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The American University in Cairo

School of Global Affairs and Public Policy

PROTECTING THE POOR AGAINST HEALTH RELATED FINANCIAL BURDEN: ASSESSMENT OF THE LEGAL-INSTITUTIONAL FRAMEWORK IN EGYPT

A Thesis Submitted to the Public Policy and Administration Department in partial fulfillment of the requirements for the degree of Master of Public Policy

By Omkolthoum EL-Sayed

Supervised by

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May 2014

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List of Abbreviations

BBP: Basic Benefit Package
CAPMAS: Central Agency for Public Mobilization and Statistics
CCIs: Critical Conditions and Injuries
EIPR: Egyptian Initiative for Personal Rights
EU: European Union
FHF: Family Health Fund
GDP: Gross Domestic Product
GNP: Gross National Product
GoE: Government of Egypt
HIO: Health Insurance Organization
HSRP: Health Sector Reform Program
HIS: Health Information Systems
ISEqH: International Society for Equity in Health
MDGs: Millennium Development Goals
MMR: Maternal Mortality Rate
MoHP: Ministry of Health and Population
NGO: Non Governmental Organization
NHA : National Health Account
NHS: National Health Service
OECD: Organization for Economic Cooperation and Development
OOP: Out-Of-Pocket
PHC: Primary Healthcare Center
PTES: Payment on the Expense of the State
SHIP: School Health Insurance Program
THE: Total Health Expenditure
U5MR: Under 5 Mortality Rate
UK: United Kingdom
UNDP: United Nation Development Program
US: United States of America
USAID: United States Agency for International Development
UHC: Universal Health Coverage
WHO: World Health Organization

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Abstract

Egypt is ranked 113 out of 187 countries on the UNDP human development index, with about 40% of population living below the international poverty line. This research is intended to assess how the state is providing a social protection policies/ systems in order to protect disadvantage citizens in healthcare service provision sector. Measuring healthcare coverage and protection against financial risks answers the main research question which is "To what extent does the legal-institutional framework of the Egyptian governmental healthcare system(s) protect the poor from the health-related financial burden?"

The interventions that are subject to the study are Health Insurance (HIO), Payment on the Expense of the State (PTES) and Family Health Fund (FHF). The draft Social Health Insurance Law was also subject to the study. The researcher found that the draft Social Health Insurance Law provides good protection against financial risks associated with catastrophic health expenditures and Out-Of-Pocket (OOP) health expenditures. On the other hand, FHF offers the best program providing universal health coverage for both Millennium Development Goals (MDGs) related diseases and Critical Conditions and Injuries (CCIs) related illness comparing to other programs.

Formularization of unified framework of those systems in order to integrate together along with clearly determining the roles of each system are the main policy recommendations of this study.

Key Words: **Healthcare System in Egypt, Health Insurance in Egypt**, **Poverty and Healthcare in Egypt, Governance in Healthcare System, Healthcare Sector Legal-Institutional Framework in Egypt, Healthcare System Coverage and Healthcare Financial Risk Protection in Egypt.**

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Introduction

We all need social protection during the course of our life; from infancy to adulthood and as elderly people. Special social protection is needed in cases of illness and disability. So, we can say that social justice is a matter of life and death as it shapes our living, extent of potential risks of having illness or premature death. The link between degree of social disadvantages and health/ wellbeing is a social well-known phenomenon. The unfair distribution of health status which could be avoided is not only a product of how people grow, live, or work. Actually, it is a product of policies and systems put in place by the state to protect the disadvantage citizens.

According to the Central Agency for Public Mobilization and Statistics (CAPMAS) report 2013, Egypt's poverty rate has increased, reaching 26.3% in 2012/ 2013 compared to 25.2% in 2010/ 2011. The report states that the domestic poverty line is at an annual EGP 3,920 per capita. The average Egyptian households' expenditure is EGP 26,161. About 5.6% of Egyptian families are having expenditures less than EGP 10,000 annually; while, 6.2% of total families expend more than EGP 50,000 annually. This demonstrates the importance of looking carefully how the state provides social protection policies, including health policies, to disadvantage citizens.

This research intends to assess to what extent GoE is providing a social protective policies/ systems in order to protect disadvantage citizens. The research has a close look at the governance system in terms of legal and institutional framework of the public healthcare programs run by GoE and how it reflects the purpose of protecting disadvantage citizens. The findings of this research paves the way for further research about public policies and programs run to protect the disadvantages.

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Statement of the Problem

"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".

The General Assembly of the United Nations in 1948 Article 25

In the light of the previous statement, this research intends to assess the legal-institutional framework of the Egyptian public policies/ interventions related to health from the perspective of protecting the poor against health related financial burden. As example of these policies, the research assesses the main interventions/ programs that Egyptian government runs which are; Public Health Insurance, Payment on the Expense of the State and Family Health Fund programs. An analysis and reflection on the draft Social Health Insurance law is also done. Most of the public service sectors in Egypt suffer weak economic conditions along with inefficient administrative apparatus. As result, low and middle income class of Egyptian society pays the bill for such inefficient ineffective public sectors. If found in public healthcare sector, the system will not be able to fulfill the general main goals of healthcare systems effectively. These goals are; being affordable, geographically accessible, sustainable, and of good quality. The calls for increasing the public healthcare sector budget along with Doctors' Strike asking for financial and administrative reform within the sector, increases the need for these types of assessment. The discussions run for the implementation of a universal social health insurance system along with calls for social justice that aroused after 25th Jan revolution, illustrate the importance and urgency to study more deep this vital issue. Finally and most important, the issuing of the 2014

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constitution stating the gradual increase of public health spending to reach 3% of GNP needs thorough study of how this increased fund will be best allocated.

There are a lot of public programs that aim to help low and middle income class of the Egyptians to face the health-related financial burden. These programs include Public Health Insurance, Payment on the Expense of the State and Family Health Fund. These programs experienced long periods of improvements and piloting in order to close the gap exists in public health sector reform field and to provide a social safety net. Vast categories of Egyptians complain of inefficient ineffective healthcare services provided through these programs; while, others say that these programs offer good service compared to the limited resources available.

The main research topic is investigating how the legal and institutional framework, as one of the good governance criteria, of different programs affects their contribution to protect the poor from health-related financial burden in Egypt. The assessment of these programs entails the institutional-legal framework that governs the performance of these interventions and how this framework support the achievement of its goals.

Literature review mainly focuses on governance in healthcare system, international public health systems and policies, different forms of healthcare financing system, legal and institutional framework in healthcare system, and health-related financial burden reported and studied through international entities and official Egyptian agencies. Also, the review entails review of laws, regulations, and decrees that provide institutional and legal framework for the major interventions/ programs implemented in Egyptians public healthcare sector. The findings of this research not only answers the main research question, but also opens the door for further research about public policies and programs run to protect the poor.

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Research Question

To what extent does the legal-institutional framework of the healthcare system(s) run by the Egyptian governmental sector protect the poor from health-related financial burden?

Background

About Egypt

Egypt is located in the northeast corner of Africa, with an extension to Asia. The surface area is about 1000 km^2. Administratively, Egypt is divided into 27 governorates, which in turn are divided into 274 districts. More than 98% of the population lives on 6% of the surface area along the Nile Valley and Delta. The population is estimated at 81 million[1] (4 million outside the country). As a result, Egypt has one of the highest population densities in the world. About 43% of total population are urban, 51.1% male, 26.6% females of reproductive age (15-49 years), 20.5% married females and 10.6% under 5 years of ages (CAPMAS, 2013).

Egypt is ranked 113 out of 187 countries on the UNDP human development index[2] (UNDP, 2011), with about 40% of population living below the international poverty line of US$ 1.25 a day. Life expectancy at birth is 73/ 69 years (Female/ Male), fertility index is at 3, immunization rates among the highest worldwide (over 95% coverage for children under 5 years). There is an increase of chronic conditions affected by longer life span, industrialization and unhealthy life-styles (diet, smoking and physical inactivity). Under 5 mortality rate (U5MR) and maternal mortality rate (MMR) were reduced to reach the levels needed for the achievements of Millennium Development Goals (MDGs) (at 23/ 1.000, and 55/ 100.000 in 2008 respectively). Hepatitis B is endemic (prevalence 2-8%); while, hepatitis C has an epidemic trend with

[1]Central Agency for Public Mobilization and Statistics (CAPMAS, 2013)
[2] Human Development Report, UNDP, 2011.

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prevalence rate of 10%: as a consequence, hepatic cirrhosis is a top cause of death among adults (Handoussa, 2010).

Egypt Healthcare System

At central level the Ministry of Health has the role for regulatory authority, at governorate level acts as a financing agency, and at district level also has a service provider role, managing many hospitals and healthcare centers.

1- Role of Ministry of Health

Generally when we talk about the roles of Ministry of Health (as service provider, regulator, purchaser, or mix of some or all of it) we should consider these main tasks; policy formulation on health issues, development and maintenance of the relevant standards and technical regulations of healthcare service provision in public and private institutions, promotion and encouragement the implementation of an effective quality management system and monitoring systems and programs in health to guarantee compliance with standards and technical regulations (Ministry of Health and Population official website, May 2014).

Moreover, Ministry of Health has to develop and maintain an effective regulatory framework supported by sound legislation, identify areas for quality improvement and provide guidance for the development of quality improvement programs in the health management system, maintain critical linkages locally, regionally and internationally, insure the access to safe, effective products of acceptable quality (including narcotics, psychotropics, herbal products and other drugs, cosmetics, foods and medical devices), and improve healthcare delivery by health professionals (Ministry of Health and Population official website, May 2014).

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2- Healthcare Financing System

The most recent official financial report related to health in Egypt, is available in the National Health Account (NHA) 2008-2009 report. This report was developed by efforts of MoHP, WHO, and USAID.

According to NHA 2008/ 2009, Egypt has a fragmented health system with multiple sources of financing and financing agents. The financing sources include *government* spending that comes from direct tax revenues, *out-of-pocket* spending by households as premium payments for insurance as well as direct spending on health, *employers'* spending on the health of their employees, and *donor* assistance usually by charity entities.

Although the Constitution pronounced free medical care as a basic right for all Egyptians within a universal health coverage system, the health expenditure financing has a strongly regressive pattern that leads to maintain, if not to expand, the social and health inequalities. In 2008/ 2009, Egypt spent 5.9% of GDP on health; while, the health spending as percentage of total government budget was at 4.3%. It is the lowest value in comparison with other countries in the region. Household out-of-pocket spending financed 71.8% of total health spending compared to 51% in 1995. Therefore, among low-middle income countries in the region, Egypt has the highest burden of out-of-pocket spending, the lowest percent of public spending on health and the lowest proportion of the government's budget allocated to health (NHA 2008/ 2009).

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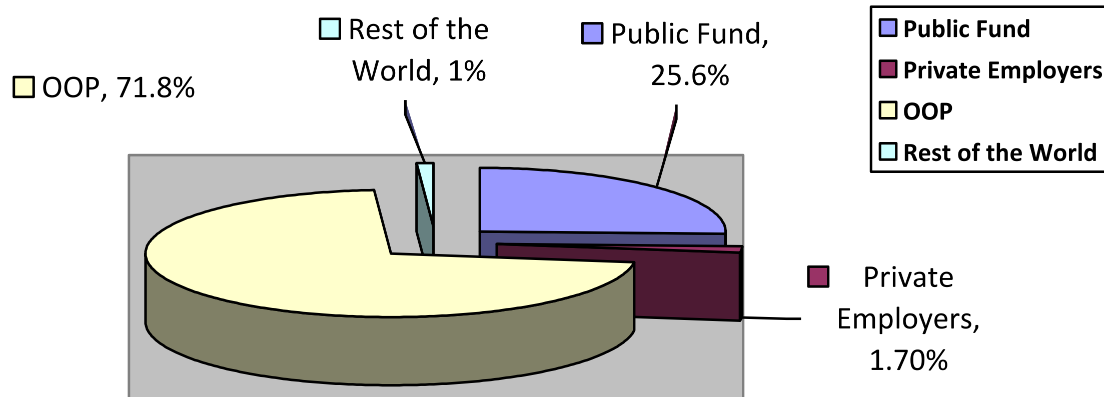

Figure1: Sources of Fund in Egypt, NHA 2008/ 2009

3- Healthcare Service Provider System

As we see from the previous section; health financing is used by entities including the Ministry of Health, Ministry of Higher Education, Health Insurance Organization (HIO), other Ministries, and public sector administrative office. The market of healthcare service providers is as well fragmented. The Ministry of Health directly manages its own hospitals and healthcare centers all over the country. Other public entities, including HIO and universities, manage their own facilities. There is a growing private market of hospitals, clinics, and pharmacies. Financial flows from financing entities to purchasers (if exist) and from purchasers to providers. In general, households manage 72 % of Total Health Expenditure (THE), public entities manage 26 %, and private sector entities manage the remaining 2 % (NHA 2008/ 2009).

4- Healthcare Purchaser System[3]

Health Insurance Organization **(HIO)** is the public insurance entity that provides financial coverage for certain benefit package of healthcare services to nearly 60% of population. Other private insurance sector includes private companies or certain categories of employees (such as

[3] Purchaser: the contracting and purchasing agency which purchase the medical service on behalf of the beneficiaries from different service providers according to contracting criteria.

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medical syndicate). This sector provides a similar service (Health Insurance Organization official website, May 2014).

Since 1970s, Egypt has had a special purchaser/ fund program, the program for Treatment on the Expense of the State (**PTES**), to pay for certain healthcare services within the country and abroad for people who cannot afford such services and are not covered by any scheme of health insurance. In 2013, almost 1.5 million citizens benefited from this program. The spending for the program reaches EGP 2.8 b in 2013 for treating chronic diseases, renal failure, Hepatitis C virus, orthopedic surgeries, cardiovascular diseases, and oncology compared to more than EGP 3 b in 2008. This program was initially launched as a transitional period till the launching of a national social insurance system that provides universal coverage (MoHP report 2014).

In 1997, Health Sector Reform Program (HSRP)[4] was initiated to achieve many objectives among which are the financial and the institutional reform. Both objectives need the establishment of a purchaser of healthcare services within the public health sector in Egypt. The proposed purchaser should have a legal entity, effective organizational structure/ institution, and definite financial resources. This proposed purchaser was established in 2001 and called the Family Health Fund (FHF). The concept of the FHF is to act as the main contracting and purchasing agency for the quality basic healthcare services on behalf of the beneficiaries.

