

Impact of COVID-19 on Health Systems in the Mediterranean

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Since January 2020, the world has been experiencing the worst public health crisis in recent history, with the COVID-19 pandemic affecting hundreds of millions of people in more than 200 countries and territories around the world. The pandemic is challenging health systems, economies and societies around the world and creating unprecedented disruption for the global health and development community. Additionally, it is exposing the fallacy of the Western superiority paradigm; the gold-standard responses were those in East Asia and Pacific, by countries like Singapore, South Korea, China and Vietnam. Wealthier has not been healthier, at least with respect to COVID-19.

The Mediterranean is a dynamic region with diverse social, economic and demographic conditions, spanning countries in southern Europe, the Levant and North Africa regions. Countries of the Mediterranean have demonstrated different responses to the pandemic, particularly during its first wave. Italy and Spain became, at that time, the epicentres of the COVID-19 pandemic in Europe. These countries – rated as some of the best prepared in the world to combat infectious diseases – have dramatically lagged behind, as they failed to recognize the magnitude of the pandemic and make decisions in real time, as the crisis was unfolding. While middle-income countries of the Mediterranean, from the Balkans to the Levant and North Africa regions managed the first wave well, despite having public health systems and economies that could not sustain the pressures of a prolonged outbreak.

In particular, the Eastern Mediterranean Region (EMR) which is the focus of this paper encompasses 22 countries that vary in terms of population health outcomes, health system performance and level of health expenditure. Despite the varying levels of health system preparedness, the strict containment measures implemented in the very early stages of the outbreak have proven efficient in limiting human losses and the spread of the pandemic in the region, particularly during the first wave, in comparison to western Europe and the US (OECD, 2020). As new cases of COVID-19 continue to surge, countries have struggled to mitigate the public health and economic impacts of the virus, while the influx of patients continues to stretch the limits of national health systems. Responses have been particularly limited in countries that are facing conflicts and unrest.

Impact of the Pandemic on Health Systems

As of 24 May, 2021, the 22 countries of the EMR have reported a total of 9,862,629 cases, which represent about 6% of the global count, with 197,947 associated deaths (a case fatality rate (CFR) of 2%). The country that has reported the highest number of total cases in the region is Iran (2,823, 887 cases; 28.6% of the region's total), followed by Iraq (1,164,149; 11.8% of the region's total) and Pakistan (897, 468; 9.1% of the region's total). Iran also reported the highest number of total deaths (78,381; a CFR of 2.8%) followed by Pakistan (20,177; a CFR of 2.2%) and Iraq (16,158; a CFR of 1.4%) (Charts 30 and 31). When factoring population size, a different trend is revealed: Bahrain has the highest total confirmed cases per million population followed by Lebanon and Qatar; whereas Lebanon has the highest total confirmed deaths per million followed by Tunisia and Iran.

The highest CFRs were reported by Yemen (19.6%) followed by Syria (7.2%) and Sudan (7.0%), while the lowest CFRs were reported by Qatar (0.3%) and the United Arab Emirates (UAE) – amounting to 0.3% – followed by Bahrain (0.4%). Testing strategies, and testing rates vary widely with the UAE and Bahrain having the highest number of tests conducted per 1 million population (WHO EMRO, 2021). Although most countries in the Mediterranean have not been among those worst affected by COVID-19, as reflected in the relatively low number of deaths from COVID-19, the pandemic has seriously tested their public health capacities, exposing pre-existing weaknesses in health systems, as well as disparities in access to health care in several countries, particularly in conflict-affected settings (Al-Mandhari et al., 2021). At the same time, the pandemic has accelerated reform in a few important areas. These are further discussed below:

Challenge of Upscaling Health Systems to Respond to the Outbreak while Protecting Health Workers

With the healthcare sector being the epicentre of this unprecedented global pandemic, the surge in

