Egypt

ILO CONSIDERATIONS ON THE SOCIAL HEALTH INSURANCE REFORM PROJECT IN EGYPT

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Foreword

The ILO completed an in-depth social budget for the Government of Egypt in 2001. In September 2008, Dr Mohammed Maait, Deputy Ministry of the Ministry of Finance, sent a formal request to Dr Michael Cichon, Director of the Social Security Department of the ILO, to extend its technical assistance to the Government of Egypt about the new proposal on social health insurance legislation, in addition to a request to provide support in relation to the pension reform and other financing issues relevant to the social security system of Egypt.

It was agreed to carry out two ILO advisory missions: the first focusing on the reform of the health insurance policy and the second on the pension insurance and financing considerations relevant to the health insurance reform. Subsequently, Mr Assane Diop, Executive Director of the Social Protection Sector of the ILO met H.E. Minister Boutros Ghali during his mission to Cairo, Egypt in April 2009 to discuss considerations on the social health insurance reform project.

This report focuses on the request for technical assistance on the policy aspects in the context of the social health insurance reform. It concentrates on the assessment of the reform proposal with a view to achieving nationally and internationally agreed objectives as regards the design, financing mechanisms, benefits, and administration proposed in the draft laws no 8 and 11 on social health insurance. The financing considerations are only preliminary in view of the arrangements with the ILO.

The present report provides an analysis of key information and data publicly available and received during discussions with high-level representatives of the Government, the Labour Unions, the Employer Associations and the international community active in the field of social health protection in Egypt. Further, a visit to the Suez Pilot Project permitted to evaluate progress and potential impacts of a possible nationwide implementation.

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Acronyms and Abbreviations

CCO	Curative Care Organizations
FHC	Family Health Centre
FHF	Family Health Fund
GDP	Gross Domestic Product
GOE	Government of Egypt
HIO	Health Insurance Organization
HSR	Health Sector Reform
ILO	International Labour Organization
MIS	Management Information System
MOF	Ministry of Finance
MOHE	Ministry of Higher Education
MOHP	Ministry of Health and Population
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NGO	Non-governmental Organization
PHC	Primary Health Care
PTES	Patient Treatment at the Expense of the State
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

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An ILO team headed by Dr Xenia Scheil-Adlung and including Ms Veronika Wodsak, Mr Thomas Wiechers, Ms Mara Skaletz and Ms Aliya Rao carried out the assessment. The financing and actuarial aspects of the report were reviewed and approved by Ms Anne Drouin and Mr Hiroshi Yamabana. Further, Mr Yousef Qaryuti, Director, ILO Subregional Office Cairo and his team significantly supported the assessment mission undertaken from the 7th of March 2009 to 13th of March 2009 to Cairo and Suez, Egypt by Dr Xenia Scheil-Adlung and Veronika Wodsak, ILO Geneva. The report has been approved by Dr Michael Cichon, Director of the Social Security Department.

The ILO mission team who went to Cairo in February would like to thank the ILO Office in Cairo, Egypt, particularly Dr Youssef Qaryouti, Director SRO Cairo and Ms Nashwa Belal, ILO SRO Cairo, Ms Amal Mowafy, ILO SRO Cairo provided extremely valuable support in organizing the mission. Further, logistical support and advice during the mission contributed significantly to the success of the mission. In addition, this report has significantly benefited from the valuable input of colleagues from the ILO Social Security Department, Geneva.

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1. The socioeconomic context

With the largest population in the Arab world, Egypt counts about 82 million inhabitants. 63.5% of the population is aged between 15 – 64 years, 31.8% of the population is aged between 0-14 years and 4.7% of the population is 65 years and over[1].

Egypt ranges among the lower middle-income countries with a GDP of USD 5,500 per capita. Most significant parts of the GDP accounted for services, public administration, tourism and the Suez Canal.[2] The international economic crisis is affecting Egypt's economy: While it grew by 7.1% in 2007 and by 7.2% in 2008, recent analyses forecast an economic growth of only 3.6% in 2009.[3]

The workforce in the formal economy is mainly involved in manufacturing and tourism, and it is likely that these two sectors will be hit hard by the economic crisis. Additionally, in the near future decreases in government revenues from the Suez Canal, tourism and remittances from a significant lower number of migrants than in the past are to be expected. The situation is tightened by expected increases in unemployment that will fuel the informal economy and might lead to public discontent. In contrast to 2008, a year with high inflation rates of more than 20%, inflation has been slowing down and is estimated to be 9.1% in 2009 and 7.1% in 2010.[4]

Currently, unemployment is particularly affecting specific groups –women and the youth are the most affected: "Among the age group 15 to 24 years, 23 percent of males and 61 percent of females are unemployed compared to 2 percent of males and 10 percent of females in the age group 25-64 years".[5]

The workforce in the informal economy accounts for some 40 percent of the total workforce or 6.5 million people.[6] Based on estimates in 2004, the informal economy contributes about 20 percent of GDP[7].

Work in the informal economy is usually characterized by longer working hours, with a lack of employment security or social safety nets and low wages. That holds true in the case of Egypt as well. Using data from 1998, studies have found that "informal workers earn approximately 84% of what formal economy workers earn."[8] The informal workers' situation might deteriorate more in times of crisis, because one of their major employment branches, tourism is already being affected by the economic downturn. Employment in the informal economy raises questions not only of poverty, but also of gender-based poverty. For instance the period from 1988 to 1998 saw a decline in the wage gap between men and

[1] Central Intelligence Agency. 2009.

[2] Economist Intelligence Unit. 2008.

[3] Economist Intelligence Unit. 2009.

[4] Economist Intelligence Unit. 2009.

[5] Ministry of Economic Development. 2008. Page 9.

[6] Avirgan et al. 2005. Page 8.

[7] O'Regan. 2004.

[8] Avirgan et al. 2005. Page 15.

women in the formal economy, whereas the wage difference became even larger in the informal economy: "In Egypt women earned an average of 70% of male wages in formal employment and 82% of male wages in informal employment in 1988. By 1998, women's average wages as a percentage of men's had risen to 86% in the formal economy but declined in the informal economy to 53%. These changes took place as real wages fell dramatically in both sectors."[9]

Given the impact of the financial crisis on tourism where informal economy workers are active, a related impact on poverty is to be expected. Currently, the national poverty level is estimated at 19.6 percent by the government. The percentage of the population living under USD 2 a day is estimates between 20[10] and around 40[11] percent. While the percentage of the ultra poor living beyond USD 1 a day has decreased over the last years, an increase in percentage of the population living beyond USD 2 a day could be observed.

There is a significant regional segregation of poverty levels in Egypt. Whereas governorates like Alexandria, Cairo and Suez are relatively wealthy, the rural area of Upper Egypt shows a disproportionately high poverty level – 39.1% of the population in this area lives beyond the national poverty level. –compared to 5.7% in metropolitan areas. Poverty in rural Upper Egypt is also characterized by being concentrated specific areas. Data reveals that the poorest hundred villages are located in Upper Egypt as well as "one third of the poorest one hundred sub-districts or Sheykhas exist in Sharkyia, Menoufia, and Qena".

Through its geographic targeting[12] in poverty reduction efforts, the government of Egypt works on smoothing this imbalance. Further, in order to address the situation, Egypt has launched an extensive poverty reduction programme. Its objective is a reduction of poverty by 15% until 2011/12. Two programmes are implemented in pursuit of this target: 'Geographic Targeting' and 'Supporting the Most Vulnerable Families'.

More generally, poverty is also addressed by government subsidies: An estimated 80 % of the population is receiving some form of subsidies, e.g. in the form of food (bread) subsidy or oil subsidies.[13] While these subsidies seem to reach some of the poorer segments of the population, there is large agreement within the government that they could be targeted more efficiently.

As far as the Human Development Index is concerned, Egypt ranks 116 out of 179 countries in the HDI, which is low compared to its categorization as a (lower) middle-income economy. The 2008 Human Development report points out that "…there has been consistent improvement in Egypt's overall HDI score since 1996, although the component

[9] Avirgan et al. 2005. Page 8

[10] World Bank. 2007.

[11] Bradley. 2009.

[12] The geographic targeting social policy is based on reallocating resources, public expenditure and policy interventions to reach the neediest people in the poorest areas, and emphasize the complementarities of public services and household support.

[13] The 1997 Egypt Integrated Household Survey (EIHS) results indicate that 82.9 percent of Egyptian households held ration cards. (International Food Policy Research Institute. 2000)

indicators in the areas of health, education, and income have been less consistent throughout the period".[14]

2. The Health Care System

2.1. Relevant national and internationally agreed objectives

This section outlines the most important nationally and internationally agreed objectives of Egypt's health system. First, national objectives as prescribed in the constitution, the health legislation and the government's reform strategy will be presented. This is followed by an outline of internationally agreed objectives, which should be taken into account when striving for universal access to health care. Reference is made to the Universal Declaration of Human Rights, the Millennium Development Goals and ILO's strategy towards universal access to health care based on ILO Conventions and approaches in the field of social health protection.

2.1.1. Constitution

The fundamental national document defining essential features of the health system is the constitution. It provides the basic principles that related laws should be built on. The most important articles in the constitution relevant for the design of the health system are the following:

"*Article 16*

The State shall guarantee cultural, social and health services, and work to ensure them for the villages in particular in an easy and regular manner in order to raise their standard."

"*Article 17*

The State- shall guarantee social and health insurance services and all the citizens have the right to pensions in cases of incapacity, unemployment and old-age, in accordance with the law."

This shows that the responsibilities of the state concerning health care are explicitly regulated by the constitution: Article 16 emphasizes the role of the State as the guarantor of social and health services. Special attention is given to the improvement of the situation in rural settings. Article 17 commits the State to guarantee health insurance. The related laws are outlined in the following section.

2.1.2. The current health insurance legislation

The current legislative framework on health insurance established the Health Insurance Organization as an autonomous public entity in charge of the health insurance scheme. The legislation has developed over several decades between 1965-1997, during which time

[14] The inconsistencies in the health indicators do not necessarily mean a decline in the health profile of the population. One reason for inconsistencies is for example a new more demanding definition of access to sanitation that caused a decline in the percentage of households with access to sanitation. (UNDP. 2008. Page 33.)

successive laws passed and gradually extended health insurance to every larger parts of the population:

- Law 32, 1975, regulates health insurance coverage for civil servants, and employees of public authorities. The financing of the costs of their treatments relies on monthly payroll deductions from their wages, 0.5% paid by the employee and 1.5% by the employer. The law allows co-payments up to 50% to be regulated by decree.

- Law 79, also 1975, provides coverage for private and para-statal employees as well as pensioners. The contribution rate is set at 1% for employees and 3% for employers, 1% for pensioners. Companies are allowed to opt out of the HIO coverage under law 79 and purchase private health insurance for their workers instead. In this case, employers still have to contribute a solidarity payment of 1% of the salary to the HIO. No co-payments are foreseen for people covered under law 79.

- Decree 1, 1981, allows widows entitled to a pension to request health insurance coverage. Their contribution, 2% of their pension, is deducted directly by body that pays the pension.

- Law 99, 1992, introduces a mandatory enrolment of kindergarten children and students of private and public schools. Besides the yearly lump sum of EGP 4 per child or student, additional contributions of 10% of the school enrolment fee have to be paid for students or children in private schools or kindergartens, up to a maximum of EGP 50. The public treasury subsidizes this scheme with EGP 12 per year and student of public schools or of private schools that receive public subsidies. Article 8 foresees the creation of a special account for this subscheme within the HIO: the public treasury shall clear deficits; surpluses remain in the account for the next year. This law introduces an extension of social dialogue in the HIO: besides three ministerial delegates, a representative of the parents becomes member of the HIO board of directors.

- Decree 380, 1997, regulates the coverage of pre school children. This is financed through a lump sum contribution of the each child's guardian of EGP 5 and further public subsidies

An overview of the coverage of different groups by the various schemes is provided in the table below:

Table 1. Social health insurance schemes in Egypt

Law No. Year	Coverage
Law 32 (1975)	Government employees
	Para-statal employees
	Private employees
Law 79 (1975)	Companies can opt out
	Pensioners
	Widows
Law 99 (1992), School Health Insurance Program (SHIP)	School age children
Ministerial decree 380 (1997)	Pre-school children

2.1.3. Human rights

The Human Rights to health and social security are enshrined in the United Nations Universal Declaration of Human Rights and are fully reflected in the national legislation. As clearly stated in the title, the declaration emphasizes the universality of these rights. In the health system context, the most important articles of the Declaration are the following two:

Article 25

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Motherhood and childhood are entitled to special care and assistance. (…)"

Article 22

"Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality."

2.1.4. Millennium Development Goals

In 2000, the international community adopted a core set of objectives which are highly relevant for progress in development and which emphasize their commitment to work together towards eliminating poverty by pursuing the Millennium Development Goals (MDGs). The Millennium Development Declaration recognizes explicitly the interdependency between social and economic development and establishes targets and indicators for measuring progress and/or achievement of these goals. MDGs 1, 4, 5 and 6 are of particular relevance for the health sector. Below is the list of the health-related MDGs together with the respective indicators established in the declaration. MDG 1 on poverty and hunger has been included due to the strong relation between income level and health outcomes and the importance of nutritional status for good health outcomes (see indicators for eradicating hunger):

Table 2. Indicators of MDG 1, 4, 5 and 6

MDG 1: Eradicate extreme poverty and hunger
Target 1a : Reduce by half the proportion of people living on less than a dollar a day
Target 1b : Achieve full and productive employment and decent work for all, including women and young people
Target 1c : Reduce by half the proportion of people who suffer from hunger
MDG 4: Reduce child mortality
Target 4a : Reduce by two thirds the mortality rate among children under five
MDG 5: Improve maternal health
Target 5a : Reduce by three quarters the maternal mortality ratio
Target 5b : Achieve, by 2015, universal access to reproductive health
MDG 6: Combat HIV/AIDS, malaria and other diseases
Target 6a : Halt and begin to reverse the spread of HIV/AIDS
Target 6b : Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it
Target 6c : Halt and begin to reverse the incidence of malaria and other major diseases

Since the passing of the declaration, the MDGs have become a universal frame of reference for all states and development actors. The goals and indicators are constantly referred to and applied when designing, implementing and evaluating policy reforms, development projects and programs, donor activities and development progress of poor and middle-income countries. Egypt has shown strong commitment to these goals.

2.1.5. ILO's strategy towards universal access to health care

Social health protection is defined by ILO as all public and private measures that aim at achieving universal access to health services including e.g. national health services, social or community-based health insurance or cash transfers. ILO's strategic approach towards universal social health protection coverage[15] is based on worldwide experience and aims at accelerating progress towards universal access to health services.