FHF mandates are;

- to separate service finance from service provision, which ensures high quality service and competition between providers to contract with the fund on equal quality based criteria,

[4] HSRP: In 1997, Egypt initiated Health Sector Reform Program (HSRP). Its objectives are to develop a sound and integrated healthcare system that can operate a market-oriented services. The main goals are; to increase coverage and accessibility to higher-quality healthcare at the primary and secondary levels to reach universal coverage, separate the purchasing and providing roles, to apply decentralization and autonomy at governorate and district levels and to rationalize public health expenditure (WHO 2006; MOHP 2003).

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- to act as an agent and contractor to purchase services for families (insured and non-insured) through different health units (public, NGO and private),
- to ensure sustainability of finance, and finally to ensure provision of services of high quality for poor people through implementation of exemption policies.

FHF applies necessary mechanisms to collect and disburse financial resources in the framework of the regulations, laws, and decrees. FHF has been implemented in five pilot governorates (Alexandria, Menofia, Quena, Sohag and Suez). These governorates represent different geographic and socio-economic variations in the country and the financing of the FHFs began in fiscal year 2001/2002. FHF contracts the accredited healthcare facilities and the payment mechanism developed to "fee for services" model. FHF is financed through revenues of premium and copayment of enrollees and payment received from the HIO to provide primary healthcare services to insured population receiving healthcare services from FHF contracted facilities (NHA 2008/ 2009).

Research Objective

The main thesis objective is to investigate how these different programs contributed to protect the low and middle income class of Egyptians from the health-related financial burden. The discussions run for the implementation of public social health insurance along with calls for social justice that aroused after 25th Jan revolution illustrate the importance and urgency to study more deep this vital issue. The findings of this research paves the way for further research about public policies and programs run to protect the disadvantages by answering the main research question.

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Theoretical Framework

The main focus of this study is the role of the state in social protection of the poor. This focus is well illustrated in the United Nation Development Program mission statement. The UNDP mission states *"UNDP is the UN's global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. UNDP is on the ground in 177 countries, working with them on their own solutions to global and* ***national development challenges****."* (UNDP official website, May 2014). This mission statement justifies the selection of UNDP mandates as the core of the theoretical framework for this research.

The main variables of the research are the social-health protection policies/ programs and the fiscal burden of health. The main theories that studied social protection have two common themes. The first theme is about providing service package to the whole population that covers basic health needs with tailored targeted programs for the vulnerable groups. The second theme is about providing a financing model that protect against the fiscal burden of health for the universe and especially for vulnerable groups. These themes are the pillars of the theoretical framework of this study.

The theoretical framework begins with the United Nation Development Program (UNDP) (2010 Global Program Annual Report) description of Rule of Law, Equity and Inclusion as being at the centre of UNDP's mandate. These mandates are essential to human development and reduction of poverty. It becomes clearer as we make the connection between poverty, health and inclusion. Inclusion in health could be expressed as **Universal Health Coverage** which is a constitutional right for all Egyptians. This incorporates the financial obligation of Government of

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Egypt (GoE) to provide quality healthcare services to its citizens with particular emphasis on accessible health services for **vulnerable** groups.

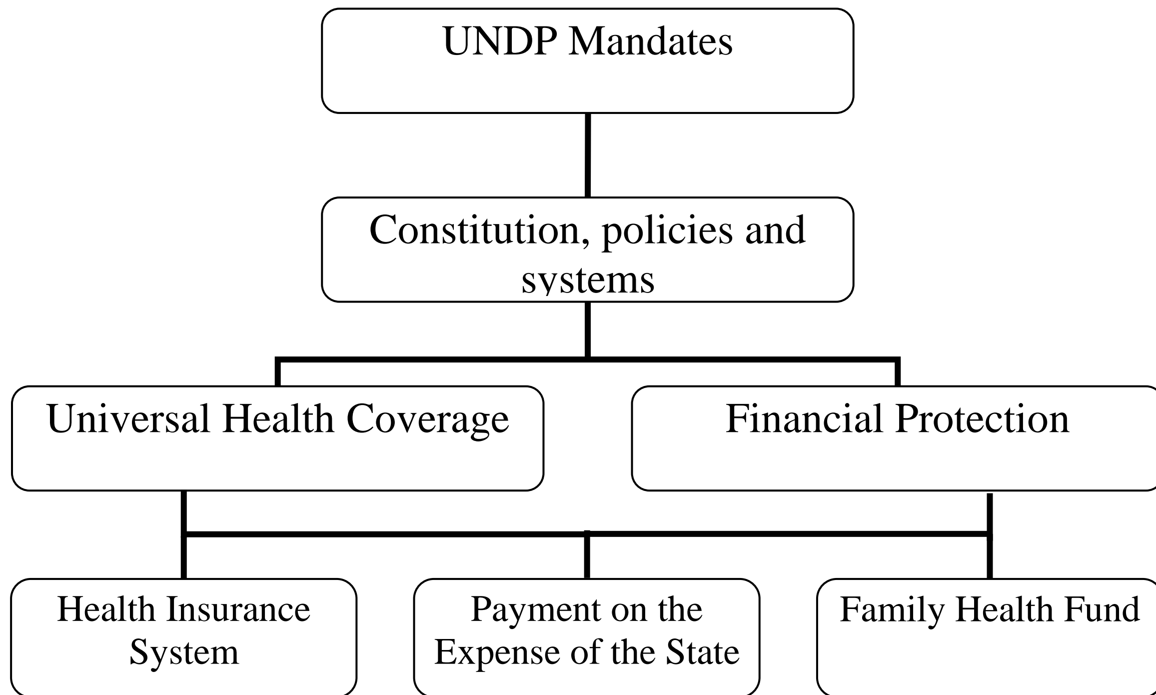

Figure 2: Theoretical Framework of the Study

This framework constitutes a mean for measuring to what extent these constitutional obligations and promises are met by GoE. This will be achieved by assessing how legal and institutional framework of the public health programs run by GoE are providing social protection policies and systems to disadvantaged citizens.

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Literature Review

It mainly sourced from published governmental official reports, Ministry of Health and Population official reports and international agencies. It focuses on health-related financial burden, a review of the different forms of healthcare financing system, international public health systems and policies and legal-institutional framework in healthcare system. It also focuses on governance aspects in healthcare system.

1. Governance in Healthcare System

1.1. Good Governance

The concept of governance started long ago. According to UNDP (1997), governance is identified as “the exercise of economic, political and administrative authority to manage a country's affairs at all levels”. This includes institutions and procedures used to apply good governance. According to the same report, characteristics of good governance are;

- **Participation:** All men and women should have a voice in decision-making, either directly or through legitimate intermediate institutions that represent their interests. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively.
- **Rule of law:** Legal frameworks should be fair and enforced impartially, particularly the laws on human rights.
- **Transparency:** Transparency is built on the free flow of information. Processes, institutions and information are directly accessible to those concerned with them, and enough information is provided to understand and monitor them.
- **Responsiveness**: Institutions and processes try to serve all stakeholders.

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- **Civil Society Participation and Consensus orientation**: Good governance mediates differing interests to reach a broad consensus on what is in the best interests of the group and, where possible, on policies and procedures.
- **Equity**: All men and women have opportunities to improve or maintain their well-being.
- **Effectiveness and efficiency**: Processes and institutions produce results that meet needs while making the best use of resources.
- **Accountability**: Decision-makers in government, the private sector and civil society organizations are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organization and whether the decision is internal or external to an organization.
- **Strategic vision**: Leaders and the public have a broad and long-term perspective on good governance and human development, along with a sense of what is needed for such development. There is also an understanding of the historical, cultural and social complexities in which that perspective is grounded.

1.2. Governance and Healthcare

Good governance, as seen in the previous section, affects efforts to improve the healthcare sector in different ways. First, it would contribute to the development of the Egyptian healthcare sector, and empower healthcare facilities to become well-performing. Second, as the healthcare sector is multi-faceted and upholds many conflicting interests, this could be settled in a way that balances between different interests. Governance for health equity as defined by EU Expert Group on Social Determinants of Health (Meeting Report, April 2011) means universal actions that benefit all of the population, hence aiming to reduce health inequities across the social gradient, specific measures for population sub-groups who may, due to social exclusion

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processes, be missing out on **universal services**, action to ensure that health systems enable equitable outcomes (of highest level possible), and finally action across sectors to address the underlying determinants of health and **safeguarding the right to health**.

1.3. Legal and Institutional Framework and Social Protection

In order to guarantee a social protection environment in any society for all groups of population, governments should be aware of the following;

- Social protection is a rights-based approach. The right to social protection should not be ignored or underestimated during crisis or transition times (as in Egypt after 25th Jan Revolution). On the contrary, it becomes more pressing. In order to ensure that social protection systems are based on solid human rights standards, governments should have a well-established legal-institutional framework for social protection measures at the national level.
- Once this system is created, governments should make sure that beneficiaries are behaving as rights-holders. This will guarantee the sustainability of the programs and protecting it from being manipulated or biased by the private sector.
- This established legal and institutional framework, should define the roles and responsibilities of all stakeholders and guarantee the existence of user friendly complaint system (United Nations General Assembly, March 2011).
- Legal-institutional frameworks facilitate and improve the permanence of social protection programs. These programs which will then be incorporated as part of state policy, not just government policy, by creation of government structures and coordination mechanisms needed to met the intended goals. On the other hand, implementing social protection programs in the absence of specific legal-institutional frameworks includes a number of

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risks; sustainability, scope, legitimacy and human rights related risks (United Nations, 2009).

- However, a proper legal-institutional framework is not sufficient to guarantee social protection programs as a long-term programs and not vulnerable to changes in government. Financial sustainability is an important consideration. Moreover, monitoring and evaluation of these programs is needed to verify that programs are actually benefiting people especially vulnerable groups (United Nations, 2009). For example, Brazil's 1988 Constitution adopting a social protection vision and defines the state responsibility for financing the system that ensures the universal coverage and access of social services. By the same token, Colombia's 1991 Constitution ensures rights for social security and assistance (Cecchini and Martínez, 2012). These Constitutions ensuring and strengthening the social protection systems regardless of the political changes that may happen over years.

1.4. Equity and Healthcare

One of the interesting papers is Targeted Health Insurance in a Low-Income Country and its Impact on Access and Equity in Access, (Yip and Berman 2001). The paper took Egypt's school health insurance experience as its main case study. The paper highlighted that School Health Insurance Program (SHIP) is a government-subsidized health insurance system that targets school children. Its primary goals include improving **equity** and **access** to healthcare for children. The paper empirically assessed the extent to which the program achieved its stated goals. The paper concluded that the program reduced differentials in visit rates between the highest and lowest income children. However, by targeting children through school enrollment, the program increased inequalities in accessibility between school-going children and those not

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attending school who tend to be poor and living in rural areas. The study concluded that there is a need for defined targets in programs designed to reduce inequity.

On the other hand, the majority of literatures discussing equity in healthcare sector focuses on access, utilization and financing of health services (Van Doorslaer, et al 2000; Waters 2000). The main approaches used are; improving the provision of **health services** to those in greatest need and developing **financing mechanisms** to aid the disadvantaged. Mainly, literatures discussed horizontal equity (the equal treatment of equals). Mooney, G. and S. Jan examines possibilities for incorporating vertical equity (the unequal, but fair treatment of unequals) into healthcare policy through **distributive** (distribution of health outcomes across individuals and groups) and/ or **procedural justice** (fairness with respect to processes rather than outcomes) (Mooney and Jan 1997).

1.5. Governance and Social Inclusion

According to EU Expert Group on Social Determinants of Health meeting report (2011), to reach inclusive governance, we need to incorporate inclusiveness as a core value of democratic governance, in terms of equal participation, equal treatment and equal rights before the law. That means that all people including the poor, women, and other disadvantaged groups have the right to participate effectively in governance processes and influence decision making process that affect them. At the institutional level, it also means that governance institutions, systems and policies are accessible, accountable and responsive to these groups, protecting their rights and providing equal opportunities for public services such as health.

1.6. Social Inclusion and Healthcare

The World Health Organization (WHO, 1948) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Based

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on that definition we can see the similarity between definition of health and economic development. Both are a result of activities that include related social factors.

There are different approaches used to insure social inclusion in healthcare sector according to Inclusive Governance for Human Development, UNDP (UNDP, 2010):

- **Service Delivery;** non-discrimination in service delivery including promotion and prevention services, increase health system literacy among populations and strengthening Primary Healthcare Center (PHC) that represents the first line treatment for patients.
- **Resource Generation;** improve the capacity of health professionals' know-how (including policy-makers especially in areas with large populations), integrate and standardize the role of outreach health workers from the community (e.g., midwifery). Finally, develop standard selection criteria, standard trainings before and during service and standard compensation schemes.
- **Stewardship;** effective Health Information Systems (HIS) with health equity surveillance, equity-oriented health impact assessment and strengthening the universality of healthcare systems using **targeting** of special groups as a backup for those who may not be protected by the net of universal systems due to social exclusion.
- **Financing;** evaluate different public **interventions** and identify, verify and disseminate promising practices on health, minimizing the burden of **Out-Of-Pocket** (OOP) health expenditure (for services as well as for medicines) and move towards prepayment systems and risk-pooling of financial burden across population groups, and cross-government mechanisms/ processes to ensure **access** to services.

