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Improving social health protection for refugees in Egypt through their inclusion in the Universal Health Insurance (UHI) scheme

Summary

Egypt is a populous, lower-middle-income country with a gross domestic product (GDP) per capita of US$3.32 thousand in 2023 (IMF 2023). Financing of healthcare in Egypt is overly reliant on out-of-pocket (OOP) payments – in 2019, these represented up to 59.3 per cent of current health expenditure – meaning an increasing number of households are at risk of catastrophic spending on health and, therefore, impoverishment (WHO Regional Office for the Eastern Mediterranean 2023).

In 2018, the Universal Health Insurance (UHI) law was enacted as part of the Government of Egypt's commitment to progress towards universal health coverage and universal social protection (Government of Egypt 2018, 2). The UHI law aims to extend financial protection to the entire population when accessing health services. It is being implemented in phases between 2019 and 2032; the first phase is already under way in six governates (Port Said, Ismailia, Suez, South Sinai, Luxor and Aswan).

For the past decade, Egypt has been hosting a large number of refugees – 737,000 as of August 2024 (UNHCR 2024). Their access to healthcare is regulated through a Memorandum of Understanding (MoU) signed between the Ministry of Health and Population and UNHCR. This MoU grants refugees and asylum-seekers from all nationalities access on an equal footing with nationals to primary, secondary and emergency health services financed through the Ministry of Health and Population and provided in public facilities free of charge.

In addition, several NGOs partner with UNHCR to provide primary, secondary and tertiary healthcare services that refugees otherwise would have difficulty to access.

Within the context of the phased implementation of the UHI law, the ILO and UNHCR jointly assessed the feasibility of including refugees and asylum-seekers in the new Universal Health Insurance scheme (UHIS) (ILO and UNHCR 2023). The study's main findings are outlined below.

Main lessons learned

- In Egypt, the new Universal Health Insurance law established a legal framework to extend social health protection to the entire population. The new law provides a pathway to include refugees in the UHIS.
- Currently, refugees face barriers and financial hardship when accessing health services, putting them more at risk of impoverishment. Integrating refugees in the national social health protection systems would be in compliance with global human rights instruments, the 1951 Refugee Convention and international ILO standards on social security and equality of treatment. This approach bolsters economic policies that promote solidarity and social cohesion, safeguard public health, and foster healthy, productive communities for economic and livelihood growth.
- The study assessed the feasibility of enrolling refugees in the new UHIS and proposed policy options for their inclusion based on socio-economic status. Various scenarios were considered to assess how the refugee population would enter the scheme.
- The study and consultations with national counterparts highlighted the need for greater focus on the informal economy, in which a significant share of refugee households is likely to work. In particular, the mechanisms to identify, enrol and collect contributions from workers in the informal economy need to be strengthened and the vulnerability assessment currently in use needs to be reviewed.

Background

The delivery of health services in Egypt is highly fragmented and involves a wide range of public and private providers. The Ministry of Health and Population (MoHP) is the main provider of promotive, preventive and curative services across primary, secondary and tertiary levels of care in the public sector. All services it provides are either free of charge or highly subsidized and accessible to the entire population, including for non-nationals and refugees (Gericke et al. 2018; UN Egypt 2022). In the private sector, healthcare is delivered by a wide array of specialized providers, including those that are for-profit, not-for-profit, non-governmental organizations, and faith-based and charity-based organizations (Ministry of Finance of Egypt 2020).

Public spending on health is low compared with other lower-middle-income countries and there is high reliance on OOP[1] as a source of financing – in 2019, it accounted for 59.3 per cent of total health expenditure (WHO Regional Office for the Eastern Mediterranean 2023). Government spending on health is mainly channelled through the Ministry of Finance (MoF) and amounts to a third of total health spending, which funds the healthcare activities of both the Ministry of Health and Population (MoHP) and the Ministry of Higher Education. Private health insurance plays a limited role, accounting for just 3 per cent of health financing and targets the wealthy.

Egypt has pursued universal health coverage since the 1950s, shortly after it became a republic. Policies aimed at nationalizing services were introduced to provide universal healthcare, free education and affordable housing for the entire population. These were supported by the 1962 National Charter and aimed to protect the vulnerable. In the mid-1960s, a contributory social insurance scheme was implemented to ease the burden on the State budget. Initially covering public sector employees, it was later extended to those in the private sector and State-owned companies (Horton 1962; Elsayed 2018; du Pradel and Youssef 2015; Gericke et al. 2018).