While there is no single right approach for all countries, there are some principles that should be taken into account when striving for universal coverage. They include that the government should play a pivotal, active role as facilitator and promoter and define the operational space for each subsystem. This entails developing and enforcing an inclusive legal framework for the country and ensuring adequate funding and comprehensive benefits for the whole population. The framework should also regulate voluntary private health insurance, including community-based schemes, and consider regulations to ascertain good governance and effective protection. This framework establishes a rights-based approach to social health protection, which takes into account the health service needs and the capacity to pay, thereby realizing the objective of including the population not covered by social health protection. In this context, the ILO considers the minimization of out-of-pocket (OOP) spending and introduction of pre-payment mechanism a key objective as OOP spending is the most inequitable way of health-financing, leading to delays in seeking care, underutilization and impoverishment.

The ILO strategy takes into account that countries tend to use multiple health financing mechanisms such as national health services, social health insurance, community-based

[15] ILO. 2008. Pages 6, 34, 42f., 48.

insurance and cash transfers in parallel without coordinating them. This often results in gaps in access, disjointed or overlapping subgroups of the population, while others remain uncovered, and high out-of-pocket payments significantly impacting on poverty.

Given the diverging performance of the various schemes for e.g. the formal and informal economy with regard to reaching out to the poor a pragmatic strategy is suggested to work towards providing effective access based on sustainable funding. It consists of rationalizing the use of pluralistic financing mechanisms aiming at creating linkages and synergies between schemes and improving all schemes with the objective of providing universal access to affordable quality health care. In this context compulsory and voluntary schemes, for-profit and non-profit schemes, public and private schemes ranging from national health services to community-based schemes should be considered, if they contribute, in the given national context, towards achieving universal coverage and equal access to essential services for the population.

A pragmatic strategy to rationalize the use of various health financing mechanisms with a view to achieving universal coverage and equal access should be developed in stages ranging from developing a coverage plan to fill gaps in an efficient and effective way to improving health financing mechanisms, designing adequate benefits packages and creating institutional and administrative efficiency based on social dialogue.

ILO Convention 102 (Social Security) can serve as an orientation when it comes to benefit packages. The benefits shall be chosen with view to maintaining, restoring or improving the health of the person protected, the ability to work and to attend to personal needs and include general practitioner care, including domiciliary visiting, specialist care, pharmaceutical supplies; and hospitalization where necessary.

In case of pregnancy and delivery and their consequences, benefits carried out by medical practitioners or qualified midwives are foreseen under Convention 102 including pre-natal care, confinement care, post-natal care and hospitalization where necessary.

As for contribution rates or co-payments, the convention explicitly stresses the importance of avoiding catastrophic health expenditures, taking into account the ability to contribute.

The convention also refers to the role of social dialogue in the administration and oversight of the health protection scheme. Social dialogue can play a major role in health policy development and reform by providing the workers and employers' associations as well as others with the opportunity of expressing suggestions and concerns. Participatory decision-making is crucial when it comes to sustainability, e.g. in social health insurance tripartite governance constitutes an important tool in this respect.[16]

Evidence from many countries shows that successfully extending social health protection requires consensus building on various levels and entities of government, social partners, civil society and others. Also the discussions in Egypt on features of the reform point in this direction.

2.2 Core indicators on health

Over the last decades, Egypt has achieved significant progress concerning the health status of the population. Life expectancy has been rising and reached 70 years for females and 66

[16] ILO. 2002b. Page 6.

for males in 2006. In comparison to the average of the Eastern Mediterranean Region, Egypt's life expectancy is roughly five years higher. [17]

This can partly be attributed to the extension of primary care coverage, a broad network of health care facilities in urban and rural areas and a relatively high density of medical staff in the country as well as improved water and sanitation.[18] Additionally, immunization programmes for one-year-old children are close to coverage of 100% with regard to diseases such as tuberculosis, polio, hepatitis B, diphteria-pertussis-tetanus and measles.[19.]

Regarding maternal and child health, Egypt has also been able to achieve progress. Maternal mortality could be reduced by one quarter between 1992/92 and 2005. Both under-5 and infant mortality have been reduced considerably: between 1990 and 2006 they were reduced by 62% and 57% respectively.[20] In spite of these positive developments, regional and related socio-economic differences in maternal and child health are disconcerting: Especially in Rural Upper Egypt, the poorest region of the country, child mortality rates are noticeably higher than the national average and the rate of births attended by skilled medical personnel is lower.[21] There are also further challenges ahead, as the overall health status of Egypt's population is low compared to countries of a comparable income level.

Overall, the disease burden in Egypt is typical for a transition country, where typical disease patterns of low income countries such as infectious diseases and malnutrition, co-exist with non-communicable diseases such as depression and heart disease, typical for rich countries. Egypt thus faces a double burden of disease, as the poor still struggle with diseases typical of developing countries, while the rich suffer from typical diseases of a developed society. It is of high importance for the health system to anticipate the future development of morbidity profiles.

The by far most frequent cause of death in Egypt is the ischemic heart disease (21%), followed by cerebrovascular disease (7%) and hypertensive heart disease (6%).[22] These three major causes of death reflect Egypt's development towards a typical mortality structure of a developed country. Still, there are other important shares of deaths caused by communicable diseases like lower respiratory infections or diarrhea. This shows that communicable diseases, typical of developing countries, still play an important role in Egypt. Egyptian is also facing a high prevalence of liver disease as well as relatively high levels of hepatitis B and C, demonstrated by that fact that liver cirrhosis is a major cause of death (see table below). During the coming years, communicable diseases like tuberculosis, malaria, respiratory and perinatal diseases are expected to decline, especially in the wealthier parts of the population. At the same time, diseases related to higher standards of living and longer lifespan will probably become more frequent: cancer, diabetes, cardiovascular, respiratory and digestive diseases. By 2030, the most prevalent

[17] WHO. 2006b.

[18] In comparison with the neighbor countries: Nursing and midwifery personnel per 10.000 population: 34 in Egypt, 22 in Algeria, 8 in Morocco; physicians density: 24 in Egypt, 11 in Algeria, 5 in Morocco (source: WHO. 2009a)

[19] WHO. 2009a.

[20] WHO. 2009b.

[21] WHO. 2009b.

[22] WHO. 2006b.

diseases are expected to be HIV/AIDS, depression, cerebrovalscular conditions, heart disease and chronic obstructive pulmonary disease.[23]

Table 3. Deaths and lost years of healthy life by selected causes, 2004[24]

Cause	Deaths per 100,000 of population	DALYs ('000)
Ischemic heart disease	148.1	1,076
Cerebrovascular disease	50.1	422
Hypertensive heart disease	40.2	244
Perinatal conditions	36.3	1,134
Lower respiratory infections	31.2	499
Nephritis and nephrosis	29.8	248
Cirrhosis of the liver	26.5	262
Diarrhoeal diseases	16.2	404

2.3. Social Health Protection

2.3.1. Organization

The current system is based on pluralistic and fragmented financing by various schemes including tax-funded and social health insurance schemes covering different groups of the population and providing access to different benefit packages and different providers, both public and private.

Both, the tax-funded and insurance-based schemes run hospitals and health care facilities that provide preventive, primary and curative care (secondary and tertiary care) such that provider and purchaser functions are not separated. In addition to the MOHP and the HIO, the MOE and the Curative Care Organizations (CCO – a non-profit provider of inpatient care) also run their own facilities. Its eight regional branches operate public health insurance programmes and provide health care at their own provider network including hospitals, health centres and clinics.

All staff members in public facilities are subject to the Civil Service Code and therefore MOHP and HIO continue to fund the base salaries and medical and administrative overhead of providers. Other providers are contracted on the base of a mix of capitation with reduced fee-for-service rates for in and outpatient services and receive performance-based bonuses.

[23] Hewitt Associates SA. 2008. Page 42.

[24] WHO. 2009d.

2.3.1.1. Tax-funded schemes

The tax-funded scheme/public sector includes delivery of free services at the hospitals and facilities operated by the MOH as well as a special tax funded scheme for treatments at the expense of the state (PTES).

Public sector hospitals provide free services or services at nominal fees. The quality of care at public facilities is low due to a number of factors; the most important are related to underfunding and understaffing. Further, a lack of standards, oversight, incentives and training for staff play an important role.[25] Major steps of the government to upgrade healthcare facilities and improve management therefore support the current reform process.

Access to primary care is organized through the Family Health Fund (FHF) in some governorates, however, some 60% of primary health care visits are registered with private facilities, clinics or hospitals, reflecting the low user satisfaction with public services. However, private providers do not serve rural areas. Against this background, the government decided to upgrade primary health care facilities and 1.500 out of the planned 4.500 have already been upgraded.

The FHF are conceived as pilot projects for a single-payer mechanism. The related Family Health Centres (FHC) offer primary care (and referral) to the whole family and are intended to reduce transportation costs and to improve the quality of care.[26] The Family Health Model is also targeted at the uninsured population, however it is unclear if it targets mainly the lower income groups or the whole population.[27]

Using FHCs requires payments such as registration fee and co-payments, which can be a heavy financial burden for the patients. In some cases, the conversion of health facilities into FHC has resulted in higher out-of-pocket payments. In fact, evidence suggests that the poor are seeking services of facilities that have not yet been upgraded yet and still operate under the cheaper fee structure. Only about half of the registered persons decided to renew their registration at the FHC.[28]

People insured by the HIO can also register in an FHC. They pay reduced registration fees and are exempted from co-payments on drugs. It has been argued that the sum transferred from HIO to the FHF is not sufficient to cover the related costs, constituting a financial burden on the scheme.[29]

PTES[30] is a financial support scheme open to both the uninsured and the insured, mainly to cover high-cost treatments (tertiary care), including treatments abroad. PTES payments are decided on case-by-case bases eligibility criteria for granting requests are not clear. The budget of PTES equals the budget of HIO and is considered as one of the main cost drivers

[25] WHO. 2006a. Page 60.

[26] World Bank. 2006.

[27] Ikegami. 2006. page 2.

[28] Ikegami. 2006. Page 6f.

[29] Ikegami. 2006. Page 7.

[30] World Bank. 2006.

of public spending in the health sector.[31] Most of the health care financed through PTES takes place in the Specialized Centers run by the MOHP since 2001, e.g. for cancer treatment.[32] With these new centers and the reduction of overseas treatments, costs per PTES patient could be reduced by nearly 50 per cent, but remains very high compared to the average cost of an HIO member. The cost savings were offset by the enormous growth of cases paid for through the PTES, increasing from 100,000 in the late 1990s to 1.2 million nowadays.

2.3.1.2. Social health insurance (HIO)

The HIO is a public institution under the supervision of the MOHP, which is the final decision-taker on policies, structural and managerial questions regarding the HIO.[33] It was created in 1964 to provide social health insurance to formal workers and extending coverage to the whole population.

Besides its function as a social health insurance body, the HIO is an important provider of health services through its own network of facilities. The introduction of new regulations like the insurance schemes for students and preschool children caused a considerable extension of HIO coverage. As a result, the HIO was confronted with the necessity to contract external health care providers.[34] The HIO struggles with the challenges based on its multiple functions as an insurer, provider and purchaser. The legal fragmentation of HIO schemes and the subsequent complex administration and management structures create additional difficulties and inefficiencies.

The Egyptian health insurance covers various groups through different schemes, most of them compulsory. The current coverage is 38.8 million persons as of 2008 equaling about half of the population.[35] Most of the people not covered by HIO belong to low-income groups.[36] Coverage rates across regions vary considerably because of different population structures in the regions.[37]

Coverage has increased since the 1990s, especially in the schemes targeting schoolchildren. Therefore, most of the insured are children followed by government employees as shown in the graph below. However, the increase in coverage was not matched by a related increase in funding. For many new scheme members, a low flat-rate contribution rate, that was not related to any actuarial estimation of the costs of coverage was introduced. It was foreseen that deficits should be covered by the treasury, but evidence suggests that the extension of coverage resulted in underfunding and a deterioration of the quality of services.

[31] Hewitt Associates SA. 2008. Page 4.

[32] World Bank. 2006. Page 12.

[33] WHO. 2006a. Page 35.

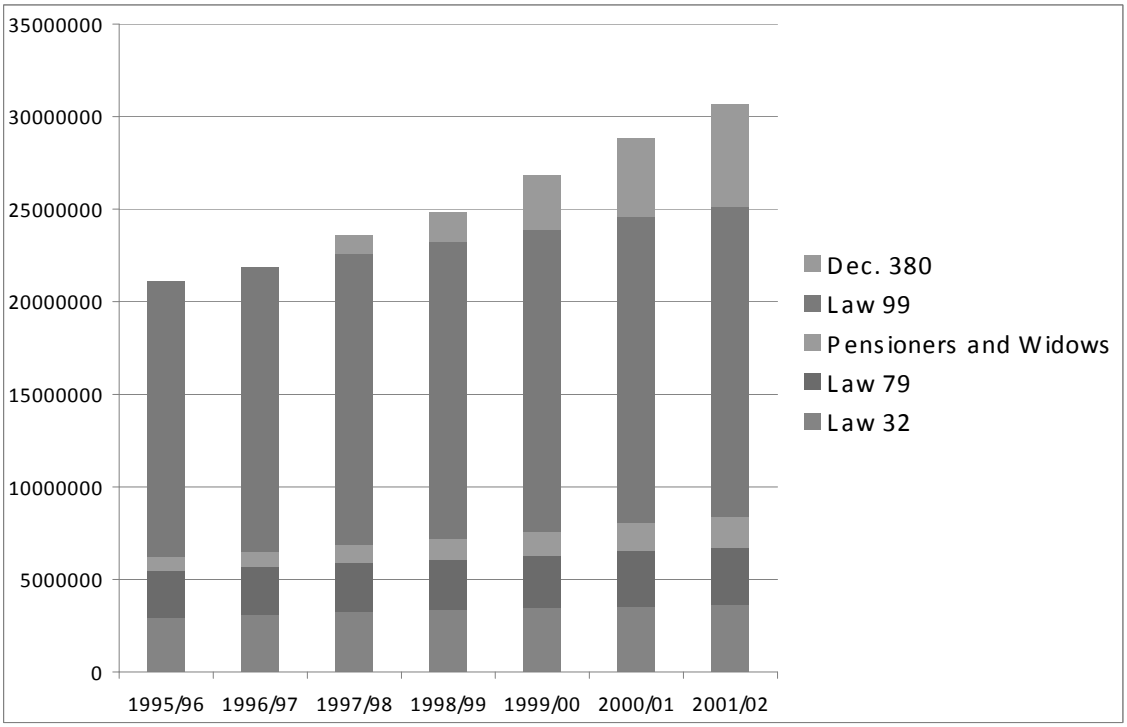
[34] WHO. 2006a. Page 36.

[35] Hewitt Associates SA. 2008. Page 28.

[36] Hewitt Associates SA. 2008. Page 4.

[37] USAID. 2005. Page 50.