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2. *International Public Healthcare Systems/ Policies*

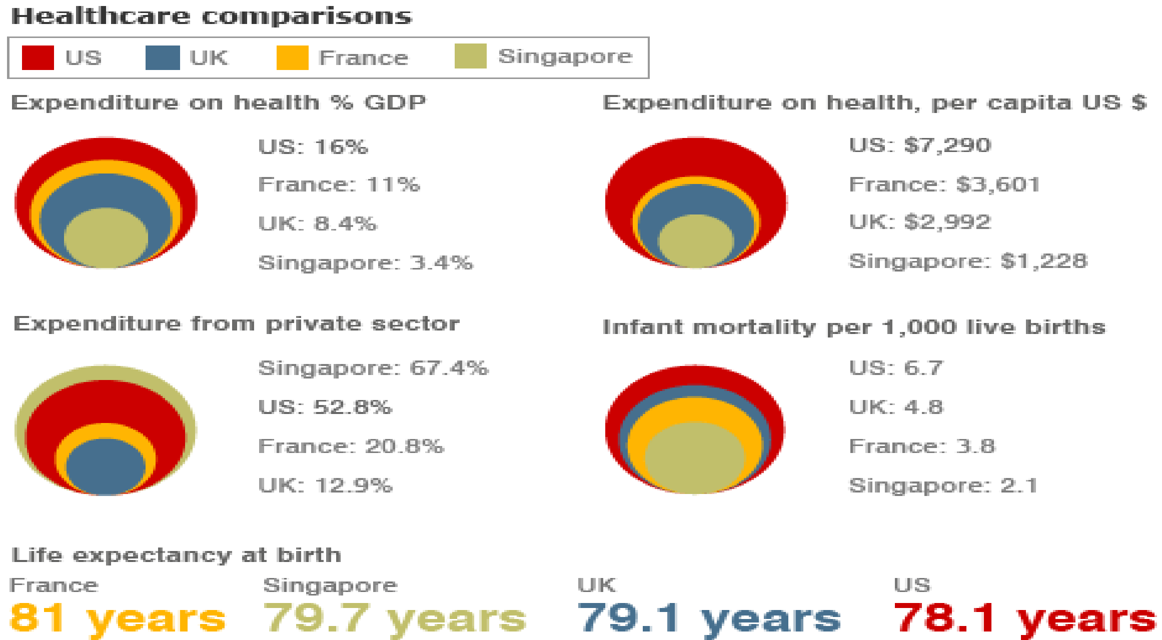

Figure 3: BBC Healthcare Comparison, 2009

Figure 3 illustrates the health status, expressed as life expectancy at birth and infant mortality versus expenditure on health expressed as percentages of GDP and private sector in four different OECD countries; US, UK, France, and Singapore. Interestingly, it shows that US may have the highest expenditure percentage of GDP and it has the highest infant mortality among the four countries subject to comparison. On the other hand, Singapore has the lowest health expenditure percentage of GDP and the lowest infant mortality. This comparison illustrates how countries should define its own vulnerable groups and efficiently reallocate its available resources in order to best utilize it with the best health outcomes.

Comparing Egypt to other countries of the same socio-economic status (namely Algeria, Djibouti, Iran, Jordan, Libya, Lebanon, Morocco, Syria and Tunisia) in financial terms is well illustrated in NHA 2008/ 2009. The main findings are that Egypt has the highest OOP percentage of total health expenditure among these countries (regional average is 45.4% versus 72% in

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Egypt) and also the governmental spending on health as percentage of total governmental spending is the lowest among the same countries (regional average is 8.6% versus 4.3% in Egypt). (NHA 2008/ 2009)

Looking at the international public health systems implemented from different perspectives, needs more detailed discussion about countries that are ranked among the top countries in healthcare systems according to WHO report (2010). This ranking is based on health profile status, health equality, and fair financial contribution. This review of international healthcare system helps to identify the main approaches that these countries adopted to be ranked as world-wide models for good healthcare systems. According to WHO report, this countries are:

1. France

The French system is a mix of private and public service providers that insure *universal healthcare coverage* and the fund is from both payroll (employers and individuals) and income taxes as well as taxes on tobacco, alcohol and pharmaceutical company revenues (10% to 40% copayments). The private insurance is for supplemental services. The *medical bills are co-paid by the government* and the remainder is by individual's complementary private insurance. The system offers a choice in hospitals, doctors, and care. Expenditure on health per capita ranking worldwide is the fourth. The French system is the third expensive healthcare system which represents 11% of GDP. The system is characterized by very little waiting lists. French constitution has no statements about the rights to health, with the exception of the preamble section to its constitution.

2. Italy

The Italian system is characterized by *universal healthcare coverage.* The *medical bills are paid by the government* and the central government provides regulatory assistance. Expenditure

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on health per capita ranking worldwide is the eleventh. The current Italian Constitution (1948) explicitly grants a legal right to health to its citizens.

3. Singapore

A *universal healthcare coverage* system run by government which coexists with a private healthcare sector to provide the service while the *government mostly controls prices*. Expenditure on health per capita ranking worldwide is the thirty eighth.

4. Spain

A *universal health coverage* system run by government which coexists with a private healthcare sector to provide the service. Expenditure on health per capita ranking worldwide is the twenty fourth. The system is characterized by long waiting lists.

5. Japan

A mandatory *universal healthcare* system financed through either government or employer based which split evenly between employer and employee. The *copayment is 10% to 30% with a cap* of US$ 677 per month per family (i.e. upper ceiling). For the public sector physicians, government pays salaries while the government pays on "fee for service" base for private sector healthcare providers. The citizens have the free choice on both physicians and hospitals. Expenditure on health per capita ranking worldwide is the thirteenth. The system is characterized by long waiting lists.

6. Netherlands

Also a mandatory *universal healthcare* system through private insurance system and the government plays a regulatory role and *gives assistance to low income patients*. It is an equally distributed benefits and risks system; however, if citizens wish to opt out, they have their tax

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money in a private health care saved. Expenditure on health per capita ranking worldwide is the ninth.

7. United Kingdom

A *universal National Health Service* (NHS) run *free* by government which is funded by taxes and operates on huge deficit with no copayment. Most of healthcare providers are from the public sector. NHS expenditure represents 7.5% of GDP. Expenditure on health per capita ranking worldwide is the twenty sixth. The system provides little choice of providers. The system is characterized by long waiting lists. Terminally ill patients may be left untreated. UK has no written constitution. The right to health was first codified under the Human Rights Act of 1998 and was being effective in 2000.

8. Canada

A *universal comprehensive healthcare* system run for *free* by the federal government without deductibles or copayments through taxes and single payer system. Healthcare providers are from both public and private sectors and the government pays on "fee for service" base. Expenditure on health represents 9% of GDP. The system provides little choice of providers. The system is characterized by long waiting lists.

9. Germany

A *universal healthcare* system at which the federal government decides the budget and procedures included in the benefit package. The system is funded by taxes *split between the employer and employee* without deductible or copayments. Currently, German Constitution does not include any health statement. Article 1 of German Basic Law of 1949 states that “the dignity of man is inviolable. To respect and protect it, is the duty of all state authority”. Moreover, Article 20 states that Germany is a “democratic and social federal state”. This statement

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obligates Germany to adopt public policy which improves social welfare of its citizens. In addition, the Federal Constitutional Court decided that Germany is demanded to provide healthcare. On the other hand, the constitution does not allow for making claims to the health insurance system for the provision of healthcare service

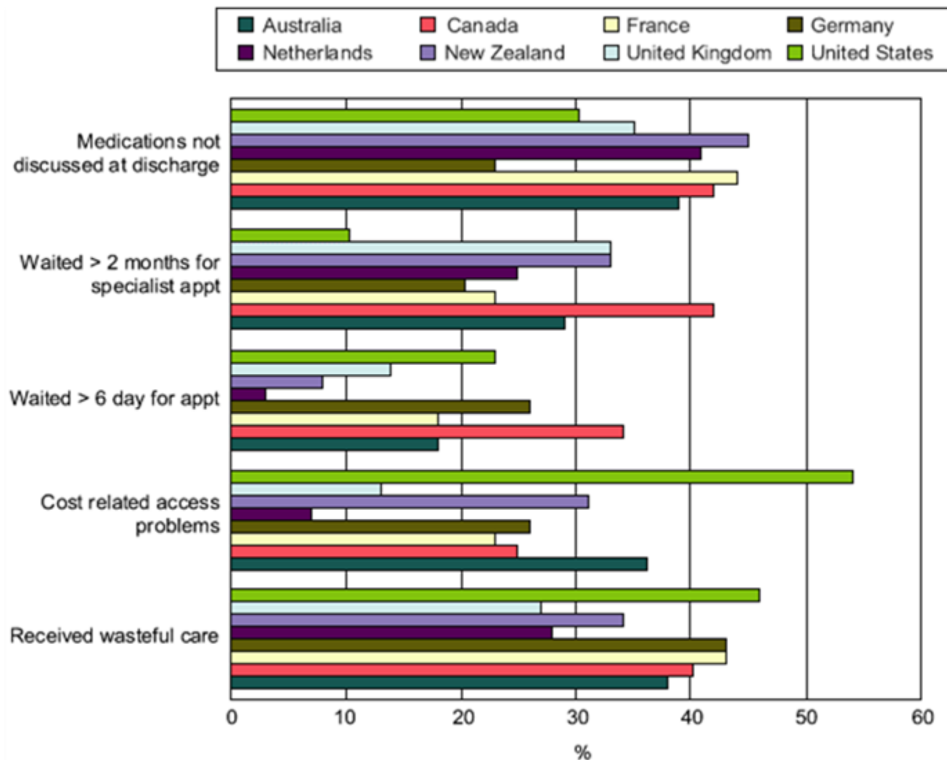

Figure 4[5]: Healthcare Comparison, Schoen C et al., 2008

This figure illustrates comparison between top ranked countries which suffer a lot of problems related to accessibility, inefficiency, and long waiting time. From that comparison, we can see that countries are evaluating their inefficiency areas in their healthcare system and decide which area would have the best outcomes if it gets more attention. These countries, as previously discussed, are very different from each other in their governing system but they share the same goal of improving and better utilizing their available resources for the benefit of the patients.

[5] Wasteful care: represents spending that does not return value and in some cases causes harm

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3. Public Healthcare Financing Models

3.1. International Public Healthcare Financing Models

According to "Healthcare Models across the Globe - A Comparative Analysis" by Sibu Saha and Alley-Sheridan (2010), healthcare system in any country is a product of its history, politics, economy, and society values. Healthcare system cost can be funded by three methods; Tax Revenue, Insurance, or Out-Of-Pocket. These three different resources of fund are illustrated in healthcare financing models below;

1. The Bismarck Model

This model is named by Otto von Bismarck (1883). It is applied in the top ranked countries in public healthcare system like Germany, Japan, France, Belgium, and Switzerland. This model is characterized by having private healthcare service providers and payers while applying a cost control system on the fees of the services provided. The system is jointly financed by both employees and employer through private health insurance system. Although the system is private, but it does not make profit and provides a universal coverage of healthcare (senior budget officials-OECD meeting report, 2011).

2. The Beveridge Model

This model is named by William Beveridge (1948), the founder of National Health System (NHS) applied in UK. This model is applied in many countries like *Great Britain, Italy, Spain*, and Cuba. This model is characterized by having a private and governmental healthcare service providers and the payer is the government only while applying a **low cost system** on the fees of the services provided. The system is financed through tax payment and the medical treatment is a public service with no medical bills (senior budget officials-OECD meeting report, 2011).

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3. The National Health Insurance Model

This model is applied in many countries like *Canada*, Taiwan, and South Korea. This model is characterized by having a private healthcare service providers and the payer is the government who collects monthly premiums from each citizen and pays medical bills based on its substantial negotiation power to get lower fees. The system **controls the cost** by having a limited list of healthcare services the government pays for. Also, the patients waiting list add considerable factor to the cost control tool used (T.R. Reid's, 2009).

4. The Out-Of-Pocket Model

This model is applied in rural regions of Africa, India, China, and South America. This model is characterized by having no government plans for healthcare service providers or payer and each citizen pays medical bills out of his/ her pocket. Here, the poor are expected to stay sick or die (T.R. Reid's, 2009).

The above two sections highlights the main features of the successful healthcare system. The common features of the healthcare system in the top ranked countries, according to WHO reports, are adopting **universal healthcare coverage** for citizens and **protective funding models**, either Bismarck, Beveridge or National Health Insurance Models for financing. On the other hand, countries which are not ranked as providing successful healthcare system to its citizens, are depending on Out-Of-Pocket model of financing. This forms the base of the criteria used in the analysis section of this research.

3.2. Pre-payment in Healthcare System

World Health Organization suggested in its report issued 2005 that there is no one best pre-payment mechanism that could be used in all countries to raise funds or to protect households from health related financial burden. Based on several factors like socioeconomic status, political

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views, etc, countries determine which systems and policies to apply in order to raise funds, providing service tools and pool the risk associated with health-related financial burden. So, there is no agreement on one best pre-payment mechanism that should be implemented; however, there is a wide agreement among scholars that reducing as much as possible the amount of out of the pocket (OOP) in financing healthcare is a major tool to protect households from health-related financial burden (Xu et al., 2007). According to Xu et al. (2007), the main factor that explains how-wide is the prevalence of health-related financial burden in any society is the proportion of government health spending to total health spending (as opposed to OOP share of total health spending) (Xu et al., 2003). In that context, there are two methods to calculate it; Van Doorslaer et al. (2007) suggested that when OOP on health is higher than a definite fraction of household income or total expenditure in a year, high health expenditure occurs. The second method suggested by Xu, et al. (2003), which defines high health expenditure when OOP on health is above 40% of household's capacity to pay.

3.3. Effect of Healthcare-Financial Burden on Poverty

The relation between health-related financial burden and poverty is obvious and discussed in many social contexts. Poor health status is a cause of increased poverty and is also an obstacle to escape from it. This is because illness reduces savings, productivity and leads to a diminished quality of life. The poor also are exposed to higher personal and environmental risks as they are often less nourished, have less health awareness and less able to access healthcare. A healthy worker produces more and saves more. Healthy children are more able to learn (Rebecca Dodd and Lise Munck, 2001).

Public Health role in financial risk protection is to achieve protection against catastrophic health expenditure and against impoverishment related to illness. This role has become in the

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core determinants of social protection and social justice. Catastrophic health expenditure refers to health spending that makes households reduce their consumption or to sell assets or to borrow to pay for healthcare bill to the level that leads to disruption of their living standards. Among the globally accepted goals to provide social safety net from health perspective, are the reduction of Out-Of-Pocket spending and equity in financing (Xu et al., 2003).

Van Doorslaer et al. (2006) searched the effect of OOP spending on health on poverty in eleven countries in Asia. It was found that poverty estimations after paying for health, were much higher than the baseline estimates by value ranges from an additional 1.2% in Vietnam to 3.8% in Bangladesh. So, it was concluded that OOP widen the extent of poverty. Therefore, social safety network and poverty alleviation policies should consider OOP spending on health.

3.4. Healthcare Service Coverage

Universal health coverage (UHC) is based on WHO constitution (1948) which decelerates health as a fundamental human right. UHC is also based on Health for All agenda set by the Alma-Ata declaration (1978). Based on that, UHC is defined as "ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship". According to Berman et al., 2013, UHC core concepts are;

- **Population**: defining who is covered and increasing the share of the population that benefits from pooled financing;
- **Costs**: proportion of direct costs that are covered and reducing the amount of out-of-pocket payments and risk pooling; and
- **Services**: defining the service package which are covered and expanding the scope of services that are paid for from that pooled financing.