Social health insurance (SHI) was established in Egypt in 1964 and was managed through the Health Insurance Organization (HIO), a social security agency. The scheme provided compulsory coverage to workers in the formal sector and was mainly financed through contributions from employers and workers, payroll taxes and earmarked taxes, among other sources. Initially, the Egyptian government planned to extend coverage to the entire population, but this never happened and the scheme's design was not modified to include workers in the informal economy and the self-employed. SHI coverage was extended, however, through various policy reforms, to other population groups – namely, widows and women heads of households, pensioners and farmers, as well as to pre-school- and schoolchildren, through the School Health Insurance Program (SHIP) (HIO 2024; Government of Egypt 1975; 2012; 2014; 1992).

Employee showing his health insurance card at the Al Rashidy El Mizan production site. © Marcel Crozet / ILO

In 2014, Egypt signed a new constitution that addressed health as a basic human right and committed to expanding access to quality healthcare for all Egyptian citizens. In line with this commitment, the new Universal Health Insurance law was enacted in 2018, transforming the national health financing system with a view to progress towards a more inclusive social health protection system for the entire population, including the vulnerable. The law aims to provide financial protection and equitable access to quality health services for all, through a public compulsory health insurance system.

The system-wide reform, which is being implemented in phases, introduces functional and structural changes in terms of health financing, delivery and regulation. Expansion of coverage to the entire population is planned to take place over 15 years through six phases. The initial phase is currently being rolled out in six governorates: Port Said, Ismailia, Suez, South Sinai, Luxor and Aswan. Reforms to the governance system of the scheme were introduced through the establishment of four independent agencies: the Universal Health Insurance Authority (UHIA); the General Authority of Healthcare (GAHC); the General Authority for Healthcare Accreditation and Regulation (GAHAR); and the Egyptian Authority for Standard Procurement and Medical Technology Management (EASPMTM).

1 Insufficient quality of care (poor infrastructure; inadequate human resources, drugs and medical supplies; perceived low quality) is the main driver for out-of-pocket payments, despite the existence of free or highly subsidized services. This lack of quality pushes people (even those on low incomes) to access services by paying private providers out of pocket, thus negating the objective of financial protection.

SHP coverage for refugees

Many international and regional human rights agreements, including the 1948 Universal Declaration of Human Rights and the 1966 International Covenant on Economic, Social and Cultural Rights, stipulate the universal human right to social security. International social security standards affirm refugees' right to social security, including social health protection.

These standards include the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), which defines nine life contingencies – including healthcare – for which all members of society need to be protected across the cycle of life through a right-based approach; the ILO Equality of Treatment (Social Security) Convention, 1962 (No. 118), Article 10 of which establishes the application of the Convention's provisions to refugees and stateless persons without any condition of reciprocity; the ILO Medical Care Recommendation, 1944 (No. 69), which establishes that medical care services should cover all members of the community, regardless of their employment status; and the ILO Social Protection Floors Recommendation, 2012 (No. 202), which includes equity and non-discrimination among the key principles to be applied in standards for social protection.

Relevant ILO instruments on equality of treatment and social protection

- The Equality of Treatment (Social Security) Convention, 1962 (No. 118): "The provisions of this Convention apply to refugees and stateless persons without any condition of reciprocity." (Article 10.1)
- ILO Guiding Principles on the Access of Refugees and Other Forcibly Displaced Persons to the Labour Market, adopted in November 2016. (Principles 19 and 22)
- The Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) and Migration for Employment Convention (Revised), 1949 (No. 97) also include provisions relevant for refugees. According to the Committee on the Application of Recommendations and Standards (CEACR), the provisions of Convention No. 143 apply to all workers employed outside their home countries, including refugees. The Committee of Experts explicitly included refugees in the scope of application of Convention No. 97. Among others, Article 6 relates to equality of treatment in respect of social security

In addition, the 1951 Refugee Convention, the 2016 New York Declaration for Refugees and Migrants, and the 2018 Global Compact on Refugees all call for the inclusion of refugees in social protection systems.