Figure 1. Beneficiaries by Law[38]



The following picture can be drawn when breaking down the HIO coverage by households:

- Only one third of the national workforce is covered by the HIO.[39]
- Dependants of workers are not covered;
- The typical HIO member is male and lives in urban area, where formal employment is usually found.[40]
- Benefit coverage varies even within households, according to the scheme under which household members are insured.
- In many households, especially in the informal sector, only some members (e.g. children attending school) are covered.

Given the high share of informal economy workers in Egypt, a large part of the population is excluded from HIO coverage and vulnerable to poverty impacts due to out-of-pocket payments.

Contribution rates for the HIO are modest ranging between 0.5 and 2 % for the insured and up to 3 % for employers or lump sums. The rates also depend on the sector, as contributions for government employees are half of the rates for employees in private or para-statal companies. Contributions are calculated only on the basis of one salary received

[38] USAID. 2005. Page 50.

[39] World Bank. 2006.

[40] WHO. 2006a. Page 34.

for formal employment. It does not take into account the usually numerous other sources of income and salaries that people receive. Therefore, solidarity in financing is at a rather modest level and the principle of contribution payment according to the ability to pay is only partially implemented.

Employers contribute some 40 % of the overall revenues of HIO. However, for the time being the possibility of opting out and ensuring the employees privately instead exists, if employers continue to contribute 1 per cent of the salaries. This undermines the financial sustainability of the HIO, as it replaces the potentially relatively large contribution of well-earning formal sector workers with a modest payment.[41] Low quality of services covered by the HIO schemes is perceived as the main reason for opting out.[42] Requiring small and medium enterprises and their employees to subscribe to HIO insurance could significantly enlarge the contribution base.

The insured and the MOF contribute each a share of some 20 % to the HIO revenue. Finally, public firms (15 per cent) and non-profit organizations (<1 per cent) contribute the rest of HIO funds.

[41] WHO. 2006a. Page 34.

[42] World Bank. 2006. Page 9.

Table 4. Sources of revenues in different HIO schemes

Law No. Year	Group of insured	Contribution employee	Contribution employer[43]	Co-payments	Specific public subsidies
Law 32 (1975)	Government employees	0.5 per cent of salary	1.5 per cent of salary	General practitioner visit: EGP 0.05 Specialist visit: LE 0.10 Tests: max. EGP 1 Drugs: 50 per cent	
Law 79 (1975)	Private and parastatal employees	1 per cent of salary	3 per cent of salary	None	
	Pensioners	1 per cent of income	/	None	
	Widows	2 per cent of income	/	None	
Law 99 (1992), School Health Insurance Program (SHIP)	School children	LE 4 per year		Drugs: 33 per cent	MoF adds EGP 10 per student and earmarked tax of EGP 0.10 per package of cigarettes
Ministerial decree 380 (1997)	Pre-school children	LE 4 per year	/	(Except for chronic diseases) Visit: EGP 0.50 Drugs: 33 per cent	

Sources: Hewitt (2006), HIO Annual Report 2002/03

Over many years, the financial situation of the HIO was characterized by high deficits, which could only recently be balanced. As shown in the table below, expenditure regularly exceeded revenues, except for the scheme for students (Law 99) that reached a surplus.

[43] Hewitt Associates SA. 2008.

Table 5. Budget developments of HIO 1996 - 2001

	FY1996/97	FY1997/98	FY1998/99	FY1999/00	FY2000/01	Net Balance
Revenues by law						
Law 32 in 1975	89,309,211	103,277,214	111,775,057	117,717,030	126,701,710	
Law 79 in 1975	274,319,994	294,421,741	319,108,528	356,678,415	385,918,966	
Law 79 in 1975 (P&Wd)	25,988,424	31,681,153	39,010,691	45,260,661	70,173,443	
Law 99 in 1992	516,042,731	537,590,693	551,470,656	562,419,407	603,329,558	
TOTAL REVENUES	905,660,360	966,970,801	1,021,364,932	1,082,075,513	1,186,123,677	
Expenditures by law						
Law 32 in 1975	236,313,477	260,018,174	267,666,232	271,857,280	296,109,866	(169,408,156)
Law 79 in 1975	275,819,107	316,868,215	329,504,759	359,170,844	390,615,614	(4,696,648)
Law 79 in 1975 (P&Wd)	166,002,418	206,996,144	236,852,113	279,993,738	315,189,890	(245,016,447)
Law 99 in 1992	392,703,358	434,412,443	487,279,348	541,583,008	581,301,764	22,027,794
TOTAL EXPENDITURE	1,070,838,360	1,218,294,976	1,321,302,452	1,452,604,870	1,583,217,134	
NET BALACE	(165,178,000)	(251,324,175)	(299,937,520)	(370,529,357)	(397,093,457)	

Source: NHA (2005), p. 51

Due to the limited payroll contributions in the scheme for government employees, this sub scheme accounts for an important part of the net deficit, only exceeded by the pensioners and widows insured under law 79, representing only 6 per cent of the enrollees and causing around 60 per cent of the deficit. The scheme regulated by Decree 380, offering voluntary coverage to pre-school children, needs subsidies because contributions are low and young children represent a high-risk group.[44]

Contributions are not adjusted relative to inflation rates, so costs are predicted to surpass HIO revenue again in the near future.

In this context, also the private provider sector, both concerning hospitals/clinics and provision of drugs plays an important role. Currently, some 80 % of the pharmaceuticals are produced in state-owned enterprises where the government sets the prices. However, the government opened perspectives of privatization of these enterprises and as a result, price increases are to be expected.

Against this background, financial sustainability based on a better balance of revenues and expenditure needs to be a priority for the HIO. The government has already taken various measures to address the imbalance by reducing costs: The use of non-HIO pharmacies has been limited, specialist referrals were reduced, HIO staff was reduced and the construction of new facilities was frozen (with some of these measures adversely affecting the quality and accessibility of services). Also in the field of purchasing, there are efforts to negotiate more efficient contracts with providers.[45]

[44] World Bank. 2006. Page 11.

[45] World Bank. 2006. Page 12.

2.3.2. Benefits

Benefits provided by the HIO and tax funded schemes vary significantly. An overview is provided below.

Table 6. Benefit packages in social health protection schemes

Scheme	Benefit package
HIO	Comprehensive benefit package (primary, secondary and tertiary care) for all HIO beneficiaries
PTES	Reimbursement of cost for tertiary care for successful applicants (both uninsured and HIO beneficiaries)
Family Health Funds	Primary care mainly for those not covered under HIO or other insurance
Government clinics and hospitals	Primary, secondary and tertiary care for the uninsured

As compared to the tax-funded schemes, HIO benefit packages cover a broad range of treatments without limitations to quantity of services and costs, as shown in the table below. Treatment abroad is covered as well, except for pensioners and widows. However, actual benefits of the current health insurance scheme are perceived as low and seem to lead to unequal uptake by men and women.

Table 7. Benefit packages in HIO schemes[46]

	Employees (Law 32 and 79)	Students (Law 99)	Pensioners and Widows (Law 79)
Curative care:			
General practitioner service			
Specialist services	Yes	Yes	Yes
Dental	Yes	Yes	Yes
Home visits	Yes	Yes	Yes
Inpatient care	Yes	Yes	Yes
Surgical and medical	Yes	Yes	Yes
Radiology, lab, other investigations	Yes	Yes	Yes
Medicines (drug benefit)	Yes	Yes	Yes
Ante, natal, post-natal care	Yes	Yes	Yes
Prosthesis and	Yes	Yes	No

[46] USAID. 2005. Page 49.

	Employees (Law 32 and 79)	Students (Law 99)	Pensioners and Widows (Law 79)
physiotherapy			
Overseas treatment	Yes	Yes	Yes
Preventive care:	Yes	Yes	No
Annual medical exams (at the start of the school year)			
Immunization	No	Yes	No
Periodic medical exam	No	Yes	No
School hygiene	No	Yes	No
Health education	No	Yes	No
Nutrition supervision	No	Yes	No
	No	Yes	No

The health insurance scheme is integrated with the occupational / accident insurance scheme, funds of both schemes are not separated in the accounts and cross subsidization remains unclear.

2.3.3. Recent trends in health financing

2.3.3.1. Overall structure of total health expenditure

In 2006, total health expenditure in Egypt amounted to 6.3 % of GDP and the expenditure on health per capita to 316 US$. Out-of pocket payments constituted nearly 95% of private and more than 50 % of total health expenditure. Expenditure on formal social health protection accounted for 26 per cent of general government expenditure on health (see table below).

The MOHP is the largest recipient of funds, followed by the HIO. The budget of the HIO amounts to 10 per cent of the total health expenditure[47]. This seems to mismatch HIO's coverage of some 50 % of the population.

The total health expenditure has increased remarkably since 1995. Since the early 1990s, the budget of the MOHP has grown faster than GDP and total government budget growth rates. However, this rise has been achieved through a significant increase of private health expenditure, while general government expenditure on health has actually fallen. Particularly, the share of out-of-pocket expenditure as percentage of private expenditure has increased in recent times.

[47] WHO. 2006a. Page 31.

Table 8. Recent trends in health financing[48]

	1995	2000	2005	2006
Total expenditure on health as percentage of gross domestic product	3.9	5.6	6.1	6.3
Private expenditure on health as percentage of total expenditure on health	52.9	59.9	62	59.3
Out-of-pocket expenditure as percentage of private expenditure on health	89.6	94.1	94.9	94.9
General government expenditure on health as percentage of total expenditure on health	47.1	40.1	38	40.7
General government expenditure on health as percentage of total government expenditure	5.5	7.5	7.3	7.3
Social security expenditure on health as percentage of general government expenditure on health	25.1	23.8	26.3	26.4
Total expenditure on health per capita (US$)				316

As outlined in the table below, expenditure on health care is mainly characterized by:

- Expenditure on pharmaceuticals which accounts for almost one quarter of total health expenditure
- Curative care making up 57% of total health expenditure and
- Expenditure for administration, which accounts for 4%.

Total public health expenditure by types of services shows that two thirds are spent on hospitals, one third on health centers (see Table 9 below).

[48] WHO. 2009b.

Table 9. Distribution of Public Health Spending

	2006-2007	%
Total Public Health Spending	10'433'764'045	100.00
Hospitals' services	6'741'263'963	64.61
Public Hospitals' services	6'175'600'490	91.61
Specialized Hospitals' Services	565'663'473	8.39
Public Health Services	3'620'603'653	34.70
Researches and reform in Health sector	60'572'671	0.58
Health affairs non categorized in other places	11'323'758	0.11

Source: Ministry of Finance, 2009

Out of total public health expenditure, some 10 per cent are used for subsidies, whereas three fourths are used for salaries and purchase of goods and services (see Table 10).

Table 10. Distribution of expenditure by various cost components

	Amount	%
Total Public Health Spending	10'433'764'045	100.00
Wages and Indemnities for workers	4'637'835'783	44.45
Goods and Services purchased	3'195'359'171	30.63
Benefits	19'415'800	0.19
Subsidies and social benefits	1'104'762'213	10.59
Other expenses	50'939'627	0.49
Purchasing non-financial assets	1'425'451'451	13.66

Source: MOF, 2009

The share of spending on hospitals and doctors is with 4 resp 5 % low compared to the share spent on drugs. Also, when breaking down household expenditure by provider-type (see table 8), we find that pharmacies receive the second highest share with about one third of household expenditure just following expenditure on private clinics of approx. 42%.

Table 11. Household Expenditure by provider

Type of provider	Amount	Percent
MOHP hospitals	481,157,369	3.5%
University hospitals		
Other public hospitals	420,177,651	3.1%
HIO hospitals	127,899,671	0.9%
Private hospitals	104,110,896	0.8%
Private clinics	1,224,202,433	9.0%
MOHP health centers	5,722,246,844	41.9%
Pharmacies	437,619,662	3.2%
Others	4,593,449,039	33.6%
Total	550,480,529	4.0%
	13,660,344,095	

Source NHA 2005, p.46

The MOHP spends approx. one third of its funding on hospitals and about 44% on health centres. The share of expenditure for administration of the MoHP is at 19%.[49] The expenditures at HQ level have more than quintupled between 1994/95 and 2001/02, whereas the expenditures in the regional offices of MoHP increased by only approx. 29%[50].

[49] USAID. 2005. Page 36.

[50] USAID. 2005. Page 38.

Table 12. Total health expenditure by function[51]

Type of function	Amount (in LE)	Percent
Curative care	13,195,604,498	57%
Prevention and public health	2,081,189,303	9%
MCH	219,843,466	1%
Pharmaceuticals	5,360,745,709	23%
Administration	993,774,536	4%
Capital formation	1,074,578,120	5%
Not specified by any kind	155,404235	1%
Total	23,081,139,868	

Private expenditure now constitutes almost 60% of total health expenditure. Almost all private health expenditure is out-of-pocket expenditure, reflecting the gaps in social health protection coverage. The high share of out-of-pocket spending illustrates the potentially severe impoverishing effect of health spending, threatening especially low-income groups. Health spending patterns and levels are highly diverse across different income groups and locations.

Generally, Households spend the largest share of their expenditure (see table below) on drugs (43%), followed by x-rays and other laboratory tests. The share of spending on hospitals and doctors is with 4 and respectively 5 % low compared to the share spent on drugs.

[51] USAID. 2005.

Table 13. Household Expenditure by various cost component in LE[52]

	Outpatient	Inpatient	Drugs	Others	Total Household Expenditure	Percent
Annual per capita	120.7	15.1	68.9	9.2	204.9	
Hospitals		7.22			481,469,452	4%
Doctors	6.34	3.68			667,942,648	5%
Drugs	17.74	1.4	69.9		5,869,487,251	43%
Lab	15.65	0.65			1,086,197,088	8%
X-ray	30.89	0.67			2,104,086,873	15%
Transport	3.43				228,802,551	2%
Others	46.65	1.48			3,222,358,222	24%
Total					13,660,344,095	

Several aspects contribute to the very high share of out-of-pocket expenditure:

- With its limitation to specific groups of the population, health insurance coverage is low and the uninsured are required to pay for health services out of pocket.
- Even if insured, co-payments are required for certain or all types of services.
- Quality of healthcare provided by some of the accessible public or publicly contracted providers may be perceived as insufficient and, therefore, households may choose private providers even if these require out-of-pocket payments.

2.3.3.2. Flow of funds

Being the main government entity tasked with fulfilling the constitutional pledge of free healthcare for all citizens, the MOHP is the main recipient of general government budget funds for health and the largest single payer and provider. It transfers approx. 60% to the health directorates in the governorates (see Table below). Nevertheless, the governorates have little discretion of spending, because most of the funds are earmarked for specific budget line items. Approx. 52% of the funding for public hospitals (excluding HIO facilities) comes from the MOF.[53]

[52] USAID. 2005.

[53] As communicated by the Ministry of Finance during the ILO Mission in March 2009.