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4. Public Healthcare and Legal Framework

This section is based on the discussions and conclusions of Hiroaki Matsuura 2013 paper which assesses the role of democratic governance in terms of constitutional health rights in relation to public health in 157 countries. The author mainly evaluated the impact of introducing right to health into the national constitutions of 157 countries, on the health indicators (mainly infant and under-five mortality rates). The data was collected from 1970 to 2007.

The main results were that the introduction of right to health in constitutions reduced both mean infant and under-five mortality rates. Also, the higher the scores for democratic governance, the higher the effect; while, in countries with low scores for democratic governance, the effect of introducing a constitutional right to health was reduced to half.

These findings illustrates the importance of introducing right to health in constitutional framework to provide an effective mechanism for improving health status especially in countries with high democratic governance scores. In countries with low scores of democratic governance, a longer duration is needed to get the same health outcomes.

From the literature review, the researcher could formulate the main features of successful healthcare systems which should be considered when evaluating healthcare system in Egypt. These features are adopting **universal healthcare coverage** and **protective funding models**. On the other hand, Out-Of-Pocket expenditure should be limited as much as possible. This forms the base of the criteria used in the analysis section of this research. Also, the literatures is missing the Egyptian case of legal-institutional assessment. This justifies the selection of that research and opens a window for more research on the Egyptian case. The literatures about Egypt are also missing the updated financial data and the correlation between poverty and health.

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Methodology

1. Research Objective

Based on the previous review of the *Egyptian public healthcare system*, *international healthcare systems*, *financing health* and *good governance*, the importance of this research revealed. The main thesis objective is to investigate how the Egyptian public healthcare programs contributed to protect the low and middle income class of the Egyptians. The main research question is to what extent does the legal-institutional framework, in Egyptian public healthcare context, protect the poor against health-related financial burden. This is achieved by clarifying the relationship between policies/ systems adopted by GoE in relation to the discussions run for the implementation of public social health insurance along with the calls for social justice that aroused after 25th Jan revolution and the 2014 constitution health obligations.

Methodology used is qualitative assessment of the national programs implemented which are national Health Insurance System, Family Health Fund and Payment on the Expense of the State. The assessment depends on content analysis of the institutional and legal framework that affects the operation of these programs.

2. General Concepts

The indicators used in the methodology has to be reflected in the program/ policy studied in terms of exclusion/ inclusion of disadvantaged groups and equity in public healthcare policy/ system. Also, the indicators should be used easily to assess the extent of inclusion and equity of disadvantaged groups in the Egyptian healthcare system.

The policy assessment should include both *de jure* and *de facto* forms of governance in health. At this stage, *de facto* assessment in this study is limited to verification of the index

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developed based on the assessment came out of *de jure* assessment. This verification is made by key informants health experts in the field of the programs subject to the research.

- **De jure;** the existence of formal rules found in laws and regulations. It usually relies on objective indicators.
- **De facto;** what happens in practice. It is measured by objective or subjective indicators.

Table 1: Comparison of *De Jure* and *De Facto* Indicators

	Information Provided	Indicator Type	Data Type	Data Source
De jure	Existence of laws/ policies that include **equity** and **social inclusion** in public services	Objective	Qualitative	Archive
	Quality of laws/ policies, in terms of **fairness**, participation and accountability.	Subjective	Qualitative and/ or quantitative	Experts
De facto	Actual experiences of how the laws/policies are implemented	Objective	Quantitative	Documents, focus groups discussions, in-depth interviews
	Opinions about how laws/ policies are implemented	Subjective	Quantitative and/or qualitative	Surveys, opinion polls/ focus groups

3. *How to Apply the Method*

In order to start applying the method chosen, **desk research** and **verification** are done;

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- **Desk Research;** it relies on content analysis of archival data, administrative data, laws, and legal documents. This tool is suitable for examining *de jure* governance status in the healthcare public sector which the researcher used.
- **Verification;** relies on obtaining professional verification on the index developed and the main findings. Verification is made by key informants and health experts. This tool is suitable for examining *de facto* aspect of the research.

4. *Measuring Equity*

4.1. What to Measure

Equity, as defined by the International Society for Equity in Health (ISEqH), is: "the absence of potentially remediable, ***systematic*** differences in one or more aspects of health across socially, economically, demographically, or geographically defined population groups or subgroups". Equity in health services "implies that there are no differences in health services where health needs are equal (**horizontal equity**) or that enhanced health services are provided where greater health needs are present (**vertical equity**)" (ISEqH official website, May 2014).

According to Social Determinants Of Health, sectoral briefing series 4, WHO (WHO, 2012), in order to achieve social equity in healthcare sector, we should consider the following; delivering basic **healthcare services** that is **universal** and **equity in finance** through reduction of OOPs, address fragmentation and risk pooling, and compulsory contribution.

4.2. Method of Choice

For the purpose of this research, the researcher used some of the indicators used in the method discussed in Benchmarks of Fairness for Health Care Reform (Daniels, et al 2000). It represents a policy tool for developing countries evaluating healthcare system. This method was originally developed for evaluating health insurance reforms in the United States. Then further

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developed by a team from Colombia, Mexico, Pakistan, and Thailand to form a policy tool into "benchmarks of fairness" which assess healthcare system in developing countries. The benchmarks asses barriers to access to services either financial or non-financial, comprehensiveness of benefits, quality of care and administrative efficiency. The criteria used in that method got a wide acceptance among different developing countries despite the differences in their cultural and socio-economic status as presented in the same report.

4.3. Indicators Used

The indicators used in this methods are; intersectoral public health services and systems; financial and nonfinancial barriers to **access** to services; **comprehensiveness** and **equity** of health benefits; **equitable financing**; efficacy, efficiency and quality of care; administrative efficiency; democratic accountability and empowerment; and patient and provider autonomy. For the purpose of this research, the researcher measured **comprehensiveness/ universal coverage,** and **equitable financing** as these indicators represents the common indicators used in the above mentioned literatures that discuss protection of the poor**.**

5. Overall Method Used

The chosen method for that study is developed collectively from the mentioned different indicators. It assesses two main aspects of equity and inclusion in healthcare systems which are; delivering basic **universal healthcare services** and **financial risk protection.**

So, in conclusion these aspects is measured using these indicators;

- **Healthcare Services Coverage:** laws, regulations, etc that support;

1. Achieving the Millennium Development Goals (MDGs)[6] in Health:

[6] MDGs: according to WHO report 2013 on MDGs, they are eight goals that UN Member States have agreed to try to achieve by the year 2015. MDG 1, 4, 5, 6, 7 and 8 are health related. For more information see http://www.who.int/mediacentre/factsheets/fs290/en/. They mainly aiming to improve public health indicators especially those related to mothers and children health, vaccination coverage, etc

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a) Aggregate/ *Universal*: MDG-related service coverage that is an expansion of single intervention coverage measures that should be provided to the whole population (e.g. vaccination).

b) Equity/ *Targeting*: MDG-related service coverage provided for the poorest 40% of population.

2. Coverage of Chronic Conditions and Injuries (CCIs)[7]:

a) Aggregate/ *Universal*: CCIs-related service coverage that is an expansion of single priority interventions that is provided to the whole population.

b) Equity/ *Targeting*: CCIs service coverage provided for the poorest 40% of population.

- **Healthcare Financial Risk Protection Coverage:** laws, regulations, etc that protect against;

1. Catastrophic Expenditure:

a) Aggregate/ *Universal*: level of citizens protected from incurring catastrophic health expenditures and provided to the whole population.

b) Equity/ *Targeting*: level of citizens among the poorest 40% of the population protected from incurring catastrophic health expenditures.

2. Impoverishing Expenditure:

a) Aggregate/ *Universal*: level of citizens protected from impoverished due to (OOP) expenditures on health and provided to the whole population.

b) Equity/ *Targeting*: level of citizens among the poorest 40% of the population protected from impoverishment due to (OOP) expenditures.

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[7] CCIs: physical injury, illness, or disease that develops slowly and is persistent and long-lasting, or constantly recurring over time e.g. Hypertension and Diabetes.

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So, the researcher used these indicators for assessing the rules, laws, regulations and other related legal framework. The measurements used are ranked from 0 – 4 while “0” indicates that there is no policy related to such indicator, “1” indicates that there is a minor level policy related to such indicator, “2” indicates that there is a fair level policy related to such indicator, “3” indicates that there is a high level policy related to such indicator and , “4” indicates that there is a strong level policy related to such indicator. See table 2.

Verification of the findings of the above assessment and analysis was done for each program. It is made by key informants and health experts including the two readers on the thesis panel. This verification represents the *de facto* part of the analysis. The verification clarifies to what extent the expert agreed on the researcher assessment and why. It also enriches the overall recommendations and policy implications of this research.

Table 2: Measurements and Indicators Used in Data Analysis

Measure	**Indicators**		**Intervention/ Program 1**					**Intervention/ Program 2**				
			0	1	2	3	4	0	1	2	3	4
Health Services Coverage	1. Does it include MDGs related diseases?	Universal										
		Target poorest 40%										
	2. Does it include CCIs related diseases?	Universal										
		Target poorest 40%										

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Measure	Indicators		Intervention/ Program 1					Intervention/ Program 2				
			0	1	2	3	4	0	1	2	3	4
Financial Risk Protection Coverage	1. Does it protect against catastrophic expenditure?	Universal										
		Target poorest 40%										
	2. Does it protect against impoverishment incidence due to OOP?	Universal										
		Target poorest 40%										

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Description of Data Collected and Limitations

The data collected are groups of laws, presidential decrees, prim-ministerial decrees, ministerial decrees and manuals that regulate and govern the interventions that are subject to the assessment. These programs/ systems are Health Insurance Organization (HIO), Payment on the Expense of the State (PTES) and Family Health Fund (FHF). The main principles of the draft Social Health Insurance Law are also assessed.

1. *Health Insurance Organization (HIO) Legal Framework;*

   1.1. *Legal Framework*

There are four Presidential laws and decrees since 1960s till now that govern the procedures and policies of Health Insurance Organization. The first one is number 1209 for the year 1964 that states the decision of establishment of Health Insurance Organization. The other three decrees issued between 1964 and 2014 and regulate some operational functions of the Health Insurance Organization. Their main scope is to regulate pharmaceutical related guidelines and some administrative affairs.

There are three Prime-Ministerial decrees issued in 1978, 1981 and 2013 till now that govern the procedures and policies of National Health Insurance. 1978 decree is about reconstruction of the HIO board; while, 1981 decree is about the beneficiaries. The last prime-ministerial decree is decree 470 for the year 2013 that extends the Health Insurance coverage to include the poor in four upper Egypt governorates which are; Sohag, Qena, Luxor and Aswan starting from July 2013. This decree was released in May 2013 and it is ineffective due to fall of the regime.

There are 372 Ministerial decrees since 1960s till now that govern the procedures and policies of National Health Insurance. Eighteen Ministerial decrees of them are dealing with

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administrative and regulatory affairs of the HIO. One of them (Decree 179 for the year 1982) is dealing with the healthcare service package delivered by HIO. The rest of the decrees are dealing with the beneficiaries by the HIO system.

Table 3: Overall Health Insurance Legal Framework

Overall Health Insurance Legal Framework	
Presidential laws and decrees	4
Prime-Ministerial decrees	3
Ministerial decrees	372

According to the researcher desk search, the current main working laws and decrees that govern HIO are eight; law 32 for the year 1975, law 73 for the year 1975, law 79 for the year 1975 (modification to law 63 for the year 1964), prime-ministerial decree 1 for the year 1981, law 99 for the year 1992, ministerial decree 380 for the year 1997, law 23 for the year 2012 and finally, law 86 for the year 2012.

- The law 32 for the year 1975, is mainly targeting governmental employees. The premium deduction is 0.5% from employee's salary and 1.5% from employer.
- The law 73 for the year 1975, is targeting insurance of employees to the work-related injuries. The premium deduction is 1% from employer.
- The law 79 for the year 1975 (modification to law 63 for the year 1964), is targeting public and private sectors employees. The premium deduction is 1% from employee's salary and 3% from employer. For pensioners, the premium is 1% of monthly pension.

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- The prime-ministerial decree 1 for the year 1981, is mainly targeting widows. The premium deduction is 2% of monthly pension.
- The law 99 for the year 1992, is mainly targeting school children. The premium deduction is EGP 4 from parents/ guardian and EGP 12 from treasury. About third of medication (outpatient) fees is paid by the parents/ guardian except for chronic-ill children. As an extra source of financing, 10 piasters per each cigarette pack sold is deducted to finance the GoE obligation by this law.
- The ministerial decree 380 for the year 1997, is mainly targeting pre-school-aged children. The premium deduction is EGP 20 from parents/ guardian. About third of medication (outpatient) fees is paid by the parents/ guardian except for chronic-ill children.
- The law 23 for the year 2012, is mainly targeting breadwinner women. The premium deduction is 1% from woman (minimum EGP 12 annually) and EGP 200 annually by GoE.
- The law 86 for the year 2012, is mainly targeting pre-school-aged children. The premium deduction is EGP 8 from parents/ guardian and EGP 12 annually by GoE.

Table 4: Health Insurance Main Legal Framework

Health Insurance Main Legal Framework	
Presidential laws and decrees	6
Prime-Ministerial decrees	1
Ministerial decrees	1

The laws and decrees of HIO does not define an explicit benefit package, yet throughout years, HIO put general rules that control and govern services provision.

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Basic Benefit Package (BBP) represents an executive manual which provides a plan of healthcare services coverage. It consists of a diseases list to be covered, along with limitations on reimbursement such as cost sharing, maximum reimbursement, and a negative coverage list for certain procedures or benefits. BBP was originally developed in order to improve accountability, gaining higher efficiency, equity and providing a benchmarking level of benefits. BBP could be categorized as follows;

- ***First: "Negative List";*** that comprise services HIO does not provide. The list is subdivided into Drugs (not included in HIO drug formulary), some surgical procedures, some prostheses, outpatient visits outside HIO, inpatient hospital stay, epidemic diseases, hospice care, complementary and alternative medicine, home health care, ambulance services and natural catastrophe insurance.
- ***Second: "Co-insurance";***

1. **Neonates, Preschool Children and School Students** share one third of the prices of outpatient medications, with exception of chronic diseases, where patients are exempted from sharing.
2. **Law 32 beneficiaries** share 10% of each outpatient investigation price, with a maximum of EGP 20 for each test.
3. **Law 32 beneficiaries** share 25% of the outpatient medications.

