health needs with declining or stagnant resource availability. That is not just in terms of the size of public health in the economy,³¹ but also in terms of government allocations within total government outlays.

Table 5: Government spending on health in MENA, 2000-2010

	Govt Spending on Health in Total Health Spending		Govt Spending on Health in Total Govt Spending			Per capita government expenditure on health (PPP int.\$)		
	2000	2010	2000	2005	2010	2000	2005	2010
Algeria	73.3	79.9	8.8	7.9	9	138	160	291
Egypt	40.5	39.2	7.3	6.4	6.1	81	91	115
Iraq	1.1	81.2	0.1	3.3	10.2	<1	82	281
Jordan	48	67.6	10.9	11.6	19.2	147	202	333
Lebanon	32.6	27	7.9	11.9	5.8	246	353	235
Libya	50.8	70	6	5.5	4	214	245	401
Morocco	29.4	35.3	4	4.7	6.9	32	51	98
Syria	40.4	46	6.5	6.8	5.6	65	86	80
Tunisia	54.9	54.3	8.1	9.2	10.8	161	208	295
Yemen	53.8	21	8.3	4.8	4.3	47	39	33
AVERAGE	42.5	52.2	6.8	7.2	8.2	125.7	151.7	216.2
MEDIAN	44.3	50.2	7.6	6.6	6.5	138.0	125.5	258.0
Iran	41.6	40.2	8.4	8.8	10.1	127	228	320
Turkey	62.9	74.8	9.8	11.3	12.8	286	421	777
Brazil	40.3	47	4.1	4.7	10.7	203	279	474
India	26	28.2	7.4	6.8	6.8	17	21	36
Thailand	56.1	75	11	12.4	14.3	93	153	248

Source : Health expenditure series, World Health Organization, Geneva, <http://apps.who.int/nha/database/DataExplorerRegime.aspx>

Indeed, as is clear in Table 5, a striking feature of the levels and patterns of public health spending in most MENA countries is the relatively low levels and declining or stagnating trends. In Karshenas and Alami (2012), public and total health spending were shown to be below international norms: for example, average public spending on health as a share of GDP for 2005-2010 was below the average of 2.7% in Sub-Saharan Africa, except in Lebanon, Algeria, Jordan, and Tunisia. Only in four MENA countries did the government accounts for at least half Total Health Expenditure (THE). In Egypt, Iran, Lebanon, Syria and Morocco, household spending accounted for the lion's share of THE.

Regional indicators point to a similar direction. In FEMISE (2013), the average share of health spending in GDP for the Arab World³² was *the lowest of all regions between 2000 and 2010*. Falling central government health expenditure (CGHE) in Government Expenditure (CGHE/GE) resulted in falling CGHE/THE in Syria and Egypt, whereas improving Moroccan and Lebanese government commitments pulled up MENA shares of CGHE/THE, but only to 38 and 39 percent respectively.

³¹ Note that shares out of GDP have to be interpreted cautiously given the wide variety of levels, be it for similar income levels or at the same point of time. There can be large and small "allocators" (WHO 2011), and a 4% of GDP in Korea is different than say 4% in an LDC.

³² Includes GCC countries.

Similarly, WHO data in Table 6 show that at 7.7%, the East Mediterranean region³³ had the *lowest regional levels* of CGHE/GE.

Table 6: Per capita expenditure on health, group averages, 1995-2010

(PPP int.\$)	1995	2000	2005	2010
East Asia & Pacific	75	99	151	313
Latin America & Caribbean (developing only)	417	468	530	846
Sub-Saharan Africa	75	79	109	146
Low income	27	30	37	64
Middle income	139	162	213	375
<i>Arab countries average</i>	<i>151</i>	<i>157</i>	<i>155</i>	<i>183</i>

Source : Health expenditure series, World Health Organization, Geneva,.

In terms of trends over time, most MENA countries followed a fairly global trend of falling health spending in the 1990s. Thereafter, middle income countries tended to register a recovery, with Government Health Expenditure in Total Health Expenditure (CGHE/THE) rising from 45-46% in 2000 to 52% in 2010.³⁴ In contrast, in most MENA countries, government allocations *fell* or stagnated. Even in Jordan, public spending on health shrank from 4.1 to 3.2 of GDP between 2006 and 2010 (ESCWA 2012).