Over the years, there have been many attempts by the Egyptian government to regulate the inclusion of refugees in the health system. The Ministry of Health and Population and UNHCR signed two MoUs – in 2014 and 2016 – granting refugees from all nationalities access on an equal footing with nationals to public primary, secondary and emergency healthcare. Nevertheless, refugees still rely heavily on subsidiary schemes offered by UNHCR through partner NGOs, which cater for refugees' healthcare needs through referral-based services.

For example, one NGO provides primary outpatient services and subsidizes the cost of medication for chronic conditions through co-payments based on the socio-economic status of the refugees. Another NGO partners with UNHCR on two initiatives: one that enhances refugees' access to public health facilities and another that contracts non-profit facilities to provide secondary- and tertiary-level services (ILO and UNHCR 2023).

According to Article 68 of the executive regulations for the 2018 UHI law, the Egyptian government can design a new programme to include refugees in the national health insurance scheme (Government of Egypt 2018). Doing so, however, requires significant political will, advocacy efforts, financial resources, infrastructure preparedness, human resources and institutional capacity. The ILO, in collaboration with UNHCR, jointly assessed the inclusion of refugees in the UHIS as it is being gradually implemented, through a feasibility study. The study proposed scenarios for the integration of refugees in the so cial health insurance scheme within the new UHIS framework (ILO and UNHCR 2023).

Social health protection reform

Governance

The UHI law enacted in 2018 introduced significant structural changes to the health system, moving it from the previous integrated set-up to a provider-purchaser split. Under this reform, current pools of different schemes were merged into a single pool to improve risk-sharing mechanisms, increase purchasing power and reduce administrative inefficiencies. In addition, the provider-purchaser split means the Ministry of Health and Population (MoHP) and the HIO – the main national insurer – no longer assume both roles, that is, as payer *and* service provider (Fasseeh et al. 2022; WHO Regional Office for the Eastern Mediterranean 2023).

An increased level of management autonomy is introduced, with governance mechanisms divided into different entities. A new body, the Universal Health Insurance Authority (UHIA), was established, with the responsibility for the overall management of the scheme, collecting contributions and pooling, as well as purchasing health services. The UHIA works under the supervision of the Ministry of Finance and reports directly to the Prime Minister's Office. Then there are the General Authority of Healthcare (GAHC), which is now responsible for healthcare service provision at all three levels and works under the supervision of the Ministry of Health, and the General Authority for Healthcare Accreditation and Regulation (GAHAR), which is responsible for regulation and accreditation of healthcare providers. Finally, the Egyptian Authority for Standard Procurement and Medical Technology Management (EASPMTM) is responsible for medical procurement mechanisms.

Population coverage

The new health insurance scheme is compulsory for all Egyptians resident in the country, with the exception of military personnel and their families.[2] Membership is family-based, and the State fully subsidizes the contributions of the poor and vulnerable through general budget transfers by the Ministry of Finance. Subsidized population groups include people entitled to social assistance under the two main national social assistance schemes, unemployed heads of households who are ineligible for unemployment benefits, people with no income, those with disabilities who cannot earn a living, indigent people who are unable to meet their basic needs, and those living in specific geographic areas who temporarily experience natural or manmade disasters.

Benefit package and co-payment levels

The new UHI scheme provides family-based coverage in the form of a comprehensive and broad benefits package backed by low co-payments. The benefits package is designed to include only curative services (all disease diagnostics, treatment and rehabilitation). Preventive and promotion health services are financed and provided by the Ministry of Health and Population free of charge to both Egyptians and refugees, as per MoH Decree No.601/2012.

Co-payment mechanisms – whereby patients pay part of the costs of the health services they access – apply to medications, radiology, laboratory tests and inpatient services and have a relatively low ceiling.[3] The poor and the vulnerable, as well as patients requiring medication for chronic conditions and tumours, are exempt from co-payments.

Network of service providers and provider payment methods

Under the UHI law, healthcare services are provided through a network of public and private providers, all of whom must fulfil accreditation criteria stipulated by the GAHAR in order to be contracted by the UHIA (JICA n.d.). Primary healthcare (PHC) facilities, the first point of entry, establish a gate-keeping mechanism and provide a set of preventive, therapeutic, diagnostic, reproductive and emergency services. Beneficiaries are assigned to a PHC facility based on the area in which they live. However, they have a choice when it comes to secondary- and tertiary-level providers, which can be accessed through referrals by the PHC and offer therapeutic, diagnostic and emergency services, as well as surgery and specialized health treatments (UHIA 2021b).

