

Systems, Resources and Access to Health

Tackling Inequalities in Global Health

Case Study 1- Health Insurance Coverage in Mali

- Mali organises health coverage around three schemes:
 - AMO (Assurance Maladie Obligatoire): compulsory insurance for public and private formal-sector workers, financed by contributions from workers and employers.
 - Mutuelles de santé: community-based system aimed at the informal and agricultural sectors. Members pay a premium and enrolment is voluntary.
 - RAMED (Régime d'Assistance Médicale): a non-contributory public scheme targeting extremely-low income people (5% of the population)
 - Private insurance also exists, but it is small.
 - Mali has also been reforming this system into a single universal scheme, the RAMU, to reduce fragmentation.

Country	% poverty rate	% unemployment rate	% informal employment rate	% coverage with any insurance	% coverage with national (public) health insurance	% coverage with private or employer health insurance	% coverage with community- based health insurance (CBHI)
Mali	43.6	9.7	42.6	5.6	1.6	1.8	2.6

Case Study 1- Health Insurance Coverage in Mali

- Define UHC. Why equity is one of the central tenets of Universal Health Coverage?
- Does Mali's current health insurance system cover the whole population? Is coverage equitable?
- Is health insurance coverage a pro-rich or pro-poor inequality? What are the possible main factors contributing to inequalities in health insurance coverage? Name three.
- As a policymaker, how would you design RAMU to achieve more equitable and universal health insurance coverage? Do you think a publicly owned health insurance system that rely substantially on tax financing would be more equitable than a system that depend on voluntary contributions?

Case Study 2 – Mobile Health Interventions

- Case A:

In country A, the Ministry of Health spearheaded a nationwide mobile health initiative aimed at reducing maternal and child mortality in remote rural areas. Rather than relying on disparate external software or short-term projects, the government established a unified, standardized SMS-based platform developed through Community Health Workers (CHWs).

- **Implementation Process:** The central government mandated a single standardized protocol and provided simple feature phones to all front-line CHWs across the country. The system captured real-time data on pregnancy tracking, emergency triage, and child nutrition, directly integrating it into the national health management information system. CHWs received continuous training and clear supervision, embedding digital reporting into their daily public health duties.
- **Initial Observation:** Early implementation showed high reporting compliance among CHWs and consistent data flow from rural villages to the central ministry.

Case Study 2 – Mobile Health Interventions

- Case B:

In country B, mobile health projects emerged primarily through a constellation of international donors, NGOs, and global health partnerships addressing specific health domains (e.g., malaria, HIV).

- **Implementation Process:** Multiple independent organizations deployed distinct, highly innovative mobile applications and pilot programs across selected districts. Some focused on direct-to-consumer health information via SMS, while others built localized clinical reporting tools. These project operated highly in technical silos without overarching national data standard or central government integration.
- **Initial Observation:** Following the introduction of these advanced mobile technologies, immediate positive impacts were observed in pilot regions, increasing local health awareness.

Case Study 2 – Mobile Health Interventions

1. What are the key visible differences between case A and case B?
2. How do you think these two projects will develop in the long term? Why?
3. Is technological innovation alone enough to create lasting change in a health system, or can it create new challenges? In making digitalization of health care systems sustainable, what else do you think is needed?
4. Should digital health interventions be standardized at the national level, or should they be adapted to local contexts?
5. Do you think digitalization of health systems is a bridge or a barrier to vulnerable populations?
What conditions should be met for digital health technologies to truly serve the most vulnerable rather than widening inequality gap?

Case study 3 - Healthcare worker shortages in Australia

- Even though Australia has universal healthcare, there are significant discrepancies within Australia in terms of health outcomes.
- Major health gaps are present between urban and regional/ remote areas, with the National Rural Health Alliance finding that people in very remote areas live 13 years less than their urban counterparts. Regional and remote areas are often under-serviced, with most healthcare specialists concentrated in urban areas.
- Gaps in health outcomes are also present between Indigenous and non-Indigenous Australians, with a difference of 8 years in life expectancy. This is due to multiple factors, including systemic racism and ongoing impacts of colonisation leading to lack of access to key health determinants such as housing and education.