- ***Third: "Co-Payment";***

1. **Law 79 beneficiaries, pensioners and widows** pay one EGP for every outpatient consultant visit.

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2. **Law 32 beneficiaries** pay EGP 0.5 for the general practitioner visit, one EGP for the specialist visit and one more EGP for the consultant visit in the outpatient services.
3. **Law 32 beneficiaries** pay EGP 0.5 for every day as inpatients.
4. **Beneficiaries** pay the prices of all contraceptive means.
5. **All beneficiaries** pay EGP 2 for every home visit; while, school students pay EGP 3 - 5 according to distance their home is from the clinic.

- ***Fourth: "Reimbursement";*** HIO provides the beneficiaries with surgical procedures and other healthcare services in its own hospitals. Beneficiaries, also have the right to be treated in other hospitals that are contracted with HIO through having transferrable letters from HIO. In case of emergency, usually patients are treated outside HIO hospitals, HIO should be informed within 48 hours from admission in order to visit the patient and assess the feasibility of transference to HIO hospital. Reimbursement is done in accordance to the following regulations:

1. **Laws 79 and 32 beneficiaries**: maximum reimbursement is done according to HIO price list for services that are available in HIO facilities, or , according to the least contracted prices for services not available in HIO facilities. This service is provided if the case is urgent and cannot be postponed, while there is no HIO hospital providing the same service in the area of the patients home. The documents needed in such case are; the medical report, receipts and invoices, lab and x-ray tests and a letter from the patient's work place.
2. Same conditions are applied to **school students**, but only in cases of accidents.
3. No reimbursement is done for preschool children.

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- ***Fifth: HIO Cost Sharing;*** HIO shares in the costs of the following catastrophic conditions, provided that there is a beforehand approval from HIO to have the service; liver transplantation, cornea transplantation, kidney transplantation, heart surgery, Cochlea transplantation and Hip and Knee Arthroplasty.

The draft Social Health Insurance Law is supposed to be issued this year 2014. It is a draft law and not officially issued and the researcher can only discuss its main concept with health experts in the field. The draft version the researcher used is January 2014 version.

1.2. Institution

There is no developed organizational structure/ institution of the proposed system yet. It will be developed after the formal issuing of the law. The general idea about it that it will be independent entity reports directly to minister of health and has a board represents the executive authority of it. The current institution Structure of HIO is in figure 5;

Figure 5: Institution Structure of Health Insurance Organization – Central, MoHP Website, 2014

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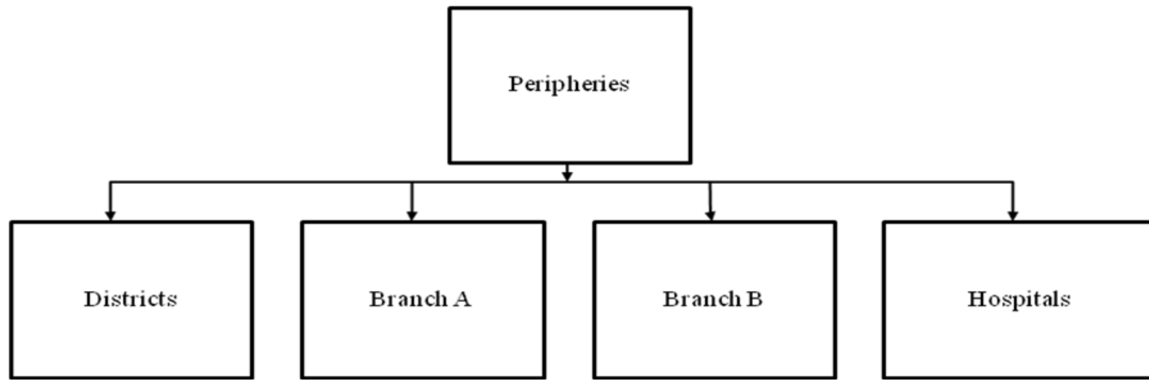

Figure 6: Institution Structure of Health Insurance Organization - Peripheral, MoHP Website, 2014

1.3. Cycle of Documents

There is no developed cycle of documents of the draft Social Health Insurance Law/ System yet. It will be developed after the formal issuing of the law. The general idea about it is based upon a wide network of *customer service offices* that helps and informs beneficiaries about the needed procedures and also receives the premiums if they prefer cash payment. Moreover, it receives citizens' complaints and directs it to concerned parties to investigate and solve it. These offices may be located physically or virtually through using web based technologies.

For the current system, the patient goes to the clinic determined in his/ her medical insurance card. At this clinic, the doctor, usually general practitioner, diagnose, prescribe medicine needed, and make referral to hospital if needed.

The patient receives the *referral* letter which determines the hospital name, the specialty and the date of visit. At the hospital, the patients has to pay for a ticket, gets the medical examination by a specialist, makes the laboratory investigation if needed, and finally receives the medicines from the pharmacy.

The fees for the ticket, laboratory investigation and medicines are all considered as copayments of affordable prices. The medication is prescribed in generic name not the trade

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name. If the patient prefers more expensive trade-named medicine instead of the prescribed one, (s)he has to pay the difference in prices out of his/ her pocket.

The follow up system for chronic ill patients needs them to pass through the whole procedures starting from the referral step. It is done every while according to the medical condition.

2. *Payment on the Expense of the State (PTES) Legal Framework;*

   2.1. *Legal Framework*

There are two Presidential laws and decrees issued in 1975 that govern the procedures and policies of Payment on the Expense of the State system. The decrees regulate the beneficiaries criteria, criteria for treatment abroad and administrative issues.

There are twelve Prime-Ministerial decrees issued since 1975 till 2008. These decrees are related to delegation of the decision of issuing a decree of Payment on the Expense of the State to different ministers including the minister of health and population at 6 decrees. The current decision is number 187 to the year 2008 which delegates the decision of Payment on the Expense of the State to minister of health and population.

There are eight Ministerial decrees since 1975 till 2011 that govern the procedures and policies of Payment on the Expense of the State system. Three Ministerial decrees are dealing with administrative and regulatory affairs of the PTES. Three Ministerial decrees (Decree 290 for the year 2010, Decree 342 for the year 2010 and Decree 530 for the year 2011) are dealing with the healthcare service package provided by PTES. One decree (Decree 691 for the year 1975) is dealing with the beneficiaries by PTES system. The last decree (Decree 58 for the year 2010) is dealing with the pricing of the healthcare services provided by PTES system.

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Table 5: Payment on the Expense of the State Legal Framework

Payment on the Expense of the State Legal Framework	
Presidential laws and decrees	2
Prime-Ministerial decrees	12
Ministerial decrees	8

2.2. Institution

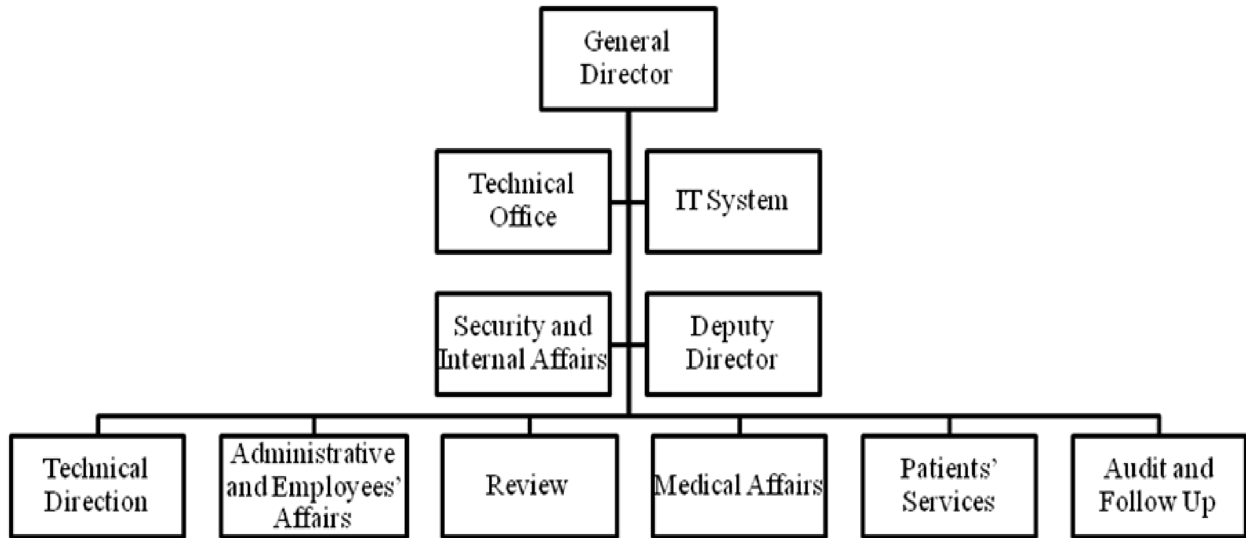

Figure 7: Institution Structure of Specialized Medical Councils, MoHP Website, 2014

The main features of the institution structure consist of General Director, Deputy Director, and six Departments. The departments are *administrative and employees' affairs department, review department, medical affairs department, patients' services department, audit department, and technical affairs department.* This structure is typical for any similar administration within Ministry of Health and Population (based on data available at MoHP website, May 2014).

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2.3. Cycle of Documents

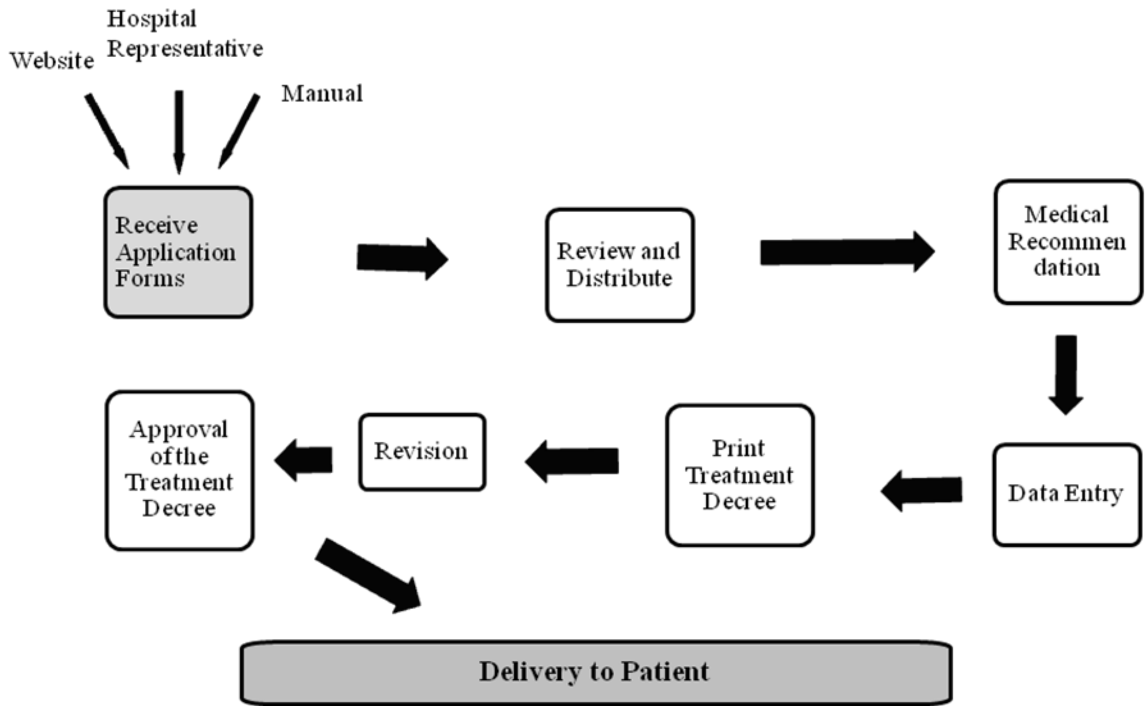

Figure 8: Decree Release Cycle of Documents, based on data available at MoHP website, May 2014

The patient goes to the nearest governmental hospital (affiliated to MoHP, university, armed forces, etc) to his/ her residency. There, the patient is subjected to medical check by number of specialists who diagnose and choose the treatment code. The treatment code include the intervention of choice, the health facility the patient will be treated in and the price coding of the service. Then, the PTES office at the hospital completes an application form for the patient attached with the patient's National ID and the medical reports/ investigations. At that point, the treatment should start immediately.

These documents are submitted electronically or manually to the central department at which the application is revised to validate the eligibility. Then, the decree is issued in not more than 48 hours for emergency cases and 10 days for non emergency cases. The treatment is done

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in the determined health facility in the treatment decree without any claims addressed to the patient. The decree issued is valid for determined period ranging from 3 week to 6 months based on the medical condition itself. In order to renew it, the same cycle is followed again (MoHP website, May 2014).

3. *Family Health Fund (FHF) Legal Framework;*

3.1. legal framework

The legal framework of the Family Health Fund is based on the foundation of the current insurance laws. It was founded centrally and peripherally by the ministerial decree number 160 for the year 2001. The decree deals with the basis for management and administrative aspects of FHF and its responsibilities.

The ministerial decree 109 for the year 2002 determines the organizational structure/ institution of FHF at both central and peripheral levels. It also determines its organogram, the financial and administrative system as well as sources of revenues and expenditures.

The ministerial decree 147 for the year 2003 adds another funding source to FHF by applying co-payment system. Co-payment system is the system at which the beneficiaries share in treatment cost of healthcare service provided. The decree also sets rules for exemption policy.

The ministerial decree number 231 for the year 2006 is dealing with the initiation of the financial pilot FHF at Menoufia Governorate in-terms of extending the cost sharing mechanism by modifying some of the contracting terms with providers as well as the procedures at the secondary level of medical care (at hospitals).

