



## POLICY BRIEF # 3

# Pro-Poor Healthcare for Egypt

Egypt's expenditures on health are at 6% of GDP, a level comparable to many countries of similar socioeconomic conditions. Financially, both the Ministry of Finance (MOF) and out-of-pocket contributions have increased significantly since 1995, despite which health inequity persists — even though there are more physicians per 100 thousand population in Egypt than most developing countries — including many who have achieved better population health status, such as Sri Lanka and Costa Rica. Egypt also has an abundance of health facilities and hospital beds. Yet, health provision remains inadequate, with the burden of ill-health disproportionately large amongst the poor.

The most common sources of financing health care in Egypt are out-of-pocket (61%), followed by the Ministry of Finance and donors. The MOF generates resources from taxation and makes them available to the Ministry of Health and Population (MOHP). At the present time, an insurance scheme is not available to the very poor, or to people who are not in formal or in organized occupations, or to the unemployed and housewives. A good health policy for the poor should provide them with some form of health security, particularly to protect them from paying for catastrophic medical episodes. Recent studies however, have shown that the poor are increasingly seeking outpatient care in private facilities (EHDR 2004) which are perceived as providing better services, and are therefore incurring costs out-of-pocket that cut deeply into their budgets.

### **I. The Problems of Access and Health Care Provision**

#### **1. Regional Disparities**

In all geographical areas, whether rural or urban, beneficiaries choose to utilize private facilities for out-patient care more frequently than they do government or other public facilities. The national health facility utilization figure is 22.7% for MOHP and 57% for private facilities. The low uti-

lization of public facilities is also apparent if we look at income differences. Comparing the poorest and richest 20% of the population, the use of private service providers is still higher than that of public services for both groups.

Although Egypt will achieve the MDG targets for 2015 at the National level, it will not do so equally at the governorate level. More children suffer from anemia and other nutritional deficiencies in those governorates that rank low on the Egypt Human Development Index Scale.

Concentrations of poor populations are mainly in rural areas. Upper Egypt is the home of almost 41% of all the poor, and from a health sector perspective rural Upper Egypt shows the slowest and least progress in improving its health outcomes. Upper Egypt, in general, has the highest mortality rates for infants, at 59 deaths of infants twelve months old or younger per 1,000 live births in 2003, while the national average was 44.7 infant deaths for 2003. It is anticipated that many Upper Egypt governorates will fail to achieve the Millennium Development Goals (MDGs) at the governorate level because of the poor performance of rural areas, although the interventions needed to improve the health outcomes in rural Upper Egypt are acknowledged, available, tested and cost-effective.

The differences between Upper Egypt and the rest of Egypt, as well as between the rich and poor both in rural and urban areas are also produced by households and communities and not just by flawed health services. Slow progress in rural Upper Egypt or in informal urban settlements cannot be blamed on absent health services alone but is the outcome of interacting cultural and educational factors that need to be addressed along with shortcomings in public service health delivery.

Pro-poor policies thus require (i) improved information on hygienic practices; (ii) access to better quality health services; and (iii) a means of providing the poor with security, particularly

financial security, to protect them against chronic or catastrophic health conditions.

## 2. The Complex Underlying Factors

Understanding that health outcomes are a result of many interlinking factors is the basic requirement for improving health delivery and sustaining health gains. But Government policies have usually not taken an integrated approach into consideration, given the wide range of variations, numerous clients, multiplicity of laws, supervisory entities and health service providers and the capacity to make use of synergies. Currently, Egypt's public health system uses a combined strategy of providing free services and targeted insurance schemes. The dilemma for the state is to choose which healthcare services can continue to be delivered for free, which should receive a slice of the expenditure pie — and by how much, and whether the state should incur all or part of the costs through a variety of cost-sharing measures. The issues of universal or targeted coverage, and how to fund these is also a major concern.

There are multiple reasons behind poor health provision. One reason lies partially in underutilized capacity and administrative overstaffing rather than in shortages, although population growth has also stretched the carrying capacity of the public health system. Paradoxically, some of the system's successes — the decrease in child-birth and in child mortality, and the raised level of life expectancy — have meant, respectively, a decrease in health expenditure per citizen and an increase in chronic diseases of the elderly.