Table 14. Distribution of MOHP budget

	MOHP HQ	MOHP Regions	Total	Percent
Inpatient curative care	432,764,385	655,555,790	1,088,320,175	22%
Outpatient curative care	111,469,614	168,855,279	280,324,894	6%
Pharmaceuticals and other medical non-durables		-	-	0%
Prevention and public health services (incl. family planning and maternal health care)	695,954,536	1,054,238,844	1,750,193,380	36%
-Family planning	41,694,051	63,158,562	104,852,613	2.1%
-Maternal health care	42,626,636	64,571,252	107,197,888	2.2%
Administration	296,096,032	448,529,210	744,625,241	15%
Capital formation	536,892,000	354,859,329	891,751,329	18%
Not specified by any kind	61,939,863	80,130,702	142,070,565	3%
Total	2,135,116,430	2,762,169,154	4,897,285,584	100%

Source: MOH, Annual Statistical Report 2003

However, the allocation of funds to public facilities has decreased from 44% to 40% recently while the allocation of total health expenditure to private facilities has increased since the mid-1990s. The National Health Accounts for 2001/02 state that 56% of health expenditure occurs at private facilities, as compared to 50% in 1994/95.

Besides the MOHP, HIO and private households are the largest purchasers of health care.[54] The flow of funds is as follows:

1. The Ministry of Finance transfers funds raised from general taxation mainly to the MOHP (and, to a lesser extent, to other ministries such as the MOHE). These funds are used to pay for services and administration at the facilities owned and controlled by the respective ministries. They are normally not used for facilities of the HIO and never for purchasing services from private providers. The facilities generate additional but limited revenue through user fees.

2. Public insurance schemes receive funds from contributions of the members and their employers (payroll tax), tobacco consumption tax, household premiums and co-payments and transmit these funds to the Health Insurance Organization. The HIO uses approx. 50% of these funds to purchase services from public and private providers including the curative care organizations (CCO) at primary and secondary care level and the remaining funds for its own facilities and administration.[55]

3. Out-of-pocket funds are channeled almost exclusively to private providers, including private clinics and hospitals, pharmacies and other providers. Private facilities also receive a small amount of funds from large employers, which purchase services directly (or via private health insurance) for their employers.

4. The CCOs receive funds from service contracts with private employers, user fees and limited funds from public sources such as the HIO and grants from the government for poor patients.

These funding channels are isolated, i.e. a mix of funds almost never occurs. The only exception is the HIO's purchasing of services from private providers with funds from

[54] USAID. 2005.

[55] USAID. 2005.

public health insurance. The CCOs' funding is exceptional for its pluralism, but only a few numbers of CCOs exist.

3. The Social Health Insurance Reform Project

Over the last years, Egypt's health care system increasingly failed to meet the expectations of the population, particularly regarding issues related to equity, quality, and efficiency. In 2005, the president addressed these concerns by announcing the introduction of a national universal health insurance.

The following years were characterized by significant steps to improve social health protection and allow for better quality and access of the population: The government of Egypt has focused on implementing pro-poor policies, developed and implemented specific programmes focusing on family and maternal health and upgraded related facilities. Additionally, Egypt has also made strides in collecting hard data regarding health, especially in the area of child mortality and maternal health.

Most recently, the government has engaged in developing a draft law for reforming the social health insurance to extend coverage and increase efficiency. The government is willing to allocate additional funds to implement these reforms.

The draft law versions number 8 and 11 were provided as the latest available versions to the authors of this report.

3.1. The draft legislation and Suez Pilot

The draft legislation as outlined in versions 8 to 11 of the Social Health Insurance Law and annexed to this report aims at addressing persisting challenges in the current health system, particularly

- High OOP due to fragmented approaches in financing: In this context the overall approach is taken, that those who can afford contribution payments should pay. Therefore, the draft legislation foresees compulsory coverage and excludes opt-out possibilities
- Gaps in coverage and access of the poorer parts of the population
- Improving quality of services
- Unifying the various existing schemes under a single administrative structure

The draft legislation covers all citizens except those who are disabled (Art 11). The insurance coverage is based on contribution payments as follows:

Table 15. Rates of contributions according to draft law 8

Employees:	1.5% of total income
Employers:	4 % of payroll / wage
1 % of wage for work injury	
Students:	5% of tuition fee, min. EGP 10
Professionals with irregular salaries:	EGP 15/month
Artisans with irregular salaries:	EGP 10
Pensioners:	1% of pensions
Body responsible for payment of pensions:	3 % of pensions
Widows:	2% of pensions
Body responsible for payments of widow's pensions	3 % of widow's pensions
Unemployed wives:	EGP 10/month
Pre-school aged children:	EGP 20/year

The contribution base in case of income from several sources is not specified.

Further revenues mentioned in the draft law refer to user fees, investment returns and taxes. While the last two are not further specified, user fees to be set up by decree include fees for

- Various services: Up to 25% of costs
- Outpatient medicines: 1/3 of costs
- Outpatient examinations/tests: 1/3 of costs

Additional revenues of the new scheme will consist of subsidies. They are specified as EGP 12 for all school children and students and full subscription costs for those eligible for full subsidies. Further, it is foreseen that the government provides funds for treatments of the needy (Art 11)

According to draft law 8 the benefit package is specified as

- Preventive, remedial and rehabilitation services, medical tests; to be defined by ministerial decree (Art. 11).
- Insurance will apply in the case of natural disasters or epidemics.

A more limited approach is spelt out in draft law 11: The draft law does not apply to preventive services offered by the government (Art. 4) and natural disasters and epidemics seem not to be covered. Further, minimum benefits currently offered by the HIO (Art 3) shall be reconsidered if needed.

The administrative reform foreseen is significant: Accordingly to Art. 1 it is foreseen to separate financing and provision of services and aim at decentralization. In this context the

HIO should become a service enterprise - an independent public network holding – that negotiates prices, contracts providers, insures quality, and pays for services.

The discussion on the above draft laws has been underpinned by a pilot set up in Suez. Suez ranges among the wealthier Governorates of Egypt and is therefore not representative for the whole country. Therefore, further pilots are currently being prepared for Alexandria and Sohag as of 2010. No timeline was mentioned concerning the remaining 23 Governorates.

In Suez, high tax investments have been used to significantly upgrade hospitals and facilities and might be competitive to the private sector. It was mentioned that it might also serve patients from neighboring countries given their up-to-date high-technology equipments.

3.2. Current discussions and international support

Currently, discussions within the government and other policy makers continue. This was prompted by a recent decision of the Constitutional Court on Decree 637/2007. The Decree aimed at transforming the HIO into a holding company which could have significant impacts for insurance-owned assets. The Constitutional Court rejected the Decree referring to a violation of the Constitution which assigns an important role to the government in providing for health care.

Against this background, the government explores various pathways for progress:

The MOH has developed a comprehensive benefit package which should be provided to the population. An exclusion list for services not covered, such as anesthetic and cosmetic surgery, is spelt out in detail.

Further, discussions evolve around the definition of the (ultra) poor to be covered whose contribution would be subsidized by the government. The MOF explores options to define a more limited package which would particularly address health concerns of the vulnerable to make universal coverage affordable. The Minister of Social Solidarity (MOSS) has been active in identifying two million ultra poor households to be subsidized under the new scheme given the fiscal space available. The Minister of Manpower and Migration (MOMM) and also the Trade Unions Association are supporting a focus on the poorer parts of the population and highlight the need for solidarity. They are also concerned about the quality of services and possible impacts in case of an increase of contribution rates and co-payments. More generally, the government supports a strong role of the private sector and the need to improve infrastructure by focusing on primary care and family facilities. This viewpoint is particularly emphasized by the Minister of Investment and the Insurance Supervisory Authority and the Federation of Egyptian Industries.

The definition of the poor and vulnerable to be covered as well as the nature of the benefit package will determine the amount of public subsidies needed and the burden of those who pay taxes. These aspects are dominant in the public debate on the reform project.

The international community supports the government in its efforts to improve social health protection and emphasizes particularly the need to provide universal coverage defined as effective access to affordable health services. The World Bank’s Health Sector Reform Project supported the development of various pilots aiming at improving the health status of the population with a view to consolidating multiple social insurance programs under a National Health Insurance Fund and enhancing economic incentives to improve

quality and efficiency of government health services. Most recently, the World Bank supported actuarial studies developed by Hewitt.[56] The WHO is supporting the strengthening of the health system, e.g. in cooperation with USAID regarding data development ranging from National Health Accounts to demographic health surveys among others. UNICEF particularly focuses on maternal and newborn health.[57] The European Commission (EC) is particularly engaging in developing family health care.[58]

3.3. The government's financing strategy scenarios

Against this background, the government has prepared three scenarios as outlined in the table below. Three scenarios (low, middle, high) are suggested with regard to premiums / contributions, co-payments and earmarked taxes.

The financing strategy relies on contribution payments from insured persons and their employers as well as possible state subsidies. Contribution rates for employers range between 2 and 4 percent of gross salary and for employees between 1 and 1.5 percent. This does not cover work injury, which will be financed as in the current legislation. Contribution rates for widows remain 2 % in all scenarios, whereas rates for pensioners vary between 1 and 1.5 percent of pensions. School children's contributions range between 10 and 20 percent of school fees depending on the scenario and are limited between 15 and 240 EGP. University students will have to contribute between 10 and 20 percent of university fees with minima and maxima ranging between 10 and 240 EGP. Preschool children will contribute a yearly indexed amount of 15 to 25 EGP and informal workers of 120 to 240 EGP.

Co-payments vary between drugs and type of care. 25 to 35 percent of costs of drugs to be capped at 25 (minimum scenario) or 40 EGP (middle and high scenario) are proposed in case of outpatient treatments. Outpatient treatment itself will also be charged by co-payments ranging between 5 and 10 EGP per visit. Co-payments for primary care are suggested to be lower and are between 3 and 5 EGP per visit. Dental care co-payments are limited at 50 EGP and range between 10 and 20 % per treatment below that level. Inpatient care will require co-payments per day between 5 and 15 percent with a maximum of 50 EGP.

Subsidies will be covered by revenues from earmarked tobacco taxes and amount to 20 resp. 30 percent of total tobacco tax. Further, subsidies for school, preschool and university students remain at 12 EGP as currently applied. In addition, subsidies for the unemployed and poor range between 120 and 240 EGP and will be supplemented by subsidies of co-payments for the poor only.

[56] Hewitt Associates SA. 2008.

[57] As communicated to the ILO mission in March 2009.

[58] As communicated to the ILO mission in March 2009.

Table 16. Actuarial scenarios, Government of Egypt, 2009[59]

Key variables			Unit	Low		Base		High		Comments/Source
				2009		2009		2009		
Premiums/ contributions	Workers	Employer	% of salary	2%		3%		4%		As a % of the gross salary, excludes insurance for accidents at work & With a min.
		Employees	% of salary	1%		1.25%		1.5%		As a % of the gross salary, excludes insurance for accidents at work
	Widow(er)s		% of income	2%		2%		2%		As current, and in draft law
	Pensioners		% of income	1%		1.25%		1.5%		
	Schoolchildren		% of School fees	10%		15%		20%		
				Min.	Max.	Min.	Max.	Min.	Max.	
				15	120	20	180	25	240	
	University students		% of University fees	10%		15%		20%		
				Min.	Max.	Min.	Max.	Min.	Max.	
				20	120	25	180	30	240	
	Infants (preschool)		Amount/person/per year	15		20		25		to be adjusted every 3 years according to an inflation index
	Informal worker (Hewitt categories casual workers, unemployed)		Amount/person/per year	120		180		240		to be adjusted every 3 years according to an inflation index
Co-payments	Drugs (outside hospital)		% of cost	25% cap at 25		30% cap at 40		35% cap at 60		
	Inpatient		Amount / Day	5		10		15		Max. 50
	Outpatient		per visit	5		7		10		
	Primary Care		per visit	3		4		5		
	Dental		% of treatment cost	10%		15%		20%		Max. 50 per treatment
Earmarked	Tax from tabacco		% of total tabacco tax	20%		25%		30%		
	Subsidies for infants, children, university students		Amount/person/per year	12		12		12		As currently applied to schoolchildren and university students
	Subsidies to the poor and the unemployed		Amount/person/per year	120		180		240		Co-payment for the poor also to be subsidised

[59] Information received from the Government of Egypt during the ILO mission in March 2009.

4. Assessment

The following assessment is based on the data and information received prior to and during the mission and other available data. It concentrates on the issues and aspects outlined in the terms of reference of the mission. Since the discussion of the scheme design is still ongoing, a particular focus will be on related features, particularly

- The extent of the benefit package with a view to addressing both Constitutional and financial constraints
- Providing effective access (as compared to the legal coverage) for the poor and vulnerable parts of the population e.g. working in the informal economy
- Affordability and income generation at the national level
- Organizational aspects regarding the role of the government, HIO and the private sector.
- Issues related to the nationwide implementation

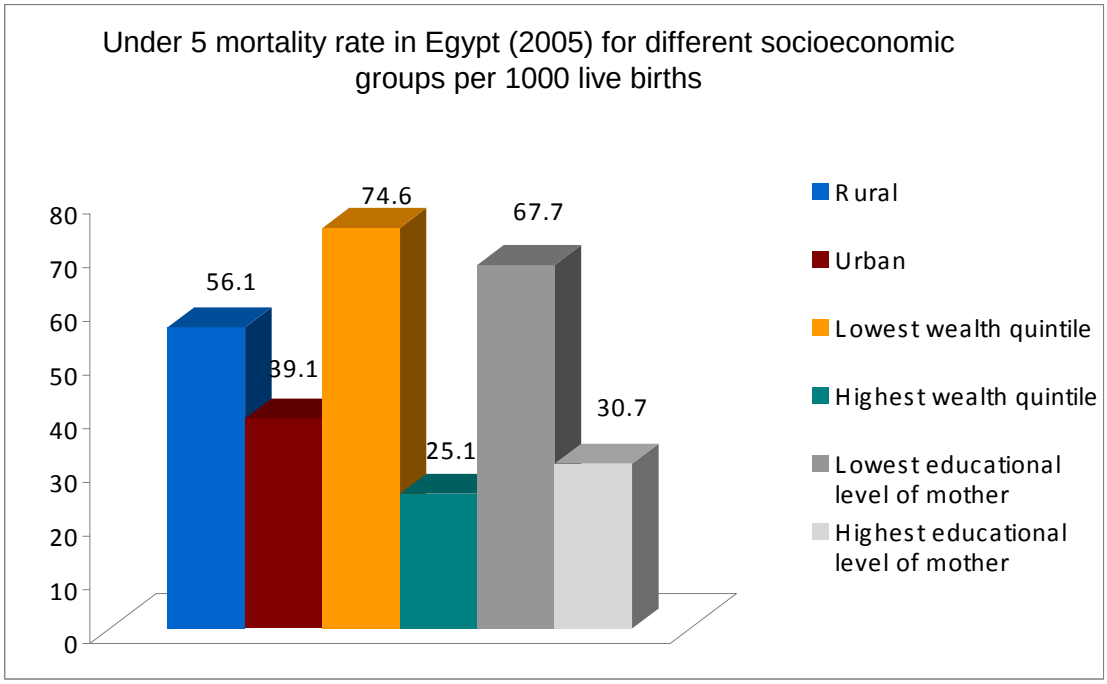
As mentioned in several chapters of this report, information on some key aspects relevant for assessing the achievement of universal coverage – defined as access to affordable quality health services – is still missing. This concerns e.g. definitions of the poor, decisions on the benefit package to be provided, contribution rates and co-payments particularly for the vulnerable etc. Therefore, it is currently not possible to fully evaluate the achievement of international objectives as outlined above. However, in the following, all information which is already available was considered and commented on to the extent possible.