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Table 6: Family Health Fund Legal Framework

Family Health Fund Legal Framework	
Presidential laws and decrees	0
Prime-Ministerial decrees	0
Ministerial decrees	4

3.2. Institutions

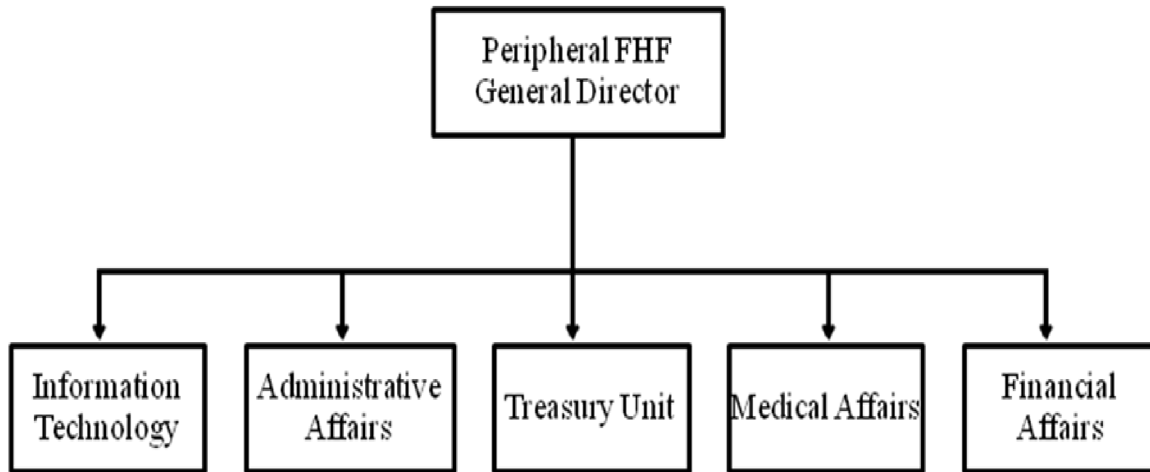

Figure 9: Family Health Fund Institution, MoHP website, May 2014

The main features of the institution structure of the peripheral FHF consist of General Director and five Departments. The departments are *administrative affairs department, treasury unit, medical affairs department, information technology department, and financial affairs department.* The general director reports to the rapporteur of the executive committee. This committee is responsible for the administrative management of all peripheral Family Health Funds. This committee, in turn, reports to the Central Committee headed by Minister of Health and Population. The two committees composed of the same structure of the peripheral Family Health Fund representation (MoHP website, May 2014).

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3.3. Cycle of Documents

The patient goes to the nearest primary healthcare center (PHC), affiliated to MoHP, to his/ her residency. There, the patient is subjected to medical check and get a beneficiary medical file. Then, when needed, the patient goes to the same health center to get the basic healthcare services. Secondary healthcare services is provided in Menufia only through referral from primary healthcare center first (MoHP website, May 2014).

4. Limitations

The documents used in the assessment are collected from different websites that publish the laws, presidential decrees, prime-ministerial decrees and ministerial decrees in Egyptian public service including health.

The researcher assessed the draft Social Health Insurance Law which is supposed to be issued this year. As it is a draft law and not officially issued, the researcher was acquainted by the draft law main principles through participation in different technical meetings of the committee for drafting New Social Health Insurance Law. Also, the researcher verified the assessment with health experts in that field. This makes the assessment more concise and also provides policy recommendations to the committee responsible for drafting the law based on its findings. The draft version the researcher used is January 2014 version.

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Discussion and Data Analysis

The researcher tested the rules, laws, regulations and other related legal framework. The indicators used are ranked from 0 – 4 while "0" indicates that there is no policy related to such indicator, "1" indicates that there is a minor level policy related to such indicator, "2" indicates that there is a fair level policy related to such indicator, "3" indicates that there is a high level policy related to such indicator and "4" indicates that there is a strong level policy related to such indicator.

Verification of the results of the assessment is made by health experts working at the programs subject to the study. The main questions of the analysis are; Does the system covers MDGs related diseases?, Does the system covers CCIs related illness?, Does the system protects against catastrophic expenditure? and Does the system protects against impoverishment incidence due to OOP for each program. The verification main point is to what extent the health expert agreed on the researcher assessment and why.

1. *Current Health Insurance Legal Framework;*

1.1. Healthcare Services Coverage

1.1.1. MDGs Related Diseases

- *Universal*; according to the main eight laws and decrees governing HIO procedures, the researcher concludes that HIO is open and accessible to nearly all population which indicates its nature as a universal program. **According to the basic benefit package used, HIO is not providing preventive health-related services (a).**

  ○ *Target 40% poorest*; the same as universal. Moreover, according to governing laws and decrees, HIO provides a safety net for vulnerable groups. It defines them

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as societal categories; widows, pensioners, etc. Those groups pay less premiums, if not totally exempted, than other groups.

1.1.2. CCIs Related Diseases

- *Universal*; according to governing laws and decrees, **HIO is applied to work-related injuries (b).**
- *Target 40% poorest*; the same as the Universal.

1.2. Healthcare Financial Risk Protection Coverage

1.2.1. Catastrophic Expenditure

- *Universal*; according to the **basic benefit package used, HIO is applied to some of, not all, the catastrophic diseases (c).** The governing laws and decrees also includes the work-related injuries.
- *Target 40% poorest*; the same as the Universal.

1.2.2. Impoverishment Incidence due to OOP

- *Universal*; the **basic benefit package used is defining the copayment and reimbursement mechanism (d).**

  o *Target 40% poorest*; as mentioned before, the governing laws and decrees obligates the state to provide a safety net for vulnerable groups through **paying less premium or copayment (e).** It defines them as societal categories; widows, pensioners, etc. Those groups pay less premiums, if not totally exempted, than other groups.

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Table 7[8]: Measurements and Indicators Used in Health Insurance Organization Data Analysis

	Indicators		Health Insurance Intervention					Score
			0	1	2	3	4	
Health Services Coverage	1. Does it include MDGs related diseases?	Universal			√			**4 [a]**
		Target poorest 40%			√			
	2. Does it include CCIs related diseases?	Universal			√			**4 [b]**
		Target poorest 40%			√			
Financial Risk Protection Coverage	1. Does it protect against catastrophic expenditure?	Universal			√			**4 [c]**
		Target poorest 40%			√			
	2. Does it protect against impoverishment incidence due to OOP?	Universal			√ [d]			**5**
		Target poorest 40%				√ [e]		
Score								**17**

[8] a, b, c ,d and e represent the justification of the score based on the law/ decree content analysis provided on pages 48 and 49.

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Further Analysis

For the fourth question *"Does it protect against impoverishment incidence due to OOP"* the researcher changed the grading. That is because the OOP value paid by patient may be beyond the capability of the insured population which the governing laws determine.

Cycle of Documents

As mentioned before, the patient goes to the clinic determined in his/ her medical insurance card. At this clinic, the doctor, usually general practitioner, diagnose, prescribe medicine needed, and make referral to hospital if needed.

The patient receives the *referral* letter which determines the hospital name, the specialty and the date of visit. There, the patients has to pay for a ticket, gets the medical examination by specialist, makes the laboratory investigation if needed, and finally receives the medicines from the pharmacy.

The fees for the ticket, laboratory investigation and medicines are all considered as copayments of affordable prices. The medication is prescribed in generic name not the trade name. If the patient prefers more expensive trade-named medicine instead of the prescribed one, (s)he has to pay the difference in prices out of his/ her pocket.

The further analysis revealed that all mentioned procedures are undergone at the same health facility except for the first step before the referral and are characterized by long waiting times at each step of it. Moreover, the specialists have predetermined working hours which make the waiting lists more crowded and longer.

The follow up system for chronic ill patients needs them to pass through the mentioned procedures starting from the referral step. Follow up is done to monitor the progress of the

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disease and modify the medicines as required. Usually follow up is done every two months according to the medical case.

2. Payment on the Expense of the State (PTES) Legal Framework;

2.1. Health Services Coverage

2.1.1. MDGs Related Diseases

- *Universal*; according to ministerial decree 290 for the year 2010 article (2), the **system is limited to the uninsured population (a)** either national health insurance or private insurance or any other type of medical health insurance.
- *Target 40% poorest*; according to the same ministerial decree and same article, the decree identifies service package under which the system is operating. **The package includes malignant tumors, cardiac diseases, renal failure, viral hepatitis, chronic diseases and orthopedic surgeries (a).** According to ministerial decree 342 for the year 2010 article (1), the decree adds **emergency cases** [a] to the service package that is treated through this system. **This service package is not a typical service package needed for achieving MDGs related to health (a)**.

2.1.2. CCIs Related Diseases

- *Universal*; as mentioned before, this system is not intended to be universal.
- *Target 40% poorest*; as mentioned above, ministerial decree 290 for the year 2010 article (2) and ministerial decree 342 for the year 2010 article (1), **both decrees identify service package under which the system is operating**. Usually **this service package represents CCIs disease (b)**.

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2.2. Healthcare Financial Risk Protection Coverage

2.2.1. Catastrophic Expenditure

- *Universal*; as mentioned before, this system is not applied to the universe.
- *Target 40% poorest*; as previously mentioned, the ministerial decree 290 for the year 2010 article (2) provides a safety net for the uninsured population either national health insurance or private insurance or any other type of medical health insurance. Usually, those who are eligible to be treated within this system with these criteria are among the poorest population. The same article identifies service package under which the system is operating. **Ministerial decree 342 for the year 2010** article (1) adds more to the service package. Usually **this service package represents catastrophic disease (c).**

2.2.2. Impoverishment Incidence due to OOP

- *Universal*; as seen before, the system does not target the universal coverage.
- *Target 40% poorest*; according to **ministerial decree 290 for the year 2010 articles (5 and 6),** the decree determines a **pricing code for each type of intervention and treatment which may or may not represents part of the whole cost based on the medical decision (d)**. For example, PTES provides a pricing code which can cover the cost of ordinary coronary stent but does not cover the cost of drug-eluted coronary stent. The same article also ended by a statement that permits adding more services to this package based on availability of necessary resources.

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Table 8[9]: Measurements and Indicators Used in Payment on the Expense of the State Data Analysis

	Indicators		Payment on the Expense of the State Intervention					
			0	1	2	3	4	
Health Services Coverage	1. Does it include MDGs related diseases?	Universal	√					0 [a]
		Target poorest 40%	√					
	2. Does it include CCIs related diseases?	Universal	√					**3 [b]**
		Target poorest 40%				√		
Financial Risk Protection Coverage	1. Does it protect against catastrophic expenditure?	Universal	√					**4 [c]**
		Target poorest 40%					√	
	2. Does it protect against impoverishment incidence due to OOP?	Universal	√					2 [d]
		Target poorest 40%			√			
Score								**9**

[9] a, b, c and d represent the justification of the score based on the law/ decree content analysis provided on pages 52 and 53.

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Further Analysis

The researcher made further analysis for the assessment of table 8. For the second question "*Does the system include CCIs related diseases"* the researcher changed the grading as the system does not cover completely CCIs related diseases especially injuries that have some difficulties in practice. Difficulties include refusal of hospitals to accept patients with injuries to be treated under PTES system. The researcher noticed the need for enforcement of the law which obligates any health facility to accept emergency cases and treat them accordingly. Finally the grade is 3 not 4.

For the fourth question *"Does it protect against impoverishment incidence due to OOP"* the researcher noticed the nature of the coding system which determines the value that will be paid for each intervention and the need for OOP contribution in some cases.

The major observation that PTES cannot actually verify the poor beneficiaries. The eligibility process and verification point is done through National ID. The National ID verifies only if the patient has insurance or not but the patient not necessarily to be poor if (s)he is not insured. For example, some of the informal sector beneficiaries are considered among the wealthy population in Egypt e.g. mechanics.

Cycle of Documents

As seen from "Description of the Data Collected Section" of this research, the patient goes to the nearest governmental hospital (affiliated to MoHP, university, armed forces, etc) to his/ her residency. There, the patient is subjected to medical check by number of specialists who diagnose and choose the treatment code for treatment. The treatment code includes the intervention of choice, the health facility the patient will be treated in and the price of the service. Then, the PTES office at the hospital completed an application form for the patient

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attached with the patient's National ID, the medical reports and investigations. At that point, the treatment should start immediately.

These documents are submitted electronically or manually to the central department at which the application is revised to validate the eligibility. Then, the decree is issued in not more than 48 hours for emergency cases and 10 days for non emergency cases. The treatment code is done in the determined health facility in the treatment decree without any claims addressed to the patient. The decree issued is valid for determined period ranging from 3 week to 6 months based on the medical condition. In order to renew it, the same cycle is followed.

This system highly guarantees that the service is not subject to fraud or misuse. Also, the time-limited decree allows for medical checkup for chronic conditions, following up its progress and modifying the treatment protocol as required.

The patient is informed about that cycle through different tools. Either through the hotline 137 or website. These tools are user friendly for all categories of beneficiaries. Moreover, short messages via mobile phones are sent to applicants to inform about the issuing of the decree and follow up.

3. Family Health Fund (FHF) Legal Framework;

3.1. Healthcare Services Coverage

3.1.1. MDGs Related Diseases

- *Universal*; according to **ministerial decree 160 for the year 2001**, this fund is applied for all population for the basic healthcare services including chronic conditions. This **service package does not cover most of MDGs-related diseases (a)**.

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- *Target 40% poorest*; ministerial decree 147 for the year 2003 introduced the exemption policy as one of the governing policies of FHF. The exemption policy enumerates the indicators and measures used to exempt the poor from all financial burden either premiums or copayments which are paid by the fund itself using the risk pooling concept.

3.1.2. CCIs Related Diseases

- *Universal*; as previously mentioned in the **ministerial decree 160 for the year 2001**, this fund is applied for all population for the **basic healthcare services including chronic conditions and injuries (b)**.
- *Target 40% poorest*; as discussed before in the MDGs related diseases, this fund is applied for all population for the basic healthcare services including chronic conditions and injuries. Moreover, ministerial decree 147 for the year 2003 introduced the exemption policy.

3.2. Healthcare Financial Risk Protection Coverage

3.2.1. Catastrophic Expenditure

- *Universal*; as discussed before in the MDGs related diseases, this fund is applied for all population for the basic healthcare services including chronic conditions and injuries. **It is not applied to catastrophic diseases (c)**.
- *Target 40% poorest*; as discussed in universal section, the system is not applied to catastrophic diseases.

3.2.2. Impoverishment Incidence due to OOP

- *Universal*; as seen, this fund is applied for all population for the basic healthcare services including chronic conditions. The **ministerial decree 147 for the year**

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2003 article (10, 11, 12 and 13) (d), co-payments are relatively affordable. Diagnosis fees is EGP 3 and free for emergencies. Medicine price is third the total market price. Premium is EGP 10 for the first time and EGP 5 annually afterwards. Scans, lab diagnosis and minor surgeries fees ranges between EGP 1 to EGP 200 (tonsillectomy).