Education, sanitation, nutrition, housing and environmental conditions as well as culture and tradition are part of the dynamics of health production. A woman is more likely to die of child-birth if she is not allowed to seek professional help, if she has had repeated and un-spaced pregnancies, suffers from anemia and calcium deficiency because of poor nutrition, was married at a very young age, or was unable to reach a hospital in time because she has no access to telephones and transport. Similarly, a child treated for diarrhea has a high chance of re-infection as he/she returns to the same unhygienic environment and is repeatedly exposed to the same factors that led to the first infection. It has become clear that health services have also been too narrowly conceived. In the past, Egypt addressed many of its health problems by

targeting a specific ailment. An example is the success in markedly reducing the prevalence of what once was endemic schistosomiasis (bilharzia). This example of an intervention by disease or geography illustrates the capacity of Egypt's health system to reach the poor when goals are clear, the medical tools and technicians available, and national awareness campaigns are used to prepare the recipients. To achieve similarly successful programs requires a comparable focus, adequate resources and better dissemination of information. However, these types of intervention are highly specific and as such address only one out of many health needs.

## 3. An Integrated Approach to Healthcare

Some examples of overlap illustrate the advantages of an integrated program:

- *Water and sanitation:* The combination of safe drinking water and hygienic sanitation facilities is a precondition for health. The Ministry of Health and Population (MOHP) can advocate for full and quality coverage, train its service providers in the relevance of water and sanitation, cooperate in pilot programs and demonstration models as interventions for better health. It can also provide information about water born diseases and the risks of poor sanitation, water shortages and water quality for policy planning;
- *Public works:* Dredging canals, covering sewers, improving access to remote areas, providing efficient solid waste disposal, expanding awareness on the need for clean environments are not necessarily the purview of the MOHP. But as health-related programs, they require closer cooperation between MOHP and other bodies to be able to direct energies beyond limited curative services and narrow health promotions and into prevention measures that address causes rather than symptoms;
  - *Education:* Promoting health awareness in school
  - curricula, amongst teachers and administrators, and through the media (particularly radio and television to reach the poor) can, for example, reduce diarrheal disease by focusing on hygienic practices and simple dehydration measures, or highlight the elements of a balanced diet, or the damage caused by smoking. At a more ambitious level, it can give instructions to



local communities on how to construct simple but effective latrines or how to convert rice stubble into building material for inexpensive housing;

- *Nutrition:* The MOHP can promote a health intervention that would meet the nutrition needs of poor children through the provision of balanced meals that include milk and proteins in all public sector schools. The Ministry has already focused on providing micro-nutrients and food supplements such as iron, vitamin A and iodine and should eliminate the current rations of dry biscuits, helva and flavored and sweetened drinks that have very little nutritional value. An effective partnership between health, education, and supply ministries, combined with the oversight of communities and parents could insure the success of this essential pro-poor health intervention. A private sector fund for the provision of free meals for poor schoolchildren could be promoted and managed through a transparent not-for-profit organization with a board of businesspersons;

- *Affordable pharmaceuticals:* Egypt has a flourishing and competitive pharmaceuticals industry but still imports some drugs or their components. The price of pharmaceuticals is increasing in the global markets, making it difficult to produce medication at a reasonable cost and within the budget of the poor. Drug prices were once controlled but under current trade conditions this is no longer possible. Alternative means to supply affordable generic drugs with limited mark-ups is for MOH or HIO to enter into long-term supply contracts which entail huge savings for buyer and producer. Cost saving measures could be made by rationalizing ministry procurements and supply of drugs. Cost savings could include a limit placed on the present wastage incurred by selling the full commercial pack of medication.