Case study 3 - Scenario

Coleman Creek is a hypothetical town of 3,500 people, 400 km from the nearest regional hospital. About 22% of residents are Aboriginal and Torres Strait Islander. The town's two primary care physicians are both over 60 and plan to retire within three years. The local hospital has lost its obstetric service, so pregnant women travel 3 hours for birth and many relocate from 36 weeks, leaving children and family support behind. The nursing roster depends on agency and temporary staff, who rotate every few weeks, so patients rarely see the same healthcare worker twice. The Aboriginal Community Controlled Health Organisation (ACCHO) has two vacant health worker positions and a waiting list for chronic disease management.

Case study 3 - Discussion

- What do you think the consequences of this workforce shortage is?
- Can you identify any similar health system inequalities in your own countries?
- How can we encourage clinicians to work in regional and rural areas? Australia currently pays temporary healthcare workers in remote areas a much higher salary to try and incentivise them to go there. What are the ethical considerations of doing this, and do you think having a highly paid short term workforce will solve the issue or make it worse?
- Australia also often tries to fill healthcare worker shortages by recruiting overseas healthcare workers, often those from low/middle income countries. How does this impact health equity globally?

Case study 4- healthcare worker shortage in a LMIC

- Health care worker shortages are also present in LMICs. One additional factor to consider is that doctors and nurses often migrate to wealthier countries who are experiencing their own workforce shortages (such as Australia).
- Country Y is a LMIC of around 40 million people. It is politically stable, has a national health insurance scheme and has a community-based primary care model, all elements of a well functioning health system. Yet it has lower numbers of doctors, nurses, and midwives than what the WHO considers necessary for universal healthcare coverage. Health workers are also concentrated in the largest cities, with much lower levels in regional and remote communities.
- Country Y has good medical and nursing schools, and has trained many healthcare professionals who migrate to countries such as the US, UK, and the Gulf for better opportunities. Country Y is on the WHO Health Workforce Support and Safeguards List, which lists countries with the most pressing health workforce needs and advises wealthier countries against actively recruiting from them. Country Y paradoxically also has trained nurses and other health workers that have at times been unemployed because of budget limits, even while hospitals are understaffed.

WHO workforce safeguards list 2026

AFR			AMR	SEAR
Angola	Equatorial Guinea	Niger	Haiti	Timor-Leste
Benin	Eritrea	Nigeria		
Burkina Faso	Ethiopia	Senegal	EMR	WPR
Burundi	Gabon	Sierra Leone	Afghanistan	Papua New Guinea
Cameroon	Guinea	South Sudan	Djibouti	Solomon Islands
Central African Republic	Guinea-Bissau	Togo	Somalia	
Chad	Liberia	United Republic of Tanzania	Sudan	
Congo	Madagascar		Yemen	
Cote d'Ivoire	Mali			
Democratic Republic of the Congo	Mauritania			

Case study 4 - Scenario

- District D is a hypothetical rural district of 180,000 people in Country Y. It has one district hospital and several community health centres. The hospital was designed for a much larger clinical team than it has now. It has two doctors, one who is a young graduate on mandatory service who will leave after a year. Two experienced midwives recently resigned after receiving overseas job offers, and the hospital cannot easily replace them. Senior nurses who trained in the capital have left, so those remaining are mostly recent graduates without much experience. Women with obstetric complications are referred 4 hours by road to the regional hospital, often at night and often without an ambulance. Unemployed nurses live in the district's towns, but the health service has no approved posts or funding to hire them.

Case study 4 - Discussion

- What do you think the consequences of this are?
- Can you identify any similar inequalities in your own countries?
- How does emigration impact inequalities within Country Y as well as between Country Y and wealthier countries?
- How do we balance maintaining adequate levels of healthcare workers in LMICs while recognising individuals' right to make choices to better their lives? Is the WHO workforce support list fair?
- What would a fair global health workforce look like?
- If there are high levels of trained nurse unemployment and also shortages of staff, how can the issue of lack of public funding be resolved?