- *Target 40% poorest*; as discussed, the exemption policy states the indicators and measures used to exempt the poor from financial burden either premiums or copayments stated in ministerial decree 147 for the year 2003 article (10, 11, 12 and 13) which are paid by the FHF using risk pooling concept. **Poor are 100% exempted (d)**

Table 9[10]: Measurements and Indicators Used in Family Health Fund Data Analysis

	Indicators		**Family Health Fund Intervention**					
			0	1	2	3	4	
Health Services Coverage	1. Does it include MDGs related diseases?	Universal			√			4 [a]
		Target poorest 40%			√			
	2. Does it include CCIs related diseases?	Universal					√	**8** [b]
		Target poorest 40%					√	
Financial	1. Does it protect	Universal	√					0 [c]

[10] a, b, c and d represent the justification of the score based on the law/ decree content analysis provided on pages 56, 57 and 58.

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	Indicators		Family Health Fund Intervention					
			0	1	2	3	4	
Risk Protection Coverage	against catastrophic expenditure?	Target poorest 40%	√					
	2. Does it protect against impoverishment incidence due to OOP?	Universal			√			4 [d]
		Target poorest 40%			√			
Score								**16**

Further Analysis

The researcher made further analysis for the assessment of table 9. For the third question "*Does the system protect against catastrophic expenditure*" the researcher changed the grading as the system does not cover catastrophic diseases. That is because at first, the researcher considered the implementation of Decree 231 for the year 2006 which states the procedures of referral. Then, the researcher reconsidered that decree again because it was released as pilot for Menufia governorate only and for limited service package at hospitals. Finally, the grade is 0.

Cycle of Documents

According to the laws and regulations, the patient goes to the nearest primary healthcare center (PHC), affiliated to MoHP, to his/ her residency. There, the patient is subjected to medical check and get a beneficiary medical file. Then, when needed, the patient goes to the same health center to get the basic healthcare services. Secondary healthcare services is provided in Menufia only through referral from primary healthcare center first (Decree 231 for the year 2006). This

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cycle is convenient to the process of poor identification. Identification of the poor is done through Ministry of Social Solidarity. Poor enrolled in that system should have a report from Ministry of Social Solidarity to confirm eligibility.

4. *Draft Health Insurance Legal Framework; a Glance into the Draft Social Health Insurance*

4.1. Healthcare Services Coverage

4.1.1. MDGs Related Diseases

- *Universal*; according to article (1), this law is applied to all population except those work for Armed Forces which indicates its nature as universal applied law. On the other hand, **article (27) (a)** obligates the claim for the healthcare service by being enrolled and paying the premium defined in the annexes of the draft law. According to **article (4) (a)**, the draft law is not applied to public and prevention health-related services. **Vaccination services are not included (a)**.
- *Target 40% poorest*; the same as universal. Moreover, according to **article (12) (b)** fifth item, the draft law provides a safety net for the poor. It defines the poor by those identified by Ministry of Social Affairs. It also includes widows, pensioners and disabled population who suffer chronic diseases. The law states that those identified categories of population are below or near to the poverty line. Those population will have paid their premiums through the state treasury. Moreover, in case of illness, the state treasury will pay for their co-payments according to the identified percentages at the annexes of the draft law.

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4.1.2. CCIs Related Diseases

- *Universal*; according to **article (4),** this draft law is **applied only to chronic conditions and not applied to injuries (b)**.
- *Target 40% poorest*; the same as the Universal.

4.2. Healthcare Financial Risk Protection Coverage

4.2.1. Catastrophic Expenditure

- *Universal*; according to **article (3)**, this draft law is **applied to catastrophic diseases (b)** provided the definition of the catastrophic diseases by the concerned authority which is Ministry of Health and Population.
- *Target 40% poorest*; as mentioned above, according to article (12) fifth item, the draft law provides a safety net for the poor. Also, article (3) in this draft law ensures the coverage of catastrophic diseases.

4.2.2. Impoverishment Incidence due to OOP

- *Universal*; according to **annex (4)** which identifies the **co-payments**, the diagnosis and medicines **prices are relatively affordable (d)**. Diagnosis ranges from EGP 3 for regular visit to EGP 30 for the home visit. Medicines price EGP 5 for each item without capping for number of items. Scans and lab investigations fees are also affordable. Scans copayments are 20% of the total cost and lab investigations are 10% of the total cost
- *Target 40% poorest*; as mentioned above, according to article (12) fifth item, the draft law provides a safety net for the poor. Moreover, to annex (4) identifies the **co-payments which is paid by the state treasury (d)**.

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Table 10[11]: Measurements and Indicators Used in Draft Health Insurance Law Data Analysis

	Indicators		**Health Insurance Intervention**					
			0	1	2	3	4	
Health Services Coverage	3. Does it include MDGs related diseases?	Universal		√				2 [a]
		Target poorest 40%		√				
	4. Does it include CCIs related diseases?	Universal			√			4 [b]
		Target poorest 40%			√			
Financial Risk Protection Coverage	3. Does it protect against catastrophic expenditure?	Universal					√	**8 [c]**
		Target poorest 40%					√	
	4. Does it protect against impoverishment incidence due to OOP?	Universal					√	**8 [d]**
		Target poorest 40%					√	
Score								**22**

[11] a, b, c and d represent the justification of the score based on the law/ decree content analysis provided on pages 60 and 61.

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Further Analysis

The researcher made further analysis for the assessment of table 10. For the second question "*Does the system include CCIs related diseases"* the researcher observed that the system covers the chronic conditions but misses the injuries part. The draft law states that it does not cover first aid and emergency conditions and this is the responsibility of the state. In practice, it cannot be avoided and the draft law should be revised. For example, if patient suffers stroke due to his critical heart condition that was treated under the health insurance system. The stroke condition is an emergency condition but at the same time it is a complication of his health status at which health insurance system is paying its bill. Now, when the patient admits to emergency department at hospital, who will pay the bill? Is it the proposed Social Health Insurance system? Is it Ministry of Health and Population? Or both?.

For the fourth question *"Does it protect against impoverishment incidence due to OOP"* the researcher noticed that the system protects against impoverishment incidence due to OOP by determining affordable contributions for the services provided but, at the same time, the contributions paid in cases for catastrophic diseases and expensive interventions are not included in the contribution part of the draft law. For example, the law misses the contribution basis of surgical operations, radiation treatment for cancer patients, physiotherapy, transplants, replacement apparatuses, etc. These types of interventions are expensive and should be clearly addressed in the draft law if it is free service or will have a mechanism of contribution.

Cycle of Documents

As mentioned before, there is no developed cycle of documents of the proposed system yet. It will be developed after the formal issuing of the law. The general idea about it will be based upon a wide network of *customer service offices* that helps and informs citizens about the needed

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procedures and also for receiving the premiums if they prefer cash payment. Moreover, it will receive citizens' complaints and direct it to concerned parties to investigate and solve it. These offices may be located physically or virtually through using web based technologies.

This method, is convenient to most of beneficiaries. It provides one check point for all kinds of questions. It is accessible for all kinds of population. Finally, it is user friendly and will provide a tool for customer relationship management for the benefit of all parties.

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Conclusion and Findings

1. *Health Insurance Organization (HIO) Legal Framework;*

Based on the assessment illustrated in table 7, we can observe the following;

- The overall score was 17. For the **universal healthcare coverage** (UHC) indicators, the score is 2 for the degree of coverage of MDG related diseases and 4 for the coverage of CCIs related illness. This represents how HIO is not designed to cover those types of healthcare services taking into consideration that other types of public entities provide these services (MoHP). For the **financial risk protection** indicators, the score is 4 for protection against catastrophic health expenditure and 5 for protection against impoverishment due to OOP. This illustrates how HIO is to some extent designed to protect against financial risk protection using methods of risk pooling and obligation of the system.

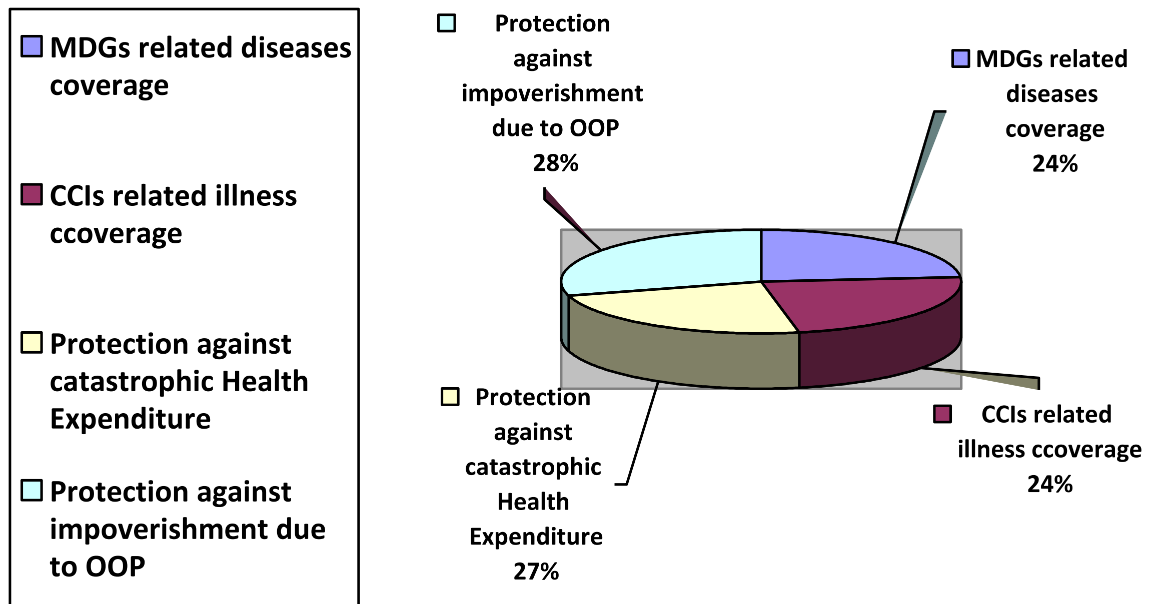

Figure 10: Findings of the Data Analysis of Table 7 of the Health Insurance Organization Legal Framework

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2. *Payment on the Expense of the State (PTES) Legal Framework;*

Based on the assessment illustrated in table 8, we can observe the following;

- The overall score was 9. For the **universal healthcare coverage** (UHC) indicators, the score is 0 for the degree of coverage of MDG related diseases and 4 for the coverage of CCIs related illness. This represents how the PTES is designed to serve certain types of diseases not MDG related diseases but CCIs related illness. For that reason MDG related diseases should be covered by other types of policies or systems provided and regulated by other public entity. For the **financial risk protection** indicators, the score is 4 for protection against catastrophic health expenditure and 2 for protection against impoverishment due to OOP. This illustrates how PTES is well designed to protect against catastrophic diseases using methods of right selecting service package covered by PTES but not as well designed to protect against impoverishments due to OOP.

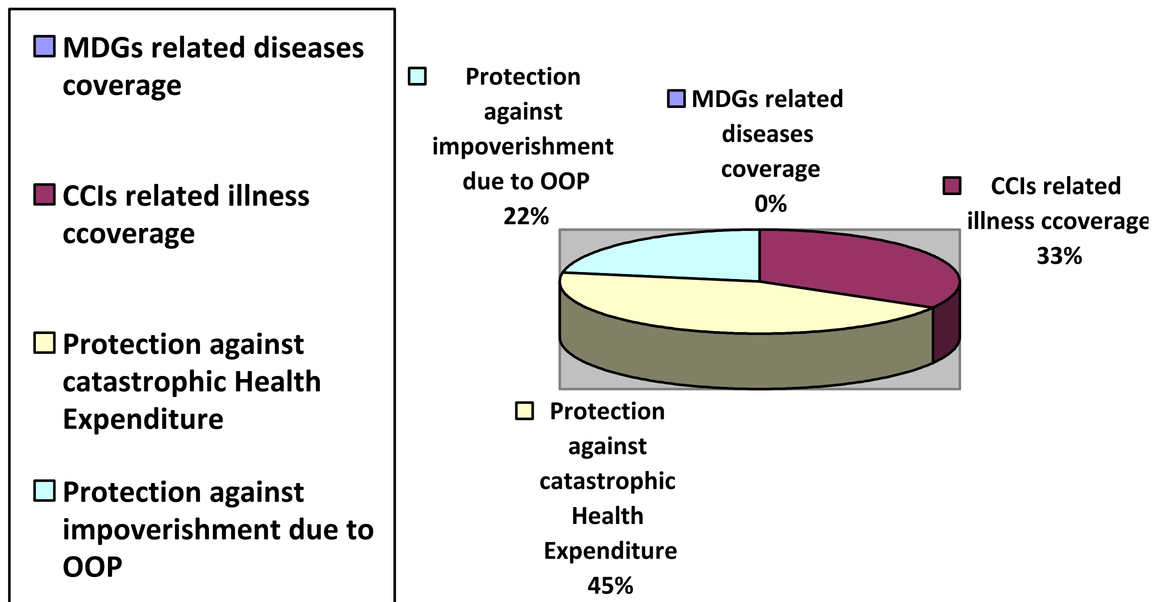

Figure 11: Findings of the Data Analysis of Table 8 of the Payment on the Expense of the State

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3. *Family Health Fund (FHF) Legal Framework;*

Based on the assessment illustrated in table 9, we can observe the following;

- The overall score was 16. For the **universal healthcare coverage** (UHC) indicators, the score is 4 for the degree of coverage of MDG related diseases and 8 for the coverage of CCIs related illness. This represents how the FHF program is well-designed to cover MDG related diseases and CCIs related illness. For the **financial risk protection** indicators, the score is 4 for protection against catastrophic health expenditure and 4 for protection against impoverishment due to OOP. This illustrates how FHF program is well designed to protect against financial risk protection related to both catastrophic diseases using methods of right selecting service package covered by the system and those risks related to impoverishments due to OOP using methods of risk pooling and obligation of the system.