#### 4. Changing Attitudes and Behavior

Primary health care services are offered free of charge including the medications at the primary health care facilities. In addition, hospital services in public hospitals are free for the non-insured. Changing this established expectation

as a 'right' will be met with resistance from both providers and beneficiaries. The fact that a large proportion of people seek care at private facilities and that both poor and rich pay significant amounts out-of-pocket for health services does not automatically mean that they would be willing to pay for public facilities. There is a need to change the public's attitude towards free public health services if these are to continue. This can only come about if the services themselves are upgraded and brought up to a standard that cancels the necessity of using private services.

One example of shared cost can be found in Qena where rural health units, hospitals and clinics charge a fee of LE 3, paid by each beneficiary who is not covered by health insurance for medical check-up, plus one-third of the medicine cost (to be deposited in the Service Improvement Fund) while LE 10 is paid for home visits. In addition, radiology, dentistry and small operations services are delivered against nominal fees. However, needy categories are treated for free. To avoid the practice of transferring patients to private clinics, physicians' salaries have been increased to LE 1500 monthly.

The role of NGOs to date is limited to helping provide basic services and undertaking health education. Both they and community agents can provide public awareness and help in co-financing services, for example by setting up a revolving fund that can cost share with clients who need services that require fees. They can also play a greater role in oversight to ensure that the basic package of services is indeed up to standard.

#### 5. Creating Provider Incentives

Providers, particularly physicians, show a rapid turnover in rural areas, particularly in Upper Egypt. They prefer a more lucrative urban private practice, frequently alongside a government job, to ensure a sustainable income and gain additional social status. Working in government service, although poorly remunerated with a larger numbers of poor patients, nevertheless ensures a minimum constant income and benefits at retirement, and it is mainly new medical graduates with limited experience who accept state appointments for services for the poor.

Some countries give higher pay or greater incentives to physicians in the poorest areas. In Egypt, best practice in Qena Governorate indi-

cates that when salaries are sufficiently raised under a proviso that private practice is forbidden, physicians are willing to give all of their time to the public facility. Other countries sometimes add a component of client satisfaction or good performance to the incentive systems.

The MOHP in Egypt health sector reform initiative seeks to collect financial contributions from beneficiaries of the services for the family 'file' and co-payments for medications and some services. Incentives need not be financial only. Other measures include better physical conditions in the shape of clean and well-tended clinics that are properly equipped with basic medical tools and medicaments, free housing, attractive promotion criteria, or limited period contracts. Opportunities for training, research and other avenues for career advancement could also be considered.

Trained community workers for primary health care services at the district or village level are often an alternative to the use of physicians. In Iran, basic health care is provided by a male and a female health worker with two years basic training followed by extensive on-the-job training. These operate through health units, each serving 1500 rural inhabitants, and have helped Iran overcome the problem of medical professionals unwilling to be posted in rural areas. Their direct contact with beneficiaries has helped early identification of medical problems needing referral to higher levels, and has played a major role in reducing Iran's fertility rate.

Egypt suffers a severe shortage in the number of nurses in hospitals and public clinics. There are about 276 nurse for every 100 thousand population, which is a relatively low ratio compared to international levels, which are 425 nurses per 100 thousand population. Shortage is more severe in the governorates of Upper Egypt. The Education for Egypt Foundation has now launched a US\$6 million initiative to educate university graduates to become qualified nurses. It remains that local nursing schools — often for reasons of culture — are not working at top capacity.

A project by a Cairo-based NGO to enhance the standard of nursing in Aswan has succeeded in combating taboos surrounding the nursing profession and changing the predominantly negative image of nursing. By and large, nursing is a female profession, and reluctance to allow girls

to become nurses is due to traditional values against women working in close proximity to men (doctors and patients), in locations at a distance from their homes. Activities to address these issues included intensive work with local NGOs and associations to raise community awareness and respond to concerns; encouraging more pro-active recruitment measures by the boards of nursing schools, and a wide-ranging media campaign to publicize the importance of nursing, stressing the positive aspects of the profession to the public. As a result, enrollment at nursing schools rose from 170 to 535 after the first year.