Data on a per capita basis show similar trends (see Figures 4, 5, and Table 6). In general, levels in Arab countries were lower than Latin America, Iran, Turkey, but ahead of India. On a PPP basis, the regional average THE of US\$183 per capita in 2011 was a little higher than the \$146 per capita in Sub-Saharan Africa, while the regional median for 2010/11 was only at US\$114-115. Egypt, Syria, Morocco, and Yemen are well below the African average. The MENA average also recorded the smallest growth amongst all regions. In constant 2005 US\$ terms, the group average CGHE/THE per capita was US\$92 in 2010, with Algeria, Jordan, Lebanon, Libya and Tunisia spending between US\$115-US\$170 per capita. Worryingly, in 2011, governments in Egypt, Syria, Morocco, and Yemen spent \$51 per capita or less, below the US\$62 argued be needed to reach MDGs (WHO 2010).

Aggregates for government health spending in MENA are also below levels in most reforming countries who embraced UHC (Argentina, Brazil, South Africa, or Turkey). These reformers saw rising shares for health in government outlays, improving outcomes, and falling OOP. *Turkey has been the only MENA country to achieve a decline in OOP and increases in coverage and resources, both in terms of the shares of public health spending in GDP and in government spending.* On the other end of the scale, Yemen saw the already small levels of total and government health spending spiral down, with OOP shooting up to over 75% of THE.

³³ The region covers Arab countries, less Algeria, plus South Sudan, Iran, Afghanistan, and Pakistan.

³⁴ See WHO data series, also found in the World Bank Development indicators.

Figure 3: Average per capita expenditure on health in MENA, 1995-2010

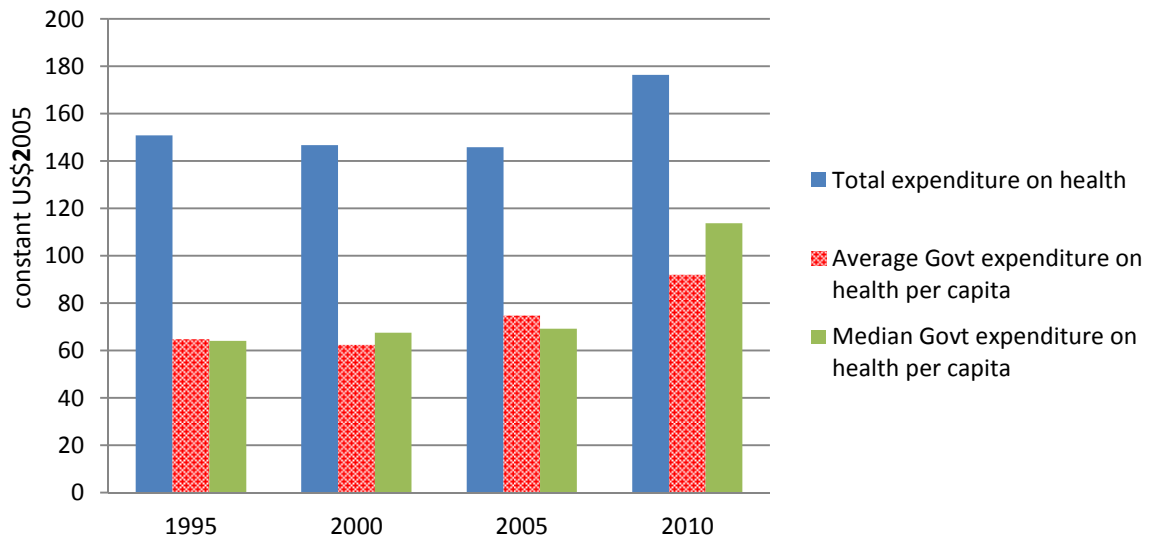
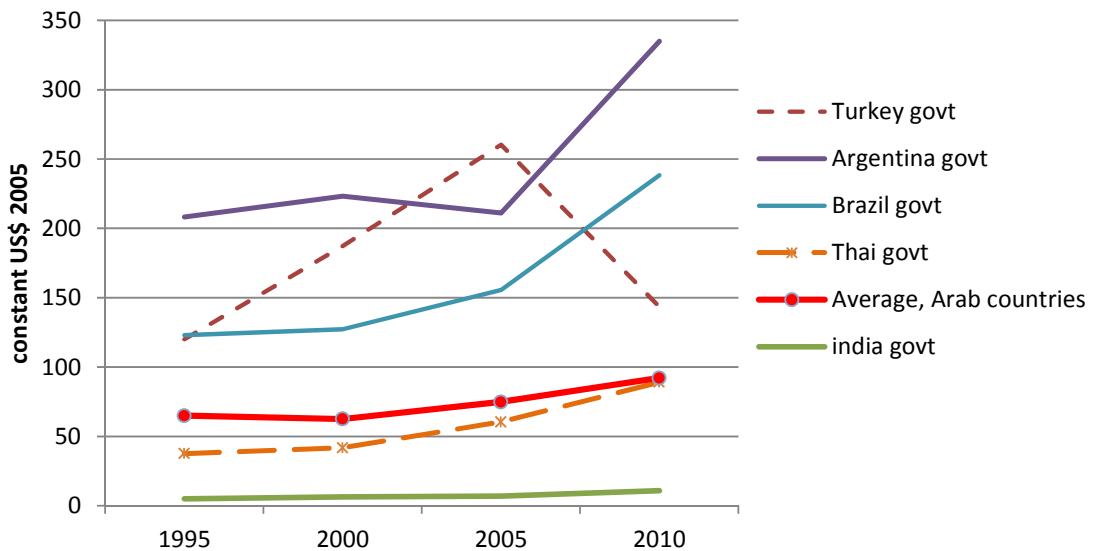