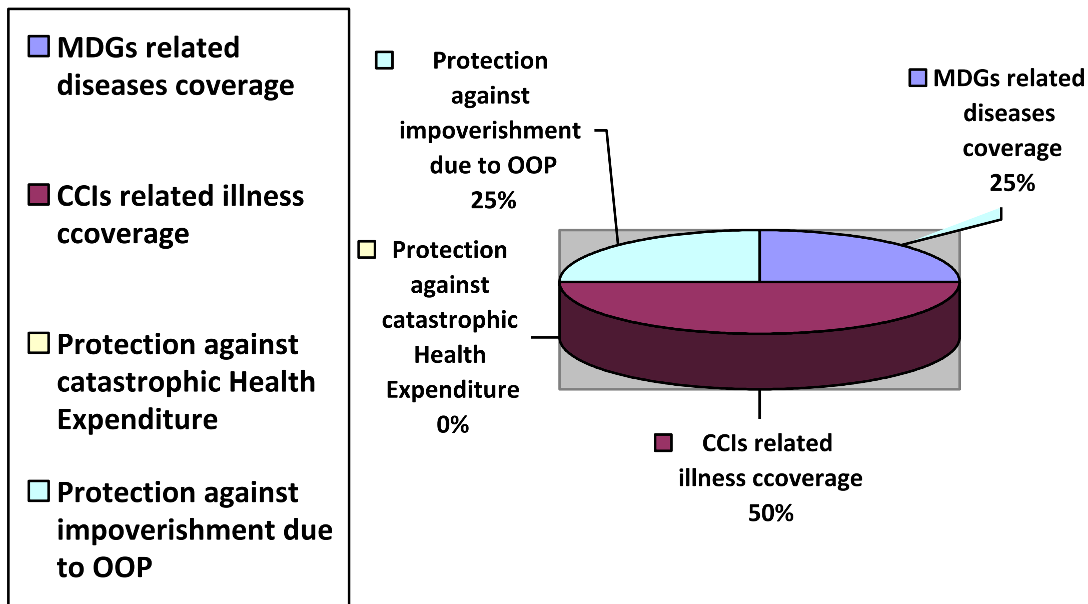

Figure 12: Findings of the Data Analysis of Table 9 of the Family Health Fund

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4. *Proposed Health Insurance Legal Framework;*

Based on the assessment illustrated in table 10, we can observe the following;

- The overall score was 22. For the **universal healthcare coverage** (UHC) indicators, the score is 2 for the degree of coverage of MDG related diseases and 4 for the coverage of CCIs related illness. This represents how the draft law of social health insurance is designed to cover certain package of healthcare services; while, other types of illness especially MDG related diseases and CCIs related illness should be covered by other types of policies or systems provided and regulated by other public entity. For the **financial risk protection** indicators, the score is 8 for protection against catastrophic health expenditure and 8 for protection against impoverishment due to OOP. This illustrates how the draft law of social health insurance is better designed to protect against financial risk protection using methods of risk pooling and obligation of the system.

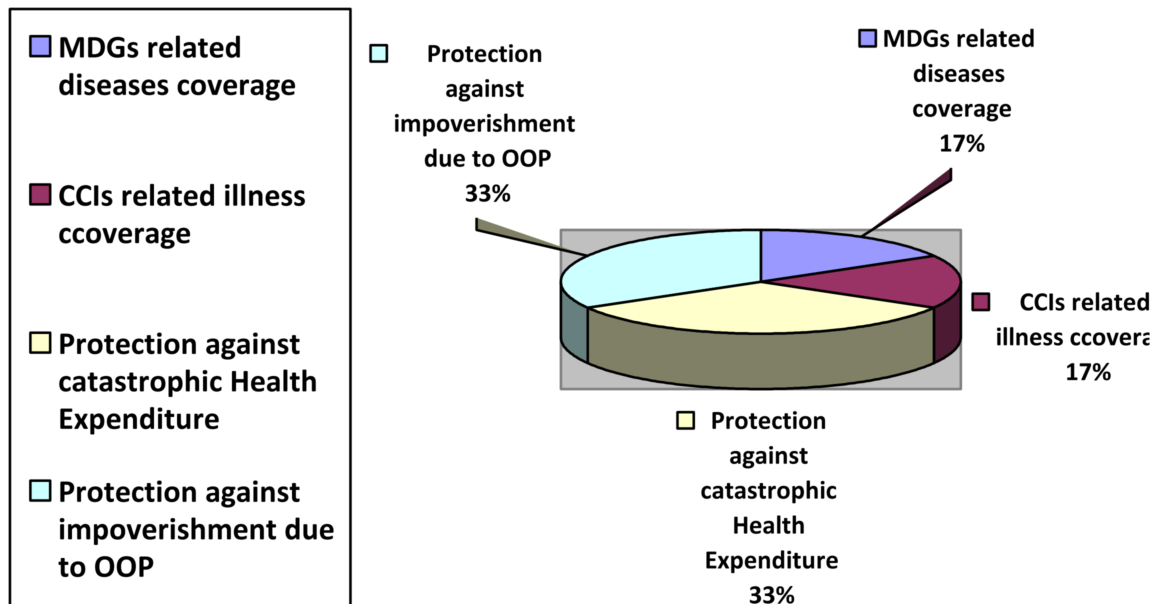

Figure 13: Findings of the Data Analysis of Table 10 of the Draft Health Insurance Law

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Overall Findings

By comparing the findings of the programs, we can observe the following;

- Draft health insurance law provides strong protection against financial risks related to both catastrophic expenditures and OOP expenditures.
- FHF provides the best program to address universal health coverage for CCIs related illness compared to other programs and equal protection with the current HIO for MDGs related diseases.
- The current HIO program provides moderate level of protection against financial risk and also provides reasonable services package (basic benefit package).

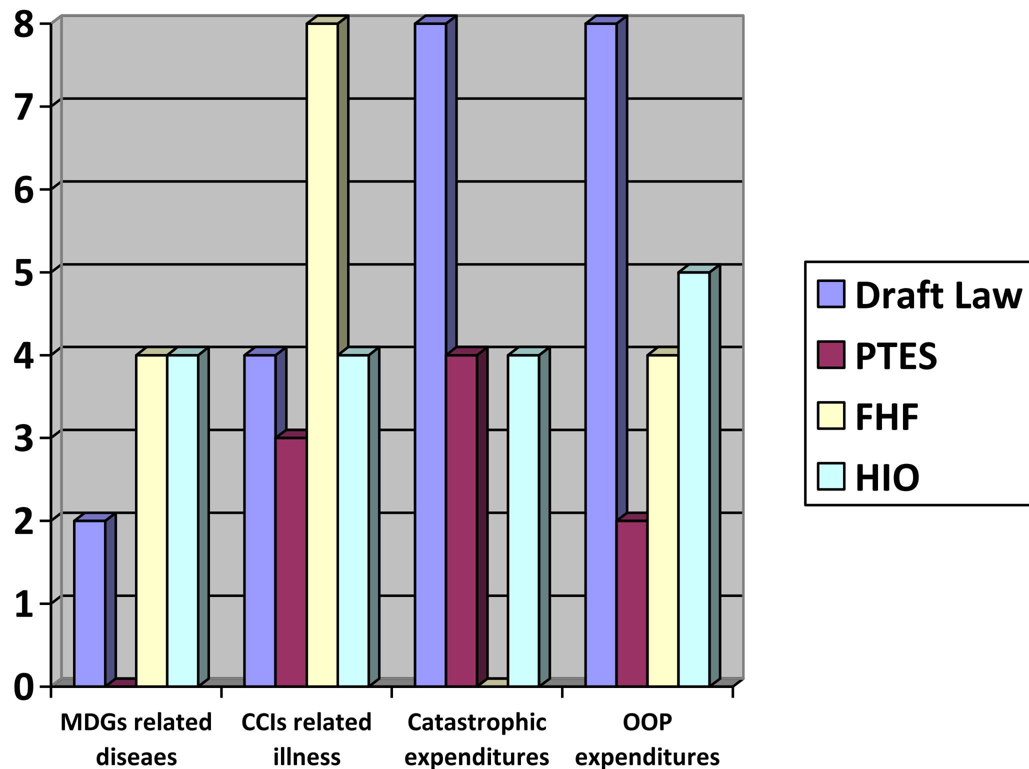

Figure 14: Comparison of the Findings of the Data Analysis of all Interventions

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These findings, illustrated in figure 14, show that the proposed law will have great impact on improving the social safety net for vulnerable groups in Egypt. In-terms of both universal health coverage and financial protection, it provides better protection.

From the perspective of targeted beneficiaries, HIO targets mainly public sector employees. PTES targets those who are not covered by any type of health insurance whether public or private insurance. FHF is universal and open to any beneficiary but it is limited to five governorates up till now. The proposed Social Health Insurance Law is applied to the whole population except for those working in armed forces.

On the institutional aspect, the researcher observed the effect of the political and economic instability during the past three years on the capacity of different public institution to provide the needed service as before 2011.

Also, the researcher during the desk search observed that the number of laws and decrees issued after 2007 significantly decreased. This is may be due to the political will, at that time, to formulate and issue a unified one health insurance law instead of making amendments to the current fragmented laws and decrees.

Answer for the Research Question

The answer the researcher found for the main research question, is that Egypt is not yet protecting the poor against health related financial burden according to the legal-institutional assessment of health programs run by government. In the meanwhile, Egypt is moving toward achieving this goal through the draft law which gives better overall results compared to other programs subject to the study.

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Policy Implications of Recommendations

When the researcher started this study, there was an assumption that those who have a health insurance system are having a strong social safety net against health-related financial burden compare to those who have not or those enrolled in other systems for treatment like PTES or FHF. The findings reveal different perspective of thinking. The draft law shows good results for all indicators used in the assessment of universal health coverage and financial risk protection but, it still needs a complementary system to fully cover MDGs related diseases and CCIs related illness. This may not fit its intended purpose as it is not a tool to provide public health services such as vaccination which is left to be provided by other entity.

Family Health Fund provides a good intervention which provides good coverage against MDGs related diseases and strong coverage against CCIs related illness. It also provides reasonable protection against financial risks.

PTES system represents a good model for targeting risk groups but with moderate results due to the limited service package that it covers.

1. Formularization of unified framework

The overall recommendation of the study is to integrate and complement all these programs within unified framework aims to utilize the best in each system and provides best outcomes. As seen in the conclusion section, each program has points of strengths and also has weaknesses. These different strengths points if compiled together in one system, will maximize the value provided to disadvantage citizens. By the same token, weaknesses could be limited when these systems work together under one governing system.

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2. Roles Determination

Defining the roles and complete separation between *Regulator*, *Provider* and *Payer* entities at the Egyptian healthcare system is crucial to better integrate and complement the services. MoHP should play *Regulator* role. FHF or HIO could play the *Payer. Provider* should be a mix of all key players including public, private and NGOs service providers with regulation of prices and medical practice by MoHP.

MoHP's role should be the regulator of all the healthcare network within the country. It should also coordinate effectively with all stakeholders to ensure the effectiveness of its role i.e. MoHP should coordinate with universities in the process of education and training of medical schools students who will form the future medical staff at all health facilities. It should also develop a sound monitoring and evaluation system at all levels.

The philosophy of the draft Social Health Insurance Law is to formulate one payer entity that contracts and purchases healthcare services in behalf of all beneficiaries. That necessitates the inclusion of already established payer entities i.e. HIO, PTES and FHF. These entities, as previously discussed, have positive and strong aspects that should be best utilized in the proposed system. Moreover, the process of inclusion should be as smooth and efficient as possible for the benefit of both beneficiaries and employees.

The publicly owned health facilities should be integrated under one provider network. This separation from regulator (MoHP) and integration in one network, will help in improving the quality and competition levels of these facilities.

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3. Further Research

We may need to go for further deeper research about the following;

- What is the real value and quality provided to Egyptians by the current healthcare programs/ interventions adopted? Measuring the impact of all applied social protection policies and programs, is the real indicator measuring the success of the healthcare system and the state success as well.
- What are the tools used in identification of the poor by authorized stakeholders? What are the findings? As well-illustrated in case of PTES, there is no definition of the poor. Depending on descriptive criteria does not necessarily lead to targeting the poor. Informal sector, school children and breadwinner women are not necessarily to be poor. More objective socioeconomic criteria based on financial studies, may be better alternatives in defining the vulnerable groups.
- How much is the budget allocated to MoHP under 2014 constitution? What is its breakdown? How to reach that percentage? Shifting into program based financing, instead of line items, helps in better allocation of financial resources. Separation of roles will help in this financing approach.
- What is the financial sustainability for all these programs and to the proposed system in particular? Which one is the more sustainable system? As discussed in the literature, financial sustainability is an essential element in designing social protection policies and programs.
- How the proposed Social Health Insurance system will be applied? What is the vision for the transitional period?

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- How will the emergency cases be covered under the draft Law for Social Health Insurance? What is the copayment mechanism, if any, in cases of expensive treatments/ interventions (e.g. radiotherapy)? As seen from the analysis, a revision of the draft law may be needed to cover these missing parts. Also, articles about implementing financial stability mechanisms to the proposed payer entity, should be incorporated in the draft law.
- How NGOs, Civil Society[12], private sector and international entities can contribute to developing better system that protect the poor? These entities with its long experience and knowledge can effectively help in all technical aspects rather than financial assistance.

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12 As an important recommendation regarding the role of civil society to enforce the role of the state to protect the poor, is the case of Egyptian Initiative for Personal Rights (EIPR).
The Egyptian Initiative for Personal Rights or EIPR is an independent Egyptian human rights organization, established in 2002 to adopt the rights and freedoms of human-being. EIPR works in four main areas: *Right to Health, Freedom of Religion and Belief, Right to Privacy and Violence* and *Bodily Integrity. Right to Health* program defends people's right to access to health services, treatment and essential medicines.
On September 4th 2008, the Court of Administrative Justice decided to suspend the establishment of the Health Care Holding Company. This decision was in favor of a lawsuit filed by the EIPR, jointly with the Hisham Mubarak Law Center, demanding the suspension of Prime Ministerial decree 637 for the year 2007 to establish a Health Care Holding Company. According to the decree, the company would have control over the assets of the HIO hospitals and clinics. It would procure healthcare services from HIO health facilities as well as non-HIO health facilities. According to the same decree, it would be a for-profit company and could offer healthcare services at a for-profit margin. It would also have the legal right to sell HIO health facilities to private investors. HIO was covering about 52% of Egyptians at that time. This rule by the court adds a significant protective rule to the Egyptian legal framework.
The court rule included the full scope obligation of GoE towards the citizen in protecting the right to health. It argued that it is the State's constitutional obligation no matter how strong is the justification for issuing such decree. It also highlighted that the right to implement new administrative procedures must consider the rules organizing public ownership and the right of citizens to receive an affordable health services. More important, the court rejected the government's argument that the defendant (group of civil society organizations) has no legal right to file the lawsuit and the court added that they are citizens and state is obliged to offer them their health rights. In conclusion, The court assured that the HIO would remain intact. (Egyptian Initiative for Personal Rights – Right to heath program, A Landmark Decision Sets New Basis for the Legal Protection of the Right to Health in Egypt., September 2008).

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