## 6. Accountability Mechanisms

- One proven technique to raise quality of services is by enhancing community participation. Paying the providers based on defined performance indicators empowers the clients, even if payments are minimal.
- Service upgrade would benefit from the creation of a 'Citizen's Health Charter' that is prominently exposed at all health facilities, and which clearly spell out the level and quality of services the users can expect, as well as redress mechanisms for poor service.
- Create and spell out the redress mechanisms if services do not meet certain quality standards.
- Provide salaries and incentives at all levels of medical practice to match market levels to prevent health care staff from moonlighting or taking on second jobs.
- New regulations with penalties under the supervision of the localities introduced to control absenteeism, and fight petty corruption.

## II. Decentralization of Public Health Provision

In order to understand the complexity of achieving health gains and also advocate decentralization of the health sector, it is useful to refer back to the World Health Organization definition of health. This is defined as "... a state of physical, mental and social well-being and no merely the absence of disease or infirmity". Health thus becomes by definition, a product of complex socioeconomic factors that are specific to a community. It follows that improved health outcomes will be better achieved if priorities, implementation of policies and methods of financing the system, paying providers or selecting suit-



able pharmaceuticals are done at local levels where particular needs and priorities are clearer. Decentralization will obviously also facilitate better identification and targeting of specific groups within the population, such as women, children or the economically disadvantaged.

The health system in Egypt includes more than 29 different public entities that involved in direct health related services. The MOHP, the Health Insurance Organization (HIO), the Teaching Hospitals Organization, the Curative Care Organization (CCO), and a number of other Ministries are all involved in direct delivery of health care services. The private sector, which is relatively well developed, tends to be concentrated in the capital city and in large urban centers. It provides private not-for-profit services as well as private-for-profit services.

The health sector is undergoing a major initiative for reform in which decentralization would be adopted as the basis for new mechanisms of financing and administering in Egypt. The Health Sector Reform Program (HRSP) was initiated in 1997. The focus for reform was to make the governorates and districts as the units for change and build capacities at the central level.

Several Aspects of HRSP can be highlighted:

- local technical support teams were established from local governorates staff;
- Several aspects of the planning process were moved to governorate level;
- financing mechanisms were developed at governorate level to separate the financing from the provision of health services;
- Capacities were addressed at governorate level and training – including health policy training was provided for local MOHP personnel.

To be fully implemented, the move to a decentralized system needs not only the delegation of authority to the health directorate at the governorate level but the full involvement of the governor, other officials in the governorate and that of Popular and local Executive Councils. Beneficiaries, media and other stakeholders such as community leaders must be pulled into the change process at the governorate level.

A change to a decentralized system also extends beyond service provision. It should include a strong training and needs assessment compo-

nent, the power to influence legal frameworks, particularly for funding, recruitment and deployment, involvement in priority setting and identifying the contents of the basic benefits package of services, and the capacity to mobilize and keep funds.

Decentralization should improve access to quality care and increase competitiveness between the public and private sectors, which is a new notion for the Egyptian health system. Accreditation for units or clinics will raise standards.

In the absence of local incentive systems – whether financial or otherwise – many governorates find it difficult to retain new graduates or trained health care providers. Studies have shown that 89 percent of all private physicians have at least two jobs. Governorates should give preference in recruitment to their own graduates who would otherwise move to other governorates and cluster in capital cities.

Decentralization should allow for changes in the criteria of selection, job descriptions and reporting systems of the directorship of the health directorate. The director is appointed by the Minister of Health so that his/her affiliation is more to the central rather than to governorate level. Recruiting health directors should be through a competitive process and priority given to those who understand local conditions. This will also help to reduce turnover of physicians who will be given an added opportunity for career development if they remain in their own governorates.

Health allocations to governorates are inadequate and usually come from the Ministry of Finance with earmarked expenditures. The governor and the directorate of health in the governorate need more authority in spending their funds and more flexibility in selecting their priorities. Financing health care and defining provider payment mechanisms can be left to the governorates to be able to identify the most suitable mechanisms for the local conditions.