Figure 4: Govt health expenditure pc: Arab countries vs others



4. The political economy of health policies and the international context

Piecing together the above evidence, three propositions can be put forward. Firstly, despite relatively good progress in many health outcomes, MENA countries fair well from a historical perspective but not from a more recent perspective or when compared with many of their peers. Secondly, the region does less than well in terms of equity of outcomes (gender, income, or locality), financial burden, social protection. Thirdly, these inequities reflect serious problems in the provision and delivery of healthcare, both in terms of access and quality. In turn, these problems are rooted in the underlying public financing and infrastructure, both of which are deficient or declining. In order to classify these deficiencies and place them in an international context, the analysis proceeds to benchmark regional health policies against the requirements of moving towards UHC as defined in the WHO framework (Stackler et al 2010). The results are in Table 7.

The first trend that springs to the eye from Table 7 is that few countries have comprehensive social protection, with social health insurance mainly available on a contributory basis. As such, at least 40% of the region's population do not have health cover, though in Tunisia, Algeria, and Jordan, the formal gap in coverage is 20% or less. Secondly, these three countries (and possibly Libya) fair better than the rest of the region, pulling up regional averages for most indicators. Thirdly, barriers to healthcare and vulnerability levels are high, and typically worse than levels in countries with medium level of vulnerability, particularly in terms of financial barriers and shares of OOP in THE.

The table is organised according to levels of estimated deficits in health coverage, with Algeria having the lowest *de jure* levels, and Yemen displaying the largest gaps. This ranking clearly shows that countries with smaller gaps in coverage, lower barriers, and lower OOP, tend to be those where government health expenditure in THE is the highest.

However, data also reveal a number of problems: the scores are often inconsistent with survey results/evidence. For example, Algeria and Tunisia have significant financial and physical barriers that do not gel with the estimated *de jure* level of coverage. Lebanon and Tunisia have high OOP, though their score suggest low financial barriers. Similarly, health staff ratios hide significant bottlenecks and deficiencies.³⁵ So even among the star performers in MENA, the dominance of government spending provision in health care is yet to be translated into low vulnerability and low OOPs, a result achieved by Turkey. For the rest of MENA, huge barriers remain in terms of finance, with staffing and physical resource deficiencies also noted in Yemen, Morocco and Syria. For these countries in particular, it will be impossible to close the deficits without scaling up government health spending.