4.1. Achieving universal coverage

Over the last years, Egypt has achieved significant progress in the health sector and this is particularly reflected in the overall achievement of the MDGs. The progress towards MDG 4 concerning under-five- mortality is significant with a drop in related mortality rates by 62 percent between 1990 and 2006.[60] However, socio-economic determinants, particularly poverty is reflected in higher mortality rates among children from the poorest quintile of the population as compared to the riches quintile. As shown in the figure below it is five times higher in the poorest segment of the population.

[60] Ministry of Economic Development. 2008. Page 28.

Figure 2. Under-5-Mortality (2005) for different socioeconomic groups per 1000 live births[61]



A similar picture can be drawn when it comes to maternal health outcomes: A stark difference by income groups, particularly worrying in the area of Upper Egypt, remains an important characteristic. The prevalence of HIV/AIDS is currently low in Egypt and the overall objective should be to prevent new infections.

Against this background, addressing inequalities in health with a particular focus on the poor parts of the population remains an important issue which can be addressed by extending social health protection. Emphasizing on the poor and vulnerable should be considered among the key priorities when striving for universal access to health services. Given the poverty map of Egypt, it is suggested to particularly working towards progress in Upper Egypt.

All policies applied to extend social heath protection should be embedded in a broader anti-poverty strategy and build a social protection floor that aims at:

1. Ensuring universal access to at least essential health services

2. Guaranteed income security for all children aimed to provide for nutrition, education and care

3. Guaranteed social assistance and other mechanisms for all residents of active age unable to earn sufficient income due to sickness, unavailability of remunerated work etc and

4. Guaranteed minimum income security for the elderly and disabled people through pensions for old age and disability.

The overarching objective of the social health insurance is to improve equity and solidarity in health financing through risk pooling, by this ensuring effective access to healthcare for

[61] WHO. 2009b.

all people. The ILO suggests underpinning the legal coverage of the whole population by concrete measures to achieve effective access to health services.

This requires substantial efforts both for the supply and demand side of health services. Investment in the health infrastructure is a necessary condition for the functioning of the SHI scheme, especially in rural areas and the government has already achieved considerable progress in this regard. On the demand side, the percentage of the population legally covered is stated at about 52%, including government employees, public and formal sector workers, pensioners, widows, students and pre-school children. The challenge therefore lies in covering informal economy workers, the self-employed and dependents.

One option discussed consists in insuring each person separately, independent of the socio-economic or family status either through flat rate contributions or subsidies. This would imply the identification of the vulnerable and those in need of subsidies:

- International experience proves that the identification of these groups is extremely challenging and has to be seen as an ongoing process rather than a one-time effort given the fluctuation of the poverty status of individuals and households based on individual events, such as sickness of those who generate income in the household or economic events at the community, national or global level ranging from weather impacts on harvest to global food and financial crises.

- As far as school children are concerned the high rate of children leaving school without having any income or related coverage in the health insurance scheme might pose problems regarding the objective to reach universal coverage.

- A similar issue in achieving universal coverage is regards the exclusion of the disabled from insurance coverage.

Against this background it might be considered to aim at insuring households/families based on the main income generated rather than individual coverage.

Currently there seem to be no definition of the poor and vulnerable that is shared at the national level. Therefore, efforts of the MOSS aiming at identifying some 2 million households of the ultra poor on criteria that are defined in addition to income indicators are very valuable and useful. The MOSS is using proxy-means testing rather than a poverty definition that is only based on cash income. It should, however, be taken into account that these efforts might have to be repeated periodically in order to ensure accurate targeting. Further, given the country's size of the population, the large informal economy and the concentration of the poor in certain areas, e.g. Upper Egypt, it has to be ensured that coverage is provided according to the size of the poor and the regional distribution.

It should also be taken into account that the focus on 2 million ultra poor families could only be seen as a first step towards universal coverage given the need to cover some additional 50 percent of the population as compared to the current coverage rates. Therefore, it is suggested to clearly develop a national coverage plan that provides overall objectives in terms of coverage rates and timelines both by the number of the vulnerable and needy population insured and by governorates.

4.2. Providing affordable benefits

4.2.1. Affordability of health services under the reform project

Affordability of health services for the poor ranges among the key criteria for effective access as compared to legal coverage. It is mainly defined by the extent to which contribution rates and co-payments are related to the individual's ability to pay. In most countries setting contributions/premiums or flat rates for those who do not gain regularly income poses challenges. This concerns particularly workers in the informal economy and their families. In Egypt, the ability to pay of the poor and informal economy workers and their families has not been evaluated until to date, thus making it difficult to assess the possible impacts of the draft legislation in this respect.

Current versions of the draft law and the government scenarios foresee modest contribution rates for formal economy workers complemented by co-payments up to a maximum. This approach is most likely to provide access to health services for this group. In many cases this group will also have to pay contributions and co-payments for dependants without income. Depending on the number of family members the contributions and co-payments might add up to a significant amount and present a barrier to access services.

These proposed co-payments contrast with the current system, in which co-payments are negligible, most people are either exempted or pay only nominal fees like 1 EGP per outpatient visit. Free (or almost free) healthcare services at the point of delivery are an important principle of equitable social health protection and ensure the absence of financial barriers to access services in case of need. Nevertheless, carefully designed co-payments can be useful in health insurance, because they allow limiting moral hazard, i.e. the tendency to over-consume or over-prescribe. The design of such co-payments needs to be matching the ability to pay/contribute of the insured and ensure access and treatment according to needs, thus guaranteeing affordability of services. The suggested fees of up to 25% of actual costs would be impossible to shoulder for large parts of the population that would not qualify for exemptions. In fact, the reform of the fee schedule in some governorates that raised co-payments from 1 to 3 pounds in upgraded facilities showed that people did not seek services in the upgraded facilities due to the higher costs. Against this background, it is advisable to use either flat rates of co-payments for services that are affordable or to link co-payments to income, not to actual costs. Moreover, there should be a ceiling for co-payments both per treatment and over a given time period (e.g. per year).

The level of contributions and co-payments has also to match the willingness to pay. This willingness is perceived to be very low in Egypt. Many Egyptians have a strong belief that the constitution entitles them to free healthcare. As a result, many people might question the solidarity aspect of social health insurance, i.e. the transfer of resources from the rich to the poor and from the healthy to the sick. Implementation and further development of social health insurance has to address these barriers to (higher) willingness to pay.

The exclusion of preventive services, which might allow reducing e.g. catastrophic costs related to the very frequent chronic diseases or maternal care, is likely to have cost impacts that might lead to barriers in access to related services.

As far as informal economy workers and their families are concerned, it is usually difficult to set a flat rate contribution that is based on the ability to pay. Some might be able to pay a higher amount, while others might not be. Evasion might be an issue if the amount is too high. Given the co-payments per treatment and relatively high maximums per hospital day and drugs it might be considered to develop contribution rates that allow reduced co-payments serving as a cost control rather than a potential financial barrier.

It is further suggested to provide information on advantages of insurance and specific incentives to the workers in the informal economy aiming at attracting them to the scheme. Another approach consists in improving the quality of services with a view to meeting needs and expectations. Focusing on improved services for primary and family care is a successful strategy already undertaken in the Suez pilot and beyond. It is suggested to consequently follow this approach in all governorates.

The suggested subsidization of contributions and co-payments of the poor is an important step towards providing affordable access to services for the poor and sustainable financing for the health system

By setting a minimum contribution of EGP 15, 20 or 25 for school children and EGP 20, 25 or 30 for university students, especially low-income families with many children might have difficulties to afford the enrolment of their children into the scheme. It might be important to assess the potentially impoverishing impact of such contributions on families in lower income groups and the poor.

It should also be taken into account that the allocation of funds to facilities used by the poor and vulnerable need to be improved to avoid under-the-table payments e.g. for syringes and other equipment.

4.2.2. The comprehensiveness of benefits

In the context of the current reform debate in Egypt visions and concrete concepts have already evolved but some issues are at present further examined, such as the definition of benefit packages that are affordable and meet internationally agreed standards and objectives.

Currently, there are two major approaches to defining the benefit package in the reform project: A rather comprehensive that might challenge fiscal space and the search for more limited benefit packages that would be more readily affordable.

Generally it should be taken into account that a package that is too limited will not lead to access to needed health services and result in out-of-pocket payments with related poverty impacts. The same holds true for services that are of low quality due to underfunding of facilities. Therefore, it is important to balance benefit packages with a view to meeting the needs, particularly of the poor and the financial constraints of the overall scheme. Inclusiveness, solidarity and equity should be referred to.

Possible approaches consist of embedding health insurance policies into a broader context of pro-poor policies and developing linkages between social security and health protection policies. This could be achieved by providing a set of benefits for different needs, such as comprehensive primary care services and targeted conditional cash transfers e.g. for maternal health. In this context primary care services should not be misunderstood as cheap but effective services that include e.g. referrals and prevention.

It might be useful to learn from international experience with countries that have successfully undertaken social health insurance reforms and were challenged in similar ways.

4.2.2.1. Peer countries' approaches

Countries that have recently implemented extensive reforms of their health system include Colombia, Costa Rica and Thailand. All three countries can be compared to Egypt in terms of their socio-economic development and levels of financing devoted to health care provision.

In Colombia for instance, total expenditure on health as per cent of GDP was 7.3% in 2006 and its per capita annual expenditure on health was USD 626 for the same year[62]. Likewise, for Costa Rica the figures stand at total health expenditure amounting to 7% of GDP in 2006, with per capita expenditure being at a higher level of USD 743[63].

Thailand has much lower levels of both total health expenditure as percentage of GDP as well as per capita annual expenditure, with the figures at 3.5% and USD 346 respectively[64]. The figures from Thailand especially provide an example of a how a country can achieve a high level of coverage, even with lower levels of total heath expenditure as percentage of GDP and with lower per capita expenditure. All three countries have, in their own ways, achieved remarkable success in the extension of social health protection.

While Costa Rica started its social protection and health protection measures from the 1940s onwards, the experiences of Colombia and Thailand are more recent and illustrate that near universal coverage is achievable in a relatively short period of time. The reform approaches are briefly outlined in the annexes.

All three countries have achieved nearly universal coverage through various forms of insurance. It varies between 97.8 percent[65] in Thailand, 87.8 percent in Costa Rica [66] and 87 percent in Colombia.[67]

In Thailand universal coverage was achieved by coordinating and rationalizing schemes for various groups of the population such as civil servants and the poor. The scheme for the poor – UC Scheme – is covering 75.3 percent of the whole population and financed by general taxation mainly deriving from a fixed proportion of taxes on tobacco and alcohol. No co-payment is currently applied for the poor. It was introduced in 2001 and consists of a compulsory coverage of all those who are not covered by the Social Security Scheme (SSS) or the Insurance for Civil Servants (CSMBS).

In Colombia, the mandatory health insurance scheme covers the formally employed (formal sector workers) and the self employed (informal sector workers) who can pay, and pensioners[68]. Health insurance for those under the CR covers the contributing members as well as all “first degree family members as beneficiaries of the contributing individuals”.

Costa Rica gradually increased coverage over a period of several decades by progressive inclusion of different population groups as outlined in the table below.

[62] WHO. 2009b.

[63] WHO Country Website Costa Rica, http://www.who.int/countries/cri/en/

[64] WHO Country Website Thailand, http://www.who.int/countries/tha/en/

[65] ILO. 2008.

[66] ILO. 2008.

[67] ILO. 2008.

[68] Gottret et al. 2008.

Table 17. Development of the health protection system in Costa Rica[69]

1941	Obligatory social security protection of urban salaried workers
1947	Obligatory protection of urban salaried workers concerning disability, old age and death
1962	Extension of health insurance to rural areas
1965	Application of family protection
1974	Creation of the non contributory disability, old age and death scheme
1975	Obligatory protection for non salaried workers
1975	Creation of the voluntary insurance program
1976	Obligatory contributions to health insurance for pensioners
1984	Creation of the insurance at state costs
1984	Protection through collective insurance conventions
1995	Obligatory to have a old age insurance in order to be able to enroll in the health insurance
1996	Insurance for all students of the country
2005	Obligatory old age and health insurance for all independent workers

The international experience in peer countries of Egypt shows similar approaches towards addressing the challenges. The use of social health insurance combined with tax funded components to cover the contributions of the poor has proven to be a successful approach when striving for universal coverage. An important parallel could also be seen in phasing increases of coverage over a longer period of time.

4.2.2.2. Experiences with different benefit packages

Given similarities in socio-economic background and social health insurance approaches and results of the three countries, what benefit package was considered to meet the objectives and standards and affordable?

The benefit package in ***Thailand*** under the UC-Scheme for the poor is characterized by aiming at providing universal access to essential health care and reducing catastrophic illnesses from out-of-pocket payments by establishing a tax-based financing system and paying providers on a capitation basis.

All Thai citizens are entitled to access quality health care and a single standard benefit package. The standard benefit package includes a set of health interventions stipulated in a contract between purchaser and provider at every level of health service. It has been classified into three components: the curative package, the high-cost care package, and the promotive and preventive package.

[69] Rodriguez Herrera. 2006. Page 26.

The curative package covers ambulatory and hospitalization services. It includes in particular:

- Inpatient and outpatient services
- Childbirth
- Dental care, with exceptions for 15 specific cases
- Annual checkups and special room charges.
- Disease prevention and health promotion
- Essential drugs

However, there are some exclusion, such as cosmetic surgery, infertility treatments, organ transplants, and the provision of private room and board.

Excluded is also kidney dialysis for cases with chronic kidney failure. For high-cost care, the UCS has adopted a similar package to the one provided by the SSS in order to standardize the packages across the scheme to minimize inequities in health care services"[70]

The services and procedures included in the high-cost care package included in the UCS are encapsulated in the following table:

Table 18. Benefit package (high cost care) in Thailand

Inclusive List	Exclusive List
Chemotherapy for cancers	Renal replacement therapy including kidney transplants for patients with end-stage renal disease
Radiation therapy for cancers	Other organ transplants
Open heart surgery including prosthetic cardiac valve replacement	Cosmetic surgery
Percutaneous transluminal coronary angioplasty (PTCA)	Infertility treatment
Coronary artery bypass grafting (CABG)	
Stent for treatment of atherosclerotic vessels	
Prosthetic hip replacement therapy	
Prosthetic shoulder replacement therapy	
Neurosurgery, e.g. craniotomy	
Antifungal treatment for cryptococcal meningitis	
ARVs for HIV	

[70] Gottret et al. 2008.