Targeting specific areas and activities can improve the health status of a community. The lessons learned from the Healthy Mother, Healthy Child (HMHC) project that targeted Upper Egypt indicates that capacity of local providers can be significantly improved with con-

tinuous training and monitoring. Upper Egypt governorates have achieved a remarkable reduction in maternal mortality in spite of the fact that this region is usually the slowest to improve its HD indicators.

Given the fact the MOHP has an extensive network of PHC services and that ultimately 80% of health care needs are covered at this level, it is important that MOHP prioritizes the allocation of its human and financial resources to PHC. Currently around 25 percent of nurses and less than 25 percent of MOHP budget are allocated to PHC. On the other hand, secondary and tertiary care receive more attention, particularly investment allocations, and although MOHP services are the most utilized (50% of all admissions), their occupancy rate does not exceed 40%, which calls for a more rationalized expansion of those levels of service.

**A division of roles:** Decentralization is not dissociation. National health policies must be made at the central level and the governorates should be able to adapt their policies accordingly without compromising national goals. Regulatory functions must be left to the MOHP to ensure standardized services. Functions that are most cost effective at the central level should remain centralized. Pharmaceuticals and medical supplies are an example of the importance of the central role to ensure sufficient supplies and appropriate pricing.

**The culture of change:** Often, those at the central levels resist change because of a vested interest in maintaining the status-quo with its administrative and financial power. Personnel are also afraid to lose some of the financial and other incentives they earn through participation in training and supervisory activities in the governorates.

Some policy recommendations include the following:

- Accelerate the process of introducing health sector reform models that adopt the Family health approach after evaluating experiences and drawing on lessons learned.
- Improve communication channels between the central and governorate levels with a higher representation of governorates in the decision-making process
- Provide options for financing the health sector at the governorate level and allow inno-

vative approaches that will encourage local resource mobilization and utilization

- Involve governorates and districts in monitoring progress towards achieving the MDGs
- Allow flexibility in provider payment mechanisms, recruitment and deployment of personnel to suit the needs of each governorate and create incentive systems that would encourage providers to practice in their home governorate
- Improve the methods of data collection and interpretation and train governorate personnel on their use and implications
- Improve planning capacities and the use of information systems to manage and distribute financial, human and infrastructural resources based on actual needs
- Strengthen the inter-sectoral approach to health at the governorate and district levels.
- Encourage the establishment of local health councils to improve the role of stakeholders and build their capacities to set priorities
- Promote health systems and epidemiologic research at both the central and governorate levels.

### III. Health Insurance Reform

Egypt's health insurance system is meant to provide financial protection through risk pooling and protection from catastrophic illness that can push people into poverty, but it does not cover the whole population and leaves out the most vulnerable.

The Health Insurance Organization (HIO), the main body responsible for health insurance, is constrained by insufficient revenues to provide adequate services to its targeted members, and these deficiencies in service provision push the insured to pay out-of-pocket for private services (EHDR 2004, National Household Survey 2002, and Governorate of Suez Survey 2004). The annual health insurance budget deficit is estimated at LE 200 million. Budget deficits are likely to increase with Egypt's changing demographic profile and the expected increase in the elderly population.

#### 1. Best Practices in Health Insurance

The HIO acts both as a financier and provider of services. This dual responsibility increases managerial costs and does not allow for proper monitoring, with consequent administrative loopholes and petty corruption as a result of poor supervi-



sion. International experience indicates that effective insurance policies rely on a separation between funding, and service delivery. A central fund maintains a balance between revenues and expenditures, pays out directly to the various bodies responsible for health care and manages the balance sheet in accordance with market considerations. Health administrations do not directly contract out for external services. This task is assigned to specialized bodies — frequently at the local level — who are also responsible for validating invoices and audits, and managing the database related to patients. Revenues for health insurance use public-private partnerships for funding and service delivery. Citizens are expected to contribute to costs (annual subscriptions or tax contributions) against receiving the service. All or some medication is sometimes subsidized for target social groups.

## 2. Health Insurance for the Poor

Current political thinking proposes to cover the whole population with a social health insurance system, under a unified law aiming at achieving equity in access to and financing of health care through the elimination of existing disparities in health outcomes and the provision of quality services to the whole population, especially disadvantaged groups. State supported treatment, the provision of employment opportunities to all medical graduates, and a culture of dependence on the MOHP are just a few of the obstacles that need to be faced. This ambition will need a number of reform measures.