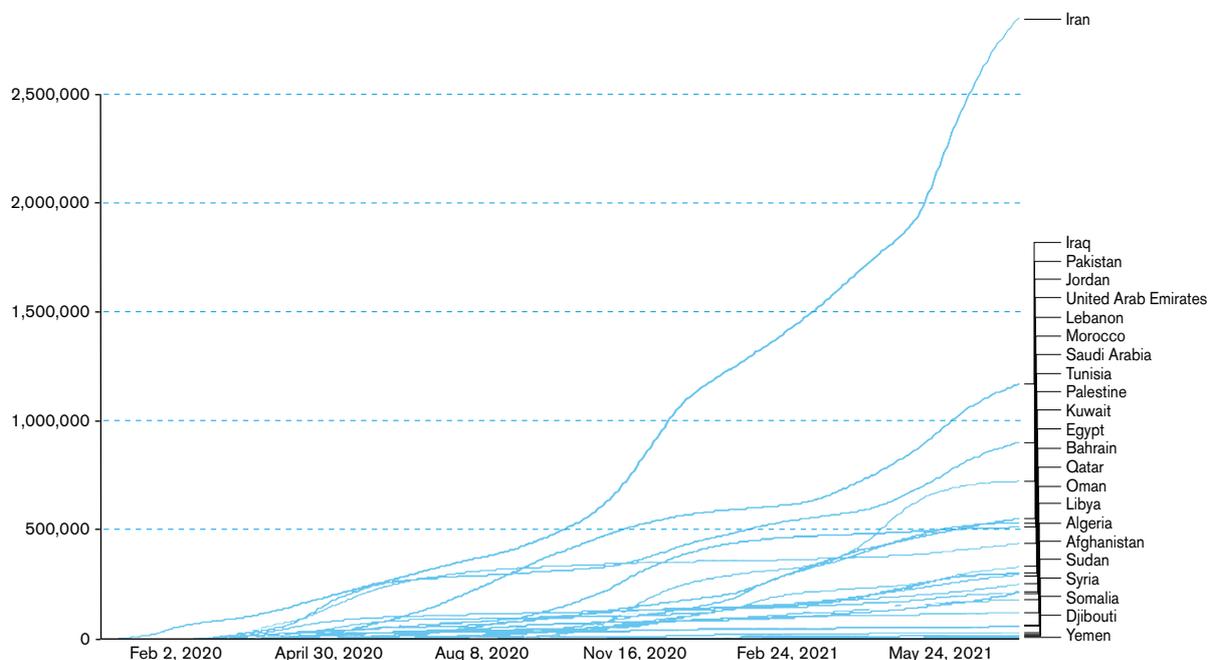
demand has put most health systems under immense pressure and stretched others beyond capacity; countries with fragile healthcare services and infrastructure have been affected the most. Countries are leveraging different strategies to re-purpose health systems, ranging from rapid hiring, training, incentivization and certification of health workers, to the freeing up of bed space and staffing resources to accommodate surges in infected patients, to suspension of non-essential health services, to the expansion of health infrastructure and augmentation of testing capacity (Duran & Menon, 2020).

Furthermore, the pandemic has taken its toll (mental, emotional and physical) on the provider workforce. In a systematic review of infection and mortality of healthcare workers from COVID-19, the region had the highest case fatality rate (5.7 deaths per 100 infections) (Bandyopadhyay et al., 2020).

Disruptions in the Delivery of Essential Health Services and the Medical Supply Chain