The aforementioned scores can be used to draw a picture of the regional deficit in health and effective access to health.³⁶ *Panel A* of Figure 5 shows MENA countries with less severe health sector problems, and compares them to Turkey and to the average for countries with low level of vulnerability. *Panel B* depicts MENA countries with high vulnerability, due low health coverage and major deficiencies in provision.³⁷

Clearly, MENA countries face enormous policy challenges in moving towards good quality, accessible and affordable healthcare for all, a key desired outcome of both IG and UHC frameworks. While the large gaps in provisions in Morocco and Yemen are not unusual amongst poorer countries, many of their peers have made better progress in closing many gaps. Moreover, throughout the Arab world, public sectors have at best not done well, and typically suffered a deterioration in performance and status. As Jabbour (2013) notes³⁸, the public health sector in the region is weak "in institutional capacity and human resources, undermining its leadership potential".

³⁵ See Section III.

³⁶ These panels are based on Figure 3.10 of the *World Social Security Report 2010/11*. Here, national outcome indicators (life expectancy, maternal mortality) were removed as there is as not much regional variation.

³⁷ Libya and Iraq are not represented due to the paucity and quality of data.

³⁸ Jabbour (2013) is a summary of the findings on public health in MENA by the regional public health alliance.

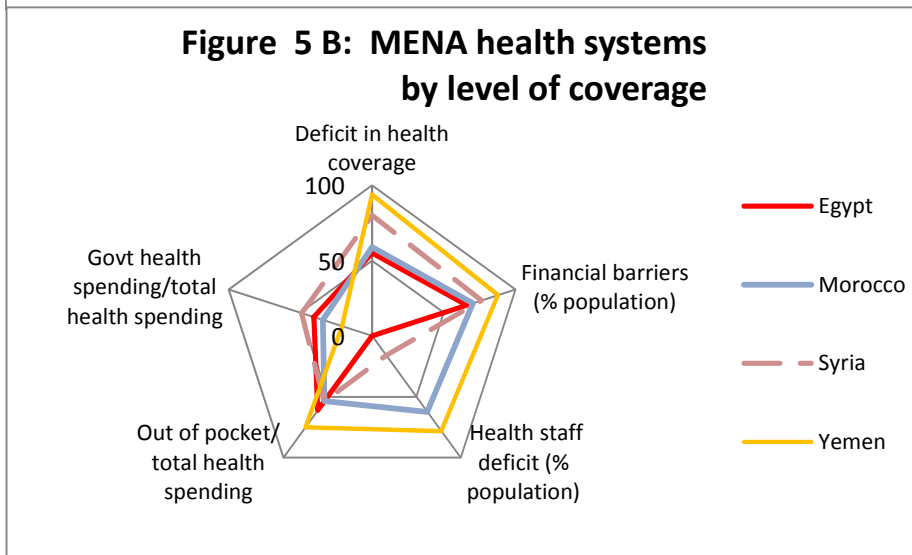
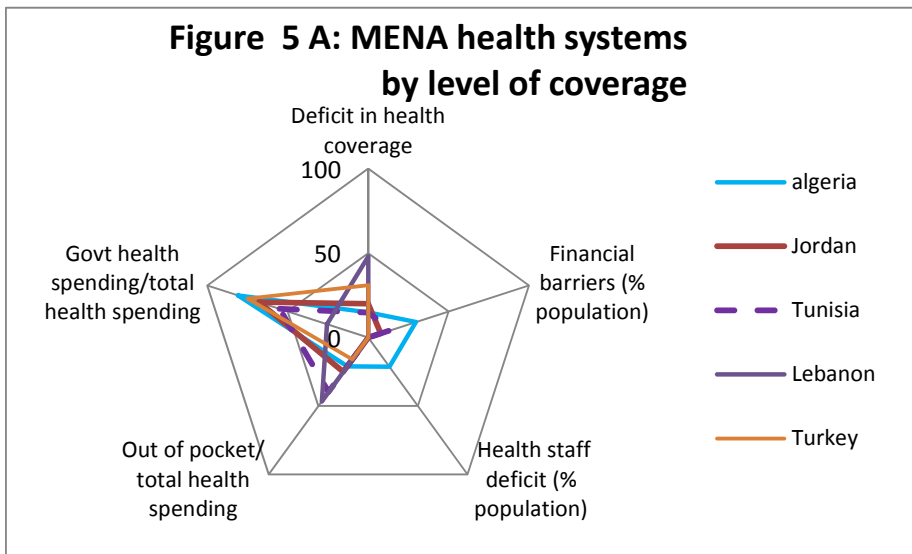
TABLE 7: Coverage and status of social protection and health systems in MENA