Purchasing arrangements and provider payments vary across different services, with a mixed payment method in place. Curative health services are paid for by the UHIA through output-based payment methods. For outpatient and PHC services, a blend of partial capitation and fee-for-service payment methods for priority interventions plus performance payments were suggested and approved in May 2019 by the UHIA board. For other specialized outpatient services, the UHIA decided to consider the fee-for-service method. For inpatient services, the UHIA approved a mix of case-based payment (for surgical interventions) and fee-for-service (for non-surgical interventions), with a soft budget cap during the first phase of implementation (2019–2023) (Khalifa et al. 2022).

2 These people are covered by the Armed Forces' medical service scheme.
3 A cap on the total amount paid out-of-pocket as co-payment per service.

Financing

The Government of Egypt made a commitment to increase reliance on public funding sources and public spending on health as a share of GDP. Revenue-raising policies for the new UHI scheme are based predominantly on social security contributions, with contribution rates determined by monthly income for the different population groups.

▶ **Table 1. Contribution rates per population group (UHIA 2021a).**

Population	Contribution rate(s)
Formally employed workers (including civil servants and employees in the public and private sectors)	1% of monthly wage +3% for unemployed spouse +1% for each child 4% of insurable salary by employer
Pensioners and widows	2% of monthly income
Migrants, the self-employed and temporary workers	Cumulative contribution rate of: 5% of the monthly income of the family head + 3% for an unemployed spouse +1% for each child Up to a maximum of 7% for each household in this specific group

Vulnerable and poor populations are subsidized from a budget managed by the Public Treasury. Other sources of financing include earmarked taxes, tobacco tax, road tolls, as well as co-payment mechanisms. Nevertheless, depending on payroll contributions as the primary source of financing requires a robust strategy for effective collection of contributions beyond the formal sector, that is, from workers in the informal economy, the self-employed and refugees with a contributory capacity.

Inclusion of refugees in UHI

As of August 2024, the total number of registered refugees and asylum-seekers in Egypt was 737,000, with the majority living in urban areas and concentrated in Greater Cairo and Alexandria (UNHCR 2024; ILO and UNHCR 2023). UNHCR conducts a regular vulnerability assessment[4] (EVAR) to identify the socio-economic status of refugees and asylum-seekers in Egypt. In 2018, a vulnerability assessment covering refugees from 38 different countries revealed a rising trend in vulnerability levels in recent years. Approximately 19.3 per cent were classified as extremely poor, 20.3 per cent as poor, 33.2 per cent as near-poor and 27.3 per cent as non-poor. It is likely that vulnerability levels have risen further since 2018, driven by the country's economic situation. The assessment used the HIECS 2017/18[5] to establish the official poverty line and cost of basic needs, designating households as poor if their consumption was below this threshold. Different poverty classifications were determined based on the food poverty line, with those unable to meet their basic food needs classified as extremely poor. Poverty levels varied among governorates, with the highest rate of extremely poor refugees (56 per cent) residing in Cairo. Regarding employment status, an unemployment rate of 29 per cent was identified, while the majority of those who were working were in informal, temporary-wage arrangements or self-employed (El Laithy and Armanious 2019).

Although the Egyptian government granted refugees access to public primary, secondary and emergency services on an equal footing with nationals, refugees still face significant gaps in access and availability of services. These gaps can be attributed to several factors, including the quality of care and financial barriers, such as co-payments, transport costs and opportunity costs. According to the 2021 UNHCR Health Access and Utilization survey, 41 per cent of the refugee households surveyed paid an average of 980 Egyptian pounds at public facilities, while 33.9 per cent used private facilities and paid around EGP 1,228. Patients with chronic conditions also reported an inability to access treatment, mainly due to cost of medication, which averaged around EGP 400. The survey also found that 61 per cent of respondents preferred private healthcare, despite the high cost, because they felt the quality of care was better and there was less waiting time. Furthermore, health services provided for refugees through UNHCR programmes are limited to selected critical conditions, owing to limited resources. Many barriers exist within these programmes, including a lengthy process between diagnosis and obtaining approvals for dispensing medicines for chronic conditions.