The third level of health care package included under UCS is the health promotion and disease prevention package which covers "immunizations, annual physical check ups, premarital counseling, voluntary HIV counseling and testing, antenatal care and family planning services, as well as other preventive and promotive care."[71]

The medical service welfare scheme has no exceptions for kidney diseases and all three schemes use the national essential drug list in the benefit packages"[72]

Besides covering the above and "comprehensive personal curative, preventive and health promotion (P&P) and rehabilitative services (with some exclusion lists)"[73] the benefits were updated to include ARV for HIV/AIDS, RRT and influenza vaccine by 2008.

In ***Colombia*** both schemes (subsidized and contributory) provide a 'basic benefits package'. The difference in the two schemes arises when it comes to the level of care provided. The contributory regime is more comprehensive than the subsidized regime and it covers all levels of care, while the subsidized system only includes the most essential care, which has to be complemented with services provided by public hospitals.

Both contributory and subsidized packages provide for general care, treatment in a facility of average quality, pharmaceuticals and ambulance service. The Obligatory Plan of Health excludes and limits all activities, procedures, and interventions that do not contribute to diagnosis, treatment and rehabilitation of disease; those that are considered cosmetic, aesthetic or sumptuary; and those that are experimental as defined by the National Council of Social Security in Health, such as cosmetic surgery, nutritional treatments or those with aesthetic aims, infertility treatments, treatments not recognized by scientific or medical associations or experimental treatments, treatments for sleep disorders, experimental treatment with drugs or substances, treatment with individual psychotherapy, treatment of periodontal conditions, orthodontia and prosthesis and treatment of varicose veins for aesthetic purposes.

The EPS - a scheme co-financed by contributions from both the employee and employer - provides the same basic benefits as Social Security and, for an additional charge, can provide some supplemental benefits including coverage for certain catastrophic illnesses or diseases

The scheme in ***Costa Rica*** provides a wide range of benefits for the population covered under the CCSS scheme. Benefits are usually provided by the facilities of the Social Insurance Fund CCSS. They include workers and their dependents.[74] It includes primary care, specialist care, surgery, maternity care, hospitalization, medicines, dental services, auditory services, limited optometry services and appliances (at a reduced cost). Further, cash subsidies and funeral stipends, social provision (only for direct affiliates) are provided.

The provision of benefits is split into different levels, giving the highest importance to primary health care. Primary health care is provided by Basic Comprehensive Health Care

[71] Gottret et al. 2008.

[72] Ministry of Public Health, Government of Thailand. 2002

[73] Jongudomsuk. 2008.

[74] Social Security Administration (SSA)/International Social Security Association (ISSA). 2007. Page 94.

Teams (EBAIS) covering 90% of the population[75]. EBAIS are typically composed of a general practitioner, a nurse and a technical assistant for primary health care. They offer the following services: health promotion, preventive and curative care and rehabilitative care for uncomplicated cases. In every area, normally composed of 9 or 10 EBAIS, there is an additional team of specialists to support the EBAIS.[76]

Cases that cannot be treated in primary health care units, which serve as the entry point of the health provision system, are referred to the higher levels of care. Secondary care takes place within a network of specialized hospitals offering medical-surgical treatment, internal medicine, pediatrics and gynecology-obstetrics. High-tech medicine is provided in a few national hospitals. In the provision of tertiary care, demand surpasses supply: Long waiting lists for patients have accumulated, especially concerning oncological treatments and some types of surgery.[77]

For medicines, a list of covered pharmaceuticals is defined by CCSS regularly and expanded continuously.[78] It is composed of more than 500 medicines and covers 97% of the country's morbidity/mortality profile.[79] So far, there is no price regulation for medicines.[80] Exceptional prescriptions of medicines, which are not included, are possible following a certain request procedure. This can lead to very high costs for the CCSS spent on very few patients.[81]

Regarding medical services, no definition of a benefit package exists. Only few treatments are excluded, e.g. plastical surgery. The regular practice is the inclusion of every advance in medical technology, mostly without taking financial feasibility into account.[82]

Given the above experience, the extensive list of services to be provided in the Egyptian health insurance would surely move Egypt to the top end of peer countries. There is, however, evidence, that providing an extensive benefit package will only be possible in stages and cannot be assumed to be available immediately for the whole country. The full package will most likely in the near future not be available in e.g. Upper Egypt given the available infrastructure and size of the poor population. While the extensive benefit package should remain a long-term goal, it is suggested to develop an initial benefit package focusing on family and primary health care centred services and develop it in stages over time towards more comprehensiveness. International experience provides evidence that achieving universal coverage through providing for comprehensive primary care benefit packages but excluding services that are perceived not to be essential could be a successful avenue for Egypt.

[75] Pan American Health Organization. 2008. Page 254.

[76] Rodríguez Herrera. 2006. Page 13.

[77] Pan American Health Organization. 2008. Page 257f.

[78] Caja Costarricense de Seguro Social. 2008.

[79] Rodríguez Herrera. 2006. Page 22.

[80] Pan American Health Organization. 2008. Page 258.

[81] Rodríguez Herrera. 2006. Page 23.

[82] Rodríguez Herrera. 2006. Page 44.

4.3. Preliminary comments on the government's financing scenarios

4.3.1. General observations

The following initial comments on the government's financing scenarios are related to the overall assessment of the reform project. A more comprehensive assessment will be provided as soon as the revised results of actuarial studies will be made available.[83]

The set of financing options provided by the MOH vary from the indications e.g. on contribution rates and co-payments in the draft laws 8 and 11 received during the mission. However, it is assumed that the government's scenarios reflect current thoughts. Therefore, differences between both approaches will not be discussed in the following.

The new scheme is planned to be financed from different sources including contributions, co-payments, lump sums and subsidies. It is assumed that it will be possible to mobilize funds through these domestic resources, including from the currently uncovered population in the informal economy and the poor. However, it seems that currently no exact definition of the poor has been agreed upon nor has their ability and willingness to pay been evaluated: Based upon official sources some 22 percent of the population are assumed to be poor; this is in line with ILO estimates that currently some 20 percent of the population have no access to health services when needed; the MOSS is working along the assumption that some 2 million households are ultra poor and 20% of the population are poor whereas international statistics point to the fact that more than 40 percent of the population are living beyond the 2 US$/day poverty line. It is important that an extensive study of the economic and social characteristics of the different covered population groups be undertaken as well as a review of their contributory capacity to pay for contributions and to provide co-payments.

The overall financial and fiscal affordability of the various financing options is of utmost importance once the different categories of the population are agreed upon in order to set realistic options for the reform.

For the time being further important elements for costing are missing. They include

- Piloting in various governorates
- The full expenditure forecast and the fiscal impact analysis in light of the government budget.
- Start up and transition costs for the new scheme, such as upgrading of facilities in poor governorates and addressing gaps in the health workforce
- Monitoring and evaluation of the new scheme
- Institutional/administrative set up including capacity building of staff

Gaps in funding for these aspects might lead to significant delays in implementation, impacts on inclusiveness and equity and should be taken into account in due time.

[83] The Ministry of Finance had indicated to the mission that the revised calculations would be made available to the ILO by end of April 2009.

For the time being, no information on mechanisms for provider payments, accreditation processes and incentives have been provided. These mechanisms impact significantly on the take up of benefits and cost control (and service quality) and should be specified in due course.

The government scenarios explicitly mention that contributions for work injury have not been included; however, it seems that the current regulation envisages that work injuries and occupational diseases will be covered through HIO. This raises concerns given the different risks and responsibilities for funding.

Generally, it should also be mentioned that it would be advisable to embed budgeting efforts for social health protection into the broader approach of poverty alleviation and ensure that synergies can be developed between various social security programmes e.g. for the elderly, the unemployed, the poor and vulnerable groups. The concept of social budgeting would be useful to ensure a coherent perspective on the requirements for future public social expenditure and to assist policy-makers in making the most appropriate priorities when making use of limited financial resources for social protection in a coherent and consensual way.

4.3.2. Costing of the benefit package

Based on the government financing scenario (high), the costs of the benefit package are set at a maximum of 240 EGP/year and person (equals the contribution/subsidy for e.g. the unemployed and informal worker). However, the MOF informed the mission that some cost estimates are up to 400 EGP/year (ca 80 US$) and person in public institutions and 780 EGP/year and person in private institutions. Experience in the Suez Pilot points to the fact that costs in private institutions might be even three times higher than in public institutions: A complicated delivery at a public hospital is estimated at 500 EGP and in private hospitals at about 1.500 EGP. It seems to be unlikely that even the amount of 400 EGP would be sufficient to cover real costs of the very comprehensive benefit package outlined by the MOH.

The review of the financing strategy needs to be based on a sound projection of expenditure in relation to the various government financing scenarios as behavioral variables will likely differ from one scenario to the other. The projections ought to be made on the basis of projected expenditure rather than on the basis of projected income. It would be useful to rely on the detailed analysis of the present data on the average cost and utilization of health care. More analysis should be also made on the future development of the number of medical personnel catering for increasing demands and personnel cost as well as possible development of the non-personnel cost including the development of drug price as one of the most essential cost driver as non-personnel cost.

As for the dynamics of the cost increase of health care, it is important, first of all, to analyze the past experiences of increases in utilization and the average cost. However, in the mid- and short term significant increases in the cost of services are to be expected and need to be taken into account. This relates to both, quantitative and qualitative effects. It would be unlikely if both costs and utilization patterns of those currently insured would remain unchanged given the extension to a large part of the population that faces specific health challenges due to their socio-economic profile.

It seems also important to take changing poverty and disease patterns into account given the impacts of the financial crisis on Egypt and its transition to a higher middle income country. Cost increases are particularly to be expected from increased utilization of services for chronic diseases.

The increasing number of patients with chronic diseases might also be challenged by the relatively high co-payments requested for drugs and services and therefore threatened by poverty. The related impact would be seen on an increased need for subsidies.

Further, health care cost of the disabled, including rehabilitation cost, would need to be properly taken into account given their need to join the scheme.

4.3.3. Health care financial projections

It is to be expected that a high number of non-contributors that need subsidies will be insured under the new scheme. The MOF assumes that a total of 25 % of the population will have to be subsidized.

Against this background, it seems to be narrow to focus on some 2 million households of the ultra poor. While this is an important step into the right direction, further efforts should be undertaken to avoid an underestimation of the funds necessary and ensure that those who are eligible for subsidies will not be excluded.

The suggested contribution rates for the formal economy seem to be moderate compared to countries with comparable health insurance approaches and development levels.

Also the contribution basis suggested raises concerns: It relates to just one out of usually several sources of income, particularly of those parts of the population that is more affluent. It is most likely that this group could afford to pay a higher share of their overall income for social health insurance and thereby increase required funds for the poor and contribute to solidarity in financing.

The government suggests increasing public health care financing resources by introducing an earmarked tobacco tax. More efficient targeting and controlling of the use of various subsidies provided in other sectors such as oil have also been mentioned. It is suggested to further elaborate this avenue in order to ensure that sufficient funds be available for the new scheme in line with the various scenarios of projected expenditure as well as to establish a new financing structure for health care.

Fiscal space is closely linked to enforcement of the law and macroeconomic conditions. Therefore, the government should take measures to ensure full enforcement and test the design of the social health protection system for its resilience against effects of the economic crisis and establish well-defined contingency measures together with the social partners, so that these measures can be enacted quickly if needed.

Finally, it is suggested to review the current allocation of funds in the health system. This concerns e.g. the use of funds allocated to the PTES scheme, should it be continued or if not, an assessment if in future these funds – equal to the budget of the current HIO – could be channeled through the new health insurance scheme. Further, funds currently used for the Family Health Fund should be added to the overall funds available for the new scheme.

4.4. Excellence in organization and administration

In the context of the ongoing discussion of the health insurance reform project in Egypt some observers speak about a “privatization” of the health system, whereas others refer to using the advantages of the private sector in the context of a universal health insurance scheme. In order to clarify the situation and avoid unnecessary dispute it is suggested to clearly define the leadership role of the government and the specific roles of social partners, civil society, providers, professional associations and the private sector. The

government's leadership should be inclusive and seconded by participatory decision-making.

Given the missing information on the roles of the public and the private sector, only general comments can be made on organizational aspects. It is emphasized that improvements in efficiency and effectiveness should be aimed at with a view to achieving expenditure reductions in administration, development of sound provider payment and cost control mechanisms and linking social health insurance to broader social security approaches.

Of key importance are also issues related to governance, social dialogue, purchasing and contracting.

4.4.1. Governance and social dialogue

The responsiveness to the concerns of contributors and users of services of the health system is an important factor. If the law creates guaranteed entitlements to certain services, this will only be meaningful if a body is set up where these rights can be claimed in case of failure to obtain them. This complaint mechanism should be easily accessible at the local level and decentralized. In this context, it is essential to establish mechanisms of social dialogue on the different levels of governance (national, governorate, local). Only if members have a real influence on the management of the scheme, they will fully support it and comply with it. In addition, the users can give very important feedback as they get to know the system from the inside and perceive needs for improvement. To be concerned about user satisfaction, giving users a say can contribute considerably to the quality of the system.

Good governance of SHP systems is closely related to institutional and administrative efficiency. Good governance is an integral part of the strategy design of SHP. Decision-making in social health insurance needs to be based upon, among others, accountability, transparency, equity and inclusiveness and participation and consensus.

The concept of tripartite governance of social health insurance – e.g. through a tripartite membership of the board – is an excellent tool for achieving good governance. It will also address the lack of transparency and quality that marks current public health protection and the current reform process. This challenge has become particularly important since the current legislation is perceived as turning the social health insurance into commercial one on the basis of its increased subscription fees and co-payments and the reduced benefit package.[84]

It is, therefore, advisable to establish a broad national and social dialogue, which discusses reform aspects and proposals and ensures a broad consensus on the features, governance and implementation of SHP. Participants of this dialogue should be representatives of workers associations, trade unions and informal economy workers, patients, health workforce, public and private healthcare providers, employer representatives and the relevant government and public sector institutions. The dialogue on the reform process should lead to a governance structure for social health insurance that ensures all important social partners are included in monitoring, reviewing and decision-making in SHP. An important tool could be tripartite boards of the SHP institutions, which bring together patients/civil society, employers/providers and government with equal decision-making power. This board reviews all relevant financial and administrative matters and jointly decides on important aspects such as treatment standards,

[84] Egyptian Committee on the Right to Health. 2008.

