IMPROVING THE QUALITY, ACCESS AND EQUITY OF NCD SERVICES FOR URBAN REFUGEES AND HOST COMMUNITIES IN JORDAN

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Purpose

The aim of this policy brief is to highlight opportunities to strengthen the Jordanian health system with a focus on healthcare quality, access and equity for people with noncommunicable diseases (NCDs). It is noted that this brief may be relevant to both government health actors as well as potential partners in the non-profit and for-profit health sectors. This document is based upon a 3-phase process that took place in 2018 and 2019 and included (1) a scoping review of the NCD intervention literature from urban refugee contexts in the Middle East and North Africa, (2) a qualitative NCD study conducted in Jordan with urban based Syrian refugees[3] and (3) an expert consultative convening, hosted in Amman, to identify intervention and policy recommendations.

Scoping review: NCD interventions for refugees in urban MENA.

Qualitative study: Experience of refugees with NCDs residing in urban Jordan.

Expert consultative process: Prioritize focal areas with health, education, humanitarian and academic actors in Jordan.

The first two phases focused on the NCD needs of refugees in urban settings. However, in an effort to ensure quality, access and equity across all communities, the third phase and the final recommendations address common NCD needs across all populations residing in Jordan. This brief also builds on Jordanian national plans and strategies, research and implementation efforts conducted in the Middle East and North Africa (MENA) and examples from diverse settings across the globe.

Jordanian health sector strategies and responses

Jordan has achieved measurable improvements in health and development, while managing social and economic pressures, including conflicts in neighboring nations and the influx of more than one million Syrian refugees. More specifically, Jordan has made impressive strides in the health domain including the reduction of child mortality from 37 per 1,000 live births in 1990 to 18 per 1,000 live births in 2015, and the reduction of maternal mortality from 110 per 100,000 live births in 1990 to 58 per 100,000 live births in 2015.[4,5] In addition, life expectancy stands at 74.4 years and the nation has effectively controlled vaccine preventable diseases, including measles and polio.[6]

Building on these achievements, the 2015-2019 Health Sector Strategy outlines further advances in health with commitments to universal health coverage (UHC) and the improvement of the quality of services provided in hospitals and health centers. The strategy articulates a specific focus on achieving UHC for Jordanian citizens, reducing variation in the quality of care provided and increasing the utilization of clinical guidelines and protocols. In addition to strengthening the health system for Jordanian citizens, the government is also focusing on these issues among refugee populations, as described in the 2018-2020 Jordan Response Plan (JRP). The JRP presents specific health objectives including the improvement of quality and access at the primary, secondary and tertiary levels.

This policy brief is well aligned with Jordan's National Health Sector Strategy and the 2018-2020 JRP. The brief aims to build on Jordan's approaches and identify additional steps for improving the access

and quality of NCD care and the equitable distribution of services for both citizens and displaced populations in urban areas. The following sections outline NCD challenges in Jordan and provide recommendations and case examples from MENA, as well as other settings across the globe.

The NCD burden

In 2018, NCDs accounted for 71% of all deaths globally,[7-9] 74% of deaths in the MENA region and 76% in Jordan.[10 11] The vast majority of NCD deaths are due to cardiovascular disease, chronic respiratory disease, cancer and diabetes.[12] Prevalence of these diseases and their risk factors are particularly high in Jordan.[13-15] In 2018, Abujbara et al. conducted a national survey in Jordan that identified hypercholesterolemia (a risk factor for cardiovascular disease, stroke) in 44.3% of the adult population, a two-fold increase since 1994.[13] Diabetes and impaired fasting glucose prevalence was also high--approximately 25% in 2008, with obesity prevalence at 51.7% of the population.[13 16] Jordanian citizens share a similar epidemiologic profile to Syrian refugees. Thus, the presence of large numbers of refugees has likely increased the health burden and made health system strengthening vital.