4 EVAR is a comprehensive survey focusing on refugee households in Egypt that was developed in a collaborative effort between UNHCR and other organizations. It provides evidence of refugee demographics, their protection, education, economic situation, housing and coping strategies. The assessment measures household vulnerability based on the minimum expenditure basket (MEB), that is, what a household requires in order to meet basic needs and the average cost of doing so.

5 HIECS is a national representative survey, conducted biannually under the Central Agency for Public Mobilization and Statistics (CAPMAS). It collects data on household demographics, education and employment statuses, expenditure and consumption.

Feasibility assessment: findings and options

For the joint ILO/UNHCR feasibility study, data regarding vulnerability and income assessment was based on the aforementioned EVAR, in which refugees were grouped into four categories: extremely poor, poor, near-poor and non-poor.[6] Two policy options for including refugees in the UHI schemes were determined based on different costing scenarios. In scenario 1, all poor refugees (extremely poor, poor and near-poor) would be included in the UHI in the subsidized "vulnerable" category, given the limited capacity of refugees classified as near-poor to make contributions. In scenario 2, only the refugees classified as extremely poor and poor would be included in the "vulnerable" category. The near-poor and non-poor would contribute to the scheme through the informal economy workers' entry point, on a par with nationals.

Adopting policy option 2, whereby the near-poor are not included in the subsidized category, would have significant ramifications. In this group, earnings are way below the proposed minimum wage[7] and below the minimum expenditure basket, so these people already face difficulties meeting their basic needs (the predicted proxy income is EGP 1,106). Additionally, setting contribution rates as a percentage of the minimum wage would render them unaffordable and risk pushing people in this category below the poverty line. Alternatively, including the near-poor in the "vulnerable" category would align with international ILO social security standards, notably the Social Protection Floors Recommendation, 2012 (No. 202), which prioritizes social health protection through solidarity in financing and considering the contributory capacities of various groups (para. 3(h) and 11).

Based on this assessment, these implications are equally important for the general Egyptian population, particularly those working in the informal economy. Given that the income assessment assumes a minimum wage that may exceed actual earnings in some categories, lowering contribution rates for near-poor Egyptian households and those working under informal arrangements could make contributions more affordable and improve adherence to the scheme.

What's next?

Considerations regarding the inclusion of refugees in UHI in Egypt

- **Legal framework:** the inclusion of refugees in the current UHIS legal framework allows for a high-level decree to give effect to Article 68 of the executive regulations related to the law, supported by a government resolution regarding operational and implementation considerations.
- **Pilot phase:** field tests should be undertaken among refugees residing in one or two of the governates in which the UHIS is being rolled out. These would enable all the legal, operational and financial processes to be tested through a pilot program and thus guide the full implementation process. The processes tested would help in formulating policy decisions regarding income assessment, contribution rates, contributory capacity, and subsidization rates. Refugees should be included on an equal footing with nationals in terms of contribution rates and benefits packages.
- **Administrative consideration**: the UHIA should issue a pilot-phase card to refugees, similar to that issued to those enrolled in phase 1, to facilitate access to healthcare facilities. It is important to avoid linking the validity of the card to duration of residency, to prevent frequent costly renewals.
- **Parallel measures:** plans should be in place to address the health needs of the majority of refugees (77 per cent of the refugee population) who will not be covered under the UHIS until phase 6. One strategy would be to include refugee children in the school health insurance scheme managed by the HIO.
- **Economic self-reliance opportunities:** strategic national-level initiatives should focus on enhancing refugee livelihood opportunities and reducing poverty. This would improve not only refugees' living conditions but also their capacity to actively contribute to the UHIS. This, in turn, would have a positive impact on human capital development, foster economic growth and enhance the sustainability of the scheme.

6 For this study, upper limit threshold values were used to estimate average monthly consumption per capita. The national monthly minimum wage of EGP 2,400 was assumed as an average income for the non-poor category. The adjusted poverty line, based on the CAPMAS (2020) survey, was EGP 858 monthly, with the monthly minimum MEB set at EGP 1,603.

7 Current minimum wage is set at EGP 6,000.

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This policy brief was prepared by Salma ElGamal (ILO) under the PROSPECTS project.

It was reviewed by Lou Tessier, Shana Hoehler, Aya Gabr (ILO) and Jakob Arhem (UNHCR).

Contact details

International Labour Organization
Route des Morillons 4
CH-1211 Geneva 22
Switzerland

T: +41 22 799 7239
E: @ilo.org

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