At the national level, a phased strategy would require a revision of the legal framework and administrative structures as well as decentralization measures to transfer responsibilities away from the center and to localities. An integrated system would also assume that the Ministry of Health and Population aims beyond targeting morbidities to forestalling the conditions that produce these morbidities. One proposed measure is to integrate health data and needs with other non-health sector programs.

The decision of who pays for health services and how is a political one and will determine if the poor will or will not be exempted from financial contributions and whether provided with all or some services free or at a low cost by other means, or if a minimum universal package should be developed for all. Innovative welfare delivery approaches such as that applied by Iran

have targeted the poor and markedly reduced the rich-poor gaps while improving the overall national health outcome.

## 3. Targeting Insurance

Targeting is a process of directing public resources towards a specific group of people to achieve a policy objective. Programs which target the poor but are delivered to the population at large have very often failed to reach their target population. The Egyptian health insurance scheme is a good example where GOE subsidies in the health sector tend to support the richer segments of the population more than the poorest, since methods of organization and access to collect individual or group contributions or to disburse benefits are tasks made easier by use of formal channels. Targeting the poor therefore needs to have specific organizational methods as well as consciously earmarked resources to effectively reach vulnerable populations. Some leakage is always expected and should not be a deterrent.

Precise targeting can promote cost-effectiveness and would allow the government to reduce poverty more effectively at a lower cost. Universal coverage, on the other hand, may be too costly to implement. The GOE must weigh the implied equity in adopting universal coverage in comparison to the benefits expected from targeting the poorest, such as in Upper Egypt, and the effect each level of intervention would have both on resources and outcomes.

## 4. Financing Health Insurance

The main challenge for a successful health insurance system is its financial viability and sustainability. To ensure risk pooling and the continuous flow of funds to cover the needs of the poor, the system must secure funding sources either through progressive taxation or alternatively through contributions from the entire population both rich and poor. It also should not allow for any group to opt out of the system — although scaling by income would be necessary. The current system does not provide room for progressive premiums based on household income. In the HIO, students regardless of their social background or residence, pay equal amounts and Law 32 puts an upper ceiling to the person's contribution.

Contribution should be mandatory, regardless of



willingness to use the services. Those who wish to turn to other services must look at their contribution through the lens of social support to the less advantaged. Some countries that have successfully implemented this model provide more than one package of social health insurance, a basic package that would address the main health problems offered at a minimal cost or exempting the very poor and additional packages with more services and benefits at higher prices for those able to pay more.

Sustaining a successful program could also include a free choice of provider and incentive payments for those providers who give quality services — measured for example, by number of patients. The system must also have a mechanism for monitoring provider performance and allow the discontinuation of the services of the non-performers. The above parameters would be essential to achieve financial sustainability of the system and equity in access to quality care. Using the family health model currently piloted by the MOHP could be an entry point to gradually reach the whole population as originally planned. For the poor, the state could provide targeted transfers that help them buy insurance coverage.

### 5. Are Solutions on the Way?

In a speech given to the National Democratic Party (July 2005) in Upper Egypt President Mubarak suggested that a better health service would need to incorporate all of the elements of Egypt's health provision and their components into one system within the ambitious period of five years. The focus would be to upgrade and streamline the health insurance component which covers the present Health Insurance Organization (HIO); extend the Family Healthcare Fund to all of Egypt's governorates; and create a new insurance scheme for citizens not covered by the current scheme. Further, primary healthcare units would be increased, and the services of state-owned hospitals improved.

The President has asked for more private sector participation and investments so that combined state and private efforts would meet the treatment and medication needs of all citizens, particularly the poor and the needy. This interconnected approach, promoted at the highest level of political commitment, will require additional time and effort to

link the work of more than one ministry so as to increase synergies, enhance efficiencies, reduce duplication and waste, and will go a long way towards eliminating disparities in healthcare provision.