In addition to the adverse impact of NCDs on the health of the population, NCDs are also a threat to economic development.[12 17] They decrease productivity among employed adults, increase disability as a result of secondary complications and cause catastrophic spending, pushing people further into poverty.[12 18] NCDs are an urgent concern to various stakeholders who are tasked with promoting wellness among both Jordanians and displaced populations. National health systems and humanitarian actors are challenged by these pressures and are called to adapt and innovate. Opportunities exist to prioritize quality, access, and equity for all those seeking NCD care in Jordan.

Why invest in quality, access and equity?

This policy brief is focused on strengthening the Jordanian health system with specific attention to the quality, access and equity of NCD services in urban areas. In 2018, the Lancet Commission on High Quality Health Systems linked poor quality care to resource wastage (i.e., inadequate care coordination, medical errors), reduced confidence in the health system and poor health outcomes, such as loss of function and mortality.[9] People with NCDs require healthcare that is well-coordinated, comprehensive in nature and continuously available. Several studies, in Jordan and globally, note gaps in the health systems' ability to provide care that meets these criteria.[7 16] It was estimated that in 2016, 5 million deaths in low-and middle-income countries were a result of poor quality care.[19]

The equitable distribution of services is also key to achieving national targets and the Sustainable Development Goals. Equity has been defined as "the absence of systematic disparities in health between groups with different levels of underlying social advantage/disadvantage." Inequity in health systems may result in specific groups being unable to access high quality care. Kruk et al (2018)[9] noted that inequity in the health system impacts the most marginalized (i.e., people with disabilities, the poor, migrants and refugees). The authors also state that health is a public good – a service that exists for the benefit of whole societies.

The purpose of this brief is to present recommendations that will strengthen the quality, equity and access to care for people with NCDs in Jordan. Consistent with Jordan's commitment to the UHC 2030 Compact and the Jordan Response Plan, these recommendations apply equally to refugees and Jordanians living with NCDs in urban settings.

Recommendation #1: Pilot financial mechanisms that reduce healthcare costs and expand coverage for NCD services among vulnerable populations

Refugees and vulnerable citizens experience difficulties accessing high quality health services.[9] In middle-income settings limited access is partly a result of health services being unaffordable. Universal health coverage (UHC) has been touted as the solution to issues of access and equity but has been difficult to achieve for all citizens and displaced persons.[20] One part of the debate centers around who should be included in the term "universal"?[21] The SDGs frame UHC as inclusive of all, including traditionally marginalized groups, such as migrants and refugees.[20] Host countries critique this broad definition as burdensome and unsustainable.[21] However, the protracted nature of forced migrations has resulted in the exploration of new mechanisms for funding health services and reducing cost.[22]

There are various approaches to expanding coverage for marginalized groups. The first option is traditional health insurance.[2] Several countries have expanded their national insurance plans to incorporate refugees, while others have developed parallel insurance schemes, specifically created for refugee populations. For example, Costa Rica's national health service covers select needs for refugees (i.e., emergency care) and requires enrollment in the national insurance plan to access other services. UNHCR, however, covers the costs of the most vulnerable refugees diagnosed with chronic illnesses.[23]

The second option is community-based health insurance (CBHI), which is common for addressing the needs of citizens and is increasingly being considered for displaced populations. CBHI often focuses on the poor and is administered at the community level by NGOs, rather than the national government. This mechanism has been implemented in Ethiopia, China, Rwanda and India to support women and farmers.[24] In addition to traditional insurance and CBHI, other mechanisms have been suggested, including catastrophe bonds and pay-for-performance.[2] Costing exercises and novel funding mechanisms must be explored in order to provide equitable access to high quality care.

Salamat Health Insurance Case Study: Iran[2]

More than 1 million Afghan refugees reside in urban settings in Iran. In response to the protracted nature of displacement, the Iranian government, in partnership with UNHCR and a public-private company, established Salamat Health Insurance Coverage for refugees from Afghanistan. UNHCR contributes to the insurance scheme in order to lower the premiums paid by enrollees and pays the premiums or co-payments for the most vulnerable (less than 15% of the population).