Additionally, the government needs to ensure that appropriate regulatory conditions and oversight is established. An important aspect of these regulations is to separate the social health insurance fund from the government. The financial resources and revenues earmarked for or generated by social health insurance should be kept entirely separate from the government budget. This should also be the case with regard to different social risks such as old age or unemployment. It is important to keep the funds for different risks separately. Against this background, it is suggested to separate health insurance from work injury as currently foreseen in the draft law and take into account the different risks and responsibilities of employers for financing this.

Authority over funds should rest with the (tripartite) boards of the organization(s). The current position of the HIO as an institution that is not under the MOHP provides a useful starting point for institutional reform. Government allocations (i.e. mainly the subsidies for the contributions of the poor and ultra-poor) should be transferred to the insurance organization and be entirely under its control. The contributions from workers and employers should also be collected and administered by the organization. Decision-making over these funds should be with a tripartite board of and should only be allowed to be used for healthcare related benefits and internal administration.

An adequate communication strategy to explain reform plans, the logic of a health insurance scheme and the need for a phased implementation over a long term could improve the reputation of the reform and newly established organization among the general public. In this context, it will be crucial for the further reform process to attribute a lot of importance to information and awareness rising. The challenge for the implementation of the reform will lie in taking strong, technically sound decisions on many issues ranging from the size of the benefit package, the level of contributions and co-payments, the contracting and payment mechanisms, the provision of quality services to the monitoring and quality assurance. It is equally important to communicate these complex technical matters understandably to the public to build trust in the new organization and the new system. To a large extent, this will depend on the quality of services but it will also depend on the governance, structure and administration of being perceived as efficient, accountable and fair.

Punishing abuse and corruption will further help to build trust. No system operates without a limited level of abuse but implementing procedures to track expenditure, quality and user satisfaction and visibly act on poor performance will improve the public reputation of the scheme. Having established a trusted institution with strong lines of accountability, will also make it easier for the new payer to justify contribution rates to employees and employers, attract new members to the scheme, especially better-of informal economy workers that may otherwise evade contribution payments.

Efficiency and effectiveness in administration is important for the overall quality of the scheme. However, it seems improvements in administrative structures have not been clarified yet in great detail in the current version of the law.

The new law aims at the separation of provider and financing functions currently assumed by the health insurance organization/Ministry of Health. However, important details impacting on the overall costs of the new scheme such as provider payments and accreditation procedures have not been clarified yet.

Despite the government’s wish to unify all existing schemes into one system, the PTES scheme might remain. Given its gaps in transparency and its high costs it will be necessary to develop further details on its functioning, eligibility criteria, cost coverage etc.

4.4.2. Purchasing and contracting

An important mechanism, through which social health insurance contributes to better equity and responsiveness in health systems, is the strengthening of the demand side in the health sector. This is achieved by establishing a strong purchaser of healthcare services, i.e. the health insurance fund. This can have important benefits for the availability and affordability of good quality services, particularly for the poorer segments of the population.

Further, for the time being, no provider payment or accreditation mechanisms to deliver quality services have been suggested in the draft legislation for primary, secondary and tertiary care. Given the significant impact of related decisions for the costing it is suggested to evaluate and - if necessary - revise the proceedings with a view to more efficiency, effectiveness and quality in service delivery.

The experience of the HIO concerning purchasing and contracting should be made available for the new system. The HIO is experienced in contracting inpatient and outpatient health services. At the same time, the HIO constituted only a relatively small purchaser of services compared to overall health expenditure. It is expected that the 'new payer' will be a stronger purchaser, representing a bigger share of the total provider capacity, both due to increased coverage of the poor and the informal economy workers and increased utilization in light of improved services under the new system. In this function, the 'new payer' will face the same difficulty as any purchaser in a SHI system: to balance considerations for cost containment with considerations of quality. Under the current system, cost issues often seemed to prevail over those for quality. However payments to providers should cover their marginal costs and contribute to their capital expenditure for upkeep and investment needs. Otherwise, providers will be driven out of business or quality levels will deteriorate. This is important particularly in light of the recent investment in upgrading to ensure that these investments in the infrastructure and improved levels of quality in many facilities (partly financed by donors like the EU, UNICEF and the World Bank) will be sustainable in the long run. At the same time, purchasing an expanded volume of services through the new payer might use up current excess capacities, strengthening the autonomy of providers and possibly driving up prices. These effects would vary greatly in different areas depending on the availability of services.

The new payer will need to quickly build up capacity in the area of purchasing and establish an adequate payment mechanism. While hospital care is often reimbursed on a fee-for-service basis, primary care could be paid by capitation or on the basis of diagnostic-related groups (DRG), which may also be suitable for some hospital treatments. However, DRG systems are costly since they require a large amount of data gathering to establish adequate levels of reimbursements that take into account age, sex etc. of cases and related costs. The question of choosing suitable payment mechanisms relates to the need of building up capacities for contracting of providers. Unlike the HIO, the new payer will not own any facilities but contract services (both public and private). However, the HIO has only limited capacity to manage these contracts effectively, ensuring both adequate payments and levels of care.

On the providers side, it might be useful to develop approaches aiming at ensuring better compliance with reporting, issuance of invoices by providers, avoiding under-the-table payments for equipment and addressing leakage of funds by developing efficient mechanisms of payments and contribution collection, mechanisms of management of public funds, control and reporting and enforcing related regulations in the context of upcoming public finance reforms.

4.5. Piloting implementation

It has become clear, that strong political commitment and society's demand for a reform of social health insurance in Egypt exists, in particular with regards to improvement of service quality and extension of coverage.

Several important steps have to be taken in this reform: The gaps in coverage and access in the current system have to be fully understood and defined before taking conclusions on policy changes. This includes taking stock of all existing social health protection systems and legal provisions for coverage.

Important steps to develop a sustainable scheme providing for quality services include developing feasibility studies, piloting, implementing and monitoring/evaluating in different socio-economic and geographical environments and related further adjustment of scheme features as foreseen by the government in the Governorates of Sohag and Alexandria.

This should be based on results of testing and costing of different benefit packages, assessing income from different sources and allowing for flexible adjustment through monitoring of results at the administrative, financial, demand and supply level. Special consideration should be given to covering women, informal economy workers and families. In addition, further Governorates with high poverty levels, should be selected for piloting and implementation.

On the basis of these conclusions, a plan for the extension of coverage should be developed. This plan – partly consisting of legislation – would be a coherent design for a pluralistic national health protection system and delivery structures, aiming at universal coverage. The plan would address all relevant aspects, such as coverage mechanisms for specific population groups; benefit package(s), regulation on sources and usage of revenues, institutional and administrative processes and the timeframe for the achievement of universal coverage, including details on how the transition to the new system will be phased. The implementation of the plan requires the strengthening of all relevant national capacities, such as training for decision-makers and administrative staff, upgrading of capacities in designing, implementing and monitoring and overall development of knowledge sharing and usage.

The suggested phased implementation e.g. by governorates will require additional funding for

- Piloting, evaluation and monitoring
- Capacity building of decision and policy makers in the government, trade unions and employers' association, administration of the new scheme.

5. Suggestions for technical cooperation

The implementation of the following activities and strategies in relation to the social health insurance reform are recommended. The ILO stand ready to support their implementation and/or supervision. Depending on the availability of funding, possible implementation might be sought in cooperation with the international community, local partners or others. These suggestions aim at contributing to achieving national and internationally agreed objectives and focus on:

- Refining the options for financing, benefit packages, extension of coverage to the vulnerable etc. on the basis of a thorough actuarial assessment in line with social insurance principles
- Undertaking a review of the projected health budget in relation to the public social expenditure - the social budget
- Undertaking a micro-simulation study on the projected impact on poverty according to the different government financing strategies
- Facilitation of national and social dialogue on the reform process
- Finalizing the legislative process
- Developing and implementing an information and communication strategy for the SHP reform
- Strengthening capacity for development, implementation and management of social health insurance
- Developing an implementation strategy

5.1. Financial, actuarial, social budgeting and micro-simulation studies

The government supported by the international community has already compiled actuarial studies and scenarios. However, an actuarial study based on the most recent legislation, government scenarios and issues addressed in this report was not available at the time of writing. The following comments aim at providing a framework for assessing more current actuarial studies.

The results of the studies and commentaries already made and to be expected from within the political decision making process, from social partners, civil society, experts and others should be taken into account in order to achieve a realistic picture of the financing scenarios envisaged so to better assess their implication in terms of behavior of the covered population, related projected costs and to draw more accurate appreciation of the potential advantages of each of the various options under the new scheme.

It is advisable that aspects related to affordability both at the national and household level be carefully considered. A broad approach should be pursued in which social health protection is seen as an instrument to contribute to alleviating poverty (in particular, health-related impoverishment), improving access to and quality of healthcare services and overcoming socioeconomic challenges (such as social and economic differences between urban and rural areas). It would be beneficial that the actuarial study be conducted based on coherent demographic and economic assumptions. It should cater for adequate financing strategies for a broader social protection mechanism including universal access

to basic health care, income security for children and the elderly as well as for the working age poor. The social budgeting concept could be revised on the basis of the prior work undertaken by the ILO in 2001.

5.2. National dialogue on the reform process

Extending social health protection requires strong political commitment and support from the whole society in order to be sustainable. Visions on the schedule and priorities for the reform as well as the financing often differ. Experience of ILO suggests that reforms based on a broad national dialogue involving workers' unions and employers' associations contributes significantly to building consensus and thereby sustainability. Failure of discussing reform issues widely often results in a lack of mutual understanding and creates mistrust and evasion.

However, given the diverse interests of all partners involved, achieving the necessary support is highly complex and difficult. Problems often arise when concerns are ignored or misunderstood and participatory decision-making was limited. This might result in lack of support for the implementation, enforcement, funding, and compliance with new laws and ultimately leads to further reform activities, sometimes even after parliamentarian hurdles have been passed.

Against this background, it is suggested to develop opportunities and provide forums to develop a national and social dialogue to achieve as a broad a consensus as possible on the reform process.

Basing reform decision on sound technical advice is important, however the ILO's experience suggests that health policy reforms also involve value judgments and diverging perceptions of interests and should therefore be agreed upon through broad national consultations with all those who are concerned, such as the various government ministries, workers unions and employers associations representing those who pay and receive benefits. Such a consultation process might contribute to advancing the reform project, ensuring that negative impacts could be anticipated and mitigated, reflecting the interest of all concerned and sustaining support of all actors involved. Possible topics might include developing and implementing sustainable consensus on

- Financing mechanisms, including setting of contribution rates and subsidies for health services
- Extent of benefit packages
- Defining needs for capacity building including for social partners
- Developing strategies for gradual extension of coverage e.g. an implementation plan of the reform proposal

It is in this context that the "ILO Dialogue on Social Health Insurance: The Reform Project in Egypt" will take place in Cairo. It aims at facilitating an open dialogue on key issues related to the Reform Project and providing inputs to the discussion from international perspectives in achieving universal coverage with social health insurance.

The meeting is intended to be a forum for high-level policy and decision-makers of the Government and other national authorities, the trade unions' federation, the employers' federation, international organizations, national experts and the press.

5.3. Support for piloting

The implementation should be based on a coverage plan and phased by governorates. This will set out the path towards developing and implementing comprehensive benefit packages according to a common diagnostic framework aiming at identifying needs of various income level groups, financial and geographical barriers to access health services and taking into account specific outreach targets, financial projections, requirements for subsidies, infrastructure development etc.

It will be important to take a gradual approach towards increasing insurance/benefit packages that include essential services, maternal neo/post-natal child health, catastrophic referrals and possibly transportation taking into account constitutional requirements, fiscal space and ability to pay.

In the context of the evaluation and monitoring of pilots in Suez, Alexandria and Sohag, an assessment of issues related to the following aspects can inform the overall implementation process:

- Efficiency and effectiveness of proposed determination of wages, contribution bases, and contribution rates
- Development of options for supplementary non-wage contributions for the formal sector
- Changes in income/poverty status of vulnerable population groups within 12 months
- Cost impact of accident insurance and use of private health care facilities and hospitals as compared to public facilities and hospitals
- Role of social partners and civil society
- Willingness to pay for insurance, reasons for non-take up of benefits by the poor, better targeting of women, children and elderly, people with chronic diseases.

5.4. Information campaign

Furthermore, education and awareness building should also be employed to inform public behavior and address particularly misunderstanding and evasion of social health insurance concepts by providing consistent and uniform messages on key topics.

It seems to be important to address these through a communication strategy on the social health insurance and its reform. Multimedia campaign tools, known and appropriate to the people should be utilized to build public awareness. These may comprise campaigns aired on local television and radio programs, printed articles in broadsheets, tabloids and brochures and published via the Internet. Generally, the approaches should be culture-appropriate tailored to the sensitivities of different audiences and based on the vernacular. For example, they should target specific population groups as in the use of radio programs to reach the members of informal economy and their families including the poor or those in the rural areas.

In this context, a major national conference should be held and led at the highest level of the Government involving the President and responsible government ministers. It should aim at launching the information campaign, education and awareness building activities. A forging of commitments by relevant stakeholders (e.g. insurers, trade unions, and employers, policymakers, health providers and decision makers) may be done to signify consensus, support and intent to pursue the reforms. This conference may also be used to

institutionalize social dialogue / consensus building as a mechanism to achieve national and local level plans and reforms.

5.5. Capacity building

Capacity building for health insurance schemes should take place at two levels:

The system or managerial level with regard to the use of funds, efficiency, management capacity, legislation and enforcement, decision making process etc and

The service delivery level focusing on responsiveness, provider behavior, medical intervention, infrastructure, equipment and staff.

The training activities should tackle selected issues at both levels including enhancing administrative, management and technical capacity aiming at improving the system and managerial level as well as responsiveness and provider behavior.

The objective of the training should be to ensure efficiency and effectiveness of the administration and management of the scheme, develop management capacity, legislation and enforcement and enhance the decision-making processes. Related training components could include:

- Accounting skills/budgeting and cash flow management
- Actuarial and social budget modeling and analytical skills
- Statistical data collection and analysis
- SHI management at both national (e.g. National Health Account) and provider levels (e.g. accounting, costing of benefit packages, utilization)
- Cost estimation and cost control
- Information management skills (collection and analysis of patient data)
- Capacity to collect contributions
- Capacity to contract providers/process claims
- Membership management
- Capacity to enforce regulations
- Monitoring capacities
- Communication strategies

Besides training activities focusing on technical and administrative issues, it is also suggested to provide for capacity building of decision makers in the government, social partners and civil society given the need for agreement on key features of the reform and the current deficiencies in consultative processes on the reform. This should be based on approaches to consensus building and national dialogue, board representation, regulation, and information sharing in social health insurance

The capacity building measures and the above-mentioned national dialogue event could be seen in the context of broader information and awareness raising campaigns aiming at

advocacy for the reform and its objectives to improve access for the poor and is particularly important in the light of the financial crisis and necessary adjustments.