Nature and basis of social protection system (1)		Estimated deficit in health coverage (2)	Financial barriers (% population) (3)	Health staff deficit (% population) (4)	Out of pocket/ total health expenditure (5)	CGHE/total health expenditure (6)	CGHE/Govt expenditure (7)
Algeria	Comprehensive, mostly social insurance basis	15	29.8	21.2	20.9	80.8	8.3
Jordan	Limited statutory - contributory, social insurance basis	20	7.8	0	25.1	67.7	17.6
Tunisia	Comprehensive, mostly social insurance basis	14.8	14.5	0	39.8	55.1	10.8
Iraq	Limited statutory - social insurance basis	SI	52	50.3	19.0	80.7	10.2
Libya	Limited statutory - contributory, social insurance basis ?	SI	13.4	0	31.2	68.8	7.9
Lebanon	Very limited statutory - contributory, social insurance basis	48	0	0	46.7	25.5	5.8
Egypt	Semi-comprehensive, contributory, social insurance basis	55	66.1	0	61.2	40.5	6.9
Morocco	Semi-comprehensive - contributory, social insurance basis	59	70.4	62.3	53.6	34.3	6.5
Syria	Limited statutory - contributory, social insurance basis	80	76.5	16	54.0	49.0	5.6
Yemen	Limited Statutory - contributory system, social insurance basis	94	87.9	78.2	75.0	20.9	4.3
<i>Median</i>		<i>51.5</i>	<i>40.9</i>	<i>56.3</i>	<i>43.3</i>	<i>52.1</i>	<i>7.4</i>
<i>Average</i>		<i>48.2</i>	<i>41.8</i>	<i>22.8</i>	<i>42.7</i>	<i>52.3</i>	<i>8.4</i>
Iran	Comprehensive	30.7	6.2	38.5	58	39.7	10.1
Turkey	Semi-comprehensive	31	0	0	16	74.9	12.8
Average for countries with LOW vulnerability		16.25	19.3	14.7	38.5	60	
Average for countries with MEDIUM vulnerability		30.8	39.7	27.3	41.7		

Sources: 1- El-Laithy (2011); 2 - Elgazzar *et al* (2010) and *World Social Security Report 2010/11*;

3- Financial barrier is defined in *WSS Report 2010/2011* as a country THE per capita minus OOP, in percent of the benchmark for countries with low level of vulnerability (\$350 per capita on a ppp basis). Figures were calculated using the same formula and benchmark, but per capita spending and OOP figures used more recent data from WHO (averages for 2006-2010).

4-Calculated using the latest WHO data (mostly 2010), using the formula in *WSS Report 2010/11*. The deficit here is the ratio of health personel in a country minus the ILO benchmark in percent of that benchmark, which is 40 per 10,000. 5, 6, 7 Latest data from WDI and WHO, and relate to 2011.



In many ways, the demise of public health sectors in MENA is due to the same two factors that undermined health sectors elsewhere. Firstly, budgetary pressures and economic crises have contributed to declining trends. Secondly, and more significantly, a large body of literature documents the negative impacts of neo-liberal reforms inspired by the WC, which prioritise cost recovery and financial goals over clinical soundness and equity.³⁹ On the regional level, such a diagnosis is also put forward by Salti *et al* (2010), Kronfol (2012 b), Jabbour (2013) and Sen and Al Faisal (2011). The latter show EU's privatisation-driven modernisation program had negative effects the Syrian public health sector, and was designed with little consideration for equity

The negative impact of declining public health care provisions in developing countries is very palpable, as is its reversal since the mid-2000s. Arguably, the state of Arab public health sectors is worse because whilst many developing countries began to reverse their neglect since then, Arab health sectors have yet to see a clear reversal of fortunes. Many continue to suffer a lack of progress

³⁹ See Whitehead *et al* (2001), Van Doorslaer 2006, Xu *et al* 2008.

even during the period of strong economic growth in 2003-2009. Clearly, the neglect of public health in the region is not just in terms of government resources. As Kronfol (2012 b) and Jabbour (2013) put it, it is more that, throughout the region, the *lack of political commitment come on top of insufficient resources*.