Insurance coverage for refugees was introduced in 2011 and has continuously grown to meet the needs of more members of the refugee community. This insurance package covers hospital stays, outpatient services, antenatal care, family planning, primary care visits, labs, medications and other treatments. The program has been lauded for its innovative approach and for its attention to specific NCD diagnoses including hemophilia and multiple sclerosis, as well as common treatments including dialysis and kidney transplant.

Several other countries have also extended their insurance schemes to cover refugees including Cambodia and Costa Rica. Formal evaluations of the effectiveness of these insurance schemes have not been completed. However, UNHCR continues to champion the inclusion of refugees into national insurance plans and to partner with interested parties, both private and public.

Recommendation #2: Create national level quality improvement (QI) collaboratives aimed at enhancing NCD services across all sectors

Quality improvement initiatives "make changes that lead to better patient outcomes, better system performance and better professional development."[25] Investing in quality also increases the demand for services as people recognize the value of engaging with the health system. QI includes improving healthcare services at the facility level, as well as large-scale national level leaps forward in the quality of care provided to all people, across all settings.[1 26] These efforts may include introducing key performance indicators, adapting clinical guidelines, refining referral pathways, developing checklists to prevent medical errors, or measuring patient satisfaction and reducing patient wait times.[1 27-29]

Key performance indicators (KPIs) measure health systems performance and provide decision-makers with the tools to track progress and improvement, compare quality across sites, reward good performance and support poor performing teams. Examples of KPIs include process measures such as average patient wait time to treatment, percent of diabetic patients who received eye exams, the proportion of people who had heart attacks and received rehabilitation, or the rate of infections post-surgery in the hospital setting. At the national level, health systems benefit from measuring and monitoring these indicators, using the results to guide action to enhance care. KPIs have been implemented in various settings including the United States, Ethiopia, Spain and South Africa.[30 31]

Clinical guidelines and algorithms are also useful for improving the quality of NCD services. These tools aid clinicians in decision-making about medications, counseling, laboratory testing and referrals. Studies in MENA region note challenges to introducing clinical guidelines and encouraging adherence among physicians. However, other studies present effective interventions that aid clinicians in using these tools (on electronic platforms) to change their practice behavior, better document service delivery and improve the quality of care provided to people with NCDs and other comorbidities.[27 32 33]

Ethiopian Hospital Alliance for Quality Case Study: Ethiopia[1]

Between 2012-2014, the Ethiopian Ministry of Health (MOH) implemented a national level quality collaborative/alliance aimed at improving patient satisfaction across 120 government hospitals. This work was commissioned in reaction to large variations in health systems performance and healthcare quality across various districts and regions.

All hospitals were enrolled in the collaborative and had to report patient satisfaction on a quarterly basis to the MOH. Fifteen hospitals were recognized and rewarded for their performance on patient satisfaction and other related key performance indicators (KPIs). These high performing facilities were then assigned the role of mentor/coach to other hospitals that struggled with achieving key targets. Coaching efforts took place by phone and through tailored workshops. Coaching focused on identifying operational problems, understanding root causes and piloting solutions to gaps in patient care.

Hospitals were provided with a Change Package, a concise, creative tool for introducing best practices that would improve patient satisfaction. The Package contained practices from across Ethiopia, highlighting the feasibility of transforming service delivery in resource-limited settings. A pre-post intervention study identified significant changes to patient satisfaction nationally.

Conclusion

The rising burden of NCDs in Jordan calls for greater investment in healthcare quality, access and equity for marginalized Jordanians and refugees living in Jordan. Opportunities exist for national level, transformative approaches to expanding insurance coverage and engaging in continuous quality improvement efforts. Insurance models that cover the most vulnerable will not only expand access and equity but also improve health outcomes and reduce catastrophic expenditures among people with NCDs. In addition, large-scale quality improvement initiatives will motivate the health sector to provide NCD care that is comprehensive, coordinated and continuous and thus reduce the likelihood of increased suffering, morbidity and mortality among people with long-term illnesses. A focus on quality, access and equity is centered in the global commitment to the SDGs and will aid Jordan in building a resilient health system that can effectively respond to future stress, pressures and crises.

Further reading

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