As regards the pilots in Sohag, it is suggested to support the implementation process through joint capacity building activities in cooperation with WB, WHO, UNICEF, USAID and EU such as training of administrative staff on their new role as purchasers of services, audit and investment policies, contribution collection from informal economy workers, decentralization etc.

Annex

Mission team

Dr. Youssef Qaryouti, Director SRO Cairo

Dr. Xenia Scheil-Adlung, Health Policy Coordinator, ILO Geneva

Ms. Veronika Wodsak, Health Policy Officer, ILO Geneva

Ms. Nashwa Belal, ILO SRO Cairo

Ms. Amal Mowafy, ILO SRO Cairo

Officials met during mission

Minister of Finance

H.E. Minister Yousef Botros Ghali

Dr. Mohamed Ahmed Maait, Deputy Minister of Finance

Mr. Ahmed Rashwan, Pension and Insurance Reform

Minister of Manpower and Migration

H.E. Aisha Abdel Hady

Ms Mervat Wahbi, Director of International Relations

Minister of Social Solidarity

H.E. Minister Dr. Ali Elmoselhy

Egyptian Trade Unions Federation

Mr Ossama Elashiry, Ambassador

Mr Mostafa Mohamend Zaki Rostom, Head, International Relations Department

Mr. Mostafa Mongy

Egyptian Insurance Supervision Authority

Dr. Adel M. Rabeh, Chairman

Dr. Ali El-Ashry, Deputy Chairman

Dr. Ehab Abul-Magd

Federation of Egyptian Industries

Mr. Samir Hassan Allam, Heal of Labour Committees

Mr. Amr Ibraheim El Desouki Abed, FEI, Human Resource Manager

Mr. Hamdy Kobaisy, FEI, Board Member

Mr. Hend Nadim, FEI, Board Member

Mr. Khaled Abd El Fatah Sayed Ebrahem, FEI, Board Member

Health Insurance Organization / Ministry of Health

Dr. Said Rateb, Director

Dr. Abo Bakr A. Elmekawy, Head of Technical Office

General Social Insurance Fund / Ministry of Finance

Mr. Ali Mahmaud Nassar, First Undersecretary, Head of Government Fund, Ministry of Finance

Private Social Insurance Fund / Ministry of Investment

Advisor to the Chairperson

Central Chairman of electronic data documentation

General Director of insurance technical orientation

Director of central insurance evasion combat

Director of System Analysis

Suez Pilot Project

Dr. Emam Mohamed Mosa, Director of Health and Population

Dr. Mohamed Hassanein

EU

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Dr. Vijayakumar Moses, Chief, Young Child Survival and Development

Dr. Magdy El-Sanady, Health Specialist

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Ms. Vikki Stein, Health, Population and Nutrition Officer

Ms. Mahinaz El-Helw, Health and Population Office

World Bank

Mr. Emmanuel E. Mbi, Director Central Middle Eastern and North Africa Department

Mr. Sidi Mohamed Boubacar, Deputy Head of Office

WHO

Dr Ahmed Ali Abdul Latif, WHO Representative, Egypt

Dr. Belgacem Sabri, Director, Division of Health Systems and Services Development

Dr. El Idrissi Zine-eddine M. Driss, Health Economist

Draft legislation on Health and Social Health Insurance

Decree issued by the President of the Arab Republic of Egypt

Draft law

For the promulgation of a Law Concerning Health and Social Insurance

The president of the Republic

Having perused the Constitution;

And Law No. 10, for the year 1967, regulating the trade in the medicines of the General Authority for Health Insurance;

And the provisions of Law No. 32, for the year 1975, regulating medical treatment insurance for employees working for the government and local Authority bodies and public organizations and institutions, and the Social Insurance Law No. 79, for the year 1975;

And Law No. 99, for the year 1992, regulating health insurance for students:

And Law No. 203, for the year 1991 promulgating the Public Sector Companies Law,

And President Decree No. 1209, for the year 1964, establishing the General Authority for Health Insurance and its branches for employees of government and local Authority bodies and public institutions and organizations,

Has resolved that,

This draft Law shall be submitted to the People's Assembly and the Consultative Council.

Article 1

The provisions of the attached Law shall apply to the Social and Health Insurance System.

Article 2

The following laws shall be annulled:

– Law No. 10, for the year 1967, regulating the trade in the medicines of the General Authority for Health Insurance;

– Law No. 32, for the year 1975, regulating medical treatment insurance for employees working for the government and local Authority bodies and public organizations and institutions;

– Any provisions of Law No. 79, for the year 1975, regulating Social Security which contradicts the provisions of the attached law;

– Law No. 99, for the year 1992, regulating health insurance for students,

And,

– Any provisions that contradict the provisions of the attached law.

Article 3

Existing regulations and decisions applicable at the date of entry into force of this Law shall remain in force until the regulations and decisions provided for under this Law shall be issued, provided the former do not conflict with the latter.

Article 4

The Minister for Health shall issue the executive regulations for this Law within six months of its coming into force.

Article 5

This Law shall be published in the Official Gazette and shall come into force at the beginning of the month following the date of its publication.

Social Health Insurance Law

Chapter I

Scope of application of the provisions of this law

Article 1

Social health insurance is a compulsory system founded on social solidarity and covers all citizens and that the State shall cover the cost on behalf of the needy. Its provisions shall come into force on a gradually basis under decrees issued by the Prime Minister based on a presentation by the Minister for Health.

The insurance shall cover sickness and work related injuries.

The insurance shall not include natural disasters or epidemics.

This system shall be based on the principle of separation between service finance and service provision.

Article 2

Health insurance refers to the services provided within the Republic, which are:

Preventative, remedial and rehabilitation services and medical tests as listed in a set of services prescribed by a decree issued by the Prime Minister. Such services may be reviewed, as required, pursuant to a presentation by the Minister for Health.

Article 3

A portion of the resources available to this insurance system shall be allocated for the coverage of personal health catastrophes (which have a destructive impact on the financial stability of families). The rate of such allocation, the qualifying cases, and the method of coverage shall be prescribed by decree issued by the Prime Minister pursuant to a presentation by the Minister for Health.

Chapter II

System administration

Article 4

Administration of this system shall be carried out by a public body having a juridical personality and reporting to the Minister for Health and Population pursuant to a Presidential decree setting its competences and internal codes. Until such a Presidential decree is issued, the General Authority for Health Insurance, which is subject to Presidential decree No. 120, shall administer the system.

Article 5

The Authority shall, either directly or through its branches, implement health insurance through a decentralized administrative system based on self administration by the Authority's branches or regions.

Chapter III

Finance

Article 6

The health insurance system shall be financed from the following sources:

1. Subscriptions by insured persons:

    1. Employees subject to the social insurance Law at a rate of 1.5% of total income.

    2. School and university students at a rate of 5% of tuition fees, at a minimum of EGP10.

    3. Professionals with irregular salaries at a rate of EGP15 per month.

    4. Artisans with the irregular salaries at a rate of EGP10 per month.

    5. Pensioners at a rate of 1% of monthly pensions.

    6. Widows at a rate of 2% of monthly pensions.

    7. Unemployed wives at a rate of EGP10 per month.

    8. Pre-school aged children at the rate of EGP20 per annum.

Husbands shall pay the subscription for their unemployed wives and children at home.

2. Employers' contributions:

    1. Sickness insurance at a rate of 4% of total wages of employees registered with the employer.

    2. Work injury insurance at a rate of 1% of total wages of employees registered with the employer.

    3. 3% of the pension paid to pensioners and widows by the body responsible for insurance and pensions.

3. Fees and contributions by insured persons:

    1. Fees paid upon receipt of various services (overnight hospital stay, examination by practitioners, examination by specialists, home visits, etc.). Such fees shall be set by a decree of the Minister for Health and Population pursuant to a presentation by the head of the Authority, and shall not exceed 25% of actual costs.

    2. A third of the cost of outpatient medicines.

    3. A third of the cost of outpatient examinations/tests.

4. Public treasury contributions:

1. EGP 12 for every school and university student and every child under school age.

2. Full subscription costs for insured persons eligible for a full subsidy as prescribed under decrees issued by the Minister for Health and the Minister for Social Solidarity.

3. The value of the contributions payable at receipt of service for persons eligible for full subsidies.

4. A percentage of Gross Domestic Product as prescribed under decree issued by the Prime Minister.

5. Subsidies, gifts, awards, and other resources approved by the Authority's board of directors.

6. Returns on the investment of the Authority's funds.

7. Other sources:

- 10% of the price of each unit of tobacco sold.
- The sum of …. at obtaining the first driving license.
- The sum of …. at renewing vehicle licenses according to engine size.
- The sum of …. per ton of cement.
- The sum of …. at obtaining licenses for treatment centers, hospitals, and pharmacies.
- The sum of ….at registering a first child, increasing gradually by …. based on the number of children.

Article 7

The value of subscriptions, contributions, and other funding sources may be amended by decree issued by the Prime Minister pursuant to a presentation by the Minister for Health in light of the results of a review of the Authority's financial position conducted every three years.

Article 8

The public treasury shallow undertakes to pay any shortfall in the Authority's funds if its various reserves are insufficient to meet such shortfalls.

Article 9

Any surplus in the Authority's funds shall be transferred to a special account from which no disbursements shall be made unless approved by the Authority's board of directors.

Chapter IV

Service providers

Article 10

Health insurance services shall be provided through contracts with government, non-government, and private health care providers in accordance with quality standards and contractual regimes prescribed by the Authority.

Chapter V

General provisions

Article 11

– The Authority shall be responsible for treating the injured and sick and providing them with medical care until cured or until their condition stabilizes or they are shown to be disabled. The Authority shall be entitled to monitor the injured or sick wherever their treatment takes place.

– The level of insurance related healthcare services may not be below the levels prescribed under a Minister for Health decree.

– The State undertakes to treat the needy through financing treatment costs. Executive regulations shall prescribe the terms and conditions governing the eligibility of the needy.

Article 12

The Authority shall provide tests for employees exposed to any of the occupational illnesses listed in Schedule I attached to Social Security Law No. 79, for the year 1975, against a fee of EGP10 payable by the employer for each insured person exposed to the said illnesses. The value of this fee shall be reviewed every three years pursuant to a decree by the Minister for Health in agreement with the Minister for Labour.

Article 13

Cases of incapacity prescribed under the aforementioned social security law shall be attested to by a certificate from the Authority covering such information as shall be prescribed by a Minister for Health decree in agreement with the Minister for Social Security. Medical commissions nominated by the Authority shall decide on the incapacity of insured persons in cases of work injury and sickness (the date and proportion of such incapacity).

Article 14

Basic care units and family medicine units shall keep medical records relating to all family members within their geographical jurisdiction. The executive regulations shall set out the information to be contained in such records.

Article 15

All competent authorities shall supply the Authority with required data on the number of persons covered by this Law, as well as their geographical location, age, profession, and any further information required by the Authority in the course of carrying out its tasks.

Articles 16

Benefits provided under this insurance shall be suspended in all cases where payment of subscriptions is interrupted for any reason whatsoever.

Articles 17

The fixed and movable assets of the Authority, as well as all its investment activities, shall be exempt from all taxes and levees.

Articles 18

Subscriptions payable pursuant to this Law shall be exempt from or taxes and levees.

Article 19

Claims relating to the implementation of the provisions of this Law filed by the Authority or insured persons, at all court levels, shall be exempt from court fees. In such claims, the competent court may issue decisions requiring expedited execution and refuse to accept bonds.

Article 20

Amounts payable to the Authority pursuant to the provisions of this Law shall have first claim on all debtors' fixed and movable assets and shall be paid immediately upon settlement of court expenses. The Authority may collect such amounts by means of administrative confiscation.

Chapter VI

(Penalties)

Article 21

Without prejudice to any severer penalties prescribed under any other law, any person preventing Authority employees enjoying judicial powers of inspection from entering a workplace or perusing records, books, documents, or papers as may be required for the enforcement of this law, or refusing to provide information prescribed under this Law or its executive regulations and decisions, shall be subject to a prison term not exceeding two months or a fine not exceeding EGP1000, or both.

Article 22

Without prejudice to any severer penalties prescribed under any other law, any person maliciously providing inaccurate information or maliciously withholding any information prescribed under this Law or its executive regulations and decisions, such as may lead to unlawfully obtaining funds from the Authority shall be subject to a prison term not exceeding three months or a fine not exceeding EGP2000, or both.

The same penalty shall apply to any person intentionally providing erroneous information for the purpose of evading payment of amounts due to the Authority.

Article 23

Without prejudice to any severer penalties prescribed under any other law, any employee of the Authority or any of its contractors, including doctors, pharmacies, etc., facilitating the obtaining of medicines by unlawful means or against proper medical

practice by a beneficiary or any other party to whom the Authority provides medical services pursuant to its codes shall be subject to a prison term of not less than three months or a fine of a minimum value of EGP1000 and a maximum value of EGP2000, or both.

The same penalty applies to any person to whom medicines were dispensed and subsequently sold them on to others and any person who obtained such medicines knowing they were dispensed under the medical care provision system.

Explanatory Memorandum of Article 7

Chapter Three

Draft Social Health Insurance Law on Funding

The article on funding resources of Social Health Insurance, in draft law 8, was one of the most controversial on all levels of society. Since the draft formulation committee has decided to rephrase this article in its final version of the draft law, so that it would include only titles without getting into details, the committee therefore finds it necessary to explain the following in relation to the article:

- The sustainability and continuity of funding and its ability to respond to health and economic developments constitute a key requirement in any social health insurance system.

- The needed funding must correspond to the cost of the package of services offered.

- The actuarial study has determined the cost of the package of services under 3 different scenarios, which should be of the first consideration when deciding funding resources, having taken note that ***the cost of the service package is not equivalent to the total cost of the entire health insurance system***. The health insurance system comprises other components such as public health services undertaken by the government, e.g. vaccinations, epidemic fighting, etc., the cost of the supervisory and leading role of government health institutions, and the operational cost of less frequented units, in addition to the cost of keeping employees for mere social reasons.

- The funding section in draft no. 8 listed only some of the funding resources in line with social health insurance systems worldwide. The examples were by no means exclusive nor exhaustive. Financing experts and the legislative body are, therefore, welcome to decide the best available resources to provide the required funding.

- The wide-scale society debate of the draft law has unraveled profound understanding of the funding value and sustainability, as well as a gradual acceptance of the concept of increasing subscription rates, while having reservations over the level of contributions, etc.

- The replies sent by:

    a. The National Democratic Party’s Health Committee

    b. The Egyptian General Federation of Trade Unions

have offered detailed propositions for funding. As both bodies have substantial popular weight, we believe that making use of these propositions when deciding funding resources is very important so that an agreement on detailed funding resources can be reached.

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