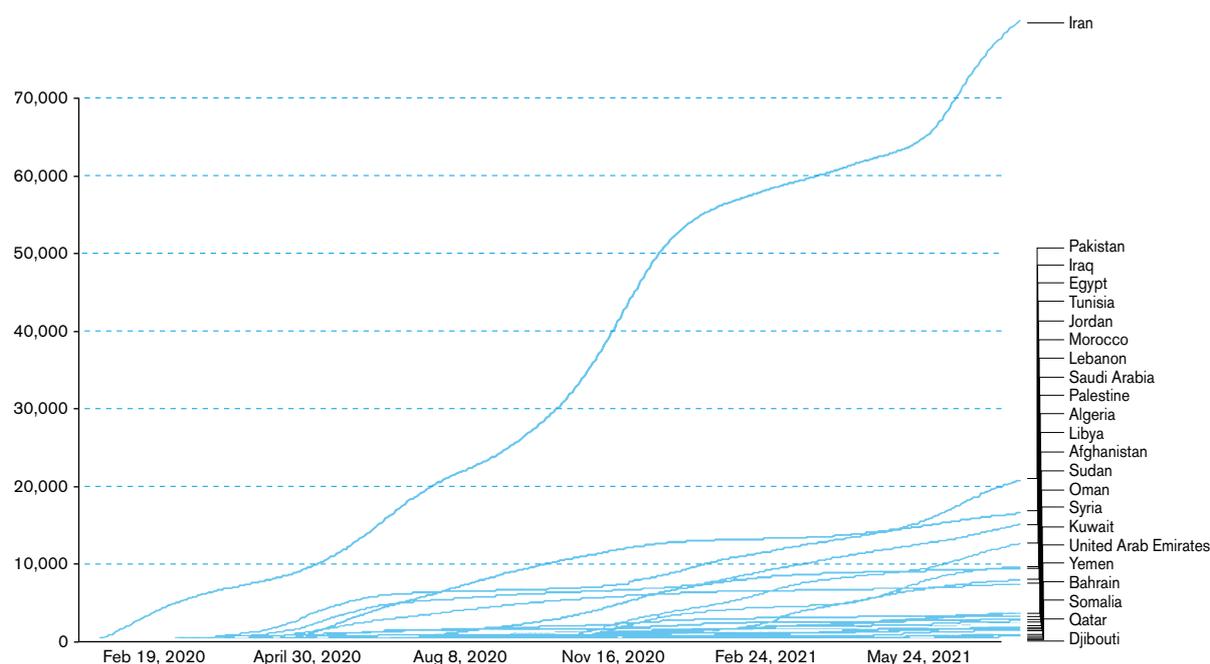
Countries in the region have been struggling to achieve a balance between fighting the COVID-19

CHART 30 Cumulative Confirmed COVID-19 Cases* in EMR



Source: Johns Hopkins University CSSE Covid-19 Data.

* The number of confirmed cases is lower than the number of actual cases; the main reason for that is the limited testing.



Source: Johns Hopkins University CSSE Covid-19 Data.

* Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

pandemic and maintaining essential health services, especially for the most vulnerable populations. An estimated 75% of essential health services have some level of disruption in 13 countries of the EMR, mostly affecting routine immunizations, dental services, rehabilitation services and family planning. Countries have also reported the postponement of non-communicable disease programme activities (WHO, 2020). Additionally, 26% of countries have reported partial or complete disruption of cardiovascular emergency care since the pandemic (WHO, 2020).

Alternative strategies such as hotline support, teleconsultations (more common in high-income countries), novel approaches to ensure the supply of medicines, and redirection of patients to alternative healthcare facilities, are being used in many countries to overcome service disruptions (WHO, 2020). While disruptions in essential health services have decreased recently, levels still reach 40% in some countries (WHO, 2021). In addition, the pandemic has exposed the fragility of the medical supply chain, with shortages of personal protective equipment, ventilators and diagnostic tests in all countries.

Exacerbation of Inequities, Exclusions and a Lack of Transparency in Health Systems

The containment policies implemented by countries have further exacerbated health and social inequities (Al-Mandhari et al., 2021); those living in poverty and crowded conditions are at higher risks of infectious disease outbreak, yet they are unable to effectively use preventive and protective measures against infection. This raises concerns in a region which hosts the largest number of displaced persons in the world, with conflict and insecurity affecting more than half of the countries. Additionally, efforts to address the social and economic determinants of the pandemic have remained challenging and unsatisfactory, with long-term implications on health.

For COVID-19 vaccination, the contrast between countries globally, as well as within the Mediterranean, is striking. For instance, at the start of the vaccine roll-out, 80% of all global vaccines had been administered in just 10 countries, while only around 1% of the region's almost 600 million population had received a first coronavirus vaccine shot. As of 24 May, 2021, all countries in the region have started vaccinating their populations. However, vaccination coverage is still

low, with only eight countries (UAE, Bahrain, Qatar, Kuwait, Saudi Arabia, Morocco, Jordan and Palestinian territories) reporting more than 10 doses per 100 inhabitants. Additionally, less than 5% of vaccine doses in the region have been administered in the countries facing severe or very severe humanitarian crises, reflecting major inequalities in roll-out.

Furthermore, in war-affected countries or those with high levels of corruption, weak health systems and a lack of accountability, there is no guarantee that the vaccines will end up going to those who need them most (Essa, 2021). This crisis further emphasizes the importance of underlying structural issues facing health systems, such as transparency and the fight against corruption, effective public procurement and open government approaches.