Therefore, it can be argued that the concern about public services, including health, and the equity dimensions of social policy only became a public issue as the result of the protests of the Arab Spring. In Tunisia and elsewhere, poverty and its implications were not seriously discussed before the revolution. Public health services, including the relevant ministries, did not have “political visibility” or “political clout” (Arfa and Elgazzar, 2013). In that sense, it seems that Arab health policies were increasingly out of synch with their populations’ needs. They were also out of synch with sectoral specialists, who have been championing UHC for some time.⁴⁰

Yet, as argued throughout this paper, the UHC is particularly relevant to Arab health sectors, because it can be used to draw a road map that both improves health outcomes and reduces inequity, both of which being important for achieving IG. Indications for this road map can be derived by comparing regional performance against benchmarks from international experiences in working toward UHC, and which are listed in Appendix Table A2. This exercise allows us to suggest the following policy directions.⁴¹

Firstly, more government resources need to be mobilised. Countries need to spend at least US\$65 per capita by 2015, and it is difficult to achieve UHC by spending less than 4-5% of GDP on health. This is particularly relevant for Egypt, Syria, Morocco, and Yemen.⁴² Similarly, the share of CGHE needs to increase, or at least be preserved. After all, the WHO Africa region has already suggested a voluntary target of 15% of government spending. Secondly, OOP levels need to be halved in most countries, particularly amongst vulnerable groups. This means improving on who is covered, and on the proportion of costs included. Thirdly, financial and physical barriers must be reduced by a combination of supply and demand interventions (see Elgazzar *et al* (2010)).

Are these feasible or reasonable propositions? A positive answer can be suggested on at least two grounds. Firstly, there are many successful reformers, including neighbouring Turkey, who followed a UHC-oriented strategy to eliminate the same challenges. According to Atun *et al* (2013), Turkish health reforms, which spanned over a decade, adopted UHC and the right to healthcare as an integral part of citizenship, and gradually filled the gaps in provisions and outreach. For example, the tenfold increase in the number of beds (including the use of spare capacity in the private sector), allowed Turkey to offer free emergency healthcare as of 2008. It improved the access of the poorest deciles through both contributory and non-contributory schemes. Likewise, the number of poor people covered rose from 2.4 to 10.2 million, and their maternal health indicators improved

⁴⁰ See the 2012 book on the state of public in health in MENA summarised by Jabbour 2013.

⁴¹ The virtual absence of data prevents us from looking at a crucial aspect, namely the availability and affordability of generic medicine. WHO data, probably for 2010, show the availability of selected generic medicines in the public and private sectors respectively to be at: 27.8% and 80% in Jordan; 64% and 95% in Algeria; at 96% in Iran.

⁴² Using constant US\$2005 or even constant US\$2011 prices.

dramatically. This expansion was built on a rise of CGHE/THE from under 10% in 2000 to 13.8% in 2011, with THE/GDP rising from 2.7% to 6.1% between 1990 and 2008.

The costs of providing basic healthcare in the rest of MENA has already been studied by ESCWA (2012) using the social protection floor framework. According to this exercise, in 2015, between 0.4% and 6.3% of GDP would have to be spent to extend basic healthcare to all, the scale corresponding to Tunisia and Yemen. Roughly speaking, if these costs were added to current levels of THE and CGHE in GDP, MENA levels would become more in line with international norms. However, because of poor coverage and considerable unmet needs, ESCWA's figures are probably under-estimated. For example, the Tunisian scheme hardly reaches 40% of the poor, and left them with an OOP of 68%. Syria's estimates make little sense in light of the current destruction.