Exposure of Inefficient Curative-oriented Service Delivery Models with Inadequate Engagement of Private and Non-state Sectors

The pandemic revealed the inefficient service delivery models in the region which are oriented towards hospital provision and not well aligned with a high non-communicable disease profile in most countries. This also reflects the underinvestment in primary healthcare, prevention and public health, which makes health systems more vulnerable to pandemics. This has been exacerbated by the historically low investment in the region's healthcare sector.

Additionally, in most Mediterranean countries (except Lebanon), the healthcare system is mainly public, but with an increasing private sector prevalence. Countries from the region have engaged with the private sector in different ways and to varying degrees in the fight against COVID-19. At the same time, the pandemic demonstrated that systematic and comprehensive engagement with non-state actors seems to be absent from countries' national response. Furthermore, country efforts have overlooked the important role that other actors such as civil society can play in extending critical services and providing social support and care to vulnerable populations.

Ineffective Use of Information Technology in Order to Make Informed Data-driven Decisions

Comprehensive and reliable data are critical to understand the implications of a health crisis, generate

meaningful epidemiological research and develop prompt and contextualized responses (Wehbe et al., 2021). Yet, the COVID-19 pandemic exemplifies longstanding underinvestment and undervaluation of routine sources of data, a dearth of available disaggregated data and challenges to data sharing across several countries of the region. The pandemic can serve to push for more comprehensive, robust, disaggregated and publicly available evidence (Wehbe et al., 2021).

Acceleration of Progress towards Multisectoral Action and Digital Health

The pandemic is also accelerating some reforms that would have otherwise taken longer. For example, it has triggered efforts towards multisectoral action – a longstanding problem in the region, where siloed ministries and vertical information flows are the norm. While the majority of countries have established national multisectoral coordination mechanisms, permanent multisectoral structures and mechanisms are preferred for their improved chance of sustainability and longevity. The coronavirus outbreak has also hastened the move towards digital health. Several countries have leveraged innovative tech solutions in areas such as contact tracing or online consultations. Yet, there are still wide variations in the readiness of individuals, businesses and societies to embrace a more digitized future.

Implications and Lessons: A Call for Action

At the Country Level

A new vision is needed if we are to strive for health systems that are accessible for all, affordable, of high quality, inclusive, equitable and contribute to the achievement of social justice and prosperity. We need to:

- Develop and update a multi-sectoral emergency preparedness plan encompassing the following main dimensions: stewardship and governance, information management systems, human resources, medical products and supplies, financing, service delivery and community preparedness;
- Scale-up public health system capabilities and human capacity for a more proactive and swift response;

- Re-orient predominantly sick care and curative-oriented health systems towards preventive and primary care;
- Enhance government stewardship and leadership capacity to steer a whole-of-government and whole-of-society response;
- Adopt a Health in All Policies approach and institutionalize multi-sectoral mechanisms with clearly delineated roles, responsibilities and decision-making authorities;
- Incorporate multiple accountability systems and enforcement tools to increase accountability and reduce corruption in health systems;
- Strengthen and institutionalize the use of evidence in health policymaking and practice, invest in robust health information systems and continue to harness and capitalize on technological and data innovations to generate more relevant, timely and high-quality data to inform decision-making.

At the Regional Level

While individual countries of the region might be implementing some protectionist strategies during the pandemic, there is a need for more cooperation, coordination, solidarity and support between countries of the region to effectively control the situation. This requires dialogue across regional member states to agree on key measures as a basis for strengthening forms of cross-border cooperation.

At the Global Level

The COVID-19 pandemic reminds us that no country acting alone can respond effectively to health threats in a globalized world. Global governance is necessary to coordinate the global health response. Yet, global governance systems have failed to inform the fair production, procurement and distribution of resources needed to test and treat COVID-19 infected individuals, revealing deep fissures in global health governance. The ongoing battle for scarce vaccines also highlights the lack of legally binding mechanisms that hold market actors accountable for failing to act for the public good, and the absence of global mechanisms for coordinating the pooling and sharing of resources (Ekström et al., 2021). The COVID-19 pandemic presents an op-

portunity to transform the global health governance landscape, as well as establish and update global governance mechanisms that better reflect the contemporary geopolitical order and truly encourage international collaboration across countries and sectors.

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