By the same token, these projections are less than health transfers in kind provided in the six Latin American countries studied by Lustig *et al* (2013), and which come on top of other transfers. Brazil was the most generous, giving over 5.2% of the 2009 GDP in non-contributory health transfers. In other countries, health transfers ranged between 2.6% and 4.7% of GDP and were almost equally split between a contributory and non-contributory basis. These transfers play a tangible redistributive role in those countries, so that social spending achieves significant reduction in GINI coefficients and poverty levels, albeit with various degrees of effectiveness.

Unfortunately, in MENA, neither the programs nor the data are available to conduct a similar exercise. Similarly MENA lacks the multi-year, cross-party, national political commitment and holistic approaches that underpinned successful reforms elsewhere. Brazil initially committed to UHC in 1990, and went on to scale up and improve its Family Health Care primary health system since 1996. Its Bolsa Familia program was the result of combining and reforming, in 2003, four assistance programs; a key element in this was the construction by a common information and registry system (ILO 2011, Prasad 2008). Thailand committed to address domestic social problems and extend healthcare to all the population in 2001, in response to the East Asia Crisis. South Korea constructed its public health system over a period of 12 years as of the 1980s (van Ginneken 2003). Similarly, political factors (such as democratic transitions or commitment of major parties), were found to be statistically significant determinants of in cases of UHC adoption (Stuckler *et al* 2010).

5. SUMMARY AND CONCLUDING REMARKS

To sum up, the scant studies of IG in MENA were concerned with macro-economic challenges, and incorporated health by using aggregated health outcomes. Consequently, they continued to emphasise historical achievements. Furthermore, they did not reflect the centrality of health and of health equity to growth, development, and social justice, and were at odds with sectoral studies and household surveys documenting pervasive problems in health outcomes and sectoral performance in MENA.

While falling short of developing a simple measure of IG, this paper, which is largely exploratory in nature, used the wider IG literature to develop an IG approach to health centred on health equity, which is itself at the core of the current global consensus on UHC. In this approach, health is looked at in terms of building blocks of health systems, in terms of ensuring healthcare for all, and in

relation to poverty reduction. Under this approach, sectoral issues could be easily related to inadequacies in social protection, and to the exclusive nature of current health policies. As such, the findings and policy recommendations were in line with studies of healthcare issues in the region, and depicted the following.

Firstly, regional health systems are far from ensuring good health for all. Outcomes are characterised by severe disparities and inequities in terms of income, locality, and gender. Large swathes of the population, particularly poor mothers, barely achieve what the rich minorities achieved a decade ago, and are unlikely to do so if current policies continue. Equity in access and delivery are compromised by a focus on often mediocre tertiary care centred on large urban centres. A few countries (Jordan, Tunisia or Egypt) do better in terms of their networks of healthcare facilities or staff levels, but bottlenecks and shortages remain. Typically, Arab health systems are described as fragmented (between levels of care, civilian/military, insured/uninsured), mismanaged, and inefficient, to which must be added conflict-inflicted damages and setbacks.

Underpinning this situation has been a policy of more or less explicit neglect of the public sector, be it in terms of financing, equipment, or staff. The paper showed that public health spending and budgetary allocations are below the norm for middle income countries. This has meant, *inter-alia*, continued serious under-provision in Morocco, overcrowding of facilities in Egypt, failure to progress on maternal mortality in Algeria, shortages in diagnostic equipment in Tunisia, etc. As a result, the private sector has become the main provider in over half of the countries considered.

The paper further documented the low and ineffective levels of social protection particularly for the poor, and the dearth of affordable risk-pooling mechanisms. Except in Algeria and Libya, social health insurance is mostly contributory, or restricted by a lack of coverage. This has reinforced the shift to the provision and access to healthcare on the basis of the ability to pay, which in turn resulted in forgone healthcare and high OOP. Indeed, a striking feature of the region is that citizens have been shouldering most of the financial burden of healthcare. This burden means that, far from being eased by a golden social contract, poverty in MENA is seriously under-estimated. The paper showed that in contrast to progress elsewhere, OOP levels remain amongst the highest in the world. It suggested that these levels were driven by: the neglect of primary health care, privatisation, poor coverage, and the inability to respond to the epidemiological transition.

To achieve IG, the region needs to address these failures, and policies need to shift from an emphasis on aggregate outcomes to responding to the needs of all, and to the additional challenges presented by NCDs. Consequently, the key policy message is that governments and public health sectors need to play a greater role, particularly in funding and covering the healthcare needs of the poor and the vulnerable. This is largely in agreement with sectoral studies, and with the recommendations emerging from the UHC debate, and which established the feasibility and importance of UHC as a way of achieving such aims, especially in middle income countries. Arab countries urgently need to develop their own road maps in this respect, and the paper showed that they face significant challenges in doing so because their performance is well below the benchmarks required to achieve the associated targets.

However, revamping health sectors is not just about financing requirements. After all, the availability of fiscal resources in the 2000s neither reduced health inequities, nor reduced sectoral deficiencies.

As hammered by mostl sectoral studies, a reversal of fortunes and a convergence towards UHC require three more strategies. Firstly, improving and developing administrative and institutional capacity in public management systems, and in the collection of information, data, and evidence. Secondly, improving the regulatory capacity so as to improve the standard, quality, and safety of care, medication, and facilities in both the public and private sectors.

Thirdly, there is an urgent need for a political determination and vision that would make these issues a priority. This means going beyond short-termist, piecemeal policy suggestions, to addressing them within a holistic road map. In other words, IG requires a political commitment to put development and social justice back into the agenda, and to tackle the political exclusions that led to regional, income, and health inequities in the first place.⁴³ This in turn requires a '*developmental coalition*'⁴⁴ that outlines and implements this vision, and requires involving all concerned through social and political dialogue. In terms of working towards inclusive health, ministries, health industries, and society all need to be involved in designing the road maps. The process itself may strengthen the institutional capacity to sustain IG, and may make citizens feel less excluded from the economy and the state. Alas, the Arab Spring may have created a political opportunity for social justice and for UHC, but developmental needs of citizens are yet to be a priority on political agendas.

⁴³ For an analysis of this exclusion in MENA, see the *Arab Development Challenges Report 2011*.

⁴⁴ Term used termed by Khan (2012). Also see Karshenas and Alami (2012) about the importance of social dialogue.

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Table A.1: Malnutrition prevalence in Arab countries (% of children under 5)

	Height for age			Weight for age		
	1985-1989	1995-1999	2005-2010	1985-1989	1995-1999	2005-2010
Algeria	16.9	22.5		8	11.3	
Egypt	36.6	32.9	30.7	11.6	10.5	6.8
Iraq			27.5			7.1
Jordan		11.1	8.3		3.8	1.9
Lebanon		17.2			3.5	
Libya		21.1	21		4.2	5.6
Morocco	34.5	29		12.7	7.7	
Syrian		26.5	28.05		11.3	10.05
Tunisia	20.3	21.4	9	8.5	5.7	3.3
West Bank & Gaza		10.6	11.8		3.6	2.2
Yemen		54.85			40.9	
Iran		22.4			11.65	
Turkey		19.1			8	

Source: World Development Indicators (Edition: April 2012)

TABLE A2: MENA Situation vs international benchmarks for UHC

Strategies to reach

UHC	Indicators	Regional vs international values
Raising sufficient funds for health	Total health spending p.c Total health spending % of GDP Govt Health spending in % of govt spending Govt Health spending in % of GDP	minimum requirement in low income countries US\$44 in 2009, US\$65 in 2015 South East Asia and West Pacific: target of 4%, though may be insufficient Sub Saharan Africa: voluntary target of 15%; East Mediterranean discussing 8% Difficult to reach UHC at less than 4-5% of GDP; Only Iran Turkey and Jordan above 4%
Levels of financial protection for vulnerable groups; Look at who is covered and proportion of costs	OOP spending in percent of THE; Who are the most affected % of households suffering catastrophe due to OOP % of households impoverished because of OOP	General evidence: little catastrophe at OOP of < 15-20%. MENA average OOP is 42%; Mostly the poor, uninsured, but also non-poor 8-18% more households thrown into poverty Poverty headcount in MENA rises by 5-14% Tunisia: only 40% of the poor reached and their OOP is 68% Less than 50% of MENA population covered by social health;

Based on Table 2,
http://www.who.int/whr/2010/10_chap5_tab02_en.pdf